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Health and Wellbeing Board

Agenda

Date:	**Tuesday, 18th November, 2014**
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**

2. **Declarations of Interest**

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

3. **Minutes of the Meeting Held on 23 September 2014** (Pages 1 - 6)

   To approve the minutes as a correct record.

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

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. **Consultation With Greater Manchester**

To receive a presentation.

6. **NHS England Accountability Report** (Pages 7 - 16)

To receive the report.

7. **Cheshire East Safeguarding Children Board Annual Report 2013-14** (Pages 17 - 102)

To receive the report.

8. **Director of Public Health Annual Report** (Pages 103 - 250)

To receive the report.

9. **Children and Young People Plan** (Pages 251 - 316)

To ratify the Children and Young People's Plan 2014 – 18.

10. **Mental Health Street Triage Scheme**

To receive a presentation.

11. **Mental Health Crisis Concordat** (Pages 317 - 326)

To approve the recommendations as set out in paragraph 2 of the report.

12. **Better Care Fund Update** (Pages 327 - 342)

To receive an update on the progress of the Cheshire East Better Care Fund plan, advising on the next stages of delivery towards the implementation date of 1st April 2015.

 Agenda Item 3

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Wellbeing Board**
held on Tuesday, 23rd September, 2014 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor J Clowes (Chairman)
Mike O'Regan, Healthwatch (Vice-Chairman)

Councillor Rachel Bailey, Cheshire East Council
Jerry Hawker, Eastern Cheshire Clinical Commissioning Group
Simon Whitehouse, South Cheshire Clinical Commissioning Group
Dr Andrew Wilson, South Cheshire Clinical Commissioning Group
Tony Crane, Director of Children's Services, CE Council
Brenda Smith, Director of Adult Social Care and Independent Living, CE Council
Dr Heather Grimbaldeston, Director of Public Health, CE Council

Associate Non Voting Member
Tina Long, Director of Nursing and Quality, Cheshire Warrington and Wirral Area Team.

Officers/others in attendance
Susanne Antrobus, Legal Services, CE Council
Guy Kilminster, Corporate Manager Health Improvement, CE Council
Julie North, Democratic services, CE Council
Louise Daniels - CVS
Jean Cunningham – CVS

Observer
Cllr S Gardiner

Councillor in attendance
Cllr B Murphy, Cllr K Edwards.

29 **APOLOGIES FOR ABSENCE**

Cllr A Harewood, Mike Suarez, Lorraine Butcher, Dr Paul Bowen.

30 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

31 **MINUTES OF THE PREVIOUS MEETING**

RESOLVED

That the minutes of the meeting held on 29 July 2014 be approved as a correct record.

32 **PUBLIC SPEAKING TIME/OPEN SESSION**

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

33 **JOINT STRATEGIC NEEDS ASSESSMENT CONSULTATION WITH THE THIRD SECTOR**

Louise Daniels and Jean Cunningham from the CVS attended the meeting and gave a presentation in respect of the Joint Strategic Needs Assessment Consultation with the Third Sector project.

It was reported that the mission was to ensure there was a long-term mechanism for enabling the Voluntary, Community and Faith Sector (VCFS) to feed meaningful intelligence into the Cheshire East JSNA. Consideration had been given to the ten Health and Wellbeing Board priorities and information had been provided by voluntary and third sector groups, comments from stakeholders and through training and events. More than fifty commissioners had attended project workshops and over 230 VCFS organisations had attend workshops. Understanding had now almost doubled amongst the VCFS organisations and the likelihood for groups to contribute had more than trebled. The commissioners would now take back the lessons from the VCFS and feed into the Council plans.

In order to try and simplify and sell the product, a JSNA “shopping bag” had been developed, containing various information including evidential information, patient experience, needs analysis surveys, research reports and consultations. The bag was handed to service leads and commissioners to use and back up their decision making. There had also been presentations to a number of bodies and various publications had been produced, including the NHS Confederation- learning for H&WB Boards, a Case study for Department of Health and “Regional Voices”.

As well as linking to the Health and Wellbeing priority areas, there were links with national and regional reports and findings and local research. It was reported that the research began with the premise “There was a likelihood of reduced life expectancy in Deaf people.” Evidence suggested that barriers existed for D/deaf people, who needed to make appointments; supportive technology was not used in many waiting rooms; there was a lack of awareness, particularly of the needs of deaf people, among frontline staff; and relatives/individuals were being asked to interpret, rather than using qualified interpreters.

There had been a number of focus groups, where research had been carried out and thematic reports, including key findings and recommendations had been produced. These related to the areas of

Rural, Older People, Gypsy and Traveller Community, Homeless, Victims of Violence, LGBT,D/deaf and Mental Health.

The next areas to be considered were how sight loss impacted on accessing health services, the transport needs of people without personal means of transport when accessing health services and geographical focus groups to elicit VCFS feedback on the new JSNA pages. Details of proposed future JSNA projects for 2015-16 were also provided.

Following the presentation, members of the Board raised a number of questions and comments. The Chairman stated that the Council had strong links with the travelling community and may be able to help in this regard. It was also noted that there were links with this work and the empowering person work and it would be necessary to consider how the Board could help to build on this for future years.

34 **STRATEGY FOR CONNECTING CARE IN CENTRAL CHESHIRE 2014 - 19**

Consideration was given to the five year Strategy for Connecting Care in Central Cheshire. Dr Andrew Wilson presented the strategy and outlined the main points.

In considering the Strategy, members of the Board welcomed the focus on the patient and recognised that the CCG had specific issues in terms of cross local authority boundaries. An easy read version of the document was also requested.

RESOLVED

That the Strategy for Connecting Care in Central Cheshire 2014 -19 be received.

35 **UPDATE ON CARING TOGETHER, HEALTHIER TOGETHER AND THE SOUTH SECTOR WORK**

Jerry Hawker reported that the Eastern Cheshire CCG five year plan had been submitted to the Board previously and was publically available. It had been produced in a format which was suitable for submission to NHS England. An attempt had been made to rework the document and the connections between the various programmes and support work in East Cheshire had been updated. A Healthier Together consultation listening event was due to take place later in the afternoon, in Wilmslow, as part of the work to improve health standards, by the joining up of local authority and health services in greater Manchester. The population of East Cheshire used South Manchester and Stockport for routine care and it was, therefore, important for the CCG to be involved and to listen to the presentations.

He also provided an update in relation to the south sector work, which was a very restricted piece of work, commissioned by NHS England, with the Trust Development Authority to look at changes in the four South sector hospitals. The South sector work had now been completed, but the conclusions would not be put in the public domain for some time. It had been concluded that the south sector work would significantly affect the Caring Together Programme and a refresh of the Programme was planned, which would then be brought back to the Board for consideration. It was noted that all partners had now signed up to the programme and that there were many similarities with the Connecting Care Programme in respect of how individuals received care. The process of producing new documents for the next 5 years was now underway and would be available by October.

Members of the Board commented that there was a theme running through both programmes and that the two plans complimented one another. I It would also be important to align the standards across both wherever possible.

Concern was expressed regarding the lack of consultation in relation to the tender for specialised cancer services in Manchester, which would affect patients in Cheshire and it was considered that this needed to be carefully scrutinised. The Chairman reported the issue of non consultation had been raised at the Council's Health and Adult Care Overview and Scrutiny Committee. The Scrutiny Officer responsible for the Committee, who was in attendance at the meeting, reported that the Cheshire and Merseyside Authorities had joined together to write a protocol in respect of this matter. The Association of Greater Manchester Authorities had a joint Scrutiny Panel, which consulted on health issues across the greater Manchester area and the Chairman of the Scrutiny Committee was invited to observe at the meetings of the Panel, but not vote.

It was noted that the Healthier Together Programme had a mandatory requirement to consult practices affected in their area and that the greater Manchester authorities had to carry out a consultation and be held to account. It was considered that the issues relating to cancer procurement and scrutiny needed to be raised with NHS England and it needed to be ensured that Cheshire was not excluded from any future consultations relating to other health services which were geographically situated outside the area, in view of the significant impact that they may have on the population of the Cheshire East area.

RESOLVED

1. That a letter be prepared for submission to NHS England requesting clarification on the process relating to the major health provider challenge.

2. That consideration be given to how other Health and Wellbeing Boards are working together in respect of the above issue.

36 **BETTER CARE FUND UPDATE**

An update was provided in respect of the Better Care Fund. The Plan had been submitted in the previous week and its receipt had been acknowledge. A technical review had been booked and a tele-conference was scheduled to take place in the following week and a decision would need to be made as to who should be involved in this. It was proposed to spend one day assessing each plan and to start printing in the following week. The work would now need to begin to implement the Plan.

Thanks were expressed to those involved for the hard work that they had put in, in order to meet the submission deadline.

37 **HEALTH AND WELLBEING PEER CHALLENGE**

In June 2013 the Board had expressed an interest to the Local Government
Association in a Health and Wellbeing Peer Challenge, being undertaken in 2014. Peer Challenges were designed to support Health and Wellbeing Boards in implementing their health statutory responsibilities.

This was done through a systematic challenge by system wide peers, in order to improve local practice. Four to six peers from local government, health, or the voluntary sector would spend four days on-site. The process involved a wide range of people, working with the Council in both statutory and partnership roles and the findings would be delivered immediately. The Peer Challenge was to take place from the 18th to the 22nd of November 2014. Guidance on the Challenge was submitted to the Board for information.

The Board was requested to note the forthcoming Peer Challenge and the published Methodology and Guidance and to consider the establishment of a Task and Finish Group to manage the Peer Challenge.

RESOLVED

That the forthcoming Peer Challenge and the published Methodology and Guidance be noted.

That a task and finish group be established to manage the Peer Challenge, to consist of Matthew Cunningham, Jo Vitta, Guy Kilminster, a Healthwatch rep, a Childrens rep and a Adults rep.

The meeting commenced at 2.00 am and concluded at 3.30 am

Councillor J Clowes (Chairman)

NHS England

NHS ENGLAND

ACCOUNTABILITY REPORT TO CHESHIRE EAST HEALTH & WELL BEING BOARD

NOVEMBER 2014

1 CONTEXT

NHS England is the national body, tasked by Government, to improve health and care, underpinned by the NHS Outcomes framework and the NHS Constitution. The mandate given to NHS England sets out objectives and deliverables for the next two years. NHS England has established agreements for successful working alongside Public Health England, and Monitor. A concordat with the LGA recognises Health and Wellbeing Boards as system leaders comprising of membership drawn from Local Government, CCG's and NHS England.

NHS England is structured by Region and Area. Each Area Team is responsible for three main activities- system development, assurance and commissioning.

NHS England undertakes some commissioning on behalf of the NHS directly, rather than through local government or CCG's. This commissioning is in five areas: Offender, Military, Public Health, Primary Care and Specialised Services.

These areas were retained by NHS England due to the scale and geography of commissioning, the expertise required and to drive England wide service standards in these areas, so they are not impacted by local variation.

2. THIS REPORT

NHS England provides a quarterly Accountability report to each Health and Wellbeing Board. This report outlines national and regional context together with specific update on priorities that the Area Team is responsible for delivering and how these priorities are progressing.

This report gives an update on Co-Commissioning, progress on the Two Year Operational Plans and introduction of the Commissioning Intentions & Planning Guidance for 2015/16.

3 CO-COMMISSIONING

In the last report we gave an update on Co-Commissioning is the term that we use to describe when two or more commissioners come together to commission healthcare services. In this context it means NHS England working together with clinical commissioning groups (CCGs) to commission some services.

The updates provide below outline how Co-Commissioning is being taken forward for Primary Care and Specialised Commissioning. (*Please note:* Public Health Services are already commissioned jointly under a Section 7a arrangements)

Primary Care

We have now started the conversation with our CCGs about the development Co-Commissioning and agreement of the governance arrangements. The CCGs and Area Team met on 17th October and agreed that a small group would meet to consider the opportunities and implications of co-commissioning. This was to be presented from an impact on patients outcomes basis, both in terms of "how it could work operationally" at different units of planning (CCG, LA, AT, etc.) and the different co-commissioning levels.

The Primary Care Operational group would be resurrected, re-energised and refocused as a platform to support the delivery of the primary care strategies including co-commissioning (in whatever form it progressed) and to act as a means to share primary care priorities, best practice and learning across the footprint. The Monthly CCG Meeting

would act as a steering group for Co-Commissioning and the frequency of meetings would need to be reviewed. This would be an agenda item at their next meeting on 5th November.

Specialised Commissioning

The portfolio of specialised services is being reviewed to identify those services that will be devolved to CCGs, those that will remain with NHS England and those that will be co-commissioned. The timeline for these changes has not been confirmed but it is likely that some services will be devolved to CCGs in 2015/16. A range of issues have been identified that require national and local input to address.

Preliminary work using neurology (likely to be devolved to CCGs) and cardiac surgery (likely to be co-commissioned) as pilot topics has begun in the North West. The first stage is to identify the activity and finance associated with these services by CCG. The next steps will include raising awareness amongst CCGs and starting to develop a governance structure, informed by the national Task & Finish Group.

4. PROGRESS ON NHS ENGLAND TWO YEAR OPERATIONAL PLANS

This 2 year operational plan represents the first 2 years of a 5 year strategic plan for Cheshire, Warrington and Wirral. CWW AT is committed to driving improvements to secure equity of access and a reduction in variation in the services all patients across Cheshire, Warrington and Wirral and the North West (for specialised services) receive.

An update is provided below for each area of direct commissioning:

Primary Care

The Primary Care team is responsible for commissioning services from the following independent contractor providers and work with both internal and external colleagues to deliver the challenging agenda.

GP Contracts	Optometry Contracts	Pharmacies	Dental Contracts
171	163	327	199

The Primary Care team have achieved 6.5 out of 9 milestones on the 2014/15 workplan for quarter 2 which represents an achievement of 72% for the second quarter. This follows an achievement of 18 out of 20 milestones that have been completed for quarter 1

The following represent high level summary of actions taken by the Primary Care Team across CWW with regard to contractor concerns, issues or outliers identified by the dashboards and other internal mechanisms.

- There are 2 GP Practices and 3 Dental Practices that have CQC action plans.
- There are a further 4 GP Practices,3 Dental Practices, 4 Pharmacy's and 1 Optometric Practice under review / being monitored by the Primary Care team.

Medical:

This quarter we have initiated the following reviews/procurements for some of our GP services:

- Chapelford Procurement of GP Medical Services in Warrington
- Westminster Procurement of GP Medical Services in West Cheshire
- Leasowe Procurement of GP Medical Services in Wirral
- Appleton Procurement of GP Medical Services in Warrington
- Culcheth Procurement of GP Medical Services in Warrington

The timetable for the procurements will see the new providers in place from 1st July 2015 (with current agreements being extended for 3 months from April-June 2015 whilst the procurement process is undertaken).

- Wirral All Day Health Centre – the current APMS Contract is under review and discussions are in place with Wirral CCG
- St Werburgh's APMS Agreement has been extended for a further 2 years whilst a full service review and needs assessment is undertaken with NHSE and West Cheshire CCG

Further updates will be provided in future reports.

Pharmacy:

The LPN work streams have given professional support to Public Health and CCGs to transition and develop existing community pharmacy enhanced services where there is deemed to be a need to amend or develop the service. Examples of work stream support include:

- Eastern, Vale Royal, & South Cheshire

Think Pharmacy Community Pharmacy Minor Ailments Service was re-launched on 1st August 2014 with additional conditions. The service aims to divert patients with specified minor ailments from general practice and other Urgent care settings (e.g. out of hours, urgent care centre, Accident & Emergency department) into community pharmacy where the patient can be seen and treated in a single episode of care.

This service is commissioned by Eastern, Vale Royal and South Cheshire CCGs from community pharmacies across their area; staff promoting the service have attended the Engagement Events including the Nantwich Show, AGM, Fresher's Fair Winsford and Northwich, Northwich: Independent Living Day and Self Care Week 17th – 23rd Nov.

Think Pharmacy Community Emergency Supply Service has been commissioned by NHS Eastern Cheshire CCG and is being introduced by Vale Royal and South Cheshire CCG. The purpose of this Service is to ensure that patients can access an urgent supply of their regular prescription medicines where they are unable to obtain a prescription before they need to take their next dose. The service may be needed because the patient has run out of a medicine, or because they have lost or damaged their medicines, or because they have left home without them. The aim of this service is to relieve pressure on urgent and emergency care services and general practitioner appointments at times of high demand

- West Cheshire

West Cheshire CCG are about to re-launch Pharmacy First on 17th November with additional conditions added. The service aims to divert patients with specified minor ailments from general practice and other Urgent care settings (e.g. out of hours, urgent care centre, Accident & Emergency department) into community pharmacy where the patient can be seen and treated in a single episode of care

Self Care Week 2014 takes place from November 17th to 23rd. It aims to help people take care of themselves, and lets them know what's available to help them look after their health. This year's theme is "Self care for life – be healthy this winter" and aims to raise awareness of how many common winter ailments don't require antibiotics, and that visiting a pharmacy for advice and treatment is often your best bet. Community Pharmacy will be represented at the Tarporley Self Care Event on Tuesday 18th, November.

- Wirral

Wirral pharmacies are supporting CWP with Alcohol Awareness Week 2014 from 14th November 2014. This campaign supports and moves forward the Wirral Alcohol Harm Reduction Strategy aspiration of constantly improving the effectiveness and impact of the alcohol screening and brief advice programme.

There are 112 practices now live across Cheshire, Wirral and Warrington on the Electronic Prescription Service (EPS). The rollout in Wirral is now almost complete with 75% of practices on EPS and of those complete 90% are over the 40% utilisation threshold. This is the point that most practices start to really feel the benefits. A few practices are now even at the 90+% mark. This is now the top EPS utilisation location in the country.

133 pharmacy sites are offering the Pharmacy Seasonal Influenza Immunisation Programme which aims to give improved access to the influenza vaccine across Cheshire, Warrington & Wirral for eligible patients during the

2014/15 influenza season i.e. 1st October 2014 to 31st March 2015 in order to maximise uptake within the high risk groups.

NHS England's 'Feeling under the weather?' winter marketing campaign is now running until early December 2014. The campaign builds upon last winter's 'The earlier, the better' campaign, and is designed to encourage people – particularly those aged over 60 and their carers – to pop in to their local pharmacist to get early advice when they start to spot signs of common winter ailments. The aim is that by getting advice from their pharmacist early on, they can often prevent coughs and other respiratory problems getting worse and turning into serious issues.
The 'Feeling under the weather?' campaign messages are focussing on two key motivational barriers that emerged from last year's research. The messages therefore emphasise the fact that for older people minor illnesses can develop into something worse; and also reassure them that it's OK to seek advice from a local pharmacist.

All pharmacies have been contacted to ensure they have plans in place for business continuity and suggested they review their plans in readiness for the Winter Season. The Area Team have offered to act as a repository.

Dental

- CDS Review update

NHS England CWW & Merseyside Area Teams are procuring up to 20 new salaried dental services contracts. Once complete, this procurement exercise will lead to the delivery of focused, well defined salaried dental services that are able to meet the needs of our local community in Cheshire and Merseyside and offer good value for money.

The EU procurement process is lengthy and complicated, this particular re-procurement exercise, the largest ever undertaken within the salaried dental services in England, will take 18 months to complete and will 'go live' on 1.4.15. A small experienced NHSE team is coordinating the effort and we can report that the process is running smoothly and is also running on time.

Currently we are in the bid evaluation phase. Some 45 experts from around the country are formally assessing all the bids with the support of the North of England Commissioning Support (NECs). This phase of the process is sensitive and there is little we would currently wish to say about these developments. We are however, confident that by the end of November/early December we will be in a position to make recommendations to the Area Team directors in regard contract award.
Once directors have made their formal decisions on the recommendations of the evaluation team, we will move into the mobilisation phase which will ensure that there is a seamless transfer of services in line with the newly negotiated contracts on 1.4.15. The dental commissioners will, of course, carefully monitor the new services to ensure that the new arrangements operate as expected.

- Oral surgery development: Update

NHS England CWW has now reviewed the demand for oral surgery services across Cheshire, Wirral and Warrington. This exercise has demonstrated that a significant proportion of oral surgery cases are straightforward (for example removal of wisdom teeth), and could be undertaken in a primary care setting by a specialist oral surgeon. Other areas have successfully made this transition of service from secondary to primary care and as a consequence, have improved access to high quality services and reduced waiting times for patients.

Initial meetings with clinicians have taken place to initiate work on developing a system for managing referrals from local dentists to the most appropriate and convenient local oral surgery service. Running alongside this piece of work, the process for re-commissioning of oral surgery services in the primary care setting has now commenced. Following a recent engagement meeting with potential providers, the service specification for services across Cheshire Warrington and Wirral will be finalised by the end of November 14 with a view to the procurement process commencing in December / January 15. Newly commissioned services will be in place for 1/7/2015.

Public Health

Childhood Immunisation Programme 0 – 5 years

Coverage of immunisations for children aged 0 to 5 continues to be at high levels with improvements in a number of areas, for example all local authority areas are now above the national target of 95% for the first dose of the MMR vaccination. There continues to be low uptake for the pre-school booster and the second dose of MMR, although there has been improvement in most areas.

Seasonal Flu Campaign

The Area Team are focusing on improving uptake by at least 10%of the flu vaccine for people aged under 65yrs who are in clinical at risk groups including pregnant women. This group now has the option to use community pharmacies for their vaccination and pregnant women are being offered the vaccination by maternity services.

The team is also aiming for at least 75% uptake in people aged 65 and over and is working closely with partners in Warrington, since that was the only local authority area in CWW not to achieve this level last year.

Bowel Cancer Screening

A new test kit for bowel screening (FIT) is being piloted and has resulted in more patients requiring colonoscopy. This has slightly increased waiting times but they are being managed within clinically appropriate timescales. The pilot is due to end soon and will be subject to evaluation, which is expected next year.

Bowel scope screening for people aged 55 has started in Cheshire and will start next year for Wirral and Warrington. Roll-out of the programme is on a phased basis, according to GP practice.

Breast Screening

The Breast Screening Programmes serving Warrington and Chester had experienced some delays in inviting women. The Warrington programme is now back to acceptable performance levels, whilst the Chester programme is making good progress and should be compliant with standards in the near future.

Discussions are in progress for the implementation of the Breast Screening Services Review with a formal offer being issued by NHS England to the Chester and Wirral BSPs with Wirral University Hospitals Trust as lead provider for the merger programme with an intended implementation timeline for April 2015. An options appraisal for the implementation of the proposed merger for Crewe BSP is being presented on November 11th 2014 to determine the next stage.

Cervical Screening

There has been a slight reduction in coverage in all areas other than West Cheshire CCG. All areas except Wirral remain above North West and England coverage levels. The Screening & Immunisation Team have developed a practice-level scorecard to enable comparisons and are working with CCG Quality leads to identify actions for improvement.

Breaches of the 14-day turnaround target from test to result had occurred in one of the laboratories. This situation has been addressed and the position has returned to target levels.

Antenatal Screening

The team are concerned that the One-to-One Midwifery service cannot generate NHS numbers at birth, which is due to not having an N3 connection. This situation results in screening information not flowing to the correct systems and therefore in data being inaccurate.

New-born Screening

An extension to the New-born Blood Spot screening test is due to be implemented from January 2015. This will enable earlier identification of rare, serious genetic conditions, leading to improved outcomes for those babies.

Diabetic Eye Screening

Issues have previously been identified with collating a single complete list of all patients with diabetes who are eligible for Eye Screening. As a result, intensive work has been undertaken to cleanse the lists and ensure that all eligible patients have been referred into the programme.

Specialised Commissioning

All contracts are signed. Data has been submitted by all Trusts, broadly in line with our expectations. As at M4 the overall financial forecast is for a small over performance. This is mainly around drugs at Chester and Wirral, and is offset to an extent by an underspend by Warrington in the same areas.

The Trusts in CWW Area Team have minimal specialised commissioning with the exception of Clatterbridge Cancer Centre where there are no new issues. Mid Cheshire Hospital quality review action plan is underway and mortality has reduced to within expected rates.

There are a number of significant service issues that are currently being addressed by the Specialised Commissioning Team in partnership with key Cheshire, Warrington and Wirral colleagues. These include:

Major Trauma

Major trauma in Cheshire and Merseyside is provided through a MTCC comprising RLBUHT, Aintree and the Walton Centre. There has been a significant improvement in clinical outcomes since the establishment of the major trauma network.

Neurorehabilitation

The Cheshire and Merseyside Rehabilitation Network (CMRN) has been asked to consider the benefits and potential timescales associated with of becoming an ODN. The CMRN and CWWAT highlighted the shortfall of CCG-commissioned level 2 services for Cheshire patients together with potential solutions to Cheshire CCGs. Agreement was not reached on an interim or long term solution and is subject to further work at individual CCG level.

Specialised Cardiac

A review of specialised cardiac services across the North West is nearing completion. This has focussed on compliance issues and confirming the models of care and service configuration that should be in place to address issues of equity of access, capacity and demand management and compliance with the national service specifications.

Upper GI Cancer

Specialist upper GI cancer (oesophago-gastric) services are configured around two SMDTs, at Aintree and LHCH. National guidance and the service specification indicate that for the volume of surgical activity being undertaken, there should be a single team providing services for the population of Merseyside.

NHS Merseyside initiated a procurement process in 2012. With the transfer of commissioning responsibility to NHS England, a review of the process was undertaken which identified a number of technical flaws. The procurement was therefore stopped.

Providers have failed to reach a collaborative solution which would bring services on to a single acute site in line with external clinical advice. LHCH has subsequently proposed that specialist surgery currently undertaken on the LHCH site is transferred to Royal Liverpool in order to meet this recommendation.

Discussions are underway to ensure that the planned transfer meets quality and safety standards, including a reduction in the number of surgeons to meet compliance with national standards.

Strategic discussions are underway between CWW AT and CEOs which may resolve this issue and avoid the need for procurement. If a procurement is required to establish a single SMDT/surgical service for Merseyside, this will be initiated in March 2015 as a single 'lot' alongside the procurement of upper GI cancer in Greater Manchester.

Clatterbridge Cancer Centre Business Case

Discussions are progressing with Clatterbridge Cancer Centre services regarding the financing of the move to Liverpool, and the review of the Business Case- a specific review group has now been established with CCG and Area Team sponsorship to undertake the assurance process on this business case.

Offender Health

Prisons - There are 3 prisons in Cheshire, Styal women's prison in Cheshire East and Risley and Thorn Cross in Warrington. There are no prisons within the Cheshire West and Chester area.

Police – It is now expected that the transfer of commissioning responsibility for police custody healthcare will occur in 2016. Partnership work is ongoing with Cheshire Police around the management of the police custody healthcare contract with Tascor Medical Services. Regular quarterly meetings are held with Tascor, NHS England and police colleagues. Tascor continue to develop their services in police custody, making excellent links with community services to ensure onward referrals for individuals can be made.

L&D – The Divert programme continues to deliver services to young people in all areas of Cheshire apart from Cheshire East, although work is ongoing with Cheshire East YOS to develop such a service in this area. Warrington CJLT also continues to deliver services in the Warrington area. Work has commenced with Cheshire Police and Courts services to map out and work towards development of liaison and diversion services in accordance with the national specification.

Armed Forces

For the financial year 2014/15 five contracts have been put in place; South Tees Hospitals NHS Foundation Trust, York Teaching Hospital NHS Foundation Trust, Harrogate District Hospital NHS Foundation Trust, Hull and East Yorkshire Hospitals NHS Trust and North Lincolnshire and Goole NHS Foundation Trust. These were the Trusts where armed forces activity in 2013/14 exceeded £100k. All other activity this year (as with last) is picked up as NCA. As Armed Forces Commissioning is viewed as a national function the three area teams who lead on this have a risk sharing agreement in place to ensure that the national picture is balanced, even if this is not the case locally. As at M4 the overall financial forecast is for a balanced position nationally.

Commissioning Intentions have now been developed for 2015/16 and look to build on work that is already underway, e.g. priority areas will include encouragement of large scale use of choose and book across the Armed Forces to encourage choice, re-procurement of Veterans Mental Health outreach services (Murrison funding that ends in 2015), future funding for Veteran's Prosthetics, improved access to screening services, improved transition from Armed Forces to civilian life, especially for those who are medically discharged, review of continuing healthcare and personalised budgets, and review of MSK pathways.

NHS England Armed Forces Team are currently working closely with MOD colleagues to transfer Primary Care Out of Hours commissioning responsibility from MOD to NHS to enable services for the Armed Forces to be provided within local unscheduled care pathways. There are legal and financial issues to be worked through but as this project develops there will need to be engagement with all CCG's who have military bases in their patch to ensure they extend their existing provision to cover this population. Funding will transfer from MOD to support this.

As part of the NHS England re-structure it is being proposed that the Armed Forces structures be consolidated into one team, likely to be led by the South (given they have the largest Armed Forces population). The intention is that

there would still be a presence in each of the regions but full details are yet to be published but it is very likely that there will be a change to the current arrangements.

Commissioning Intentions 2015/16 & Planning Guidance

Primary Care

The following are the Cheshire Warrington and Wirral Primary Care Team Commissioning Intentions for 2015/16 which aligns with the Primary Care Strategies for the area. They are in draft at this stage.

1. Co-commission Primary Care Services in line with national guidance and CCGs level of interest.
2. Continue to support the Clinical Commissioning Groups and their health economies with the development and implementation of their Primary Care Strategies for integrated care including the delivery of co-commissioning.
3. Progress the delivery of equitable funding of Primary Medical Care by implementing the PMS review.
4. During 2015/16, commission all Directed Enhanced Services in line with NHS England guidance.
5. Review the outcomes of the Prime Ministers Challenge Fund to inform the outcomes of commissioning 7 day services.
6. By Q2, 2015/16 complete the work begun in 2014/15 to review, redesign and re-procure (where appropriate) the Warrington Local Pharmacy Services contract in line with the revised Pharmaceutical Needs Assessment for Warrington Borough Council.
7. Continue to decrease the number of referrals to secondary care oral and maxillofacial surgery providers by implementing the national dental care pathways which will move more minor oral surgery procedures into the community.
8. To commission secondary care dental services on the PBR tariff based on current activity levels, within financial allocations.
9. During Q3 and Q4 2014/15 and 2015/16, establish and commission robust patient centered CQUINs from all secondary care dental providers.
10. Review, redesign and re-commission (where appropriate) the following primary care services to meet the current and future needs of the population where contract end dates provides the opportunity:
    i. By Q2, 2015/16 complete the process for recommissioning Primary Care Oral Surgery Services across the Area Team whose end date for all current provider contracts is 30 June 2015. This developed service will have increased capacity and capability to manage and treat a greater volume of Level 2 activity.
    ii. Secure a Primary Medical Care service for the patients currently registered with the Wirral All Day Health Centre.
    iii. The following five provider who hold contracts Alternative Primary Medical Service contracts whose end date for is 30 June 2015.
        - Chapelford MC,
        - Westminster MC,
        - Leasowe MC,
        - Appleton MC and
        - Culcheth MC.
    iv. Primary Care Orthodontic services whose end date for all the current services is 31 March 2016.

Public Health

The Public Health Commissioning Team intentions are as follows:

1. Deliver the requirements of the national Section 7A Agreement, specifically:
    - Increase the pace of change for the implementation of national service specifications and review Provider compliance with performance standards. Performance ‘floors’ by programme may be set to address unacceptably low performance by Providers.
    - Expand children’s seasonal flu expansion to cover all 2, 3 and 4 year olds
    - Implement HPV testing for women with mild/borderline cervical smear results (already completed in CWW)
    - Extend the Bowel Screening programme for men and women up to age 75 (already achieved in CWW)
    - Roll out Bowel scope Screening for 60% delivery by March 2015
    - Implement potential pilots in Meningitis B vaccinations subject to national approval

- Implement Meningitis C vaccination catch up for university entrants
- Implement of DNA testing for sickle cell and thalassaemia screening

2. Benchmark services on quality, costs, outcomes and activity
3. Implement the results of the breast screening review
4. Achieve targets locally for expansion in health visiting and family nurse partnerships.
5. Safely transfer commissioning responsibility for Health Visiting and FNP to Local Authorities
6. Transform Health Visiting and FNP services to meet the specified service model and the objectives of local early years strategies
7. Undertake joint procurements with local authorities for all health visiting and FNP services
8. Develop a health inequalities strategy to improve overall coverage rates for screening and immunisation and reduce variation in coverage with a focus on vulnerable groups. Tools to support the strategy include the development of practice level performance benchmarking for targeted support to improve uptake and the implementation of the health inequalities CQUIN in Provider contracts.
9. Review the costs of Diabetic Eye Screening services and identify a 'Best Price' approach

Specialised Commissioning

The Commissioning Intentions of the Specialised Commissioning function of the Cheshire Warrington and Wirral Area Team can be broken down into three parts. Our regional (NW wide) intentions, highlight the key work programmes and our consistent approach to contracting for the 15/16 contract round. The intentions are as follows:

1. Commissioning Responsibilities and Prioritisation

As per 2014/15, Commissioners will be required to manage any national changes in guidance and commissioning responsibilities (specialised or highly specialised services) and work in partnership with providers to agree implementation plans. This will include the outcome of any review of the respective commissioning responsibilities, which may result in the devolution of some services to Clinical Commissioning Groups. For some services, this may mean co-commissioning arrangements with CCGs to ensure better alignment of decision making, to help restore pathway integrity, and to improve the transition between specialised and non-specialised care.

2. Local Priority Work Programmes

A number of work programmes have been identified locally as priorities. These are detailed in Appendix 1. They are ongoing and will be progressed through the second half of 14/15 and onwards into the 15/16 contracting year. Contracts will be negotiated taking into account the impact of these programmes where it is known and understood. Where the details are not yet understood then the contracts will be set in line with current provision, but commissioners will request contract variations in line with contractual process to implement the outcomes of the work programmes.

3. Organisational Delivery Networks and Streamlined Contracting

We will continue to work to develop and support ODN's. Funding will be as described in the national NHS England commissioning intentions. Where a provider delivers a service that has an ODN, or where an ODN is being developed, it will be a requirement that providers of those services engage and participate in the ODN. The list in Appendix 2 details the current established ODN's, and those in development.

4. Contract Planning for 15/16

The following paragraphs outline the intended basis for contract planning for 15/16.

- Contract Basis: We expect to be developing a single NHS England contract with each provider, covering all aspects of NHS England's direct commissioning. This is likely to be a standalone contract, rather than NHS England becoming an associate to CCG commissioned contracts.
- Activity basis: Activity plans for 15/16 will be set on M8 forecast for the full year at 2015/16 prices, and taking into account known part year impacts, growth and other negotiated service changes.
- Counting and coding: Where contracts contain block agreements, these must be evidenced by activity data as outlined above. Where a trust cannot substantiate the activity behind a block payment then we will look to review the payment, and remove elements that cannot be substantiated.
- Benchmarking Review: Throughout 2014-15 there has been an ongoing review of local prices across all major specialist areas both locally and nationally. As a result CWWAT will re-negotiate prices of Providers who are outliers as part of this process. We will move towards the most efficient provider pricing, and where the

movement required is significant then we will look to agree a transitional approach. Specific details of this review will be shared with Providers as part of the contract negotiations.

- NEL Thresholds and Readmissions: We expect to follow PbR guidance and apply the contract sanctions for the non-elective threshold and for readmissions. We will work with the trust to establish the baseline, and share with you NHS England's plans to reshape demand.
- CQUIN: We will again be utilising centrally developed CQUIN schemes. The CQUINs will be representative of the services that we commission from you. We expect to be able to share the CQUIN schemes with providers by the end of the year, and will be aiming to have agreed CQUIN schemes with providers by the end of January 2015 for the following contract year. Where baselines are required these will be agreed, with appropriate clinical input, as part of this process. For the national CQUIN that are part of all NHS Contracts we will work with CCG commissioners to ensure consistent targets for each of those schemes. Further details on CQUIN is covered in the National Commissioning Intentions.

5. QIPP

Through the remainder of 14/15 and into 15/16 NHS England will continue to pursue the QIPP agenda, looking to identify efficiencies and cost savings through improving quality and productivity. QIPP will run as a constant theme through our contract negotiations and planning process. This will be underpinned by three programmes, focussing on medicine optimisation, efficient contracting and service issues. There will be a number of projects within each programme, and details of these schemes will be shared with providers over the coming months.

6. Trust specific commissioning intentions

The Commissioning Intentions for Armed Forces & Offender Health are yet to be agreed nationally.

Organisational Alignment & Capacity Programme

NHS England is currently reviewing its operational arrangements to ensure that our structures are fit for purpose and within available funding going forward.

This will mean that changes at a local level will be necessitated, and with larger Area Teams will be established to cover the North of England. This program is essentially an internal restructure, aimed to create better working between national and regional teams – creating four larger integrated teams for the North. Cheshire and Merseyside will be one of the new teams.

Our functions will remain the same for now as there is no change envisaged currently. However we will be working closely with our CCG partners to continue to develop their leadership role and take on wider commissioning responsibilities over time specifically for Primary Care and Specialised Services.

We are now consulting internally on the new structures which is aimed to improve and strengthen key areas – such as specialised commissioning, but also is aimed to reduce costs by around 15%. At the same time as the structural changes, we are also seeking to create best operating practices so that NHS England can perform its duties effectively. We have asked for feedback from partners including the Health & Well Being Board to form part of this consultation.

Tina Long
Lead Director

Agenda Item 7

Cheshire East Safeguarding Children Board

Annual Report 2013-14

Business Plan Priorities 2014-15

Cheshire East Local Safeguarding Children Board

Foreword from the Independent Chair

Welcome to the 2013-14 Annual Report of Cheshire East Safeguarding Board (CESCB). In my first year as Independent Chair of the Board it has been a busy and challenging one for CESCB. Ensuring that the Board responded swiftly and effectively to Ofsted's recommendations in their inspection report on Cheshire East's arrangements to protect children, published in April 2013 and the Notice to Improve from the government Minister, David Laws, has significantly increased the pace and change of the Board's work. In addition, the revised Working Together to Safeguard Children guidance, published in March 2013, provided us with an opportunity to review our work and to ensure that we are doing the best we possibly can to safeguard children and young people in the Borough.

The work of CESCB over the past year has been to focus on the key issues identified by Ofsted. CESCB reviewed its priorities and business plan for 2013-14 to align it to the Children's Improvement Plan and the requirements of the newly established Children's Improvement Board. We have worked closely with the Improvement Board, the Children and Young People's Trust and other key partnerships to provide a joined up strategic partnership approach to improvement. I am assured that there have been real improvements in quality of practice across the partnership, but there is still so much more to do to achieve the challenging ambition we have set ourselves to be the very best partnership in the country for safeguarding and improving outcomes for our children and young people.

The purpose of this report is to provide a detailed account of what we have done as a Board, what impact we have made on improving arrangements to safeguard children and young people in Cheshire East and to clearly set out where we still have challenges and areas we are determined to improve. The annual report is intended to provide information for a wide ranging audience including Cheshire East residents (a summary is included for children and young people), staff in all agencies responsible for safeguarding children and promoting their welfare and those who are scrutinising the effectiveness of our work.

I would like to take this opportunity to thank all the frontline staff and managers across Cheshire East for their work over the past year in safeguarding children. We have only just started the work we want to do with children and young people, but already they are making a big impact on our partnership and I thank them for that. Finally, I would also like to thank members of Cheshire East Safeguarding Children Board for the welcome and support they have given to me as the new chair and for their commitment to 'rise to the challenge'. I look forward to working with you all in 2014-15.

Ian Rush, *Independent Chair, Cheshire East Safeguarding Board*

Executive Summary

Report Summary for Children and Young People

It is important to Cheshire East Safeguarding Children Board (CESCB) that children and young people are able to understand what it is the Board does and why. A report summary for young people is therefore included in this document.

Background

CESCB is a partnership working to safeguard and promote the welfare of children in Cheshire East. This Annual Report provides an account of the CESCB activities and achievements during 2013-14 and the work of the partnership in keeping children and young people safe from harm. It should be read alongside the Children's Improvement Plan 2013-14.

Review of 2013-14 Priorities

The priorities for 2013-14 were aligned with the Children's Improvement Plan under the following broad areas:

- **Governance and Accountability** – improving the Board's own effectiveness and its understanding of the effectiveness of partners safeguarding activity
- **Performance Reporting and Quality Assurance** - understanding areas of strength and areas for development through scrutiny of quantitative and qualitative information
- **Engaging Children, Young People and their Parents** - voice of children, young people and their carers are heard
- **Understanding the Safeguarding System** - improving multi-agency referral and response to safeguarding concerns
- **Learning and Improvement –** reflections and learning from to improve quality of practice
- **Key Safeguarding Risk Areas** – ensuring that the needs of specific groups of children are met, eg, those missing from home or at risk of child sexual exploitation.
- **Early Help** – the effectiveness of acting early to prevent problems escalating.

Summary of Improvements made across the Partnership

- Improved effectiveness of CESCB – appointed a new chair, increased capacity, new governance, aligned the LSCB business plan with the Improvement plan, launched new performance and learning frameworks.
- The Cheshire East Consultation Service (ChECS), the new front door into Children's Social Care was established in April 2013, with new ways of working – by March 2014, this included the Police and Catch 22 as part of the wider team.

- Reviewed and reissued the 'levels of need' by which all agencies determine the threshold, type of assessment and level of intervention required when cases involving potential risk to Children and Young People are identified.
- Developed pan-Cheshire Policies & Procedures new online site in line with Working Together 2013.
- Developed an outcome focussed quality assurance framework so that CESCB can have oversight of the quality of frontline practice and the impact of services in helping families to keep children safe and achieve positive outcomes.
- Significant increase in scrutiny to inform improvements in practice, including 5 multi-agency thematic audits.
- Commissioned thematic review into suicide and self-harm in young people.
- Encouraged external evaluation through Ofsted Improvement Pilot, LGA Safeguarding Peer Review and Peer Challenge of Child Sexual Exploitation arrangements.
- Reviewed business function of CESCB to improve alignment with the Children and Young People's Trust (CYPT) and Improvement Board.
- Established new Executive Group to improve the business function of CESCB
- Carried out a number of reflective reviews and disseminated learning. Also carried out 'is it true for us' exercises to learn from serious case reviews in other areas.
- Established process for Section 11 audits.
- Focused on safeguarding needs of vulnerable children.
- Delivered training programme based on emerging themes from Ofsted report, SCRs, audits and operational practice, including bespoke safeguarding awareness training to Elected Members, bespoke practice workshop for Social Workers around CSE and training for a pool of multi-agency staff around case reviews.
- Evidenced improvements and impact of Early Help.
- Moved to a combined assessment ahead of schedule.
- Agreed a Memorandum of Understanding across all key partnerships in respect of safeguarding
- Significantly improved the Joint Strategic Needs Assessment (JSNA) to include areas of children's safeguarding.
- Set up a fortnightly Early Help and Protect Panel primarily to manage Police Consultations on a multi-agency basis to ensure early help is offered to those families not reaching the threshold for specialist intervention.
- Improved framework for listening to the voice of children and young people through the set up of the Children's Rights and Participation Service, run by the Children's Society and joining up participation with young people across the partnership.
- 'Inside our Mind - Have you Heard' Conference developed and run by young people to present to agencies on key safeguarding issues that affect them.
- Extension of the advocacy and independent visitor service.
- Practice Standards for Cheshire East Social Worker launched.

Summary of Improvements to the Quality of Practice:

- There has been significant improvement in timeliness of planning and assessments - 82% of combined assessments are completed within 45 days (as at end of March 2014).
- A low number of child protection plans are open for 15 months or more.
- 92% of children and young people are participating in their plans, 87% of children are seen within 10 days of combined assessment.
- A significant number of child protection reviews take part within timescales (94%).
- 80% of social work files met the practice standard for decision making and recording.
- 100% of ChECS consultations audited met the practice standard for decision making.
- 98% of CIN plans had an appropriate decision or recommendation for a change of plan.
- Only 1% CIN cases (1 case) in the last bi-monthly audit were identified where there should have been a section 47.
- 91% of CAFs were judged as adequate or better.

A CESCB Challenge day took place in December 2013 where Board members undertook challenge activity against the revised Ofsted Framework.

Safeguarding Peer Review, March 2014

A major safeguarding peer review was carried out by the Local Government Association (LGA) in March 2014. In summary, the team found the following

- Real improvements can be seen and good progress on your improvement journey
- A structured and systematic approach to service improvement around front door, quality of practice and partnership challenge and scrutiny
- You know yourselves well and are serious about 'getting it right for children'
- Cheshire East is winning the hearts and minds of the staff
- Strong commitment to safeguarding at political and corporate and level
- Comprehensive audit activity
- Clear evidence of improved front door
- Clear evidence of improved quality of social work practice
- Good progress made regarding the voice of the child
- Good recruitment and retention strategy
- Good levels of staff satisfaction and feeling of being supported
- LSCB is in process of being re-vitalised and more focused
- Good use of resources to meet priorities
- Comprehensive JSNA

In summary, the past year has been one of progress and development in key priority areas. However it is recognised that these developments need to become more

embedded in the Board's work to make a really positive impact on multi-agency practice. The Board must continue to focus strongly on core safeguarding and child protection issues, ensuring effective scrutiny of safeguarding work and co-ordinating developments that improve the quality of front line safeguarding practice and the child's journey through the system.

Summary of Priorities for 2014-15

Cheshire East aims to be the best partnership in the country for improving the lives of children and young people. At a meeting in June 2014, CESCB and Children and Young People's Trust set themselves an ambition to be the best partnership in the country.

In order to achieve this, the partnership has agreed that the objectives for 2014 are:

- **Frontline practice is consistently good, effective and outcome focused**
- **Listening to and acting on the voice of children and young people**
- **The partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East**

As a whole partnership we will drive change by focusing on these joint priorities. This will ensure that improvements to partnership working are aligned and made across all aspects of Children's services from commissioning to delivery, universal to specialist services.

As the LSCB moves into 2014-15 areas for improvement and development include:

- the next stage in the development of a multi-agency 'front door' model;
- the potential for strengthening the early help and preventative services though working differently and across a wider range of services and providers;
- improving communication and prompt information sharing;
- engaging better with frontline practitioners to drive up quality of practice;
- Increasing partnership ownership of CESCB business and improvements;

- developing the confidence to challenge plans and actions across agencies if they are not sufficiently outcome focused or making clear decisions based on robust evidence;
- putting in place a better model for engaging young people in safeguarding - gathering and collating the voice of children and young people from across all CEC agencies to inform practice and service development;
- improving the combined response to specific safeguarding areas such as Child Sexual Exploitation, including a more developed approach to online/digital risks, Female Genital Mutilation;
- jointly re-commissioning further services for adults with significant needs, who are also parents, and recognising the potential increase in risk of harm to children and young people;
- ensuring the LSCB evaluates itself on an ongoing basis against the Ofsted grade descriptors;
- ensuring potential risks to safeguarding practice and arrangements are kept under review in response to increasing demand for services and ongoing re-shaping of public services;
- embedding robust and rigorous quality assurance activity;
- embedding CESCB learning and improvement framework;
- safeguarding Cheshire East children who are living outside the authority in residential, educational or secure settings;
- ensuring effective arrangements are in place for safeguarding children with disabilities;
- improving pathways and procedures around children exposed to domestic abuse; and
- development and implementation of a new neglect strategy, practitioner training and tools.
- reviewing local requirements for CiN documentation, including timescales and circulation of plans and minutes.
- clarifying agency use of, and participation in, the CAF process.
- ensuring a process whereby all agencies involved with a family are known.
- reviewing and clarifying expectations around core groups.
- reviewing expectations of agency use of chronologies or case summaries
- reviewing the core documentation used in CP cases and its completion
- looking at developing standards across agencies setting out expectations around supervision.

The Improvement Board has been passing the monitoring and development of some activities to the CESCB and this will continue and expand to further develop the CESCB as the vehicle for challenge and improvement after that Board has completed its work.

Key Messages

For local Politicians:

- You can be the 'eyes and ears' of vulnerable children in your ward making sure their voices are heard by Cheshire East Safeguarding Children Board. Councillor Rachel Bailey is the lead member for children and families and provides the lead route into the Board for individual councillors and so that councillors can be made aware of local safeguarding children priorities.
- When you scrutinise and plans for Cheshire East it is important to keep the protection of children at the front of your mind. Ask questions about how any plans will affect children and young people.

Clinical Commissioning Groups:

- CCG's have a key role in scrutinising the governance and planning across a range of organisations.
- You are required to discharge your safeguarding duties effectively and to ensure that services are commissioned for the most vulnerable children.

Police & Crime Commissioner

- Ensure that the voices of all child victims are taken notice of within the criminal justice system, particularly where children disclose abuse.
- Make sure that police and probation staff share information regarding MAPPA and MARAC cases and the risks that some adults present to children.

Directors and Chief Executives

- Ensure your workforce is able to contribute to the CESCB safeguarding training, to attend courses and learning events.
- Your agency's contribution to the work of CESCB must be given a high priority and every agency must take account of the priorities within the CESCB Business Plan and the agency's own contribution to the shared delivery of the CESCB work.
- Ensuring the agency meets the duties of Section 11 of the Children Act 2004 and contributes to any work programme with appropriate personnel & resources.
- Make sure that the CESCB understands the impact of any organisational changes on your agency's capacity to safeguard children and young people in Cheshire East and that you identify any risks or challenges to the Board.

Children's Workforce

- Book onto and attend all safeguarding courses or learning events required for your role.
- Be familiar with and use the CESCB Threshold Criteria.
- Know who your agency representative is on the CESCB and use them to make sure the voice of children and young people is heard and understood.
- Read information sent to you from CESCB and make sure you act on lessons learnt from audits, case reviews and the findings from Ofsted.

Report Summary for Children and Young

You may have heard about Cheshire East Safeguarding Children Board (CESCB), but you might not be sure what we do or why we are here. CESCB is made up of local services working with children (for example, police, youth justice, education, health and children and adult services). CESCB makes sure that all those working with children and young people in Cheshire East work together to keep you safe and make your life better. You have a right to be kept safe from anything that might do you harm and you have told us that this is your most important right.

Working Together to Safeguard Children (usually just called Working Together) is a document that tells the different professionals – like teachers, doctors, school nurses, health visitors, social workers and others working with you and your family - what they should be doing to improve your life and to keep you safe from abuse and neglect. In Working Together, 'children' means anyone who is not yet 18 years old.

Ofsted is a national body that judges how well we work together to keep you safe. When Ofsted came to Cheshire East in March 2013, they came up with a number of areas where we needed to get better. They said:

- The council has done a lot of work to make services better in order to keep children safe but sometimes progress has been too slow and could be faster.

- Some cases of children who were at possibly risk of harm were not always considered carefully enough when they were referred to social workers. This meant that sometimes decisions and actions to find out more about their situations were not taken at all or not taken quickly enough.

- Some children in need plans that describe how children are to be helped and supported are not clear or checked well enough. Also not all children who have these plans are visited regularly to check that they are well and that they are safe.

- All the agencies work well together to make sure that children and young people who have a child protection plan are helped and that they are safe.

- Children, young people and their families are not always asked about their

views or opinions. This makes it harder for the council to know how to improve services to make sure children are getting the services they need.

- The ways in which managers check that work is being done and written down properly varies a lot and need improving.

- The council and other agencies need to think carefully about the different communities living in Cheshire East and make sure that children from all these groups are supported by services that understand their needs.

CESCB has done a lot of work since March 2013 to make things better.

- We have helped you and your family/carers get early help before your problems get worse.

- We have made sure that, when you do need our help, you get this quicker, especially when you need help from a Social Worker.

- We have got better at listening to what you want and how you feel – you are the most important person to us, so it matters more to us what you want than what your parents/carers might tell us you want.

- We have set up a new service, Cheshire East Consultation Service (ChECS), where those people who know you best, for example, teachers can talk to people who know the best way to help you and your family if you have problems.

- CESCB is working better together as a Board to learn from what changes could make your life better.

- We have set ourselves standards to meet to give you the best experience when you and your family get support from us.

We still feel that we can do more to make your lives better and we have set out some of the main ways that we will do this. Involving you in more of our business is at the heart of our plans. We have made a pledge to make sure that every meeting we have looks at what you tell us you need. We will have people on our Board who will work with you and put forward your views so that we don't forget what our work is about – keeping you safe.

Cheshire East Safeguarding Children Board

Background

The Cheshire East Safeguarding Children Board (CESCB) is a partnership working to safeguard and promote the welfare of children in Cheshire East. This Annual Report provides an account of the CESCB activities and achievements during 2013-14 and the work of the partnership in keeping children and young people safe from harm. It is aimed at everyone who is involved in safeguarding children, including members of the local community as well as professionals and volunteers who work with children and families. Our aim in producing this report is to provide an assessment of how well services work together to safeguard children, to explain how we have addressed our priorities, what our strengths and weaknesses are, and what we are doing to improve. The report will also outline the priority areas on which the CESCB will focus in 2014/15.

The Annual Report should be read in conjunction with the CESCB Business Plan, and the Children's Improvement Plan for 2013-14 and 2014-15 in response to Ofsted's inspection report on Cheshire East's Arrangements for the Protection of Children, published in April 2013.

The CESCB oversees a number of subgroups who deliver the work streams of the Board. The work of these subgroups and their achievements during the year are described in the body of this Annual Report.

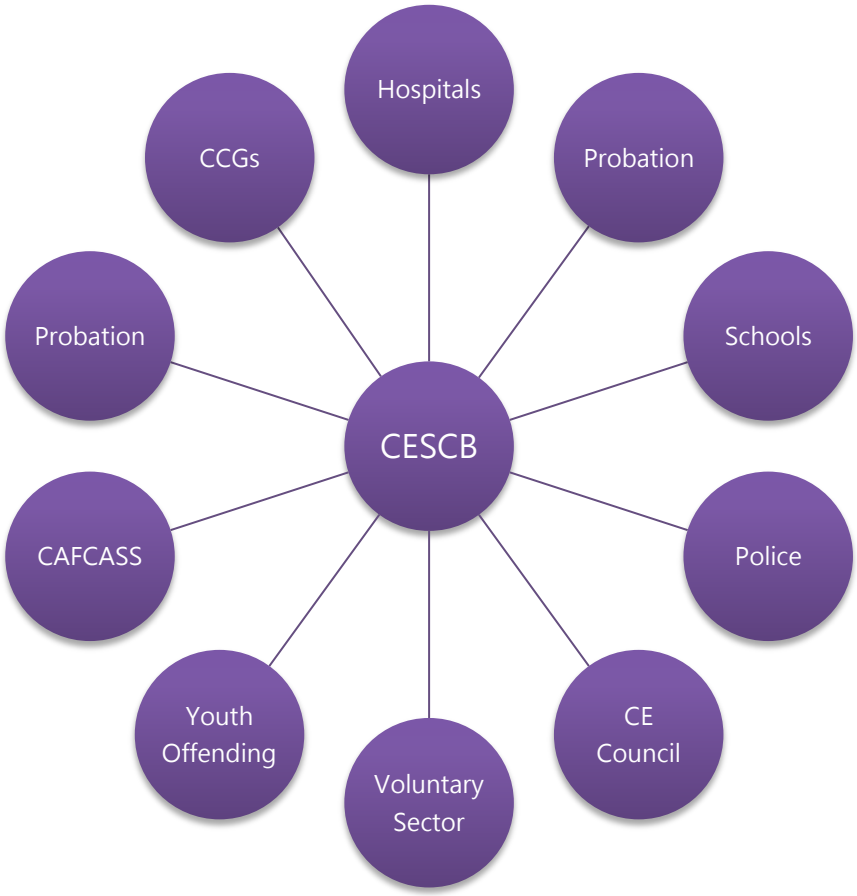
In line with statutory requirements, a copy of this Annual Report will be sent to senior local leaders, including the Chief Executive of the Council, the Leader of the Council and the Director of Children's Services. The report will also be sent to the Children's Improvement Board, Health and Well-Being Board, Children and Young People's Trust Board, Community Safety Partnership. Individual agencies will also be encouraged to present this report through their internal Boards and scrutiny arrangements.

The Board

Section 13 of The Children Act 2004 requires all local authority areas to have a Local Safeguarding Children Board in place to oversee, monitor and scrutinise local arrangements for safeguarding children and promoting their welfare. The Cheshire East Safeguarding Children Board (CESCB) is the partnership body responsible for co-ordinating and ensuring the effectiveness of Cheshire East services to protect and promote the welfare of children.

The Board is made up of senior representatives from agencies and organisations in Cheshire East concerned with protecting children and its main objectives are to co-ordinate the actions of all agencies represented on the Board and to ensure the quality and effectiveness of agencies' safeguarding work and hold them to account.

The Board's responsibilities are laid out in primary legislation, regulations and statutory guidance, the most recent of which is Working Together to Safeguard Children, March 2013.



The Cheshire East Safeguarding Children Board relies on its independence and is responsible for scrutinising the work of its partners to ensure that services provided to children and young people actually make a difference. The effectiveness of the CESCB relies upon its ability to progress and improve outcomes for children by exercising an independent voice. The main roles for the CESCB are set out in its constitution and are:

To co-ordinate and ensure the effectiveness of what is done by each agency on the Board for the purposes of safeguarding and promoting the welfare of children in Cheshire East.

We aim to do this by co-ordinating local work in:

- developing policies and procedures;
- participating in the planning of services for children in Cheshire East; and
- Communicating the need to safeguard and promote the welfare of children and explaining how this can be done.

To ensure effectiveness of that work by:

- monitoring what is done by partner agencies by safeguarding and promoting the welfare of children undertaking Serious Case Reviews and other multi-agency case reviews – sharing learning opportunities;
- collecting and analysing information about child deaths; and
- publishing an annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children.

Governance

The Cheshire East Safeguarding Children Board has three tiers of activity (see Appendix 1):

Main Board – this is made up representatives of the partner agencies as set out in statutory guidance. Board members must be sufficiently senior to ensure they are able to speak confidently and have the authority to sign up to agreements on behalf of their agency.

Executive – is made up of representatives from statutory member agencies and has strategic oversight of all Board activity. The Executive takes the lead on developing and driving the implementation of the Board's Business Plan. It is also responsible for holding to account the work of the sub groups and their chairs.

Sub groups – the purpose of CESCB sub groups is to work on the various areas of concern to the CESCB on a more targeted and thematic basis. The sub groups report to the Executive and are ultimately accountable to the Main Board. These subgroups are:

- Serious Case Review
- Training and development
- Safer Working
- Policy & Procedures
- Private Fostering
- E Safety
- Child Sexual Exploitation/Missing from Home & Care
- Pan-Cheshire Child Death Overview

Key Roles

Independent Chair – all Local Safeguarding Children Boards appoint an Independent chair who can bring expertise in safeguarding and can ensure the Board fulfils its role. The Independent Chair also frees up Board members to participate equally without the added influence of chairing the Board.

Ian Rush was recruited to this post in June 2013 and brings with him a wealth of experience in safeguarding and child protection. As part of the Outcomes Framework

the Chair will be subject to an annual appraisal to ensure the role is undertaken competently and that the Chair retains the confidence of CESCB members.

Working Together 2013 states that Independent Chairs should be accountable to the Chief Executive of the local authority and in Cheshire East the role is accountable to Mike Suarez. The Chair meets regularly with the Chief Executive through the Safeguarding Review Meeting to raise safeguarding concerns.

Director of Children's Services – this post is held by **Tony Crane** and he sits on the main Board of the CESCB. The Director has a responsibility to ensure that the CESCB functions effectively and liaises closely with the Independent Chair who keeps him updated on progress.

Lead Member – the Lead member for Children's Services has responsibility for making sure that the local authority fulfils its legal duties to safeguard children and young people. In Cheshire East during 2013/14 **Councillor Rachel Bailey** held this role. Councillor Bailey contributes to the CESCB as a 'participating observer'. This means that she takes part in the discussion, asks questions and seeks clarity but is not part of the decision making process.

Lay Members – Working Together 2013 recommends that Boards appoint 'lay members' to support stronger public engagement on local child protection and safeguarding and contribute to an improved understanding of the CESCB's work in the wider community. The Board appoints on a bi-annual basis and, at the time of writing in the annual report, is in the process of recruiting new lay members.

Key Relationships

CESCB has a number of key relationships with other Boards. Appendix 2 sets out the partnership framework. A Memorandum of Understanding has been agreed by the relevant Boards that sets out safeguarding arrangements between key strategic partnerships in Cheshire East.

Member Agencies Management Boards – CESCB members are senior officers within their own agencies providing a direct link between the CESCB and their own single agency management boards. It is essential that the management boards of each statutory agency in Cheshire East build a close connection with the Safeguarding Children Board and invest in its work.

Cheshire East Improvement Board - The **Improvement Board** monitors, challenges and ensures sustainable improvement across the partnership, ensuring that the requirements set out in the Ofsted Inspection Report and Improvement Notice are met. The Board has an independent chair and is overseen by the Department for Education. The LSCB also monitors and challenges those recommendations relevant to the partnership, but its remit is not limited to the Ofsted recommendations in the same way at the Improvement Board. Many members of the

LSCB also sit on the Improvement Board, including the Independent Chair of CESCB. The LSCB is kept informed on the work of the Improvement Board and all reports are shared with LSCB members. The minutes of the LSCB are also shared with the Improvement Board.

Children and Young People's Trust Board – The Children and Young People's Trust is a partnership Board that aims to improve outcomes for all children and young people in Cheshire East through strategic leadership and decision making, determining joint priorities, joint planning, and ensuring integrated working. The CESCB reports to this Board on matters affecting children and young people at risk in Cheshire East and the Safeguarding Children Board holds the Children and Young People's Trust Board to account to ensure that they commission the services that are identified as safeguarding priorities. The CESCB will participate in the review and development of the Children and Young People's Plan overseen by the Children and Young People's Trust Board.

Health & Wellbeing Board – The CESCB links with the Health & Wellbeing Board and is held to account for key safeguarding issues for children in Cheshire East. Priorities within the Health and Wellbeing strategy will be delivered by the LSCB

Cheshire East Safeguarding Adults Board (CESAB) - The CESAB carries out the safeguarding functions in relation to adults 18 years and over and domestic violence and sexual assault strategy and commissioning. A number of members of the LSCB also sit on the LSAB.

Safer Cheshire East Partnership (SCEP) – SCEP is responsible for the commissioning of Domestic Homicide Reviews (DHR's), which are undertaken on its behalf by the CESAB. It also receives bi-annual reports on domestic abuse and sexual violence partnership working. The SCEP has a role in ensuring that it maintains and supports partnership awareness and effective response to domestic abuse and sexual violence in Cheshire East.

Pan-Cheshire Boards – There are a number areas where it is considered that practice can be improved by adopting a pan-Cheshire approach at Board level. These include Domestic Abuse, Child Sexual Exploitation/Missing from Home/Trafficking, Policies and Procedures.

Police and Crime Commissioner – The Police and Crime Commissioner (PCC) provides support to vulnerable young people at risk. The Independent Chair of the LSCB and the other Cheshire chairs meet with the PCC four times a year. The Youth Ambassador is a member of the Board.

The **Participation Network** is a multi-agency group that brings together engagement and participation workers across the partnership to share and develop good practice and join up services in engaging with children and young people.

Board Membership and Attendance

A summary of Board membership and attendance for 2013-14 is set out at Appendix 3.

Financial Arrangements

The finances of the Board, including member contributions is set out at Appendix 4.

The Child's Journey in Cheshire East

Summary

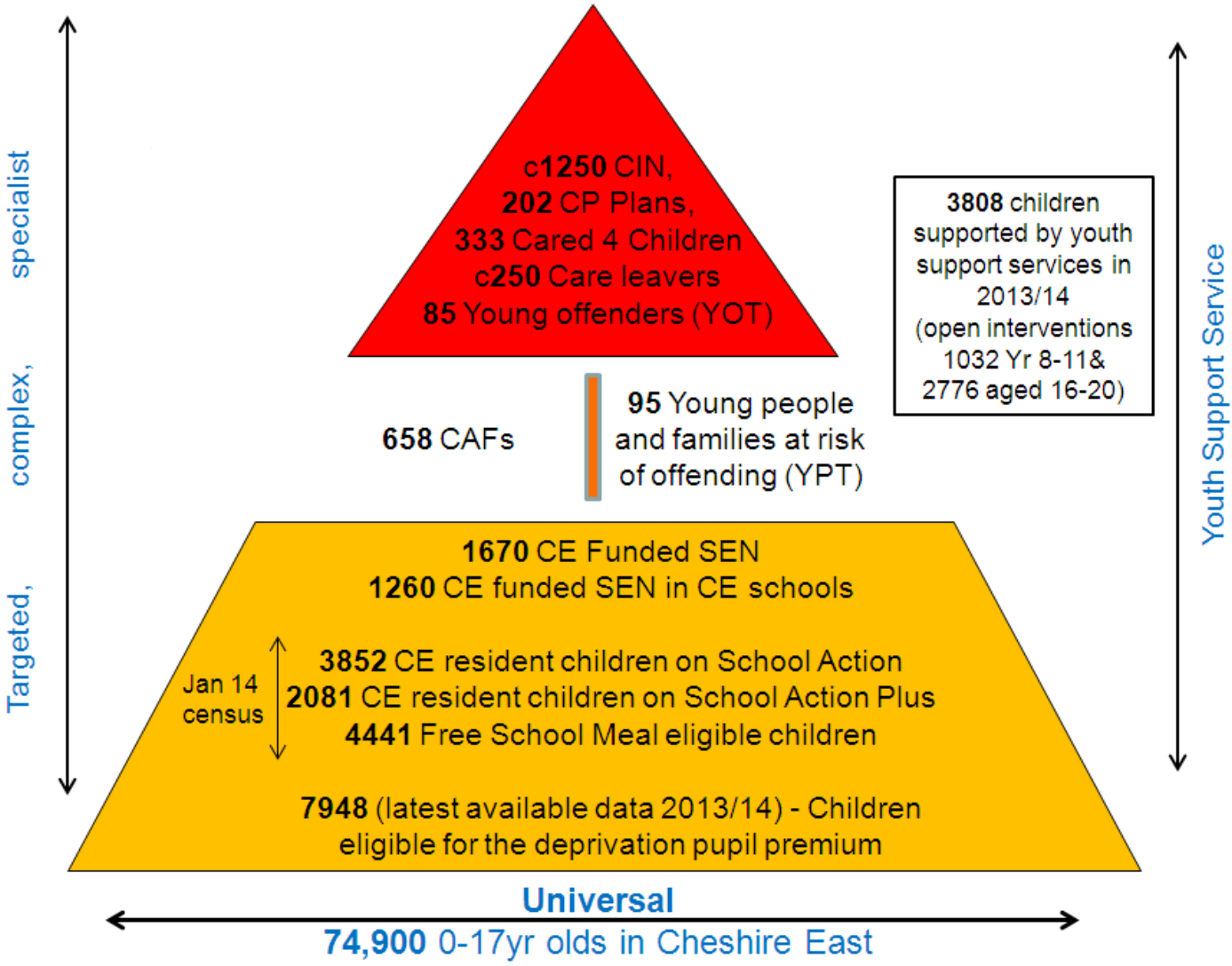
There are approximately 74,900 children and young people aged 0-17 in Cheshire East, which is approximately 20% of the total population. There were 333 children in care, 202 children subject to a child protection plan and 1250 Children in Need (as at 31st March 2014). There are 10 open children's care homes in Cheshire East – 7 of which are private providers taking children from outside the borough. There are also a number of private foster carers. The record maintained by Cheshire East would suggest there are 148 children and young people placed from other Local Authorities who live in Cheshire East. The vulnerability profile below demonstrates the level of need in Cheshire East from targeted to specialist services as at March 2014.

2013-14, has been a period of extensive change within Cheshire East's safeguarding services and the broader children's services arena. In March 2013 an Ofsted inspection of Arrangements to Protect Children judged the overall effectiveness of safeguarding services as inadequate.

The CESCB's main priority in 2013-14 has been to jointly oversee, with the Improvement Board, the implementation of the Children's Improvement Plan developed in response to the inspection findings and to ensure timely progress. The Board has begun to develop a more performance orientated and outcomes focused approach, through the development of an Outcomes Framework. Through the use of multi-agency audits it has also put in place mechanisms for ensuring that it has a closer view of frontline safeguarding practice which can be used to identify and drive improvements.

In addition, the joint strategic needs assessment has been extended and improved to provide a better needs analysis around safeguarding.

Cheshire East Vulnerability Profile (March 2014)



Common Assessment Framework (CAFs)

In Cheshire East the need for help early when problems start is assessed by services using a common assessment framework (CAF). In 2013-14 532 CAFs were opened for children in Cheshire East; at the end of the year, there were 658 open CAFs. Approximately half of all CAFs are from the Crewe area. An analysis of the reasons for referral consistently show that need for parenting support is the main issue, particularly for families with children under 5. The next issue is for behavioural difficulties for school age children. Considerable effort has been made to ensure that early help is effective in Cheshire East and that the use of CAF is embedded across the partnership.

The launch of Cheshire East Consultation Service (ChECS) created a single point of contact for anyone with concerns about children or young people. Three CAF Practitioner Support Officers and the CAF database are based within ChECS. The

take up of CAF is tracked monthly from consultations where CAF is the agreed outcome, and cases that are stepped down to CAF from Social Care, to ensure that this support takes place.

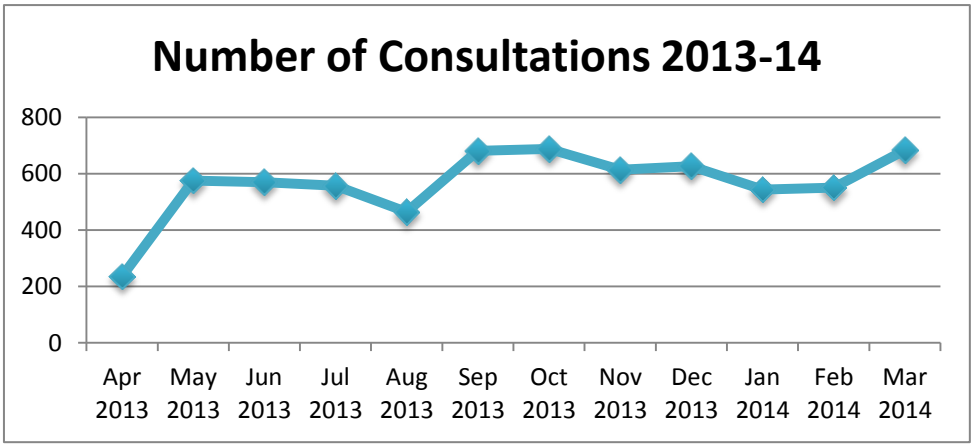
The number of CAFs has improved. The multi-agency CAF audit completed in Autumn 2013 found that the majority of CAFs audited were of a good quality. The rate of CAFs per 10,000 was 87.9 at the end of 2014, which exceeded the target for that year of 75. The Early Help lead is a Member of CESCB and brings report for scrutiny and challenge.

Cheshire East Consultation Service (ChECS)

The Cheshire East Consultation Service (ChECS) was launched in April 2013. ChECS is an advice and support service that operates across the continuum of need. Advice is given by fully qualified Social Workers and contacts are encouraged to be made by phone to encourage full discussion and understanding of all the information and issues. Outcomes are mutually agreed for the family, this may be to continue with single agency support, CAF, or assessment from CSC. Support for agencies to lead CAF is also located within ChECS. Take up of CAF is tracked to ensure that families receive support, whether CAF is agreed in a consultation or as step down from CSC. This is a large improvement on the previous system which did not offer monitoring of step down or advice on lower level support, so families could be left without a service.

During 2013-14 the Board refreshed and revised its 'Levels of Needs' in Cheshire East, or what is known as agreement over 'thresholds'. CESCB has offered training to staff in establishing a common understanding of levels of need in Cheshire East.

During the year ChECS recorded 7271 consultations reaching a monthly high in September 2013.

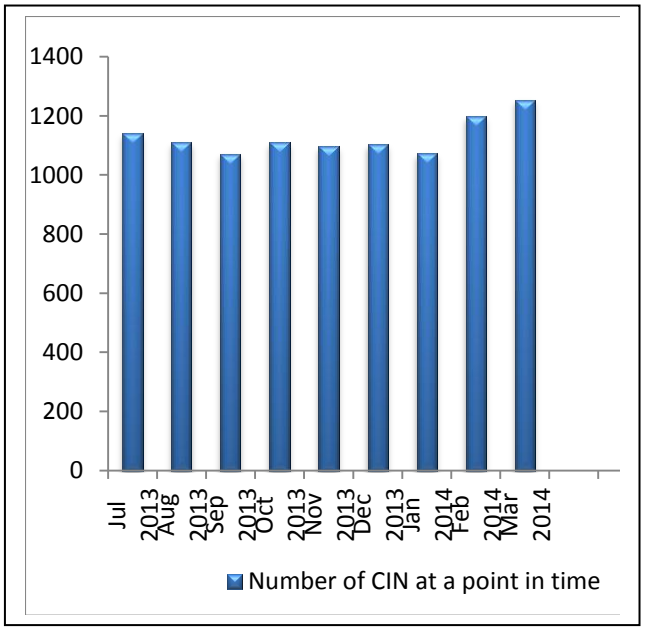


2444 referrals were made to CSC in 2013-14. 87% of consultations in March 2014 were passed to CSC within one working day. Application of thresholds appears to be working well with only 9% CAFs being stepped up to Social Care in 2013-14.

The peer review of ChECS, Ofsted Improvement Pilot and the Local Government Association (LGA) Safeguarding Peer Review all provided external verification that ChECS is operating successfully. Partners have commented positively on the new system and the difference it has made to practice. The Improvement Board signed off the Ofsted recommendations for the front door in September 2013.

Children in Need

A child in need is defined under the Children Act 1989 as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services, or the child is disabled.



Children in need are the largest group of vulnerable children in Cheshire East and the incidence of Children in Need Plans is higher in the most deprived areas of Cheshire East.

The start of the calendar year 2014 saw a sharp increase in CiN cases from 1073 in January to 1250 at March 2014, however, this is still in line with statistical neighbours and is significantly less than the same time in 2012-13. Audits have shown that most children are at the right level of intervention; in November 2013 97% children in need cases were found to be the right level of intervention.

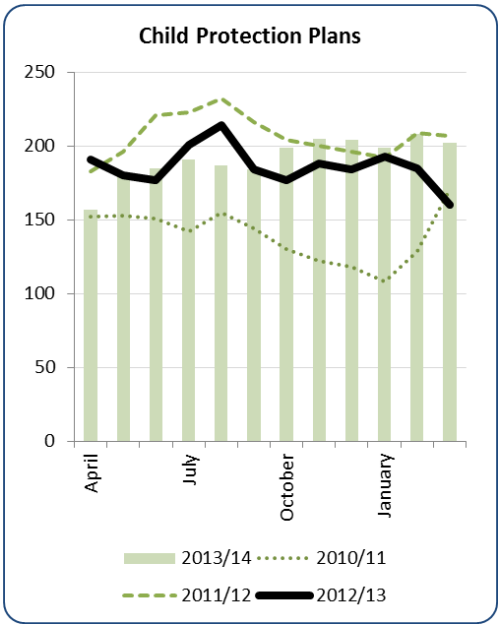
In 2013-14 CESCB carried out a multi-agency audit of 8 cases where a child is subject to a Child in Need plan who had a combined assessment that commenced during September/October 2013. Whilst this provided some reassurance that the right agencies were involved and in most cases impact on the child of agency interventions were being reviewed and agencies were working to promote the child's participation in the plan, there were also areas for development.

Children with a Child Protection Plan

Children who have a child protection (CP) plan are considered to be in need of protection from neglect, physical, sexual or emotional abuse. The child protection plan details the main areas of concern, what action will be taken by the multi-agency core group to reduce risk, how the child's safety will be established and maintained, what progress and improvement will look like and how the family and professionals will know this has been achieved.

The number of children subject to CP plans in Cheshire East has shown an increase of 30% across the year and at the end of 2013-14 was 204.

Over half of the children were registered under the category of Neglect with the next category being Emotional abuse. The multi-agency Neglect Strategy is under review and will be launched in 2014-15.



The level of emotional abuse has remained fairly consistent over 2012-13 and 2013-14. This follows a national trend in which children subject to Neglect is increasing; in Cheshire East neglect accounts for 56% of child protection cases on average which is substantially higher than our statistical neighbours of 44% on average and Northwest 39% on average.

The category of Emotional abuse, along with Physical, is used to record incidents where children are at risk due to Domestic Abuse. The percentage of Child Protection plans for emotional abuse and neglect is higher in Cheshire East than the national level. The table below sets out the number of children and young people on child protection plans over the last 3 years due to neglect and emotional abuse.

	No. on CP Plan	No. due to Neglect	% due to Neglect	No. Emotional Abuse	% Emotional Abuse
End of March 2012	207	123	59	70	34
End of March 2013	161	101	63	52	32
End of March 2014	202	99	49	62	31

Over 50% of CP plans for Neglect are in the 0-5 age range, with increases in the first year of life and around 4 and 5 years. This is possibly because of greater involvement by midwifes and Health Visitors in the earlier age group, and then child care and Primary School in the second. Based on this, there may be additional children whose needs for a Plan are not currently being identified. Work is underway to ensure robust case finding to bridge this gap and provide early help to children and families.

Many children subject to Child Protection Plans for Neglect are in sibling groups. For example, the sample for a recent report came from a cohort of 106 children which contained 22 sibling groups of between two and five children. A concern or referral in relation to one child may result in all the children of that family becoming subject to a Plan. Neglect is also localised within specific areas of the Borough. A large proportion of children subject to Child Protection Plans for Neglect live in deprived areas.

The duration of CP plans is highest for 0-6 months at 68%. If children cease a plan too soon or without sufficient support in place to sustain the changes that may have been achieved there is a risk they may become subject to a CP plan for a second time. The rate of repeat plan in Cheshire East is 16% against a national average of 14.9% and a statistical neighbour average of 16.1%. The LSCB has undertaken a multi-agency audit of repeat CP plans and the recommendations will be carried forward as part of the new Business Plan.

Cared for Children

Cared for Children are those children who are looked after by the local authority. The number of Cared for Children at the end of 2013-14 represents a 14% reduction since year end 2012-13. This progress and steady downward trajectory means we are gaining alignment with our statistical neighbours. Of those children who are cared for by the local authority 133 (40%) were being cared for outside of Cheshire East, although this figure reduces to 58 (17%) for children in placements 20 miles or more outside of the borough.

Care Leavers

There are usually between 30 - 40 young people eligible to leave care each month. Young people leaving care face multiple challenges, and a disproportionate number of care leavers will be not in education, employment or training when compared to their counterparts. In Cheshire East, 32% of care leavers are NEET at 19 which rises to 48% by age 21, which is broadly in line with the national and North West averages. All care leavers are in suitable accommodation by age 21, which compares favourably with the national and North West averages.

Details on specific safeguarding areas such as young offenders, children missing from home or at risk of child sexual exploitation, disabled children and adolescents at risk can be found in the key safeguarding risk areas section of this report.

Review of Priorities for 2013-14

Governance and Accountability

Improving the Board's own effectiveness and its understanding of the effectiveness of partners safeguarding activity

Why this was a priority

Working Together 2013 sets out in detail the arrangements for the work of the Local Safeguarding Children Board. The overall role of the LSCB is to coordinate local work to safeguard and promote the welfare of children and to ensure the effectiveness of what the member organisations do individually and together. The inadequate Ofsted judgement on arrangements for the protection of children means that is more important than ever for Cheshire LSCB to ensure that its policies and procedures, structures and plans are as effective as possible.

What we have done

- Following the Ofsted outcome, an initial review was carried out of the capacity of the Board to be able to deliver the improvements required.
- Appointed a new chair with significantly increased capacity.
- Established new governance, including establishment of an LSCB Executive who has
  - supported the board in the delivery of its key objectives;
  - improved connectivity between the main board, its subcommittees and key workstreams;
  - assisted the board in anticipating and addressing emerging difficulties and challenges at an earlier stage;
  - ensured that all parts of the business plan are being pursued and completed, and are reported to the board in an appropriate and timely way; and
  - brought additional capacity and pace to the delivery of the LSCB agenda.
- Aligned the work of the LSCB with the Children's Improvement Board and Children and Young People's Trust
- LSCB business plan aligned with the Improvement plan
- A new and improved pan-Cheshire online procedures manual, led by Cheshire East, has been commissioned and managed by a pan-Cheshire working group.
- Agreement across four LSCBs and the establishment at the beginning of 2014 of a Pan-Cheshire Policy and Procedures sub-group with Terms of Reference and membership across LSCBs and agencies.
- Policies and procedures reviewed to ensure compliance with revised Working Together guidance.

- Improved the needs analysis around safeguarding through extending the focus of Cheshire East's Joint Strategic Needs Assessment
- A young person, the lead on domestic violence delivery and a representative from early help and troubled families have all been recruited to the LSCB.
- The local Government Association (LGA) carried out a full Safeguarding Peer Review in March 2013.
- Cheshire East accepted an invitation to take part in a national pilot of Ofsted's improvement framework, along with Devon and Northamptonshire.
- Arranged a peer challenge of Child Sexual Exploitation in January 2014
- Peer challenge of CheCS by another local authority area.
- Safeguarding Review Meetings include Chief Executive and Chair of LSCB
- Agreed a Memorandum of Understanding across all key partnerships in respect of safeguarding (attached at Appendix 5)
- Involved voluntary sector through Voluntary Hub Member on the Board.

Impact

- Good attendance at the Board by statutory partners.
- The relationship between the LSCB Chair and Chief Executive, Lead Member, portfolio holder and senior Managers in Children's Services has been strengthened through the Safeguarding Review Meetings.
- Peer Review said '*Overall the team was impressed with the improvement work that has been undertaken since the Ofsted inspection. Your clear and structured strategy and action plan to drive that improvement is proving successful.'*
- Peer Review said *'The team had a strong feeling that you 'know yourselves' and what has to be done'.*
- Peer Review Said '*consistently positive comments were made regarding the improvements made in recent months and the catalyst of a new independent Chairman. In particular all partners felt that improvements had been made as regards focus, creating a culture of constructive challenge and streamlining of processes.*
- Peer Review Team said *'As regards effective practice, there is visible leadership from the senior team down, with a clear message regarding improving standards and supporting staff. There is clear evidence that emphasis and resources have been devoted to this.*
- Peer Review Team also commented on the strong commitment to safeguarding at political and corporate level, that Information sharing was reported as appropriate across partners and that the LSCB is in the process of being re-vitalised and more focused.

The team had a strong feeling that you 'know yourselves' and what has to be done'.
Peer Review Team, March 2014

Consistently positive comments were made regarding the improvements made in recent months and the catalyst of a new independent Chairman. In particular all partners felt that improvements had been made as regards focus, creating a culture of constructive challenge and streamlining of processes.
Peer Review Team, March 2014

Next steps to improvement

- Improve the process of sharing of good practice around policies and procedures pan-Cheshire.
- Review of LSCB structure and sub-groups to increase partnership ownership of CESCB business and improvements and ensure fit with new business plan and ambition to become the best partnership.
- Continue to align work with the Improvement Board, Children and Young People's Trust and Health and Wellbeing Board.
- 'Take the baton' from the Improvement Board.
- Further improve business processes to challenge and scrutinise practice, including development of a challenge log and risk register.
- Recruitment to replace Lay Member.
- Extend links to the voluntary sector.
- Recruit children and young people's champion for the Board and amend ways of working to put the voice of children and young people in every part of Board business.
- Embed Member appraisals in business planning process.

Performance Reporting and Quality Assurance

Understanding areas of strength and areas for development through scrutiny of quantitative and qualitative information

Why this was a priority

In March 2013, the LSCB performance framework was not sufficiently outcome focussed and concentrated on the work of the local authority. Ofsted recommended that the partnership *'Develop, implement and evaluate the impact of an outcome focused quality assurance strategy that includes early help, referral arrangements and child in need and child protection planning; to ensure that this results in consistent and improved standards of practice across services.'*

Ofsted also recommended that *'The Cheshire East Safeguarding Children Board to further develop, implement and evaluate systems to comprehensively monitor and challenge the quality of child protection practice and performance of all statutory partners, including robust multi-agency case audit; to ensure that this results in measurable improvements to the quality of practice'.*

What we have done

- The LSCB Outcomes Framework has been developed which is the quality assurance framework for the partnership. The purpose of the Outcomes Framework is to allow the Board to:
  - Have a planned approach in scrutinising and challenging the quality and effectiveness of services – how much did we do?
  - Assess the safeguarding outcomes for children and young people using performance – how well did we do it?
  - Evidence improvement and learning from audits and local and national reviews – outcome/impact – so what?
- Established a robust multi-agency audit process of 20-25 cases established on a bi-monthly basis; 5 audits have taken place over 2013-14 including:
  - Effectiveness of multi-agency work for cases stepping up to Children's Social Care, November 2013
  - Child Protection Plans for Neglect, December 2013
  - Peer Review Case Mapping, January 2014
  - Repeat Child Protection Plans, February 2014
  - Child in Need Plans, April 2014

- All audit findings have been reported to the LSCB and this has included an audit on Neglect, case mapping audit for the LGA Peer Review, and CSE Peer Challenge.
- Peer Challenge of ChECS in September 2013.
- Regular partner responses to 'key questions' presented to the Improvement Board.
- Established process for S11 Audits to be carried out by all partners.
- A sample of consultations that have been agreed to be appropriate for early help have been followed up to assess and increase the take up of early help services and the impact of services.
- A sample of CAFs are audited by a multiagency group on a quarterly basis. Uptake of CAF following consultations with ChECS is tracked.
- Cheshire East have also been part of the Pilot of Ofsted's Improvement Tool and have been audited by Ofsted through monthly monitoring sessions. This involves interviews with partners on particular cases.
- A Peer Review of Cheshire East's safeguarding arrangements was undertaken in March, and this also included an independent audit of cases in the case records review.
- The LSCB has undertaken a Peer Challenge around CSE.

Impact

- A significant volume of audit has been undertaken. This has provided clear information on the effectiveness of improvement activity and areas requiring development, allowing managers to challenge and support quality of practice.
- External auditors have consistently agreed with the judgements of audits.
- Peer Review Team said 'You know yourselves well and are serious about 'getting it right for children'.
- The Peer Review Team also reported that "Quality assurance is driving up standards".
- "75% of staff surveyed said they know how well their team and service is performing."
- The Peer Review Team reported that "Multi-agency case audits are encouraging reflective practice."
- Peer Review Team said that the LSCB is starting to build challenge into the system

"Quality assurance is driving up standards".
Peer Review Team, March 2014

"Multi-agency case audits are encouraging reflective practice."
Peer Review Team, March 2014

Next steps to improvement

- LSCB to analyse themes and issues arising from S11 Audits.
- Employ a performance specialist to work with agencies to develop a performance report in line with the agreed outcomes framework.
- Establish core performance measures, process and relationships with agency performance leads.
- Produce revised Quarter 1 performance framework in line with new outcomes framework.
- Establish improved feedback mechanisms to key stakeholders.
- Establish sector specific challenges.
- Set up a new LSCB sub-group to focus on outcomes and performance.

Engaging Children, Young People and their Carers

Voice of children, young people and their carers are heard

Why this was a priority

Ofsted recommended that Cheshire East '*Demonstrate that feedback from children, young people and parents is effectively incorporated into service planning and delivery*'. Inspectors also made a recommendation to '*Ensure that children and young people's experiences, views and wishes are incorporated into assessment and planning and that these are effectively recorded'.*

What we have done

- Children's Rights and Participation Service established and run by the Children's Society – contracted to work on joining up participation with children and young people on wider partnership basis.
- Participation Network set up with multi-agency representation, including links to LSCB.
- Participation strategy under development for children's partnerships
- Participation standards under development for children's partnerships
- The Youth Police and Crime Commissioner attended the LSCB meeting in September to discuss options for improving engagement with young people, including establishing a young person's reference group. He is now part of the Board.
- Plans are underway for the Lay Member of the Board to connect with frontline staff through existing fora.
- A new post 'Children and Young People's Challenge Champion' has been created to drive the vision for young people in Cheshire East and ensure the voice of children and young people shapes service delivery and planning. Champion provides an added layer of challenge to partnerships engagement with children and young people.
- Children and young people led a conference on safeguarding in June 2014 telling professionals what was important to them and what support they need.
- LSCB took part in 'takeover day' in November 2013. A number of young people 'took over' the roles of Board members and attended the Board. The CAMHS young person group gave a presentation to the Board.

Impact

- Positive feedback from 'Have you heard conference'.
- The last bi-monthly audit found that children's views and wishes are being incorporated in the majority of cases (65%), and that Social Workers are engaging more effectively with children, their families and other agencies in completing assessments that are appropriate and result in good plans to support children.
- 87% of children and young people participated in their Child Protection plan in February. This has been consistently high.
- Audit has shown that children are being seen routinely and their views are actively being sought.
- Ofsted reported that "Practice is increasingly child centred and underpinned by Cheshire East practice standards." "The effectiveness of the assessment process in deepening workers understanding of children's emotional needs has improved and there is evidence of positive engagement of children and young people in their assessments." "Children are routinely seen and seen alone where appropriate. Practice is increasingly reflecting a child centred approach."
- The Peer Review Team clearly saw an improvement in evidencing the views and wishes of children and activity around capturing the voice of children and young people across services. They reported that "There has been good progress made regarding the voice of the child". "There is a clear 'picture' of the child when reading the files in the case records review and a very positive view of children when speaking to Social Workers." "Foster carers feel they are involved and listened to regarding children's views." "Improvements in reflecting children's views in casework was seen in the review". There is a "Vision for gold standard and resources provided to improve participation across young people in Cheshire East."
- They also saw evidence that the views of children and young people are influencing service delivery across the partnership, "CAMHS are using service users as young advisors for service development," "the new youth service offer has been informed by people's views". Staff were found to be engaged with and committed to the improvement journey and feel consulted and included: "Practitioners are motivated and feel involved in improvements, listened to and praised."
- The Ofsted recommendation around incorporating the voice of the child was signed off by the Improvement Board in February 2014.
- Peer Review frontline survey was completed by over 400 staff.

There is a "Vision for gold standard and resources provided to improve participation across young people in Cheshire East."
Peer Review Team, March 2014

"I thought today was outstanding. The schools and the young people who participated both before and during the day were an inspiration"
Attendee, Have you Heard Conference

“Practice is increasingly reflecting a child centred approach.”
Ofsted Monitoring Report

Next steps to improvement

- Continue to look at ways of improving engagement and participation with staff, families and young people.
- Ensure LSCB is involved in launch of participation strategy and standards
- Embed voice of C&YP and carers at every part of business process.
- Allocate budget to appoint and support young advisors.
- Ensure LSCB participates fully in Rights Respecting Month – celebrating the rights of children and young people.
- Engage children and young people challenge champions on the Board to represent the views of children and young people and to challenge Board members.
- Focus on children and young people’s voice on every Board meeting.
- A feedback survey for children and young people and for parents who have received Child in Need support is planned for implementation in 2014.
- Develop options for adopting the 'Strengthening Families' framework.

UNDERSTANDING THE SAFEGUARDING SYSTEM

Improving multi-agency referral and response to safeguarding concerns

Why this was a priority

In March 2013 the front door to Children's Social Care was Contact and Referral, based in the Children's Assessment Team. This front door was purely for referrals requiring a response from Children's Social Care. If it was felt that an assessment by Social Care was not required, the case would be closed. Following the inspection in March 2013 Ofsted made recommendations to improve the function of the front door, ie, to *Ensure that the local authority's new assessment service is implemented as a matter of priority and functions effectively, and incorporates robust data analysis and performance management of contact and referral arrangements and workloads'.*

What we have done

- The Cheshire East Consultation Service (ChECS) was launched at the end of April 2013. ChECS is designed to bridge between early help services and Social Care and provides support to children, their families and Professionals across the continuum of need. The service is staffed by qualified and experienced Social Workers and Practitioner Support Officers who give advice about cases and agree actions from the consultation. Practice Consultants have management oversight of all consultations.
- Since April, the amount and quality of partner involvement at the front door to provide a more joined up approach – as at March 2014, the Police and Catch 22 were part of the wider front door team.
- A consultation exercise on the thresholds document was completed by the LSCB in November 2013.
- The LSCB thresholds document was reviewed, revised and launched, led by two LSCB Board Members from Police and Probation (Attached at Appendix 6).
- ChECS complete a monthly 10% dip sample of consultations that are not referred to Social Care to check that these are at the right level of need.
- A sample of consultations that have been agreed to be appropriate for early help are followed up to assess and increase the take up of early help services and the impact of services.
- A sample of CAFs are audited by a multiagency group on a quarterly basis.
- A one minute guide has been developed on step up and step down to make this clear to all staff.
- The CAF database is held within ChECS and the Cheshire East Family Service and Youth Offending Service (YOS) have access to this database. The ChECS Practitioner Support Officers provide support around CAF processes and use a tracking tool for Consultations where the action has been 'CAF Agreed'. This tool is then used to follow up the progress of CAF's with identified Lead Professionals. ChECS also receive a monthly report of cases that have closed to Social Care and stepped down with an action of

'CAF Agreed '. This information is also tracked and professionals are contacted to ensure that they are progressing the agreed action.

- A report of CSE activity was presented to the LSCB in July.
- ChECS has had a Peer Challenge in 2013.
- The LSCB has had a Peer Challenge on the robustness of multi-agency partners to respond to child sexual exploitation (CSE) in Cheshire East.
- A one minute guide for practitioners on the new thresholds was produced on step up and step down.

Impact

- Throughout all the internal and external audit activity no child was found to be unsafe.
- 100% agencies felt confident that they could share their concerns with social care (Case Mapping Audit)
- Feedback from partners has been extremely positive. Professionals are finding it helpful and reassuring to speak to a Social Worker and are also finding the support of the Practitioner Support Officers useful when working with or establishing a CAF.
- Ofsted reported that "There is an extensive audit programme of social work practice within the ChECS service, which is regularly undertaken by independent and internal auditors. This rigorous approach to case audits provides the local authority with a detailed understanding of compliance of front line practice and is central to driving improvement."
- Since April this year the level of referrals, admissions to care, and new child protection plans have significantly increased. This is strong reassurance that practice is much better at identifying children in need of safeguarding.
- The Peer Review of ChECS was very positive about the service, "There are positive links and ongoing support and monitoring for the CAF process from the ChECS team which is well valued by other agencies. This enables a more robust step down process."
- The LGA Peer Review Team found that "ChECS is seen as positive by all agencies" and "a wide range of early help services across agencies is making a difference."

"Agencies spoken to felt that they had a better understanding of thresholds and in discussing cases with the ChECS this was a more inclusive approach to partnership working which was welcomed."
ChECS Peer Review Team

Next steps to improvement

- Embed sector specific challenge sessions within the outcomes framework.
- Continue to extend the partner involvement at the front door.
- Engage with politicians on key campaigns and awareness raising.

Learning and Improvement

Reflections and learning from to improve quality of practice

Why this was a priority

Working Together sets out the reasons what a robust learning and improvement framework is essential for LSCBs. Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

Local Safeguarding Children Boards (LSCBs) should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.

The CESCB has a responsibility to ensure that child protection training is available to meet the multi-agency and voluntary sector training needs across Cheshire East. The programme for the year has covered a number of topical areas. The Board also oversees training provided by single agencies to their own staff which is then monitored through S11 audit. CESCB's multi-agency basic awareness training is delivered through the Board's training pool and continues to be an effective model of delivery.

There are 2 processes for responding to a child death in Cheshire East, depending on whether abuse or neglect is known or suspected to be a factor in the death.

Child Death Review

Since 2008 Child Death Reviews have been a statutory requirement for Safeguarding Children Boards, who will review the circumstances of all children's deaths up to age 18.

In Cheshire East the CDOP (Child Death Overview Panel) has oversight of child deaths ensuring that:

- reviews occur in a timely way
- there is referral or investigation of any deaths where there are safeguarding or criminal questions
- where lessons emerge that have broader relevance or public health implications, they are effectively disseminated

There were 21 death notifications in Cheshire East from the period April 2013 - March 2014 including deaths where a CDOP review has not been completed.

Serious Case Review

Safeguarding Children Boards are required to consider holding a Serious Case Review (SCR) when abuse or neglect is known or suspected to be a factor in a child's death and there are concerns about how professionals may have worked together.

The purpose of a SCR is to:

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result
- Improve multi-agency working in safeguarding children

During the year 2013-14 there were no SCR's commissioned. The Board considered a number of cases that did not meet the threshold for a SCR but did warrant an independent review to consider learning and how to encourage improved practice across operational services.

Reflective Reviews

A number of other agencies have been trained to conduct reflective reviews. Based on the findings, over-arching lessons for practice have been produced and presented to the boards to give front line workers effective guidance on what they can do to improve their safeguarding practice

During the last year there have been no requirements for a serious Case review. The table below reflects the direct activity:

	CE SCR (cases to panel)	Request for IMR for another LA	Reflective reviews	True for us exercise
Children's	0 (1)	1 (Surrey)	3	1
Adults	0 (0)	0	1	0
Domestic Abuse	0 (1)	1	1	1

What we have done

- The Learning and Improvement Framework for Cheshire East was developed using the North West model.
- Established Child Death Overview Panel on a pan-Cheshire basis
- The systems approach to learning was advocated by the Munro Review of Child Protection. In 2011, CESCB took part in a programme with Social Care Institute for Excellence to learn a systems approach to Serious Case Reviews

(SCRs), and has been developing the application of the model to other Case Reviews and Audits, producing learning that impacts on practice.

- Develop a clear pathway and good practices for conducting Reflective Reviews.
- Monitor completion of Case Review Task Group actions following recommendations and impact on practice
- Train a pool of potential Review Group members form across all LSCB partner agencies.
- Developed the 2013/14 training programme based on emergent themes from national SCR's and local management reviews, operational practice and Ofsted recommendations.
- Two new courses have been developed and successfully delivered within the existing program.
- Increased focus of evaluation of LSCB Training on outcomes and impact on practice.
- Enforced a charging policy for unexplained non-attendance.
- Bespoke basic awareness safeguarding training was elected Members through a number of sessions. A distance learning package was sent to those Councillors who were unable to attend the arranged learning sessions.
- Developed a 'true for us' model of reflective practice to be used by all Board Members as a learning tool from Serious Case Reviews in other areas.
- A bespoke practice workshop on child sexual exploitation was attended by 57 social care staff
- A bespoke "systems review approach" workshop was delivered to 22 multi-agency partners.
- Pan- regional serious case review best practice workshops have been attended by 18 Cheshire East staff.
- Peer Challenge of CSE in January 2014.
- Commissioned independent thematic review into suicide and self-harm in young people.

Impact

- At 2013- 2014 year end 1350 places had been made available for training within the planned annual training program over 54 courses.
- 1327 places were allocated which equals 98% uptake of places available.
- Participants attended for 1144 places which equates to 86% attendance of allocated places. These included a wide range of multi-agency colleagues across the Borough.
- Evaluations and impact on practice surveys all show evidence of improved knowledge, understanding and confidence with all courses being rated as useful or very useful by participants. (In depth review of this data will be available to the board in July). Average 60% return rate from post course questionnaires (researched average is 33%).
- No courses were cancelled as a result of a lack of interest. This reflects well against our regional comparators.
- Overall the attendance data shows 1% improvement on last year.

- Timely Integration of data from audit processes, and from the Cheshire East Consultation Service (CHECS) into all training and development. Excellent communication pathways between training sub group and CHECS service.

COURSE	PLACES OFFERED	ATTENDANCE	% TAKEN UP
Basic Awareness	206	173	**84%**
Intermediate	348	298	**86%**
Neglect	81	67	**83%**
DCACP	38	35	**92%**
Sexual Exploitation	75	65	**87%**
Digital Safeguarding	42	36	**86%**
Domestic Abuse Level 1	179	159	**89%**
Domestic Abuse Level 2	96	85	**89%**
Information Sharing	66	59	**89%**
Child Protection Process	76	63	**83%**
Managing Allegations	44	42	**95%**
Toxic Trio	76	62	**82%**
TOTAL	**1327**	**1144**	**86%**

Next steps to improvement

- Review independent report on suicide and self-harm and implement agreed action plan.
- Review attendance figures per course and predict course requirements for the year ahead.
- Review the numbers of courses offered where attendance is below 85%.
- Look at pan-regional training options around Female Genital Mutilation, Forced Marriage and Honour Based Violence workshops.
- Review quality assurance standards and policy to promote and support more partners to undertake relevant safeguarding training within a single agency context. This policy will include an expectation that partners evidence “Impact from training on practice” evidence.
- Carry out a comprehensive training needs analysis
- Review the training around Neglect to include suite of DFE approved neglect modules and align with new Neglect Strategy.
- Review the training and development strategy
- Review single agency training policy
- Liaison with Children and young people to inform training and development agenda
- Develop professionals’ website to include suite of basic e-learning modules.
- Ensure the actions arising from audits, reflective reviews, true for us exercises etc are included in the 2014-15 business plan.

Key Safeguarding Risk Areas

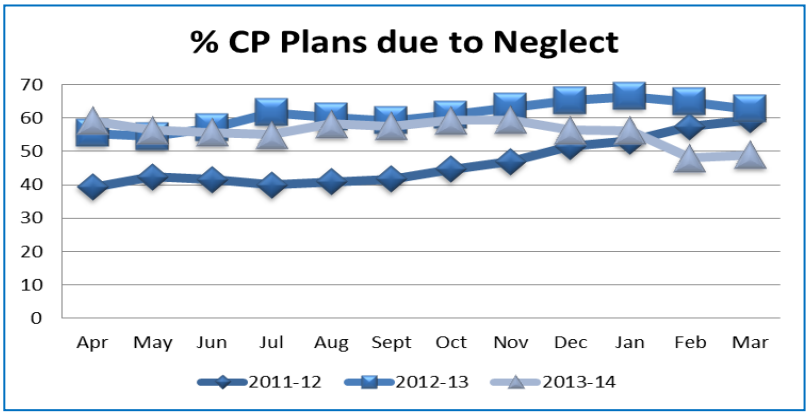
Ensuring that the needs of specific groups of children are met, eg, those missing from home or at risk of child sexual exploitation.

Why this was a priority

There are always specific groups of children who are at more risk of harm due and where particular approaches are needed to safeguard them.

Children Suffering Neglect

The percentage of Child Protection plans for emotional abuse and neglect is higher in Cheshire East than the national level. In Cheshire East neglect accounts for 56% of child protection cases on average which is substantially higher than our statistical neighbours of 44% on average and Northwest 39% on average. Over 50% of CP plans for Neglect are in the 0-5 age range, with increases in the first year of life and around 4 and 5 years. This is possibly because of greater involvement by midwifes and Health Visitors in the earlier age group, and then child care and Primary School in the second. Work is needed to ensure robust case finding to bridge this gap and provide early help to children and families.



Many children subject to Child Protection Plans for Neglect are in sibling groups. For example, the sample for a recent report came from a cohort of 106 children which contained 22 sibling groups of between two and five children. A concern or referral in relation to one child may result in all the children of that family becoming subject to a Plan. Neglect is also localised within specific areas of the Borough. A large proportion of children subject to Child Protection Plans for Neglect live in deprived areas.

Youth Offenders

Young offenders are a group vulnerable to poor outcomes. There has been a significant year on year reduction in the numbers of young people coming into contact with the youth justice system for the first time, with a 31.6% reduction (from 177 to 121), between 2012/13 and 2013/14 which is better than the national rate of 23.8% reduction. The number of total offences committed by young people over the past year has reduced from 427 in 2012/13 to 358 in 2013/141 which is a 16.2 % reduction.

The number of young offenders who receive a custodial outcome has increased, in part as a consequence of increasing numbers in breach of court order which is the most prevalent offence for which custody was received. There has been an increase in the seriousness and frequency of offending by MAPPA offenders, with all having re-offended. These young people in the youth offending cohort are the most complex cases.

There has been a reduction in the numbers of young offenders under 16 in education from 69.2% to 47.7%, and a reduction in those over 16 who are in education, employment or training from 55.5% to 50.5%. Between 2012/13 and 2013/14 there was a 20% increase in the numbers of cared for children who offend, largely due to the increased number of out of area young people in private homes in Cheshire East, bringing with it some very challenging behaviours.

Children Missing and at risk of Child Sexual Exploitation

The data relating to the children and young people in Cheshire East who go missing from home and care (MFH/C) or are subject to a Child Sexual Exploitation (CSE) plan is monitored through the LSCB on a quarterly basis.

Cheshire East has improved its multi-agency tracking and monitoring in respect of both MFH/C and CSE and not surprisingly over the last year there has been an increase both in relation to identifying instances of children and young people going missing but also in those requiring CSE plans. This increase has had an impact on the services to support and safeguard these children and young people and has inevitably raised challenges as to how best we understand the causes for the children who go missing

Between 1/4/2013 and 31/3/2014 there were a total of 832 instances of children going missing, which is a substantial increase on the 2012-13 total of 497. There were a total of 495 (59%) instances of children going missing in the first six months, which is virtually the same as for the whole of last year. However this figure needs to be considered in context of a better screening process and alert system.

Also, there were a small number of young people who went missing from care on a high number of occasions, these young people accounted for 214 (26%) instances (as opposed to 23 repeat instances last year).

There has been a national and local focus on how we improve our recognition and response to CSE.

As we know from the high profile that the activity in Rochdale and Oxford has generated, children who are at risk of sexual exploitation are some of the most vulnerable young people in challenging circumstances that agencies have to work together to safeguard. This is made particularly complex because the victims themselves often do not view themselves as at risk until they are already being abused.

In **2012-13** in Cheshire East:

- 14 young people were been made subject of a multi-agency plan to manage and reduce risk.
- A majority, 13 (93%). were girls.
- The youngest has been 13 years old and the oldest 17.

In **2013-14** in Cheshire East:

- 16 young people were made subject of a CSE plan.
- The majority (15 or 94%) were girls.
- The youngest was 12 and the oldest was 17.

This year there were 12 young people who were removed from a plan as the risk was considered to be managed and reduced. There are no particular patterns in respect of the times that CSE plans are made. The Local Authority has commissioned Catch 22 to provide skill and expertise in our recognition and response to these children and young people. The impact of the operational group and the commissioned service for CSE should start to reveal an impact over the next year. The figures are a crude measurement of the activity for this vulnerable group of young people, services are often working with children were this is a risk factor but where a focused plan is not required, and there will be victims that are not yet identified as such.

> "Assessments for CSE had clearly engaged young people in beginning to understand the abuse they had experienced."
> **Ofsted Monitoring Report**

The priorities for work for the Board in 204-15 are to:

- Set out a programme for targeting raising awareness of CSE;
- Share information across agencies at an early stage to prevent sexual exploitation;
- Use the experience of service users to inform our interventions and service provision;
- Develop a CSE peer mentoring project;

- Review the CSE protocol and update following the findings from national research and enquiries;
- Better link data from children who go missing across agencies;
- Ensure we are compliant with the statutory guidance for children who go missing from Home or Care; and
- Provide the workforce with tools and training to ensure they are confident about recognising assessing and responding to risk of CSE.

"Dear young people, I am writing this to you all, I've been where you all are, it's horrible being stuck on a CSE plan. But honestly it gets better when you attend all your meetings and co-operate with everyone supporting you! My saying is "you have a voice and you voice needs to be heard". You all might feel like it's never ending, but it will end soon. I know because I've been on a CSE plan, I attended all my meetings, I made my voice be heard and now I'm free off the CSE plan, and finally getting my life on track! You can all do it too!"

Excerpt from a letter written by a young person to support other children and young people going through a CSE plan.

Privately Fostered Children and Young People

Whilst the number of children and young people identified as privately fostered has increased over the past 3 years, the number of Private Fostering notifications remains low both locally and nationally. The 2013-14 age breakdown is set out below.

2013 - 2014	AGE	PERCENTAGE
Age 0 – 5	0	0
Age 6 – 10	0	0
Age 11 -14	3	37.5%
Age 15 – 16	5	62.5%
Age 17 – 18 (disability only)	0	0

Significant work has been carried out in 2013-14 to increase awareness and notifications around private fostering. This is detailed in the Private Fostering Annual Report.

Disabled Children

Significant work has been undertaken in 2013-14 in readiness for the implementation of the Children and Families Act 2014. The aim of part 3 of the Act is to give good

support to children and young people aged 0-25 with special educational needs and disabilities (SEND), and their families by:

- Creating a new single assessment process and an Education, Health and Care Plan (EHC Plan) where applicable for each child. This would replace the statutory SEN assessment process and statement
    - Parent carers and young people will be central to this new process
    - The publication of a Local Offer of services and provision
    - Education, health and social care services being brought together to meet the shorter-term needs and longer-term aspirations of children and young people with SEND

- Working with partners across education, health and social care to commission and deliver joined up services
- The offer of personal budgets to families so that they can buy the services they want to where appropriate
- Earlier planning with young people and their families to enable them to prepare for adulthood

Children exposed to Domestic Abuse

140 referrals were received from April 2013 – April 2014 by Cheshire Without Abuse, a service commissioned to enable children and young people exposed to domestic abuse access to early support and intervention. During the year there has been a 10% increase in the number of children allocated onto a programme from the previous year end. The majority of these are for children aged 13 and under (75%) and approximately 2/3rds of referrals are for boys. The service has been targeting 'child to parent' violence and relationship violence. Child to parent violence is more common in boys (in particular toward mothers 67%) and tends to be reported to the police for young people age 14-16.

Her Majesty's Inspectorate of Constabulary (HMIC) conducted an inspection relating to Domestic Abuse in October 2013. This was part of a national inspection of all Police forces. Overall the findings of the inspection were positive for Cheshire Police. Key areas of strengths included the force initial repose to domestic abuse, multi-agency working, MARAC and provision of specialist officers. The force is currently leading on an action plan to address areas for development, including, investigative quality, range of training issues and post investigations management.

Domestic Abuse continues to be a critical factor in the experience of many children and young people. The Department of Health has estimated that up to 75% of

children subject to a child protection plan have witnessed or been exposed to Domestic Abuse.

MARAC

The Multi-Agency Risk Assessment Conference (MARAC) is part of a coordinated community response to domestic abuse. 357 clients with 455 children were subject to MARAC in this year which is an 8% decrease on the previous year. Referrals to MARAC were particularly low in April to July and increased later in the year.

The repeat rate was 22%. National Guidance indicates an effective MARAC should have a repeat rate of between 28 and 40%, illustrating victim and agency confidence in re-referring incidents. The repeat rate has increased towards the end of the year and is continuing to rise. Referrals for clients from black and minority ethnic communities remains high.

Referrals for clients who have a disability and those who identify as Lesbian, Gay, Bisexual or Transgender continue to be below the Co-ordinated Action Against Domestic Abuse (CAADA) recommended levels. Training sessions have been delivered to professionals who work with disabled people with further sessions scheduled in the coming year.

MARAC continues to provide an effective process for addressing complex repeat cases. We continue to work alongside CAADA to develop this model and measure outcomes.

Female Genital Mutilation (FGM)

Female genital mutilation is a collective term for procedures which include the removal of part or all of the external female genitalia for cultural or non-therapeutic reasons. It is typically performed on girls between 4 and 13 years although it may also be performed on new born babies and young women before marriage or pregnancy. Increasing the awareness of FGM across the frontline is a priority for the training programme in 2014-15.

Forced Marriage and Honour Based Violence

Both forced marriages and honour crimes are human rights abuses and fall within the government's definition of domestic violence. How frontline staff should identify and deal with forced marriage and honour based violence is included in the multi-agency safeguarding procedures.

Local Authority Designated Officer

The LADO working across Cheshire East currently sits within the Integrated Safeguarding Unit and is supported by a LADO Business Support Officer who undertakes the administrative responsibilities. The LADO reports to the Head of Service Integrated Safeguarding Unit for Children, Families and Adults.

The Safer Working Sub Group provides a role in scrutinising, supporting, monitoring and promoting safe practice and effective response and management across agencies. The LADO provides quarterly reports to the Safer Working Sub Group and in turn the Sub Group plays an integral role in overseeing any concerns or to resolve any interagency issues.

There has been a significant increase in contacts to the LADO service from April 2013 to March 2014. There has been a year on year increase from the previous year's 2012-2013, 2011-2012 and 2010-2011- 127 in the 2011-2012 period to 205 in 2012-2013 to 325 in this reporting period, of which 20% met the LADO threshold. Education, Fostering and Residential employees have produced the greatest number of referrals and this is consistent with previous years. Physical abuse referrals are the main type of harm.

Summary of Activity

- The CESCB responded to the risks highlighted through the reports of the Children's Commissioner and has established a sub group to respond to the increasing risk of children missing and CSE.
- A Peer challenge of CESCB's response to CSE across the partnership was conducted in January 2014 and identified a number of areas for development.
- Cheshire Police has appointed a new role of CSE/MFH Coordinator, who works within the Strategic Public Protection Unit. This role focuses on developing strategy, procedures and process across the Pan-Cheshire area in relation to this critical area of business.
- Child Sexual Exploitation has been a key area of activity for the Police. At a local level an additional Detective Constable role of Child Sexual Exploitation Coordinator has been established in each Local Authority areas. In Cheshire East, the officer is now collocated with the Missing from Home Coordinator (Police Officer) and working as part of the wider partnership with Catch 22 and the Local Authority CSE Coordinator. This is delivering immediate benefits in terms if improved intelligence and information sharing, joint case management and consistency in approach.
- A range of work has been progressed in relation to Child Sexual Exploitation and children missing from care. All premises that accommodate children in care have signed up to the revised Pan Cheshire MFH Protocol; this is aimed at ensuring there is clarity in process, responsibility and ownership. A dedicated resource has been assigned to act as a point of contact for all premises that accommodate children in care.

- The Police has adopted and implemented the new definition of 'missing' that includes a category of 'absence' This has been supported through the Pan Cheshire Protocol and ensures that each events is appropriately risk assessed, recorded and resourced.
- Cheshire East has been part of the development and implementation of the Pan Cheshire CSE/MFH Strategic Group communication strategy. A range of activity has been progressed during the past year, including, a formal event to launch the Pan Cheshire CSE Strategy in May 2013, a CSE Conference at Cheshire Police HQ in November 2013 and a week of targeted activity in January 2014. A range of material has been developed that is now being used in Cheshire East and across the Pan Cheshire area.
- Cheshire East has responded to the requirements set out in the Legal Aid Sentencing & Punishment of Offenders Act 2012 (LASPO). The Youth Engagement Service and local authority Children's Social Care have joint responsibilities for their welfare and have produced a protocol which will be reviewed on a six monthly basis by the CESCB Executive Group. The Board recognises that those young people either in custody or leaving custody will frequently have safeguarding needs which may be unmet. CESCB have accepted the recommendations of the protocol in response to the LASPO which mean that all children and young people remanded to youth detention have the status of a 'cared for child' and will review the recommendations of the joint protocol on a six monthly basis.
- Cheshire Without Abuse has been contracted to establish a service that enables children and young people to access early support and intervention. This service was developed in partnership with a number of statutory and voluntary services across Cheshire East to ensure as wide a point of access as possible.
- All children and young people who completed a programme with Cheshire Without Abuse in 2013/14 showed improvement in at least one area. The most significant improvements were in reducing conduct issues and improving levels of pro-social behaviour.
- The MARAC Audit process has been developed to review the effectiveness of MARAC at reducing risk over the longer term. Cheshire East MARAC has undergone a self-evaluation process facilitated by CAADA (Co-ordinated Action against Domestic Abuse) which highlights the MARAC's many strengths.
- An action plan has been formulated by the MARAC Steering Group to address relevant development points. These include volume and diversity. CAADA regularly point out that our volume should be 600 and that the police referral rate in particular is low. The Domestic Abuse Family Safety Unit (DAFSU) has delivered training to all front line police officers and is promoting the 'live referral' route to facilitate early intervention and engagement with support. In addition, multi-agency MARAC/RIC awareness sessions have been delivered to increase confidence of practitioners in the use of the

CAADA Risk Assessment tool to identify referrals to MARAC/IDVA or Outreach services as appropriate.

- In response to the government change in the definition of domestic violence to include young people aged 16-17 and the CAADA Young People's Programme we are now gathering data for the numbers of young people whose cases have been heard at MARAC and are working with partners to ensure appropriate support is available for this vulnerable group. In quarters 3 and 4 a total of 7 cases were heard where the victim was under 17.
- The LSCB Allegations Management Training Programme has delivered training to 42 Designated Senior Managers. The LADO has delivered an overview of the LADO process and safer working practice guidance at two primary designated leads meetings and one secondary designated leads meeting, at the private providers forum, two sessions to Early Years settings owners and managers and two social care practice and performance workshops encompassing residential workers, social workers, fostering employees, children and families workers.
- Work has been completed by the Safer Working group around supporting the development of LADO quality assurance through agreeing audit tools for cases going to strategy meeting and those not.
- Operation Encompass - need more info

Next steps to improvement

- A number of key developments will be addressed over the next 12 months and these are set out in the Cheshire East LADO work plan and North West Regional LADO work plan.
- A key priority for 2014-15 will be to implement strategies to increase referrals from professionals working with underrepresented groups, eg, disabled.
- Work continues to raise awareness amongst young people and their families, professionals and the wider public around specific safeguarding issues such as CSE, FGM and private fostering.

Early Help

The effectiveness of acting early to prevent problems escalating.

Why this was a priority

Early help is a priority for Cheshire East in providing children and young people with support as soon as they need it and at the right level, and in reducing demand to specialist and targeted services. Increasing the use and effectiveness of CAF is important to enable effective early help. The Common Assessment Framework is proven to be an effective tool at coordinating support and services for children and young people, and having one method of joint working enables the partnership to operate together effectively.

Following the Ofsted inspection in March 2013, the report set out a recommendation to demonstrate that all partner agencies are able to evidence that they are fully and effectively engaged in common assessment framework (CAF) processes to identify, assess and support vulnerable children and young people

What we have done

- The early help workstream of the Children and Young People's Trust is effectively driven by the multi-agency Early Help Children's Trust Sub-Group (EHCTSG).
- The use of CAF is monitored by all agencies.
- A monthly report is sent to managers in the East Cheshire Trust (ECT), Mid Cheshire Hospital Trust (MCHT) and Cheshire and Wirral Partnership (CWP) to advise them about CAF activity for their service.
- Regular reports on CAF activity are presented to the EHCTSG and LSCB.
- The Early Help and Protect Operational Group was introduced in August 2013. This Group is effectively the virtual multi-agency team around early help. The primary objective of the Group is to establish and ensure appropriate services are targeted at families using the Continuum of Need. This group has aided communication between services and achieved proactive responsibility for the ownership of intervention. This group feeds in to the Early Help and Protect Strategic Group.
- Early Help Hubs were developed in 2014 for the four locality areas to monitor performance and determine local early help priorities.

Impact

- The Peer Review of ChECS found positive links and ongoing support and monitoring for the CAF process valued by partners and contributing to a more robust step down process.

- The Peer Review found evidence of a proactive approach and use of the step up and step down to appropriate services, particularly in relation to the signposting or step down to CAF.
- Agencies have reported a better understanding of thresholds and in discussing cases with the ChECS this was a more inclusive approach to partnership working which was welcomed.
- The Help and Protect Group was reported as a good example of partnership working in enabling appropriate signposting of services to support families that did not meet the threshold for a social care assessment. It also enabled the group to hold agencies to account regarding commitment of services/resources.
- Alongside this multi-agency Operational Group, ChECS continue to promote Early Help and Intervention with partner agencies and have attended and presented at sessions set up with Education Safeguarding Leads and local 'Working Together' lunches with Health Visitor and Midwives in both the Crewe and Macclesfield Locality. These sessions have been an opportunity to promote multi-agency working, pathways and process between Services such as 'step up/step down', supporting practitioner to undertake Early Help work and assessments as well as being clear about the expectation ChECS have around the quality of information provided at the point of Consultation. This is all contributing the continued improvement of the Early Help offer and impact within Cheshire East.
- The Improvement Board agreed that the recommendation to increase partners engagement in CAF had been met in December 2013. In the Ofsted Improvement Pilot Ofsted found that "The early help offer is clear and has resulted in families benefiting from support prior to cases reaching the need for statutory intervention."
- 2,977 professionals to date have been trained to use CAF. Two workshops were held in September 2013 to feedback the results of the multi-agency CAF audit and launch new CAF forms to support improvement in the quality of practice and inclusion of the voice of children and young people.
- Between 1st August and 30th November there were 558 consultations from the Police of which 113 were processed via the Early Help and Protect Operational Group. This represented 19% of the Police Consultations. An exercise has been undertaken of the 80 cases that were discussed at the Early Help and Protect Operational Group during September and October 2013 to see if there have been any subsequent Consultations. 20 children (25%) have had a further Consultations with ChECS and of these 8 (10%) children have since been referred to Social Care.

"A wide range of early help services across agencies is making a difference."
ChECS Peer Review Team

"The CAF Assessment form and delivery and review documentation is an effective tool to assess; review and plan for children and families who need help outside the statutory framework."
Ofsted Monitoring Report

Next steps to improvement

- The volume of CAF and supporting targeted and universal work is thought to be at about the right level for effective early help. This needs to be sustained over 2014-15. The future focus needs to be improving and developing the quality of partnership practice.
- Commissioned early help services from April 2014 will be contractually required to use CAF as the assessment method, which should result in an increase in CAFs and CAFs led by professionals other than the LA for 2014-15.
- Ensuring practice is outcome and child focused is a priority for Children's Services for 2014. The EHCTSG needs to monitor inclusion of the voice of children and young people in CAFs, the new CAF training programme needs to have a child and outcome focused approach and the impact of this needs to be monitored through audit by the EHCTSG.
- Schools and Health services need to take the lead on CAF. Some schools are fully engaged in the CAF process, however this is not the case for all schools.
- The Early Help Hubs need to be developed over 2014 to become effective multi-agency forums for driving local early help services. Effective contract monitoring of early help services needs to be developed hand in hand with the Early Help Hubs.
- From April 2014 all CAF training will be delivered in house allowing a more flexible and local approach and building links with local providers.
- LSCB to monitor effectiveness of early help through outcomes framework.

2013-14 Annual Reports

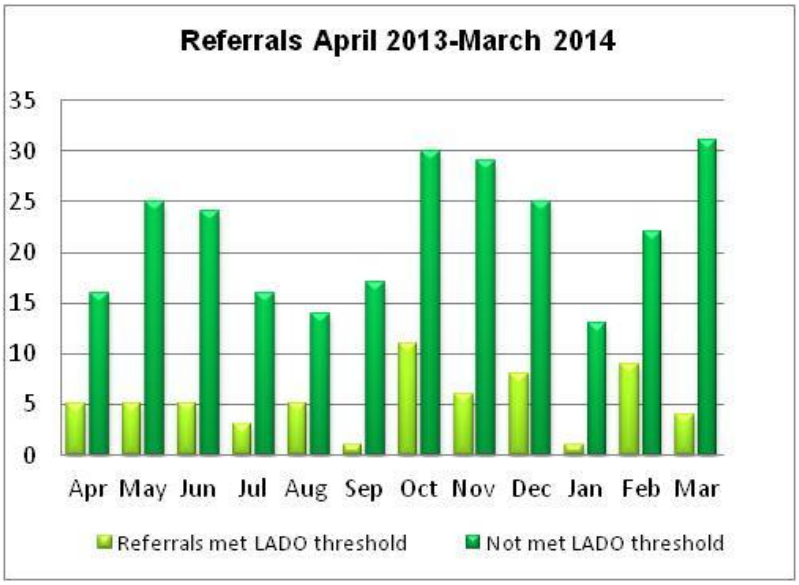
A number of key Annual Reports have been considered by CESCB and will inform the priorities for the 2014-15 Business Plan. A summary of the reports is set out below.

Local Authority Designated Officer (LADO) Report 2013-14

The Cheshire East LADO sits within the Integrated Safeguarding Unit of the Local Authority and works across the Borough.

The LADO oversees individual allegation cases, provides advice and guidance to employers, voluntary organisations and liaises with the Police and other agencies, as required. The LADO has a responsibility to monitor the progress of individual cases to ensure they are dealt with quickly, fairly and consistently, as well as identifying significant patterns and trends across the workforce.

The LADO Annual Report outlines the duties and responsibilities regarding managing allegations made about people who work with children and young people. It provides information on activity and performance within the last 12 months highlighting the key themes, service impact, and comparative annual data over the last three years and further areas for development for 2014-2015.



The table opposite shows that the number of contacts into the LADO service has significantly increased from 205 in the 2012-2013 to 325 in this reporting period. The increase is attributed to the number of consultations and provision of information and advice undertaken that don't meet LADO threshold.

The growth in consultations has been predicted over the two previous annual reports as awareness of the LADO role broadened and more individuals access the service.

Education remains for the third year the agency making the most referrals meeting threshold at 30%. Education referred 17 of the 19 cases. Fostering and Residential are second and third main highest referrers, which is consistent with the previous two years. There has been an increase in the number of residential providers in the CESCB boundary, which may account for greater numbers.

Physical abuse referrals are the main type of harm. However, it is uncertain whether this is a result of the impact of the changes to the threshold criteria as one perception from the NW Regional LADO Group is that 'may pose risk of harm' appears harder to evidence than 'suitability' and therefore issues that would have previously been referred may not in this reporting period.

There is evidence of good links between the LADO service and the Police measured by attendance at strategy meetings. This has increased each year since the 2011-12 reporting period.

Wider safer working practice dilemmas continue to be raised in the safer working sub-group and will continue to be addressed throughout the coming year such as other cohorts of vulnerable children such as those in work placements, those in receipt of services using direct payments and private tutoring where the 'employer' is the parent.

The LADO, in conjunction with the LSCB Training Manager, has delivered training to Forty two designated senior managers regarding allegations management in 2013-14 with education being the agency most well represented.

In response to the East Sussex Serious Case Review the CE LADO procedures have been revised and updated, including a one minute guide to the LADO role. Additionally, formal cover arrangements have been embedded for planned and unplanned leave, sickness and training to ensure that there is access to LADO advice at all times during office hours.

A review of the service development plan demonstrates good progress on the action agreed for the 2013-2014 period. The audit processes are embedded and the focus for the next year will be on further quality assurance and greater analysis of the data next year and the effectiveness of the LADO function.

A number of key developments will be addressed over the next 12 months and these are set out in the Cheshire East LADO work plan and North West Regional LADO work plan. The areas broadly relate to the following:

The audit process is now embedded and timetabled for the 2014-2015 period yet this remains a key priority. Peer audits within the NW Regional LADO group are a focus for the following year.

- The implementation of a service user feedback process to provide an evaluation of the impact of the LADO service. The literature sent from the LADO service to service users will also be a work stream within the NW Regional LADO group.

- A discrete piece of work identifying support options for the service users in the LADO process including the alleged individual, employer and involved child and their family.

- Attendance at the licensing panel for taxi drivers is envisaged for the year going forward following the identified concerns regarding transport operatives.

- Chairing the Learning, Development and Training Subgroup of the NW Regional LADO to ensure that the National LADO voice will continue to gain momentum in achieving a collective view on National issues and providing some consistency to the execution of the LADO role.

Private Fostering Annual Report 2013-14

Cheshire East's Private Fostering Annual Report for April 2013 to March 2014 is based on the requirements set out in the National Minimum Standards for Private Fostering and provides an overview of the Private Fostering activity during the year 2013-2014. It also outlines the planned developments for the year 2014 – 2015.

The priorities and activity for 2013-14 were:

Relevant staff are aware of Cheshire East Council's duties and functions in relation to private fostering;

This has been achieved through the updating and circulation of procedures, the role out of training through team meetings, the development and circulation of a one minute guide for all multi-agency staff.

Cheshire East Council is notified about private fostered children living in the Borough

Cheshire East continue to receive private fostering notifications and an increase in notifications occurred in 2013-14.

The welfare of privately fostered children is safeguarded and promoted

Three of the five notifications received were acted on within 7 days and visits to children took place at least six weekly in line with private Fostering Regulations 2005.

Private foster carers, parents of privately fostered children and children and young people in private fostering arrangements receive advice and support so that their welfare is safeguarded

All privately fostered children have an individual child in need plan. The leaflets for professionals, carers, parents and young people were updated in 2013-14. The Cheshire East Pledge is applicable to privately fostered children and a copy will be provided prior to the first Child in need meeting.

Cheshire East has an effective communication strategy in place in relation to private fostering

A communication strategy was developed that targets key stakeholders around private fostering.

Cheshire East monitors the way it discharges its duties and functions in relation to private fostering

This has been achieved and monitored through Audit and safeguarding reviews.

Priorities for the 2014-15 private fostering action plan include:

- Developing private fostering presentations for A&E staff, CAF coordinators, Language schools, Independent schools;
- Developing e-learning package for all agencies;
- Rolling out multi-agency workshops on private fostering;
- Developing and organising agency private fostering self-assessment;
- Developing an annual agency audit check list for private fostering;
- Reviewing and updating private fostering content in LSCB safeguarding training;
- Developing and circulating private fostering training packs for agencies;
- Developing links with language schools, Independent schools and faith organisations;
- Developing links with community Police through links with the safeguarding board; and
- Organising six monthly e-communication shots and promote private fostering through agency bulletins.

LSCB Annual Training Report 2013-14

The LSCB Annual Training Report sets out the activity and impact of multi -agency training.

At the end of 2013-14, 1350 places had been made available for training within the planned annual training programme over 54 courses. 1327 places were allocated which equals 98% uptake of places available and is an improvement on last year. Participants attended for 1144 places which equates to 86% attendance of allocated places. From the detailed overview of attendance, it is evident that a wide range of multi-agency colleagues across the borough and from all areas of service delivery are accessing the multi-agency training, including social care, police, voluntary sector, private providers, health and education.

In addition to the planned programme, a number of bespoke courses took place including basic safeguarding awareness training to elected members, a bespoke practice workshop on child sexual exploitation for social care staff, a “systems review approach” workshop to multi-agency partners.

Impact on practice data is collected utilising a step wise process:

- Pre course self-evaluation of learning by participants
- Post course evaluation at the end of the event
- Questionnaire via email to all course participants
- Questionnaire to managers via email to establish impact on practice evidence from PDP processes and supervision

The learning and development sub group have recognised the need to evidence in a meaningful way that training has a positive impact on practice. Steps were taken to collect this data via a deep dive research based “Impact” questionnaire, however the results from this approach did not yield the quality data which was hoped for and could have informed the direction of training and development activity. A short questionnaire is being developed to send to managers to evidence impact on practice from training in conjunction with appraisal, supervision, personal development plans or similar processes.

To date 6 Impact surveys have been issued. Average response rate is 55% return which is excellent in research terms (expected return rate 33%).

The surveys have all demonstrated impact on practice with participants acknowledging more knowledge and confidence around safeguarding issues.

Child Death Overview Panel Annual Report 2013-14

This Child Death Overview Panel Annual Report presents a summary of the work of the pan-Cheshire panel over the past year April 2013 – March 2014. The panel undertakes a rigorous review of child deaths of those children ordinarily resident in one of the four areas and is a good example of effective multi-agency partnership. The panels provide a robust overview and insight into how child deaths can be prevented. The report is a key resource for driving public health improvement and promoting child safety and wellbeing.

The report highlights the key data and findings of the panel.

- 58 child deaths were notified in the period April 2013 – March 2014
- 35 child deaths were reviewed by the panel from April 2013 - March 2014
- The Child Death Overview Panel met on five occasions over the year, four of these to review child deaths

Of those deaths reviewed

- 63% of the deaths occurred before the child reached one year of age (22 deaths)
- 63% of the deaths were male (22 deaths)
- Perinatal/Neonatal events accounted for 37% of deaths (13 deaths)
- 74% of deaths were classed as 'unexpected' (26 deaths)
- 31% of deaths reviewed had 'modifiable factors' (11 deaths)
- Recommendations/actions identified at case discussions and at the panel aimed at reducing risks and supporting families, have been taken forward.

CDOP Recommendations and learning points

Learning points identified following multi-agency review of child deaths at the CDOP, including lessons identified at any internal reviews of the child death by individual agencies, were disseminated nationally where relevant, via the CDOP co-ordinators national network, to facilitate learning and improved quality of care.

The following summarises key themes from the recommendations, learning and action points gathered from CDOP meeting minutes. These themes are related to factors associated with all child deaths discussed.

Safe sleeping

- One of the key areas that the CDOP identified from their considerations during the year was the number of deaths where unsafe sleeping positions or "co-sleeping" had been a modifiable factor. As a result of their considerations, the panel commenced a subgroup to review safe sleep (relating to deaths where co-sleeping or safe sleeping was raised as an issue). This group has joined with the Merseyside CDOP and are planning to run a joint campaign on safe sleep across the Cheshire and Merseyside footprint – to ensure consistency of messages and to reduce duplication and costs.

Disengagement by families from services

- The CDOP identified that there had been a number of cases where families had "disengaged" from health, social care or other related support services. The CDOP wrote to the Chairs of the LSCBs to highlight this issue and also to key agencies to request that they ensure a suitable pathway was in place to follow up with families who "did not attend" scheduled appointments to ensure they had not actively disengaged from services.

Suicide

- The Panel identified that whilst numbers of deaths through suicides notified in the year it met were low, there was, what appeared to be an increased number within the Cheshire East LSCB area. Cheshire East Council advised the panel that it planned to undertake an in depth review of suicides in children over the past few years and would report back on the findings to the panel in due course.

Child death rapid response

- The CDOP has identified that a "true rapid response process" is not undertaken for unexpected deaths across the Pan Cheshire footprint whereby a suitably trained health professional undertake a visit to the home where a child death occurred, alongside the police. A letter was sent to the six CCGs covering the four LSCBs advising them that this was identified within the guidance. Warrington CCG has agreed to take a lead with a view to commissioning and implementing a true rapid response process across the four LSCB areas. The panel will continue to monitor this to ensure this is undertaken.

Identifying deaths in hospital for children aged 16-18 years

- When a child reaches the age of 16, in a healthcare setting they are treated as an adult and not placed on a children's ward or under the care of a paediatrician. As such if a child dies between the ages of 16 and 18 they are treated as an adult. It is possible therefore that some child deaths may not be notified to the CDOP Co-ordinator and therefore a review into the death of that child may not take place. Following a presentation by a Paediatric Consultant from a neighbouring area who had tackled this issue successfully in their own area, the CDOP contacted all the Acute Trusts to request that a similar notification system was put in place.

Smoking in pregnancy

- The CDOP identified that there were a number of cases where the mother had smoked during pregnancy, smoking in pregnancy can lead to a range of health issues for newborns as well as premature births and underweight babies. The panel wrote to acute trusts and Directors of Public Health requesting that reducing smoking in pregnancy remains a key priority through smoking cessation services and through specially trained midwives who work with mums to reduce the numbers smoking in pregnancy.

Medical advances - resuscitation

- The Consultant Paediatricians cascaded to acute trusts the findings from a case of a failed newborn resuscitation that could potentially have been avoided through the use of a 'Meconium aspirator device' attached to the endotracheal tube, to enable suction of the airways during resuscitation. This led to enquiries from other hospitals in the country so they can procure the kit and incorporate into their practise.

Learning from child deaths – sharing widely to prevent future deaths

- The CDOP wrote to one Acute Trust following a child death where a Root Cause Analysis (RCA), (an RCA is a systematic method for reviewing adverse incidents, ie a problem solving methodology for discovering the real, or root cause(s) of problems or difficulties) had been undertaken in the trust to request that the learning points from the RCA be shared across the Pan Cheshire footprint.

Administrative/support processes

- Perinatal mortality and summary information - The CDOP wrote to each Acute Medical Director in NHS hospital trusts where Cheshire children may be admitted and subsequently die, to request that minutes from Perinatal Mortality meetings were submitted to the CDOP Co-ordinator so that any learning from these meetings can be reviewed as part of the panel considerations.
- The panel also requested that the Acute Trusts send to the CDOP Co-ordinator, the 'Summary Letter' that is sent to GPs from the Paediatricians to aid the panel considerations.
- Letters to families - The CDOP introduced a process whereby a letter is sent to the parents or guardians of a child following their death. The letter, sent some three to four weeks after the death, advises them of the child death overview process and also invites them to meet the Chair of the panel if they feel they have anything they wish to disclose to the panel to support the core aim of the panel in preventing future deaths. During 2013/14 only one family took up this offer.
- Timely notification - The CDOP identified that some notifications were not made in a timely way - in particular those which had involved road traffic incidents where a child died. The Cheshire Police who are a member of the panel have liaised with relevant colleagues to ensure that notification is undertaken in a timely way. This is being monitored.
- Missing data – a number of older forms have incomplete data on them – particularly in relation to the wider family and the father of the child. Key members of CDOP are working with partner and provider organisations to support them to understand the importance of having robust information to support the panel considerations and to improve the information that is supplied to the panel on the forms.
- Ambulance Trust – CDOP identified that the Ambulance Trust were not following the established processes and protocols for child deaths. The panel wrote to the Ambulance Trust to ensure that they were aware of the protocols so that these could be followed.

Future work for the CDOP

- During 2014/15 the panel will continue where feasible to review cases using a thematic process – themes planned for 2014/15 include – cardiac cases where a Consultant specialising in Paediatric Cardiology from Alder Hey will be invited to attend the panel as a subject expert to support the panel in their considerations. A further CDOP will focus on neonatal deaths.
- However, it must be borne in mind that reviews should not be overly delayed to await possible future deaths of a similar nature.
- The Panel are proposing to hold a half day professional development day for relevant health and social care professionals and academics who may work in areas where they respond or deal with child deaths. The panel propose to share the learning from the panel and also to

- The Pan Cheshire CDOP will continue to explore the potential of closer working with the Merseyside CDOP.
- The CDOP will also during 2014/15 give consideration to the frequency of the meetings in order to assist progress in presenting cases to the CDOP in a timely fashion. The panel currently meet on a quarterly basis and for a whole day.
- The panel through the CDOP Co-ordinator are looking to produce a set of Pan Cheshire CDOP webpages that can be embedded within each LSCB website.

Priorities for 2014-15

Partnership Objectives

The improvements made in 2013-14 has enabled the Improvement Board to have the confidence to sign off 10 Ofsted recommendations in full, 5 in part, and 10 Improvement Notice actions. Cheshire East has made considerable improvement. There is a clear ambition across the partnership to reach a 'Gold Standard' of services for families in Cheshire East. The internal audits and external validation highlighted areas for further development.

Cheshire East aims to be the best partnership in the country for improving the lives of children and young people. At a meeting in June 2014, the LSCB and Children and Young People's partnership set themselves an ambition to be the best partnership in the country.

In order to achieve this, the partnership has agreed that the objectives for 2014 are:

- **Frontline practice is consistently good, effective and outcome focused**
- **Listening to and acting on the voice of children and young people**
- **The partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East**

As a whole partnership we will drive change by focusing on these joint priorities. This will ensure that improvements to partnership working are aligned and made across

all aspects of Children's services from commissioning to delivery, universal to specialist services.

Each partnership board will drive progress in their areas under these priorities. The partnership boards have identified what the priorities 'mean for them' in terms of protecting and improving outcomes for children and young people. How the partnership boards will achieve these outcomes will be outlined in the LSCB Business Plan, Children and Young People's Plan and Health and Wellbeing Strategy for 2014. The responsibilities and accountabilities of each Board in delivering these objectives are set out at Appendix 7.

Declaration of Intent

CESCB has set itself an ambition to become the best partnership in the Country. A partnership leadership event in June 2014 focussed on the vision to achieve this ambition. This document sets out the key changes agreed by the partnership.

- Increase participation of children and young people in Board business.
- Commit to become a Cheshire East Partnership Leader.
- Reduce the content and format of Board meetings to facilitate solution focussed discussions.
- Improve the decision making focus of the Board through finding new ways to communicate and brief on awareness raising issues, including e-governance solutions.
- Increase reflection and challenge within the Board, including the nomination of an Observer and Critical Friend for Board meetings.
- Review governance arrangements to improve the membership and focus of the Board, Executive and sub-groups.

- Simplify agendas, papers and minutes to focus on purpose, outcomes and actions required.
- Improve the connections between the Board and frontline practitioners
- Celebrate success when things go well.
- Embrace innovative ways of working.

Engagement in developing priorities

New plans for the LSCB business plan and Children and Young People's plan have included significant engagement with children and young people, frontline staff and strategic managers.

Strategic Managers

A development session with Members of the LSCB and CYPT took place in June 2014. This resulted in a 'declaration of intent', ie, new ways of working for both Boards. A review of the structure of the LSCB has been carried out and a proposed new structure will be agreed by the Board.

Children and young people

A survey for children and young people in Cheshire East, known as Good Childhood Conversations and facilitated by the Children's Society, has gathered the views of children and young people on all the key areas of young people's lives from family relationships to feelings about the local area.

Frontline staff

Workshops for frontline staff across the partnership were held in June/July to consult with frontline staff on priorities and themes for the new plans.

Priorities for 2014-15

As the LSCB moves into 2014-15 areas for improvement and development include:

- the next stage in the development of a multi-agency 'front door' model;
- the potential for strengthening the early help and preventative services though working differently and across a wider range of services and providers;
- improving communication and prompt information sharing;
- engaging better with frontline practitioners to drive up quality of practice;
- Increasing partnership ownership of CESCB business and improvements;
- developing the confidence to challenge plans and actions across agencies if they are not sufficiently outcome focused or making clear decisions based on robust evidence;
- putting in place a better model for engaging young people in safeguarding - gathering and collating the voice of children and young people from across all CEC agencies to inform practice and service development;
- improving the combined response to specific safeguarding areas such as Child Sexual Exploitation, including a more developed approach to online/digital risks, Female Genital Mutilation;
- jointly re-commissioning further services for adults with significant needs, who are also parents, and recognising the potential increase in risk of harm to children and young people;
- ensuring the LSCB evaluates itself on an ongoing basis against the Ofsted grade descriptors;
- ensuring potential risks to safeguarding practice and arrangements are kept under review in response to increasing demand for services and ongoing re-shaping of public services;
- embedding robust and rigorous quality assurance activity;
- embedding CESCB learning and improvement framework;

- safeguarding Cheshire East children who are living outside the authority in residential, educational or secure settings;
- ensuring effective arrangements are in place for safeguarding children with disabilities;
- improving pathways and procedures around children exposed to domestic abuse; and
- development and implementation of a new neglect strategy, practitioner training and tools.
- reviewing local requirements for CiN documentation, including timescales and circulation of plans and minutes.
- clarifying agency use of, and participation in, the CAF process.
- ensuring a process whereby all agencies involved with a family are known.
- reviewing and clarifying expectations around core groups.
- reviewing expectations of agency use of chronologies or case summaries
- reviewing the core documentation used in CP cases and its completion
- looking at developing standards across agencies setting out expectations around supervision.

The Improvement Board has been passing the monitoring and development of some activities to the CESCB and this will continue and expand to further develop the CESCB as the vehicle for challenge and improvement after the Improvement Board has completed its work.

The Neglect Graded Care Profile was introduced in March 2012 as a tool for practitioners. The LSCB conducted a thematic review of neglect cases in November 2013 and will be producing a Pan Cheshire multiagency strategy on addressing neglect in 2014.

Considerable audit activity of child protection and children in need casework has taken place over 2013-14 following the Ofsted inspection. This has reassured us that children are being protected. The audit findings have revealed that we have achieved a level of compliance and considerably improved the timeliness of assessments. Improving the quality of practice across the partnership needs to be a key area of focus for 2014.

Early help remains a key priority in supporting parents and preventing children becoming at risk from neglect or abuse. Cheshire East offers a wide range of parenting programmes and open access groups through Children's Centres, and commissions a number of parenting support services, such as one to one support in the home establishing a routine for caring and interacting with children, parenting courses and family counselling sessions as part of our early help offer.

Commissioned services are targeted to the areas of the greatest need and should result in a reduction in future demand to Children's Social Care.

Improving the quality of frontline practice for child protection and children in need is a key priority area across the partnership in 2014. Child protection plans for families where neglect is the primary concern need to be more explicit in the consequences for failure to improve the impact on safeguarding the child. Planning needs to be SMART, child and outcome focused. All agencies need to be clear that the child is being seen appropriately (and if not the reason why). All agencies need to know what a good service looks like, and have the confidence to challenge other agencies when a plan is not being fulfilled or is not meeting the need of the child or young person.

The structure of the LSCB will be revised in 2014 to deliver on the priorities and a new Outcomes Monitoring Framework has been developed, which will enable it to more effectively monitor and challenge all partners on their role in protecting children and young people in Cheshire East.

Communications Plan

The success of the improvement plan in Cheshire East relies on communication and engagement with a number of different stakeholders. A stakeholder analysis and communication plan is attached at Appendix 8.

Summary of Outcomes Framework

An Outcomes Framework has been agreed and we will work to improve CESCB's approach to performance management and quality assurance in a way that strengthens the scrutiny and challenge role of the Board. Performance and outcomes will be a priority for the year ahead along with a concerted effort in holding partners to account in improved outcomes for children. The outcomes framework will measure performance across the partnership under four themes of what good looks like:

1. What does good look like for the child?
2. What does good look like for the team around the child?
3. What does good look like for the agency around the team?
4. What does good look like for the Board around the agencies?

Selected measures from the framework will be drawn into thematic reports that will be presented to the LSCB for scrutiny and challenge.

The CESCB Outcomes Framework programme is a three yearly cycle focusing on cross and inter-agency themes and issues. A sub-group will lead on multi-agency themed work with the Executive driving the overall framework.

The programme will consist of:

- Annual in depth analysis of one or two priority areas each year
- Annual light touch review across selected agencies
- Annual audit of experience of frontline staff
- A one off learning case review
- Annual analysis of safeguarding self-assessments (Section 11, Section 175)
- Quarterly performance data, summary reports, voice of the child and a "performance spotlight"
- When required Individual local case reviews and serious case reviews (local and national)
- Three-yearly Joint inspections of multi-agency arrangements for children and young people
- Regular Information from individual organisation's safeguarding quality assurance activity

The Outcomes Framework will cover the following elements in the three yearly cycle:

- **Content area:** a service area for example ChECS, Accident and Emergency; or a vulnerable group of children for example disabled children, children missing education etc. or specific risk areas for example domestic abuse, parental mental health.
- **Organisation/practitioner areas**: workforce capacity, supervision, use of resources, evidenced informed practice
- **Wider picture areas**: for example, the impact of poverty and poor housing, bullying, poor health outcomes
- **Voice of the Child** – do children feel safer and have services made a difference?

These activities are completed through:

1) **In-depth analysis of one or two priority areas each year.**
   The Executive will identify the areas for in-depth analysis based on the quantitative, qualitative and outcome based data available. Each in-depth analysis will include elements of multi-agency file audit, deep dives into individual cases, staff feedback via survey and/or focus groups and child and parent feedback and surveys.

2) **Light touch reviews**

Light touch reviews may consist of individual agency audit information, feedback from staff and sub group multi-agency case file audits.

3) **Annual audit of experience of front line staff**

We will ask each agency to undertake a survey of their staff focussing on their experience of safeguarding supervision and partnership working and to share the results with the CESCB.

4) **Analysis of safeguarding self-assessments**

The CESCB will undertake an annual section 11 audit. All schools will be asked to undertake an annual self-assessment audit of their compliance with section 175. The Executive will receive annual reports analysing both these self-assessment exercises.

5) **Quarterly performance data, summary report and "performance spotlight"**

The Executive will receive quarterly performance reports based on the 'Munro' dataset. The Executive will identify areas for further investigation by the sub groups through a light touch or in-depth review.

6) **Individual local case reviews and serious case reviews (local and national)**

Sub groups will undertake local case reviews where a case does not reach the criteria for a serious case review but where organisations feel that a case review will provide useful insights about the way organisations are working together to safeguard children and where lessons can be learned for future practice. The CESCB will consider the lessons learned from analysis of national serious case reviews and may ask a sub group to test out local practice in the light of findings from national serious case review analysis.

7) **Information from individual organisation's safeguarding quality assurance activity**

The CESCB will ask each agency represented on the Board to evidence the impact of their internal safeguarding quality assurance activity. Agencies should report to the CESCB on their single agency safeguarding audits; undertake and report annual safeguarding staff surveys and provide evidence of consultations and feedback from children and young people.

Challenge log

One of the key roles of the LSCB is to challenge partners on the effectiveness of their safeguarding arrangements. In 2014-15, the LSCB will developed a challenge log to demonstrate how it is challenging partners on their responsibilities. The log will provide

evidence of the issue, what action has been taken to address the issue and any further actions identified.

Sector-specific Challenge Sessions

Sector-specific Challenge Sessions will be held for Health, Public Health, Police and Schools between May and July 2014. The panel will include the Chair of the LSCB, Chair of the LSCB and CEC Head of Safeguarding, a sector expert, and two young people. These sessions will challenge sectors to demonstrate that they have effective arrangements to protect children and young people and will identify areas for development which will inform the Improvement Plan for 2014. Sector-specific Challenge sessions will be implemented annually from 2014 following section 11 audits.

Budget for 2014-15

An outline budget for CESCB's work in 2014-15 is set out at Appendix 9.

Risks/ Issues

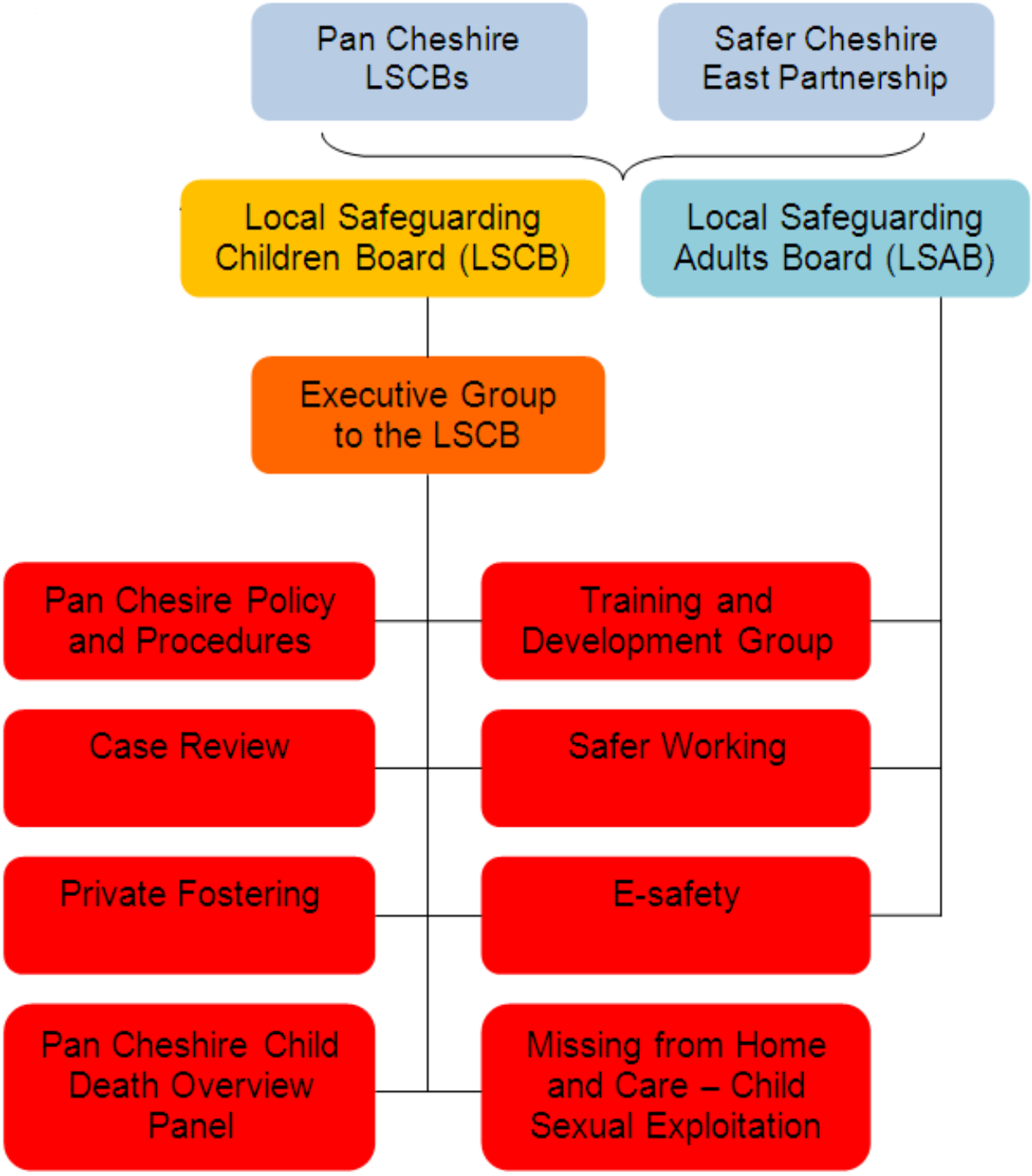
It is essential to identify, analyse and prioritise risks as part of the improvement process to ensure that these risks are managed effectively.

One of the biggest risks to the improvement plan is delivering high quality of practice with the existing level of Agency Social Workers and changes in Social Workers. In response to this, a risk mitigation strategy has been developed, and the application of this strategy will be monitored. This risk has also been logged as high on the corporate risk register.

A risk register for CESCB is attached at Appendix 10.

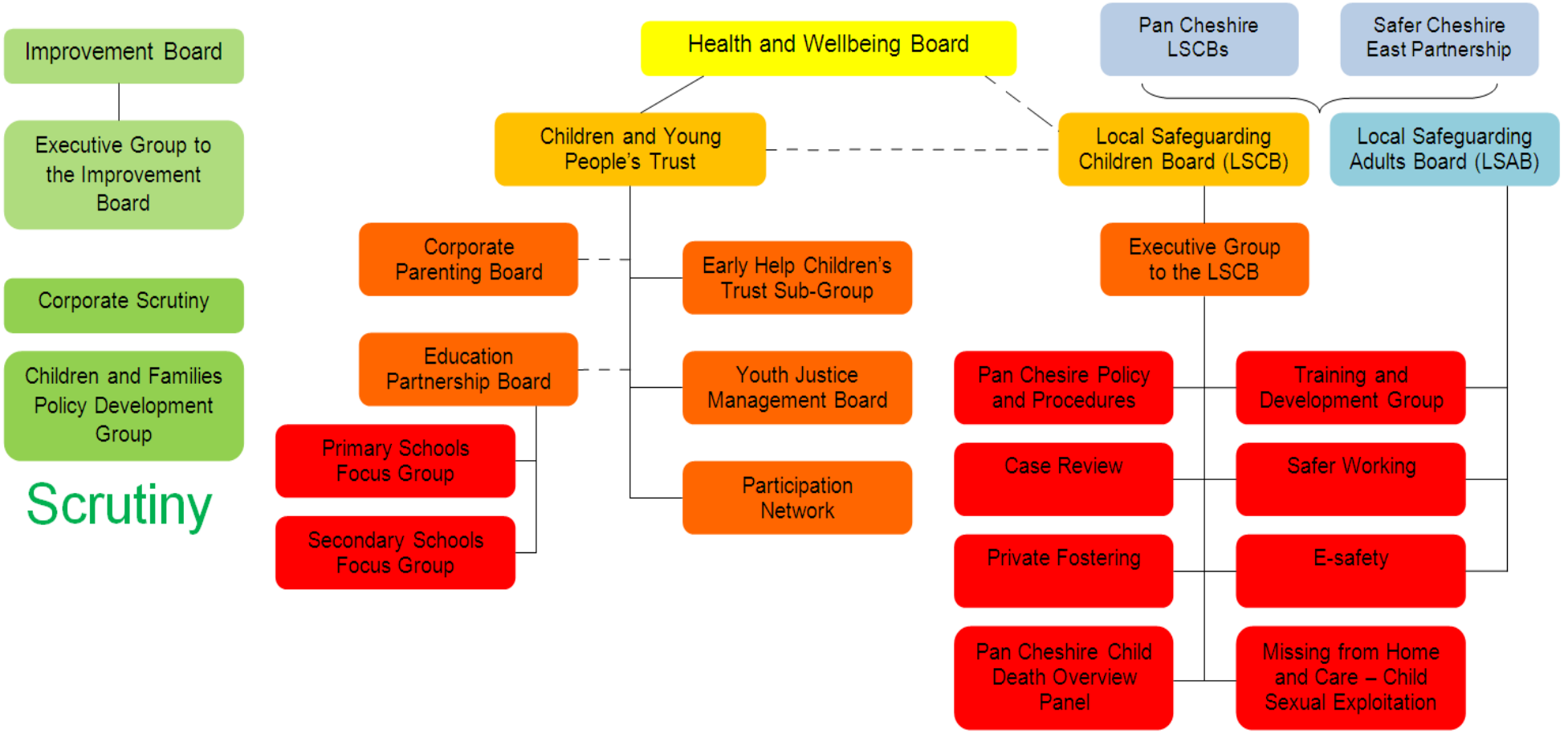
Appendix 1

Cheshire East Safeguarding Board Structure



Appendix 2

Partnership Boards Governance Framework



Appendix 3

Board Membership and Attendance

	10.5.13	12.7.13	21.8.13	18.9.13	22.11.13	24.1.14	21.3.14
Cheshire CAFCASS	1	1		1	1	1	1
South Cheshire CCG	1	1			1	1	1
East Cheshire CCG	1	1	1	1	1		1
CEC Director of Children's Services	1	1	1	1	1		1
CEC Head of Safeguarding	1	1	1	1	1	1	1
CEC Head of Early Help & Protection	1	1	1	1	1	1	1
CEC Principal Social Worker	1	1		1	1	1	1
CEC Principal Manager for Early Help	1	1	1	1	1	1	1
CEDAP						1	1
CEC Lead Member for Children' s Services	1	1	1	1	1		1
Cheshire Police	1	1		1	1	1	1
Cheshire Police Strategic Public Protection Unit	1	1	1	1		1	1
Police and Crime Commissioner's Youth Ambassador				1	1	1	1
CWP NHS Foundation Trust	1	1	1		1		1
East Cheshire NHS Trust	1		1	1	1	1	1
Representative for Colleges	1	1	1		1	1	1
HMP Styal Head of Residence and Services					1	1	
Independent Chair	1	1	1	1	1	1	1
Independent Schools Representative				1			
Lay member	1	1					
Mid Cheshire Hospital NHS Foundation Trust	1	1	1	1			1
NHS England		1	1	1	1	1	1
NSPCC	1	1	1		1	1	
Primary School Heads Representative	1	1		1		1	1
Cheshire Probation	1	1		1	1	1	1
Secondary School Heads Representative	1	1		1			
Voluntary Sector Representative	1	1	1	1			1
CEC Head of Youth Engagement Service	1	1	1	1	1	1	1
South and Eastern Cheshire CCG Designated Nurse	1	1	1	1	1	1	1

Appendix 4

Financial Arrangements – 2013/14

The tables below sets out the LSCB expenditure for 2013-14 and the financial contributions from partners for 2013-14 and the 2014-15 confirmed budgets.

LSCB Budget 2013 - 2014	
LSCB staffing - salaries & costs	**£146,916**
Office & communications	**£9,972**
Training programme	**£12,993**
Independent Chair & consultancy support	**£29,625**
LADO 50% contribution	**£27,400**
Total expenditure for 2013-14	**£226,906**
Agreed contributions total	**£215,899**
In-year 'overspend'	**- £11,007**
Reserve at the end of 2013/14	**£169,684**

CESCB Partners	2013-14 contributions	2014-15 confirmed
Eastern Cheshire NHS	£6,156	£6,156
Mid Cheshire Hospitals	£5,000	£5,000
South Cheshire CCG	£17,071	£17,071
Eastern Cheshire CCG	£17,071	£17,071
CWP	£3,721	£3,721
NHS England		0
Probation Service	£4,000	
CE Children's Services	£41,000	£41,000
Police	£22,000	£20,000
YOS	£3,000	£3,000
CAFCASS	£550	£550
HMP STYAL	£0	£0
CE Education central re LADO	£11,830	TBC
Primary Schools	£64,500	£64,500
Secondary Schools	£20,000	£20,000
Independent Schools	£0	TBC
Cheshire FE Consortium	£0	TBC
Total	**£210,899**	**£198,069**

Appendix 5

Memorandum of Understanding in respect of safeguarding between key strategic public protection partnerships in Cheshire East

Introduction:

This document makes explicit the key responsibilities and accountabilities relating to safeguarding for all the key strategic public service partnerships in CE, namely:

- Cheshire East Health and Well-being Board (HWBB)
- Safer Cheshire East Partnership (SCEP)
- Cheshire East Safeguarding Children Board (CESCB)
- Cheshire East Safeguarding Adults Board (CESAB)
- Cheshire East Children and Young People's Trust (CECYPT)

This document will also reference the key role of the Cheshire East Councils Corporate Scrutiny Committee. The legislation and guidance that underpins the status and remit of these partnerships is set out in Appendix 1b.

Principles:

- The key accountability and responsibility for safeguarding lies with the two Safeguarding Boards (CESCB, CESAB);
    - CESCB in relation to children and young people up to their 18th birthday
    - CESAB in relation to safeguarding adults 18 years and over and domestic violence and sexual assault strategy and commissioning
- However the other bodies referenced in this document all have significant roles in safeguarding;

    Cheshire East Health and Well-being Board - HWBB
    - HWBB is responsible for producing the Joint Strategic Needs Assessment (JSNA), which will identify and set the commissioning priorities for our vulnerable population.
    - The Annual Report from both Safeguarding Boards will set out how the commissioning plans from the JSNA are promoting effective safeguarding in Cheshire East. The annual reports of both Boards will be presented to the HWBB.

Safer Cheshire East Partnership - SCEP

- SCEP is responsible for the commissioning of Domestic Homicide Reviews (DHR's), which are undertaken on its behalf by the CESAB
- It also receives bi-annual reports on domestic abuse and sexual violence partnership working
- The SCEP has a role in ensuring that it maintains and supports partnership awareness and effective response to domestic abuse and sexual violence in Cheshire East.

Cheshire East Children and Young People's Trust - CECYPT

- CECYPT will set out the strategic priorities for children and young people in Cheshire East. Within this, explicit priorities in respect of prevention and early help, will be identified.
- This will influence the priorities set by CESCB and their published levels of need.
- CESCB annual report will be scrutinised by CECYPT

<u>Additional responsibilities for safeguarding vulnerable people in Cheshire East</u>

- The two Safeguarding Boards are independent of each other but need to ensure that they take a whole family approach to setting their priorities and reporting performance where warranted, for example:
  - Transition of vulnerable young people to adulthood
  - Domestic and peer abuse
  - Sexual Exploitation
  - Transfer of learning from case reviews
- Cheshire East Corporate Scrutiny Committee will scrutinise the annual reports of both safeguarding Boards and receive performance updates. Their role is to provide scrutiny and challenge to the work of the Boards.
- The Local Authority Chief Executive is responsible for the appointment for the appointment and performance of the Independent Chairs to the safeguarding Boards. (this is a requirement for the CESB). Each Chair will meet with the Chief Executive (and the respective Strategic Director) on a regular basis.

Appendix 1b

Relevant statutory guidance Cheshire East Safeguarding Children Board (CESCB)

Statutory guidance has come from the following:

United Nations Convention on the Rights of the Child (1989) –defining the basic human rights of all children and specifies 14 basic rights

In the UK the **Convention on the Rights of the Child** was ratified in December 1991 and the principals are reflected within the **Children Act 1989**

http://www.legislation.gov.uk/ukpga/1989/41/contents

The main safeguarding provisions of **The Childrens Act 1989** are Child Protection(s47), Children in Need (s17) , duty to co-operate (s27)of health, education and other public sector agencies to assist Social Care in safeguarding

The Children Act 2004 made it statutory to safeguard and promote the welfare of children across all statutory agencies except education (where it was already statutory, Education Act 2002, ss175 and 157) and set up Local Safeguarding Children Boards
http://www.legislation.gov.uk/ukpga/2004/31/contents

Working together to Safeguard Children (Dept of Education March 2013) provides guidance on how agencies should work together to protect Children

https://www.gov.uk/government/publications/working-together-to-safeguard-children

The **European Convention on Human Rights** applies equally to Children as it does to Adults and is given effect in UK law by the **Human Rights Act (1998) : Article 2**: 'the Right to life'; **Article 3**: 'Freedom from torture' (including humiliating and degrading treatment); and **Article 8**: 'Right to family life'.

http://www.legislation.gov.uk/ukpga/1998/42/schedule/1

Relevant statutory guidance regarding Cheshire East Safeguarding Adults Board (CESAB)

Prior to the implementation of the **Care Act 2014** (see below) there has been no unifying legislation in relation to adult safeguarding.

Therefore, to date, statutory guidance has come from the following:

The **Human Rights Act (1998) : Article 2**: 'the Right to life'; **Article 3**: 'Freedom from torture' (including humiliating and degrading treatment); and **Article 8**: 'Right to family life'.
www.legislation.gov.uk/ukpga/1998/42/schedule/1

No Secrets Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse ('No Secrets') March 2000.
www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care

Safeguarding Adults procedures refer to the local area-based, multi-agency response which is made to every adult *"who is or may be eligible for community care services"* (**National Health Service & Community Care Act 1990**) **and** whose independence and wellbeing is at risk due to abuse or neglect.

The **Mental Capacity Act 2005** provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.
www.legislation.gov.uk/ukpga/2005/9/contents

The **Care Act 2014,** which received Royal Assent on 14th May 2014 and is likely to be in force in April 2015, sets out the first statutory framework for adult safeguarding, which stipulates local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect.

These provisions require the local authority to:

- carry out enquiries into suspected cases of abuse or neglect (**section 42**)
- establish Safeguarding Adults Boards in their area (**section 43**). The role of these Boards, described in **Schedule 2**, will be to develop shared strategies for safeguarding and report to their local communities on their progress.

www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Relevant statutory guidance regarding Cheshire East Health and Well-being Board (HWBB)

The Health and Social Care Act 2012 gives Health and wellbeing boards a duty to encourage health and care commissioners to work together to advance the health and wellbeing of the people in its area.
When health and social care partners work together to tackle particular problems in their local area, patients can benefit and resources can be deployed more efficiently. This Act fosters such partnerships in a consistent manner through the statutory creation of Health and Wellbeing Boards, and by giving organisations the incentive to work together where it is in the best interests of the patients to do so.
http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

Relevant statutory guidance regarding Safer Cheshire East Partnership (SCEP)

The Crime and Disorder Act 1998 gives local authorities and the police the duty to form partnerships to reduce crime and disorder in their areas.

http://www.legislation.gov.uk/ukpga/1998/37/contents

Relevant statutory guidance regarding Cheshire East Children and Young People's Trust (CECYPT)

Children and Young People's Trusts are local partnership arrangements to improve children's wellbeing (the 5 outcomes). They are not defined in legislation but are underpinned by a 'duty to cooperate' in section 10 of the Children Act 2004.
http://www.legislation.gov.uk/ukpga/2004/31/contents

The Apprenticeships, Skills, Children and Learning Act 2009 amended section 10 by bringing schools, colleges and Jobcentre Plus under the duty to cooperate and requiring all local areas to have a Children and Young People's Trust board, which had to prepare and publish a jointly owned CYPP by April 2011.
http://www.legislation.gov.uk/ukpga/2009/22/contents

Appendix 6

Thresholds Document

MEETING CHILDREN & YOUNG PEOPLE'S NEEDS IN CHESHIRE EAST

1. Universal

Children and young people whose needs are being adequately met by family, friends and community, and who are accessing universal services e.g. health visiting, GP, schools, youth settings, etc.

Possible Indicators
- Child or young person generally making good progress in all areas of their life appropriate to their age.

Response
Continue meeting child or young person's needs as a universal service, in a safe environment.
Safer recruitment, professional codes of conduct, preventative education in schools, etc.
All professionals ready to identify and respond to any emerging problems, abuse or neglect should it occur.

2. Targeted

Children, young people and their families who would benefit from additional help with moderate difficulties in order to make the best of their life chances.

Possible Indicators
- Health issues which may impact on child or young person's development and wellbeing.
- Behaviour inappropriate to age and stage of development.
- Parenting skills inadequate to meet the child or young person's needs.
- Family unable to access effective support services to meet specific needs.
- Child starting to have unauthorised absences from school.

Response
A practitioner who identifies unmet needs for a child or young person should consider how these needs can best be met, usually by some additional help from within their own agency.
The Common Assessment Framework (CAF) can help identify and plan to meet needs, and involve others where necessary.
Consult ChECS for advice and guidance 0300 123 5012 (option 2).

3. Complex

Children, young people and their families who have a range of additional needs affecting different areas of life.

Possible Indicators
- Concerns shared by more than one agency.
- Parenting impacting on child and family life causing instability and inconsistency.
- Risk taking behaviour impacting on other areas of a child or young person's life.
- Caring responsibilities that impact negatively on a child or young person's life.
- Mental health and emotional well-being and/or behavioural issues.
- Child or young person no longer in need of a Child in Need or Child Protection Plan, but still has significant needs.
- Anti-social behaviour.
- At risk of entering the Criminal Justice System.

Response
Request support from other agencies such as Family Support, commissioned services, Youth Crime Prevention Team, & Education Welfare.
Agencies work together to provide a network of support to the child or young person and their family.
Identify a Lead Professional to co-ordinate support and be primary link with the family.
Hold a Multi-Agency Meeting and use the Common Assessment Framework (CAF) with child and family to assess their needs, develop and implement an Action Plan and review progress.
Consult ChECS for advice and guidance 0300 123 5012 (option 2).

4. Specialist

Children, young people and their families who need immediate protection or who require support from a statutory service such as Children's Social Care, Youth Offending Team, or Child & Adolescent Mental Health Service.

Possible Indicators
- Risk of abuse, neglect, or exploitation.
- Risk-taking behaviour which could lead to significant harm.
- Children/young people with severe or complex needs in relation to disability.
- Parent/carer has complex issues e.g. mental health, alcohol/substance misuse, domestic abuse, etc. that significantly compromise care and ability to provide a safe environment for the child.
- Children or young people in the Criminal Justice System.

Response
Any concerns about the safety of a child or young person, contact ChECS on 0300 123 5012 (option 2).
Children's Social Care lead multi-agency planning and support through a Child-in-Need Plan, Child Protection procedures, or accommodation by Children's Social Care.
Youth Offending Team lead multi-agency interventions for Court-Ordered supervision of young offenders in the community and in custody.

Family Information Service 0300 123 5033 www.cheshireeast.gov.uk/fis

Cheshire East Consultation Service (ChECS)
0300 123 5012 (option 2)
Out of office hours: 0300 123 5022
www.cheshireeast.gov.uk/ search 'ChECS'

Cheshire East Safeguarding Children Board
lscb@cheshireeast.gov.uk 01625 374 753
www.cheshireeast.lscb.org.uk

Child Protection Procedures
www.enlivenprocedures.co.uk/cheshireeast/

Appendix 7

Partnership Responsibilities and Accountabilities

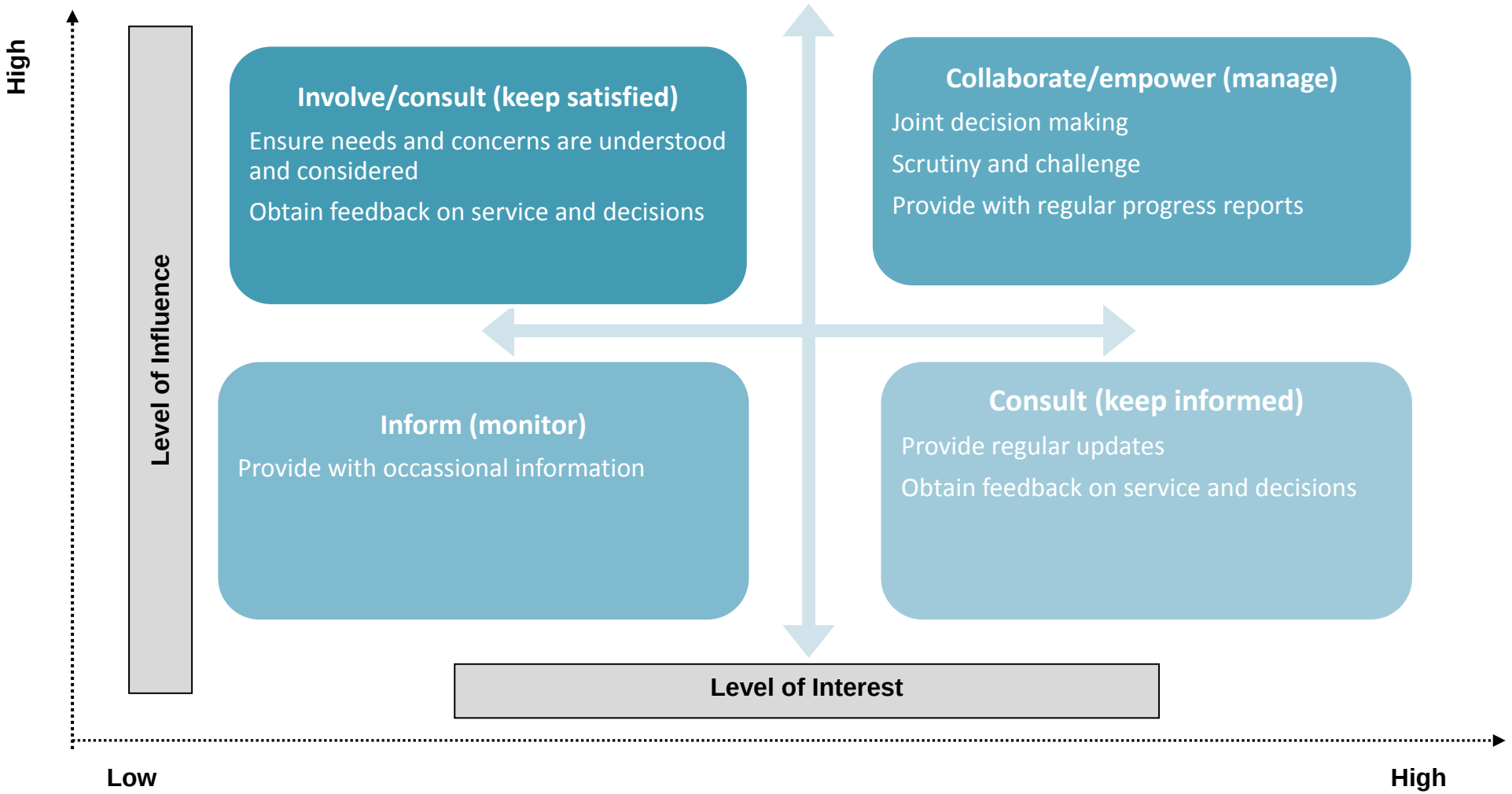
Cheshire East aims to be **the best partnership in the country** for improving the lives of children and young people.

Frontline practice is consistently good, effective and outcome focused		
High quality Social Workers and Managers are recruited and choose to remain with Cheshire East	Cheshire East Council	Improvement Board
The new case management system is implemented and effectively supports assessment and planning for children and young people	Cheshire East Council	Improvement Board
The quality and consistency of CIN planning is significantly improved	LSCB	Improvement Board
Adoption timescales are improved. There are the right number and type of adopters and there is a plan for placing harder to place children and young people	Cheshire East Council	Improvement Board
Practice is improved through audit	All partners	Improvement Board
Staff have the skills and are supported to complete high quality and timely assessments.	Cheshire East Council	Improvement Board
Workers across the partnership are skilled in safeguarding practice and can act on children's expressed views	LSCB	LSCB
Information sharing works well	LSCB	LSCB
Step up/down is effective	All partners	LSCB
CAF's are used well by all partners	All partners	LSCB
Good quality training is available, taken up and has an impact	LSCB	LSCB
Workers have sufficient access to good quality supervision	All partners	LSCB
Workers have time to do necessary work	All partners	LSCB
Partners attend planning and core group meetings when required	All partners	LSCB
Systems and processes (including IT and technology) support staff in doing their jobs	All partners	LSCB
Frontline staff are skilled and equipped to carry out their roles effectively	All partners	Children's Trust
Joined up workforce planning within commissioning arrangements	Children's Trust	Children's Trust
Engagement and participation is embedded in job design and workforce processes	All partners	Children's Trust
Children and young people feel and are kept safe	LSCB	HWBB
Children and young people experience good emotional and mental health and wellbeing	Children's Trust	HWBB
Children and young people who are disabled or who have identified special educational needs have their aspirations and hopes met	Children's Trust	HWBB
Children and young people have the best start in life	Children's Trust	HWBB

Outcomes	Responsible (planning, delivery)	Accountable (monitor, challenge)
Listening to and Acting on the Voice of Children and Young People		
Feedback from children, young people and parents is effectively incorporated into service planning and delivery	Children's Trust	Improvement Board
Children and young people are able to build a trusting relationship with professionals. Children have access to information, know their rights, have their say and make choices, and understand how decisions about them are being made.	LSCB	LSCB
Professionals recognise that children and young people have views, wishes and feelings and an interest in their own protection	All partners	LSCB
Children are respected as individuals and their voices are heard separately from their parents	All partners	LSCB
Workers are skilled at gaining the wishes and feelings of all children and young people and are confident that these are heard and acted on	All partners	LSCB
Participation of children and young people is embedded and their experience and insight is used to shape service improvement	LSCB	Improvement Board
Children and young people's participation in self evaluation and improvement activity is systematic and meaningful	All partners	LSCB
Feedback from children and young people does not indicate serious concerns	All partners	LSCB
Children, young people and adults have a good understanding of children's rights, according to the United Nation Convention on the Rights of the Child (UNCRC)	Children's Trust	Children's Trust
Children and young people are treated fairly and feel respected	All partners	Children's Trust
Children and young people express their views, feel heard and are actively involved in decisions that affect their lives in accordance with Article 12 of the UNCRC	All partners	Children's Trust
There are clear standards to ensure that children and young people participate in the planning, design and evaluation of services in Cheshire East	Children's Trust	Children's Trust
There are clear and effective networks across the Borough for engagement and participation	Participation Network	Children's Trust
Participation and engagement activity is joined up across the partnership.	Participation Network	Children's Trust
The Children and Young People's Plan addresses what is important to children and young people.	Children's Trust	Children's Trust
The voice of children and young people is fully embedded in the design and commissioning of services across the partnership	Joint Commissioning Board	HWBB
Experience, feedback, and insight from children, young people, parents and carers is a key feature within the JSNA.	HWBB	HWBB

The partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East.		
The LSCB effectively monitors and challenges the role of partners in protecting children from harm or risk of harm	LSCB	Improvement Board
The partnership has a clear vision for children's services	Children's Trust	Improvement Board
The partnership understands their roles and responsibilities and the role of partnership Boards in improving services	LSCB / Children's Trust	Improvement Board
Safeguarding and child protection needs are prioritised in the Health and Wellbeing Strategy	HWBB	Improvement Board
Cheshire East has a communications strategy that includes mechanisms for listening to the voice of the child, families, staff and partners	Cheshire East Council	Improvement Board
Embed leadership role and governance of the LSCB	LSCB	LSCB
Partners attend LSCB meetings in accordance with a revised Terms of Reference	All partners	LSCB
Review and strengthen the structure of the LSCB to respond to new priorities	LSCB	LSCB
The LSCB is able to evidence that it challenges practice	LSCB	LSCB
There is effective performance management and high level statistics do not indicate serious concerns	All partners	LSCB
Improve learning and share good practice	LSCB	LSCB
Children and young people participate in and inform the work of the LSCB	LSCB	LSCB
The voice of children and young people is embedded in LSCB key decisions	LSCB	LSCB
The LSCB monitors and challenges the effectiveness of agencies in adopting the Children's Rights respecting approach	LSCB	LSCB
The partnership has a clear and ambitious vision for improving outcomes for all children and young people	Children's Trust	Children's Trust
The Partnership has a clear understanding of the quality of life and wellbeing of children and young people in Cheshire East and the barriers to their potential	All partners	Children's Trust
The Partnership focuses its efforts on key priorities set and agreed with children and young people and monitors its progress	All partners	Children's Trust
All staff are clear on what a gold standard service looks like and committed to achieving the partnership vision	All partners	Children's Trust
Cheshire East is promoted as a good and exciting place to work with children and families where workers are valued and have an important role in service development.	All partners	Children's Trust
Frontline staff are involved in service improvement and development.	All partners	Children's Trust
The partnership understands, plans and commissions services to meet the needs of children, young people and their families	Joint Commissioning Board	HWBB
The JSNA is a live partnership document that is regularly improved and updated.	All partners	HWBB

Stakeholder Communication Analysis



Stakeholder Engagement

	Inform	Consult/Involve	Collaborate/Empower
Stakeholders	• Cheshire East staff from other departments • General public in Cheshire East	• Children and young people • Parents/carers • Children's Services staff • Health • Police • Private, voluntary & independent sector • Governors • School staff • Elected Members • Department for Education • Children's Improvement Board	• Improvement Board • LSCB • Children's Trust • Scrutiny Committee • Children and Families PDG • Cabinet • Senior Managers
Purpose of engagement	To provide stakeholders with a general understanding of what is to be achieved through the improvement plan	To obtain feedback from stakeholders on services and impact to improve practice and to ensure that any concerns /suggestions are acted upon	To drive sustainable improvement across the Children's Services Partnership through scrutiny, challenge and key decision making
Methods of engagement	• Cheshire East website • Press releases • E-bulletins – Improvement Newsletter, P&P Briefing, Staff newsletter, Schools Bulletin • Facebook • Twitter	• Advocacy • Newsletters • E- bulletins • Intranet • Cheshire East and partner websites • Press releases • Factsheets and one minute guides • Progress updates • Surveys • Focus groups and forums	• E-governance • Joint planning • Action plans • Local governance • Reports • Progress updates • Performance Book • Impact reports • Presentations • Meetings • Sub-groups • Surveys

Outline budget for 2014-15

	Budget for 2014-15
Business Unit staffing, travel, and office running costs Business Manager (full time) Business Administrator (full time)	**£86,000**
Training & Development Manager (3 days a week)	**£64,000**
Training Officer (2.5 days a week)	
Training Administrator (4 days a week)	
Training programme and venues	**£12,000**
Independent Chair	**£24,000**
LADO - 50% contribution	**£27,400**
Other - Serious Case Review - Communications - Audit support	**£20,000**
Total	**£233,400**

Appendix 10

Cheshire East Safeguarding Children Board Risk Register
Date of last revision –
Date of next review –

Cheshire East Local Safeguarding Children Board

Risk Matrix – Likelihood and Impact

Likelihood					
Very Likely	**4**	LOW	MEDIUM	HIGH	HIGH
Likely	**3**	LOW	MEDIUM	MEDIUM	HIGH
Unlikely	**2**	LOW	LOW	MEDIUM	MEDIUM
Very Unlikely	**1**	LOW	LOW	LOW	LOW
Impact		Minor **1**	Significant **2**	Serious **3**	Major **4**

The Risk Matrix (With Scores)

4	8	12	16
3	6	9	12
2	4	6	8
1	2	3	4

Risk Ref	Risk Description	Risk Owner	Existing Controls	Net Rating	Planned Actions	Target Rating
1						
2						
3						
4						

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Looking to the Future:

The Health and Wellbeing of Children and Young People in Cheshire East

The Annual Report of the Director of Public Health

2013-2014

Contributors (in alphabetical order)

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Thank you to our colleagues in other teams within Cheshire East Council and at the two Clinical Commissioning Groups who have contributed their time, knowledge and expertise towards this report:

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Becky Barber	Practice Engagement Manager, NHS South Cheshire CCG
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Jonathan Potter	Principal Manager – Early Help
Sharon Fryer	Children and Young People's Champion
Tony Crane	Director of Children's Services

Contents

Foreword

It is with great pleasure that I bring you this Annual Report for 2014. As Director of Public Health I am required by law to write an independent annual report on the health of the local population. This year's report focuses on the health and wellbeing of children and young people. It provides a current picture of how healthy the children and young people in Cheshire East are and what services they and their families use to support them. This report highlights areas which are performing well and also makes recommendations on ways to improve.

One Year On

It is now more than a year since some Public Health duties transferred from the NHS to Local Authorities. Cheshire East Council, in line with the requirements of the Health and Social Care Act 2012, appointed a specialist Director of Public Health to oversee and discharge their responsibilities.

A number of the Director's responsibilities and duties arise directly from Acts of Parliament - mainly the NHS Act 2006 and the Health and Social Care Act 2012 - and related regulations. In particular, Section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, makes the Director of Public Health responsible for all of the local authority's duties to take steps to improve the health of the people in its area. Improving the health of local people can be achieved in a number of ways. This includes influencing factors that determine health, both good and bad (e.g. good housing, vibrant economy), protecting people from disease (from pathogens or risky behaviour such as smoking or drinking), and ensuring that local services are delivered in the right place at the right time and are of the right quality. All of these approaches should reduce inequalities in health.

As the Director of Public Health, I also lead the commissioning of the mandated and non-mandated public health services and manage the ring-fenced public health grant that has been provided to the Council. Some of these services (such as those for alcohol and drug misuse, sexual health and smoking cessation) cover all age groups. The high level of clinical expertise required for the provision of some of these services, for example sexual health, means that it is not appropriate to have separate arrangements specifically for young people. However, all services are carefully tailored to specifically meet the needs of the young as well as older people.

In order to deliver these responsibilities, I work closely with NHS colleagues in Clinical Commissioning Groups (CCGs), in NHS England and Public Health England, as well as with local authority colleagues such as the Director of Children's Services and the Director of Adult Social Services. Together, we promote joined-up action across the whole life course.

The pivotal report, 'Fair Society, Healthy Lives – The Marmot Report' (2010), highlighted the importance of the life course model and emphasised the accumulation of effects seen on health and wellbeing starting before birth as well as during a person's life. The Marmot Report stated that its highest priority recommendation was 'giving every child the best start in life'. The report identified that disadvantages start before birth and accumulate throughout life. What happens during a child's early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing – from obesity, heart disease and mental health, to educational attainment and economic status.[1]

The report states that action must start before birth and be followed through the life of the child. However, the report also assures the reader that there is much that can be done to improve the lives and health of people who have already reached school, working age or beyond. It is for these reasons that together with my Council and NHS colleagues, I address health differences across the

life course to improve the health and wellbeing of all the citizens of Cheshire East from the very young to the very old. This report, however, will focus on our younger members of society, their health needs are and how we can improve their health and wellbeing, and through that, their futures.

Children's Public Health Services

In October 2013, the Chief Medical Officer, Professor Dame Sally C Davies chose to focus on children and young people in her Annual Report.[2] She found that the health and wellbeing of children and young people is a complicated mixture of genetics, sociology and psychology, and that the evidence shows that during the life course there are still opportunities to make improvements and develop a more healthy population.

There are a wide range of public health interventions that can improve the health of children and young people. These include interventions at a whole population level, for examples, to reduce and prevent birth defects, the National Child Measurement Programme and public health services for children and young people aged 5-19 (including school health services and the Healthy Child Programme 5-19). In October 2015 a further service will be added to the Director of Public Health's portfolio; commissioning the Healthy Child Programme 0-5 (including health visiting and the Family Nurse Partnership services) will transfer from NHS England to Cheshire East Council.

In this Annual Report I will:

- Explain the critical significance of a healthy pregnancy and how it contributes to the subsequent development and outcomes experienced by the child
- Assess some of the key patterns in economic prosperity and child health in Cheshire East and their influence on health
- Draw attention to the strong relationships that exist between children's environments (whether in the home, at play, being transported, or when attending school) and their state of health
- Highlight the many opportunities that exist to keep children healthy and injury free
- Summarise the current national guidance on maximising the school health team's contribution to the public health of school-aged children, and outline a way forward for the development of school health services
- Set out the complicated commissioning environment for children and young people, together with some simple steps that commissioners can take to ensure that their plans are aligned and in the best interests of children

The Local Health and Care System

Unfortunately a silent and often unrecognised feature of the current system for children and young people is that care is not always coordinated and lacks a common agreed purpose or planned outcome. Different services do what is right for an individual child, but their actions are not always aligned with other providers or agreed between different commissioners. This can lead to pregnant women, their partners, children and young people and their families experiencing inconsistent

advice and management. This is more likely to occur at key transition points such as pregnancy, infancy and later on as a young person moves on to adult services.

This has been recognised locally and the current integration programmes in both of the Clinical Commissioning Group areas are now starting to look at children and young people.

This report looks at the main reasons for ill health in the local population, and highlights the strong evidence base that shows that actions can achieve change. I highlight areas where societal change is possible, including tackling fuel poverty, where Cheshire East Council is developing innovative approaches including sourcing low-cost energy for its residents. I will also outline the improved outcomes that can occur when families are empowered to manage their child's minor illnesses themselves at home through self-care, or by knowing which health services can support them in the community, rather than waiting and then relying on urgent care or hospitalisation. These include, but are not limited to:

- The refocusing of 'public health nursing' (health visitors, school nurses, but also the roles of midwives) to predict, prevent, plan for ill health and support parents and young people to manage minor illnesses with self-care

- Greater publicity of the role and skills of the local pharmacist in providing advice and treatment for minor childhood illnesses

- Coordinated care pathways across the different services to manage childhood illnesses or unintentional injuries in the community unless life threatening or serious enough to require specialist services (e.g. broken bones)

- Reinforced messages to parents and families about self-care and how to manage their child's illnesses at home, what key warning signs to look out for and who to go to for help or advice

- An alternative approach to out-of-hours care for children and young people which does not channel them into hospital, but instead provides treatment and support in the community

This vision for the future will take time to implement, and there maybe difficulties to overcome, but it will benefit our children and young people and their families. I call upon my colleagues in the local NHS, wider council services and third sector organisations to embrace this vision and work towards it as we move ahead to improve the lives and health and wellbeing of our local children and young people.

Dr Heather Grimbaldeston
Director of Public Health

Chapter One

Applying Proportionate Universalism to Children's Health and Wellbeing

In my last Report I drew attention to proportionate universalism as an approach to reducing health inequalities across a community. In summary this means that universal action is taken but its scale and intensity is proportionate to the level of need in different areas.

A good example of why proportionate universalism is important can be taken from those children and young people experiencing limiting long-term illness (LLTI). Figure 1 and Figure 2 show the proportion and number of children aged 0-15 who were reported in the 2011 Census as having a long-term health problem or disability that limits their daily activities either "a little" or "a lot", using ten national deprivation deciles based on the index of multiple deprivation (IMD).

There is a clear health inequality between the ten types of area. Children living in more affluent areas experience lower levels of limiting long-term illness (LLTI) than children in more deprived areas. Those in the 40% most deprived areas experience greater levels of LLTI. Although the burden of disease is disproportionately focused on this 40%, a sizeable number of children who live in the least deprived areas still have a need for services (Figure 2).

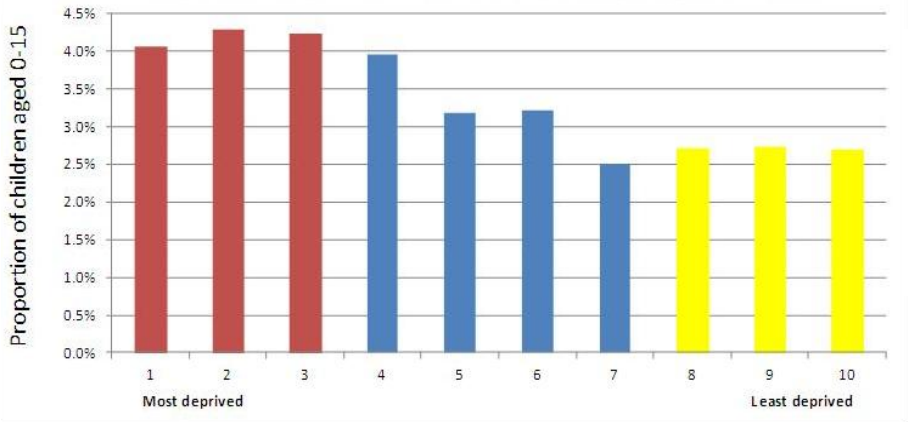


Figure 1. Proportion of 0-15 year olds with LLTI in Cheshire East areas classified by national IMD decile

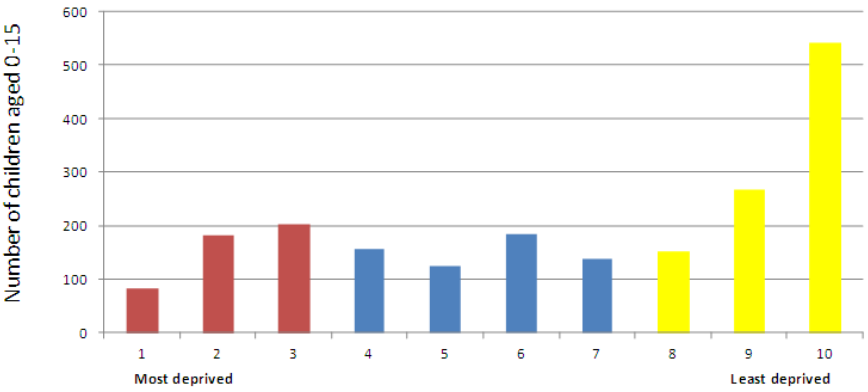


Figure 2. Children aged 0-15 with LLTI in Cheshire East areas classified by national IMD decile

There is a very easy explanation as to why this occurs. In Cheshire East only 18% of children live in the most deprived 30% of areas (illustrated in red on Figure 3). Whereas nearly 55% of children in Cheshire East live in areas that are among the 30% least deprived areas nationally (illustrated in yellow on Figure 3).

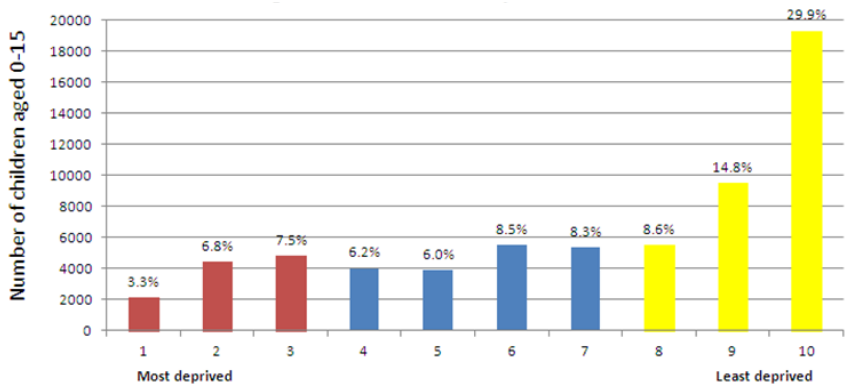


Figure 3. Number and proportion of children in Cheshire East living in areas classified by national IMD Decile

As Marmot recognised, in Cheshire East we cannot exclude any area from public health initiatives purely because of its relative national deprivation. The important requirement is to identify what the health and wellbeing needs are in each part of the Borough, and then for the commissioning process to drive improvements in the factors that underlie those individual children's needs.

Locally it has been identified that 9.5% of households in the Borough live in fuel poverty. To try to address this local need, Cheshire East Council is intending to become only the second council to offer to all its households, and local businesses, the chance to benefit from an energy deal aimed at tackling fuel poverty by enabling them to buy their supply, at a competitively low cost, through the Council.[3] This is a good example of proportionate universalism. Although anyone in the borough can benefit, households in poverty have most to gain and should be supported to take part.

Not only will this scheme directly impact the household budget of those households experiencing fuel poverty, it will have a wider impact on health and wellbeing. A warm, dry and secure home is associated with better health; chapter six focuses on this issue in more detail. In addition, if less money is spent on heating the home, more is available in the household budget for the other things that will benefit a child's health including a healthier diet. By tackling the wider societal problems, such as fuel poverty, the overall health and wellbeing of local children (and their families) can be improved.

Healthy Child Programme

The Healthy Child Programme is a national public health programme that is based on the best knowledge and evidence to achieve good outcomes for all children. The Healthy Child Programme uses proportionate universalism to ensure that children and their families receive appropriate levels of care. All families receive 'your community' services and those with children aged 0-5 receive 'universal' care, but those families identified by midwives, health visitors or the Family Nurse Partnership as needing additional support receive either 'universal plus[a]' or 'universal partnership plus[b]' levels of care.[4]

The professional redevelopment of health visiting and school health services during recent years has given both groups the necessary skills and tools to achieve proportionate universalism. They are able to actively support parents, children, young people and families when they need extra help. Some examples of this include specific parenting issues, post natal depression, asthma, emotional

[a] Universal Plus delivers a rapid response from the health visiting team when specific expert help is needed, e.g. with parental mental health, attachment, toilet training, behaviour management, domestic violence.

[b] Universal partnership plus provides ongoing support from the health visiting team, bringing together a range of local services, to help families who have complex additional needs. These include services from Sure Start Children's Centres, other community services including voluntary and community organisations and, where appropriate, the Family Nurse Partnership and referral to the GP, social care or specialist services where appropriate.

difficulties and bullying. They can also coordinate additional help from a range of other local services to work together with the family and deal with more complex issues over a period of time.

The Government has recently announced that it intends to make certain universal elements of the programme 'mandatory', namely:

- Antenatal health promoting visits
- New baby review
- 6-8 week assessment
- 1 year assessment
- 2-2½ year review

These are key points during a child's early years when parents are supported to give their child the best start in life, and to identify early, those families who need extra help (early interventions). These elements are delivered by midwives, health visitors or through the Family Nurse Partnership (FNP) targeted services for teenage mothers, as part of an ongoing relationship with families and communities. A key finding from this Public Health Report is that children from every community in Cheshire East have a range of health needs. Variations and inequalities do exist, but not to the extent that *public health services* for children should only be provided in some towns and not in others.

From October 2015 the responsibility for commissioning health visiting and FNP services will move from the NHS to local authority public health departments. Clinical commissioning groups will remain responsible for commissioning midwifery and children's acute or hospital type services.

In order to fully support proportionate universalism in the Healthy Child Programme locally, the main commissioners in the Council, both Clinical Commissioning Groups (CCGs) and Police and Crime Commissioner must work together to reconfigure this local preventive work. This will be based on an understanding of need as described by the children and their families and the expert knowledge of midwives, health visitors and school nurses. The improvement in children's health that will be achieved in each area (or outcome) will be guided by an understanding of the wide range of social and environmental factors (in addition to deprivation) that affect children and their families. Some of these variations are illustrated in the Statistical Appendix to this Report. Understanding these are key to addressing need and improving outcomes for local children.

The Family's Role

Families, right from the start and even before birth, should be provided with the information they need to help keep their child safe, healthy and happy. The concept of an 'empowered' family, able to manage their child's ill health and address what is important to them and the child is described as 'family resilience' in the Annual Report of the Chief Medical Officer 2012.

The diagram below shows how families, alongside some professional services, can support the development of an emotionally and physically robust child. Although services such as health visiting play a part, the family is the first line of defence against ill health, both mental and physical, in children and young people. Often simple "personal prevention" tasks such as good hand hygiene can help protect against gastrointestinal conditions like diarrhoea and vomiting and respiratory

conditions such as cold and flu. A good diet and good oral health can have both short (healthy teeth) and longer term (reduced risk of developing diabetes) effects. Indeed the vast majority of the preventative measures that can help to keep a child healthy and happy are enacted through their family.

Alongside this, services, including the police, housing teams, Environmental Health Teams, health visitors and midwives all have a 'preventive' role to play by helping to improve the home or environment in which a child is growing up. It is well established that the wider determinants of health such as housing or transport can negatively impact on a child's health, but through a multiagency focus on achieving proportionate universalism the health and wellbeing of children and young people in Cheshire East will improve.

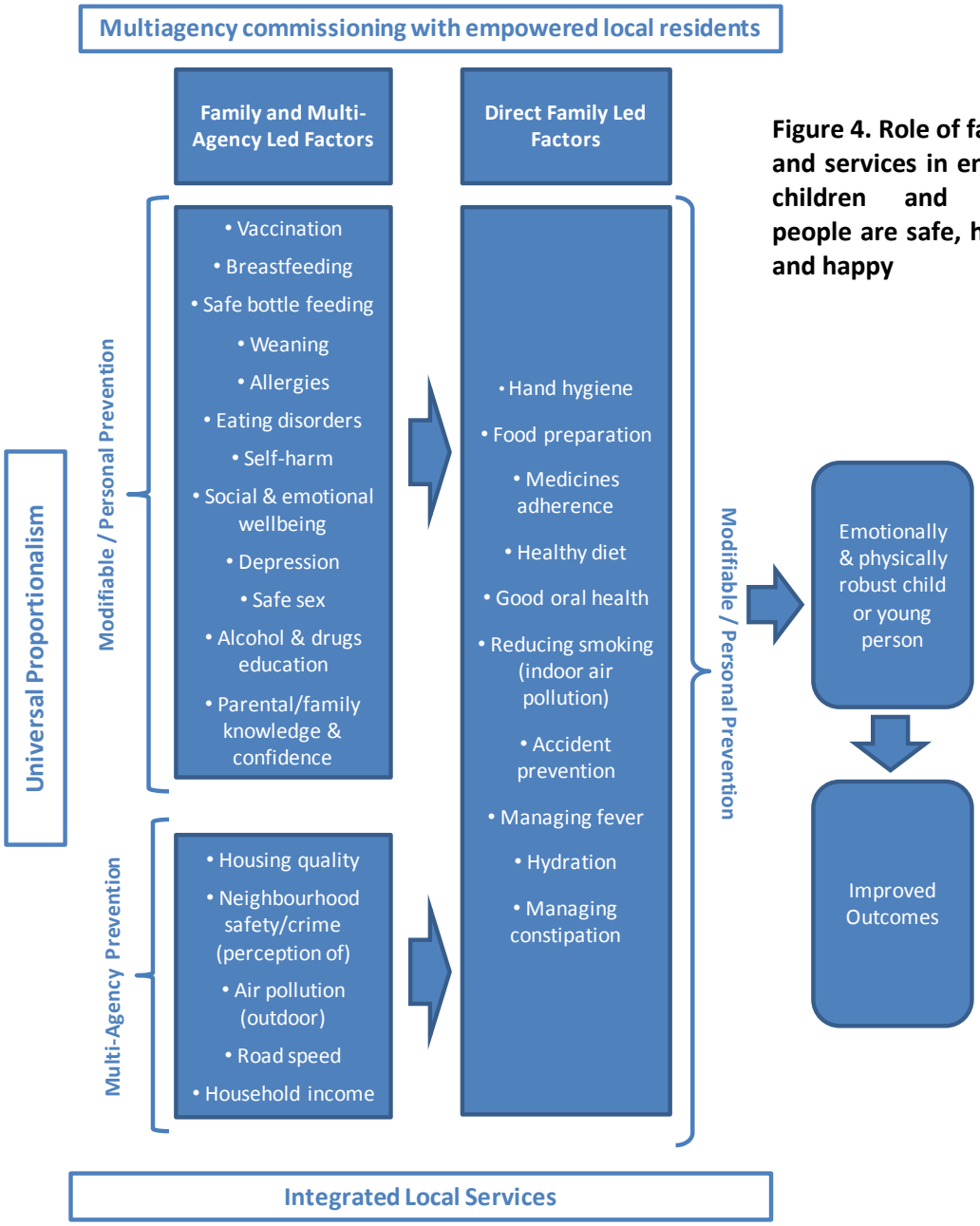


Figure 4. Role of families and services in ensuring children and young people are safe, healthy and happy

Key Points

Children from every community in Cheshire East have a range of health needs. Variations and inequalities do exist, but not to the extent that public health services for children should only be provided in some towns and not in others. Proportionate universalism, where universal action is taken but its scale and intensity is proportionate to the level of need in different areas, should be used to address the differences in need between areas and reduce the gap between them.

Cheshire East is a relatively affluent borough; nearly 55% of Cheshire East children live in areas that are among the 30% least deprived areas nationally. Yet this overall picture of affluence masks that 18% of the children in Cheshire East live in the most deprived 30% of areas and that these children experience worse health outcomes than their peers in more affluent parts of the borough. A number of examples of proportionate universalism show how Cheshire East can help to reduce the variation that exists within the borough:

- In October 2014, Cheshire East Council announced a fuel poverty initiative designed to help local residents and businesses buy their fuel at a competitively low cost. Although anyone in the borough can benefit, households in poverty have most to gain and should be supported to take part.

- The national Healthy Child Programme ensures that children and their families receive appropriate levels of care. All families receive 'your community' services and those with children aged 0-5 receive 'universal' care, but those families identified by midwives, health visitors or the Family Nurse Partnership as needing additional support receive more intensive support from these services (called 'universal plus' or 'universal partnership plus').

Families are pivotal to reducing ill health amongst children; they offer the first line of defence against ill health, both mental and physical. Further, local families need to be 'empowered' to enable them to keep their children safe, health and happy. Future developments are needed locally to support current work and continue to reduce the difference in need between local areas. This requires local commissioners to work together to reconfigure local preventative work, based on expert local understanding of need from those professionals working directly with families and children.

Chapter Two

Sure Start Children's Centres

The purpose of a Sure Start children's centre is to improve outcomes for young children and their families and reduce inequalities between families. These outcomes include child development and school readiness; parenting aspirations and parenting skills; and child and family health and life chances.[5]

Children's centres are a good example of proportionate universalism. They make available universal and targeted early childhood services either by providing the services at the centre itself or by providing advice and assistance to parents and prospective parents in accessing services provided elsewhere. The scope of the children's centre is very wide but it includes health services relating to pregnancy (and preconception care for subsequent pregnancies), as well as health services for young children up to the 31st August following their fifth birthday.

A children's centre is defined in the Childcare Act 2006 as a place or a group of places:

- which is managed by or on behalf of, or under arrangements with, the local authority with a view to securing that early childhood services in the local authority's area are made available in an integrated way
- through which early childhood services are made available (either by providing the services on site, or by providing advice and assistance on gaining access to services elsewhere), and
- at which activities for young children are provided

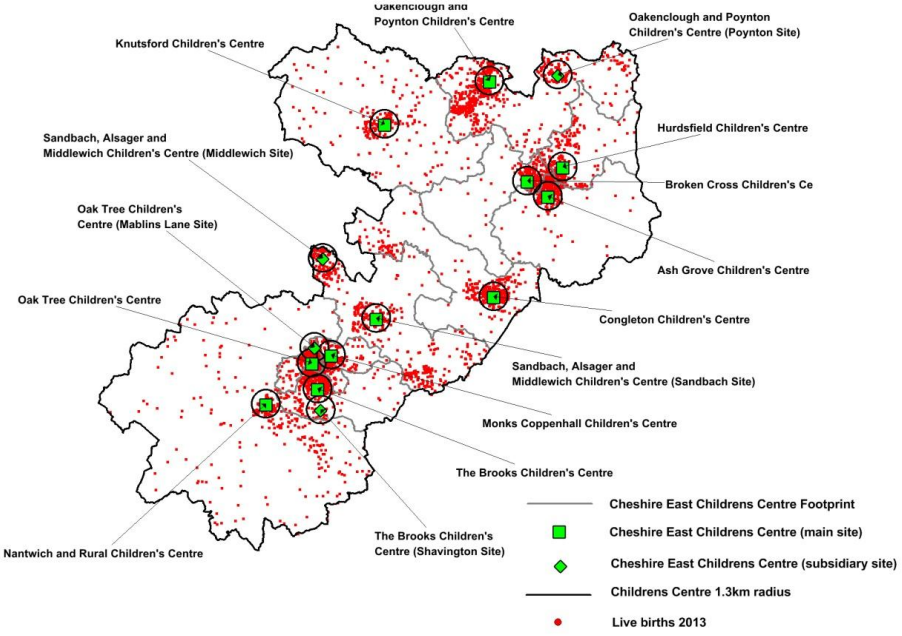
Children's centres were originally planned to be a physical building from which all services for families would be provided – a 'one stop shop' within pram-pushing distance from the family home. The model has changed due to national policy changes, reductions in national funding and the needs of the community. Many provide services at other locations, however the majority of services are still provided through the main local hub.

Cheshire East Council has eleven children's centres. They provide a range of clinical and peer support services all designed to improve health and wellbeing of parents and children. These include antenatal and postnatal care for women, well baby clinics, and support groups, for example breastfeeding groups and multiple birth groups, smoking cessation courses, baby weaning groups, support groups for new mothers with postnatal depression, eczema groups, baby massage groups, dads groups and messy play.

These activities and other services such as play sessions are spread throughout the day and week.

Map 1 illustrates that several medium-sized towns and many rural villages may be some distance away from the main children's centre's building which covers their area. These include Alderley Edge, Alsager, Bollington, Disley, Goostrey, Holmes Chapel; Wilmslow and Nantwich and surrounding rural areas. In these areas, families and babies with higher needs, and those rural families without private transport, may require extra support to be able to access their children's centre.

Map 1. Map showing the location of Cheshire East Children's Centres with a 1.3km radius, their footprint, and births in 2013



Children's Centres in Rural Areas

Deprivation is a key indicator for the positioning of a children's centre and helps them identify those families who can most benefit from their services. Whilst deprivation is usually seen as an urban issue, rural poverty is real,[6,7] but it is often hidden and unacknowledged. Statutory guidance, published in April 2013, for Sure Start children's centres highlights that the reduction of child poverty should be a priority for local authorities, commissioners and the leaders of children's centres.[8] It is important therefore that the needs of families in Cheshire East's rural communities are recognised in the planning of services at or from local Children's Centres.

The Commission for Rural Communities reports that for the majority of parents in rural areas who have cars, internet access, a reasonable income and friends and family close by, the disadvantages of living in a rural area are regarded as occasionally troublesome but no more than that. But for a minority, the disadvantages are very significant, causing some of them to miss out on primary health care, continuing education, the opportunity to have social relationships, childcare and employment.[7]

The Evaluation of Children's Centres in England Report (2013)[9] looked at how far users or potential users travelled to the children's centre. Overall most centres' users live nearby with the average distance travelled being just less than 1.3km. This figure is based on the 'crow flies' distance, rather than actual travel distance or travel time but gives a general level of magnitude. Nationally 78% live less than 1.5km from the centre, 61% less than 1km and less than 5% of users are likely to live more than 3km from their children's centre. In Cheshire East, these 5% are likely to be from rural communities.

Although the majority of births in Cheshire East are to women living in urban areas, nearly a fifth of all births (18.7%, 751/4013) in 2013 were from rural areas (Map 1). The 2011 census shows that in the rural communities of Cheshire East 2% of residents aged 0-15 have no cars or vans in the household and 20% have one car or van in the household. With the latter category, it can be

assumed that the car or van would usually be used by the member of the family who was going to work, so it would not be accessible during the day to family members at home. It is therefore likely that parents in most need in rural areas in Cheshire East may not have ready access to private transport during the day.

In addition public transport in rural areas of Cheshire East is limited. The design of some buses are not suitable for prams or young children and the timetables will not necessarily coincide with the timings for sessions at children's centres. This leaves the most vulnerable rural families isolated from services that should be supporting them.

In a 2012 evaluation of children's centres services, managers of rural children's centres spoke of particular problems with transport and long distances between services. They highlighted the importance of play/outreach buses going out into rural areas which other transport did not reach; this was described as particularly important in addressing social isolation.[9] Indeed other local authorities with similar rural geographies have tackled this issue. Cumbria has large numbers of children's centres (29) with satellite centres in village halls. Lincolnshire County Council uses mobile toy buses and clinics,[6] and the Ilfracombe children's centre has developed a "Tiny Travellers" transport scheme using volunteer drivers who are trained and CRB checked.

Summary

Although the greatest level of need is found in urban centres such as Crewe where high numbers of children and young people live within the most deprived deciles, the needs of those families living in deprivation and isolation in rural areas should not be ignored. Coordinating activities on particular days or sessions (morning/afternoon) may help to increase access to children's centres' services by making the travel justifiable to families living in rural communities. However, some families will still be unable to attend due to lack of transport, so additional activities and infrastructure (such as play buses) are still needed to bring the services to these families. Currently there are a few examples of outreach sessions at some of the children's centres serving the rural communities, but the number of these and their locations should be reviewed. The Health Sector need to engage with the development of community hubs across Cheshire East, which includes work to address rural needs looking at maximising the potential of existing community assets and better use of mobile services to our rural communities. Using proportionate universalism as a basis will help recognise the needs of families in Cheshire East's rural communities and identify what alternative provision may need to be made to reach these isolated families.

The Role of Children's Centres in achieving Health Outcomes

Children's centres are able to provide health services from preconception advice to support for the child up to five years of age. All eleven children's centres host health visitor clinics (though not at all sites) and the majority host midwifery-led antenatal care clinics, with about half also hosting midwifery-led postnatal care clinics. However, these clinics, as alluded to earlier, are not always joined-up with the provision of other services, such as peer-led breast feeding support in the centres.

The five health outcomes that are specifically identified in "An Equal Start: Improving outcomes in children's centres"[10] are:

- fewer children born with low birth weight
- fewer children with high or low Body Mass Index
- fewer mothers smoking during pregnancy

- more mothers who breastfeed
- increase in the number of parents with good mental wellbeing

However, local needs assessments and the analyses in this report suggest that in Cheshire East at least two other health outcomes should be added to this list (see chapters four and five for further information). These are:

- fewer children exposed to household cigarette smoke (chapter four)
- fewer children experiencing serious unintentional injuries during the first three years of life (chapter five)

In order to monitor the improvement on health outcomes, we need good information on children's health. Maternity, child health, general practice and hospitals already capture data on a wide range of children's health outcomes. Much of this information is published at community level in statistical indicator sets. Children's centres do not need to gather this information again.[11] With the mother's permission local NHS Trusts are able to share details of live births with children's centres.

Children's centres should use the information to target limited resources on children and families where there is a risk of good health outcomes not being achieved. Commissioners need to track these outcomes and monitor the services, ensuring they are available in the right places for those who need to access them, which includes a wide range of location (not all will be children's centres). Every children's centre has access to a named health visitor, who can work with the centre leader and management team to ensure that information about children is shared securely and used appropriately.

In addition, some children's centres deliver a diverse community programme, well in excess of the core role. As the centres are situated amongst the most disadvantaged communities in the Borough, there is scope to extend this role and become integral in the current planning for a community hub network for Cheshire East. The work which is currently delivered from some centres includes holiday play, adult education and self-esteem classes for parents, gardening and job clubs.

The centres are ideally placed to operate as community hubs as they already build trust and credibility within the local community through intensive family support. The extended role does not need to be delivered by family support staff but could offer an opportunity to engage the local community in contributing to a social enterprise. This model could run alongside the conventional children's centre programme but could utilise the centres on evenings and weekends for a number of community activities, thus generating income and making better use of the facilities. Other key partners who centre their work on these estates, such as neighbourhood and community development workers and Police Community Support Officers could be accommodated as part of the hub design.

This development could build stronger communities within disadvantaged neighbourhoods, offering training, support to return to work as well as social and recreational opportunities and could have a very positive effect on mental health and well-being. In addition, a vibrant local centre could also be well placed to deliver a range of additional conventional and 'out of hours' health services for adults including flu jabs, clinics, promotions and road shows and mental health support. Community pharmacies could also deliver outreach services.

An Eleven Point Plan for Improving Public Health Outcomes at Children's Centres

The planned changes to children's public health services provide a new opportunity to strengthen the role of children's centres in delivering the Healthy Child Programme. There is also some scope for children's centres to help to prevent many common childhood illnesses and injuries. This will require the main commissioners (local authority, both Clinical Commissioning Groups (CCGs) and the police) to work together to reconfigure the preventative work of the Healthy Child Programme, which can be consistently implemented across all of the children's centres in Cheshire East. It is recommended that children's centres are developed in the following ways in order to improve public health outcomes:

1. Increase the proportion of antenatal care that is carried out at children's centres.[c] And develop links with midwifery, looking at the potential to share information to ensure we reach all those families we need to.

2. Cigarette smoking is particularly common among younger pregnant women aged under 30 and their partners. Specialist smoking cessation services (commissioned by public health) should be provided alongside antenatal clinics and new baby clinics.

3. Members of the Cherubs Team (Che(shire) Really Useful Breastfeeding Support) should be available at all new baby clinics to ensure all new mothers can access breastfeeding support particularly in the early days, weeks and months after birth (see Appendix A for more information on Cherubs).

4. Preconception care can reduce the number of babies who are exposed to risks during the earliest stages of their development, particularly from alcohol and smoking. There should be access to preconception advice for second and subsequent pregnancies from health visitors. Children's centres should help and support couples to receive alcohol counselling and advice, smoking cessation services and signpost to weight reduction if needed.

5. All children's centres should provide weaning advice to families which includes information on dental health for infants and children.

6. As children's centres become established as part of the antenatal pathway, they need an agreed approach to enable them to respond to midwives' and health visitors' assessment of which families and children are most able to benefit from support to improve their health, including those that have newly moved to the area. Children's centres must agree methods to track the outcomes that are achieved amongst these children.

7. As part of the development of Community hubs, children's centres should actively consider the needs of every new parent in rural areas who are not able to access the children's centre. Outreach activities in rural communities will always have to be proportionate to the level of need that exists at that time and, with advanced planning, children's centre activities should change to meet the needs of different groups of infants and young children.

8. Children's centres have a responsibility towards the health and wellbeing of all pre-school children. The evidence consistently demonstrates the positive effects of living in a safe and warm house on the health and wellbeing of children. Achieving a safe environment in every home to reduce risk of injuries and illness to young children should be a locally determined

[c] By increasing the number of antenatal visits that occur at children's centres, families will be introduced to the centres and their services before the birth of their child. Families can be registered with the children's centre antenatally; thus more children and their families can benefit from the services available immediately from birth.

priority for children's centres activity. Children's centres should take ownership of the process to improve families' homes by coordinating families' access to relevant and appropriate services, based on needs identified by other partners (e.g. health visitors, midwives etc), and ensure work is completed.

9. Vitamin D supplementation has been recommended for all pre-school children, and pregnant women, to promote good bone health. The children's centres should actively promote vitamin D supplements to pregnant women and families with young children. Those families from more deprived areas should be encouraged to register for Healthy Start and make use of the free vitamins as well as the food vouchers. Alternative models of delivery may be trialled in a pilot to provide free vitamin D supplements for pregnant women and children under 4 within Cheshire East.

10. Children's centres should clearly understand the local position for all of the Public Health Outcome indicators that relate to young children, and they should be able to quantify all the actions that they take to achieve improvements in these indicators.

11. Children's centres could play a key role in engaging parents, families and the wider community in a range of health interventions and could provide a safe and trusted venue as part of a community hub.

Chapter Three

Pregnancy and Early Years

Experiences during the nine months of pregnancy can have lifelong effects on a child's growth and development. During pregnancy, due to the extremely rapid development of the baby's organs and structures of the body, the behaviours and living conditions of the pregnant woman can have profound effects on her unborn baby. Most body systems continue to develop throughout early and late childhood, so the quality of the child's environment (home, nursery and school environments) throughout its childhood will heavily influence the maturation of the child's body systems and its health as well as its social development. The impact of environments on children's health and wellbeing is discussed further in chapter seven.

Preconception Care

Preconception care describes the support available to women and their partners to enable them to optimise their health prior to pregnancy, thus providing them with the best chance of having an uncomplicated pregnancy and delivering a healthy baby.[12] As some women become pregnant through an unplanned pregnancy all women of childbearing age are encouraged to be healthy.

Antenatal care begins when pregnancy is confirmed. There are many common themes running through preconception and antenatal care.

The core themes of preconception care are:

1. Education on exposures hazardous to pregnancy – particularly avoiding alcohol and smoking, reducing excess weight, and not using illegal drugs

2. Improving the health of the mother – being vaccinated against rubella, taking folic acid and vitamin D supplements, and having regular exercise and a healthy diet

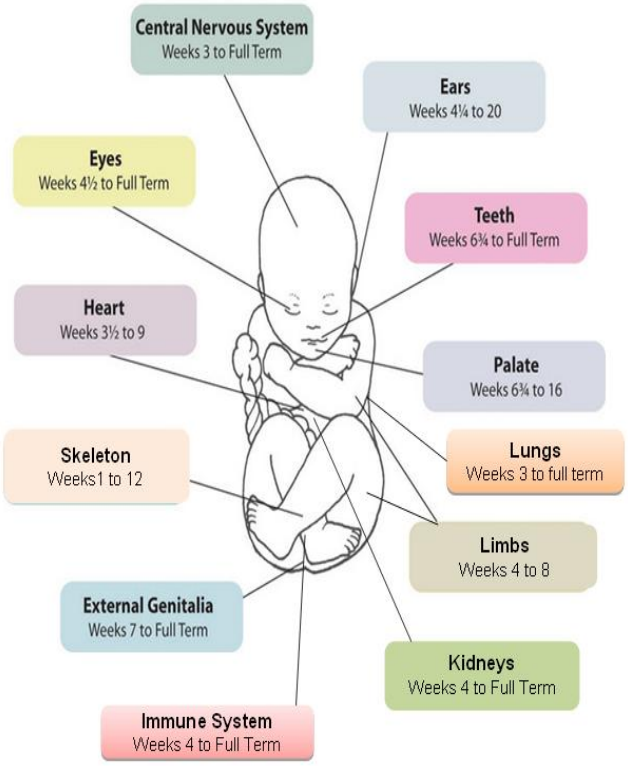
3. Improving maternal long term health conditions – including asthma, diabetes, epilepsy, heart disease, high blood pressure, mental health problems and obesity

4. Identifying couples at increased risk of having a baby with a genetic or chromosomal malformation – couples can seek advice from their General Practitioner and may be referred to a Genetics Clinician who will organise any necessary tests

An important part of preconception care is to avoid behaviours and exposures that may be hazardous to the developing baby during the earliest weeks of pregnancy. It should be possible for women to avoid their baby being exposed to alcohol or the chemicals in second hand cigarette smoke, but local data suggests that this does not always happen.

The particular windows of vulnerability are when the vital organs are developing, and these are illustrated in Figure 5. The most significant harms usually occur during very early life, which is when the major structures of the body are still being formed.

Figure 5. Fetal development during pregnancy



Folic Acid

There is strong evidence that folic acid supplementation (either alone or in combination with other vitamins) reduces the incidence of congenital malformations of the brain, spine, or spinal cord in the unborn infant. Couples who are planning a pregnancy can assess their risk of conceiving a baby with a neural tube defect. Couples are at 'high risk' if there is:

- A family history
- A relevant maternal medical history: if the mother is taking anti-epileptic drugs (which may affect folate metabolism), has diabetes at the start of her pregnancy, coeliac disease or a type of anaemia (haemolytic)
- Maternal obesity: if the mother is obese (defined as a BMI greater than 30kg/m^2), studies have shown an increased risk of 1.7 (95% CI 1.34 to 2.15) in obese women

All other women are at 'normal risk' of conceiving a child with a neural tube defect. The key message is that all women planning to conceive should take folic acid to reduce the risk of neural tube defects in their baby. Surveys of the knowledge and attitudes of low income women to folic acid supplementation have shown that many did not understand the serious nature of neural tube defects, or the role of folic acid in preventing this.

- Women at 'normal risk' are advised to take 400 micrograms of folic acid daily once they start trying to conceive and to continue this until the twelfth week of pregnancy
- Women at 'high risk' are advised to take 5 milligrams of folic acid daily once they start trying to conceive and to continue this until the twelfth week of pregnancy

Misuse of Drugs

The developing fetus is particularly vulnerable to the harmful effects of drug misuse. Women who are intending to conceive should be offered specialist support to reduce or stop their misuse, including contraceptive advice.[12] Those who have ever injected drugs should also be offered hepatitis C testing, as treatment is successful in clearing the virus in 40-60% of people and so hepatitis C treatment prior to conception can prevent the baby getting the infection.[12] Other strategies are used in pregnancy and labour to reduce the risk of transmission of HIV or hepatitis B from mother to baby and so all pregnant women are screened antenatally for these infections.

Antenatal Care

Most women will not be seen by a midwife until the twelfth week of their pregnancy. As Figure 5 shows, much of a baby's development takes place during the early weeks of pregnancy and so it is important that women take steps to protect the health of their unborn child from the moment they realise they are pregnant. For those couples planning a pregnancy it is hoped that preconception advice will have helped them change any lifestyle factors which may harm a new pregnancy and engage in protective actions such as taking folic acid and reducing alcohol intake whilst trying to conceive and once pregnant.

Overweight and Obesity

Obesity in pregnant women is linked to socioeconomic deprivation and poor access to maternity services. Being overweight or obese can reduce fertility, but if a woman becomes pregnant it can be associated with an increased risk of congenital anomalies (neural tube e.g. spina bifida, heart defects, cleft lip and palate), pregnancy complications (miscarriage, impaired glucose tolerance and pre-eclampsia) and delivery (as the baby itself may be large). Normal weight babies born to obese mothers are at increased risk of becoming obese themselves in later life.

It is estimated from national figures that about 5% of pregnant women are obese; in Cheshire East this equates to 186 women deemed to be obese during pregnancy in 2013.

The evidence recommends informing the woman of the increased health risk their weight poses to themselves and would pose to their unborn child, then supporting women who are overweight or obese to lose 5-10% of their body weight before becoming pregnant.

Smoking

Smoking whilst pregnant can increase the risk of miscarriage, stillbirth, premature birth and delivery of a low birth weight baby. Children exposed to tobacco smoke in the womb are more likely to experience respiratory illnesses in childhood.[13, 14] The national Public Health Outcomes Framework recommends measuring if a mother smokes or not at the time of pregnancy; this is aimed at ensuring that local tobacco control activity is focused on pregnant women. The national Tobacco Control Plan contains an ambition to reduce the rate of smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth).

In 2012/13, 575 mothers in Cheshire East were smokers at the time of their delivery. This represents 15.1% of all maternities, statistically worse than the England average of 12.7%. Some local authorities have smoking rates of just 2.3%, equivalent to 87 mothers in Cheshire East.

Although local data suggests that the smoking rate among mothers has reduced to 14.3% in 2013/14, there were also an additional 17.3% of maternities where another member of the household was a smoker. This means that 31.6% (approximately 1020 annually) of babies and young children are being exposed to tobacco smoke during pregnancy and from birth onwards.

In some parts of the Borough, very few infants are exposed to household cigarette smoke. In other areas over 35% of babies are exposed, including the rural areas around Sandbach, parts of Alsager, Congleton, Knutsford and Handforth, and southern parts of Macclesfield.

The most striking finding is that the highest smoking rates are concentrated in the town of Crewe, where an average of 45.5% (approximately 430 annually) of all babies are living in a household where one or both of their parents is a current smoker.

Figure 6 below shows household smoking rates decline with increasing maternal age. Three findings are of particular importance and will require significant coordinated action from midwives, health visitors and Children's Centres:

- Smoking rates are significantly higher in Crewe than the rest of the Borough in all age groups except for teenage mothers where the rates are (non-statistically) lower, possibly as a consequence of additional health initiatives in these families
- In all areas, household smoking rates are considerably higher where mothers are aged under 30 compared to those aged over 30
- Babies born in Crewe to mothers over the age of 30 are twice as likely to be exposed to household tobacco smoke than babies born elsewhere in the Borough to mothers over the age of 30

Map 2. Proportion of infants exposed to household tobacco smoke in 2013 (where either the mother or her partner smokes)

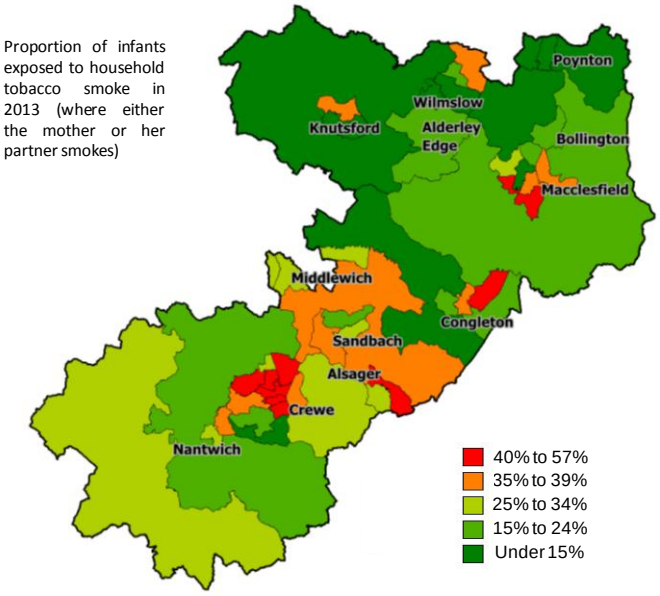
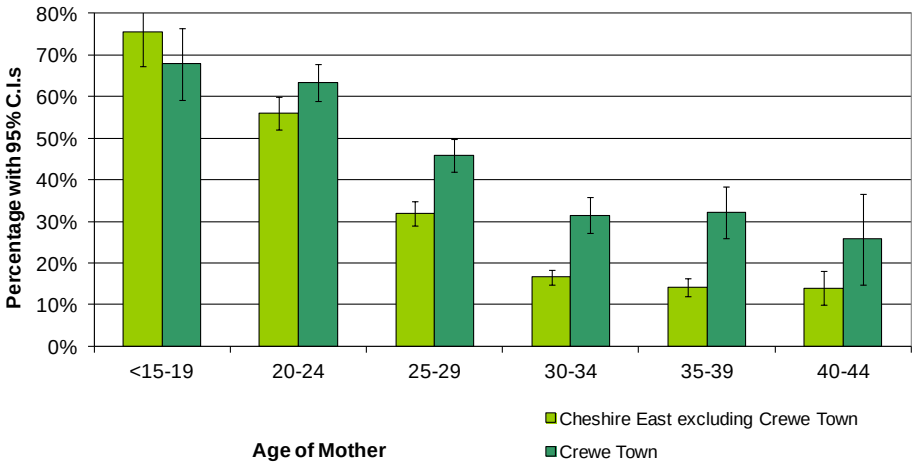


Figure 6. Proportion of infants exposed to household tobacco smoke, 2012-13 Crewe Town Area compared with the rest of Cheshire East



Alcohol

Statistics on alcohol use in pregnancy are not routinely collected, but national studies suggest that pregnant women are less likely to drink alcohol than those who are not pregnant; only one in ten pregnant women drink regularly during their pregnancy. However, there is a known association between smoking and alcohol use, and so alcohol consumption in pregnant women is also likely to be high in the areas and age groups shown above.

Alcohol crosses the placenta freely. Every time a pregnant woman consumes alcohol her unborn baby will develop similar blood alcohol levels to herself within a matter of minutes. This exposure to alcohol can have a variety of effects on the developing baby depending on the stage of gestation. Alcohol particularly disrupts the normal development of brain cells, and it can also cause physical abnormalities of the brain.

Babies are therefore at considerable risk of harm from levels of alcohol consumption that will only have a minimal effect on the long term health of their mother.[12] Women planning a pregnancy should not drink alcohol whilst trying to conceive, or during the first three months of pregnancy.[12,14] During pregnancy, women can be highly motivated to stop drinking for the sake of their unborn child, and support and specialised advice can be offered to those who wish to reduce their drinking but feel unable to do so alone.

Prolonged and high levels of drinking during pregnancy can lead to Fetal Alcohol Syndrome (FAS), where the child has characteristic facial abnormalities, growth retardation, and brain damage that results in learning disability or behavioural problems.[14] The full syndrome occurs in around 10 to 20 babies per 10,000 births – that approximates to four to eight babies in Cheshire East each year.

However, being exposed to prolonged or high levels of alcohol *in utero* does not always result in FAS. Some babies have no lasting effects, while others have partial manifestations of the disorder, most frequently lesser degrees of brain damage with little or no facial abnormality. The occurrence of any harm to the brain due to drinking alcohol during pregnancy is thought to be as high as one in every 100 births, which is equivalent to 40 babies in Cheshire East each year.

Other Exposures

Toxoplasmosis: The toxoplasmosis parasite lives in soil, raw meat and in cat faeces. Infection of the fetus causes miscarriage or congenital anomalies.[15] Pregnant women should wear gloves when gardening, wash fruit and vegetables, and avoid changing cat litter (or wear gloves).[12,15]

Vitamin A: A high intake of vitamin A (from high-dose multivitamin supplements or fish liver oil) can cause congenital anomalies.[12,14,16] Pregnant women should be advised not to eat foods that are naturally high in vitamin A such as liver pâté, liver sausage or haggis.[16]

Home decorating: Pregnant women should not strip down old paint (painted pre-1970) to avoid inhaling lead in the paint dust. They should avoid using solvent based paints until after the 14th week of pregnancy, to lessen any risk of paint fumes or chemicals harming the baby.[17]

Over-the-counter medication: Women planning a pregnancy should check with a pharmacist that an over-the-counter medication is safe for them.

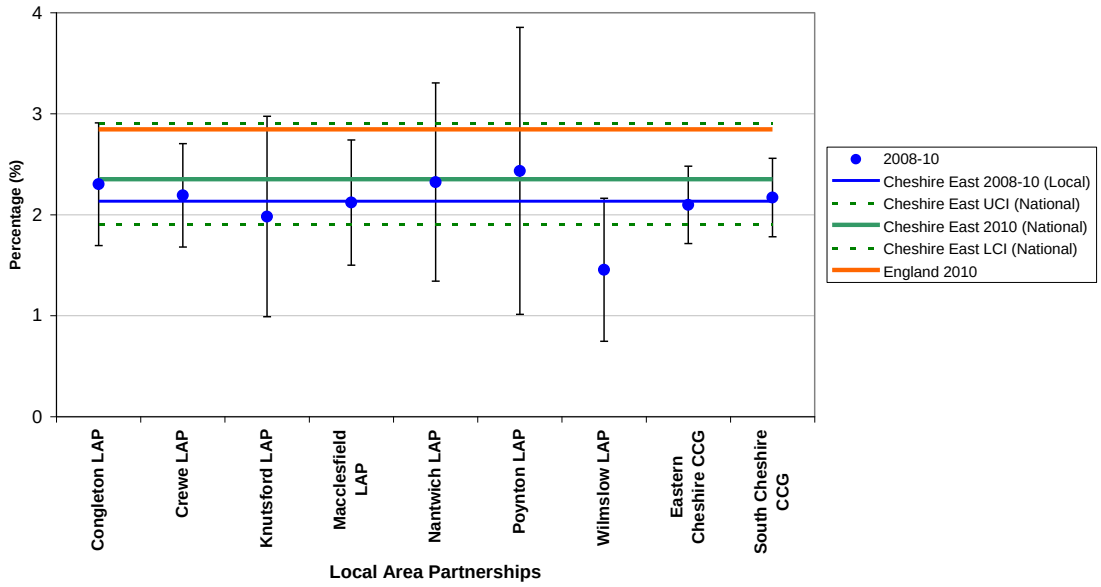
Herbal remedies: Herbal products (such as Wild Yam Root capsules or Red Clover Blossoms capsules) are not regulated, so there is little information about their safety immediately before and in the early stages of pregnancy.[12]

Low Birth Weight

A low birth weight increases the risk of developmental problems for the child and is associated with poorer health in later life. The occurrence of low birth weight (under 2,500 grams) among term births (those with 37 weeks or greater gestational age at birth) provides a way of comparing fetal growth between different populations. This is included as an indicator in the national Public Health Outcomes Framework in the context of measuring starting well through early intervention and prevention. It is also used within the context of addressing issues of premature death, avoidable ill health, and inequalities in health, particularly in relation to child poverty.

In Cheshire East, 93 babies were born with low birth weight at term in 2011. This represents 2.5% of all live births at term, which is lower than the England average of 2.8%. There is considerable scope for further improvement as low birth weight at term affected just 1.6% of babies in some Local Authorities in England. The chart below shows the locally calculated figures for Cheshire East and LAP areas for 2010. The numbers of babies are very small and there is little difference between LAP areas. Low birth weight at term is lower in the Wilmslow LAP although this is not statistically significant.

Figure 7. Low birth weight in term babies 2008-10



Optimising the Health of the Mother and Her Baby

Being a parent is a wonderful and challenging experience. Mothers care about the well being of their newborn but at the same time it is important to ensure that they are in good health themselves. First time parents often find adjustment to this new role coupled with some uncertainty about the general care of the baby an emotional and physical challenge.

Mother's Health

After delivery of the baby, the mother goes through a postpartum period which lasts about 6-8 weeks. During that time, the mother experiences physical and emotional changes, while learning how to adjust to the role of being a new mother. It is important that the mother takes good care of herself, and rests whenever possible to let her body recover and rebuild her strength. Newborn babies need to be fed, changed and comforted every 3-4 hours, which leads to disrupted sleep. Many mothers, especially first time mothers find the first weeks of motherhood particularly tiring. In many cultures and communities, families, friends and others have traditionally provided the new mother with support and help during this time.

Postnatal Depression

The experience of pregnancy, labour and delivery of the baby is overwhelming for many. Exhaustion of labour combined with hormonal changes in the body after delivery, can affect the mother's mental health. The mother may experience mood swings known as baby blues which normally lasts the first week after delivery. Baby blues is very common and affects about 8 out of 10 mothers. More distressing is postnatal depression which normally presents anytime after the second week

post delivery and affects 1 in 10 mothers. It is estimated that in Cheshire East during 2013, 374 women will have suffered with postnatal depression. The affected mother often feels tired, depressed, guilty, anxious and is unable to care for herself and her baby. A new mother should not suffer in silence and should be encouraged to talk to someone she trusts, such as her partner, family, friends, health visitor or her GP. Counselling can be offered through the GP and sometimes medications may also be helpful.

Mother's Diet

The mother's diet is key to ensuring recovery and healing after giving birth. Mothers also need to have a healthy and balanced diet to ensure adequate milk production if breastfeeding. A healthy diet for the new mother includes food rich in calcium, low-fat dairy products, vegetables, fruits and grains. It is common that mothers who breastfeed feel very thirsty while the baby is nursing. Fluid intake should be increased.

Breastfeeding

Newborn babies require good nutrition as their body grows rapidly in the first two years of life. Breastfeeding is the healthiest option for babies and has been proven to be beneficial in many ways. Breast milk contains the correct balance of nutrients needed for growth of the baby with a high concentration of fat and lower concentration of proteins. It is known that breastfed babies are less likely to have allergies or eczema than bottle fed babies. Breastfeeding also provides protection against respiratory and intestinal infections by transferring antibodies from mother to the baby.

Breastfeeding does not only benefit the baby but is also beneficial for the mother's health. Breast milk production is a natural process which occurs after delivery. The risk of developing breast and ovarian cancer later in life is reduced by breastfeeding. Breast feeding naturally uses up to 500 calories in a day and helps strengthen the bond between the mother and baby.

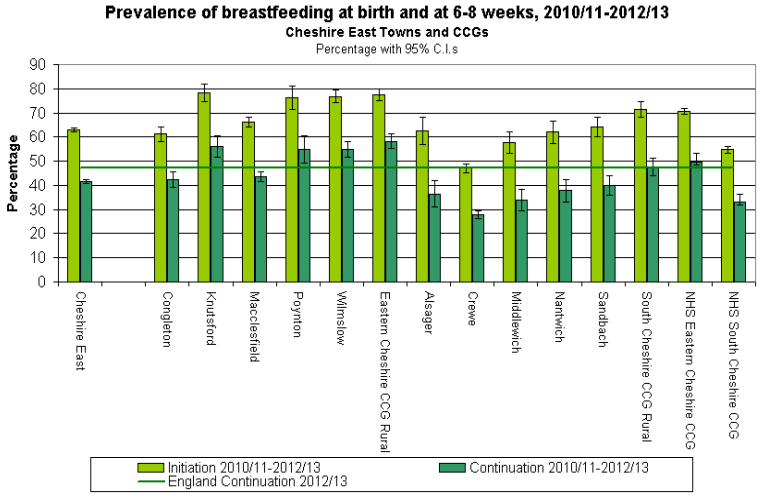


Figure 8. Prevalence of breastfeeding at birth and at 6-8 weeks, 2010/11-2012/13, Cheshire East Towns and CCGs, Percentage with 95% Confidence Intervals

Within Cheshire East, breastfeeding initiation at birth and continued breastfeeding at 6-8 weeks, differs markedly by area. Breastfeeding is less common amongst mothers in more deprived areas and amongst younger mothers. Babies who live in the least deprived areas of Cheshire East are twice as likely to be breastfed at birth as babies who live in the most deprived areas.

The difference is even more marked at 6-8 weeks when babies in the least deprived areas are three times as likely to be breastfed than those in the most deprived LAP areas (in Crewe only 29% of babies were still breastfed at 6-8 weeks compared to over 60% in Poynton and Knutsford). In the

three years 2010/11-2012/13, breastfeeding rates at 6-8 weeks were five times higher in Wilmslow Town South East (72.7%) than in East Coppenhall (14.1%).

Key Points

A healthy pregnancy should ideally start before conception. Preconception care enables women and their partners to optimise their health prior to pregnancy, thus providing them with the best chance of having an uncomplicated pregnancy and delivering a healthy baby. Women are encouraged to improve their health and avoid exposures that could be hazardous to the baby's health, such as alcohol and smoking. Preconception care is important as the most significant harms usually occur during the first few weeks of pregnancy, which is when the major structures of the body (skeleton, heart, kidneys etc) are being formed. As some women become pregnant through an unplanned pregnancy, all women of childbearing age are encouraged to be healthy.

Most women will not see a midwife until the twelfth week of pregnancy, thus it is important that women and their partners know that experiences in the womb can have lifelong impacts. It should be possible for pregnant women to avoid their baby being exposed to alcohol or the chemicals in cigarette smoke, but local data suggests that this does not always happen. Deprivation also influences the start in life that children receive in Cheshire East.

- 575 mothers in Cheshire East were smokers at the time of their delivery in 2012/13. This represents 15.1% of all maternities, statistically worse than the England average of 12.7%. Some local authorities have smoking rates of just 2.3%, equivalent to 87 mothers in Cheshire East.

- 31.6% of babies and young children in Cheshire East live in households with at least one smoker; they are being exposed to tobacco smoke during pregnancy and from birth onwards.

- In the town of Crewe an average of 45.5% of all babies are living in a household where one or both of their parents is a current smoker.

- In all areas, household smoking rates are considerably higher where mothers are aged under 30 compared to those aged over 30 (except for those with 'teenage parents').

- Approximately 4 to 8 babies each year in Cheshire East are affected by Full Fetal Alcohol Syndrome.

- Approximately 40 babies in Cheshire East each year experience some harm to the brain due to their mother drinking alcohol during pregnancy.

- Breastfeeding initiation is less common amongst mothers in more deprived areas and amongst younger mothers.

- At 6-8 weeks babies in the least deprived areas in Cheshire East are three times as likely to be breastfed compared to those in the most deprived LAP areas (in Crewe only 29% of babies were still breastfed at 6-8 weeks compared to over 60% in Poynton and Knutsford).

Chapter Four

Childhood Illness

Most children spend their childhood well, but are commonly affected by short periods of ill health. A small number of children may be disproportionately affected by ill health, and illness in the early years can affect their health and opportunities later in life. The wider determinants of health such as housing quality, poverty, indoor air pollution (smoking), poor diet and overcrowding will contribute to, or make worse ill health, particularly amongst children with long-term conditions such as asthma. Yet whilst lifestyles are of growing significance for long-term health outcomes, communicable diseases and unintentional injuries remain a major threat to the health of children.

This chapter will consider three groups of diagnoses – respiratory conditions, gastrointestinal conditions, and fever associated with viral infections. These three conditions account for 40% (5,335) of all non-injury attendances at accident and emergency departments (A&E) in Cheshire East in 2013/14 in children and young people aged 0-19. Of these attendances, 46% (2,477) relate to the 0-4 year old age group. These three conditions also account for 47% (3,485) of emergency admissions to hospital in 0-19 year olds in Cheshire East in 2013/14. Within this group 68% (2,378) relate to the 0-4 year old age group. As the youngest children are disproportionately affected by these conditions, much of the focus of this chapter will be on the 0-4 age group.

Within this chapter are examples of possible advice for families on some of the main causes for A&E attendance and hospital admissions among children and young people. These use the traffic lights key from the NHS 'Choose Well' campaign and are based on tested leaflets show-cased by the NHS Institute for Innovation and Improvement. They highlight when families should access A&E, but also illustrate when alternative management, from self-care to support from pharmacists, public health nurses or general practitioners, would be more appropriate. Such advice, if consistently and easily available and used, would help families to provide self-care to their children confidently and ensure they know where to go for help should they need it.

The majority of respiratory conditions, gastrointestinal conditions and feverish illness are preventable. Often basic prevention techniques such as good hand hygiene would help keep a child healthy.

Respiratory Conditions

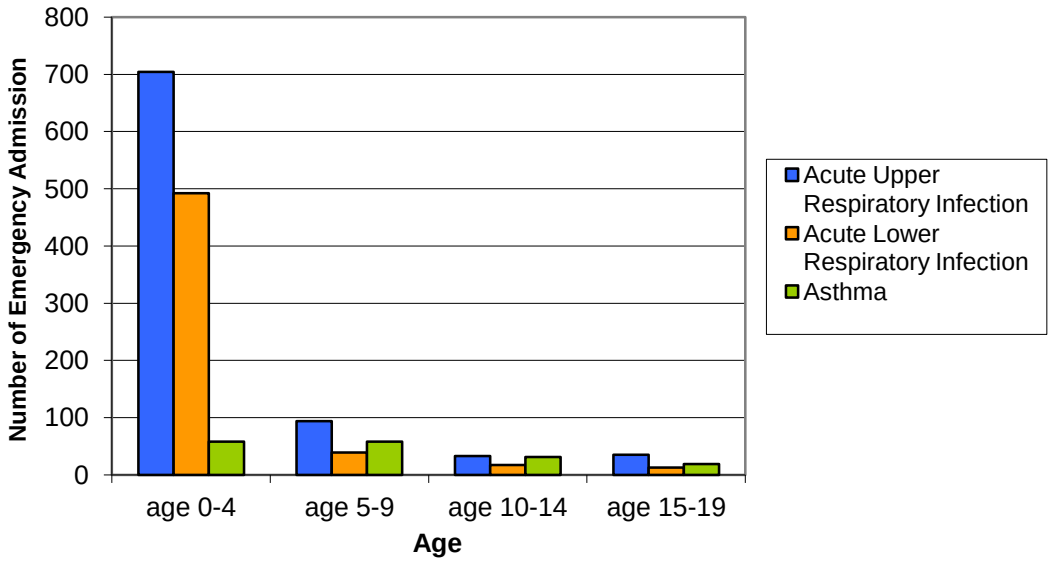
Respiratory conditions are particularly common among children, some of whom can catch between seven and ten colds each year. Most infections are due to respiratory viruses that spread easily from child to child because of their close proximity during play, social interaction and education. Young children are still learning how to use their hands or tissues to catch coughs and sneezes so this is not surprising. Environmental factors such as living in a smoky environment will also impact on the numbers of younger children experiencing poor respiratory health.

Infections of the upper respiratory tract (the nose, sinuses, ear tubes and throat) often lead to difficulties in breathing in very young children and may be very alarming to parents. In toddlers a respiratory infection may be followed by earache and fever which normally settles with medication.

Respiratory infections can also affect the lower part of the respiratory tract (the larynx, bronchial tubes and lungs) and are then associated with symptoms such as croup or wheezing. Lower respiratory conditions include asthma, bronchitis, bronchiolitis and pneumonia.

In Cheshire East, a total of 1,593 hospital admissions of children and young people aged 0 to 19 occurred during 2013/14 with conditions related to respiratory infections, including acute upper respiratory infection (866), acute lower respiratory infection (561) and asthma (166). This is equivalent to 2% of the total population of 0-19 year olds. The vast majority of those admitted for acute upper respiratory infection (81%) and acute lower respiratory infection (88%) were aged 0-4. This age group is disproportionately represented in admissions for these conditions; the equivalent of 6% of the 0-4 year old population was admitted for respiratory conditions in 2013/14.

Figure 9. Emergency admission for respiratory conditions in 0-19 year olds, 2013-14

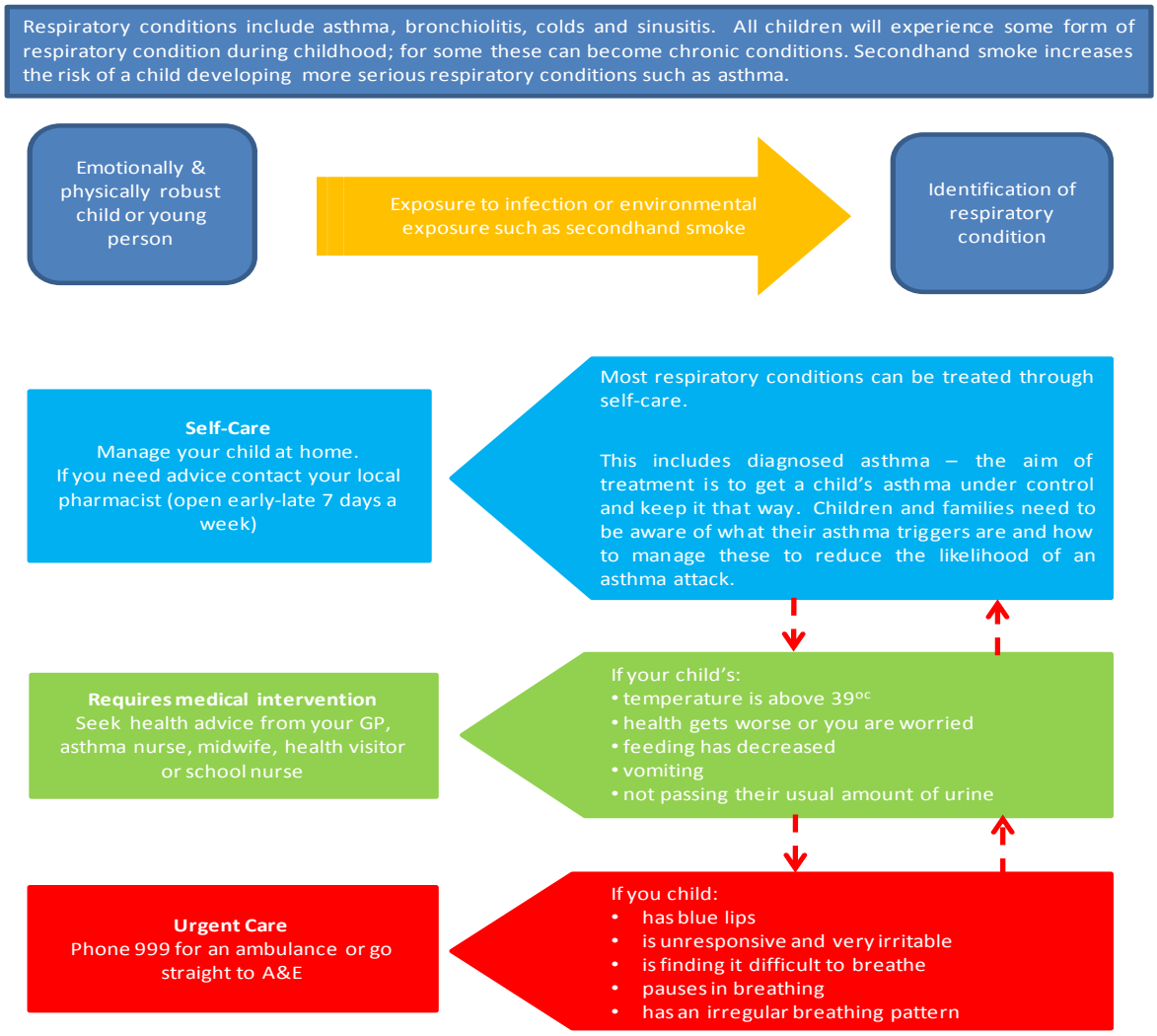


Many of these children, particularly those aged 5 upwards, presenting at A&E will have a previously diagnosed chronic respiratory condition. Ideally, children who have a pre-existing respiratory condition should not reach the stage where they are so unwell that it is necessary for them to be attending A&E. Their attendance often means that their condition was not appropriately controlled in the community. This could be due to a combination of factors including not always taking prescribed medication and a lack of knowledge and confidence around self-care.

Advice to Families

Parents, especially first time parents, will likely find the coughs and snuffled breathing of a young child or infant with a respiratory condition alarming. The illness may be relatively minor, but the symptoms can appear very serious. Providing parents with clear advice, such as the example leaflet overleaf (Figure 10), should help to reduce unnecessary attendance at hospital and increase self-care with community support if needed.

Figure 10. An Example of Possible Respiratory Conditions Advice for Parents



This advice is largely based on the leaflet 'Bronchiolitis Discharge and Follow Up Advice Sheet for Children 0-2 years' produced by NHS West Sussex Children & Young People's Urgent Care Network

Chronic Respiratory Conditions

During the six years from 2008/09 to 2013/14, the number of children and young people on general practice chronic respiratory disease registers in Cheshire East increased by over 25%, and the figure currently stands at over 3,250 children which amounts to 4% of those aged 0-19 in Cheshire East. Many of them will take their respiratory problems with them into adult life.

Asthma is a common chronic respiratory condition; it is a serious condition that can lead to hospital admission if not appropriately treated. The aim of treatment is to get a child's asthma under control and keep it that way. Asthma treatments are effective in most children and should allow them to be free from symptoms and lead a normal life. A child and their family should be shown how to recognise when their symptoms are getting worse and the appropriate steps to take. They should also be encouraged to draw up a personal asthma action plan with their GP or asthma nurse; this should be reviewed annually or more frequently if symptoms are severe or not well controlled.

It is important that children living with asthma and their families understand the specific triggers that may cause an asthma attack. These include an upper respiratory infection such as cold or flu, or exercise especially in cold weather, or coming into contact with an allergen such as dust mites or

animal fur and exposure to air pollution especially tobacco smoke. Living in poorly ventilated or damp homes can also exacerbate symptoms.

Prevention

All respiratory conditions are negatively affected by being in a smoky environment. Children growing up in homes with smokers are at greater risk of developing respiratory conditions (including chronic conditions such as asthma) than those in smoke-free homes. Second hand cigarette smoke causes damage to the protective lining of children's airways, and this makes it easier for viruses to enter and cause infection.

Exposure to second hand smoke is known to trigger the development of asthma and exacerbate symptoms; the prevalence of asthma increases with the number of smokers in the home. Parents and family members should be encouraged to stop smoking by others including by health and social care professionals. If parents or family members are unwilling or unable to stop smoking, the next best step is to at least make the indoor environment smoke free by encouraging parents to smoke outside. However, parents should be reminded that smoke remains on their clothes even if they smoke outside and so this step does not completely protect their children.

Gastrointestinal Conditions

Gastrointestinal conditions include diarrhoea and vomiting, abdominal pain and constipation. These affect children of all ages, though young children are often most at risk of becoming unwell from gastrointestinal infections due to poor hygiene practices and a lack of naturally acquired immunity.

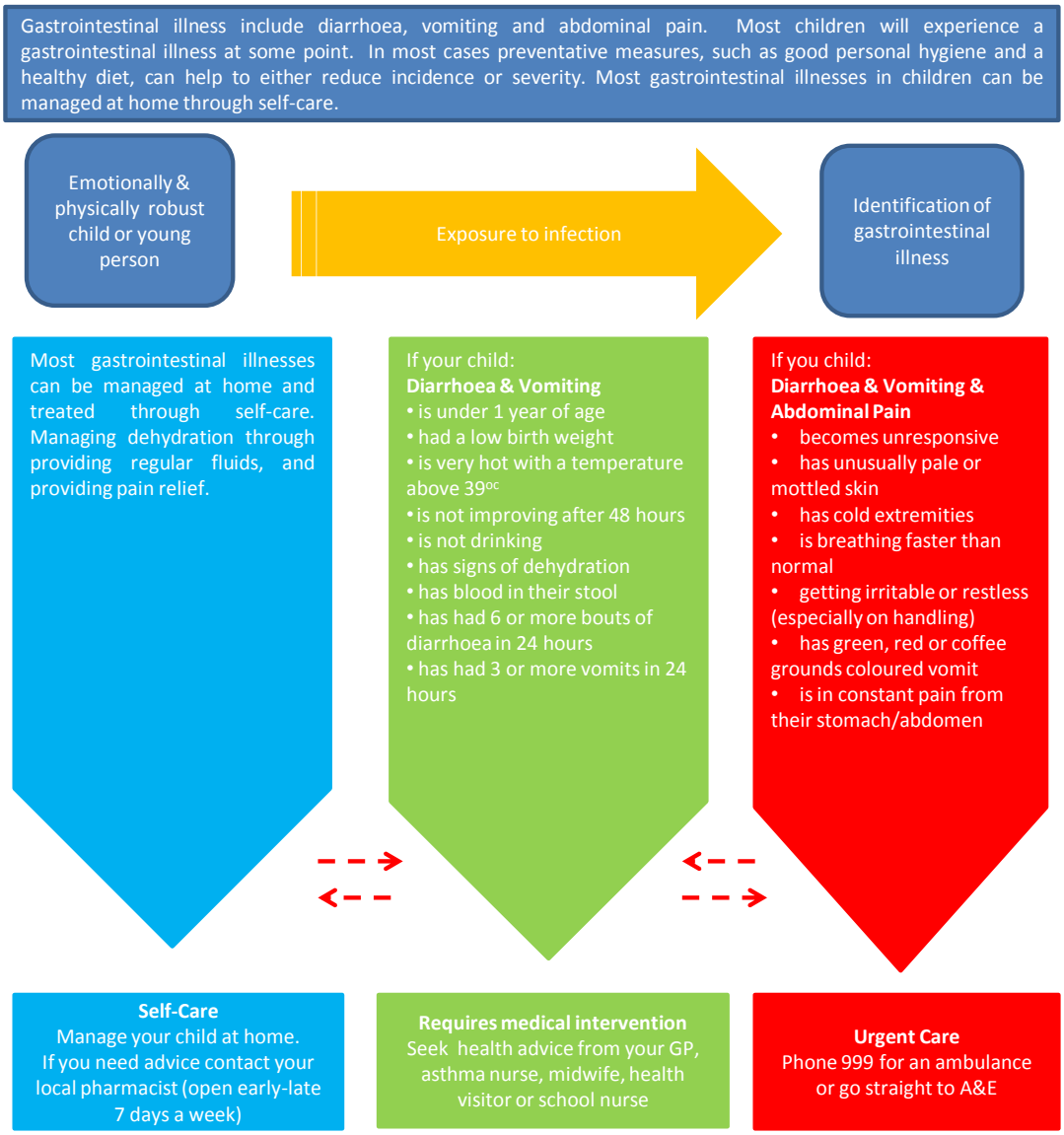
Four percent of all A&E visits (894) in children and young people aged 0-19 in 2013/14 were for gastrointestinal conditions, with 21% of this in the 0-4 age group. Whilst the overall percentage is relatively small, it contributed to nearly one in ten emergency admissions to hospital in this age group. Thirteen per cent (988) of all emergency admissions to hospital in children and young people aged 0-19 in 2013/14 were for gastrointestinal conditions. Of that number, 39% of admissions were in children aged 0-4.

Prior to 2013 around half of all gastroenteritis in children under five years was due to rotavirus infection. In 2013 a rotavirus vaccination was introduced in England for young babies, given as oral drops at age 2 months and 3 months. This highly effective vaccine is providing protection to the youngest children in Cheshire East against this extremely contagious virus.

Other causes of gastroenteritis include food poisoning. Between 2010 and 2012 there were on average 107 confirmed cases annually of food poisoning in children and young people aged 0-19 in Cheshire East. Nearly half of these (44%) were in children aged 0-4. Around a half of all confirmed case were caused by campylobacter, and a further fifth due to salmonella.[18] This will be a small proportion of the true number of cases actually experienced in the community as many episodes of diarrhoea and vomiting are either not reported to a doctor or samples are not taken to find out the cause.

Most gastrointestinal conditions will not be a serious illness and can be safely managed at home with over-the-counter medicines or oral rehydration solutions from the local pharmacy if necessary. However, some children may become more unwell and may require hospitalisation to manage serious dehydration.

Figure 11. An Example of Possible Gastrointestinal Illness Advice for Parents



This advice is largely based on the leaflet 'Diarrhoea and Vomiting Advice Sheet for Parents and Carers of Children 0-5' by NHS Nottingham and 'Gastroenteritis in children < 5 yrs – Patient information for Acute Gastroenteritis' by NHS Worcestershire Acute Hospitals NHS Trust

Prevention

Most infectious gastrointestinal diseases are transmitted via the faecal-oral route. Therefore, good hand hygiene and food hygiene practices (measures to avoid cross-contamination, appropriate storage and cooking of food) are particularly important to prevent their occurrence and spread. Families whose child is unwell should ensure potties and toilets are disinfected (including the handles and seats) after each bout of diarrhoea. Adults should wash their hands after changing nappies and younger children should be helped to wash their hands properly after using the toilet. During an episode of illness, particular attention should be paid to avoiding sharing towels and cutlery between family members.

Infants are more likely than older children to experience more serious symptoms due to gastrointestinal conditions. However, breastfed babies are less likely to experience these conditions than their bottle fed peers. Families who are bottle feeding must ensure that bottles and water are

properly sterilised to reduce the risk of infection. It is recommended that new babies should be breastfed and vaccinated against rotavirus to provide them with the best protection against gastrointestinal infections.

Feverish Illness in Children

Fever is a common presenting complaint in children and can cause anxiety for parents and carers. Between 20% and 40% of parents report their child has a feverish illness each year. Fever is an elevation in body temperature above the normal daily variation. It is typically defined as a fixed body temperature ≥ 38°C. Fever may be caused by a number of infections, the most common one being self-limiting viral infection such as an upper respiratory tract infection. Most children with fever will recover quickly and without any problems. As fever is a symptom of infections rather than an illness in its own right, data is not recorded for children or young people who present to A&E with a fever. We can assume that those children who presented with a 'diagnosis not classifiable' may have also had a fever as it is a common symptom of many illnesses particularly in younger children. Again, children under five account for the largest single proportion (46%) of all 0-19 years attending A&E with this diagnosis in 2013/14.

Babies less than 3-6 months of age rarely have fever and if present, fever can be a sign of a serious underlying illness. Temperature ≥ 38°C in babies under 3 months of age and temperature ≥ 39°C in babies between 3 and 6 months of age should be reviewed by a healthcare professional.

A high body temperature in children can be due to overheating as a consequence of being over-dressed, during teething and following vaccination. Fever in these cases is rarely significant and can be easily managed with simple interventions at home.

Management of Fever

Most children with fever can be cared for at home. Over the counter medicines such as paracetamol and ibuprofen can be helpful. They help to lower the body temperature and make the child more comfortable. Paracetamol and ibuprofen should not be given at the same time and parents should only alternate these medicines if the child has not settled with the first one. Parents should check and administer only the recommended dose for their child's age at the intervals stated on the packet.

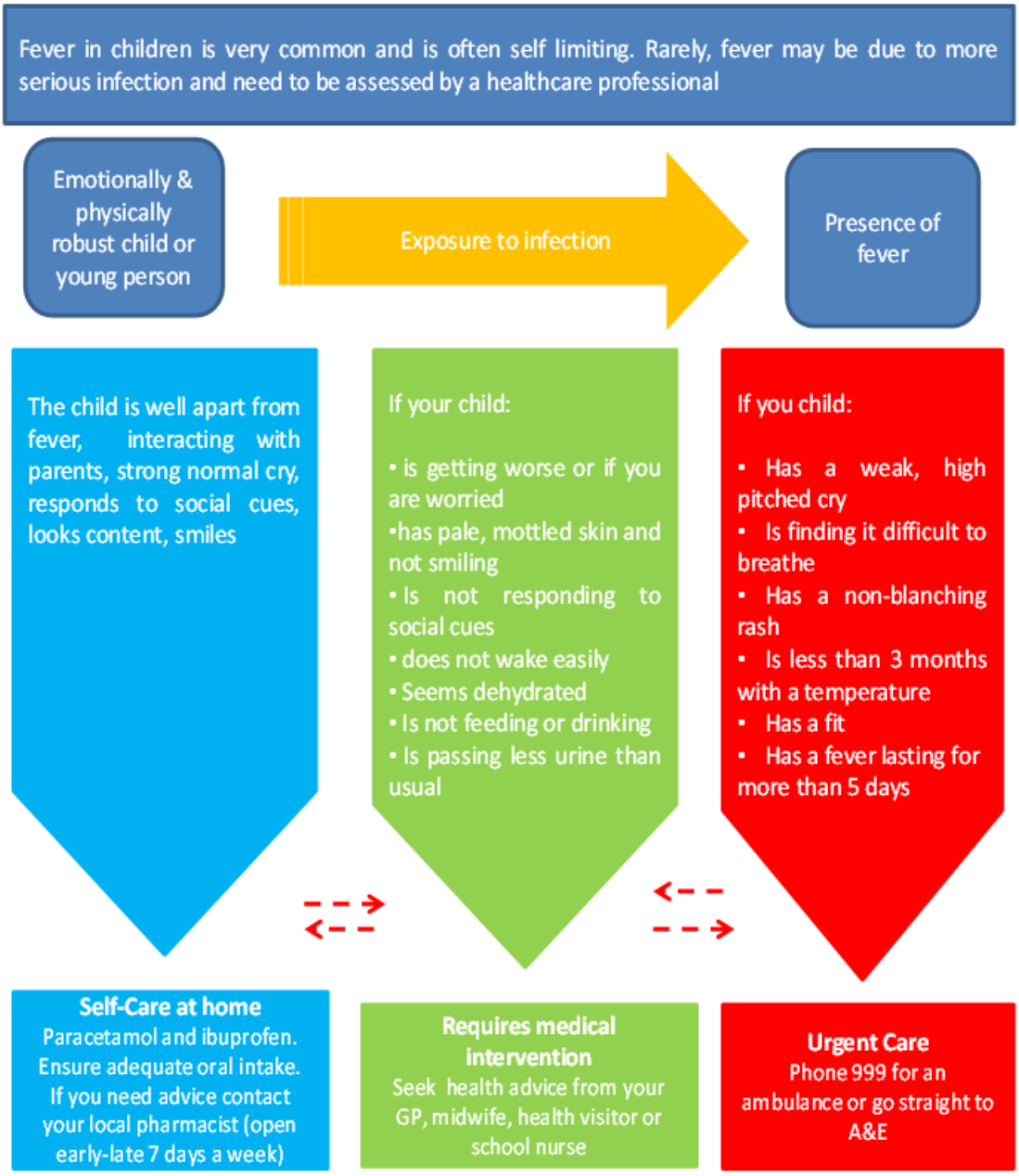
It is important to keep the child hydrated and encourage the child to drink breast milk, bottle milk or clear fluids. Parents should look out for signs of dehydration such as dry mouth, absence of tears, sunken eyes, or sunken fontanelle (soft spot on a baby's head). If parents are concerned that any of these signs are present they should seek assistance from a healthcare professional. Parents are also advised to keep the child off school or nursery if they are unwell with a fever.

Parents should be educated that fever is a natural and healthy body response to infection. By increasing the body's temperature, fever makes it more difficult for the bacteria and viruses that are causing the infection to survive. Despite the common misconception, NICE[19] recommends that children with fever should not be over or under dressed. Sponging children with cold water is not advised as cold water makes the blood vessels under the skin narrower and the heat is trapped inside the body. This reduces heat loss and can make the child worse. Providing parents with advice regarding these simple measures can help decrease the number of hospital admissions.

Parents should always be advised to seek medical attention if the child develops a non-blanching rash (a rash that does not go away with pressure), or has a fever lasting for more than 5 days, or

develops a fit, or if parents are concerned that the child is not getting better and are unable to look after the child.

Figure 12. An example of feverish illness advice to parents



This advice is largely based on the NICE clinical guideline 160 'Feverish Illness in Children' and on 'Fever Discharge and Follow Up Advice Sheet for Children 0-5 years' by West Sussex Children & Young People's Urgent Care Network

Minor Illnesses

Children and young people are frequently affected by a wide range of minor illnesses and health problems. Some of these can lead to children becoming quite unwell for short periods of time. If parents are not confident about managing these illnesses, or if they cannot readily access help and support in the community, they may seek help from their general practitioner or sometimes from an

accident and emergency department. Many illnesses will get better without any specific intervention or treatment, although over-the-counter medicines can help to control symptoms such as pain, fever and itching.

The "Think Pharmacy" Minor Ailments Service

In a move towards increasing self-care and the use of community health resources, NHS Eastern Cheshire and NHS South Cheshire Clinical Commissioning Groups (CCGs) have recently commissioned a "Think Pharmacy" Minor Ailments service that can provide advice and treatment for a wide range of minor illnesses and health problems that commonly affect children and young people. Under the "Think Pharmacy" Minor Ailments service, a community pharmacist can assess the child and supply a range of medicines that would normally need a prescription. This means that if the parent is worried about the symptoms or if things are not getting better, they can go to any community pharmacy for advice rather than having to make an appointment at their surgery. In Cheshire East pharmacies are open much longer hours than GP surgeries including early morning, evenings and weekends.

How does it work?

- People can visit any pharmacy without an appointment for advice and treatment
- The consultation will always be confidential with a qualified pharmacist in a private room
- Consultations are always free, regardless of whether the pharmacist provides any treatment
- Prescriptions are free for children under age 16 and young people aged 16, 17 and 18 in full time education, but otherwise the medicine will cost no more than the prescription charge

A Pen-picture of some Minor Ailments

- **Oral Thrush**

Oral thrush affects around one in 20 newborns. Babies with oral thrush may refuse breast feeding or become quite irritable when feeding. It usually resolves within seven days without any treatment but medicines can be used if the thrush fails to resolve or the baby is unwell. Breast feeding mothers can be given advice on breast feeding hygiene.

- **Impetigo**

Impetigo affects around one in every 35 young children each year. Without treatment it usually resolves within 2-3 weeks, but medicines may be needed if it is severe, extensive or slow to resolve. As impetigo is contagious, children should wash their hands regularly and avoid scratching the crusts. They should not attend school or nursery until the crusts have healed.

- **Eczema (affects around 14,600 children and young people locally)**

Eczema may be continuously present or come in cycles (flare-ups). It can improve over time, but asthma and hay fever can also develop. Young people with eczema should know how to avoid triggers and treat flare-ups. First line therapy involves applying a moisturiser regularly and liberally on dry skin. A short course of steroid cream can bring acute symptoms under control.

- **Acne (affects around 29,500 young people locally)**

Acne is a common skin condition that usually starts in puberty and affects most young people. It can vary greatly in severity and the young person's perception of the problem usually influences whether they will seek help for it. Good skin self-care can be supplemented with medicated gels or creams, although improvement can take several months to occur.

Improving the Management of Minor Illness

It is important that the work already undertaken locally is built upon. Consistent advice must be provided to families and young people by the different services (health, education, social services, etc) to help them to recognise and manage minor illnesses when they occur.

The promotion of information and advice through mobile phone apps, web-based resources and printed materials needs to be co-ordinated and targeted towards the illnesses and injuries that the child is most at risk of experiencing, based on their age and household circumstances. The Public Health team in Cheshire East is developing this preventive advice in conjunction with both CCGs, and it is intended that Health Visitors will use such resources to educate parents of children under 5 about managing common childhood conditions. Ideally advice and information would be provided as part of a preventative approach, but in some cases it may be provided retrospectively to help a family learn what to do, and what symptoms to watch for, should they experience a similar episode again with their child.

The Cheshire and Merseyside Public Health Collaborative Service (CHaMPs) report 'Evidence Briefing: Delivering effective health services to children and young people' (March 2014) has highlighted that particularly for young people health and care services should use new cost effective technologies. The report suggests that health promotion and service delivery can utilise a variety of approaches such as websites, social networks, YouTube, email text messaging and through apps for smartphones. The services provided through these means can include service promotion, information and advice, health promotion messages or reminders. It can also be used to facilitate service user involvement and provide interaction and discussion as well as the monitoring and management of health conditions and wellbeing.

This may seem a daunting suggestion for some services, but "...something as simple as an online list of all the services that can be accessed in your area would help" (Chapter 4, page 4).[2] This is according to a young person from the Royal College of Paediatrics and Child Health focus group (which provided the views of young people in the Annual Report of the Chief Medical Officer 2012).

By improving the knowledge of local families and young people about the services available to them in their local community and how these can help them manage minor illnesses in either their children or themselves at home, will help to see a reduction in the number of children and young people attending A&E unnecessarily or being admitted to hospital for observation.

Future Arrangements for the Unwell Child

An emerging theme through this annual report is the need for the statutory agencies - NHS, local authority and police – along with the public, to commission integrated services which meet local need and improve local outcomes. Both South and Eastern CCGs are working with partners to deliver that vision. What would success look like for children and their families?

Here I share two stories of how families could be supported when their child becomes ill.

Imagine that it is the early evening, your three year old has a fever of 39^{oC} and is restless, they are coughing and you are worried about them. Or your four year old has had a few episodes of vomiting and diarrhoea and you are not sure what to do to help them. Or your teenager is complaining of bad stomach cramps. It is getting late so what do you do? Who do you call? Where do you go?

At the moment many families who call for help are advised to take their child to be assessed at their general practice or at the out-of-hours service. A home visit is no longer common practice. Despite reassurance the family is nervous about continuing to manage their child's care in their own home and may decide to take their child directly to the accident and emergency department. Many of the children and young people who arrive at hospital in the evening may be admitted to hospital for observation. The vast majority of these children are then discharged first thing in the morning because there is no need for them to be there and they can be treated and looked after perfectly well (and more suitably) in the community and at home. As a parent you have had to arrange for someone to look after the house and other dependents so you can stay with your sick child.

Moreover your fear that your child was seriously ill and needed medical intervention and an overnight stay has been confirmed, and next time your child has similar symptoms you won't hesitate to do the same thing. In fact next time you might just go straight to the hospital.

In Cheshire East, over the last ten years, there has been:

- a move away from assessment processes that are based in the community to high levels of direct access and usage of accident and emergency departments
- increased referral by general practitioners for specialist paediatric assessment
- children being admitted to hospital for what is often a very brief period of time

This has reinforced the tendency to take unwell children to emergency departments and to an overreliance on urgent care pathways, which means that too many children are being admitted to hospital for relatively minor conditions, which risks deskilling and reducing community support.

Now, imagine that an alternative community based service is available.

The worried parent calls during the evening. A primary care nurse or suitably skilled professional from the community paediatric team visits their home, examines the child, and explains to the parent that (s)he does not need to be concerned, that the symptoms they are seeing are normal for the condition the child has (a cold, diarrhoea and vomiting or constipation), and that (s)he can alleviate their child's distress by providing pain relief or oral rehydration. The nurse explains how long symptoms are likely to last, what is likely to happen next and about any warning signs that the child's condition is getting worse and that self-care in the home is not enough, which would mean that the child would need to go to hospital.

A health professional who you trust told you that you are doing a good job and can manage. You have all the information you need and know what is likely to happen next and what warning signs to look out for. Next time your child experiences something similar you will be able to cope by yourself. You are not overly alarmed as you know you can manage this episode of ill health and equally what to do should it get worse.

An Eight Point Plan for Increasing Self-Care for Minor Illnesses

Families should be able to manage common minor conditions affecting children and teenagers themselves. Many of these are self-limiting and do not normally require healthcare intervention, such as colds and other viral infections, oral thrush in babies and impetigo in younger children. Families should know how to manage a fever or diarrhoea and vomiting so that the child's condition does not worsen, or know when a bump to the head needs medical attention and when it does not.

But this change will only happen if local services and commissioners work together to improve the information provided to local families and young people and through this increase their confidence to manage minor illnesses through self-care at home. To aid this development, I am making the eight following recommendations to help bring about the changes we hope to see in the near future:

1. Midwives, health visitors and school nurses should include within routine care health promotion work to inform parents on how to manage their children's minor illnesses through self-care at home and where to go for advice within their community if they need it. Midwives, health visitors and school nurses are a trusted source of information and a vital link in helping to improve the confidence of parents and young people to manage minor illnesses themselves and with the support of community resources such as pharmacies. They should work with young people who are unwell (or families with an unwell child) to support them to manage minor illness through self-care at home.

2. General practices need to develop or improve systems that will provide quick and consistent advice and support to families with an unwell child. This may be through face-to-face consultations, leaflets or web-based/mobile communications. General practices should identify what the preferred method of communication is for their families with young children and young people (both via parents and independently of them) to ensure messages are easily accessible for these patients or their carers.

3. The CCGs, NHS England and public health team should work together to increase parental awareness of the advice and services available at community pharmacies, their locations and opening hours. It should be highlighted that community pharmacies are an appropriate 'first port of call' for families with a child unwell due to a minor illness and for young people with health concerns. It should be publicised that community pharmacies can provide private and confidential consultations on a range of health issues and can provide some prescription drugs without patients having to attend their GP.

4. The CCGs, children and families team and public health team need to work with schools to help them, and pupils, understand the importance of self-care in relation to health and wellbeing. Self-care for minor illnesses is an important part of growing up and is a key skill for later life. Empowering pupils to take control of their own health and wellbeing, will reduce absence from school and unnecessary hospital or doctor's appointments. Self-care can be about knowledge or can be very practical, for example, pupils with eczema being supported to use moisturisers at school.

5. The CCGs, children and families team and public health team should work with schools to understand the access needs of their pupils in relation to some health services. Schools need to recognise that independent access to pharmacy services (which are now providing a greater range of self-care advice and medication) after school may be difficult for young people who are brought to school on scheduled bus services from rural areas. Older teenagers should be allowed to access local community pharmacies during the school day to obtain health advice

and support for self-care, as it may not be possible for them to access these services at any other point.

6. General practices should consider the needs of children and young people in terms of accessing their services. They should be mindful that appointments during the day are disruptive to the child's education. General practices should provide early morning or late afternoon appointments for children and young people so that their education is not disadvantaged by having to leave school for appointments.[d]

7. General practices should work to restore confidence amongst young people that their services are private and confidential. It was identified in the Annual Report of the Chief Medical Officer 2012 that many young people are concerned that their family's doctor (GP) not a confidential service and that their parents or family will be notified of their visit and the discussions they have with the doctor. Changing this preconception will help to encourage young people to access primary health care services rather than relying on other services, for example sexual health, which they perceive to be more 'anonymous'.

8. Services need to increase the methods and ways of communicating with young people in relation to their health and wellbeing. They should identify what technology local young people use and like, and ensure services use up-to-date technology that is compatible and liked by young people. Providers must have access to, and be familiar with, these technologies and methods of communication; training and support should be provided to staff if necessary and must include issues relating to online safety, information sharing and communication over the internet and other electronic devices.

Key Points

Whilst lifestyles are of growing significance for long-term health outcomes, communicable diseases and unintentional injuries remain a major threat to the health of children.

Most respiratory conditions, gastrointestinal conditions and feverish illness can be managed by parents. Though, in 2013/14, 40% of non-injury A&E attendances and 47% of all emergency hospital admissions amongst children and young people aged 0-19, were due to these three conditions. Often basic prevention techniques such as good hand hygiene would have helped keep a child healthy. Ensuring families can provide self-care confidently to their poorly child, and that they know where to go for help should they need it, will help to reduce the number of children and young people who attend hospital for these conditions.

To help families increase their use of self-care and community health resources, rather than relying on A&E services, the two local CCGs have commissioned a "Think Pharmacy" Minor Ailments service. This can provide advice and treatment for a wide range of minor illnesses and health problems (such as oral thrush, conjunctivitis, eczema and acne) that commonly affect children and young people. The minor ailments service enables community pharmacists to supply a range of medicines that would normally require a prescription. This means that families can access the required treatment for a minor ailment quickly and without needed a GP appointment.

In addition to the work already done by the local CCGs to help local families to increase self-care for minor illnesses, this chapter includes an eight point plan for further action. This recommends that

[d] This was raised as a concern by children and young people in the Annual Report of the Chief Medical Officer 2012 (chapter 4 page 6). It also related to chronic condition clinics at hospitals as well as GP surgeries.

families should receive better information and support about managing an unwell child themselves from midwives, health visitors, GPs and school health teams. Schools should be supported to understand the importance of self-care for their pupil's health and the role that pharmacies play in promoting this. Work should be done to improve trust in, and access to, general practices by young people, including appointment times that do not disadvantage their schooling. All services should also improve their methods of communication with young people in relation to their health and wellbeing, particularly using technology used and liked by young people.

Chapter Five

Preventing Childhood Injuries

The new public health responsibilities for improving health and reducing health inequalities include two outcomes relating to childhood injury, which are:

- Reducing hospital admissions from unintentional and deliberate injuries for children and young people
- Reducing deaths from road traffic injuries

Partnership working across the public, private, voluntary and community sectors is essential in order to achieve these outcomes. The local priorities for each community need to be identified in conjunction with residents, and agreed with a wide range of services including health, education, social care, housing, police, and the fire and rescue service.

Approaches that empower parents and carers can embed home safety behaviours. For example, policies developed by parents at children's centres on where hot drinks can be consumed safely are more likely to be adopted by other parents than policies created by staff alone.

In her 2012 Annual Report on children and young people's health, the Chief Medical Officer made a powerful economic case for preventing unintentional injuries, and highlighted the need for more information about the wider costs and benefits of injury prevention to help local areas prioritise investments. She pointed out that injury prevention can be low cost, and it can provide a tremendous return for young children in terms of reducing preventable years of life lost and disability adjusted life years.

NICE guidance[20,21] contains a range of approaches to prevent unintentional injuries among vulnerable children and young people. The guidance also uses the term 'vulnerable' to refer to the following groups of children and young people who are at greater than average risk of an unintentional injury:

- Children under the age of 5 years, in relation to unintentional injuries in the home
- Those over the age of 11, in relation to unintentional injuries on the road
- Children and young people who have a disability or impairment
- Children from some minority ethnic groups
- Those who are living in a low income family
- Those who are living in accommodation which may put them more at risk of injury, which includes multiple-occupied housing, and social and privately rented housing

Unintentional Injuries In and Around the Home

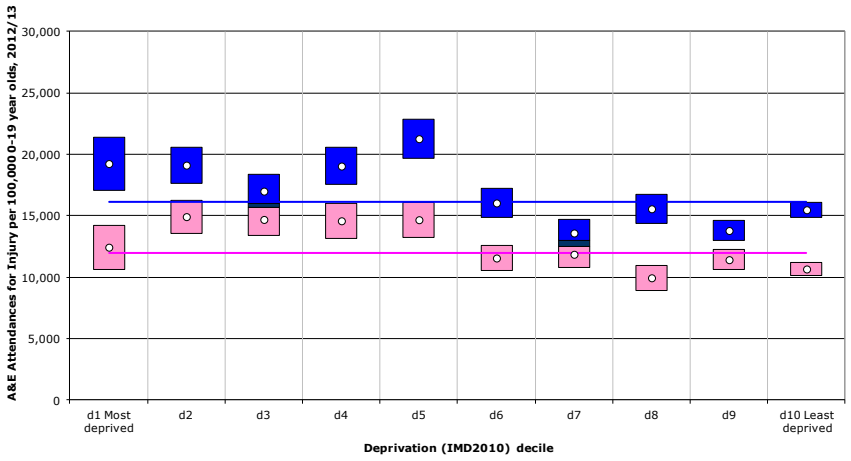
Unintentional injuries in and around the home are a major cause of ill health and serious disability for children, particularly for those aged under five.

In Cheshire East in 2013/14, a total of 2,380 children aged 0-4 years attended an accident and emergency department because of an injury. This is the equivalent of 12% of the population in this age group. Over the same period, 275 children aged 0-4 were admitted to hospital due to an unintentional injury. There is a strong relationship between the age of the child and the cause of injury, with around 65% of admissions in the under-five's resulting from falls and household knocks and a further 21% from burns and accidental poisoning.

High adult alcohol consumption, socioeconomic deprivation and maternal depression all represent important modifiable risk factors for burns and poisoning in pre-school children.[22] Since these risk factors are generally known to primary care teams and health visitors, there is an opportunity to reduce injury risk by implementing effective preventive interventions.

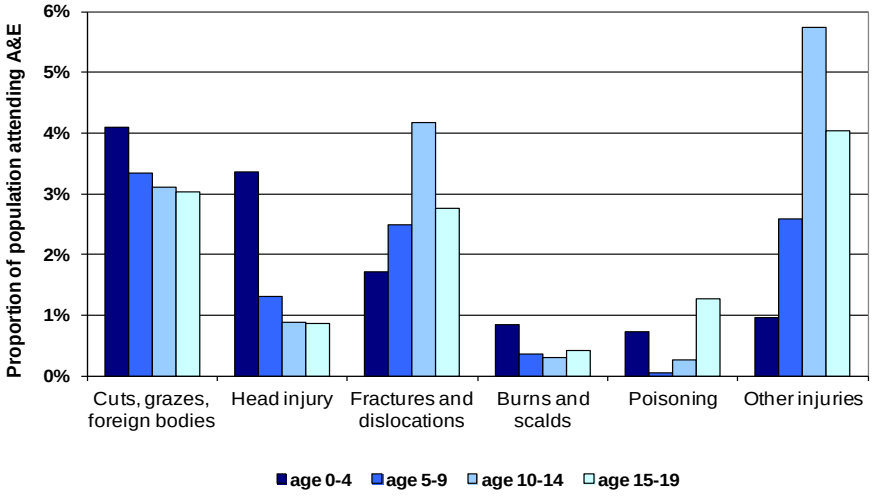
The risk of emergency admission is higher in more deprived areas in both genders, as shown in Figure 13. However, the higher than average attendance rates across the five most deprived deciles suggests that something other than the incidence of injury may be involved. The pattern may be reflective of accessibility of services and previous use of these services by the family.

Figure 13. Emergency admissions to hospital in children aged 0-4 in Cheshire East by deprivation decile, 2012/13



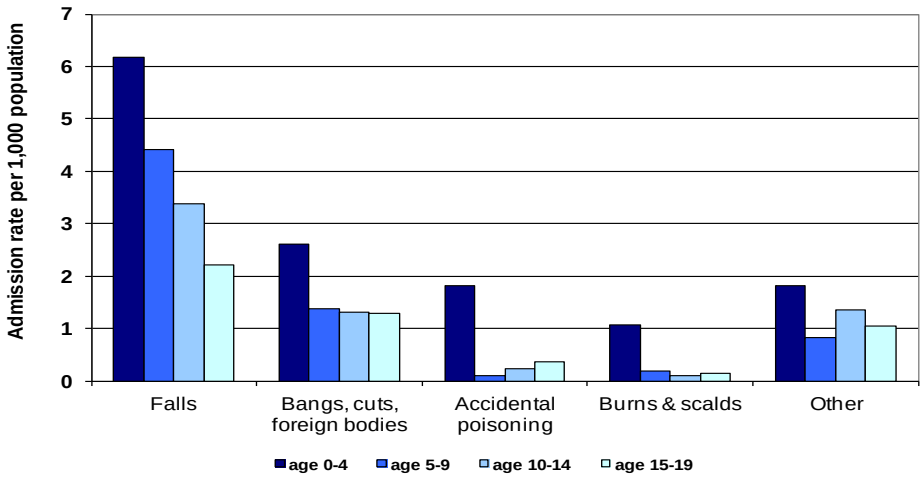
A&E attendances due to injuries in older age groups aged 10 to 19 are largely due to musculoskeletal injuries such as sprains, ligament and muscle injuries, and fractures and dislocations as Figure 14 shows.

Figure 14. A&E attendances due to injury, 2013/14



Though Figure 15 highlights that children aged 0-4 have the highest rates of emergency hospital admissions for all forms of injury.

Figure 15. Emergency hospital admissions due to injury, 2013/14



Amongst the 0-4 age range cuts, grazes, foreign bodies and head injuries account for over two thirds of all A&E attendances. These types of injuries are linked to a number of factors including child development, the physical environment in the home, the knowledge and behaviour of parents and other carers, overcrowding or homelessness, the availability of safety equipment and new consumer products in the home. Many of these injuries will have been caused by falls which account for nearly half of all emergency hospital admissions in this age group.

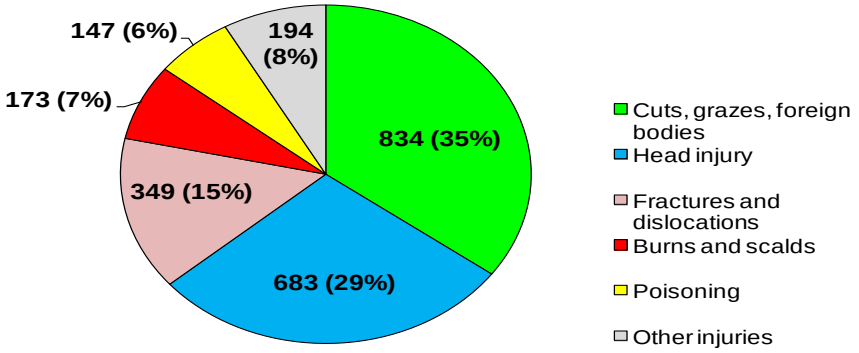


Figure 16. A&E attendances due to injury in 0-4 year olds, 2013/14

Head Injury

Some head injuries cannot be predicted or avoided – toddlers and young children are full of energy and have little sense of danger, and all children will at some point experience a bump to the head. But many head injuries can be prevented, and particularly the more serious ones.

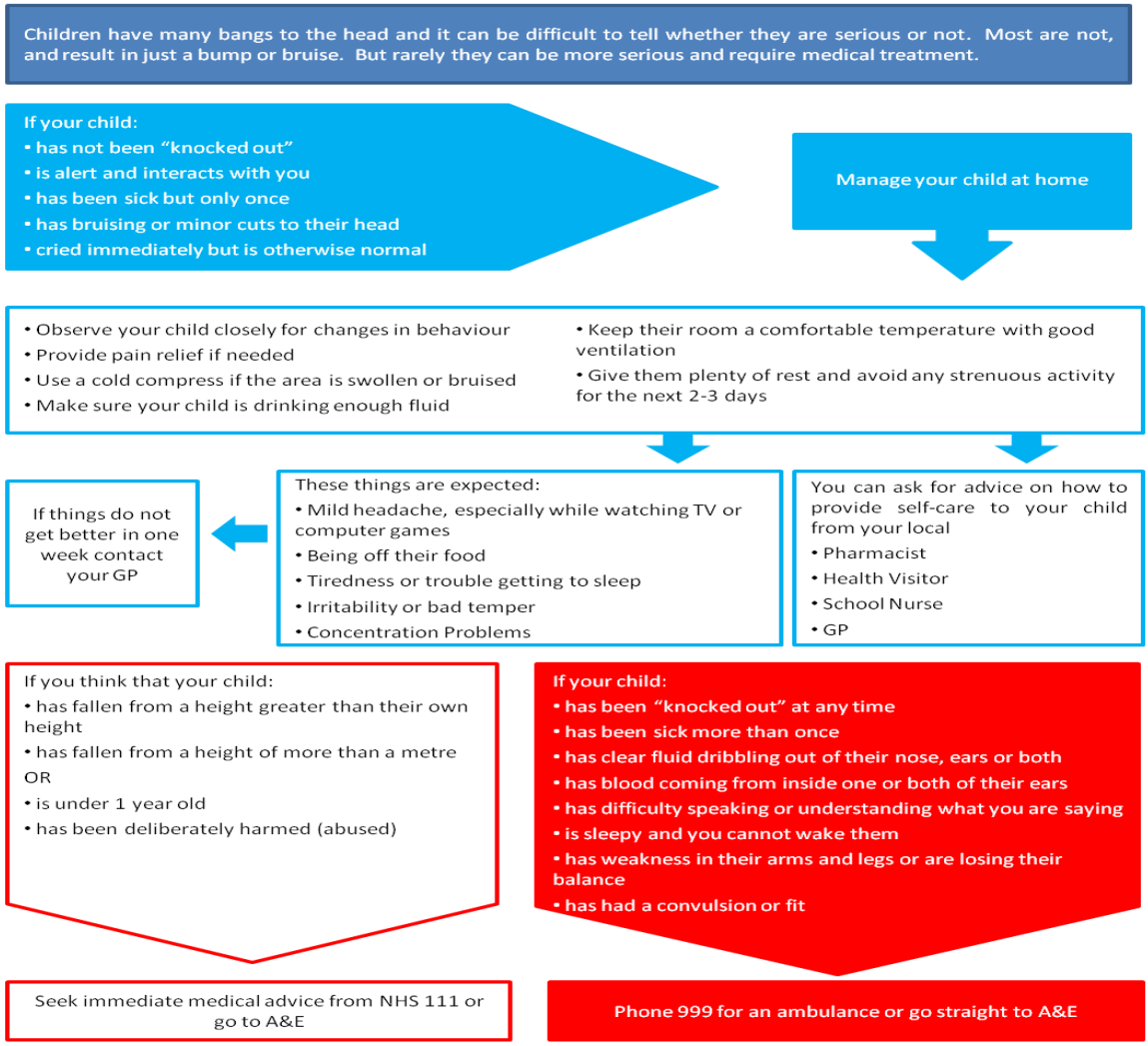
The Royal Society for the Prevention of Accidents[23] suggest that falls (a common cause of head injury) can be reduced by age appropriate 'childproofing' within the home including safety gates at both the top and bottom of stairs, removing trip hazards on the stairs, never leaving babies unattended on raised surfaces or placing baby bouncers on raised surfaces, or placing anything under a window which can be climbed on. Using cycle helmets for all family members and wearing

appropriate safety equipment when playing sports, particularly contact sports, will also help to reduce head injuries.

In Cheshire East, head injuries accounted for 1,323 (13%) of all the injury-related A&E attendances among children and young people aged 0-19 years in 2013/14. Over half (52%) of these head injury attendances were in children under five, particularly one-year olds. More than a third of the children who attended an accident and emergency department in Cheshire East with a head injury in 2012/13 required no investigation or treatment; they were sent home with advice and guidance. Their injury could have been successfully managed at home had their family felt confident they knew how to manage a head injury.

It is important that families are provided with the understanding as to what to expect following a minor head injury and what key signs to look out for which would indicate a deterioration in their child's condition necessitating a trip to hospital.

Figure 17. An Example of Possible Head Injury Advice for Parents



This advice is based on the leaflet 'Head injury advice for Parents' produced by NHS Brighton & Hove, Brighton & Hove Children and Young People's Trust and Brighton & Hove City Council

Figure 18 demonstrates the significantly higher level of A&E attendances in both males and females aged 0-4 in Macclesfield LAP, and males in Poynton LAP. Knutsford and Nantwich LAPs have significantly lower rates of attendance for both sexes, and Crewe LAP has significantly lower rates for males. The higher rates of attendance in Macclesfield could be a function of proximity to the A&E Department at Macclesfield District General Hospital. Rudge *et al* (2013) found a strong relationship between the rate of A&E attendance and distance from the A&E Department for children aged 0-14. For each additional kilometre from the department, attendances reduced by 2.2%[24]. This effect was greater when deprivation was taken into account, with those in the most deprived income quintiles less likely to attend as distance from the department increased. This effect may partly explain why higher rates of attendance are seen in Macclesfield than in Crewe, where the level of deprivation, as measured by the Index of Multiple Deprivation (IMD) 2010 is greater. It is pertinent that the A&E Department at Leighton Hospital in Crewe is located some distance from the town centre, whereas the Macclesfield A&E Department is very central. Learnt behaviour and culture are also known to influence patterns of A&E Attendance.

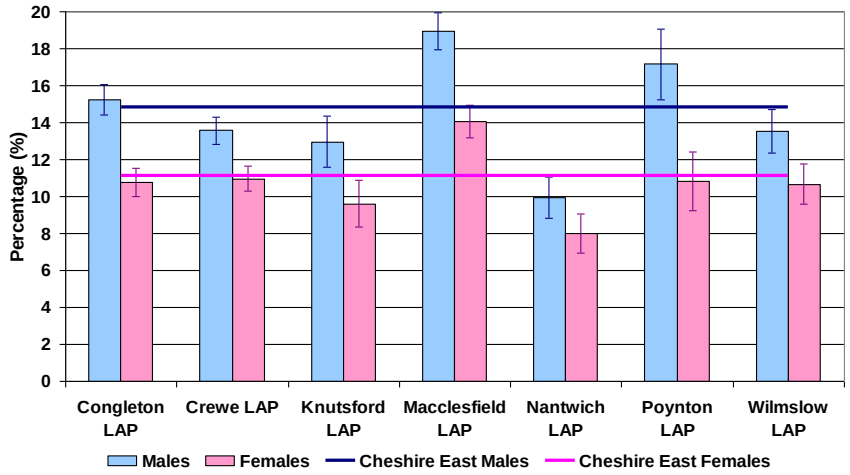


Figure 18. A&E attendances due to injury in 0-4 year olds, 2011-2014

Preventing unintentional injuries for the under-fives is an aim of targeted interventions such as the Family Nurse Partnership programme as well as of widely used parenting programmes. The work also supports the wider aims of the Troubled Families Programme and family intervention services and projects. For some families, unintentional injuries are a result of neglect which is an important aspect of child protection work. A&E departments and minor injury units also play an important role as they are able to advise families about future prevention when they see an injured child.

Community Hubs and children's centres are well placed to provide information and support to families around child accident prevention through educational input at centres and family outreach work. Training for staff and volunteers to further develop confidence and competence in this area is important. With appropriate training and supervision, voluntary and community organisations such as Home-Start are also able to support vulnerable families on injury prevention as part of customised user-led services given the trusting relationships they develop.

Focusing on Five Kinds of Injuries for the Under-fives

There is a strong argument to focus on tackling the most severe and preventable injuries, including those that result in a high risk of death and the largest number of emergency hospital admissions. Figure 19 and Figure 20 illustrate the numbers of A&E attendances and emergency admissions by single year of age from 0 to 9.

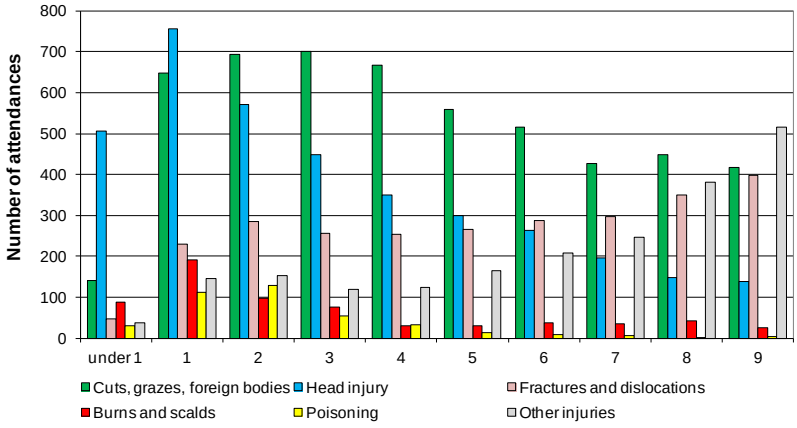


Figure 19. A&E attendances due to injury at ages 0-9, 2011/12 to 2013/14

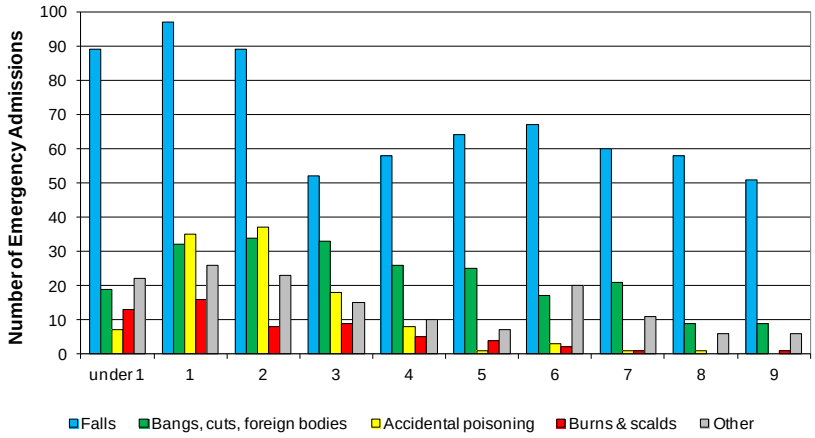


Figure 20. Emergency admissions from injury at ages 0-9, 2011/12 to 2013/14

These highlight that amongst children aged 0-4 years, five types of unintentional injury need to be prioritised, and each has its own profile and characteristics:

1. **Choking, suffocation and strangulation.** Although relatively uncommon, these injuries carry the highest risk of death among the under-fives and have already been prioritised by the Cheshire East Child Death Overview Panel. They include:

    - inhalation of food and vomit, primarily affecting children under two
    - hanging and strangulation, with window blind cords being a major hazard
    - suffocation in bed

2. **Falls.** In Cheshire East falls are the leading cause of admission to hospital from injury in children under five, with 126 admissions in 2013/14. Many parents take their child to an accident and emergency department because they are worried about the possibility of head injury. Most falls attendances and admissions are in babies and in children aged one or two, which means that robust falls prevention initiatives need to be in place from birth onwards. There are four broad groups of injuries, the first two are common but rarely result in death. The last two are less common but have a higher risk of death:

    - falls from furniture, such as beds, sofas and high chairs
    - falls on and from stairs and steps

- falls while being carried, which primarily affect children under the age of one
- falls from or out of buildings, such as from windows or balconies

3. **Poisoning.** These injuries caused 147 A&E attendances and 37 hospital admissions in children aged 0-4 in Cheshire East in 2013/14. National data indicates that poisoning admissions caused by household chemicals peak at the age of one; and those caused by medicines at the age of two. As these products can be stored well away from very young children, all of these injuries were potentially preventable:
    - medicines are the cause of over 70% of poisoning admissions nationally.
    - household chemicals account for a further 20% of admissions nationally.[25]
4. **Burns and scalds.** This is the fourth highest reason for injury admissions in under-fives in Cheshire East, with 173 A&E attendances and 22 admissions in 2013/14. In Cheshire East most burns and scalds are in children aged one, although they are also common in babies and in children up to the age of three. Serious burns and scalds are disfiguring and disabling for young children. They arise from five main sources:
    - scalds from hot drinks, which peak at the age of one
    - burns from hot household appliances, increasingly from hair straighteners
    - contact with other hot fluids, including water being heated on a stove
    - burns from hot heating appliances, including radiators and pipes
    - bath water scalds, which also peak at the age of one and cause severe injury
5. **Drowning.** The lethal nature of drowning means that it should be a core part of injury prevention. For the under-fives the main risk occurs in the bath.

Other Hazards

Although five main causes of unintentional injuries are described above, other causes of injury should not be ignored. For example, exposure to smoke, fire and flames results in a high proportion of deaths among the under-fives in and around the home. Furthermore, hazards change, especially as new products such as hair straighteners or liquid detergent capsules emerge, and as children grow up. Concerns have been raised about harm caused by swallowing powerful button batteries and more recently the dangers of nicotine poisoning from electronic cigarettes.

An Eight Point Plan for Reducing Unintentional Injuries In and Around the Home

1. Any professional working with families or children (including health care professionals, teachers, social workers, children's centre staff etc) should identify households with young children as vulnerable groups who are at greatest risk of having unintentional injuries. They should provide advice both verbally and through leaflets and work together with parents to minimise injuries in and around the home.

2. Any professional working with families or children (including health care professionals, teachers, social workers, children's centre staff etc) should provide parents and carers with advice

regarding home safety assessments, and provide advice on how to reduce risks. Assessments can be carried out by parents, carers and other householders using an appropriate checklist. Parents should be educated to systematically identify potential hazards in the home and garden. Once identified these risks should be evaluated and ways to reduce them should be sought. Home safety assessments and education should be incorporated in local plans and strategies relating to children and young people's health and wellbeing. Home safety assessments should be aimed at families with a child under five or with other children who may be particularly vulnerable to unintentional injuries. (See list of vulnerable groups on page 41).

3. Health visitors should recommend the use of appropriate safety equipment such as door guards, cupboard locks, window restrictions, safety gates both at the top and bottom of stairs to parents with young children under the age of 5. Young children starting to crawl and learning to walk are at an increased risk of falling over while doing so. These simple strategies will help prevent a number of injuries such as falls, bumps and head injuries. Community hubs supporting Life Links would be able to coordinate this with advice and issuing equipment.

4. Parents with babies should be advised never to leave them unattended on a raised surface or place baby bouncers on raised surfaces. Babies learn to roll over at a very young age and can easily fall over and suffer from significant injury.

5. Community pharmacies, general practices and health visitors should provide clear advice regarding the hazards of medicines in children. Accidental poisoning with household chemicals and medicines is very common in young children under the age of three. This can be easily prevented by keeping these products locked in cupboards out of reach from children.

6. Housing associations and landlords, working with the local Fire and Rescue Service, should ensure that permanent home safety equipment such as smoke and carbon monoxide alarms, thermostatic mixing valves and window restrictors are installed and maintained in all temporary, social and rented housing where there are children under 15, with priority given to accommodation where there are children aged under 5.

7. Accidental burns and scalds in young children due to hot drinks, heating appliances, hot fluids on stoves or other household appliances are very common. Recently there has been an increased number of burns arising from hair straighteners. Burns can cause serious harm in young children. Parents should be well educated and given advice in the form of leaflets regarding precautions to take to prevent burns and scalds in children. They should be told to always turn off any hot appliances after use, make sure that children are kept away from kitchen stoves, radiators, to avoid handling hot fluids around children and to check the temperature of bath water.

8. Local health organisations need to engage actively with, and contribute to, the Cheshire East Road Safety Partnership.

Unintentional Injuries – Road Traffic Accidents

The focus of unintentional injuries so far has been mainly on younger children particularly those under the age of five. However, accidents remain an important part of the picture of health of young people. In these older age groups accidents can be affected by behaviour.

Unlike the younger age ranges, where the greatest risks are found in the home, for older children and young people the risks are greater outside of the home, particularly on the roads. Young people locally recognise traffic as a concern; it was highlighted in the Cheshire East Good Childhood Report 2014. This showed that overall 28% of local children (both primary and secondary school ages)

wanted to see less traffic. Amongst primary school children however, it was their biggest concern with 41% wanting to see less traffic. This was statistically different from the national picture where only 26% of primary school children wanted to see less traffic. Amongst local primary school children concern was often about the speed of traffic as much as the volume of traffic. The speed of traffic was particularly of concern to those children living in rural areas.[36]

> "*It's not safe people come speeding around in cars and it's a rough area there are scary places on the estate*" – year 7 boy[36]

Amongst secondary school aged children concern about traffic was lower, but it was still above the national figure for this age range (though not statistically significant). In Cheshire East 22% of young people wanted to see less traffic compared to 19% nationally.[36] It is this age group who are at greater risk from injuries on the roads whether pedestrians, cyclists, vehicle passengers or drivers. Nationally, there is a noticeable increase in injuries between ages 10 and 11, which coincides with the move to secondary school and probably with increasingly unsupervised travel.[26] However, less traffic was not this age group's main area of concern about their local environment.

In my Annual Report last year I drew attention to road accidents as an important cause of early death. Of those who were fatally and seriously injured in 2013[e], 13 (6.3%) were under the age of 16 whilst 53 (25.9%) were aged 16-25. This means that nearly a third of deaths and serious injuries on the roads are in children and young adults.

National studies of reported road traffic injuries and emergency hospital admissions clearly show that some groups of young people are at greater risk of injury:

- young males are three times more likely to be killed on the roads than young females
- the highest rates of hospital admissions and police-reported serious and fatal casualties occur soon after young people start legally using cars and motorcycles
- one in every 1,250 young people aged between 15 and 24 years in 2012 suffered a serious or fatal traffic injury
- half of all deaths in young car occupants occur between 8pm and 4am
- the rate of fatal and serious injuries on the roads in 5 to 9 year olds is nine times higher for those who live in the 20% most deprived areas; for 10 to 14 year olds, it is more than three times higher. There is a gradient in the risk of fatal and serious injury among 5-15 year olds, with the risk decreasing as the level of affluence increases.
- the move from primary school to secondary school increases the risk of injury by almost two-fold in Year 7 pupils compared to Year 6 pupils[27]

Cheshire East Council, working alongside Cheshire Constabulary and Cheshire Fire and Rescue Service, has implemented a range of initiatives to reduce the number of road casualties. It is therefore encouraging to see that there has been a steady reduction in the occurrence of deaths and serious injuries among children under 16, and in 2012 and 2013 the local rate was very similar to the

[e] Fatal casualties sustain injuries which cause death less than 30 days after the collision. Injuries are categorised as severe when a casualty is detained in hospital as an "in-patient", or any of the following injuries whether or not they are detained in hospital: fractures, concussion, internal injuries, crushing, burns (excluding friction burns), severe cuts, severe general shock requiring medical treatment and injuries causing death 30 or more days after the accident.

national rate. However the occurrence of other road traffic injuries in children continues to be higher than nationally.

Figure 21. Road traffic casualty rates for children aged 0 to 15

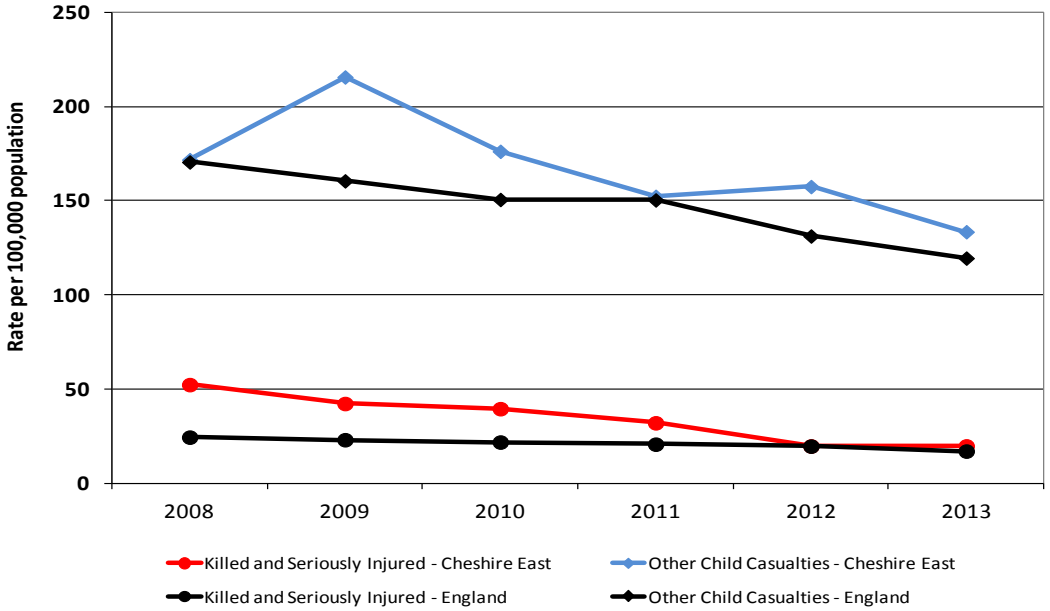
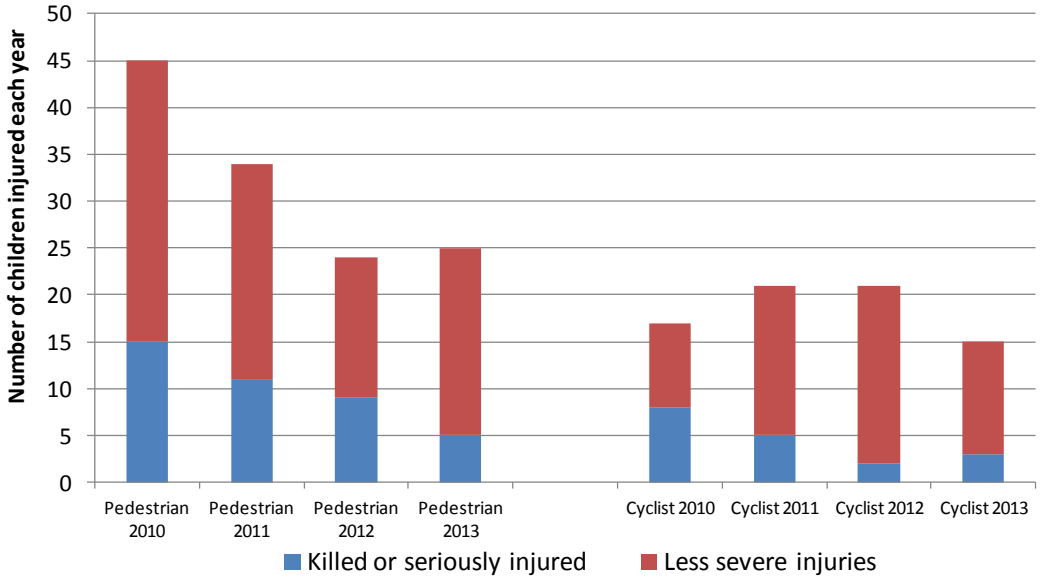


Figure 22 looks at injuries to child pedestrians and cyclists. In both groups there has been a fall in the number of deaths and serious injuries in children under 16, but it is noticeable that the overall number of injuries affecting child cyclists has not reduced significantly since 2010.

Figure 22. Trends in road traffic injuries affecting children aged 0 to 15 in Cheshire East



Young people can first get a moped licence at the age of 16, and at this age there is a sharp increase in the occurrence of fatal and serious injuries. This increases again at the age of 17 when young people can access larger motorbikes. Young car occupant injuries increase from the age of 17 and 18, and a significant proportion of fatal and serious injuries in this group occur in the evening and

early morning. On Cheshire East's large network of higher speed (60mph) roads, it is more likely that collisions will carry a risk of fatal injury.

Many young people will aspire to travel independently for work, study and leisure, although actually achieving this may result in high costs – both in affording the method of transport and from the risk of traffic injury. The Council and its partners can seek to influence these costs through developing a range of initiatives that reduce exposure of younger drivers and motorbike riders to dangerous scenarios, support their independence through the provision of age-appropriate cycling and walking facilities, and their needs for public transport.

A Three Point Plan for Reducing Road Traffic Injuries

1. Improving safety for children travelling to and from school

The largest numbers of child injuries occur between 8am to 9am and 3pm to 7pm, and safe travel for children during their first years at secondary school is of particular importance as pedestrian casualty rates for both boys and girls increase following this transition.

Every school in Cheshire East already has a School Travel Plan that is based on the specific needs of the school, community, and pupils. School Travel Plans are a good way to encourage walking and cycling on journeys to and from school, and are intended to address safety issues throughout the whole journey. Such plans need to be regularly and systematically updated, and where necessary supported by measures to:

- physically alter the road environment
- reduce vehicle speeds
- provide Bikeability cycle training (which in Cheshire East is increasing from a baseline of 3,800 in 2013/14 to 4,000 in 2014/15)
- enforce traffic laws

2. Introducing 20mph limits in priority areas as part of a safe system approach to road safety

Introducing 20mph limits and zones in priority areas can reduce vehicle speeds and thereby prevent injuries and reduce their severity. Lower vehicle speeds can also help to reduce health inequalities due to traffic injury. The introduction of 20mph speed limits should be supported with education and publicity, appropriate road engineering measures, and enforcement activities. In creating a safer road environment, the safety of pedestrians and cyclists should be considered first because of their particular vulnerability to injury. Where 20mph limits cannot be introduced, segregated walking and cycling arrangements improve safety and encourage active travel.

3. Bringing together actions to prevent traffic injury and improve health

Many actions are known to prevent traffic injuries, and these can often achieve other public policy goals or improve other areas of public health. Safe travel for children should be aligned to other agendas such as spatial planning, child safeguarding, using outdoor space for exercise and health reasons, and reducing noise and air pollution.

Cheshire East Council's Key Outcome 5 - People Live Well and for Longer – provides an appropriate focus for planning a coordinated approach to these activities across the Borough, although introducing safe travel and liveable streets into towns and neighbourhoods requires strong local partnerships that will include community leaders, schools, police, fire and rescue, health services and local businesses.

Key Points

Unintentional injuries are a major cause of ill health and serious disability for children, especially those aged under 5. All children are at risk of unintentional injuries but different risks affect different ages. At younger ages the greatest risks are found in the home, but for older children and young people the risk are far greater outside of the home, particularly on the roads.

- In Cheshire East in 2013/14, 275 children aged 0-4 years were admitted to hospital due to an unintentional injury. 65% of admissions in the under-five's result from falls and household knocks and a further 21% from burns and accidental poisoning.

- In Cheshire East, over half (52%) of head injury attendances were in children under five, particularly one-year olds. More than a third of the children who attended an A&E department with a head injury in 2012/13 required no investigation or treatment; they were sent home with advice and guidance.

- In older children other factors other than the occurrence of injury may influence decisions to attend A&E for minor injuries, for example, accessibility and previous use by the family.

Working with families/parents to develop safety behaviours can help these to become fully embedded. This chapter suggests ways in which unintentional injuries in and around the home can be reduced. This includes increasing awareness of risks around the home, supporting families to do home safety assessments and working with them to implement appropriate changes (such as safety gates on stairs, locking up household chemicals). Particular attention should be paid to reducing poisonings and burns. Permanent home safety equipment (e.g. smoke and carbon monoxide alarms and thermostatic mixing valves) should be installed and maintained in all temporary, social and rented housing where there are children under 15. Local health organisations are encouraged to contribute to the Cheshire East Road Safety Partnership.

Local children and young people have identified traffic issues as being of concern to them. Road accidents are an important cause of early death - nearly a third of deaths and serious injuries on the roads in Cheshire East are in children (under 16) and young adults (16-25 years). There are certain key times in their life when a child or young person is at increased risk of injury or death on the road. These are related to increased independence of travel at age 11 (Year 7 pupils), and at ages 16, 17 and 18 when young people are able to gain licenses to drive mopeds, motorbikes and cars.

Chapter Six

The Effects of Housing on Children's Health

It has been well reported that good quality housing has a substantial impact on health: a warm, dry and secure home is associated with better health.[28,29,30,31] In addition, there have been numerous studies to explore the effects of poor quality housing conditions on health, which suggest the existence of a causal association.[29,30]

This section looks at the effects of poor housing on its occupants, particularly children and other vulnerable members of a household.

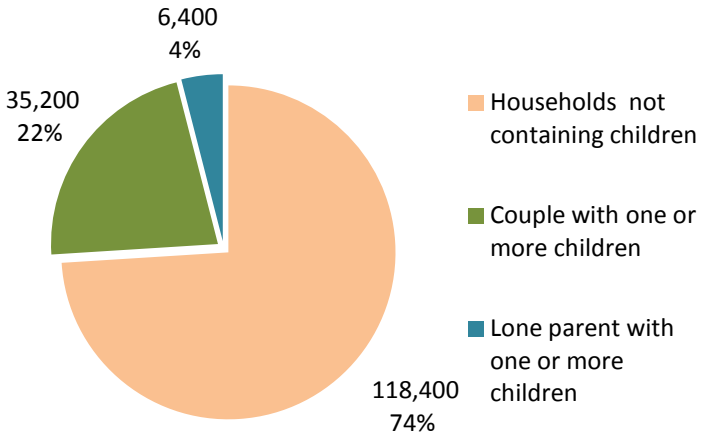
An Overview of the Housing Stock in Cheshire East

Overall there are estimated to be 165,100 dwellings[f] in Cheshire East. Eighty-nine percent of the housing stock is privately owned, with 72% owner occupied and 17% privately rented; just 11% of houses are social housing.

Despite its rural geography, most of the homes in Cheshire East are in an urban or suburban neighbourhood. The large market towns of Crewe and Macclesfield constitute the 2 main urban areas, with a number of smaller market towns including Nantwich, Knutsford and Congleton. Despite the perceived rurality only 15% of residents in Cheshire East live in a rural area.[32]

Like all boroughs Cheshire East has a mixed housing stock; over 90% of the stock is made up of houses or bungalows, and just 10% are flats.[32] The age profile of local housing is markedly different to the national picture; fewer houses were built before 1945 (pre-1945 housing constitutes just 31% of houses compared to 42% nationally). The borough has a higher proportion of more modern houses, with 18% of the housing stock built since 1990.[32] Importantly however the age profile of the stock is approximately comparable across different tenure types.[32]

Figure 23. Composition of households



Source: 2010 House Condition Survey

The 2011 Census estimated there are 159,441 households living within Cheshire East, and approximately a quarter of these households contain children.

[f] Dwellings are classified into two types, unshared and shared. The 2011 Census defines a dwelling as a single self-contained household space (an unshared dwelling) or two or more household spaces at the same address that are not self-contained, but combine to form a shared dwelling that is self-contained. A household space is the accommodation that a household occupies, and self-containment means that all rooms, including the kitchen, bathroom and toilet are behind a door (but not necessarily a single door) only that household can use. In most cases, a single household space will be an unshared dwelling.

What Causes Poor Quality Housing?

Based on the Decent Homes Standard, the term 'poor housing' describes a property that is experiencing one or more significant hazards such as:

- Damp
- Mould
- Excess cold
- Structural defects that increase the risk of an accident[31]

If a hazard presents a severe threat to the health or safety of a resident, it is known as a 'category 1 hazard'.[33] Exposure to significant hazards is recognised to negatively influence both mental and physical health and well being.

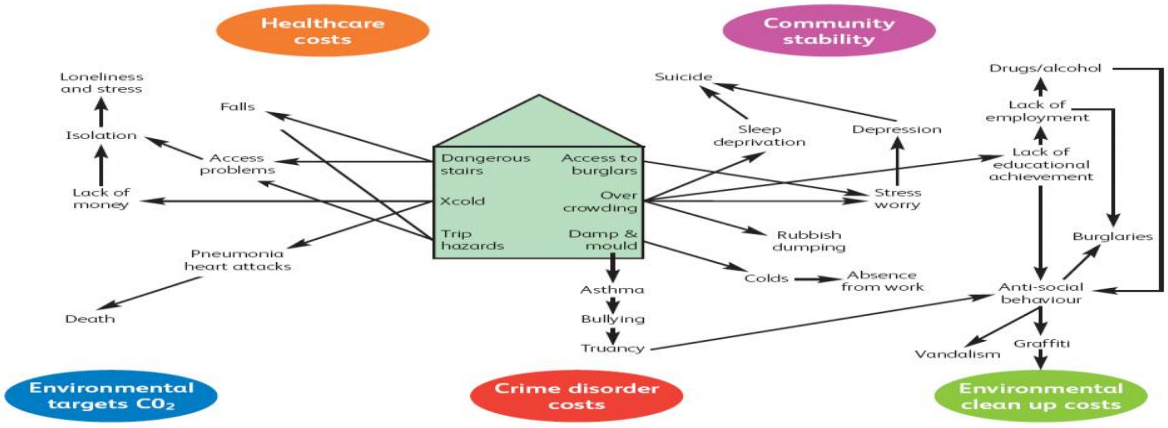
Significant hazards in the home may arise due to:

- Poor design or construction
- Failure to update or repair - whether due to choice or other constraints e.g. lack of knowledge, finance or skill
- Failure to take appropriate precautions or action to protect the household[g] - whether due to choice or other constraints

What are the Effects of Poor Quality Housing?

The potential effects of poor quality housing are extensive, and illustrated in Figure 24. The key issues associated with poor housing are described below.

Figure 24. Relating housing hazards to health



(Source: Good Housing Leads to Good Health CIEH September 2008)

[g] In the 2011 Census "household" is defined as 'one person living alone, or a group of people (not necessarily related) living at the same address who share cooking facilities and share a living room or sitting room or dining area. A household must contain at least one person whose place of usual residence is at the address. A group of short-term residents living together is not classified as a household, and neither is a group of people at an address where only visitors are staying.

Respiratory Illness

As we have described, cold living conditions can lead to the development of mould growth in damp houses. Moulds produce allergens (substances that can cause an allergic reaction) and substances that irritate the skin and respiratory tract.

Evidence from a number of studies looking at children of pre-school and primary school age have consistently shown that visible damp and mould growth exacerbates asthma and is associated with self-reported respiratory symptoms such as wheezing and chronic cough.[34,35]

Mental Health and Wellbeing

Children living in poor quality properties can feel unhappy in their home and family life. Some develop a feeling of shame and embarrassment that can lead to social isolation: others may attempt to find respite elsewhere, usually away from both their home and family. Social isolation, chronic anxiety linked to feelings of shame and embarrassment, and a low mood are all risk factors for the development of poor mental health, independently, cumulatively and interactively.

The Cheshire East Good Childhood Report 2014 highlighted these negative feelings:

> "*The place I live has a lot of litter/mess, takeaways, rundown buildings, graffiti, and pubs. I don't feel safe in my area because there are a lot of intimidating people who hang around*" – Year 7
>
> "*There are a lot of people who smoke near where I live – they are not nice people. There is a lot of dog poo. I feel ashamed to live where I live.*" – Year 8 (page 19)[36]

Poor emotional health can then impact on school attendance which can in turn impact on other issues relating to social interaction as well as education, and possibly impact on employment possibilities later in life.

Accidents

The potential for accidents is recognised as a serious concern in the home, and it is important to acknowledge their potential seriousness, as accidents are a leading cause of death in all age groups.[31,37] Children are a particularly vulnerable group as they often have a limited perception of the environment and fail to consider consequences of their actions (see chapter five).[23]

Childhood injuries are closely linked with social deprivation, and children from poorer backgrounds, who often live in poorer quality housing, are five times more likely to die as a result of an accident than children from more affluent families.

Overcrowding

Overcrowding in a home can have a significant effect on family relationships, as well as each individual's mental health and wellbeing.[38] Overcrowding is associated with an increased risk of accidents, hygiene risks, and can facilitate the spread of communicable diseases.[38] Overcrowding can impact on the whole family, through lack of privacy, reduction of tolerance, disrupted sleep patterns when large numbers of people are sharing a bedroom, and it can directly impact on a child's development and progress in school.[38] There are also practical issues such as lack of a suitable place within an overcrowded home for children to study or do their homework and a reduction in the ability to concentrate.[38] There does not appear to be a particular age group that is more vulnerable than others.[39]

Overcrowding is not recognised as a significant problem in Cheshire East with 73% of residents living in a house that averages less than one person per bedroom, and in 99.9% of settings a single family unit occupy a recognised dwelling.[40] Very few children are likely to be living in overcrowded conditions in Cheshire East. However for the small number who are it is important to acknowledge the impact that overcrowding can have on a child's mental health (e.g. due to lack of privacy, or due to disrupted sleep patterns from sharing a bedroom) and physical health (e.g. overcrowding increases the risk of accidents and facilitates the spread of communicable diseases).

Damp, Mould and Excess Cold

One of the key issues across the UK is excess cold (used to describe properties below the NHS recommended room temperature of between 18°C-21°C), which can lead to damp and mould growth within the property. Local surveys have shown that damp and mould growth are not a significant local issue. However, such surveys are unlikely to show the true extent of damp and mould growth locally, as it is very rare for it to be scored as a severe ('Category 1') hazard because it is statistically unlikely to cause extreme or severe harm. Therefore its prevalence could be (and is likely to be) a lot higher than the report indicates.

Studies have demonstrated higher rates of mortality and morbidity when living in a property that is excessively cold.[1] Excess cold occurs when households cannot afford the costs of heating their properties or fail to carry out improvements which would enable their home to be heated efficiently.

Examples of evidence, from the literature, that have demonstrated the association between cold housing and poorer health in children include evidence of the physical impact of fuel poverty.

- An American study[41] compared 2 groups of low-income children, one group received a winter fuel subsidy and the other group received no payment. The study found those not in receipt of the payment were 30% more likely to be admitted to hospital or need to consult primary care clinics in their first 3 years of life. They were also 29% more likely to be underweight. Researchers believed this was attributable to the infants burning more calories to keep warm, leaving fewer available for growth and the building of a healthy immune system. Paediatricians involved in this research have speculated that longer term risks to children's cognitive development could accrue from their being underweight in the early years of life.

  Although children not receiving winter fuel subsidy probably needed to burn more calories in order to stay warm, the study described how they actually consumed 10% fewer calories during winter months than children in homes that received the subsidy, and is a real life example of the "heat-or-eat" dilemma which many households in Fuel Poverty face in the cold weather. Whilst previous studies had shown parents often consumed less food as a way of affording more heating in winter, this study was the first to suggest young children are affected too.

- A UK study[35] inspected the homes of 193 children with a persistent wheezing illness and categorised the presence of damp in their home as very low, low, moderate or high. The occurrence of damp in the home was compared with a control group of 223 children who were well. The risk of wheezing illness was increased by 32% as the severity of damp moved up each category.

- A comparable study[35] in New Zealand found similar results. Researchers inspected 891 New Zealand homes, and compared the occurrence of damp and mould with the presence of

respiratory symptoms in residents of all age groups. As the occurrence of damp increased, the occurrence of respiratory symptoms also increased (dose-response). There was evidence of a higher risk of respiratory symptoms with increasing levels of damp for children under 7 years, compared to older children and adults. Using the study data the researchers predicted a 33% reduction in the number of people experiencing respiratory symptoms if those households currently living in the poorest quality homes were housed in the best performing houses.

Other studies have explored the physical impact of improved energy efficiency measures.

- A study[42] in New Zealand followed up 2 similar groups of families, one group had had upgrades to their home to improve energy efficiency whilst the other group had not. The groups were reviewed a year after the home improvements had been made, and researchers found that children in the group whose homes had been improved had had 15% fewer days off school compared to those whose homes had not been upgraded. This may be attributable to fewer respiratory ailments after a house is made warmer and drier, as children are particularly vulnerable to respiratory problems if they live in cold, damp conditions.

- A further UK study[43] followed up 14,000 English children over a period of 5 years by a research team at the National Centre for Social Research (NATCEN), which looked at the effects of cold and damp independently. The evidence suggested respiratory problems were more than twice as common in children who lived for 3 years or more in cold homes (15%), compared with similar children living in energy efficient homes (7%). The research also suggested a significant reduction in the prevalence of allergies in children after homes are made more energy efficient, which is likely to be a consequence of better air quality and a reduction in dust mites.

Data from the Census shows that 98% of homes in Cheshire East are fitted with central heating, although this doesn't tell us how effectively the central heating system works or whether the household can afford to use it.[44] This does however mean 2% of dwellings do not have central heating, equating to approximately 3,600 dwellings locally (this is lower than the 3% national rate).

Fuel Poverty

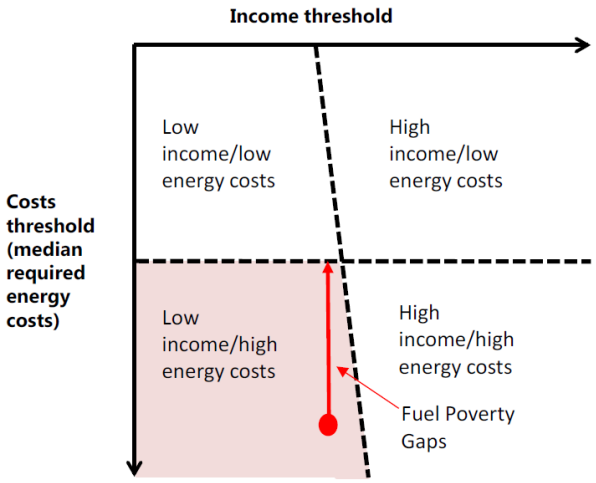
Under the Low Income High Cost definition a household is considered to be fuel poor where:

- they have required fuel costs that are above average (the national median level)

- were they to spend that amount, they would be left with a residual income below the official poverty line[45]

Figure 25 highlights an important issue - not all children who are income poor are also fuel poor. Reasons for this are many, but a primary one is that many income poor children are living in newer housing stock which is relatively energy efficient. Affordable heating then becomes achievable for

Figure 25. Fuel poverty under the low income high cost measure[45]



families, no matter what their family income, provided they live in decent, well insulated and energy efficient homes.[41]

Tackling Fuel Poverty requires a specific strategy, distinct from what is needed to tackle income poverty. The primary determinant of Fuel Poverty is the home itself. Homes which have high quality cavity wall and loft insulation, efficient central heating systems, draught-proofing, and double-glazing are least likely to create fuel poor residents, even when the residents themselves are in income poverty.

Historically senior citizens and people with disabilities have been the primary focus of Fuel Poverty interventions, however in recent years a growing bank of evidence has demonstrated two further vulnerable groups, namely people with long term illnesses and young children. This was acknowledged nationally with the introduction of the 'Warm Home Discount Scheme'. This is a four year initiative running from April 2011 – March 2015 to help those most vulnerable to the effects of fuel poverty.

The £1.1 billion scheme is funded by energy suppliers, and the government have recently committed to additional spending of £320m on the Warm Home Discount scheme in 2015/16.[46] The initiative still acknowledges that pensioners on low incomes are the most vulnerable group, but it also recognises a broader group of 'at risk' customers which consists of people who are disabled, have a long term illness or young children under five years of age. 'Cold Weather Payments' are also available for families in receipt of benefit who have a child under five or a child of any age who is registered disabled. Under the 'Cold Weather Payment' scheme payments of £25 are made for each 7 day period of very cold weather between 1st November and 31st March. Additionally, 'Winter Fuel Payments' are available for people born on or before 5th July 1952, for winter 2014/15.

The evidence demonstrates that living in Fuel Poverty has specific and significant detrimental effects on the young. However, even amongst children and young people, the effects of Fuel Poverty differ across the age groups. For infants and young children, the effects of a cold home primarily impact on their physical health. Those children most at risk are:

- babies and children under 5 years – young children are unable to recognise and respond to feeling cold, however babies are particularly vulnerable as they cannot regulate their body temperature as well as older children or adults

- children of any age who are disabled or have a long term condition that can affect their ability to respond to temperature change

Unfortunately these are the very members of society who often spend the greatest amount of time in their homes, therefore their need for heating is greater than most because they require heating all day rather than for short intervals.[45] Many of these vulnerable groups face a dilemma over whether to "heat or eat", many choosing food over keeping warm.[45] Failing to tackle the problem however makes their living conditions worse and this can be to the detriment of their health.

Amongst adolescents by contrast, effects appear to be primarily on mental health and wellbeing.[41] Within the NATCEN study, when other contributory factors were controlled for statistically, fuel poverty had highly significant effects on adolescent risk-taking (e.g. early alcohol and tobacco abuse) and truancy. Among adolescents who had lived for long periods in a home that was inadequately heated, 28% were at significant mental health risk, compared with 4% of similar children who lived in homes that were adequately heated.[41]

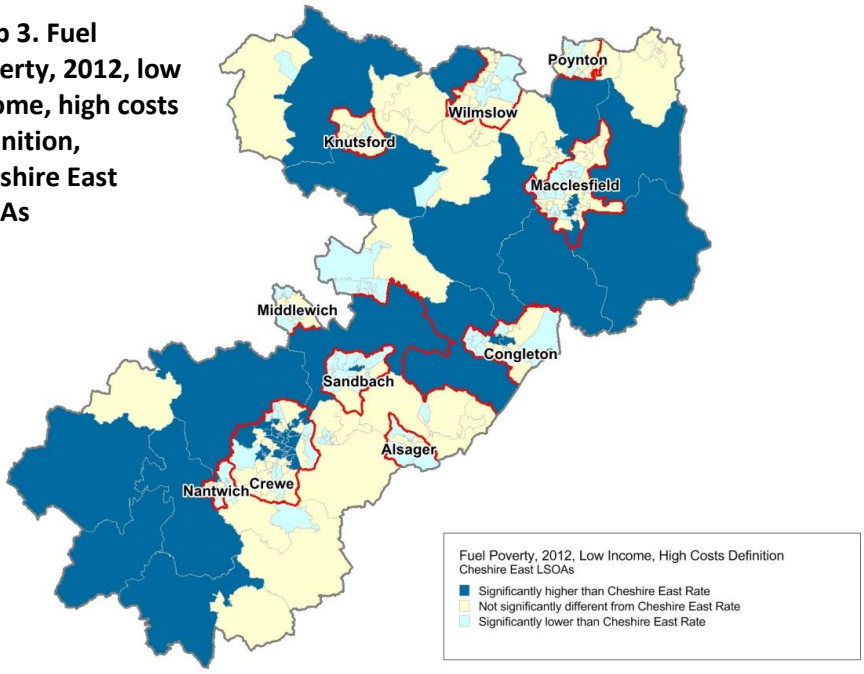
In cold homes, where heating is limited to family living rooms, and family members cluster together, problems of overcrowding may also occur. Domestic relationships often come under strain during adolescence, which could make crowding especially challenging for this age group. This is supported by the fact that 10% of the NATCEN adolescents in fuel poor homes felt unhappy in their family compared with 2% of similar teenagers living in warmer homes.[41]

This research also explored the effects of home improvement on wellbeing, and demonstrated children were more likely to complete homework in a separate room following home efficiency improvements, probably as a consequence of more rooms in the house being heated. Together with the finding that there were fewer days of absence from school post improvement, this evidence suggests it is possible that improving the quality of housing may have small but significant effects on children's longer term educational achievement.[42,43]

Taken together, these findings offer a lifespan perspective on Fuel Poverty's impacts on the young, suggesting that there may be lifelong benefits from targeting Fuel Poverty strategies towards the young.

Within Cheshire East fuel poverty occurs in many of the rural areas, but it also affects many parts of the town of Crewe, which is the only urban area in the Borough that has significant levels of fuel poverty (Map 3).

Map 3. Fuel poverty, 2012, low income, high costs definition, Cheshire East LSOAs



Whilst it is important to identify the areas within the Borough with the highest levels of fuel poverty, it's also important to acknowledge fuel poverty affects all geographies. This provides another example of how proportional universalism strategies need to be applied within the borough to improve the health of children and young people. Chapter One discusses the Cheshire East initiative to allow residents to buy their fuel through the Council at a competitively low price, which was launched in October 2014.

Locally we also know a greater proportion of lone parent households are in fuel poverty compared to any other household type. Half of lone parents are fuel poor, and are more than twice as likely to be in fuel poverty when compared with households that contain children headed by two adults.

Inadequate central heating can also lead to the use of portable heaters and open fires, which, if not managed appropriately can also pose a risk of thermal injury and burns, particularly among children in their first four years of life.

Summary

The evidence consistently demonstrates the positive effects of living in a warm home free from damp and mould, which promotes both the mental and physical health and development of children. Given that these gains have a lifetime of potential benefit, they are of prime importance in improving child health. Universal services would be well placed to identify unmet need and provide information and proactive support to families in order to tackle the problems associated with cold housing locally, and which should be a locally determined priority for Children Centre's activity.

Structural Defects

Structural defects in the home can also lead to poor quality housing and consequently impact on health. Structural defects can arise through poor construction, use of inappropriate building materials, or disrepair. For example:

- a leaking roof, poor plumbing, poorly fitted windows or inadequate ventilation could lead to indoor pollutants or mould, causing or exacerbating asthma, allergies or respiratory diseases[30]

Poor design or construction of homes is an important and preventable cause of accidents, for example:

- an unsafe staircase or banister can be a fall hazard
- poor quality flooring or lack of adequate lighting can be a trip hazard
- a poorly maintained hot water system can pose a scalding risk[30]

Other key factors that may impact on the health and wellbeing of the household include:

- poor security – the perception of poor security may be due to inadequacy of physical security measures (e.g. having the ability to securely lock doors and windows), but will also be influenced by any perceived threats within the neighbourhood
- overcrowding – overcrowding within the household can also make the dwelling unfit for purpose[38]

Local Impact of the Quality of Housing on Health

The key aims of Cheshire East Council are to ensure everyone has access to a home of decent quality at a price they can afford, in good quality neighbourhoods that are safe, attractive, and have good access to schools, leisure and employment opportunities. In practice however (whilst strict legislation exists relating to the quality of social housing, and some guidance exists relating to the safety and quality of privately rented housing) it is more difficult to influence the quality of owner occupied dwellings.

In 2010, a formal survey[33] was used to inspect the quality of a sample of the privately owned housing stock (which equates to 89% of our total housing stock). It estimated 28% of the privately owned housing stock in Cheshire East contained a hazard which could significantly impact on health, with the hazards predominantly due to one or more of three issues:

- opportunity for falls (on stairs and between levels, due to unsafe stairs etc)
- excess cold
- potential for entry by intruders

The issues are being addressed through targeted actions outlined within Cheshire East's Housing Strategy, "Moving forward" 2011-2016. These include:

- **improving the quality of housing across all tenures**
    - providing a range of affordable financial options for home repairs, targeted at vulnerable low income households, including low income families with children, living in the worst housing conditions
    - providing support to older and vulnerable households to improve, repair and maintain their homes
    - exploring approaches to improving housing within our town centres
- **improving the quality of housing in the private rented sector**
    - by improving landlords' and tenants' knowledge of good management and property standards
    - working with sub-regional partners to implement and develop the Cheshire Landlord Accreditation Scheme
    - targeting inspections on an area-based approach in areas with high levels of privately rented properties
    - ensuring houses in multiple occupation are free from fire risks and other significant hazards
- **reduce the incidence of fuel poverty**
    - by working across tenures to improve health through warmth
    - targeting practical and financial support for vulnerable homeowners, including vulnerable families with children to tackle the effects of cold and damp homes
    - utilising housing legislation to effect thermal improvements in the private rented sector
- **promoting sustainability for future generations**
    - maximising the use of government-initiated carbon reduction schemes

Key Points

A poorly maintained, cold damp home can have a negative impact on a child or young person's physical and mental health. Equally, overcrowding and lack of privacy can affect a child or young person's emotional wellbeing and their educational attainment. Although strict legislation exists

relating to the quality of social housing, and some guidance exists relating to the safety and quality of privately rented housing, it is more difficult to influence the quality of owner occupied dwellings. A housing stock survey in 2010 identified 28% of privately owned houses in Cheshire East had a significant problem that could impact on health, for example increased risk of unintentional injuries, respiratory illness and mental health and wellbeing. Of the 165,100 dwellings in Cheshire East, 89% of housing stock is privately owned, with 72% owner occupied.

Fuel poverty is also a concern in Cheshire East. The primary determinant of fuel poverty is the home itself, so not all children who are income poor are also fuel poor as many will be living in newer housing stock which is relatively energy efficient. Fuel poverty, and thus living in a cold and damp home, has significant detrimental effects on children and young people due to. For infants and young children, the effects of a cold home primarily impact on their physical health, whereas among adolescents the effects appear to be primarily on mental health and wellbeing. Fuel poverty has been shown to have highly significant effects on adolescent risk-taking (e.g. early alcohol and tobacco abuse) and truancy. Among adolescents who had lived for long periods in a home that was inadequately heated, 28% were at significant mental health risk, compared with 4% of similar children who lived in homes that were adequately heated.

Certain families are more at risk of being fuel poor; half of lone parents are fuel poor, and are more than twice as likely to be in fuel poverty when compared with households that contain children headed by two adults.

Chapter Seven

Environmental Impacts on Child Health

The Marmot Review highlighted that 'the more deprived the neighbourhood, the more likely it is to have social and environmental characteristics presenting risks to health. These include poor housing, higher rates of crime, poorer air quality, a lack of green spaces and places for children to play, and more risks to safety from traffic.[1] Whilst this is the case in urban areas, different environmental risks exist in rural areas. These include drowning in open water, injuries on farms and exposure to agricultural pesticides and herbicides. Cheshire East has a diverse mixture of urban and rural areas with approximately 39% of the population living in rural areas and 61% in towns.[47]

Ten years ago, the WHO European Region developed a Children's Environment and Health Action Plan for Europe. This plan required countries to develop national Children's Environment and Health Action Plans to protect the health of children and young people. In 2009 this led to the Department of Health commissioning the then Health Protection Agency (now Public Health England) to produce "A Children's Environment and Health Strategy for the UK". The strategy identifies a number of priority areas to reduce the burden of disease in children from environmental risk factors and promote good health and well-being.

This chapter will also consider two key settings, schools where children spend much of their lives, and farms where children and young people are at heightened risk of unintentional injury or death.

Exposure to Chemicals and Allergens

In 2002, the World Health Organisation's Regional Office for Europe and the European Environment Agency suggested that children are the "canaries in the coalmines" – the first people to show adverse health effects resulting from environmental factors, with possible lifelong implications for adults and children.[48] The risks to a child's health from the environment in which they live and play are wide and various. However, not all children will be equally affected; environmental inequalities – the unequal impact of environmental influences on health and wellbeing[49] – exist alongside other wider determinants of health.

Legislation and other initiatives have led to reduced exposures to many chemicals in children and young people. Nevertheless, chemical exposures in the womb and early life still do occur and can be linked to a wide range of congenital and developmental abnormalities. The main concern is that the health effects are often difficult to quantify, and may be as a result of chronic exposures to single chemicals or mixtures of chemicals.

Children have proportionately greater exposure than adults:

- they eat and drink more relative to their body weight
- they consume a different diet (particularly when very young)
- their higher respiratory rate means a proportionately greater air intake
- young children have a larger surface to volume ratio, and skin that is more permeable to chemicals than adult skin
- young children tend to explore their environments using their mouths

- children play on the floor close to dusts, chemicals and solvent vapours
- rugs and carpets are reservoirs of toxicants that may include moulds, aromatic hydrocarbons, and allergens such as pollens, pet dander and dust mite droppings[h]

Children's metabolic pathways are immature and easily disrupted:

- they are less able to detoxify and excrete chemicals from the body
- synthetic chemicals are present in many common household products.
- their high metabolic rates increase their susceptibility to carbon monoxide
- many environmental exposures in early life are now known to act as triggers for chronic disease in adult life

Figure 26. Timeline of physical development through childhood from birth onwards

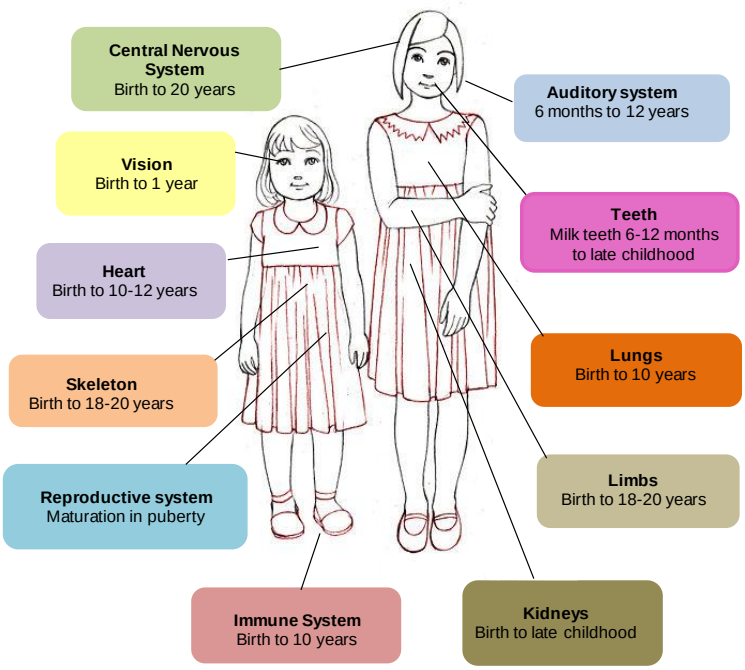


Figure 26 shows that many body systems continue to develop during childhood and into adolescence until full maturation is achieved. The purpose of this section is not to go into a discussion of the evidence, which is substantial, but to highlight the reasons why children's health is particularly at risk, and to suggest some simple steps that can be taken to reduce this risk. Some examples are given below:

Lungs: At birth the baby has about 6 to 15 percent of the full adult number of alveoli (the tiny air sacs where oxygen enters the bloodstream). The rest are formed by the age of two, although the tiny blood vessels serving the alveoli continue to develop up to the age of five years. Children who are chronically exposed to cigarette smoke will develop thicker airway walls and are at greater risk of developing asthma.

Skeleton: Limited access to sunlight or poor diets that lack vitamin D can lead to skeletal malformation, called rickets.

- This can easily be avoided if children eat vitamin D fortified foods (many cereals and margarines) and are allowed to play in sunlight for about 20 minutes a few times a week during spring and summer. Although all under-fives should receive vitamin D supplements, children in older age groups who have limited access to sunlight would benefit too.

[h] There is some evidence that regular vacuuming can lower allergen levels in carpets substantially. Carpets should be vacuumed once or twice a week. Intensive vacuum cleaning is particularly effective (4 minutes per m^2). Steam cleaning can also reduce dust mites and does not use chemicals. (Jacobs, D.E., et al (July 2008) National Centre for Healthy Housing Fact Sheet – Carpets and Healthy Homes)

Central Nervous System: Chemicals in pesticides (e.g. insecticides, herbicides and fungicides) are known to be harmful to the developing brain and nervous system, with vulnerability being at its greatest during pregnancy and during the early years of life.

- Garden chemicals should not be stored inside the house, and should be used outside with particular care where there is a possibility that young children may play in treated areas. Pregnant women should avoid directly handling pesticides.

Eyes, skin and lungs: Some household chemicals, particularly bleaches, cleaning and laundry products can be highly irritant and have the potential to lead to significant respiratory, skin and eye damage in children through accidental contact.

- These products should always be stored safely out of the reach of children and where possible should be exchanged for simple soaps and detergents.

Reproductive system: Plastic is part of our way of life. Bisphenol A or BPA, is a chemical used to make plastics including protective coatings and linings for refillable drinks bottles and food storage containers. Although the Food Standards Agency states that 'the levels of BPA found in food from food contact materials are not a concern to health'[50] it notes that it is one of a number of substances known as 'endocrine disrupters' that may have the potential to interact with human reproductive health. The European Union has legislated on the amount of BPA that can migrate from plastic food containers on contact with food.

- The market, particularly producers of food containers, drinking and baby bottles, appears to have self-regulated itself. Many of these clearly state that they are BPA free and parents are encouraged to buy such products to protect the health of their children (particularly in relation to infant feeding).

Open Spaces

Living close to areas of green space such as parks, woodland and other open spaces can improve health regardless of social class. For children, the presence of parks, playgrounds and recreational areas provides space for physical activity.[49] However, the quality of the green space is important. The Marmot Report highlighted that some groups, including children, can feel excluded if spaces are not appropriately designed, and poor maintenance or cleanliness can impact more widely on perceptions of safety.

Access to a variety of unstructured play experiences is one of the best ways for children to stay both mentally and physically strong, and there are increased levels of exercise among children where there is access to open spaces[51]. Thus, investment in parks and green spaces should be seen as investment in public health.[47]

"*There are lots of activities, I like football at the park*" –Year 8 boy

"*In my village there are a lot of ways to stay healthy because there are lots of jogging places and walking areas. It is also affordable to be active.*" –Year 7 girl

Quotes from Cheshire East Good Childhood Report 2014

In January 2013, Cheshire East Council published its *Green Space Strategy*. The Strategy brings together all the green space elements of Cheshire East Council (Open Space, The Countryside Service, Public Rights of Way, Landscape and Biodiversity) to feed into the Infrastructure Plan / Community Infrastructure Levy work. It is a tool to:

- promote green space across Cheshire East in the creation of sustainable communities

- co-ordinate the various partners to make sure that resources are effectively used and benefits are maximised, and

- to make an effective case for investment

Through this plan, Cheshire East is working towards maximising the green spaces in the Borough, as 'although Cheshire East is considered a green area, significant shortages to the quantity and quality of open spaces exists, particularly within urban areas'.[47]

Access to Safe Play Spaces

Cheshire East Council has recognised that all of the main towns have a shortage of open space and additional play facilities, teenage facilities and appropriate open spaces are needed for children and young people.[47]

The Green Space Strategy identified that a standard was needed for children's play space which equated to the size of an international football pitch (0.8ha) per 1,000 population. This could be a single site or split between sites, but should provide a kickabout area, landscaping and equipped play, and combine formal and informal play provision. The emphasis will be on creating a network of varied open spaces for children's play (all ages).[47]

Table 1. The shortage of children's play space in the key urban areas in Cheshire East.

Town/Area	Shortage of children's & teenagers play provision (hectares)	Number of international football pitches which this shortage is equivalent to
Alsager	5.61	5
Crewe	34	28
Congleton	13.11	11
Handforth	1.71	1
Knutsford	5.41	4
Macclesfield	22.28	18
Middlewich	6.5	5
Nantwich	8.97	7
Poynton	5.8	5
Sandbach	7.17	6
Wilmslow	8.8	7

Source: The Green Space Strategy

As Table 1 shows, none of the main urban areas in Cheshire East have this standard amount of children's play space. There is a shortage in every town. An example is Crewe where there is a shortage of 34ha of children's outdoor play provision, equivalent to 28 international sized football pitches. Open space provision is poorer in the north-eastern area of Crewe, the central area, the high density residential areas and parts of south western Crewe and there is a specific shortage for some types of open spaces.[47]

Whilst there is a large deficit of play space for children in Crewe (and other parts of the borough), it should be recognised, that particularly within an urban environment, it may be difficult to find the additional amount of green space that is needed. It is likely that alternative provision will have to be found. The Strategy made fifteen recommendations within Crewe, three of these related specifically to facilities available to children and young people:

- try and upgrade poor quality children and teenager sites through a variety of funding mechanisms

- explore the need for additional facilities for older children

- secure appropriate sites to address the shortage of children and teenager facilities in north-eastern and southern parts of Crewe

Teenage facilities are different to those provided for younger children. Not all parks cater specifically for teenagers. Some of the parks elsewhere in England that have achieved Green Flag status in 2013/14 have identified 'teenagers' as a key park user. These parks have facilities ranging from 'teen shelters' to skateparks and/or BMX tracks to a youth service bus attending the park. These parks also encourage teenagers to make use of the open spaces, tennis courts and football pitches available. In some parks there are 'adventure playgrounds' with facilities such as zip wires and larger climbing frames which are also suitable (and designed for) teenagers.[52]

The Cheshire East Open Space Assessment recommended that all children should live within a five to ten minute walk of a children's play area. The Green Spaces Strategy has recommended that Cheshire East Council should produce a Play, Health and Recreation Strategy.

Whilst it is preferable that children and young people have outdoor areas to play in, they equally value indoor place spaces:

> "*It's [the youth centre] boring, there isn't much to do there and they don't open up the hall so we can play football, and it's £2.50*" – year 9 boy

Utilising appropriate indoor spaces may be a way of providing some additional space for children and young people to play in (this may be particularly relevant during the darker winter months).

Playground Safety

The opportunity to play creatively in high-quality environments is essential to the development of children. Through their play they acquire skills and abilities which can be learnt in no other way. Children cannot provide these opportunities for themselves - adults must do it for them. The quality of what we provide affects the quality of what children learn. The greater the complexity of that environment the greater the quality of learning.[53]

Equipment should be appropriate for the age group and match their developmental needs - as well as being fun to play on. Younger children like sand-play, swinging, climbing and sliding - but they are small and items should be scaled accordingly. Older children like more exciting equipment - large group swings, cable runways, roundabouts etc. They want places where they can sit and talk - that is one of the most popular playground activities. They like planting and trees; places for skateboards and bicycles; flat areas for ball games.[53]

The Royal Society for the Prevention of Accidents highlights that once a playground has been provided the playground requires regular inspection and maintenance and eventual replacement. They argue that unless this can be provided it is better not to start the project.

Contaminated Land

Cheshire East Council has a Contaminated Land Strategy in accordance with the requirements in Part 2A of the Environmental Protection Act 1990. This identifies any prioritised sites, such as those

contaminated by previous industrial or commercial usage, for example gasworks, fuel stations, chemical works, mining and landfilling. The presence of contamination at a site (a source) is not sufficient on its own to present a risk. For contamination to pose a risk there must also be something affected by it (a receptor) and a mechanism for their interaction (a pathway). Only if all three elements are present does contamination present a risk.

The Environmental Health Team at Cheshire East, through the planning process, proactively identify those sites that have had a previous use which may have led to contamination. As part of the prioritisation process under Part 2A, they have identified 4,440 sites which need to be inspected further. As part of this process, the most sensitive receptor is used to identify risks based on the existing land use; this is a female child aged 0-6 years. Contamination levels are also ranked by the existing use for the land; residential is highest with schools, allotments and parks ranked second.

Contamination can occur in a number of forms. It may exist in solid form in soil, as a spillage of fuel which may affect a river or stream or as a vapour risk to residents or as ground gas (methane and/or carbon dioxide) or vapours. Land can also be determined as contaminated due to its proximity to off-site contaminated areas.[54]

Water

Drowning

In the UK, drowning causes 400 deaths every year, with more than 40 of these being children and young people, making it the third highest cause of death in children. It is estimated that for every death by drowning there are around 300 near misses.[55]

Children can benefit from learning to swim. However, it is also important that children and young people are educated on both where it is safe, and where it is dangerous, to swim.

Open waters (rivers, canals, ponds, quarries and lakes), of which Cheshire East has a wide variety, can look particularly enticing to children and young people however they can hide a number of dangers including:

- cold temperature
- hidden currents
- difficulty getting out (steep slimy banks)
- depth (which can be difficult to estimate)
- hidden rubbish e.g. shopping trolleys, broken glass
- no lifeguards/rescue
- pollution[56]

There are no open swimming sites in Cheshire East. Families who wish to enjoy open water swimming together should consult trusted sources for advice (the information included in these is not endorsed by the Council and should be treated with caution).

Drowning is a real and present danger in the worked out sand quarries (Brereton Heath Local Nature Reserve and Astbury Mere Country Park) due to the temperature of the water, and obstructions. There are no lifeguards and swimming is not allowed. The presence of green algae and the presence of wildfowl waste (campylobacter) particularly in still waters are also risks. Leptospirosis is also a low, but present concern for those by canals, ponds and riverbanks.

The canals are a significant body of water in Cheshire East. The often narrow nature of tow paths means it is vital that children are well supervised around the canals; canal water is not clean, and

there are many obstructions on the canal bottom. There is also the risk of an accident with a canal boat.

The risk of drowning is not limited to the warmer summer months. Frozen open water can be very enticing especially to children. The Royal Society for the Prevention of Accidents identifies young children and males of any age as being those of greatest risk of drowning after falling through ice into water. Children are obviously attracted to frozen lakes and canals as they present natural ice skating opportunities. It is important that children are taught of the dangers of venturing onto ice, and are reminded of these dangers during freezing weather.

Lead Pipes

Lead poisoning (when levels of lead build up in the body) is particularly dangerous for infants and children. Lead can have an adverse impact on mental development; it may also be a factor in behavioural problems.[57] Legislation has been enacted to control lead in drinking water (as well as other things such as in petrol and paint) and as a result, blood lead levels in children have significantly declined.[58]

It is estimated by United Utilities that about a third of older properties in the North West still have lead pipes either within the property itself or the pipe that connects the home to the water main in the street.

In soft water areas, such as Cheshire East, there is a greater likelihood that lead from pipes will be present in the water. Where this problem exists, water companies treat the water with orthophosphate and this reduces the problem significantly. Nonetheless, particles of lead may build up in these older pipes.[57] Since 2013 a new drinking water quality standard for lead (below 10 micrograms per litre reduced from 25µg/litre) has come into force.[58]

Outdoor Air Pollution

The 2009 publication 'A Children's Environment and Health Strategy for the UK'58 called for the prevention and reduction of 'respiratory disease due to outdoor and indoor air pollution'.

Outdoor air pollution in the UK has improved greatly in the past few decades, but there are still some localised areas where people are exposed to high pollution levels.[58] Air pollution is any chemical or other material in the air which detracts from its quality. This could be smoke (which caused the smogs of the 1950's), soot particles, odours (from agriculture or hot food takeaways), or chemicals such as sulphur dioxide (linked to acid rain) and nitrogen dioxide. Some natural events also cause air pollution such as volcanoes (like the 2010 eruption of Eyjafjallajökull on Iceland), or dust storms from deserts (as experienced in southern England in spring 2014). However, by far the largest contributor to ground based levels of air pollution is the combustion of fossil fuels. The biggest contributor to air pollution within Cheshire East is from road transport.[59]

Cheshire East Council, amongst other initiatives to reduce air pollution, is developing a Low Emission Strategy which will utilise the Development Control Framework to incentivise the use of low emission technologies to reduce transport emissions associated with future developments, thus helping to improve air quality from road traffic.

The UK Air Quality Strategy[60] aims to improve air quality, and sets out air quality standards and objectives for eight key pollutants, some of which (lead for example) it identifies as being particularly harmful to children. The air quality standards and objectives are acceptable concentrations of pollutants over a given time period. No specific information was included relating to children and

young people, though the strategy did identify the importance of providing funding for green sustainable transport such as walking buses to help reduce air pollution.

Nitrogen Dioxide and Particulate Matter

Exposure to particulate matter affects lung development in children including reversible deficits in lung function as well as chronically reduced lung growth rate and a deficit in long-term lung function.[61]

There are two types of particulate matter, the larger PM_{10} and the smaller $PM_{2.5}$. The smaller particulates are of greatest concern as these can get deeper into the airways and lungs. Recently it has been recognised that particulates have no safe threshold, and health effects have been observed at very low concentrations. At present Cheshire East Council does not routinely measure for particulates. However, the Council runs a comprehensive monitoring network for nitrogen dioxide which is the main pollutant of concern locally as a result of emissions from road traffic; emissions of nitrogen dioxide (NO_2) give rise to all of the 13 Air Quality Management Areas (AQMA's) in the Borough. The monitoring locations are reviewed on an annual basis. There is no singular linear relationship due to atmospheric chemistry between NO_2 and Particulates. However, reducing emissions will reduce both.

Educational Establishment Environmental Standards

Children, particularly young children, are efficient carriers for disease. They are still learning about personal hygiene, are frequently in close personal contact with each other and therefore easily spread bacteria and viruses from one to another.

Children and young people are also likely to be much more active than adults (and it is recommended that they do more physical activity per week than adults). Whilst learning through play and physical activity they often undertake what adults would deem 'risky behaviour' as they test their boundaries and learn their limits. These can result in accidents and unintended injuries. It is therefore important that the educational establishments are safe environments and promote the health and wellbeing of the children and young people.

In the UK primary school children spend approximately 6.5 hours a day in the school environment for 190 days per year. Secondary school children, and those involved in extracurricular activities, spend up to 8 hours a day in school. Pre-school children can spend even longer (upwards of 10 hours) with many nurseries providing early to late care for working parents often for over 50 weeks a year. Both school and nursery environments are subject to considerable regulation, but may lend themselves to further improvements. Cheshire East has 172 preschool and day nurseries, and 151 schools which consist of:

- 7 secondary schools;
- 14 secondary academies;
- 110 primary schools;
- 15 primary academies;
- 3 special schools;
- 1 special academy and
- 1 pupil referral unit.

Within the boundaries of Cheshire East there are also 10 independent schools, two of which provide boarding (one mainstream school and one special school).

Schools and nurseries are important in developing children's knowledge, understanding and skills relating to healthy lifestyles, food nutrition and health. Many lifelong dietary habits are established before the age of ten.[58] It was identified in the NICE guidance on physical activity and the

environment[62] that nurseries and other childcare providers can play a key role in minimising sedentary activities and implementing actions to reduce obesity.

Nurseries

Nurseries must adhere to specific requirements relating to the amount of space that is required per child. The regulations are very clear and require that:

- children under two years have 3.5m^2 per child
- two year olds have 2.5m^2 per child, and
- children aged three to five years have 2.3m^2 per child[63]

They must also ensure that there is a separate baby room for children under the age of two. This is to ensure the safety of all children at the nursery.

Nurseries are also required to provide access to outdoor play areas. If this is not possible providers must ensure that outdoor activities are planned and taken on a daily basis (unless dangerous to do so e.g. extreme weather). Young children, who can walk on their own, should be physically active for at least 3 hours per day. By providing active play nurseries can ensure that the number of reception school children who are overweight or obese when measured as part of the national childhood measurement programme (NCMP) is reduced over time.

Hand Hygiene

An issue common to both nurseries and schools (particularly primary schools) is teaching children effective hand hygiene. Young children in particular often have poor hand hygiene and can therefore easily spread disease amongst themselves and their carers. Both nurseries and primary schools should teach children how to wash their hands after using the toilet and before eating. There have been a number of 'hand hygiene' initiatives to support teachers and early years staff to do this. This has included the UK Schools Hand Hygiene Challenge in 2012 led by the Health Protection Unit (HPA) (now Public Health England) and guidance and fact sheets.

Environmental Health Officers inspect school premises to ensure adequate facilities are available to pupils. They advise schools when there are infection control issues on their premises such as an inappropriately located water fountain (for example in the toilets).

Adequate infection control procedures are required in schools and nurseries to reduce the risk of infection. Nurseries are required to have suitable hygienic nappy changing facilities including the use of disposable gloves and plastic aprons[64] and ensure that adequate numbers of toilets and hand basins are available (though unlike for schools the numbers are not stipulated). Nurseries are also required to ensure there is an adequate supply of clean bedding, towels, spare clothes and any other necessary items so that children can be changed out of soiled or dirty clothing and the risk of cross-infection reduced.

Recently published Public Health England guidance[64] reminds childcare settings of the importance of preventing the spread of infections by ensuring:

- routine immunisation
- high standards of personal hygiene and practice, particularly hand washing

- maintaining a clean environment

Children under five are disproportionately affected by gastrointestinal disease; though the introduction of the rotavirus vaccine is helping to reduce this. More details can be found in chapter four on gastrointestinal illness and children and young people.

School Environment Standards

There are clear regulations for many aspects of the school environment. These are clearly stated in law.[65] Some refer to the structure and layout of buildings and facilities (such as washrooms for staff and visitors must be separate to facilities for pupils with the exception of disabled facilities which can be shared).

These regulations also extend to the playing fields. Minimum areas are stipulated in law based on the age and number of pupils attending the school. The required area goes up with age and number of pupils. The regulations also examine the surfaces and equipment available. These rules apply to both mainstream and special schools (with some exceptions for the latter due to historical issues). Mainstream schools are allowed to offset some of the minimum requirements for playing field space by providing alternative physical activities through regular swimming, indoor team games or outdoor team games at other venues.

The Cheshire East Green Spaces Strategy highlighted that schools often have green space resources such as playing fields. The Strategy encourages schools to open their facilities to the local community in which they are situated to encourage safe areas for people to be active and for children to play.

Every school must have a room appropriate and readily available for use for medical or dental examination and treatment, and for the caring of sick or injured pupils. It must contain a washbasin and be reasonably near a toilet. It must not be used for teaching purposes. There are additional strict rules for boarding schools around medical accommodation (the number required, the facilities it must include and that for children over 8 years of age they must be single sex).

All schools must also adhere to structural requirements which include the amount of light in rooms, exposure to sunlight, the structure and maintenance of load bearing walls, fire risks, heating including minimum and maximum temperatures, hot surfaces (dependent upon the age of children attending), ventilation, asbestos, water, drainage and noxious fumes. All of these requirements are designed to keep children and young people safe and well in their schools.

There are also strict rules for those schools that provide boarding accommodation on the provision of sleeping accommodation for pupils (floor size, single sex accommodation, room type, and washroom and toilet facilities). All pupil accommodation must be separate from sleeping accommodation for staff. There must also be appropriate places for the eating of meals and storage facilities for pupil's personal belongings.

Food in Schools

As of September 2014, The Children and Families Act 2014 places a legal duty on all state-funded schools in England, including academies, free schools, pupil referral units and alternative provision as well as mainstream schools to offer a free school lunch to all pupils in reception, year 1 and year 2.[66] In June 2014 a new set of simplified School Food Standards were introduced. These standards are designed to ensure children get the nutrition they need across the whole school day. They apply to all pupils not just those receiving free school meals. They govern all food and drink on offer within the school and apply across the whole day, including breakfast, mid-morning break, lunchtime

and food served after school. The new standards are designed to make it easier for school cooks to create imaginative, flexible and nutritious meals.[66] To ensure these standards are met it is expected that the free infant school meals will have to be hot. As of September 2014, all schools in Cheshire East with children in reception, year 1 and year 2 have kitchens on site.

The take up of free school meals for infant pupils is not mandatory and those families that wish to provide their children with a packed lunch may still do so. It is considered best practice that cold storage is available to store packed lunches as food-borne illnesses can occur if they are not stored at a safe temperature. However there is no legal requirement on schools to provide this. It is therefore up to parents to include an ice-block or similar to ensure their child's packed lunch maintains a cool temperature until lunchtime.

Risks to Children and Young People in Rural Areas and on Farms

Cheshire East is a largely rural area with 93% of the area classed as at least 'more rural than urban', while 88% is classified as green space. Cheshire East has a large farming community and is a major dairy-producing area.[67] The beauty of this rural environment hides some rather sobering facts relating to the health and wellbeing of children and young people.

Agriculture has one of the highest fatal injury rates of any industry in Great Britain and many hazards are associated with farms particularly for children and young people. Farming is the only high-risk industry that has to deal with the constant presence of children – farms are homes as well as workplaces; children may also be visitors.

There are a number of restrictions in place to try and protect children and young people from accidents and injuries on farms. These focus predominantly on farm vehicles. The law (The Prevention of Accidents to Children in Agriculture Regulations 1988) makes it illegal to allow a child under 13 to ride on or drive agricultural self-propelled machines (such as tractors and quad bikes) and certain other farm machinery. However, it is legal for them to ride on a trailer, or on a load carried by a trailer, if there are adequate means, such as edge protection, to prevent them falling from it. Restrictions remain for the 13-16 age group with only certain vehicles being allowed to be operated or ridden on by them. But from 16-18 years, young people may use larger machines and powered implements. However, the farmer must decide if they can handle these machines safely depending on their experience and competence not just their age.

Although the law focuses on farm vehicles, the risks to children and young people on farms are diverse. Nationally, the most common causes of death or major injury to children on a farm were:

- falling from vehicles
- being struck by moving vehicles or objects
- contact with machinery
- driving vehicles
- falls from height
- drowning and asphyxiation
- poisoning
- fire
- contact with animals

Nationally, the children who died in recent accidents were[68]:

- being carried as passengers on agricultural plant or machinery
- not working under proper adult supervision
- working/helping around the farm
- playing unsupervised
- trespassing

Key Points

The environment in which children and young people live, play and learn can have both positive and negative impacts upon their health and wellbeing. Living close to areas of green space such as parks, woodland and other open spaces can improve health regardless of social class. Access to a variety of unstructured play experiences is one of the best ways for children to stay both mentally and physically strong. All of the main towns in Cheshire East have a shortage of open space; it is difficult to find the additional amount of green space that is needed to meet the standard. Despite this, investment in parks and green spaces should be seen as investment in public health.

Whilst it is important that children and young people have access to outside spaces, it should be remembered that some sites and certain environmental features can put children at risk of harm or death. In Cheshire East, as elsewhere, drowning is a real and present danger in the open water spaces (meres, canals, ponds etc) due to the temperature of the water and obstructions. Drowning is the third highest cause of death in children nationally. It is estimated that for every death by drowning there are around 300 near misses.

Farms are also a known risk for children and young people in Cheshire East where 93% of the area is classed as at least 'more rural than urban'. Agriculture has one of the highest fatal injury rates of any industry in Great Britain. Farming is recognised as the only high-risk industry that has to deal with the constant presence of children – farms are homes as well as workplaces; children may also be visitors. Risks can include farm vehicles, contact with machinery contact with animals, falls from height, poisoning, drowning and asphyxiation and fire.

In addition to their homes, children and young people spend a large part of their lives at educational establishments. There are clear regulations for schools and pre-school educational establishments to ensure children and young people remain safe whilst on their premises. Both schools and pre-school educational establishments play a large part in promoting the health and wellbeing of children and young people.

Chapter Eight

Young People

The health and wellbeing needs of teenagers and young people differ from the needs and issues affecting younger children. The Association for Young People's Health (AYPH) and Public Health England (PHE) have highlighted that:

> *'Good health in adolescence is central to wellbeing, and the bedrock for good health in later life. Yet we do not invest enough in prevention and early intervention with young people aged 10-24 and when problems do arise they can face barriers in access to appropriate care.'*[69]

Particular issues affecting young people include mental health problems including anxiety and self-harm, substance misuse, managing sleep and nutrition, sexual health, and unintentional injuries such as road traffic accidents. To help improve the health and wellbeing of young people, the Association for Young People's Health and Public Health England suggest 'collaborative working between sectors, full use of youth participation, and a focus on health promotion in education settings offer some ways forward'.[69]

In partnership with the Association for Young People's Health, Public Health England has developed a **Framework for Young People's Public Health**[70] (to be published Autumn 2014) which is aimed at commissioners, Directors of Public Health, lead councillors, Health and Wellbeing Boards, Local Authority service leads and private and voluntary sector partners who are providing services for young people. The Framework will describe six cross-cutting core principles to promote a more holistic approach to commissioning. It will also outline the most critical health outcomes to be focused upon for this group, and set out questions for local leaders to assess their capability to drive improvement in their areas.[69]

As this Framework is currently unavailable, I am focusing on some of the key issues for adolescents and young people locally. These include health inequalities, mental health, and alcohol, tobacco and drug use. I will also consider issues about confidentiality and the need for young people to be able to trust the health services they are accessing to keep their information secure.

Health Inequalities

It is well recognised that health inequalities exist between different parts of a community, and this is no different for young people. Health inequalities normally disproportionately affect those from the poorest areas. However, there is some evidence, relating to alcohol, within Cheshire East that suggests that young people from more affluent families may be experiencing inverse health inequalities due in part to their greater affluence.

Alcohol use by young people is of particular concern in Cheshire East and the rate of admission to hospital by under 18 year olds due to alcohol-specific conditions is significantly higher than the England average. Although Cheshire East has seen improvements in recent years against this indicator, the borough still remains in the worst quartile nationally. Therefore, young people who drink regularly and excessively are of particular concern in Cheshire East. The relative affluence of the borough may in part be a cause – as young people have access to a larger disposable income, the cost of alcohol is not considered prohibitive by them.

Elsewhere in this report, I have highlighted some areas where children and young people face health inequalities based on deprivation. For young people these include increased risk of serious road traffic injuries and accidents within the home, as well as the consequences of living in a cold home which include poor mental health and wellbeing, increased risk taking such as early alcohol and tobacco abuse, and truancy. Young people also recognise that their family's relative deprivation, and the area in which they therefore live, can affect their health:

> *"Mostly it's very expensive to buy fruit and healthy food. In Bollington there are mainly takeaways"* – year 8[36]

Young people from more affluent homes can have more freedom and opportunities to access a wider range of activities or places to spend time with friends:

> *"Costa is somewhere to go" – year 7*[36]

> *"I can get the train to Manchester for £2.10" – year 8*[36]

> *"I've got my* horse*" – year 7 girl*[36]

Health inequalities are also evident between young people who live in urban and rural environments. Young people living in local rural communities have highlighted that they are unable to meet with their friends because of limited things to do in their local area or long distances and the lack of public transport. This can impact their mental health and wellbeing and can affect young people from both affluent and deprived families.

> *"There's nothing to do where I live, I live in the middle of nowhere in between Sandbach and Middlewich" – year 7 boy*[36]

> *"I live so far away from my friends so I can't really like see them" – year 7 girl*[36]

Mental Health

Whilst four out of five young people report high life satisfaction, and young people aged 16-19 are among the most optimistic about what the next twelve months will bring[71], mental ill health is common and persistent amongst young people. Mental health problems have important implications for every part of a young person's life including their ability to engage with education, make and keep friends, engage in constructive family relationships, and make their own way in the world.[71]

For many, a mental health problem during adolescence will follow them into adulthood. More than 75% of adults who accessed mental health services had a diagnosable disorder prior to the age of 18. [72] Thus diagnosis, treatment and support for young people with mental health problems are all important parts of the services provided to this age group.[71]

The last nationally representative data was compiled in 2004 and is now a decade out of date. That survey highlighted that around 13% of boys and 10% of girls aged 11-15 have mental health problems[71], the most frequent being anxiety and depression, eating disorders, conduct disorder (serious antisocial behaviour), attention deficit hyperactivity disorder (ADHD) and self-harm. Early emergence of rarer psychotic disorders such as schizophrenia is also seen during the teenage years.[71]

We know relatively little about the mental health of adolescents and young people in Cheshire East. If the national figures from 2004 are applied to Cheshire East, we can estimate that around 1,400 boys and around 1,050 girls aged 11-15 may have mental health problems locally. There is evidence that mental health disorders are linked to socioeconomic status and social background.[71] It has been reported that children and young people from the poorest households are three times more likely to have a mental health problem than those growing up in better-off homes.[72]

Eating disorders tend to start in the mid-teens[71] and are most prevalent in early adulthood. [72] Overall it is estimated that around 1 in 250 females and 1 in 2,000 males will experience anorexia nervosa, usually as an adolescent or young adult, and that around five times this number will suffer from bulimia nervosa.[71] However, eating disorders may be underestimated in the general population; significant proportions will not seek help and good quality data is lacking.

The Chief Medical Officer's 2013 Report highlighted that conduct disorder[i] predicted all adult psychiatric disorders including psychosis. The report recommends that effective intervention to reduce childhood behavioural difficulties may be a particularly important lever to improve both child and adult mental health.[72] The report also highlighted that 'bullying worsens childhood and adult mental health and is experienced by between a third and half of British school children and young people'. [72] ChildLine (the UK's free 24-hour helpline for children and young people) reported 315,111 counselling sessions in 2011/12, with the primary concerns being family relationships, bullying, physical abuse and self-harm.[71]

> *"I feel sad at school all the time. It is hard to fit in at school because other people make you feel bad/poo about yourself (*especially *the popular's). There should not be people which think they are better than you. I don't have many friends"- girl year 9*[36]

> *"Many girls and boys have* started *to think it's acceptable to call each other nasty names, but it's horrible" - girl year 8*[36]

The Cheshire East Good Childhood Report 2014 highlighted as an issue of concern that from primary school age, girls were already thinking about their looks and appearance. Those of primary school age did not necessarily have negative things to say about their appearance but would reflect on it. However, amongst secondary school aged female pupils the reflections were much more negative and largely concerned with how boys and girls commented on physical appearance. Girls felt more comments were critical and boys did not realise the impact their comments could have. Whilst some girls were able to brush off the concerns this was a major issue locally for teenage girls.

> *"There's a lot of pressure to look good, you get called names no matter what, people always say stuff behind your back, boys* always *call you ugly if you have spots, or a slag if you wear makeup" – year 8 girl*[36]

> *"Boys judge you and they expect perfection from you. It only started in High school because in primary they didn't really care" – year 7 girl*[36]

> *"Because boys only want a real life Barbie" – year 9 girl*[36]

[i] The term 'conduct disorder' is generally used to describe a pattern of repeated and persistent misbehaviour. This misbehaviour is much worse than would normally be expected in a child of that age. The essential feature is a persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms and rules are violated (American Psychiatric Association, 2000). (Quoted from http://www.rcpsych.ac.uk/files/samplechapter/80_3.pdf, accessed 6/10/2014)

> *"Girls can't go out the house* without *make up looking good. Boys are mainly the ones that criticise girls for their looks, boobs or bum. Then girls feel insecure and threatened" – year 8 girl*[36]

Interestingly the report concludes that the worry and concern secondary school girls feel about their appearance was not driven by the media or images of skinny models, but instead is largely down to the way in which boys and girls relate to each other and the observations and criticisms they make of each other. Specifically it is the way boys talk to girls about their appearance.

The report recommends that further work is needed locally on issues of respect, understanding, self-worth, realism and confidence with young people. These all feed into public health work streams (Personal, Social, Health and Economic education (PSHE); Sex and Relationships Education (SRE); and school health) and by improving these, progress in public health outcomes may be seen.

Substance Misuse (smoking cigarettes, drinking alcohol, and the misuse of legal or illegal drugs)

Substance misuse is often a symptom rather than a cause of vulnerability among young people. Many have broader difficulties that are compounded by drugs and alcohol and that need addressing at the same time. Drugs and alcohol have been voted as one of the top three issues affecting young people in Cheshire East[73]. Local 11-18 year olds suggested that more needs to be done to raise awareness of the problems that alcohol and drugs cause young people. This is one of the campaigns for the Cheshire Youth Parliament in 2014/15.

Some young people are more at risk than others of becoming dependent upon alcohol or drugs; this can be measured. The "Risk Harm Profile" identifies the vulnerabilities of young people entering specialist treatment. The profile consists of 10 items designed to show risk of escalation or vulnerability. The number of risk factors that the Young Person has is added together to give each young person a 'score' out of 10. The higher the score, the more complex the need and the more likely these young people will be to go on to misuse drugs and alcohol as adults.[74] The ten items measured in the Risk Harm Profile are:

- Opiate and/or crack user
- Alcohol user
- Using 2 or more substances
- Early onset (age of first use is under 15)
- No Fixed Abode/unsettled housing
- Not in education, employment or training
- Involved in self harm
- Involved in offending
- Pregnant and/or a parent
- Looked after child

Schools are well placed to identify teenagers who are at risk of substance misuse, or who are already smoking or drinking. The process of identifying needs should aim to distinguish between pupils who require general information and education, those who could benefit from targeted prevention, and those who require a detailed needs assessment and more intensive support.[75] The new Substance Misuse Service commissioned by public health is able to work with schools to develop school based substance misuse programmes that may include preventive education, targeted prevention, peer-led alcohol and/or smoking reduction programmes, as well as more intensive support for addiction. Service provision and referral arrangements need to be clearly identified for every school.

Signposting Services and Appropriate Services

As adolescents mature and develop greater independence they should have their own access to information about the health and support services that are available. However, this provision should

be done in a guided way. The Annual Report of the Chief Medical Officer 2012 called attention to this issue as one of great concern to young people and their families.

Young people emphasized their concerns around confidentiality; as they got older they did not necessarily want their family or others to know all their medical details. They did not want their condition discussed in front of others on a ward. In primary care, young people did not understand their rights as patients to confidentiality between themselves and their GP. Privacy and confidentiality was a particular concern for young people living in rural areas, for cared-for children and with regard to mental and sexual health. Young people suggested that a clear explanation of their rights (e.g. seeing a GP without a parent, not having family told about their discussions with a clinician) would help to lessen these concerns and therefore increase their confidence in using these services.[2]

As well as age appropriate services throughout their teenage years, young people[j], particularly those with long-term disabilities or mental health problems, highlighted that the transition from children to adult services could be a very traumatic experience and was frequently badly handled by the NHS and other sectors. Specific problems included:

- lack of an integrated structured transition process
- lack of support during transition
- lack of clarity about how to navigate adult services, young people describing themselves as lost or in limbo at the time of transition
- difficulty in adjusting to the differences between adult and children's services in a short space of time, such as having to stay in hospital alone and suddenly needing to take on all responsibility of their own care
- health professionals in adult services lacking understanding of being a teenager and being able to communicate effectively with them
- the loss of relationships with trusted professionals and the loss of continuity of support[2]

> *'Moving from* child *services to adult services, I have felt the pivotal services I require fall away and I am helpless and almost stranded'* - Young person from a Royal College of Paediatrics and Child Health focus group (Chapter 4 page 7)[2]

Some of these transition issues are already recognised in Cheshire East. NHS South Cheshire and NHS Eastern Cheshire CCGs are currently working on improving the transition process for young people between paediatric and adult health services. However, transition is not just about the clinical services commissioned by the CCGs; it also relates to the various public health and social care services that the Council commissions, including substance misuse and sexual health services, and in addition wider provision relating to education, employment and good housing.

[j] The Chief Medical Officer chose to refer to children and young people in her 2012 report using the United Nations definition of young people, which includes all those under the age of 25.

You're Welcome

As outlined above, confidentiality is extremely important to young people. In 2005 the Department of Health launched 'You're Welcome' which laid out 'principles that will help health services – both in the community and in hospitals – to 'get it right' and become young people friendly'.[76] The You're Welcome criteria were updated in 2011 and continue to be strongly supported by the Department of Health.[77] The quality criteria are helping to provide a framework for change in how resources are allocated, and are helping to ensure better health outcomes. They are making health facilities become more youth-friendly, and help to improve the abilities of health workers to respond to adolescents effectively, appropriately and with sensitivity.

This approach is evidence-based – the You're Welcome criteria were devised as a result of work with young people to identify and address the barriers that prevent them from accessing health services[78] - and have been shown to be effective in systematic reviews undertaken by WHO.[76] The quality criteria cover ten topic areas – accessibility, publicity, confidentiality and consent, environment, staff training (skills, attitudes and values), joined-up working, young people's involvement in monitoring and evaluation of patient experience, health issues for young people, sexual and reproductive health services, and specialist child and adolescent mental health services.[76]

One of these key themes is confidentiality and consent. All staff should 'routinely explain their confidentiality policy to young people and their parents or carers, in order to enable them to understand young people's right to confidentiality'.[76] Services should 'explain to young people that they have the opportunity to attend a consultation without the involvement of a parent or carer'.[76]

In Cheshire East 'You're Welcome' is used in a number of different health settings including some GP practices and all of the sexual health services. However, 'You're Welcome' could be rolled out more broadly, for example in more general practices and in pharmacies to ensure young people feel welcomed, supported and able to access the necessary services for their health and wellbeing. The Department of Health would like all health services that are used regularly by young people to gain the You're Welcome quality mark by 2020.

An Eight Point Plan for Improving Young People's Public Health

1. The Public Health team should strengthen the Joint Strategic Needs Assessment (JSNA) by obtaining better information about the prevalence of mental health conditions that affect adolescents and young people. This will require a range of approaches including the use of sample surveys of young people in schools and other settings, obtaining and analysing information from child and adolescent mental health services (in conjunction with both of the Clinical Commissioning Groups), and identifying mental health conditions affecting children in need and young people in care (in conjunction with the Council's Children and Families team).

2. Increased public health involvement in local surveys of secondary school children in Cheshire East should be developed to obtain better estimates of how many teenagers smoke cigarettes, drink alcohol or take illicit drugs.

3. Schools are well placed to identify teenagers who are at risk of substance misuse, or who are already smoking or drinking. The process of identifying needs should aim to distinguish between pupils who require general information and education, those who could benefit from targeted prevention, and those who require a detailed needs assessment and more intensive support.[79] The new Substance Misuse Service commissioned by public health is

able to work with schools to develop school based substance misuse programmes that may include preventive education, targeted prevention, peer-led alcohol and/or smoking reduction programmes, as well as more intensive support for addiction. Service provision and referral arrangements need to be clearly identified for every school.

4. Children and adolescents with a mild or moderate learning disability that is not identified by their school are at higher risk of poor mental health. For these young people learning is more difficult and they often face bullying. These factors negatively influence their mental health and wellbeing. A programme should be developed to ensure that schools identify young people with a mild or moderate learning disability.

5. The expanded Troubled Families programme will be accessible to families with at least two out of a list of six problems. One of the six has a particular focus on improving poor health, and it includes parents or children with mental health problems including conduct disorder (they do not need to be receiving specialist treatment), drug or alcohol problems, and new mothers who have a mental health or substance misuse problem and other health factors associated with poor parenting.[80] Families can also be referred if they have any mental and physical health problems of equivalent concern, which may include unhealthy behaviours resulting in problems like obesity, malnutrition or diabetes. As such, the new programme has a significant potential to improve young people's public health, particularly for adolescents, and locally agreed processes will need to be established so that general practitioners, public health nurses and other health professionals can easily refer families into the programme.

6. Increase the number and range of health services who achieve 'You're Welcome' status. Develop a systematic and ongoing audit of health services against the You're Welcome criteria, led by young people.

7. Emotional and mental health problems are common among adolescents. Many schools already have their own programmes to help these young people, such as school-based counsellors or whole school approaches to mental and emotional health. However, there is sufficient need within each secondary school and college to support the development of a single, integrated, school based therapy service that provides Tier 1 and Tier 2 support for these young people, including group and peer support. There needs to be greater alignment and/or pooling of the commissioning budgets held by schools and colleges, Cheshire East Council and the two Clinical Commissioning Groups. The development of an integrated school based therapy service could most appropriately be facilitated by the Council's Children and Families team.

8. A strategy to manage the transition between children's and adult services should be drawn up for Cheshire East. This must be a joint piece of work and should enlist the guidance and input of local young people to ensure it meets their requirements.

Chapter Nine

The Development and Future of School Health Services

The importance of giving every child the best start in life and reducing health inequalities throughout life has been highlighted by both The Marmot Report and the Chief Medical Officer. The Healthy Child Programme aims to ensure that every child gets the good start they need to lay the foundations of a healthy life, and it should be available to every child and young person in the Borough. School health services are a key component of the Healthy Child Programme and these services support school-aged children (aged 5 to 19 years) to achieve the best possible health outcomes.

The Healthy Child Programme offers children and young people a schedule of health and development reviews, screening tests, immunisations, health promotion guidance and tailored support. It aims to:

- help parents develop and sustain a strong bond with children
- encourage care that keeps children healthy and safe
- protect children from serious disease, through screening and immunisation
- reduce childhood obesity by promoting healthy eating and physical activity
- identify health issues early, so support can be provided in a timely manner
- make sure children are prepared for and supported in education settings
- identify and help children, young people and families with problems that might affect their chances later in life

The Director of Public Health is the lead commissioner for school health services, and these services are funded from the public health grant. Yet, the public health responsibilities for child health are much wider than just school health services, and include:

- improving the health and wellbeing of school-aged children and young people
- bringing together holistic approaches to health and wellbeing across the full range of public health responsibilities
- optimising the ring-fenced public health budget to improve outcomes for children and young people
- leading commissioning of public health services, for example, health improvement, drug and alcohol services, and sexual health services
- emergency planning for child populations, including outbreak response in schools

School health teams lead and contribute to improving the outcomes for children and young people but they are not solely responsible for achieving these; there needs to be a partnership approach. School health works with a number of partners including health and social care teams, teachers and youth workers to deliver the evidence based public health interventions outlined in the Healthy

Child Programme, using the core principles of Making Every Contact Count for intelligent, opportunistic interventions.

The additional or targeted support that may be needed from school health services in individual schools and colleges will be determined locally according to individual and population health needs as identified in the Cheshire East Joint Strategic Needs Assessment (JSNA). This will include support to address specific health issues. Separate or additional services may need to be commissioned and funded by the responsible agencies, for example child and adolescent mental health services, domestic violence or bereavement support.

The school health team are the single biggest workforce specifically trained and skilled to deliver public health for school-aged children, and they are clinically skilled in providing holistic, individualised and population health assessment. School nurses are qualified nurses who hold an additional specialist public health qualification. The school health team co-ordinates and delivers public health interventions for school-aged children. The nature of their work requires clinical input and effective leadership, which they are equipped to provide. Because of their close working links to primary and secondary health care services, school nurses are also in a unique position to support multi-disciplinary team working within community and education settings.

The school health service is ideally placed to provide planned structured support that strengthens family relationships, with continued intervention and support to prevent deterioration as part of a multi agency team approach to meet the health needs of children and young people. In Cheshire East the service is presently based on a model of term-time delivery, and it is not currently accessible to young people from colleges and universities or those who are no longer in education. As we develop school health services in Cheshire East, there is a need to increase visibility and accessibility to children, young people and parents, in the following ways:

Developing the service in different settings that are:

- accessible for those up to and including the age of 19 years to include those no longer in school
- accessible for children who are home educated or who do not attend school
- available in the school holidays
- young people friendly and flexible to meet local needs

Using a variety of media and new technologies e.g. websites, social networks

- to raise the profile of the service and reduce any stigma associated with its use
- to provide key health messages targeted to local needs

Having portable electronic devices to access the internet and email

- to enable electronic communication methods e.g. using text messaging and email for young people and parents to request and arrange appointments, and access advice and support
- to enable referrals both into the service and on to other services as needed

- to access and signpost to relevant age appropriate information websites, for example during one-to-one consultations

Increasing involvement in health promotion activities and talks

- supporting PSHE programmes in schools including sexual health messages, personal resilience, self awareness and respect

- to encourage engagement so that young people know they can access non-judgemental support and advice

- developing links in the wider community with other services used by young people

Table 2 summarises the core elements of the Healthy Child Programme and shows how public health will commission a range of school health strategies and interventions to support the achievement of many of the above outcomes. We intend to align these plans with key providers and obtain support from other commissioners.

Table 2. The Role of School Health Teams within a Local Strategy to Improve Outcomes

Description	Suggested strategies and interventions	Delivered by
Improving access to preventative strategies and early intervention	• use of a school health profile to identify needs • a set of agreed priorities for each school, college and locality, matching allocation of services to meet needs • monitoring the proportion of children and young people receiving brief interventions, including vulnerable young people and hard-to-reach groups	School Health and schools
Health development reviews	• handover between health visiting and school health • school entry, year 6/7, and mid-teen reviews to identify need for targeted support • identify needs of children with additional or complex health needs and assess involvement of other services • identify and plan tailored packages of care for children with additional or complex health needs • identify continence issues and their management • handover to adult services	Health Visiting and School Health teams School Health and schools
Preventing injuries and accidents	• raise awareness of injury prevention and child safety • co-ordinate education programmes in schools and communities based on local injury information • brief interventions * with young people and parents • identify vulnerable families and refer into support services e.g. parenting programmes • follow-up children and young people after an A&E attendance to offer support and prevent recurrence	School Health and Accident and Emergency services
Sexual health and contraception	• active participation in PHSE development & delivery • sexual health education and puberty sessions • care pathways defined with local general practices, community pharmacies and sexual health services • brief interventions * covering all related risk-taking behaviour e.g. alcohol and unprotected sex • access to Emergency Hormonal Contraception and pregnancy testing • provision of condoms and chlamydia screening • active promotion of Long Acting Reversible Contraception (LARC) and referral for provision	School Health, Sexual Health services, General Practices and Pharmacies
Healthy weight Interventions on healthy weight and exercise National Child Measurement Programme	• develop a new healthy schools charter scheme with rewards for achievements • develop a whole school approach to healthy eating including the use of the eatwell plate • work with local supermarkets, shops and fast food outlets to encourage the availability of healthy food choices • support and promote family physical activity in the school and the local community, including use of engagement activities such as family fun days/family swim times/allotment schemes and active travel (walk/bike to school schemes) and more 20mph zones • promote opportunities for family physical activity in parks and green spaces, and increase the number of	School Health, Environmental Health, Country Parks and Ranger Service and Everybody Sport and Recreation Trust

	safe (and maintained) places to play and be active • provide brief interventions * for healthy weight	
Stop Smoking/ Tobacco Control	• development of whole school tobacco control policy • stop smoking brief interventions * and advice • nicotine replacement treatment under PGD • referrals to Stop Smoking service	School Health and Stop Smoking services
Drug and alcohol misuse	• ensure delivery of drug and alcohol education within science & PHSE tailored for primary, secondary and college ages as part of a whole-school approach to alcohol and drug harm reduction, including parents • drug and alcohol brief interventions * and advice • use of age-specific screening and assessment tools to identify and support vulnerable young people • establish referral pathways with specialist young people's substance misuse treatment services	School Health and Substance Misuse services
Emotional wellbeing	• support schools to adopt a comprehensive 'whole-school' approach to social and emotional wellbeing • identification and support for children and young people showing early signs of emotional distress • care pathways clearly defined with local general practices and mental health and wellbeing services • active referral and monitoring to CAMHS	School Health and CAMHS
Safeguarding	• develop role of prevention and early detection • support children, young people and families through integrated working, with handover to other professionals where there are no health issues or to another health professional who is already involved	School Health teams and Children's services
Targeted support Cared for children, young offenders, young carers, young people at risk of abuse including domestic violence and child sexual exploitation	• contribute to annual health assessments and support resolution of issues or concerns • contribute to in care reviews • early identification of health needs of young carers and provide support that is tailored to individual need • identification of health needs of young offenders and sign posting to appropriate services	School Health and Children's services
Dental decay and promoting oral health	• brief interventions* • use of toothbrushes and toothpaste • cutting down on sugary drinks • encourage registration with a dentist • include in whole school approach to healthy eating	Health visitors, School Health Teams and Schools
Screening	• hearing and vision screens in reception year	School Health
Immunisation	• review immunisation status at school entry • provide diphtheria, tetanus, pertussis and polio; HPV; childhood flu • work with immunisation coordinators to achieve 90% coverage for vaccination in all schools	School Health teams and PHE Immunisation Coordinators
* A brief intervention consists of a conversation that aims to give a young person and/or parents the tools to change attitudes and handle underlying problems. It should include assessing their motivation to change, explaining the consequences of behaviours, giving advice to change behaviour, providing a range of options to change, encouraging self efficacy, agreeing steps on the journey and offering follow up		

Children with Special Educational Needs

A pupil has special educational needs when their learning difficulty or disability requires special educational provision that is different from, or additional to, that which is typically available to pupils of the same age.[81] Identifying these needs early and responding to them effectively will improve long-term outcomes for that child or young person.

The four broad areas below give an overview of the range of needs. The purpose of identifying children with these needs is to help the school to take the correct action to support that child, not to fit a pupil into a category. In practice, individual children or young people may have needs that cut across these areas, and their needs are likely to change over time.

1. **Speech, language and social communication needs**. These children have difficulty in communicating with others. This may be because they have difficulty saying what they want to, or understanding what is being said to them, or they may not understand or correctly use social rules of communication.

2. **Cognition and learning difficulties.** These children learn at a slower pace than their peers. They may have specific learning difficulties (like dyslexia), moderate learning difficulties, severe learning difficulties where children need support in all areas of the curriculum, or profound and multiple learning difficulties where children have severe and complex learning difficulties as well as a physical disability or sensory impairment.

3. **Social, emotional and mental health difficulties**. These children and young people may experience a wide range of social and emotional difficulties. They may be withdrawn or isolated, or display challenging, disruptive or disturbing behaviour. Their behaviours may reflect underlying mental health difficulties such as anxiety or depression, self-harming, substance misuse, eating disorders or physical symptoms that are medically unexplained. Other children may have disorders such as attention deficit hyperactive disorder or attachment disorder.

4. **Sensory and/or physical needs**, where children and young people require special educational provision because they have a disability which prevents or hinders them from making use of the usual educational facilities. This can be age related and may fluctuate over time. Many children and young people with vision, hearing or multi-sensory impairment will require specialist support and/or equipment.

Schools tend to be very aware of children who have particular difficulties in learning. The class or subject teacher works with the child on a daily basis and liaises with teaching assistants or specialist staff to plan and assess the impact of support and interventions and how they can be linked to classroom teaching. The school may also directly commission specialist services to support the early identification of special educational need and to provide effective support and interventions. These specialist services may include:

- educational psychologists
- Child and Adolescent Mental Health Services
- specialist teachers or support services

- therapists including speech and language therapists, occupational therapists and physiotherapists

Although schools determine their own approach to maintaining records about these pupils, they are required to provide information about all children with special educational needs through the School Census. The Census covers all pupils enrolled in state-funded primary, secondary or special schools, and allows the Local Authority to identify pupils who have or may have special educational needs. It also enables the Department for Education to produce nationally comparative statistics. The Cheshire East January 2014 Census included 3,395 children which is equivalent to 6.3% of children being schooled in Cheshire East. Table 3 illustrates their primary type of need.

Table 3. Pupils with statements of Special Educational Need (SEN) or at School Action Plus by their primary type of need, January 2014

	Children in Cheshire East	Cheshire East rate per 1,000	England rate per 1,000	CE compared to England
Speech, language, social communication	720	13.4 / 1,000	16.7 / 1,000	19.6% lower
Cognition and learning difficulties	1,015	18.9 / 1,000	28.7 / 1,000	34.1% lower
specific learning difficulties	*461*	*8.6 / 1,000*	*8.1 / 1,000*	*5.9% higher*
moderate learning difficulties	*319*	*5.9 / 1,000*	*15.6 / 1,000*	*61.9% lower*
severe learning difficulties	*172*	*3.2 / 1,000*	*3.7 / 1,000*	*14.0% lower*
profound and multiple learning difficulties	*63*	*1.2 / 1,000*	*1.3 / 1,000*	*7.7% lower*
Social, emotional, behavioural difficulties	746	13.9 / 1,000	16.6 / 1,000	16.5% lower
Sensory and/or physical needs	317	5.9 / 1,000	6.4 / 1,000	8.0% lower
hearing impairment	*114*	*2.1 / 1,000*	*2.0 / 1,000*	*7.4% higher*
visual impairment	*58*	*1.08 / 1,000*	*1.09 / 1,000*	*1.3% lower*
multi-sensory impairment	*6*	*0.13 / 1,000*	*0.11 / 1,000*	*16.5% lower*
physical disability	*139*	*2.6 / 1,000*	*3.2 / 1,000*	*19.4% lower*
Autistic spectrum	325	6.1 / 1,000	9.1 / 1,000	33.7% lower
Other needs	266	5.0 / 1,000	3.5 / 1,000	42.1% higher
All pupils	**3,395 ***	**63.2 / 1,000**	**81.0 / 1,000**	**22% lower**
*** The row totals add up to 3,389 because of suppressed information relating to six children in secondary and special schools**				

It is not easy to provide a clear interpretation of these figures. They suggest that a lower proportion of school pupils in Cheshire East have special educational needs than nationally. This is consistent with other relevant indicators that also show better outcomes in Cheshire East, such as the proportion of infants with low birth weight at term and children achieving a good level of development at the end of Reception Year.

However, three groups of children show a different pattern. The recording of pupils with "other needs" is over 42% higher than nationally, which equates to around 79 children. Autistic spectrum is over a third lower than the national rate, and this equates to around 165 children. The third group of children are those with a moderate learning disability, among whom schools are recording special educational need at around 38% of the rate seen nationally – or around 518 children fewer than expected. Even taking into account the expected lower proportion of special educational needs in Cheshire East, there may be over 500 children in the Borough who have unrecognised needs. The majority of these are likely to have moderate learning disability or an autistic spectrum disorder.

There are several reasons why this under-recording is important, including:

- schools may not yet have identified or assessed these children
- schools may not be allocating appropriate support to these children
- these children are not being reported to the Local Authority through the School Census. As the Local Authority helps to populate and validate General Practice registers of people with a learning disability, their needs are not being identified to their General Practitioners
- there is clear evidence that children and adults with any degree of learning disability have worse health than their peers, and this often starts early in life. Some children and adults may require "reasonable adjustments" to be made to the health services that they receive. If health services do not know that someone has a learning disability, these adjustments cannot be made and health inequalities will persist
- young people may need additional support to make the transition to adult life. Without a good understanding of their individual needs, including the impact of any learning difficulties or disabilities that they may have, it is more difficult to co-ordinate care around these needs, and ensure continuity and the best outcomes

Health Outcomes Associated with Learning Disability

General practices were previously only required to establish and maintain a register of patients aged 18 and over with learning disabilities. From April 2014, this age restriction has been removed so their registers now include people of any age with a learning disability. This helps general practices and other health services to make plans for any "reasonable adjustments" that may be needed for a child or young person with a learning disability. Reasonable adjustments include removing physical barriers to accessing health services, and making whatever alterations are necessary to policies, procedures, staff training and service delivery to ensure that they work equally well for people with learning disabilities.

Learning disabilities are defined by the presence of three core criteria, which are: i) a significantly reduced ability to understand new or complex information and learn new skills, ii) a reduced ability to cope independently, with impaired social functioning, and iii) the disability begins in very early childhood and has a lasting effect on development.

People with learning disabilities have poorer health than the general population, and much of this starts early in life and is avoidable.[82] The impact is serious. As well as having a poorer quality of life, people with learning disabilities die at a younger age than their non-disabled peers. There are five determinants of health inequalities of relevance to learning disability:

1. Greater risk of exposure to the social determinants of poorer health such as poverty, poor housing, unemployment, discrimination and isolation

2. Increased risk of health problems associated with specific genetic, biological and environmental causes of learning disabilities

3. Communication difficulties and reduced understanding of health issues

4. Personal health risks and behaviours such as poor diet and lack of exercise

5. Problems with access to healthcare provision

A number of longitudinal studies are actively following up representative groups of children over their life course, and are accurately measuring their long-term health and wellbeing outcomes. As these studies include children with learning disabilities, they provide us with valuable evidence about the impact that a learning disability can have on the health and wellbeing of a child.

The Millennium Cohort Study is tracking the well-being of over 18,000 children who were born in the UK between 2000 and 2002. Test scores taken at age three, five and seven have been used to identify children with any degree of learning disability. The study has found that three year old children with developmental delay have significantly higher rates of emotional and behavioural difficulties in comparison to their typically developing peers. Recent work by the Learning Disability Observatory has shown that these differences are more apparent by age seven, with children with learning disabilities being over three times more likely to have conduct difficulties and emotional difficulties, over four times more likely to have difficulties relating to their peers and over five times more likely to have hyperactivity or attention deficit hyperactive disorder.

Another study[83] has suggested that children with borderline or intellectual disability were significantly more likely to exhibit persistent conduct difficulties, but only if exposed to multiple environmental risks (living in an income poor household; living in a more deprived neighbourhood; having co-morbid emotional difficulties; having poorer pro-social behaviours; poorer maternal health; greater exposure to angry/harsh parenting; and greater exposure to more inconsistent parenting). The persistence and high levels of conduct difficulties among this high risk group appears to be associated with a combination of increased risk of exposure to environmental adversity and decreased resilience when so exposed.

The Learning Disability Observatory has used the Longitudinal Study of Young People in England to look at 532 adolescents who were identified through education records as being at School Action Plus or a having a special educational need associated with a mild or moderate learning difficulty. This study is tracking adolescents as they transition from mainstream school to adult life. Boys with mild or moderate learning disabilities reported significantly poorer self-rated health and mental health than their peers. They were also more likely to have smoked in the last year, be bullied on a weekly basis at school, and to live in a poorer household. There were fewer differences between girls with and without mild or moderate learning disabilities, although these girls too were more likely to be exposed to common social determinants of poorer health, including poverty and bullying.

Mental Health

Children and young people who are emotionally healthy achieve more, participate more with their community and peers, engage in less risky behaviour and cope better with adversities they may face

from time to time. Emotional health in children has important implications for health and social outcomes in adult life.

Emotional health is not about feeling happy all the time, it is about having the resilience, self-awareness, social skills and empathy required to form relationships, enjoy one's own company and deal constructively with setbacks that everyone faces from time to time. Within the school setting, whole school approaches to emotional health e.g. through PHSE, are an important contribution to promoting emotional health in the school age population. From time to time some children and young people may develop problems which require support from others.

Schools are being encouraged to identify mental health problems in their pupils at an early stage. Many schools already have their own programmes to help children who may be experiencing mental health problems, such as school-based counsellors or whole school approaches to mental and emotional health.[84] I have discussed school based therapy services in Chapter Eight.

In addition, the new Special Educational Needs and Disability (SEND) Code of Practice provides statutory guidance for education and health services on identifying and supporting children and young people with mental health problems who have a special educational need. It will ensure a child's mental health needs are captured within any assessment of their educational, health and social care needs. It sets the expectation that there should be clear arrangements in place between local health partners, schools, colleges, early years providers and other organisations for making appropriate referrals to Child and Adolescent Mental Health Services (CAMHS).

This will require health and education professionals to work collaboratively so that the right decisions can be made to support each child, and quickly referring those who need extra support. Education services and Clinical Commissioning Groups should ensure that young people have a planned and painless transition to adult mental health services. This will lessen their chance of getting lost in transition with the attendant high risk of deterioration in their mental and physical health.

Sex and Relationships Education

Sex and relationships education (SRE) is learning about the emotional, social and physical aspects of growing up, relationships, sex, human sexuality and sexual health. Both young people and parents want high-quality education about sex and relationships.

The provision of sex education is a statutory requirement for maintained secondary schools. What schools include in their sex-education programme is a matter for local determination; however, all schools must give regard to the Secretary of State for Education's Sex and Relationship Education Guidance. This guidance, if followed, should ensure that pupils develop positive values and a strong moral framework that will guide their decisions, judgement and behaviour. It ensures that pupils are taught about the benefits of loving, healthy relationships and delaying sex, and also that pupils are aware of how to access confidential sexual health advice and support.

Academies do not have to teach sex education, but are required through their funding agreements to provide a broad and balanced curriculum. They are also required to have regard to the Sex and Relationship Education Guidance when providing sex education.

All schools delivering sex and relationship education are required to ensure that their pupils receive high-quality information on the importance of good sexual health.

Some aspects of SRE are taught in science, and others are taught as part of personal, social, health and economic education (PSHE).[85] Good PSHE is essential to support positive relationships and sexual health. Although schools are responsible for determining the content of their PSHE, the Department of Health has advised that school nurses can use the following checklist[86] to support good quality sex and relationships education in each school:

1. Are school nurses introduced in person to all pupils?

2. Do pupils learn that they can visit the school nurse and other health services 'un-invited' and that it is fine to come with a worry or a question?

3. Are younger pupils taught correct names for sexual parts of the body and about bodily privacy?

4. Do primary children learn about puberty before they experience it?

5. Is the confidentiality offered by school nurses explained to pupils in SRE?

6. Do secondary school pupils have opportunities to practice the skills for using a sexual health service by themselves, for example by using role-play conversations?

7. Does the SRE programme teach sufficient knowledge about sexual health for young people to be able to assess their own need to use a service?

8. Are school nurses documenting common questions and concerns from pupils and feeding this back anonymously to the lead SRE teacher in order to inform curriculum planning?

9. Do pupils have a way of asking the school nurse a question anonymously, for example by email or a question box, and is this facility explained in SRE?

10. Are school nurses aware of any external agencies contributing to the schools SRE, and are they confident about the medical accuracy of what they teach?

11. Are school nurses consulted when the SRE programme is reviewed or the policy updated?

Supporting Pupils with Medical Conditions at School

Parents of children with medical conditions are often concerned that their child's health will deteriorate when they attend school. This is because pupils with long-term and complex medical conditions may require on-going support, medicines or care while at school to help them manage their condition and keep them well. Others may require monitoring and interventions in emergency circumstances. The Children and Families Act 2014 requires governing bodies of maintained schools and proprietors of academies to make arrangements for supporting pupils at school with medical conditions. Schools are expected to:

- develop policies for supporting pupils with medical conditions and review them regularly

- develop individual healthcare plans for pupils with medical conditions that identify the child's medical condition, triggers, symptoms, medication needs and the level of support needed in an emergency

- have procedures in place on managing medicines on school premises

- and ensure staff are appropriately supported and trained[87]

The Annual Report of the Chief Medical Officer 2012 stressed that for school-aged children the school plays an important role in supporting them with their chronic illness or disability. An individual healthcare plan can alleviate fears about how much the school staff knows about the child's condition and how best they can help and support them. They provide clarity about what needs to be done, when and by whom. However, not all children will require one. The school, healthcare professional and parent should agree, based on evidence, when a healthcare plan would be inappropriate or disproportionate.

School nurses are responsible for notifying the school when they become aware that a child has a medical condition which will require support in school. Wherever possible, they should do this before the child starts at the school. They would not usually have an extensive role in ensuring that schools are taking appropriate steps to support children with medical conditions, but may support staff on implementing a child's individual healthcare plan and provide advice and liaison, for example on training. School nurses can liaise with lead clinicians locally on appropriate support for the child and can work with local specialist nursing teams to offer training to school staff, for example on the appropriate use of inhalers, adrenalin auto injectors prescribed for children and young people with diagnosed anaphylaxis, and any specialist equipment that may be needed by the child. Community nursing teams will also be a valuable potential resource for a school that is seeking advice and support in relation to children with a medical condition. Healthcare professionals, including the school nurse, can confirm the proficiency of school staff in a medical procedure or in providing medication.

There are a very wide range of medical conditions that might justify an individual healthcare plan being put in place. Some of these may have resulted from a serious home, sporting or road traffic injury, while others may be due to disorders such as cancer, infections, gastrointestinal and skin conditions. Many of the children and young people in the following chronic disease groups are being followed up regularly by their general practitioner and may benefit from having an individual healthcare plan:

Table 4. Children and Young People in Cheshire East on Chronic Disease Registers (2013/14)

Chronic Disease Register	Numbers	Percentage
Chronic respiratory disease (the majority of these are likely to be using salbutamol inhalers)	3,252	3.9%
Chronic heart disease	837	1.0%
Chronic neurological disease	345	0.4%
Diabetes	161	0.2%
Immunosuppression	108	0.1%
Chronic kidney disease	21	-
Chronic liver disease	18	-

Governing bodies should ensure that the school's policy is explicit about actions that are not acceptable. Although school staff should use their discretion and judge each case on its merits with reference to the child's individual healthcare plan, it is not generally acceptable practice to:

- prevent children from easily accessing their inhalers and medication and administering their medication when and where necessary

- assume that every child with the same condition requires the same treatment

- ignore the views of the child or their parents, or ignore medical evidence or opinion

- send children with medical conditions home frequently or prevent them from staying for normal school activities, including lunch, unless this is specified in their individual healthcare plan

- if the child becomes ill, send them to the school office or medical room unaccompanied or with someone unsuitable

- penalise children for their attendance record if their absences are related to their medical condition, for example hospital appointments

- prevent pupils from drinking, eating or taking toilet or other breaks whenever they need to in order to manage their medical condition effectively

- require parents, or otherwise make them feel obliged, to attend school to administer medication or provide medical support to their child, including with toileting issues. No parent should have to give up working because the school is failing to support their child's medical needs

- prevent children from participating, or create unnecessary barriers to children participating in any aspect of school life, including school trips, e.g. by requiring parents to accompany the child

Emergency Salbutamol Inhalers in Schools

Asthma is the most common chronic condition and affects around one in eleven children. On average, there are two children with asthma in every classroom in the UK. In Cheshire East there are believed to be over 7,578 school aged (5-16 years old) children and young people with asthma, and they experience 118 emergency hospital admissions for asthma every year.

The Human Medicines (Amendment) (No. 2) Regulations 2014 allows schools to keep a salbutamol inhaler for use in emergencies (as part of an emergency asthma inhaler kit). Larger schools may have several such kits located in different buildings. The inhaler can be used if the pupil's prescribed inhaler is not available (for example, because it is broken, or empty). It can only be used by children, for whom written parental consent for use of the emergency inhaler has been given, who have either been diagnosed with asthma and prescribed an inhaler, or who have been prescribed an inhaler as reliever medication.[88]

Primary and secondary schools are not required to hold an inhaler, but keeping one for emergency use could prevent an unnecessary and traumatic trip to hospital for a child, and could potentially save their life.

Key Points

School health services are a key component of the Healthy Child Programme. These services support school-aged children (5-19 years) to achieve the best possible health outcomes. School health teams lead and contribute to improving the outcomes for children and young people but they are not solely responsible for achieving these; there needs to be a partnership approach involving health and social care teams, teachers and youth workers.

- The current school health service (school-based and term-time only) needs to be remodelled. The school health services should be a key health resource for children and young people up to age 19. To ensure all young people (up to age 19) can access the service, school health services should be available to those young people at colleges and universities, and for those who are no longer in education. It should also be available during school holidays.

- The new school health service should utilise electronic devices and social media/texts as methods of communication with families and/or young people including for health promotion and service reminders (e.g. appointments).

Schools tend to be very aware of children who have particular difficulties in learning, whether due to a learning disability, a physical disability or a health condition. The class or subject teacher works with the child on a daily basis and liaises with teaching assistants or specialist staff to plan and assess the impact of support and interventions and how they can be linked to classroom teaching. However, within Cheshire East there is an under-recording by schools of children and young people with moderate learning disabilities or an autistic spectrum disorder – it is estimated that around 500 children in the Borough have unrecognised needs. This affects not only their educational attainment but also their health and wellbeing, with wider services such as health not being aware of their additional needs.

- People with learning disabilities have poorer health than the general population, and much of this starts early in life and is avoidable. Boys with mild or moderate learning disabilities report significantly poorer self-rated health and mental health than their peers. They are also more likely to have smoked in the last year, be bullied on a weekly basis at school, and to live in a poorer household.

- Recent work by the Learning Disability Observatory has shown that children with learning disabilities are over three times more likely to have conduct difficulties and emotional difficulties, over four times more likely to have difficulties relating to their peers and over five times more likely to have hyperactivity or attention deficit hyperactive disorder.

- Schools are being encouraged to identify mental health problems in their pupils at an early stage. Many schools already have their own programmes to help children who may be experiencing mental health problems, such as school-based counsellors or whole school approaches to mental and emotional health.

- An individual healthcare plan can alleviate fears about how much the school staff knows about a child's medical condition, and how best the school can help and support them. They provide clarity about what needs to be done, when and by whom.

Chapter Ten

Commissioning Services for Children and Young People

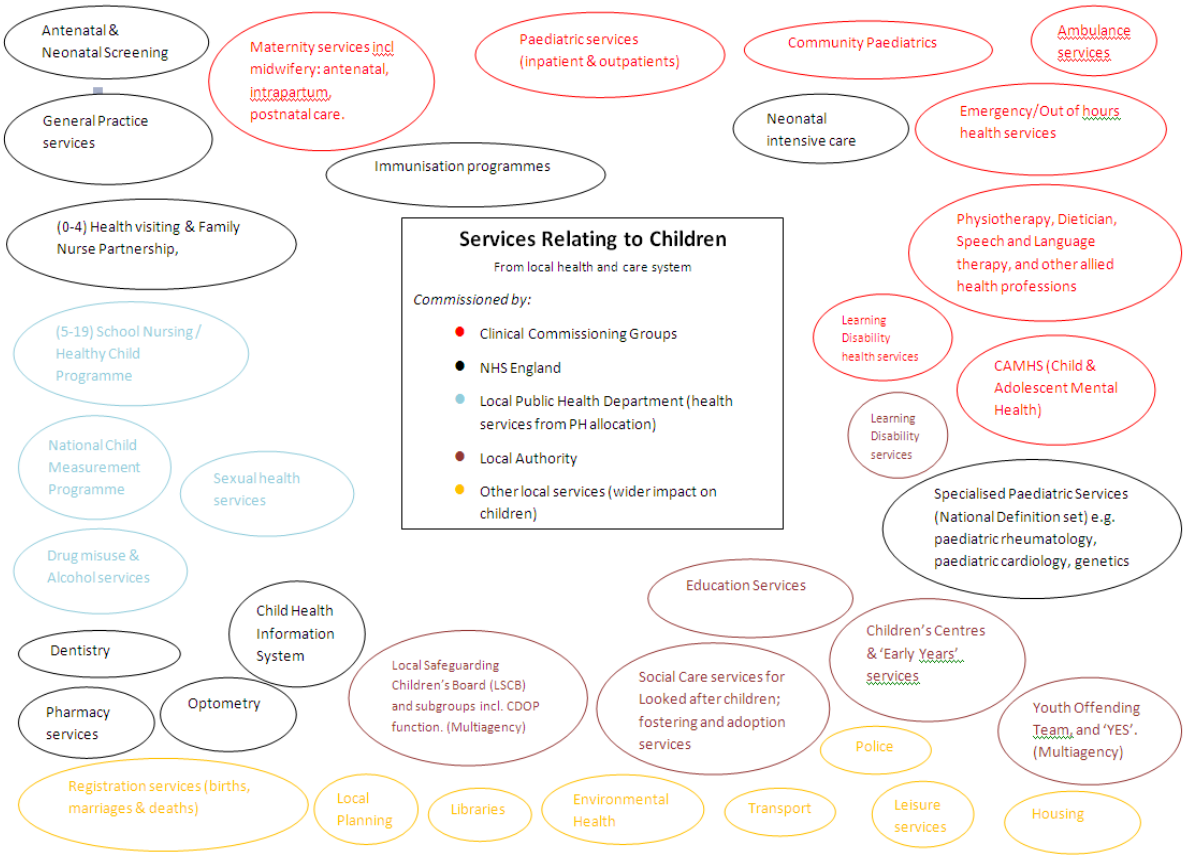
Many services are commissioned for children and young people in the local health and care system by a range of statutory commissioning organisations (see Figure 27). Some services are available on a population wide basis, for example antenatal care, health visiting, school health, accident and emergency services. Outside the health service arena, education services are an example of a population wide service for children.

In addition to all those services, some services are targeted at children in specific circumstances (for example services for cared for children).

There are also generic services serving the community that are included on the diagram because they contribute to the wider environment that children live in, for example housing, leisure and transport services.

Figure 27 also shows the local organisation with the commissioning responsibility for that service. It shows that the commissioning responsibility for services for children lies across several statutory organisations, including two Clinical Commissioning Groups, NHS England, Cheshire East Council and the police.

Figure 27. Commissioned services relating to children from the local health and care system



In relation to children and young people, the Director of Public Health has commissioning responsibilities that relate to the following statutory functions[89]:

- a range of public health services that are aimed at improving the health of children and young people. These include population level interventions to reduce and prevent birth defects, the National Child Measurement Programme, public health services for children and young people aged 5-19 (including school health services and the Healthy Child Programme 5-19) and, from October 2015 the Healthy Child Programme 0-5 (including health visiting services and the Family Nurse Partnership)

- all of the local authority's duties to take steps to improve the health of children and young people in its area. This arises from section 73A(1) of the NHS Act 2006, inserted by section 30 of the Health and Social Care Act 2012

- the provision of a public health advice service to both of the Clinical Commissioning Groups in the authority's area.[90] The purpose of the public health advice service in relation to children and young people is to assist both CCGs with the following:

    - the creation of a summary of the overall health of children and young people

    - the provision of assessments of the health needs of children and young people with particular conditions or diseases

    - advice on the development of plans for the anticipated care needs of children and young people, to improve the outcomes achieved for them by the provision of health services

    - advice on how to meet the duty on each clinical commissioning group to reduce inequalities

- such other public health functions as the Secretary of State specifies in regulations, for example the commissioning of sexual health services and, from 2015, certain universal elements of the 0-5 Healthy Child Programme (antenatal health promoting visits, new baby review, 6-8 week assessment , 1 year assessment and 2-2½ review)

As Director of Public Health I work closely with my colleague the Director of Children's Services, who discharges the education and children's social services functions of the local authority, and has professional responsibility for children's services, including operational matters. This includes responsibility for children and young people receiving education or children's social care services in their area and all cared-for children or in custody (regardless of where they are placed). The Director of Children's Services has commissioning responsibilities that relate to the following statutory functions[91]:

- securing the provision of services which address the needs of all children and young people, including the most disadvantaged and vulnerable, and their families and carers

- ensuring that the local voluntary and community sector, charities, social enterprises, the private sector and children and young people themselves are included in the scope of local authority planning, commissioning and delivery of children's services where appropriate

- helping to join up local commissioning plans for clinical and public health services with children's social care and education, where appropriate, to address the identified local

needs through the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

- being responsible for any agreements made under section 75 of the National Health Service (NHS) Act 2006 between the local authority and NHS relating to children and young people – for example, pooled budgets for commissioning and/or delivering integrated services covering children's health, social care and education

From a commissioning perspective, to achieve optimum outcomes for children with respect to preventive, treatment and ongoing care, multiple commissioners need to be aware not only of their own responsibilities but also those of partner organisations, and in turn of when it might be sensible to work together. It may even be sensible to consider commissioning together, known as collaborative commissioning (common vision, pooled funds, single contract). However, effective collaborative commissioning arrangements need mature understanding from all parties about the common goals, any financial risk sharing, and clarity about ultimate accountability.

This next section is about working out if a collaborative arrangement is suitable or not, and if not, then what arrangements is more suitable.

Firstly consider,

- is the *purpose* of the service to be commissioned clear? (if not, agree this with the responsible commissioner(s) first)

- is there sufficient clarity about the *service* to be commissioned? e.g. health visiting, child and adolescent mental health services, school health, or an out-of-hours service, etc

If answers to these questions are not clear, go back and clarify. When ready use the following steps to consider the most sensible commissioning model.

This next stage is about working out whether a simple commissioning-provider relationship is needed, or whether one of the collaborative approaches is suitable.

Consider the following factors:

- **how many commissioners** are involved? (commissioners hold the commissioning responsibility, can make decisions about using funds for this purpose)

- **how many providers** are involved? (including voluntary and fourth sector)

- **is there an aligned vision/ common goal** across commissioners about the service to be provided? Or are there several independent visions? (if there is no common vision then a collective commissioning arrangement is not suitable)

- **will funds be pooled?**

- which is/are the **accountable organisation(s)?** (accountable for the funds, responsible for holding the provider to account for quality)

See Table 5 and Table 6 to help decide. There is also a summary flowchart (Figure 28) to assist:

Table 5. Commissioning approaches (Table A)

	Number of Providers involved	**Number of Commissioners involved**	**Which type of commissioning approach is suitable?**
A	One or more providers of the service that is being commissioned	Single commissioner	**Simple commissioning relationship between commissioner and provider.** *Description:* One commissioner contracts with one provider organisation to provide a service. A commissioner may hold many of these types of contracts. Examples include: *CCG commissioning of:* Maternity services (antenatal, intra-partum and postnatal care); Paediatric services; Emergency services; Child and adolescent mental health services *NHS England commissioning of:* Primary care services (GP practices, optometrists, pharmacists, dentists); Immunisation programmes *Local Public Health Department commissioning of:* School nurses, pharmacies for emergency hormonal contraception, community sexual health services

When there is more than one commissioner involved in organising the service, one of the collaborative approaches below may be appropriate. These are the **Collaborative commissioning (collaborative contracting)** approach, or a **'Collaboration of intent'**.

With both of these models, all participating commissioners have an aligned vision of the service to be commissioned. The next matter is then whether funds are pooled into a single contract with the provider. If the answer is yes then there is a true collaborative commissioning arrangement. If the answer is no then the arrangement is probably a 'Collaboration of intent'.

Choose carefully because using a 'collaborative commissioning' arrangement when it is actually a collaboration of intent can be difficult to manage and eventually unfolds.

Table 6. Commissioning approaches (Table B)

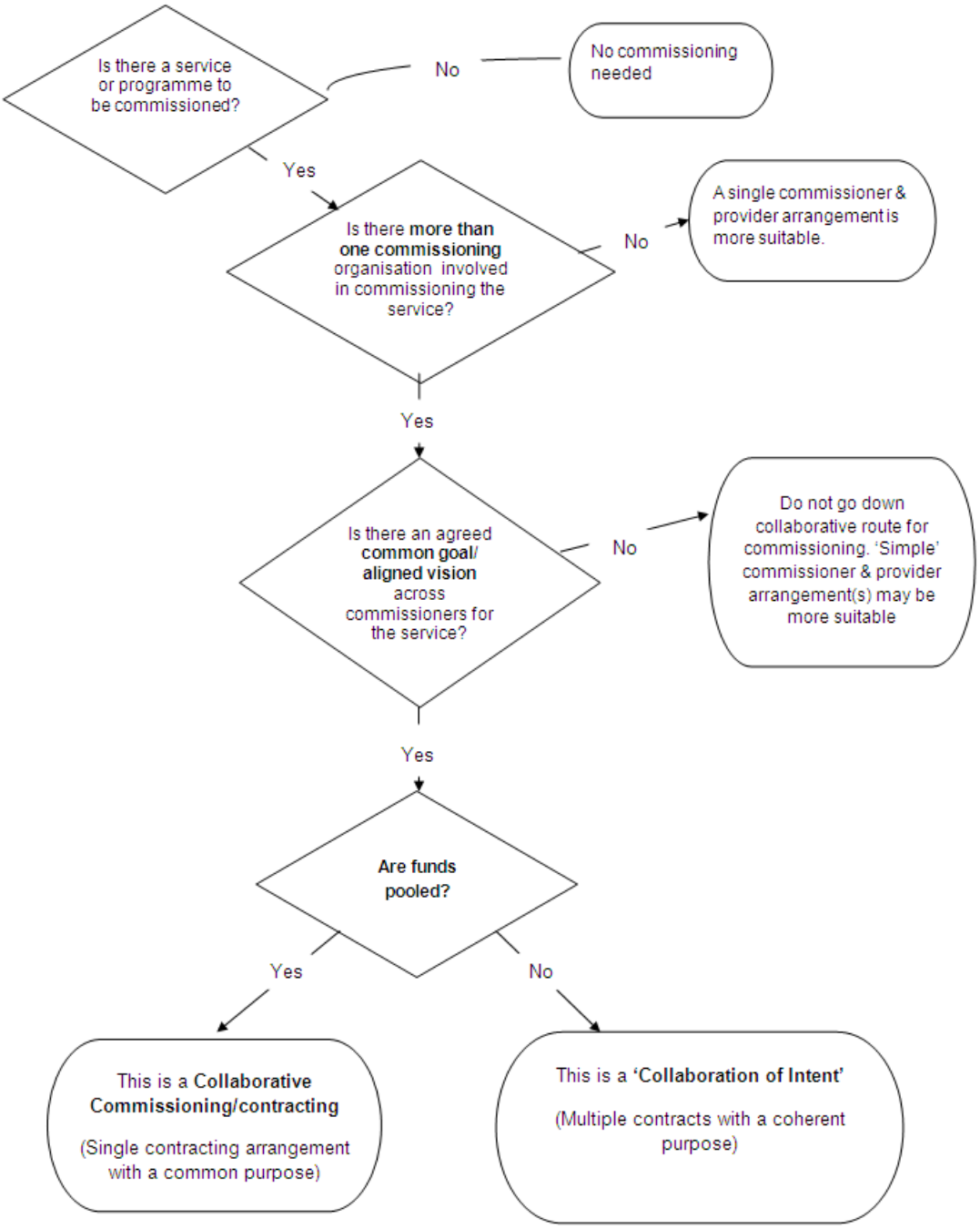
	Number of Providers involved	**Number of Commissioners involved**	**Which type of commissioning approach is suitable?**
B	Single, or very few providers	Multiple commissioners	**'Collaborative commissioning' (Collaborative contracting)** *Description:* several commissioners wish to work together with a common goal, and agree that this is best done through a single contract. Funding is pooled. There is a common commissioning process (strategically and contractually). Usually co-ordinated through a 'Lead' organisation with multiple 'co-commissioners'. Each organisation remains ultimately accountable for their

			population. *Situations suitable:* • Only 1 or very few providers and common quality standards are needed • Or, for high cost, low volume services and a financial risk share needs to be considered *Disadvantages*: All commissioners must be happy about the common standards of provision. Not suitable when each commissioner wants a bespoke service. Local examples include: • North West Ambulance services • Screening services where there are a limited number of providers e.g. laboratory services • Specialised paediatric services e.g. paediatric cardiology, neonatology, genetics, paediatric rheumatology • Local medicines management team • Potential services from the Better Care Fund
C	Multiple providers	Multiple commissioners	**'Collaboration of intent'** *Description:* There is an explicitly agreed aligned vision in the system, but there are multiple commissioners and providers and with many separate commissioning processes. Funding is not pooled. Each organisation is accountable for their own commissioning. *Situation suitable:* When several commissioners wish to work together towards a common goal, but each commissioner wishes to directly commission their own services. *Disadvantages:* Have to trust partner organisations to deliver the joint vision in this way. There is no contractual leverage over partner organisations to deliver the common vision. Many multiagency efforts are organised this way (or aspire to work this way) i.e. no money is pooled but they have (or aspire to have) a common purpose for working together. Examples include: • Health & Well-Being Strategy • 'Caring Together' integration programme (although initially focused on the frail elderly a future stage of this programme will be to look at the children's service pathways). • Local Safeguarding Children's Board and subgroup work N.B. Often, ventures referred to as 'joint commissioning' are actually arrangements that aspire to be collaborations

			of intent, i.e. no money or accountability is actually pooled but there is an agreement to work together strategically.

The term *'joint commissioning'* is best avoided as it is often not defined and can lead to unnecessary confusion. Historically it has been used to refer to many different things such as 'better joined up working at operational level', or more joined up working strategically without explicitly agreeing a common goal, or sometimes it does actually aspire to a true 'collaboration of intent'.

Figure 28. Aid to help assess whether a collaborative approach is suitable



It is very rare for the term 'joint commissioning' to be used to actually mean true collaborative commissioning with contracting. So it is better in discussions to be specific about whether we actually are exploring a collaboration of intent, or true collaborative commissioning, or whether it is none of these, just an exploratory discussion about how best for things to work together at an operational level without any change to the commissioning arrangements.

Key Points

From a commissioning perspective, to achieve optimum outcomes for children with respect to preventive, treatment and ongoing care, multiple commissioners need to be aware not only of their own responsibilities but also those of partner organisations, and when it might be sensible to work together. When organisations do work collaboratively it is best that they are clear from the start what type of commissioning or joint working arrangement they are choosing to use to avoid confusion and ensure good working relationships.

- Effective collaborative commissioning arrangements need mature understanding from all parties about the common goals, any financial risk sharing, and clarity about ultimate accountability.

- When there is more than one commissioner involved in organising the service it may be appropriate to use either a collaborative commissioning (collaborative contracting) approach, or a 'collaboration of intent'.

- Commissioners must choose carefully because using a 'collaborating commissioning approach' arrangement when it is actually a 'collaboration of intent' can be difficult to manage and eventually unfolds.

- It is less likely that true collaborative commissioning with contracting ('joint commissioning') is achieved. Therefore this term is best avoided as it is often not defined and can lead to unnecessary confusion.

Appendix A

Using Social Media to Deliver Public Health Messages

Public Health has an important role to advise and signpost other bodies such as Clinical Commissioning Groups and NHS Trusts towards accurate and reliable health information. This is to ensure that the information provided to members of the public is consistent and relevant to their needs. Partnership working is vital to achieving this.

An example is that of the Cherubs (Cheshire's Really Useful Breastfeeding Support) Project and website. The website is the base point for all information around local breastfeeding groups, peer supporter training programmes and it also provides detailed guidance to both mothers and health professionals around all aspects of breastfeeding.

Both of the acute Trusts in Cheshire East have their own supply of materials for the promotion of Cherubs including posters, pull up banners, business cards, flyers and stickers. The health visiting and maternity teams of East Cheshire NHS Trust have received the top accolade "Stage 3 Baby Friendly" from UNICEF, while the maternity team at Mid Cheshire Hospitals NHS Foundation Trust has achieved Stage 2; clearly demonstrating their commitment to Cherubs and to breastfeeding.

Cherubs is formally discussed with local parents on a regular basis. Parents receive consistent messages at different stages during pregnancy and beyond. On booking at the chosen hospital a Cherubs breastfeeding sticker is visible on the pregnancy file. Cherubs is part of the antenatal checklist – this acts as a reminder to both parents and the midwife to discuss breastfeeding. A Cherubs sticker is on the child's "Red Health Book" ensuring that breastfeeding is covered at the health visitors home check and beyond.

The Cherubs website has seen a consistent growth in the number of hits, demonstrating its increasing popularity and support. It has risen from an average of less than 100 hits per month (2011) to over 300 (2014). In its first 12 months only 19% of new mothers accessed the site, but by 2014 the website was being used by over half of new mothers locally (54%).

A web based tool is an ideal base for further information but it also has merit in directing parents to further resources. The Healthy Child Programme portrays a journey from 0-4 and 5-19 through the health visiting and school health services, and all aspects of the programme could link into a web based journey from one recognised resource to another.

Building on Cherubs as one small part of a "child's journey" would involve the design of a "brand identity" linking one set of information to another. This identity could be something as simple as a logo or sign that would appear on each of the linked web sites. A standardised home page with links to the next and previous parts of the life course would be ideal. Commitment of key health professionals such as midwives, pharmacists, general practitioners and health visitors is important in the successful growth of a project such as this.

Based on the evidence presented within this public health report, the key web resources to support improvements in health in the 0-4 age group will need to cover:

- Preconception advice
- Smoking

- Alcohol
- Breastfeeding
- Cold homes
- Safe homes
- Management of head injury
- Management of fever
- Management of respiratory conditions

In preparation for the re-tender of the health visiting and school health services in 2015, the Public Health team should work with Clinical Commissioning Groups and other commissioning partners to develop improved web-based information and health promotion resources for Children's Centres, Nurseries, Schools and General Practices. This will support the healthy childhood journey from birth up to 19 years.

Figure 29. Cheshire East: Public Health Outcomes Framework indicators

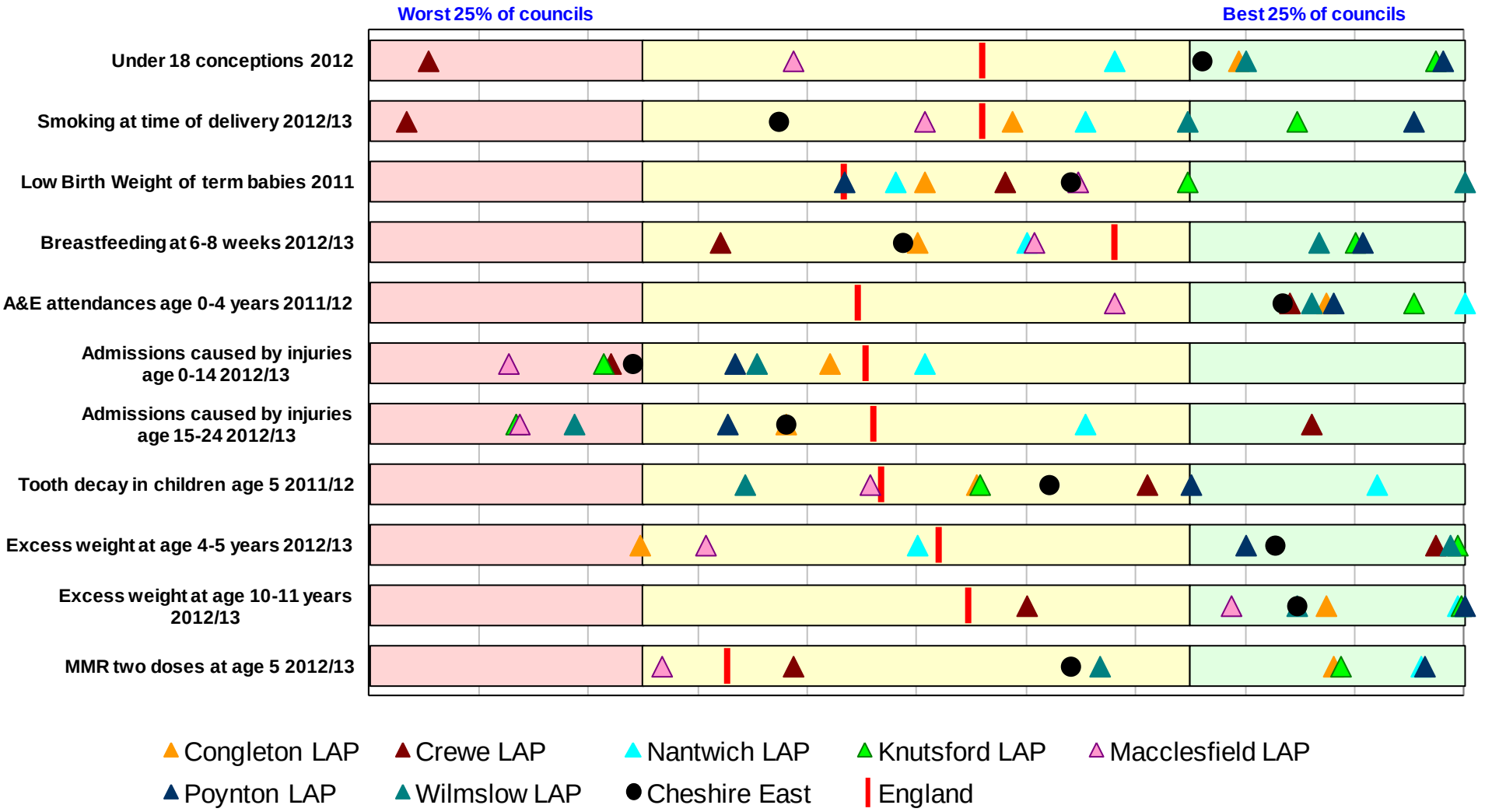
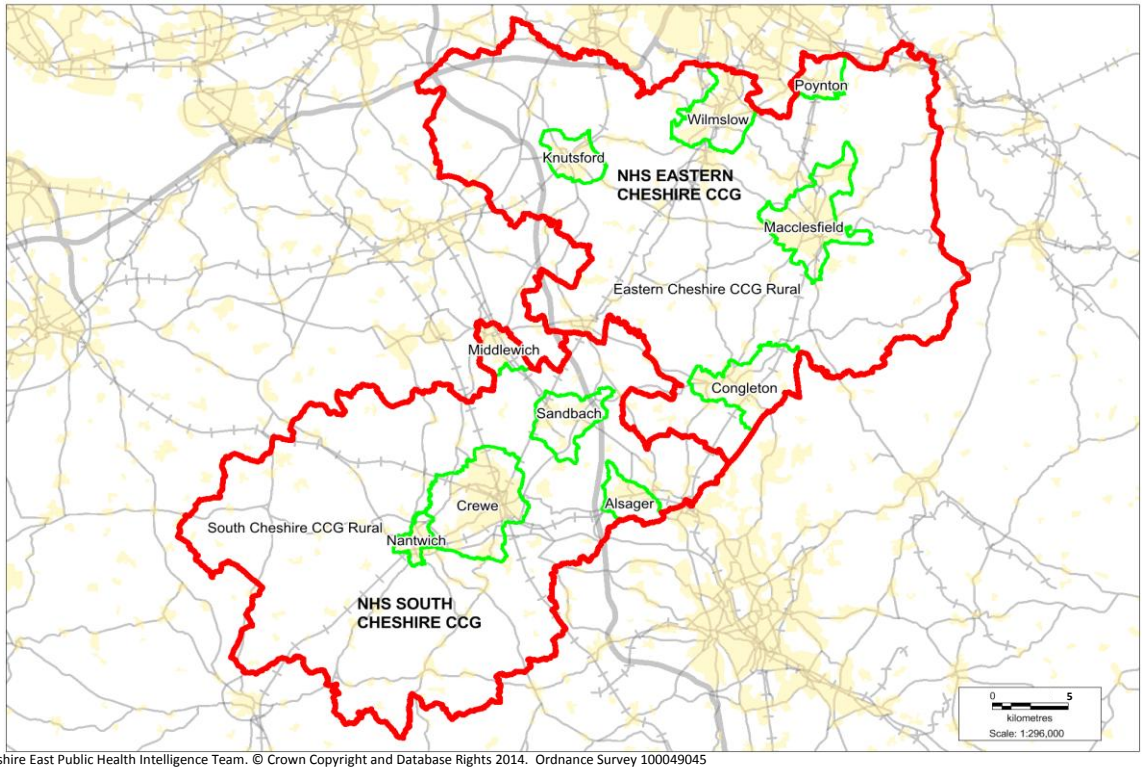


Table 7. Public Health Outcome Framework Indicators by LAP and CCG with Cheshire East and England data

Indicator	Year	Value type	Congleton LAP	Crewe LAP	Knutsford LAP	Macclesfield LAP	Nantwich LAP	Poynton LAP	Wilmslow LAP	Eastern Cheshire CCG	South Cheshire CCG	Cheshire East	England
Under 18 conceptions	2012	Crude rate per 1000	22.4	42.4	15.7	30.5	25.1	14.7	22.3	23.8	32.4	23.8	27.7
Smoking at time of delivery	2012/13	Proportion (%)	12.3	20.6	5.1	13.2	10.9	1.2	8.0	10.6	17.2	15.1	12.7
Low Birth Weight of term babies	2011	Proportion (%)	2.3	2.2	2.0	2.1	2.3	2.4	1.5	2.1	2.2	2.5	2.8
Breastfeeding at 6-8 weeks	2012/13	Proportion (%)	40.4	31.1	60.2	43.8	43.7	63.2	57.8	50.9	34.0	39.3	47.2
A&E attendances age 0-4 years	2011/12	Crude rate per 1,000	333.8	348.9	307.3	401.0	244.1	332.6	339.0	366.9	315.4	350.3	510.8
Hospital admissions caused by injuries age 0-14	2012/13	Crude rate per 10,000	106.9	128.8	130.0	140.9	101.6	114.2	113.6	128.8	112.5	122.5	103.8
Hospital admissions caused by injuries age 15-24	2012/13	Crude rate per 10,000	138.3	97.8	184.4	180.7	114.6	145.1	164.1	174.0	104.3	138.2	130.7
Tooth decay in children age 5	2011/12	Proportion (%)	23.5	20.2	23.6	25.3	12.8	19.3	28.8	25.2	19.4	22.2	27.9
Excess weight at age 4-5 years	2012/13	Proportion (%)	23.9	17.4	16.2	23.5	22.5	20.9	16.4	20.6	20.6	20.7	22.2
Excess weight at age 10-11 years	2012/13	Proportion (%)	29.3	32.9	23.5	31.1	25.6	21.3	29.7	28.1	30.9	29.5	33.3
MMR two doses at age 5	2012/13	Proportion (%)	92.7	88.2	93.0	86.6	94.4	94.6	90.8	90.5	90.3	90.5	87.7

Cheshire East Council



This map illustrates Clinical Commissioning Group and town areas.

The "town areas" shown on the above map are constructed from MSOA's (Mid-level Super Output Areas)and are used for statistical comparison purposes. There are five "town areas" and one "rural area" in each Clinical Commissioning Group. The boundary between the two Clinical Commissioning Groups straddles the Congleton Local Area Partnership area. For certain indicators, additional information at "town" level is available in the JSNA.

Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Cheshire East Council	3734	65028	57.4

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Cheshire East Council	3770	65028	58.0

Births within & outside marriage/ civil partnership (2013)

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
Cheshire East Council	1994	1776	47.1

Registrations by lone mothers (2013)

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Cheshire East Council	276	179	12.1

Low Birth Weight (under 2500g) 2009-2011

Cheshire East Council	Babies with low birth weight	Total births in 3 year period	Percentage (%)
Total LBW babies (2009-11)	768	11984	6.4
LBW at term (2008-10)	230	10782	2.1

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continu-ation %
Cheshire East Council	3774	63.0	42.6

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Cheshire East Council	3085	430	1018
Percentage infants exposed to smoke		14.0%	33.0%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

Cheshire East Council	Number of infants	Number vaccinated	Uptake
Full primary course aged 1	4100	3955	96.5%
MMR 1st dose aged 2	4211	4009	95.2%
MMR 2nd dose aged 5	4218	3813	90.4%

The primary immunisation course consists of three vaccines protecting against diptheria, tetanus, pertussis, polio and *Haemophilus influenzae type b (* Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

Cheshire East Council	Total Maternities	Smoking Exposure	Exposure to Smoking %
Aged <15-19	156	218	0.7
Aged 20-24	609	1030	0.6
Aged 25-29	602	1616	0.4
Aged 30-34	396	1974	0.2
Aged 35-39	216	1246	0.2
Aged 40+	56	357	0.2
Total	**2035**	**6441**	**0.3**

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Cheshire East Council (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

Cheshire East Council	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	20397	2656	13.0
Males aged 0-4	10500	1555	14.8
Females aged 0-4	9897	1102	11.1

Emergency Admissions for Injury, aged 0-4, 2011-2014

Cheshire East Council	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	20397	261	1.3
Males aged 0-4	10500	151	1.4
Females aged 0-4	9897	110	1.1

Total A&E Attendances aged <1 year, 2011-2014

Cheshire East Council	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	472	165	34.9
Females under 1 year	450	140	31.0

Total Emergency Admissions aged <1 year, 2011-2014

Cheshire East Council	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	472	211	44.6
Females under 1 year	450	141	31.4

A&E Attendance for injury, average per year for 2011-14

Cheshire East Council	Attended per year	Percent (%)
under 1	284	6.9
1-4	2374	14.6
5-9	2244	11.0
10-14	3231	15.6
15-19	3027	13.9
0-19	11160	13.4

A&E Attendance non-injury, average per year for 2011-14

Cheshire East Council	Attended per year	Percent (%)
under 1	1202	29.4
1-4	3120	19.1
5-9	2021	9.9
10-14	2578	12.4
15-19	3698	17.0
0-19	12618	15.1

Emergency admissions for injury, av'g per year for 2011-14

Cheshire East Council	Admitted per year	Percent (%)
under 1	49	1.2
1-4	170	1.0
5-9	161	0.8
10-14	167	0.8
15-19	180	0.8
0-19	727	0.9

Emergency admissions non-injury, av'g per year for 2011-14

Cheshire East Council	Admitted per year	Percent (%)
under 1	1657	40.6
1-4	1894	11.6
5-9	734	3.6
10-14	673	3.2
15-19	1155	5.3
0-19	6112	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalance rates applied to local population to give estimated numbers.

Cheshire East Council	Total
Oral Thrush (aged 0-4)	204
Impetigo (aged 0-4)	1302
Headlice (aged 4-11)	4227
Acne (aged 12-19)	29492
Eczema (aged 0-19)	14582
Conjunctivitis (aged 0-19)	1167

Children aged 6m to 19y with long term conditions

Cheshire East Council	6mths-<16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	2510	3252	3.9%
Heart disease	661	837	1.0%
Neurological disease	268	345	0.4%
Diabetes	124	161	0.2%

Daily activity affected by long term illness/disability 2011

Cheshire East Council	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	1.2%	1.9%	96.9%
Young people aged 16-19	1.9%	2.9%	95.2%

Ethnicity from Census data 2011

Cheshire East Council	Total	Percentage
White	96,770	94.9%
Asian/Asian British	2,032	2.0%
African/Carib/Black British	423	0.4%
Other ethnic group	279	0.3%
Mixed/multiple ethnic	2,511	2.5%

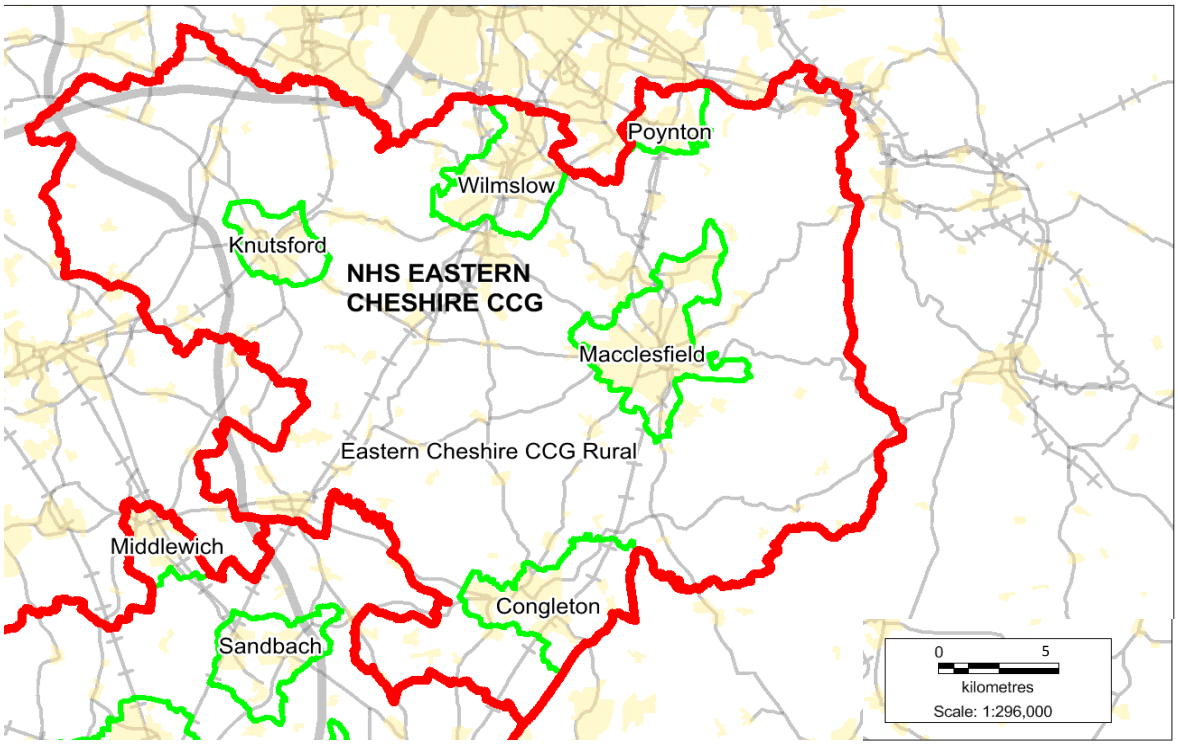
Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	20397	
Aged 5-11	28229	(Primary age range)
Aged 12-16	21823	(Secondary age range)
Aged 17-19	12874	
Total aged 0-19	**83323**	

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	4084
Aged 1-4	16313
Aged 5-9	20370
Aged 10-14	20772
Aged 15-19	21784

NHS Eastern Cheshire CCG



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Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
NHS Eastern Cheshire CCG	1967	32474	60.6

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
NHS Eastern Cheshire CCG	1993	32474	61.4

Births within & outside marriage/ civil partnership (2013)

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
NHS Eastern Cheshire CCG	1175	818	41.0

Registrations by lone mothers (2013)

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
NHS Eastern Cheshire CCG	130	89	11.0

Low Birth Weight (under 2500g) 2009-2011

NHS Eastern Cheshire CCG	Babies with low birth weight	Total births in 3 year period	Percentage (%)
Total LBW babies (2009-11)	373	6076	6.1
LBW at term (2008-10)	113	5389	2.1

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continu-ation %
NHS Eastern Cheshire CCG	1,904	71.7	50.9

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
NHS Eastern Cheshire CCG	1508	159	429
Percentage infants exposed to smoke		10.6%	28.4%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

NHS Eastern Cheshire CCG	Number of infants	Number vaccinated	Uptake
Full primary course aged 1	2130	2070	97.2%
MMR 1st dose aged 2	2242	2156	96.2%
MMR 2nd dose aged 5	2219	3813	90.4%

The primary immunisation course consists of three vaccines protecting against diptheria, tetanus, pertussis, polio and *Haemophilus influenzae type b (*Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

NHS Eastern Cheshire CCG	Total Maternities	Smoking Exposure	Exposure to Smoking %
Aged <15-19	49	13	0.7
Aged 20-24	216	118	0.6
Aged 25-29	214	327	0.3
Aged 30-34	155	646	0.1
Aged 35-39	98	473	0.1
Aged 40+	26	124	0.1
Total	**758**	**1701**	**0.2**

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

NHS Eastern Cheshire CCG (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

NHS Eastern Cheshire CCG	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	10431	1555	14.9
Males aged 0-4	5390	921	17.1
Females aged 0-4	5041	633	12.6

Emergency Admissions for Injury, aged 0-4, 2011-2014

NHS Eastern Cheshire CCG	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	10431	135	1.3
Males aged 0-4	5390	80	1.5
Females aged 0-4	5041	55	1.1

Total A&E Attendances aged <1 year, 2011-2014

NHS Eastern Cheshire CCG	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	472	165	34.9
Females under 1 year	450	140	31.0

Total Emergency Admissions aged <1 year, 2011-2014

NHS Eastern Cheshire CCG	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	472	211	44.6
Females under 1 year	450	141	31.4

A&E Attendance for injury, average per year for 2011-14

NHS Eastern Cheshire CCG	Attended per year	Percent (%)	Cheshire East (%)
under 1	175	8.5	6.9
1-4	1381	16.5	14.6
5-9	1274	12.2	11.0
10-14	1783	16.5	15.6
15-19	1626	15.4	13.9
0-19	6239	14.8	13.4

A&E Attendance non-injury, average per year for 2011-14

NHS Eastern Cheshire CCG	Attended per year	Percent (%)	Cheshire East (%)
under 1	655	31.7	29.4
1-4	1624	19.4	19.1
5-9	1157	11.0	9.9
10-14	1544	14.3	12.4
15-19	2032	19.3	17.0
0-19	7012	16.6	15.1

Emergency admissions for injury, av'g per year for 2011-14

NHS Eastern Cheshire CCG	Admitted per year	Percent (%)	Cheshire East (%)
under 1	26	1.2	1.2
1-4	94	1.1	1.0
5-9	86	0.8	0.8
10-14	90	0.8	0.8
15-19	100	0.9	0.8
0-19	396	0.9	0.9

Emergency admissions non-injury, av'g per year for 2011-14

NHS Eastern Cheshire CCG	Admitted per year	Percent (%)	Cheshire East (%)
under 1	932	45.1	40.6
1-4	1040	12.4	11.6
5-9	397	3.8	3.6
10-14	370	3.4	3.2
15-19	512	4.9	5.3
0-19	3251	7.7	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalance rates applied to local population to give estimated numbers.

NHS Eastern Cheshire CCG	Total
Oral Thrush (aged 0-4)	103
Impetigo (aged 0-4)	670
Headlice (aged 4-11)	2176
Acne (aged 12-19)	14697
Eczema (aged 0-19)	7399
Conjunctivitis (aged 0-19)	592

Children aged 6m to 19y with long term conditions

NHS Eastern Cheshire CCG	6mths-<16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	1317	1677	4.0%
Heart disease	308	387	0.9%
Neurological disease	123	155	0.4%
Diabetes	77	98	0.2%

Daily activity affected by long term illness/disability 2011

NHS Eastern Cheshire CCG	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	1.1%	1.8%	97.1%
Young people aged 16-19	1.3%	2.0%	96.7%

Ethnicity from Census data 2011

NHS Eastern Cheshire CCG	Total	Percentage
White	47,813	94.4%
Asian/Asian British	1,258	2.5%
African/Carib/Black British	147	0.3%
Other ethnic group	163	0.3%
Mixed/multiple ethnic	1,256	2.5%

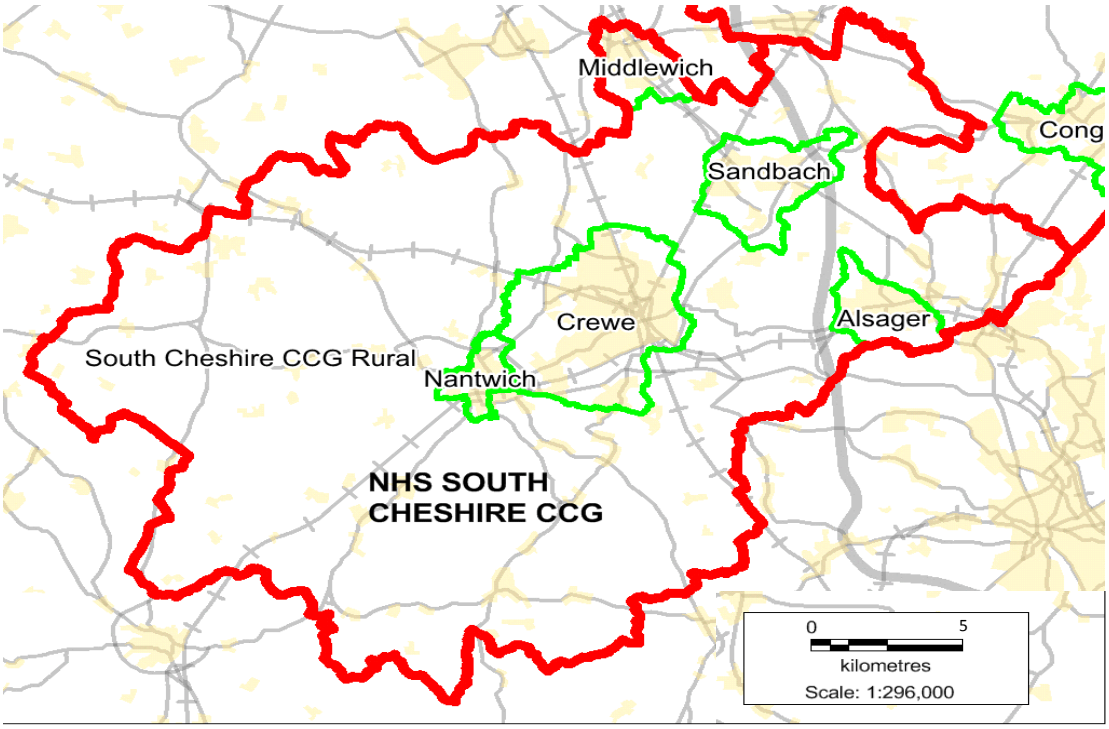
Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	10431	
Aged 5-11	14561	(Primary age range)
Aged 12-16	11240	(Secondary age range)
Aged 17-19	6050	
Total aged 0-19	**42282**	

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	2066
Aged 1-4	8365
Aged 5-9	10482
Aged 10-14	10835
Aged 15-19	10534

NHS South Cheshire CCG



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Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
NHS South Cheshire CCG	1767	32554	54.3

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
NHS South Cheshire CCG	1777	32554	54.6

Births within & outside marriage/ civil partnership (2013)

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
NHS South Cheshire CCG	819	958	53.9

Registrations by lone mothers (2013)

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
NHS South Cheshire CCG	146	90	13.3

Low Birth Weight (under 2500g) 2009-2011

NHS South Cheshire CCG	Babies with low birth weight	Total births in 3 year period	Percentage (%)
Total LBW babies (2009-11)	395	5908	6.7
LBW at term (2008-10)	117	5393	2.2

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continu-ation %
NHS South Cheshire CCG	1,870	54.2	34.0

Smoking at time of delivery, 2013

NHS South Cheshire CCG	Number of maternities	Women smoking at delivery	Household smoking exposure
	1577	271	589
Percentage infants exposed to smoke		17.2%	37.3%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

NHS South Cheshire CCG	Number of infants	Number vaccinated	Uptake
Full primary course aged 1	1970	1885	95.7%
MMR 1st dose aged 2	1969	1853	94.1%
MMR 2nd dose aged 5	1999	1805	90.3%

The primary immunisation course consists of three vaccines protecting against diptheria, tetanus, pertussis, polio and *Haemophilus influenzae type b* (Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

NHS South Cheshire CCG	Total Maternities	Smoking Exposure	Exposure to Smoking %
Aged <15-19	107	31	0.7
Aged 20-24	393	200	0.6
Aged 25-29	388	449	0.4
Aged 30-34	241	538	0.3
Aged 35-39	118	308	0.2
Aged 40+	30	92	0.2
Total	**1277**	**1618**	**0.4**

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

NHS South Cheshire CCG (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

NHS South Cheshire CCG	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	9966	1102	11.1
Males aged 0-4	5110	633	12.4
Females aged 0-4	4856	468	9.6

Emergency Admissions for Injury, aged 0-4, 2011-2014

NHS South Cheshire CCG	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	9966	126	1.3
Males aged 0-4	5110	71	1.4
Females aged 0-4	4856	55	1.1

Total A&E Attendances aged <1 year, 2011-2014

NHS South Cheshire CCG	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	472	165	34.9
Females under 1 year	450	140	31.0

Total Emergency Admissions aged <1 year, 2011-2014

NHS South Cheshire CCG	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	472	211	44.6
Females under 1 year	450	141	31.4

A&E Attendance for injury, average per year for 2011-14

NHS South Cheshire CCG	Attended per year	Percent (%)	Cheshire East (%)
under 1	109	5.4	6.9
1-4	993	12.5	14.6
5-9	970	9.8	11.0
10-14	1448	14.6	15.6
15-19	1401	12.5	13.9
0-19	4921	12.0	13.4

A&E Attendance non-injury, average per year for 2011-14

NHS South Cheshire CCG	Attended per year	Percent (%)	Cheshire East (%)
under 1	547	27.1	29.4
1-4	1496	18.8	19.1
5-9	864	8.7	9.9
10-14	1034	10.4	12.4
15-19	1666	14.8	17.0
0-19	5606	13.7	15.1

Emergency admissions for injury, av'g per year for 2011-14

NHS South Cheshire CCG	Admitted per year	Percent (%)	Cheshire East (%)
under 1	23	1.1	1.2
1-4	76	1.0	1.0
5-9	75	0.8	0.8
10-14	77	0.8	0.8
15-19	80	0.7	0.8
0-19	331	0.8	0.9

Emergency admissions non-injury, av'g per year for 2011-14

NHS South Cheshire CCG	Admitted per year	Percent (%)	Cheshire East (%)
under 1	725	35.9	40.6
1-4	854	10.7	11.6
5-9	337	3.4	3.6
10-14	303	3.0	3.2
15-19	643	5.7	5.3
0-19	2861	7.0	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalance rates applied to local population to give estimated numbers.

NHS South Cheshire CCG	Total
Oral Thrush (aged 0-4)	101
Impetigo (aged 0-4)	632
Headlice (aged 4-11)	2051
Acne (aged 12-19)	14796
Eczema (aged 0-19)	7182
Conjunctivitis (aged 0-19)	575

Children aged 6m to 19y with long term conditions

NHS South Cheshire CCG	6mths-<16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	1193	1573	3.8%
Heart disease	353	450	1.1%
Neurological disease	145	190	0.5%
Diabetes	47	62	0.2%

Daily activity affected by long term illness/disability 2011

NHS South Cheshire CCG	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	1.3%	2.0%	96.7%
Young people aged 16-19	1.8%	2.9%	95.3%

Ethnicity from Census data 2011

NHS South Cheshire CCG	Total	Percentage
White	48,957	95.3%
Asian/Asian British	774	1.5%
African/Carib/Black British	276	0.5%
Other ethnic group	116	0.2%
Mixed/multiple ethnic	1,255	2.4%

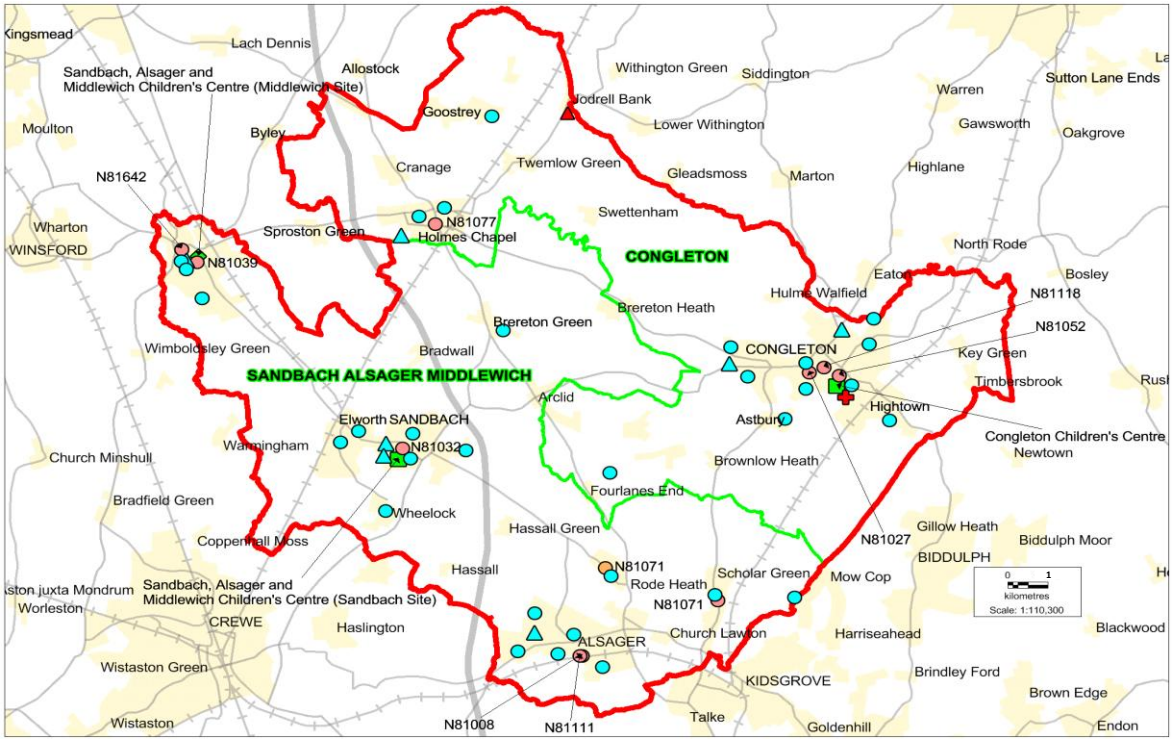
Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	9966	
Aged 5-11	13668	(Primary age range)
Aged 12-16	10583	(Secondary age range)
Aged 17-19	6824	
Total aged 0-19	**41041**	

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	2018
Aged 1-4	7948
Aged 5-9	9888
Aged 10-14	9937
Aged 15-19	11250

Congleton Local Area Partnership



Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Congleton LAP	797	15265	52.2

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Congleton LAP	807	15265	52.9

Births within & outside marriage/ civil partnership, 2013

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
Congleton LAP	508	391	43.5%

Registrations by lone mothers, 2013

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Congleton LAP	45	38	10.3

Low Birth Weight (under 2500g) 2009-2011

Congleton LAP	Babies with low birth weight	Total births in 3 year period	Percentage (%)
Total LBW babies (2009-11)	160	2633	6.1
LBW at term (2008-10)	54	2346	2.3

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continu-ation %
Congleton LAP	883	60.4	40.4

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Congleton LAP	656	81	214
Percentage infants exposed to smoke		12.3%	32.6%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

Congleton LAP	Number of infants	Number vaccinated	Uptake
Full primary course aged 1	1010	978	96.8%
MMR 1st dose aged 2	1036	990	95.6%
MMR 2nd dose aged 5	1011	937	92.7%

The primary immunisation course consists of three vaccines protecting against diptheria, tetanus, pertussis, polio and *Haemophilus influenzae type b (* Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

Congleton LAP	Total Maternities	Smoking Exposure	Exposure to Smoking %
Aged <15-19	35	26	74.3%
Aged 20-24	216	127	58.8%
Aged 25-29	334	110	32.9%
Aged 30-34	461	99	21.5%
Aged 35-39	262	48	18.3%
Aged 40+	81	9	11.1%
Total	**1389**	**419**	**30.2%**

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Key to GP practice codes

N81642 - Water's Edge
N81039 - Oaklands
N81077 - Holmes Chapel
N81027 - Readesmoor
N81052 - Lawton House
N81118 - Meadowside
N81032 - Ashfield's
N81008 - The Cedars
N81111 - Merepark
N81071 - Greenmoss

Congleton Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

Congleton LAP	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	4617	605	13.1
Males aged 0-4	2407	367	15.2
Females aged 0-4	2210	238	10.8

Emergency Admissions for Injury, aged 0-4, 2011-2014

Congleton LAP	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	4617	55	1.2
Males aged 0-4	2407	31	1.3
Females aged 0-4	2210	24	1.1

Total A&E Attendances aged <1 year, 2011-2014

Congleton LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	472	165	34.9
Females under 1 year	450	140	31.0

Total Emergency Admissions aged <1 year, 2011-2014

Congleton LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	472	211	44.6
Females under 1 year	450	141	31.4

A&E Attendance for injury, average per year for 2011-14

Congleton LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	59	6.4	6.9
1-4	547	14.8	14.6
5-9	559	11.3	11.0
10-14	814	15.9	15.6
15-19	780	14.6	13.9
0-19	2759	13.8	13.4

A&E Attendance non-injury, average per year for 2011-14

Congleton LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	247	26.8	29.4
1-4	692	18.7	19.1
5-9	530	10.7	9.9
10-14	715	14.0	12.4
15-19	979	18.3	17.0
0-19	3163	15.8	15.1

Emergency admissions for injury, av'g per year for 2011-14

Congleton LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	8	0.9	1.2
1-4	33	0.9	1.0
5-9	39	0.8	0.8
10-14	40	0.8	0.8
15-19	49	0.9	0.8
0-19	169	0.8	0.9

Emergency admissions non-injury, av'g per year for 2011-14

Congleton LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	344	37.3	40.6
1-4	414	11.2	11.6
5-9	158	3.2	3.6
10-14	143	2.8	3.2
15-19	293	5.5	5.3
0-19	1352	6.7	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalance rates applied to local population to give estimated numbers.

Congleton LAP	Total
Oral Thrush (aged 0-4)	46
Impetigo (aged 0-4)	308
Headlice (aged 4-11)	1015
Acne (aged 12-19)	7318
Eczema (aged 0-19)	3507
Conjunctivitis (aged 0-19)	281

Children aged 6m to 19y with long term conditions

Congleton LAP	6mths-<16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	718	936	4.7%
Heart disease	159	205	1.0%
Neurological disease	69	88	0.4%
Diabetes	30	39	0.2%

Daily activity affected by long term illness/disability 2011

Congleton LAP	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	1.1%	1.8%	97.2%
Young people aged 16-19	2.1%	3.0%	95.0%

Ethnicity aged 0-24 Census data 2011

Congleton LAP	Total	Percentage
White	23,547	97.0%
Asian/Asian British	237	1.0%
African/Carib/Black British	24	0.1%
Other ethnic group	38	0.2%
Mixed/multiple ethnic	422	1.7%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	4617	
Aged 5-11	6815	(Primary age range)
Aged 12-16	5492	(Secondary age range)
Aged 17-19	3117	
Total aged 0-19	**20041**	

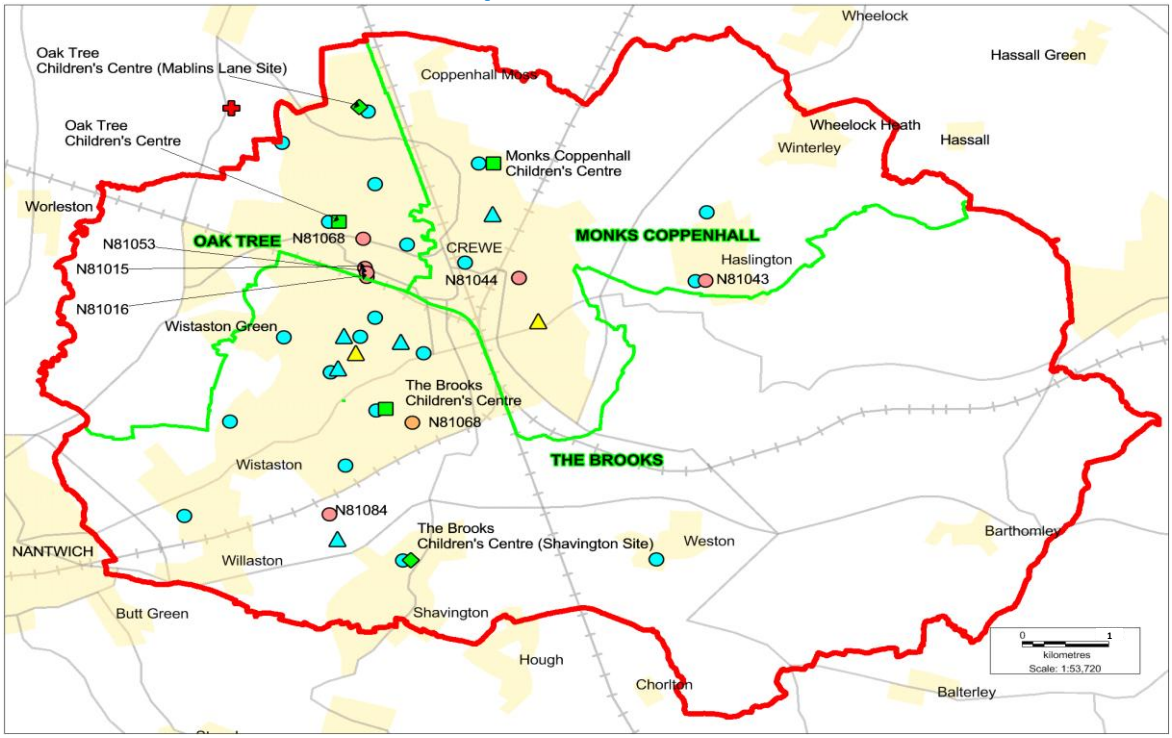
Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	922
Aged 1-4	3695
Aged 5-9	4946
Aged 10-14	5120
Aged 15-19	5358

Secondary Schools and Feeder Primary Schools

Secondary Schools	Feeder Primary Schools				
Alsager Academy	Alsager Highfield's	Cranbury	Excalibur	Pikemere	Rode Heath
Congleton High School	Astbury St Mary's	Black Firs	Daven	Scholar Green	
	Smallwood CE	The Quinta	Woodcock's Well		
Eaton Bank Academy	Bosley St Mary's	Buglawton	Havannah	Marlfields	
	Marton and District	Mossley CE			
Holmes Chapel Comprehensive	Brereton CE	Chelford CE	Goostrey	Hermitage	
	Holmes Chapel	Lower Peover CE	Peover Superior		
Middlewich High School	Byley	Cledford	Middlewich	Wimboldsley	
Sandbach High and 6th Form College	Elworth CE	Haslington	Rode Heath	St John's CofE	Wheelock
Sandbach School	Elworth Hall	Offley	Sandbach	The Dingle	
	Feeder school in another LAP		Feeder school in CWAC council		

Crewe Local Area Partnership



Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Crewe LAP	985	17367	56.7

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Crewe LAP	991	17367	57.1

Births within & outside marriage/ civil partnership, 2013

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
Crewe LAP	437	686	61.1%

Registrations by lone mothers, 2013

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Crewe LAP	102	65	16.9

Low Birth Weight (under 2500g) 2009-2011

Crewe LAP	Babies with low birth weight	Total births in the 3 year period	Percentage (%)
Total LBW babies (2009-11)	248	3436	7.2
LBW at term (2008-10)	69	3148	2.2

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continu-ation %
Crewe LAP	1102	50.5	31.1

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Crewe LAP	962	198	408
Percentage infants exposed to smoke		20.6%	42.4%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

Crewe LAP	Number of infants	Number vaccinated	Uptake
Full primary course aged 1	1078	1030	95.5%
MMR 1st dose aged 2	1105	1027	92.9%
MMR 2nd dose aged 5	1088	960	88.2%

The primary immunisation course consists of three vaccines protecting against diptheria, tetanus, pertussis, polio and *Haemophilus influenzae type b* (Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

Crewe LAP	Total Maternities	Smoking Exposure	Exposure to Smoking %
Aged <15-19	78	115	67.8%
Aged 20-24	280	449	62.4%
Aged 25-29	290	638	45.5%
Aged 30-34	499	152	30.5%
Aged 35-39	251	74	29.5%
Aged 40+	71	17	23.9%
Total	**2023**	**891**	**44.0%**

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Key to GP practice codes

N81053 - Earnswood
N81015 - Delamere
N81016 - Millcroft
N81068 - Grosvenor
N81044 - Hungerford
N81043 - Haslington
N81084 - Rope Green

Crewe Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

Crewe LAP	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	5489	674	12.3
Males aged 0-4	2784	378	13.6
Females aged 0-4	2705	297	11.0

Emergency Admissions for Injury, aged 0-4, 2011-2014

Crewe LAP	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	5489	81	1.5
Males aged 0-4	2784	46	1.7
Females aged 0-4	2705	35	1.3

Total A&E Attendances aged <1 year, 2011-2014

Crewe LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	573	239	41.7
Females under 1 year	546	181	33.2

Total Emergency Admissions aged <1 year, 2011-2014

Crewe LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	573	266	46.5
Females under 1 year	546	179	32.8

A&E Attendance for injury, average per year for 2011-14

Crewe LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	71	6.3	6.9
1-4	604	13.8	14.6
5-9	550	10.9	11.0
10-14	823	16.8	15.6
15-19	780	13.6	13.9
0-19	2828	13.3	13.4

A&E Attendance non-injury, average per year for 2011-14

Crewe LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	350	31.2	29.4
1-4	892	20.4	19.1
5-9	493	9.8	9.9
10-14	570	11.6	12.4
15-19	922	16.0	17.0
0-19	3227	15.2	15.1

Emergency admissions for injury, av'g per year for 2011-14

Crewe LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	16	1.5	1.2
1-4	48	1.1	1.0
5-9	45	0.9	0.8
10-14	45	0.9	0.8
15-19	38	0.7	0.8
0-19	192	0.9	0.9

Emergency admissions non-injury, av'g per year for 2011-14

Crewe LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	429	38.4	40.6
1-4	502	11.5	11.6
5-9	189	3.7	3.6
10-14	170	3.5	3.2
15-19	342	5.9	5.3
0-19	1632	7.7	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalance rates applied to local population to give estimated numbers.

Crewe LAP	Total
Oral Thrush (aged 0-4)	56
Impetigo (aged 0-4)	331
Headlice (aged 4-11)	1046
Acne (aged 12-19)	7460
Eczema (aged 0-19)	3710
Conjunctivitis (aged 0-19)	297

Children aged 6m to 19y with long term conditions

Crewe LAP	6mths-<16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	571	753	3.6%
Heart disease	197	249	1.2%
Neurological disease	85	112	0.5%
Diabetes	20	26	0.1%

Daily activity affected by long term illness/disability 2011

Crewe LAP	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	1.5%	2.1%	96.4%
Young people aged 16-19	1.9%	3.1%	95.0%

Ethnicity aged 0-24 Census data 2011

Crewe LAP	Total	Percentage
White	25,546	93.7%
Asian/Asian British	2.1%	2.1%
African/Carib/Black British	245	0.9%
Other ethnic group	83	0.3%
Mixed/multiple ethnic	804	2.9%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	5489	
Aged 5-11	6935	(Primary age range)
Aged 12-16	5232	(Secondary age range)
Aged 17-19	3545	
Total aged 0-19	21201	

Population size for 0-19 year olds in 5 year bands, 2012

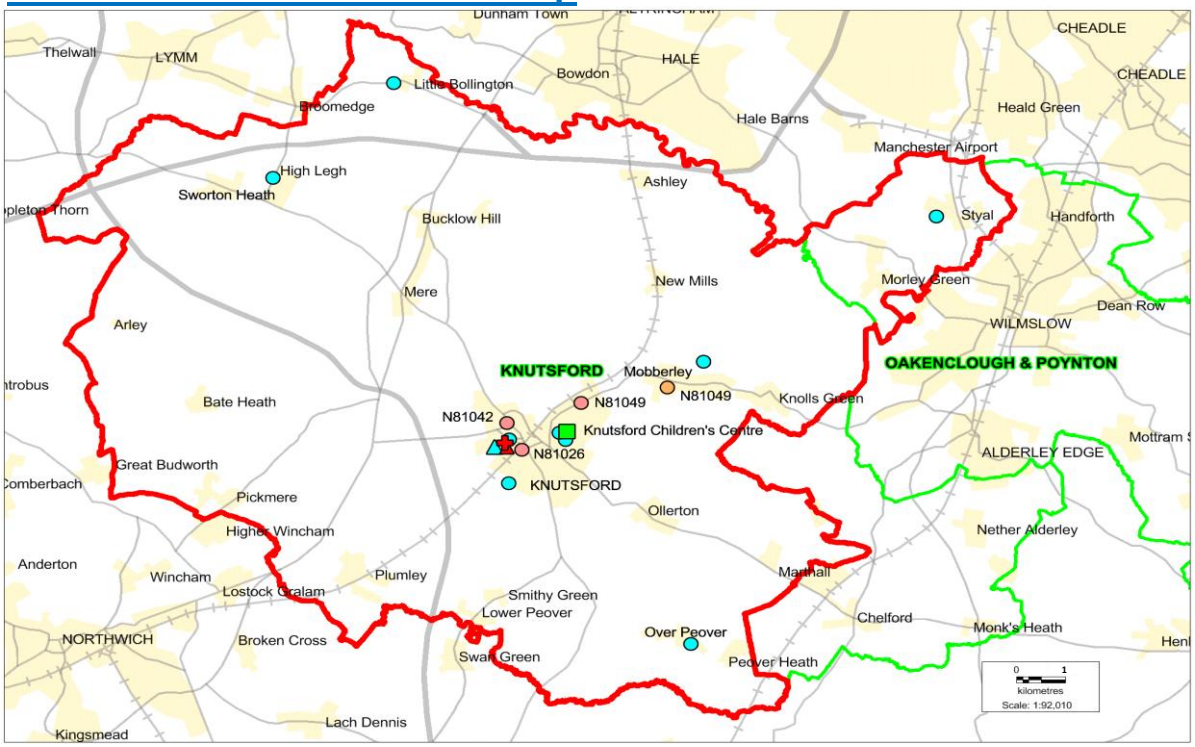
Aged <1	1119
Aged 1-4	4370
Aged 5-9	5058
Aged 10-14	4900
Aged 15-19	5754

Secondary Schools

Secondary Schools	Primary Schools			
Kings Grove School	Underwood West	Vine Tree	Wistaston Green	
Ruskin Sports College	Edleston	Gainsborough	Pebblebrook	
Shavington High School	Shavington	The Berkeley	Weston Village	
	Wistaston Church Lane	Wynbunbury Delves		
Sir William Stanier Community School	Beechwood School	Brierley	Hungerford	Leighton
	Mablins Lane	Monks Coppenhall	St Michael's Community	Warmingham
St Thomas More Catholic High School	St Mary's, Crewe	St Gabriels, Alsager	St Anne's, Nantwich	

Feeder school in another LAP

Knutsford Local Area Partnership



Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Knutsford LAP	265	4039	65.6

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Knutsford LAP	269	4039	66.6

Births within & outside marriage/ civil partnership, 2013

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
Knutsford LAP	210	100	32.3%

Registrations by lone mothers, 2013

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Knutsford LAP	13	11	8.9

Low Birth Weight (under 2500g) 2009-2011

Knutsford LAP	Babies with low birth weight	Total births in the 3 year period	Percentage (%)
Total LBW babies (2009-11)	56	903	6.2
LBW at term (2008-10)	15	757	2.0

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continu-ation %
Knutsford LAP	244	77.5	60.2

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Knutsford LAP	157	8	31
Percentage infants exposed to smoke		5.1%	19.7%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

Knutsford LAP	Number of infants	Number vaccinated	Uptake
Full primary course aged 1	250	247	98.8%
MMR 1st dose aged 2	282	274	97.2%
MMR 2nd dose aged 5	270	251	93.0%

The primary immunisation course consists of three vaccines protecting against diptheria, tetanus, pertussis, polio and *Haemophilus influenzae type b* (Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

Knutsford LAP	Total Maternities	Smoking Exposure	Exposure to Smoking %
<15-24	13	23	56.5%
25-29	14	53	26.4%
30-34	15	123	12.2%
35+	6	121	5.0%
Total	**48**	**320**	**15.0%**

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Key to GP practice codes

N81049 - Annandale
N81042 - Manchester Road
N81026 - Toft Road

Knutsford Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

Knutsford LAP	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	1449	164	11.3
Males aged 0-4	751	97	13.0
Females aged 0-4	698	67	9.6

Emergency Admissions for Injury, aged 0-4, 2011-2014

Knutsford LAP	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	1449	17	1.2
Males aged 0-4	751	10	1.3
Females aged 0-4	698	7	1.0

Total A&E Attendances aged <1 year, 2011-2014

Knutsford LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	140	61	43.3
Females under 1 year	146	33	22.8

Total Emergency Admissions aged <1 year, 2011-2014

Knutsford LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	140	70	50.0
Females under 1 year	146	44	29.9

A&E Attendance for injury, average per year for 2011-14

Knutsford LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	15	5.4	6.9
1-4	149	12.8	14.6
5-9	134	10.4	11.0
10-14	159	12.7	15.6
15-19	139	11.0	13.9
0-19	597	11.4	13.4

A&E Attendance non-injury, average per year for 2011-14

Knutsford LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	79	27.6	29.4
1-4	202	17.4	19.1
5-9	134	10.3	9.9
10-14	159	12.7	12.4
15-19	198	15.7	17.0
0-19	772	14.7	15.1

Emergency admissions for injury, av'g per year for 2011-14

Knutsford LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	1	0.5	1.2
1-4	16	1.4	1.0
5-9	9	0.7	0.8
10-14	6	0.5	0.8
15-19	13	1.1	0.8
0-19	46	0.9	0.9

Emergency admissions non-injury, av'g per year for 2011-14

Knutsford LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	112	39.3	40.6
1-4	134	11.6	11.6
5-9	51	4.0	3.6
10-14	40	3.2	3.2
15-19	61	4.8	5.3
0-19	399	7.6	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalance rates applied to local population to give estimated numbers.

Knutsford LAP	Total
Oral Thrush (aged 0-4)	14
Impetigo (aged 0-4)	86
Headlice (aged 4-11)	271
Acne (aged 12-19)	1709
Eczema (aged 0-19)	920
Conjunctivitis (aged 0-19)	74

Children aged 6m to 19y with long term conditions

Knutsford LAP	6mths-<16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	145	183	3.5%
Heart disease	36	45	0.9%
Neurological disease	19	23	0.4%
Diabetes	6	8	0.1%

Daily activity affected by long term illness/disability 2011

Knutsford LAP	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	0.9%	1.7%	97.4%
Young people aged 16-19	1.8%	3.3%	94.9%

Ethnicity aged 0-24 Census data 2011

Knutsford LAP	Total	Percentage
White	5,865	94.4%
Asian/Asian British	134	2.2%
African/Carib/Black British	22	0.4%
Other ethnic group	17	0.3%
Mixed/multiple ethnic	172	2.8%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	1449	
Aged 5-11	1798	(Primary age range)
Aged 12-16	1275	(Secondary age range)
Aged 17-19	736	
Total aged 0-19	5258	

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	286
Aged 1-4	1163
Aged 5-9	1295
Aged 10-14	1256
Aged 15-19	1258

Secondary Schools

Knutsford Academy

Primary Schools

Bexton, Egerton, High Legh, Little Bollington, Manor Park, Mobberley

St Nicholas Catholic, Northwich

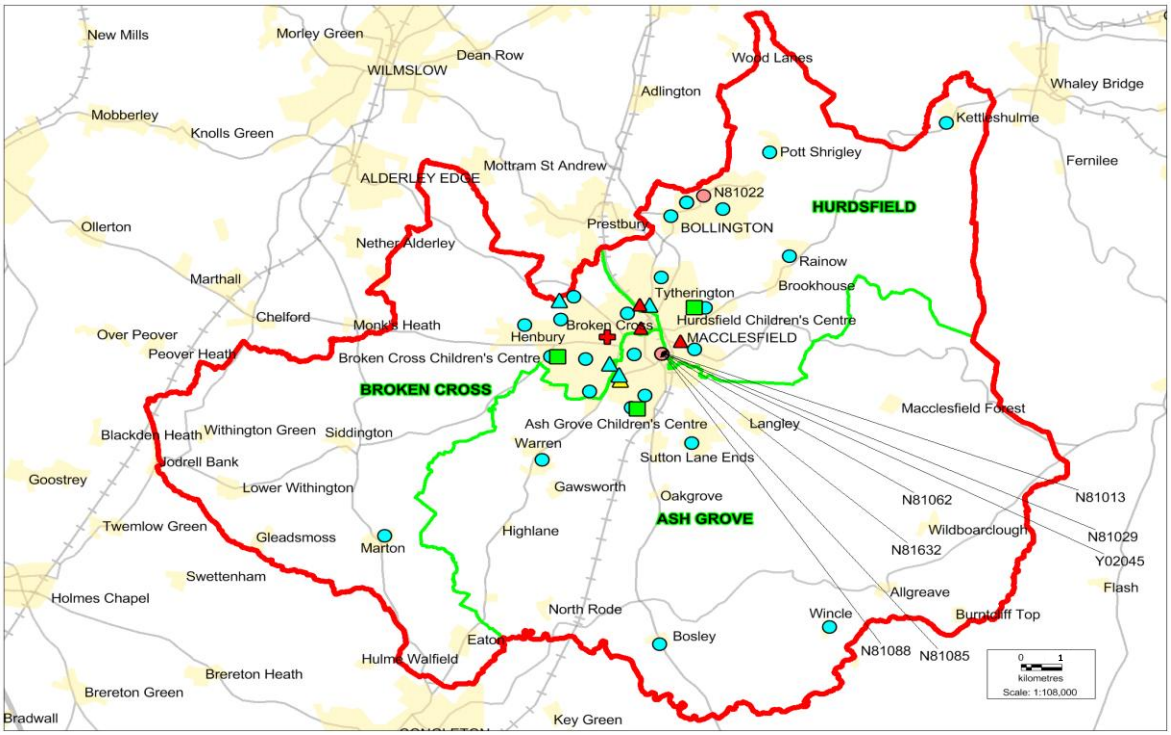
St Vincent de Paul Catholic

St Mary's, Middlewich

Secondary school in CWAC council

Feeder school in another LAP

Macclesfield Local Area Partnership



Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Macclesfield LAP	743	12498	59.4

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Macclesfield LAP	748	12498	59.8

Births within & outside marriage/ civil partnership, 2013

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
Macclesfield LAP	421	369	46.7%

Registrations by lone mothers, 2013

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Macclesfield LAP	56	38	12.6

Low Birth Weight (under 2500g) 2009-2011

Macclesfield LAP	Babies with low birth weight	Total births in the 3 year period	Percentage (%)
Total LBW babies (2009-11)	148	2293	6.5
LBW at term (2008-10)	44	2075	2.1

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continu-ation %
Macclesfield LAP	780	67.9	43.8

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Macclesfield LAP	703	93	234
Percentage infants exposed to smoke		13.2%	33.3%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

Macclesfield LAP	Number of infants	Number vaccinated	Uptake
Full primary course aged 1	788	762	96.7%
MMR 1st dose aged 2	861	823	95.6%
MMR 2nd dose aged 5	799	692	86.6%

The primary immunisation course consists of three vaccines protecting against diptheria, tetanus, pertussis, polio and *Haemophilus influenzae type b (* Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

Macclesfield LAP	Total Maternities	Smoking Exposure	Exposure to Smoking %
Aged <15-19	32	44	72.7%
Aged 20-24	132	237	55.7%
Aged 25-29	124	359	34.5%
Aged 30-34	72	454	15.9%
Aged 35-39	42	304	13.8%
Aged 40+	18	88	20.5%
Total	**420**	**1486**	**28.3%**

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Key to GP practice codes

N81022 - Bollington
N81013 - High Street
N81029 - South Park
N81632 - Broken Cross
N81085 - Park Lane
N81088 - Park Green
N81062 - Cumberland House
Y02045 - Verona Health Care

Macclesfield Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

Macclesfield LAP	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	3976	660	16.6
Males aged 0-4	2059	390	18.9
Females aged 0-4	1917	270	14.1

Emergency Admissions for Injury, aged 0-4, 2011-2014

Macclesfield LAP	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	3976	50	1.3
Males aged 0-4	2059	28	1.4
Females aged 0-4	1917	22	1.1

Total A&E Attendances aged <1 year, 2011-2014

Macclesfield LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	434	193	44.4
Females under 1 year	403	159	39.5

Total Emergency Admissions aged <1 year, 2011-2014

Macclesfield LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	434	249	57.5
Females under 1 year	403	199	49.3

A&E Attendance for injury, average per year for 2011-14

Macclesfield LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	78	9.3	6.9
1-4	582	18.6	14.6
5-9	488	13.3	11.0
10-14	707	18.4	15.6
15-19	689	18.4	13.9
0-19	2545	16.7	13.4

A&E Attendance non-injury, average per year for 2011-14

Macclesfield LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	277	33.1	29.4
1-4	661	21.1	19.1
5-9	429	11.7	9.9
10-14	589	15.3	12.4
15-19	871	23.2	17.0
0-19	2827	18.5	15.1

Emergency admissions for injury, av'g per year for 2011-14

Macclesfield LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	9	1.1	1.2
1-4	35	1.1	1.0
5-9	35	1.0	0.8
10-14	32	0.8	0.8
15-19	37	1.0	0.8
0-19	149	1.0	0.9

Emergency admissions non-injury, av'g per year for 2011-14

Macclesfield LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	439	52.4	40.6
1-4	461	14.7	11.6
5-9	176	4.8	3.6
10-14	169	4.4	3.2
15-19	232	6.2	5.3
0-19	1477	9.7	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalance rates applied to local population to give estimated numbers.

Macclesfield LAP	Total
Oral Thrush (aged 0-4)	42
Impetigo (aged 0-4)	244
Headlice (aged 4-11)	771
Acne (aged 12-19)	5245
Eczema (aged 0-19)	2669
Conjunctivitis (aged 0-19)	214

Children aged 6m to 19y with long term conditions

Macclesfield LAP	6mths-<16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	439	559	3.7%
Heart disease	82	103	0.7%
Neurological disease	37	47	0.3%
Diabetes	35	45	0.3%

Daily activity affected by long term illness/disability 2011

Macclesfield LAP	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	1.3%	2.2%	96.5%
Young people aged 16-19	2.0%	3.3%	94.7%

Ethnicity aged 0-24 Census data 2011

Macclesfield LAP	Total	Percentage
White	17,715	95.1%
Asian/Asian British	422	2.3%
African/Carib/Black British	44	0.2%
Other ethnic group	31	0.2%
Mixed/multiple ethnic	411	2.2%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	3976	
Aged 5-11	5106	(Primary age range)
Aged 12-16	3987	(Secondary age range)
Aged 17-19	2184	
Total aged 0-19	15253	

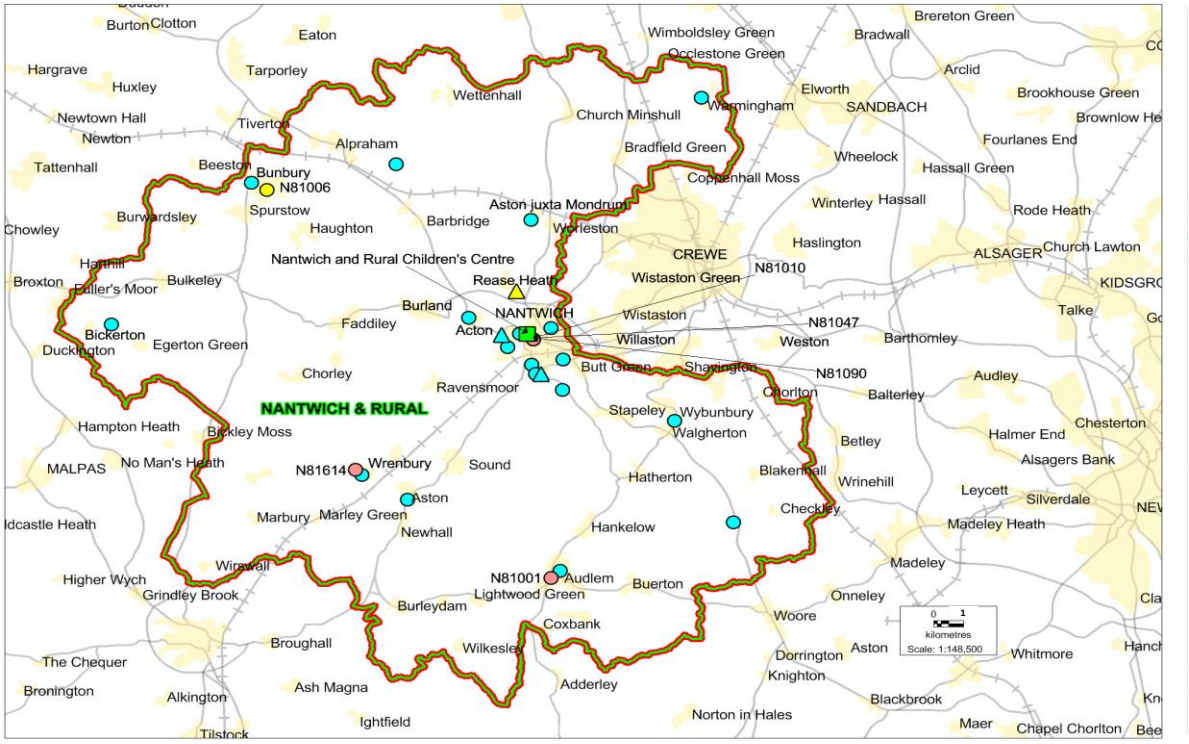
Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	837
Aged 1-4	3139
Aged 5-9	3678
Aged 10-14	3844
Aged 15-19	3755

Secondary Schools	Primary Schools			
All Hallows Catholic College	Christ the King Catholic/ CE	St Alban's Catholic	St Benedicts	
	St Gregory's Catholic	St John the Evangleist CE	St Mary's, Congleton	St Paul's (Poyn)
The Fallibroome Academy	Bollinbrook	Broken Cross	Mottram St Andrew	
	Nether Alderley	Prestbury CE	Upton Priory	Whirley
The Macclesfield Academy	Ash Grove	Broken Cross	Gawsworth	Hollinhey
	Ivy Bank	Parkroyal	Puss Bank	
	St John the Evangleist CE	Whirley	Wincle CE	
Tytherington High School	Bollington Cross	Bollington St John's CE	Dean Valley	Hursdfield
	Kettleshulme	Parkroyal	Puss Bank	Rainow
	The Marlborough			

Feeder school in another LAP

Nantwich Local Area Partnership



Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Nantwich LAP	325	5968	54.5

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Nantwich LAP	327	5968	54.8

Births within & outside marriage/ civil partnership, 2013

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
Nantwich LAP	207	103	33.2%

Registrations by lone mothers, 2013

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Nantwich LAP	17	6	7.0

Low Birth Weight (under 2500g) 2009-2011

Nantwich LAP	Babies with low birth weight	Total births in the 3 year period	Percentage (%)
Total LBW babies (2009-11)	60	961	6.2
LBW at term (2008-10)	21	904	2.3

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continu-ation %
Nantwich LAP	238	64.3	43.7

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Nantwich LAP	274	30	70
Percentage infants exposed to smoke		10.9%	25.5%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

Nantwich LAP	Number of infants	Number vaccinated	Uptake
Full primary course aged 1	302	285	94.4%
MMR 1st dose aged 2	267	258	96.6%
MMR 2nd dose aged 5	323	305	94.4%

The primary immunisation course consists of three vaccines protecting against diptheria, tetanus, pertussis, polio and *Haemophilus influenzae type b* (Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

Nantwich LAP	Total Maternities	Smoking Exposure	Exposure to Smoking %
Aged <15-19	16	19	84.2%
Aged 20-24	37	69	53.6%
Aged 25-29	40	132	30.3%
Aged 30-34	32	175	18.3%
Aged 35-39	20	115	17.4%
Aged 40+	7	37	18.9%
Total	**152**	**547**	**27.8%**

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Key to GP practice codes

N81066 - Bunbury
N81614 - Wrenbury
N81001 - Audlem
N81010 - Nantwich
N81047 - Kiltearn
N81090 - Tudor

Nantwich Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

Nantwich LAP	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	1781	161	9.0
Males aged 0-4	927	92	10.0
Females aged 0-4	854	68	8.0

Emergency Admissions for Injury, aged 0-4, 2011-2014

Nantwich LAP	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	1781	19	1.1
Males aged 0-4	927	11	1.2
Females aged 0-4	854	8	0.9

Total A&E Attendances aged <1 year, 2011-2014

Nantwich LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	175	42	24.2
Females under 1 year	172	34	20.0

Total Emergency Admissions aged <1 year, 2011-2014

Nantwich LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	175	63	36.0
Females under 1 year	172	42	24.6

A&E Attendance for injury, average per year for 2011-14

Nantwich LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	16	4.7	6.9
1-4	144	10.1	14.6
5-9	172	8.5	11.0
10-14	227	11.3	15.6
15-19	224	10.3	13.9
0-19	783	9.8	13.4

A&E Attendance non-injury, average per year for 2011-14

Nantwich LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	60	17.4	29.4
1-4	214	14.9	19.1
5-9	143	7.1	9.9
10-14	165	8.2	12.4
15-19	251	11.5	17.0
0-19	833	10.4	15.1

Emergency admissions for injury, av'g per year for 2011-14

Nantwich LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	3	0.9	1.2
1-4	14	1.0	1.0
5-9	9	0.4	0.8
10-14	13	0.7	0.8
15-19	17	0.8	0.8
0-19	56	0.7	0.9

Emergency admissions non-injury, av'g per year for 2011-14

Nantwich LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	102	29.5	40.6
1-4	131	9.1	11.6
5-9	53	2.6	3.6
10-14	53	2.7	3.2
15-19	104	4.8	5.3
0-19	443	5.6	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalance rates applied to local population to give estimated numbers.

Nantwich LAP	Total
Oral Thrush (aged 0-4)	17
Impetigo (aged 0-4)	121
Headlice (aged 4-11)	421
Acne (aged 12-19)	2866
Eczema (aged 0-19)	1397
Conjunctivitis (aged 0-19)	112

Children aged 6m to 19y with long term conditions

Nantwich LAP	6mths-<16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	203	267	3.3%
Heart disease	65	83	1.0%
Neurological disease	23	30	0.4%
Diabetes	6	8	0.1%

Daily activity affected by long term illness/disability 2011

Nantwich LAP	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	1.2%	1.8%	97.0%
Young people aged 16-19	1.7%	1.9%	96.4%

Ethnicity aged 0-24 Census data 2011

Nantwich LAP	Total	Percentage
White	9,405	97.1%
Asian/Asian British	69	0.7%
African/Carib/Black British	21	0.2%
Other ethnic group	9	0.1%
Mixed/multiple ethnic	183	1.9%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	1781	
Aged 5-11	2827	(Primary age range)
Aged 12-16	2062	(Secondary age range)
Aged 17-19	1310	
Total aged 0-19	7980	

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	347
Aged 1-4	1434
Aged 5-9	2024
Aged 10-14	2000
Aged 15-19	2175

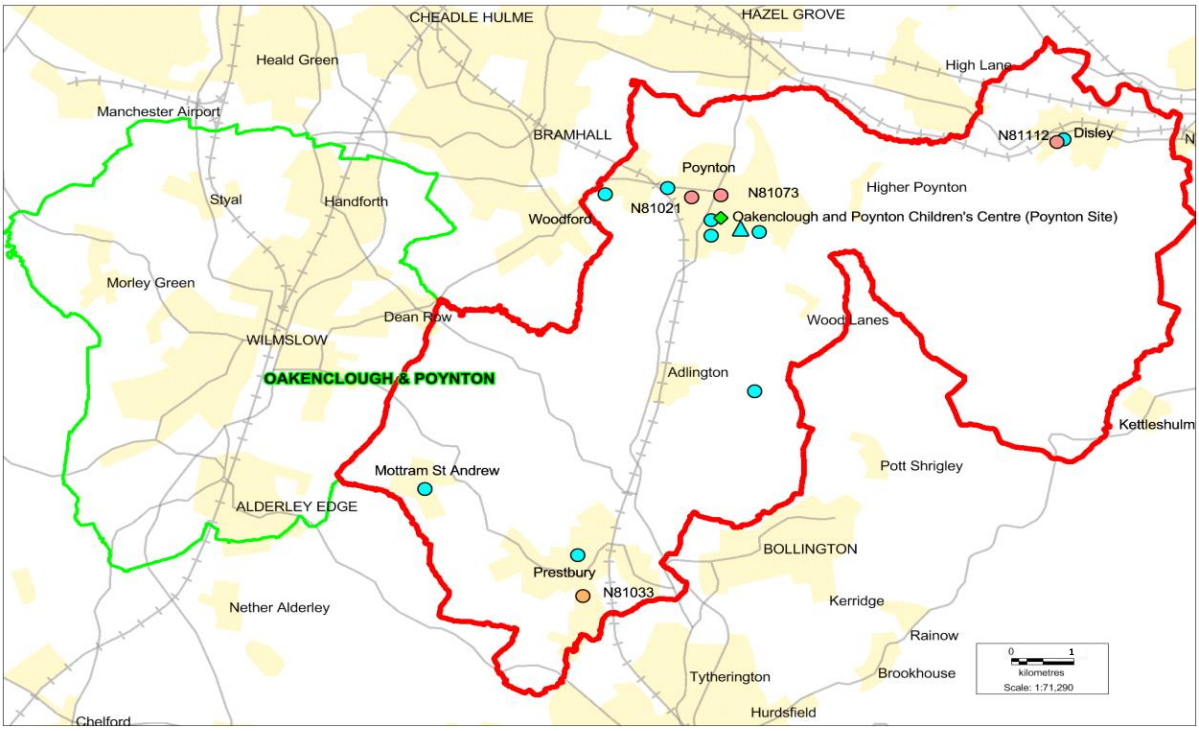
Secondary Schools	Primary Schools			
Brine Leas	Audlem St James	Bridgemere	Pear Tree	Sound and District
	Stapeley Broad Lane	Weaver	Wrenbury	Wyche
Malbank School and 6th Form Centre	Acton CE	Highfields	Millfields	St Oswalds
	Willaston			

Cheshire West and Chester Secondary's		
Bishop Heber High	Bickerton Holy Trinity	
Tarporley High	Bunbury Aldersey	Calveley

Secondary school in CWAC council

Feeder school in another LAP

Poynton Local Area Partnership



Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Poynton LAP	181	3362	53.8

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Poynton LAP	182	3362	54.1

Births within & outside marriage/ civil partnership, 2013

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
Poynton LAP	111	60	35.1%

Registrations by lone mothers, 2013

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Poynton LAP	5	6	6.0

Low Birth Weight (under 2500g) 2009-2011

Poynton LAP	Babies with low birth weight	Total births in the 3 year period	Percentage (%)
Total LBW babies (2009-11)	29	521	5.6
LBW at term (2008-10)	11	452	2.4

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continu-ation %
Poynton LAP	155	78.1	63.2

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Poynton LAP	82	s	7
Percentage infants exposed to smoke		s	8.5%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

Poynton LAP	Number of infants	Number vaccinated	Uptake
Full primary course aged 1	174	169	97.1%
MMR 1st dose aged 2	184	180	97.8%
MMR 2nd dose aged 5	204	193	94.6%

The primary immunisation course consists of three vaccines protecting against diptheria, tetanus, pertussis, polio and *Haemophilus influenzae type b (* Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012-2013

Poynton LAP	Total Maternities	Smoking Exposure	Exposure to Smoking %
<15-24	s	8	s
25-29	s	24	s
30-34	s	70	s
35+	s	74	s
Total	**13**	**176**	**7.4%**

s = data suppressed due to small numbers

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Key to GP practice codes

N81021 - McIlvride
N81033 - Prestbury (George Street branch surgery)
N81073 - Priorslegh
N81112 - Schoolhouse

Poynton Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

Poynton LAP	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	965	135	14.0
Males aged 0-4	484	83	17.1
Females aged 0-4	481	52	10.8

Emergency Admissions for Injury, aged 0-4, 2011-2014

Poynton LAP	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	965	11	1.1
Males aged 0-4	484	7	1.4
Females aged 0-4	481	4	0.8

Total A&E Attendances aged <1 year, 2011-2014

Poynton LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	79	44	55.3
Females under 1 year	80	28	34.6

Total Emergency Admissions aged <1 year, 2011-2014

Poynton LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	79	45	57.4
Females under 1 year	80	27	33.8

A&E Attendance for injury, average per year for 2011-14

Poynton LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	16	9.9	6.9
1-4	120	14.8	14.6
5-9	127	10.8	11.0
10-14	205	15.0	15.6
15-19	174	12.3	13.9
0-19	641	13.0	13.4

A&E Attendance non-injury, average per year for 2011-14

Poynton LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	56	35.0	29.4
1-4	130	16.2	19.1
5-9	74	6.3	9.9
10-14	123	9.0	12.4
15-19	193	13.6	17.0
0-19	576	11.7	15.1

Emergency admissions for injury, av'g per year for 2011-14

Poynton LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	3	1.7	1.2
1-4	7	0.9	1.0
5-9	8	0.7	0.8
10-14	14	1.0	0.8
15-19	9	0.6	0.8
0-19	41	0.8	0.9

Emergency admissions non-injury, av'g per year for 2011-14

Poynton LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	70	43.8	40.6
1-4	78	9.7	11.6
5-9	31	2.6	3.6
10-14	37	2.7	3.2
15-19	54	3.8	5.3
0-19	270	5.5	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalance rates applied to local population to give estimated numbers.

Poynton LAP	Total
Oral Thrush (aged 0-4)	8
Impetigo (aged 0-4)	73
Headlice (aged 4-11)	247
Acne (aged 12-19)	1928
Eczema (aged 0-19)	861
Conjunctivitis (aged 0-19)	69

Children aged 6m to 19y with long term conditions

Poynton LAP	6mths-<16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	165	218	4.4%
Heart disease	32	42	0.8%
Neurological disease	14	18	0.4%
Diabetes	8	11	0.2%

Daily activity affected by long term illness/disability 2011

Poynton LAP	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	1.3%	1.6%	97.0%
Young people aged 16-19	1.7%	2.3%	96.0%

Ethnicity aged 0-24 Census data 2011

Poynton LAP	Total	Percentage
White	5,620	96.0%
Asian/Asian British	87	1.5%
African/Carib/Black British	7	0.1%
Other ethnic group	15	0.3%
Mixed/multiple ethnic	123	2.1%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	965	
Aged 5-11	1687	(Primary age range)
Aged 12-16	1426	(Secondary age range)
Aged 17-19	842	
Total aged 0-19	4920	

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	159
Aged 1-4	806
Aged 5-9	1174
Aged 10-14	1363
Aged 15-19	1418

Secondary Schools

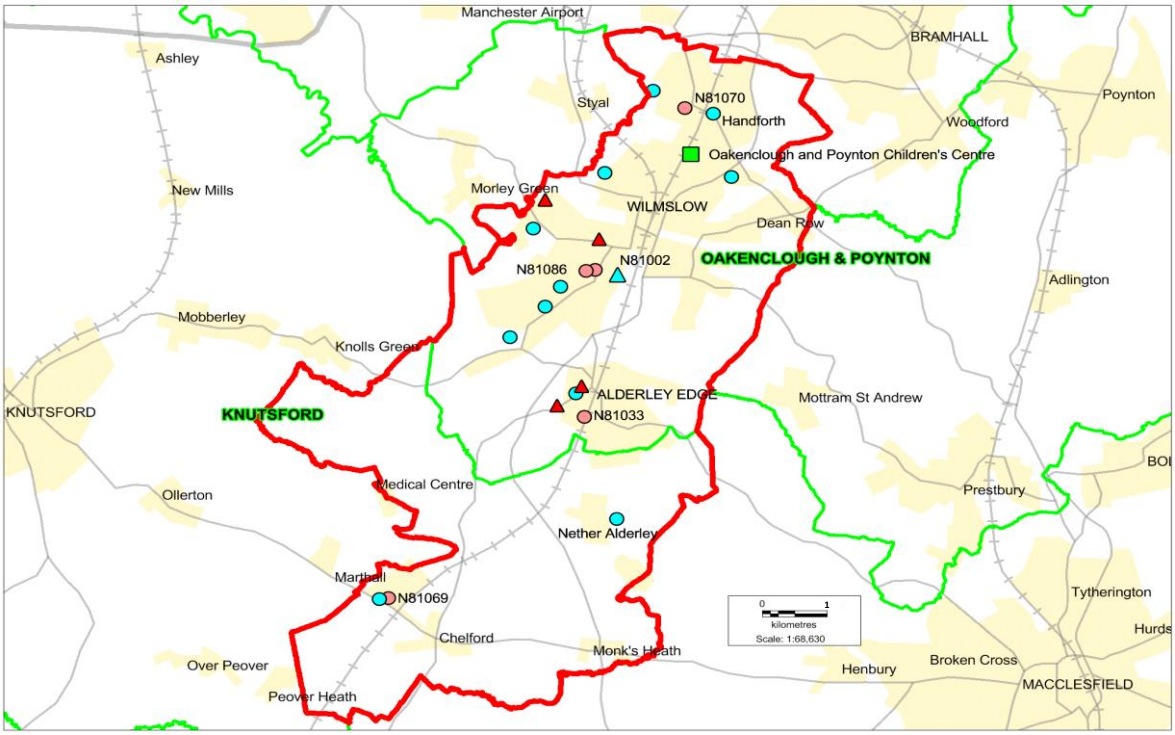
Poynton

Primary Schools

Adlington, Disley, Lostock Hall, Lower Park, Pott Shrigley, Vernon, Worth

Feeder school in another LAP

Wilmslow Local Area Partnership



Maternity rate per 1,000 women aged 15-44, 2013

	Maternities	Females (15-44)	Rate
Wilmslow LAP	438	6529	67.1

General Fertility Rate, 2013

	Live Births	Females (15-44)	General Fertility Rate
Wilmslow LAP	446	6529	68.3

Births within & outside marriage/ civil partnership, 2013

	Within marriage /civil partnership	Outside marriage /civil partnership	% outside marriage/ civil partner-ship
Wilmslow LAP	250	160	39.0%

Registrations by lone mothers, 2013

	Joint at different addresses	Sole registrations	% sole/joint registration different addresses
Wilmslow LAP	38	15	11.9

Low Birth Weight (under 2500g) 2009-2011

Wilmslow LAP	Babies with low birth weight	Total births in the 3 year period	Percentage (%)
Total LBW babies (2009-11)	67	1237	5.4
LBW at term (2008-10)	16	1100	1.5

Breastfeeding at birth and 6-8 weeks, 2012/13

	Number of births	Initiation %	Continu-ation %
Wilmslow LAP	372	79.8	57.8

Smoking at time of delivery, 2013

	Number of maternities	Women smoking at delivery	Household smoking exposure
Wilmslow LAP	251	20	54
Percentage infants exposed to smoke		8.0%	21.5%

Number of maternities reporting smoking at time of delivery and/or presence of other smokers in the household for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, 2013. This will exclude babies born elsewhere thereby reducing the number of maternities.

Immunisation uptake 2013/14

Wilmslow LAP	Number of infants	Number vaccinated	Uptake
Full primary course aged 1	498	484	97.2%
MMR 1st dose aged 2	476	457	96.0%
MMR 2nd dose aged 5	523	475	90.8%

The primary immunisation course consists of three vaccines protecting against diptheria, tetanus, pertussis, polio and *Haemophilus influenzae type b (* Hib) normally given at 2, 3 and 4 months.

Smoking exposure by age of mother, 2012/2013

Wilmslow LAP	Total Maternities	Smoking Exposure	Exposure to Smoking %
<15-24	21	33	63.6%
25-29	23	76	30.3%
30-34	22	192	11.5%
35+	26	199	13.1%
Total	**92**	**500**	**18.4%**

Number of maternities reporting smoking at time of delivery or presence of other smokers in household by age of mother for Mid Cheshire NHS Foundation Trust and East Cheshire NHS Trust, for the two years 2012 and 2013.

Key to GP practice codes

N81070 - Handforth
N81002 - Kenmore
N81086 - Wilmslow
N81033 - George Street Surgery
N81069 - Chelford Surgery

Wilmslow Local Area Partnership (continued)

A&E Attendances for Injury aged 0-4, 2011-2014

Wilmslow LAP	Aged 0-4	Attended per year	Percent (%)
Children aged 0-4	2120	257	12.1
Males aged 0-4	1088	147	13.5
Females aged 0-4	1032	110	10.7

Emergency Admissions for Injury, aged 0-4, 2011-2014

Wilmslow LAP	Aged 0-4	Admitted per year	Percent (%)
Children aged 0-4	2120	28	1.3
Males aged 0-4	1088	18	1.7
Females aged 0-4	1032	10	1.0

Total A&E Attendances aged <1 year, 2011-2014

Wilmslow LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	220	93	42.4
Females under 1 year	194	69	35.4

Total Emergency Admissions aged <1 year, 2011-2014

Wilmslow LAP	Aged under 1y	Attended per year	Percent (%)
Males under 1 year	220	90	40.8
Females under 1 year	194	78	40.2

A&E Attendance for injury, average per year for 2011-14

Wilmslow LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	29	7.1	6.9
1-4	228	13.4	14.6
5-9	214	9.7	11.0
10-14	295	12.9	15.6
15-19	240	11.6	13.9
0-19	1007	11.6	13.4

A&E Attendance non-injury, average per year for 2011-14

Wilmslow LAP	Attended per year	Percent (%)	Cheshire East (%)
under 1	134	32.3	29.4
1-4	329	19.3	19.1
5-9	216	9.9	9.9
10-14	258	11.3	12.4
15-19	284	13.7	17.0
0-19	1220	14.1	15.1

Emergency admissions for injury, av'g per year for 2011-14

Wilmslow LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	7	1.8	1.2
1-4	17	1.0	1.0
5-9	16	0.7	0.8
10-14	16	0.7	0.8
15-19	17	0.8	0.8
0-19	73	0.8	0.9

Emergency admissions non-injury, av'g per year for 2011-14

Wilmslow LAP	Admitted per year	Percent (%)	Cheshire East (%)
under 1	161	38.8	40.6
1-4	172	10.1	11.6
5-9	75	3.4	3.6
10-14	62	2.7	3.2
15-19	69	3.4	5.3
0-19	539	6.2	7.3

Estimates for Minor Ailment prevalence, 2013

Prevalance rates applied to local population to give estimated numbers.

Wilmslow LAP	Total
Oral Thrush (aged 0-4)	21
Impetigo (aged 0-4)	139
Headlice (aged 4-11)	456
Acne (aged 12-19)	2966
Eczema (aged 0-19)	1517
Conjunctivitis (aged 0-19)	121

Children aged 6m to 19y with long term conditions

Wilmslow LAP	6mths-<16yrs	6mths-19yrs	Percent (%) of 6m-19y
Respiratory disease	269	337	3.9%
Heart disease	90	111	1.3%
Neurological disease	21	26	0.3%
Diabetes	19	24	0.3%

Daily activity affected by long term illness/disability 2011

Wilmslow LAP	Activity limited a lot	Activity limited a little	Activity not limited
Children aged 0-15	0.9%	1.4%	97.7%
Young people aged 16-19	2.0%	2.3%	95.7%

Ethnicity aged 0-24 Census data 2011

Wilmslow LAP	Total	Percentage
White	9,072	89.7%
Asian/Asian British	501	5.0%
African/Carib/Black British	60	0.6%
Other ethnic group	86	0.9%
Mixed/multiple ethnic	396	3.9%

Population size for 0-19 year olds, school age groups, 2012

Aged 0-4	2120	
Aged 5-11	3061	(Primary age range)
Aged 12-16	2349	(Secondary age range)
Aged 17-19	1140	
Total aged 0-19	8670	

Population size for 0-19 year olds in 5 year bands, 2012

Aged <1	414
Aged 1-4	1706
Aged 5-9	2195
Aged 10-14	2289
Aged 15-19	2066

Secondary Schools

Wilmslow High

Primary Schools

Alderley Edge, Ashdene, Dean Oaks, Gorsey Bank, Lacey Green, Lindow, Nether Alderley, St Anne's Fulshaw, Styal, Wilmslow Grange

Feeder school in another LAP

Key for Local Area Partnership and Children's Centre maps

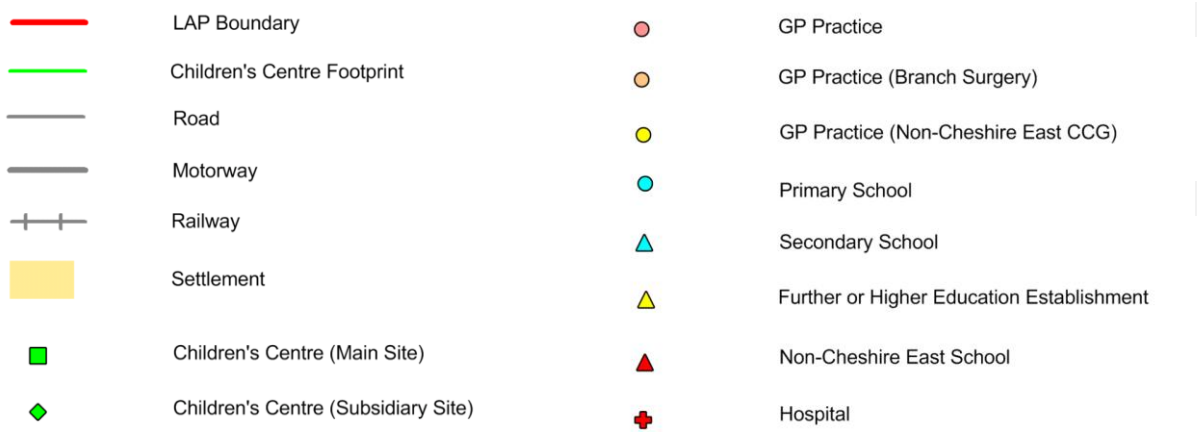


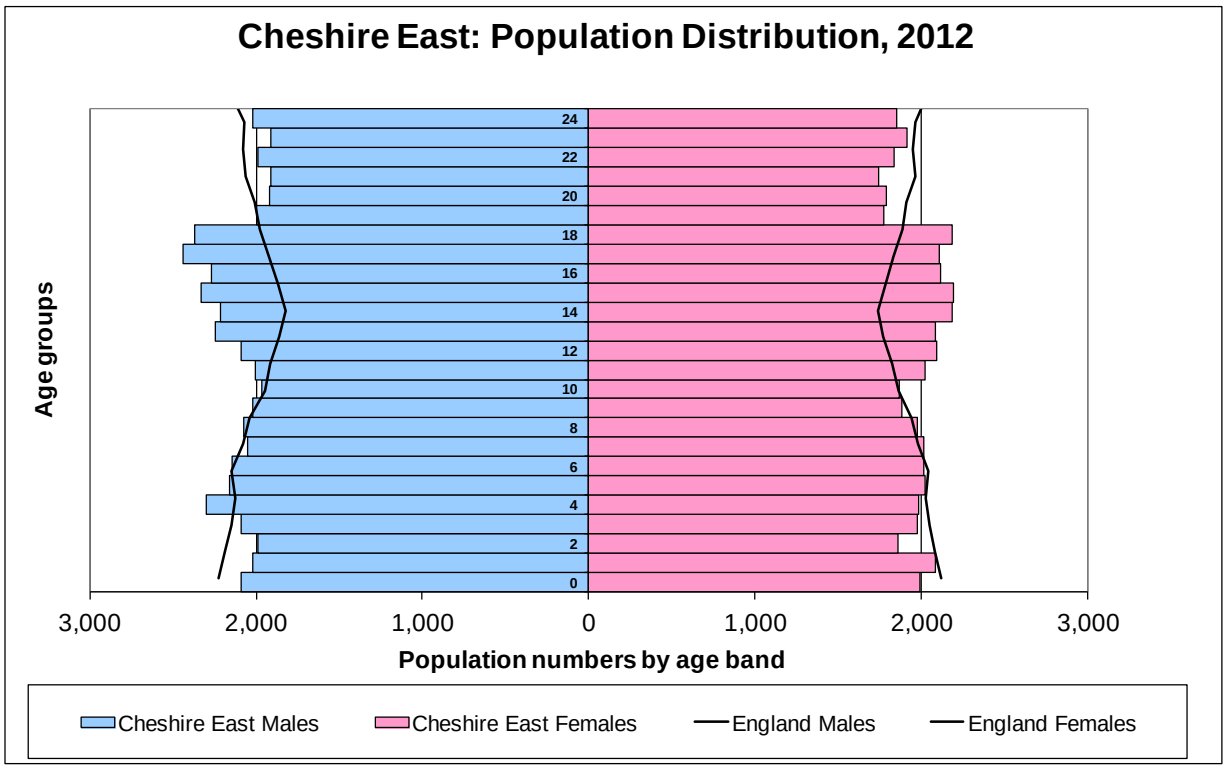
Table 8. Overview of Selected Indicators by Children's Centre

Children's Centre Footprints	Live Births 2013	Maternities 2013	GFR per 1000 2013	Maternity Rate per 1000 2013	Outside marriage or civil partnership (%) 2013	Sole registrations + Joint registrations different address 2013	Low Birth Weight <2500g (%) 2013	% Prenatal & postnatal tobacco smoke exposure 2012-2013	% Smoking at time of delivery 2013	Proportion of households fuel poor (%) 2012*	A&E attendances injury (%) 2011/12-2013/14	Breastfeeding Initiation 2010/11-2012/13**	Breastfeeding Continuation 2010/11-2012/13
Ash Grove	276	272	65.5	64.6	58.3	17.0	8.3	36.7	16.6	11.6	8.9	61.9	38.7
Broken Cross	255	256	62.5	62.8	45.5	12.5	4.3	26.7	12.3	8.1	10.8	68.2	43.5
Congleton	348	340	57.6	56.2	44.3	10.6	5.2	27.8	12.1	8.4	9.9	64.3	46.3
Hurdsfield	217	215	51.6	51.1	39.6	6.9	5.5	20.3	10.0	8.5	8.3	71.3	51.2
Knutsford	258	255	66.2	65.5	29.5	5.8	3.5	15.7	5.0	9.8	5.3	78.4	56.7
Monks Coppenhall	200	201	45.5	45.8	60.5	17.0	7.5	43.1	21.8	9.3	7.3	44.1	24.1
Nantwich & Rural	327	325	54.8	54.5	38.2	7.0	5.8	27.8	10.9	10.4	4.7	67.0	42.9
Oak Tree	397	391	71.4	70.4	66.8	19.4	8.5	50.0	24.6	11.6	5.6	41.3	25.4
Oakenclough & Poynton	639	629	63.7	62.7	35.2	11.4	7.2	15.2	6.4	8.5	7.9	76.8	55.9
Sandbach Alsager Middlewich	459	457	49.8	49.6	48.6	10.0	3.9	32.3	12.6	7.8	4.0	62.3	38.3
The Brooks	394	393	53.1	53.0	56.9	14.2	8.6	38.7	16.1	12.0	6.6	58.6	35.0
Cheshire East	**3770**	**3734**	**58.0**	**57.4**	**47.1**	**12.1**	**6.3**	**31.6**	**14.0**	**9.5**	**6.9**	**62.9**	**41.6**

* Fuel Poverty is calculated using the Low Income High Costs (LIHC) definition

**Local Breastfeeding initiation rates are self-reported and, therefore, not directly comparable with national rates.

Population Information



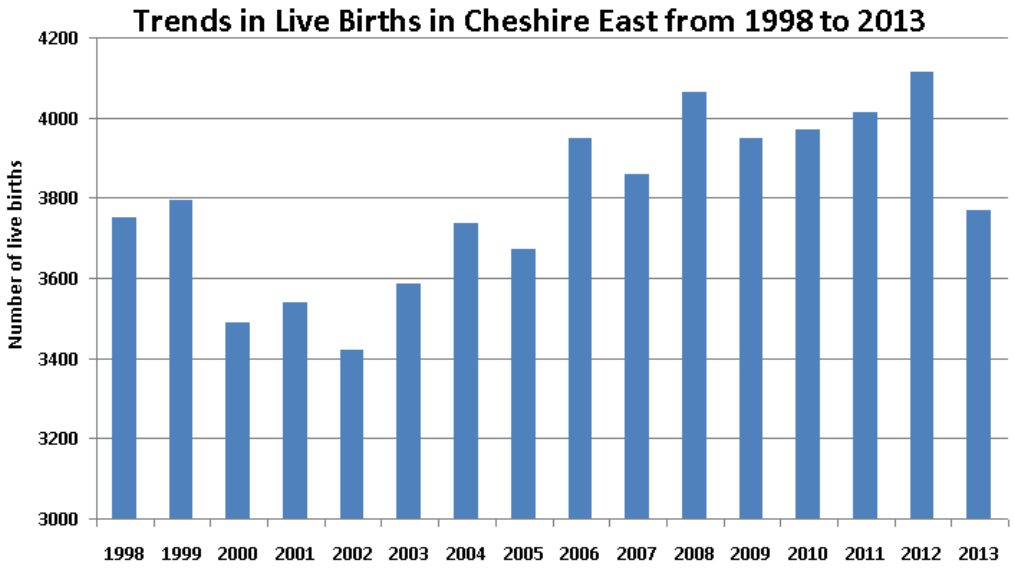
Source: ONS single year of age population estimates, mid-2012

Notes: England population comparator derived by applying England age and sex proportions to Cheshire East populations in order to scale.

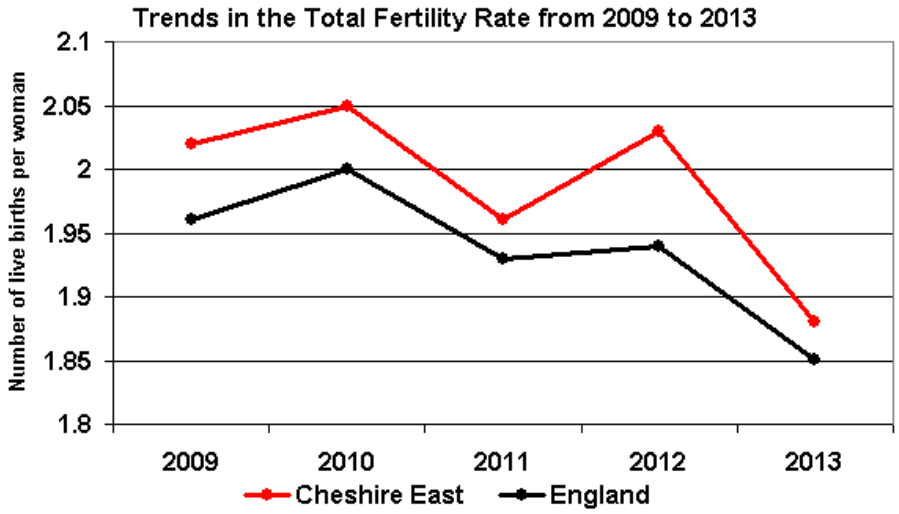
Ages	Males		Females	
	Population	Percentage of total	Population	Percentage of total
0	2093	2.05	1991	1.95
1	2022	1.98	2089	2.04
2	1991	1.95	1857	1.82
3	2093	2.05	1975	1.93
4	2301	2.25	1985	1.94
5	2162	2.12	2026	1.98
6	2143	2.10	2015	1.97
7	2048	2.00	2014	1.97
8	2074	2.03	1978	1.94
9	2024	1.98	1886	1.85
10	1968	1.93	1869	1.83
11	2001	1.96	2021	1.98
12	2092	2.05	2095	2.05
13	2244	2.20	2083	2.04
14	2211	2.16	2188	2.14
15	2331	2.28	2195	2.15
16	2267	2.22	2117	2.07
17	2437	2.38	2112	2.07
18	2370	2.32	2185	2.14
19	1995	1.95	1775	1.74
20	1917	1.88	1791	1.75
21	1913	1.87	1743	1.71
22	1990	1.95	1841	1.80
23	1908	1.87	1916	1.87
24	2018	1.97	1854	1.81

Births in Cheshire East in 2013

There were 3,770 live births in Cheshire East in 2013 compared with 4,112 in 2012 (a fall of 342 or 8.3%). This is the largest single year fall in births in recent years, and is greater than the fall of 307 births that occurred between 1999 and 2000. It is the lowest number of births since 2005 (3,672 births) and represents a marked difference from the trend of increasing numbers of births in Cheshire East since 2002 (live births rose overall by 20.2% between 2002 and 2012).



The fall in live births was not just a local phenomenon; nationally live births fell by 4.3% between 2012 and 2013. Changes in childbearing patterns from year to year can be assessed using the total fertility rate (TFR), which measures the average number of births per woman based on current patterns of fertility. In Cheshire East, the TFR has been consistently above that of England, although in 2012 it rose unexpectedly, largely due to births among women in their thirties. The TFR then decreased from an average of 2.03 births per woman in 2012 to 1.88 in 2013. Across the same period, the TFR in England fell from 1.94 to 1.85.

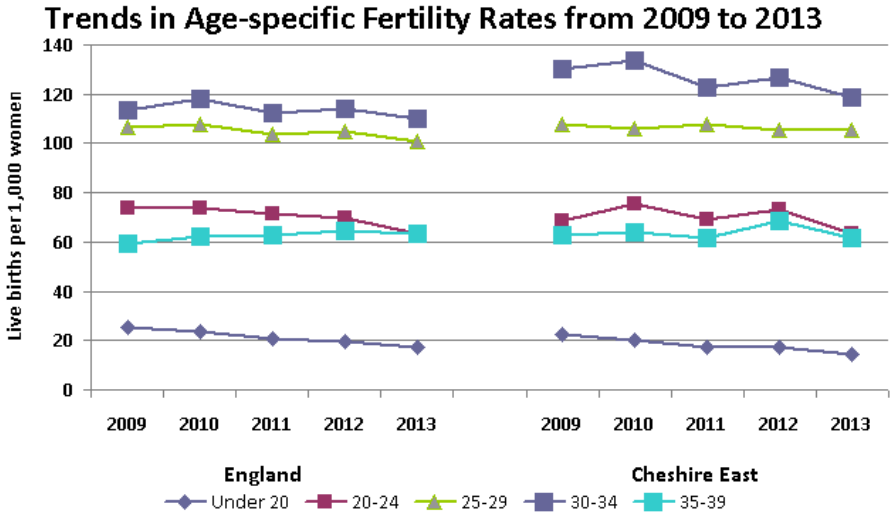


The general fertility rate (GFR) is another measure of an area's birth rate and represents the number of live births per 1,000 women aged 15 to 44. Unlike the TFR, this measure can be calculated for

local areas within Cheshire East. In 2013, the areas with the highest GFR were Wilmslow (71.8 per 1,000) and Knutsford (69.4 per 1,000); the lowest GFR occurred in the rural areas of NHS South Cheshire CCG (46.0 per 1,000), Sandbach (47.6 per 1,000) and Alsager (49.0 per 1,000). Fertility rates in NHS Eastern Cheshire CCG were 12.7% higher than those in NHS South Cheshire CCG.

Public health has not yet received information to calculate the local GFR rates for 2012, so is only able to comment on changes in GFR between 2011 (4,013 births) and 2013. Wilmslow was the only area that experienced an increase in fertility rates between these two time periods (from 63.0 to 71.8). The GFR remained stable in Middlewich, Sandbach, Poynton and the rural areas of NHS Eastern Cheshire CCG, but fell in all other areas.

The decrease in fertility between 2012 and 2013 was seen in all age groups, with the largest percentage decreases of 17.9% and 13.4% respectively seen in women aged under 20 and 20-24 . The smallest decrease in fertility (0.5%) was in women aged 25-29. Women in this and the 30-34 age group continue to have the highest fertility rates, with rates that are 4.1% and 8.2% higher than England.



In 2013, nearly half of all babies were born outside marriage or civil partnership (47.1%). This represents no change from 2012 and is consistent with the high proportion of couples cohabiting rather than entering into marriage or civil partnership.

Stillbirths

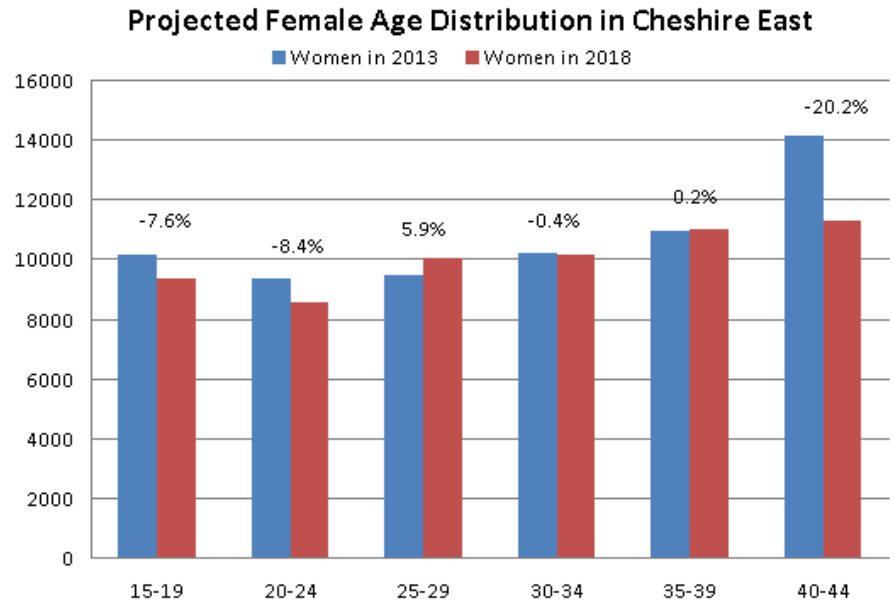
A stillbirth is defined as a baby born after 24 weeks completed gestation which did not, at any time, breathe or show signs of life. In 2013, there were 15 stillbirths from a total of 3785 births, which represents a rate of 3.96 per thousand births. In 2012, there were 19 stillbirths out of 4135 births, a rate of 4.6 per thousand births. In England, the stillbirth rate fell from 4.9 in 2012 to 4.7 in 2013.

The NHS Outcomes Framework contains an indicator aimed at reducing the number of stillbirths in England. The key risk factors for stillbirth include maternal obesity, smoking, and fetal growth restriction. The Department of Health is working on a stillbirth programme with the stillbirth and neonatal death charity (Sands) and a number of key organisations such as NHS England, Public Health England, the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists. The programme aims to raise awareness and minimise these risk factors.

Birth projections

The number of births in a given year is dependent on the number of women in the key childbearing ages (15–44 years) and on fertility rates in that year. Predicting the future number of live births

therefore depends on these two main factors. The number of women in the population can be predicted with some degree of certainty, but their future decisions around childbearing are much less easy to predict.

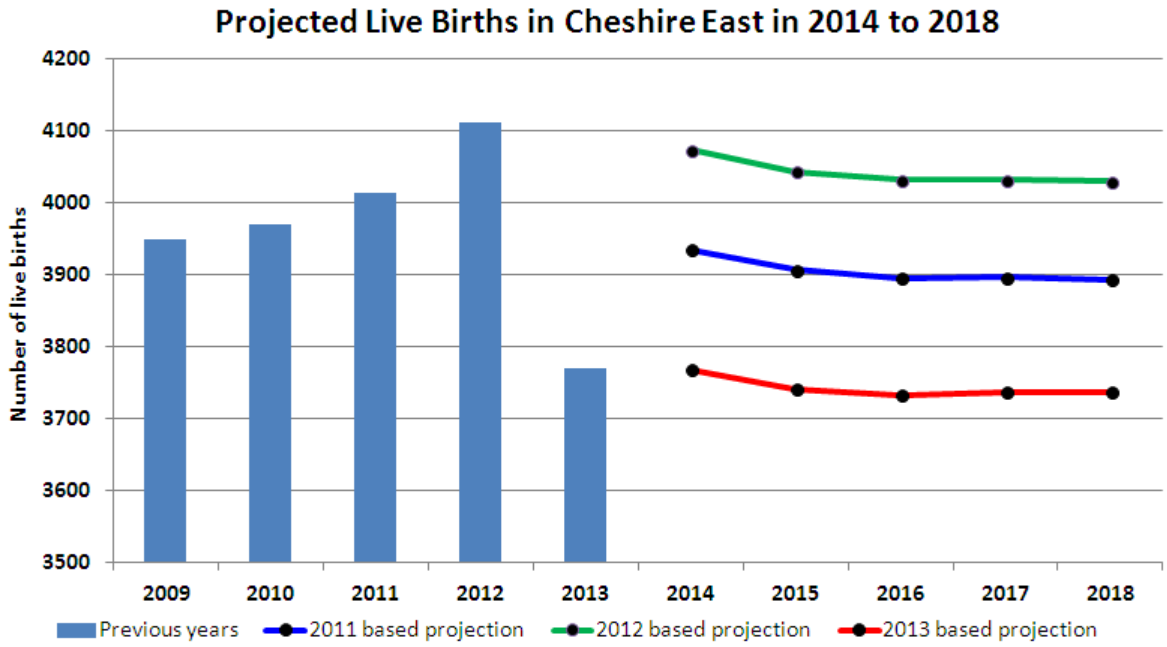


Population projections

Population projections suggest that between 2013 and 2018 the number of women in the childbearing age groups will change as shown above. The number of women aged 25 to 29 is predicted to increase by around 5.9%, but other age groups will either remain stable or reduce. If birth rates remain constant, these population changes would lead to a slight decline in live births.

It is not possible to determine at this stage whether the fall in the birth rate and the number of live births in 2013 represents an end to the increase in births since 2002. Uncertainty about employment, as well as significant changes in the benefits system announced in 2011 and 2012 may have influenced decisions around childbearing. These factors, and others, may persist into 2014 and beyond and influence birth rates to remain at the low levels seen in 2013. However, it is also possible that birth rates may return to the higher levels seen in previous years.

The diagram illustrates the number of live births that might occur over the next five years using three alternative scenarios based on the 2011, 2012 and 2013 age-specific birth rates. The birth rates in Cheshire East in 2012 were unexpectedly high, and so the 2012-based projection (green line) is considered to be the least likely of the three scenarios. For planning purposes, the blue and red lines best represent the upper and lower range of births that might occur in each of the next five years.

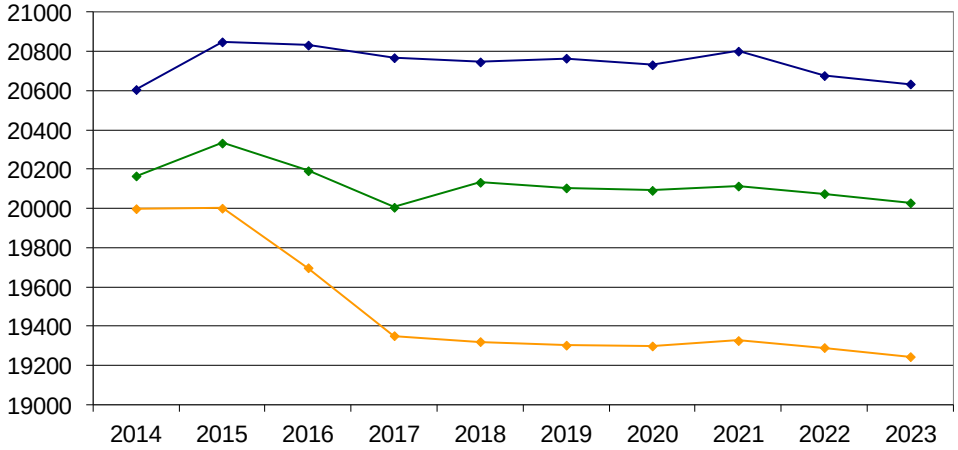


Source: Public Health Birth File 2009-2013; 2012-based population forecasts for Cheshire East, Cheshire West and Chester Council; ONS mid-2012 population estimates

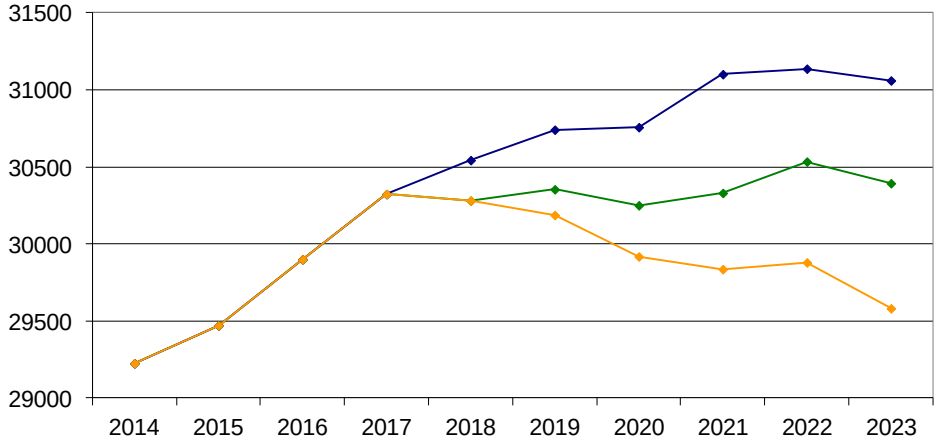
We have used these three scenarios for the number of future births in Cheshire East to create variant population projections that illustrate the possible differences in the number of 0-4 year olds and 5-11 year olds during the ten year period between 2014 and 2023.

The future size of the 0-4 year old population carries the greatest level of uncertainty. By 2017 the size of the 0-4 year old population (20,397 children in 2012) might be as few as 19,400 children or as many 20,700 children, and it may either remain stable thereafter or be somewhere between these figures. The primary school age population of 5-11 year olds (28,229 children in 2012) is projected to rise progressively to around 30,300 children in 2017, but thereafter may either increase, stay the same, or decrease depending on the three different birth scenarios.

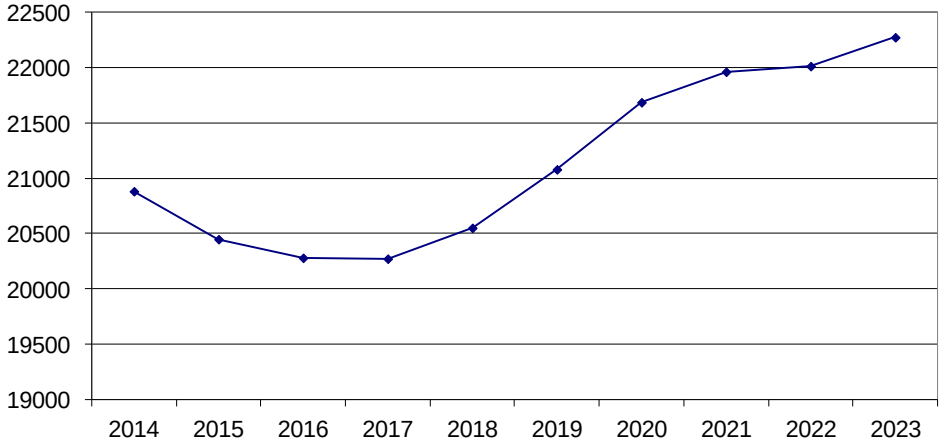
Population projections 0-19 year olds



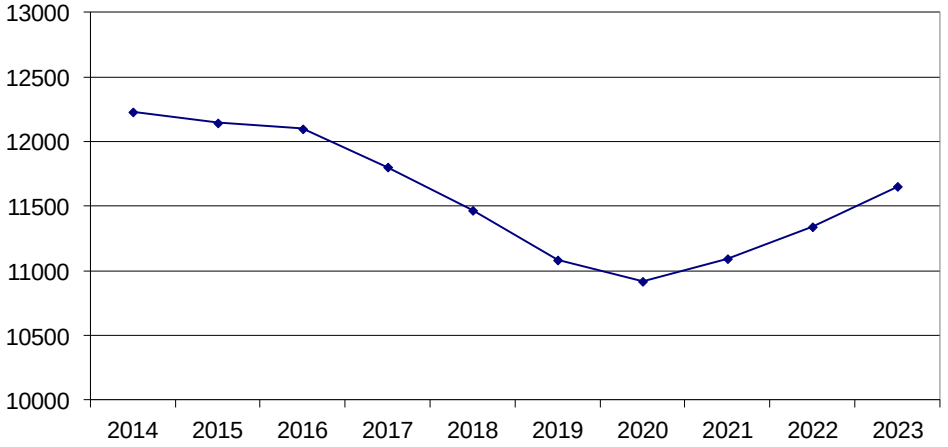
0-4 year olds



5-11 year olds



12-16 year olds



17-19 year olds

Projections based on 2011 live births
2012 based population projections
Projections based on 2013 live births

Analysis of hospital activity within Cheshire East's APHR2014

Pseudo-anonymised patient-level data for 3 financial years, 2011/12 – 2013/14, where the patient was aged between 0-24 years at the time of attendance or admission was provided via the two Clinical Commissioning Groups within Cheshire East.

The Hospital admissions data was analysed in two different ways:-

1. Data was initially analysed by the ICD10 groupings within the analysis presented in the PHE report 'Reducing unintentional injuries in and around the home among children under fives' and accompanying slides published in June 2014 https://www.gov.uk/government/publications/reducing-unintentional-injuries-among-children-and-young-people. See Table 10

2. A frequency distribution of Primary Diagnosis codes was done to identify the common reasons for admission. This was used to group relevant ICD10 codes. See Table 11

Accident and Emergency (A&E) data

A&E data was initially analysed using the A&E diagnosis 2 character codes. This was grouped further to enable comparison with the analysis presented in the PHE report 'Reducing unintentional injuries in and around the home among children under fives' and accompanying slides published in June 2014 https://www.gov.uk/government/publications/reducing-unintentional-injuries-among-children-and-young-people. See Table 9

Table 9. Diagnostic groupings used in A&E Attendance analysis

	A&E diagnosis code	Description	Grouping 1
A&E Injuries	1	Laceration	Cuts, grazes, foreign bodies
	2	Contusion/Abrasion	Cuts, grazes, foreign bodies
	4	Head injury	Head injury
	5	Dislocation/Fracture/Joint Injury/Amputation	Fractures and dislocations
	6	Sprain/ligament injury	Other injuries
	7	Muscle/tendon injury	Other injuries
	8	Nerve injury	Other injuries
	9	Vascular injury	Other injuries
	10	Burns and scalds	Burns and scalds
	11	Electric shock	Other injuries
	12	Foreign body	Cuts, grazes, foreign bodies
	13	Bites/stings	Other injuries
	14	Poisoning (inc overdose)	Poisoning
	15	Near drowning	Other injuries
	16	Visceral injury	Other injuries
A&E non-injuries	3	Soft tissue inflammation	Infection & inflammation
	17	Infectious disease	Infection & inflammation
	18	Local infection	Infection & inflammation
	19	Septicaemia	Infection & inflammation
	20	Cardiac conditions	Circulatory
	21	Cerebrovascular conditions	Circulatory
	22	Other vascular conditions	Circulatory
	23	Haematological conditions	Other
	24	Central nervous system conditions	Other
	25	Respiratory conditions	Respiratory
	26	Gastrointestinal conditions	Gastrointestinal
	27	Urological conditions (inc cystitis)	Genitourinary
	28	Obstetric conditions	Other
	29	Gynaecological conditions	Genitourinary
	30	Diabetes and other endocrinological	Other
	31	Dermatological conditions	Other
	32	Allergy (inc anaphylaxis)	Other
	33	Facio-maxillary conditions	Other
	34	ENT conditions	Other
	35	Psychiatric conditions	Mental Health
	36	Ophthalmological conditions	Other
	37	Social problems	Other
	38	Diagnosis not classifiable	No Diagnosis
	39	Nothing abnormal detected	No Diagnosis

Table 10. Diagnostic codes used in childhood injury admissions analysis

ICD10 codes, all diagnosis	Description	Grouping
W00-W19	Falls	Falls
W20-W49	Inanimate mechanical	Bangs, cuts, foreign bodies
W50-W64	Animate mechanical	Other
W65-W74	Drowning	Other
W75-W84	Suffocation	Other
W85-W99	Electric current etc	Other
X00-X09	Smoke Fire	Burns & scalds
X10-X19	Thermal	Burns & scalds
X20-X29	Venomous	Other
X30-X39	Forces of nature	Other
X40-X49	Poisoning	Accidental poisoning
X50-X57	Overexertion	Other
X58-X59	Other	Other
W00-X59	Unintentional injuries	Other

Table 11. Diagnostic codes used in hospital admissions analysis

ICD10 codes, Primary Diagnosis	Description	Grouping
A00-A09	Intestinal Infectious Disease	Gastrointestinal
A80-B34	Viral Infection	Fever
E10-E14	Diabetes mellitus	Other
G40-G41	Epilepsy	Other
J00-J06	Acute Upper Respiratory Infection	Acute Respiratory
J10-J22	Acute Lower Respiratory Infection	Acute Respiratory
J45-J46	Asthma	Acute Respiratory
K21	Gastro-oesophageal Reflux	Gastrointestinal
K35-K38	Appendicitis	Gastrointestinal
K59	Constipation	Gastrointestinal
L00-L08	Skin Infection	Other
N39	Urinary Tract Infection	Urinary Tract Infection
P58-P59	Neonatal Jaundice	Neonatal Jaundice
R10	Abdominal Pain	Gastrointestinal
R50	Fever of Unknown Origin	Fever
R51	Headache	Other
R56	Convulsions	Convulsions
S00-S09	Head Injury	Head Injury
S42, S52, S62, S72	Limb Fracture	Limb Fracture
S43-S51, S53-S61	Other Injury	Other injuries
T15-T19	Foreign body	Other injuries
T20-T32	Burns	Other injuries
All remaining codes not included above	Other	Other

Cheshire East: Public Health Outcomes Framework indicator

					Local LAP level data	
Indicator	**Year**	**National data set reference**	**Definition**	**Value type**	**Year**	**Notes**
Under 18 conceptions	2012	PHOF2.04	Conceptions in women aged under 18 per 1,000 females aged 15-17	Crude rate per 1000	2009-11	
Smoking at time of delivery	2012/13	PHOF2.03	Number of women who currently smoke at time of delivery per 100 maternities.	Proportion (%)	2013	
Low Birth Weight of term babies	2011	PHOF2.01	Live births with a recorded birth weight under 2500g and a gestational age of at least 37 complete weeks as a percentage of all live births with recorded birth weight and a gestational age of at least 37 complete weeks.	Proportion (%)	2008-2010	Rank positions for LAPs are calculated by scaling local 2008-10 data to match PHOF2011 data for Cheshire East to give relative rank position. Rates given in table are actual 2008-10 data.
Breastfeeding at 6-8 weeks	2012/13	PHOF2.02ii	This is the percentage of infants that are totally or partially breastfed at age 6-8 weeks. Totally breastfed is defined as infants who are exclusively receiving breast milk at 6-8 weeks of age - that is, they are not receiving formula milk, any other liquid or food.	Proportion (%)	2012/13	
A&E attendances age 0-4 years	2011/12	ChiMat EY	Crude rate of A&E attendances in children (aged 0 to 4 years), per 1,000 resident population.	Crude rate per 1,000	2011/12 - 2013/14	Local LAP data calculated from A&E extractions supplied by the Cheshire Clinical Commissioning Groups (CCGs) for the purpose of the APHR2014. National data source is the ChiMat Early Years Profiles.
Hospital admissions caused by injuries age 0-14	2012/13	PHOF2.07i	Crude rate of emergency hospital admissions (episode number = 1, admission method = 21 to 28) caused by unintentional and deliberate injuries (ICD 10: S00-T79 and/or V01-Y36 in any diagnostic field position), in children (aged 0 to 14 years), per 10,000 resident population.	Crude rate per 10,000	2012/13	
Hospital admissions caused by injuries age 15-24	2012/13	PHOF2.07ii	Crude rate of emergency hospital admissions (episode number = 1, admission method = 21 to 28) caused by unintentional and deliberate injuries (ICD 10: S00-T79 and/or V01-Y36 in any diagnostic field position), in young people (aged 15 to 24 years), per 10,000 resident population.	Crude rate per 10,000	2012/13	
Tooth decay in children age 5	2011/12	PHOF4.02	Percentage of children with decay experience (ie with one or more obviously decayed, missing (due to decay) and filled teeth (dmft)) - %of dmft>0	Proportion (%)	2007/08	The proportion of dmft is presented instead of the actual definition used in the PHOF4.02, this is because the public find this easier to understand. Local LAP data is taken from the 2007/08 survey as there was insufficient coverage in the 2011/12 survey to allow local data to be calculated. Rates for Cheshire East are statistical similar across the two years to allow comparison.
Excess weight at age 4-5 years	2012/13	PHOF2.06i	Proportion of children aged 4-5 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.	Proportion (%)	2012/13	
Excess weight at age 10-11 years	2012/13	PHOF2.06ii	Proportion of children aged 10-11 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.	Proportion (%)	2012/13	
MMR two doses at age 5	2012/13	PHOF3.03x	All children for whom the PCT is responsible who received two doses of MMR on or after their first birthday and at any time up to their fifth birthday as a percentage of all children whose fifth birthday falls within the time period.	Proportion (%)	2012/13	

Glossary

Adolescent	This is the stage of development between puberty and maturity, roughly between the ages of 12 and 19 when changing from being a child to an adult.
Better Care Fund	This is a pooled budget that shifts resources into social care and community services for the benefit of the NHS and local government.
Bikeability	This refers to cycling training for the 21st century which aims to get more people cycling, more safely and more often. Bikeability is designed to give the next generation the skills and confidence to ride their bikes on today's roads.
Birth Weight	This is the first weight of the baby taken just after he or she is born. The average birth weight in UK is between 2.5 and 4.5 Kg. A low birth weight is when a baby weighs less than 2.5 Kg (5.5 lb).
Blood Borne Viruses (BBV)	These are viruses that some people carry in their blood and can be spread from one person to another. Some people may show few or no symptoms of serious disease, but others may be severely ill. The most common types of BBV are Human Immunodeficiency Virus (HIV), Hepatitis B and Hepatitis C.
Body Mass Index (BMI)	This is defined as the weight in kilograms divided by the square of height in metres. For children aged two and over, BMI is interpreted by looking at the child's age in relation to their age, height and sex. All school children are routinely weighed and measured as part of the National Child Measurement Programme when the child is in reception and in year six.
Cheshire East Youth Council	The Youth Council is run by young people, and provides opportunities for 11-18 year-olds (25 if they have learning difficulties or have been in care) to use their voice in creative ways to bring about social change. The aim of a youth council is to empower young people to influence and inform the decisions that affect their lives. Young people are encouraged to get involved in their communities and democracy locally, nationally and internationally. The Cheshire East Youth Council consists of 3 tiers of involvement: <u>Leadership Group</u>: This consists of Members of UK Youth Parliament, Deputies, REP's (Representatives of other groups) and PYP's (This stands for Passionate Young People who really want to get involved). This group attends Youth Council meetings, makes decisions about campaigns and

	represents the Youth Council at other meetings. Active Group: This consists of young people who are involved with other youth groups and prefer to have their say through that group. Young people are on Facebook Group and a mailing list and choose what they want to get involved with. This group are invited to meetings and to sit on task and finish groups. They also receive online survey opportunities. Informed Group: Young people give their views and opinions through social media and join in online polls.
Chief Medical Officer	The Chief Medical Officer (CMO) acts as the Government's principal, most senior medical adviser and the professional head of all Directors of Public Health in local government.
Child And Adolescent Mental Health Services (CAMHS)	CAMHS are specialist NHS services which offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.
Commissioning	This is the process of planning, agreeing and monitoring services. Commissioning is not one action but many, ranging from the needs assessment for a population, through the design of client pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.
Conduct Disorder	This is a serious behavioural and emotional disorder that can occur in children and teenagers. A child with this disorder may display a pattern of disruptive and violent behaviour and have problems following rules.
Confidentiality	This refers to the obligation not to disclose information; the right of a person to withhold information from others.
Contraceptive Services	This offers family planning services including advice about birth control methods, emergency contraception, permanent sterilization and, where appropriate, screening for sexually transmitted infections.
Early Years Foundation Stage (EYFS)	The EYFS sets standards for the learning, development and care of children from birth to 5 years old.
Family Nurse Partnership	This is an intensive, structured, home visiting programme, which is offered to first time parents under the age of 20. A specially trained family nurse visits the mother regularly from early pregnancy until the baby is 2 years old and builds a close, supportive relationship with the family.
Fatal Casualties	This refers to people who died at the time or within 30 days of an accident.

GUM Services	A sexual health or genitourinary medicine (GUM) clinic specialises in sexual health, and gives tests and treatment for many sexually transmitted infections.
Immunisation and Vaccination	Immunisation is the most important way of protecting people from catching infections. A vaccine usually has a small dose of an active or inactive form of the germ, or the poison made by the germ. This causes the body to make antibodies against the germ or poison, and then the antibodies are ready to attack the germ if it begins to invade the body.
Infant	An infant refers to young children between birth and approximately 1 year of age. A newborn or neonate is an infant in the first 28 days after birth.
Infection	This is the invasion of the body by an infectious agent which can be a virus, bacteria, or other organisms. A bacterium is a single-celled microorganism, most are harmless, but some can cause disease such as e-coli causing urine infection, streptococci causing throat infections, campylobacter and salmonella. Viruses, e.g., rotavirus and chickenpox virus are much smaller and require a host to live in. Once they invade the body, viruses enter the cells and multiply. The most important distinction is that antibodies kill bacteria but have no effect on viruses. The overuse of antibiotics can create strains of bacteria that are resistant to some types of antibiotics, which is why antibiotics should only be given after careful assessment.
Intentional and Unintentional Injuries	Unintentional injuries include those injuries that occur without intent of harm. Intentional or deliberate injuries are injuries that are purposely inflicted with the intent to cause harm such as child abuse and neglect.
Joint Strategic Needs Assessment (JSNA)	The JSNA analyses health and social care needs to inform and guide commissioning of health, well-being and social care services within local authority areas. The main goal of a JSNA is to accurately assess the health and social needs of a local population in order to improve the physical and mental health and well-being of individuals and communities.
Lifecourse and Lifespan	Life course is the sequence of age categories that people are expected to pass through as they progress from birth, through childhood and adulthood to death. The length of time for which a person lives is called lifespan.
Local Safeguarding Children Board	The Children Act 2004 requires all local authority areas to have a Local Safeguarding Children Board in place to oversee, monitor and scrutinise local arrangements for safeguarding children and promoting their welfare. The Cheshire East Safeguarding Children Board is the partnership body responsible for co-ordinating and ensuring the effectiveness

	of Cheshire East services to protect and promote the welfare of children.
Health and Wellbeing Boards	Health and Wellbeing boards are statutory bodies introduced in England under the Health and Social Care Act 2012. According to the Act, each upper-tier local authority in England is required to form a health and wellbeing board as a committee of that authority.
Making Every Contact Count	This is a concept which aims to improve lifestyles and reduce health inequalities. It encourages conversations based on behaviour change methodologies (ranging from brief advice, to more advanced behaviour change techniques), empowering healthier lifestyle choices and exploring the wider social determinants that influence all of our health.
Mental Health Disorders	These include a wide range of disorders such as anxiety disorders, bipolar disorder, mood disorders, personality disorders and psychotic disorders.
Miscarriage and Still Birth	A miscarriage is the loss of a pregnancy during the first 23 weeks whereas a stillbirth is a baby delivered with no signs of life after 24 completed weeks of pregnancy.
National Institute For Health And Care Excellence (NICE)	NICE provides national guidance and advice to improve health and social care. NICE guidance sets the standards for high quality healthcare and encourages healthy living.
Outbreak	A disease outbreak is the occurrence of cases of disease in excess of what would normally be expected in a defined community or geographical area.
Personal Child Health Record (PCHR)	This is also known as the red book and is a national standard health and development record given to parents or carers at a child's birth. It is the main record of a child's health and development. The parent/ carer retains the PCHR and the health professionals update the record each time the child is seen in a healthcare setting.
Personal, Social, Health & Economic Education (PSHE)	PSHE education is a planned programme of learning through which children and young people acquire the knowledge, understanding and skills they need to manage their lives. As part of a whole school approach, PSHE develops the qualities and attributes pupils need to thrive as individuals, family members and members of society.
Postpartum or Postnatal	This is the period immediately after the birth of a child and extending for about six weeks.

Pregnancy Gestation	Gestation is how far along the foetus is, determined by the beginning of the mother's last period. Babies are usually born at 40 weeks, but considered full-term from 37 weeks to 42 weeks. A baby born before 37 weeks is a premature birth.
Proportionate Universalism	To reduce health inequalities, action should be universal but proportionate to the level of disadvantage.
Public Health Nursing	This consists of registered nurses and midwives including school nurses and health visitors who have gained an additional qualification in public health.
Road Safety Partnership	The partnership exists to reduce the number of people killed and hurt on the roads.
Rural	This term is based on population sparsity, remoteness from urban areas, access to services, land use, socio-economic characteristic of areas, local perceptions of whether home is rural or not, and whether it involves an economically active population.
School Travel Plan	This is a document put in place to encourage parents and children to consider healthy and sustainable forms of transport when travelling to and from school and provide practical measures for improving children's safety on the school journey.
Schools: Academy Schools, Free Schools, Studio Schools and Grammar Schools	Academies are publicly funded independent schools. They do not have to follow the national curriculum and can set their own term times. Academies get money directly from the government, not the local council although funding arrangements are broadly similar. There are many different types of Academies, some sponsored by other schools or organisations and some acting as a single academy or part of a Multi Academy Trust (several schools working together in a structured way). Free schools are funded by the government but are not run by the local council and are a type of academy. They have more control over how they do things. They are 'all-ability' schools, so cannot use academic selection processes like a grammar school and do not have to follow the national curriculum. A Studio school is a type of secondary school that is designed to give students practical skills in workplace environments as well as traditional academic and vocational courses of study. Grammar schools are run by a council, a foundation body or a trust. They select all, or most, of their pupils based on academic ability and there is often an entry exam.

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Foreword

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CHESHIRE EAST COUNCIL

REPORT TO: HEALTH AND WELLBEING BOARD

Date of Meeting: 18th November 2014
Report of: Tony Crane
Subject/Title: Cheshire East Children and Young People's Plan 2014-18
Portfolio Holder: Cllr R Bailey

1.0 Report Summary

This report seeks the endorsement of the Children and Young People's Plan (CYPP) 2014 – 18 as the borough's "Starting Well" Plan.

2.0 Decision Requested

Health and Wellbeing Board is asked to:

2.1 Ratify the Children and Young People's Plan 2014 – 18.

3.0 Background

The Children and Young People's Plan 2014 – 18 has been informed by a review of the Cheshire East CYPP 11-14, an analysis of available data, and through consultation and engagement of children and young people, stakeholders and professionals.

4.0 Key Themes/Issues

The Children and Young People's Plan 2014-18 sets out the key areas of focus which supports the "Starting Well" section of the Health and Wellbeing Strategy, providing a focus for the collective efforts of partner agencies on a small number of key priorities which limit the life chances of children and young people in Cheshire East.

The themes of the CYPP are:

- Children and young people at risk and providing help to families early
- Healthy and resilient young people
- Young People equipped and excited to enter adulthood
- Children, young people and young adults with special education needs and disabilities
- A borough that respects children's rights

Work is underway to review our infrastructure and the performance management arrangements to ensure that we can deliver on our ambition, which gives us an opportunity to work more closely as commissioning partners.

In Cheshire East we recognise the value in understanding from young people themselves what life is like in Cheshire East and children and young people were invited, through schools, to take part in a Good Childhood Conversation which aims to gauge their quality of life perceptions against subjective wellbeing measures. This survey was conducted by the Children's Society with the aim of establishing self-reported measures to understand the variations in experience and how they impact on wider outcomes. A series of geographical based and targeted focus groups of children and young people were held across the borough to gain a deeper understanding of themes that emerged. Approximately 2,800 children took part in this survey and 800 were involved in face to face consultations on the key findings of the survey.

In line with the national findings, it is the nature and strength of children's relationships with their family, friends, school staff and local adults that has the greatest impact on well being but there are some interesting insights from young people on their experiences locally which the Health and Wellbeing Board will be particularly interested in.

The survey results indicate that:

> Around 10% suggest they have low well being. This is in line with the national average.
>
> The key differences are in age and gender. Primary age children are generally happier with life than the national average. This level of happiness drops in line with the national average as children grow older, except for girls the drop is more pronounced and takes their well being below the national average.
>
> As with well being, life satisfaction drops as children move into adolescence, this is the case for Cheshire East as well as the national average.
>
> In most domains boys are happier than girls, particularly at secondary level. The key difference is in how girls feel about their appearance and how much they worry about their looks. The concerns girls have about their appearance is mostly influenced by the comments and judgements they make on each other and particularly by the observations boys make about girls. Consultation suggested that boys are generally unaware or unaccepting of the way their comments affect girls and their self esteem. This is higher than the national average.
>
> On their local area, the desire for more shops and an overall sense of safety was consistent across the authority. At primary age some children were bothered about traffic and cars, they had little sense of what a youth club was or what they offered and they wanted friendlier adults. At secondary age there was a consensus that more shops meant more places to go, there was little

interest in youth clubs and designated youth space and young people generally felt safe and unaffected by crime.

5. Conclusion

The Children and Young People's Plan is the borough's collective commitment to focus on those issues that limit the life chances of children and young people in Cheshire East. Its development at this time represents an opportunity for agencies to examine how we seek new insights and innovative approaches to address some of that face particular groups of children and young people, how can we move into a new spirit of partnership collaboration in the current climate, and how we promote the inclusion of all children and young people.

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Appendices

One: Outturn report of the current Cheshire East CYPP 11-14

Two: Cheshire East Good Childhood Enquiry 2014

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Cheshire East

Children and Young People's Plan

2014 - 18

Cheshire East
Children & Young People's Trust

Cheshire East Children and Young People's Plan

Contents

1. Foreword

Welcome to the Cheshire East Children and Young People's Plan 2014-18.

BECOMING THE BEST PARTNERSHIP

In Cheshire East we are committed to making a difference to the lives of children and young people in our communities. We want Cheshire East to be a great place for people to live, learn, work and relax; where all children and young people feel included and listen to. We want Cheshire East to be a place where children and young people thrive, are safe from harm, feel physically and emotionally healthy, have access to outstanding education and feel prepared for and excited about adulthood.

This Children and Young People's Plan comes at a time of significant change but we retain our commitment to placing the needs of ALL children, young people, families and communities at its centre. It has been shaped by the views and insights of children, young people and their families aligned to the grounded experience and knowledge of those who provide services across the borough.

This Children and Young People's Plan builds on the platform of our Health and Wellbeing Strategy as our collective commitment to continue to improve outcomes for all, with a targeted approach to improving outcomes for certain groups where they lag behind their Cheshire East counterparts.

Its development at this time represents an opportunity for agencies to examine how we seek new insights and innovative approaches to address inequality and promote aspiration, how we move into a new spirit of partnership collaboration in the current climate, and how we promote the inclusion of all children and young people. In this context the plan seeks to avoid imposing solutions. Rather it advocates a positive approach that places a strong emphasis on children's rights and further engagement, participation and empowerment of children, their families and communities in both determining priorities and providing effective outcomes for all local children.

We hope everyone who reads this plan will feel inspired and motivated to reach for excellence, as everyone has a role to play in making our vision a reality.

2. Vision and Ambition

Children, young people and staff across Cheshire East have challenged us to create a ***great place to be young.***

This plan embodies the partnership's ambition to provide strong collaborative leadership to deliver good outcomes for all and protect the most vulnerable, in a culture that listens to and acts on the voice of children and young people and where all frontline practice is consistently good, effective and outcome focused.

To this end, the Children and Young People's Trust Board has agreed to focus on a group of priorities developed around the following key themes:

- **Children and young people at risk and providing help to families early**
- **Healthy and resilient young people**
- **Young People equipped and excited to enter adulthood**
- **Children, young people and young adults with special education needs and disabilities**
- **A borough that respects children's rights**

Cheshire East Children and Young People's Plan

Our Shared Ambition in Cheshire East is that:

- Children and Young People are **valued as individuals** in their own right
- Children and Young People **feel and are safe and protected**, free from fear and danger
- Children and Young People are brought up and cared for within their own families wherever possible but **experience good care** where this is not the case
- Children and Young People are **physically, mentally and emotionally healthy**
- Children and Young People **enjoy their childhood** and youth and have a positive experience of social engagement with each other and their communities
- Children and Young People have **every opportunity to achieve** and reach their potential and enjoy their school and learning experiences
- Children and Young People **have a say in the services they receive** - and **see meaningful participation as their right**
- Children, young people, their families and services **work together to meet individual needs** and problem solve, and support is based on their lived experience
- Young People are supported into adulthood **able to shape their own destiny**
- The borough **celebrates the successes and achievements** of all children and young people

3. Context for this Plan

The Children and Young People's Plan (CYPP) is our single strategic and overarching plan which sets out how partners across the Local Authority, Health Services, Education, Justice and the voluntary and community sector intend to achieve improvements in outcomes for the borough's children, young people, young adults and their families.

The Plan is strategically aligned to the work of the Cheshire East Health and Wellbeing Board and sets out how we aim to support children to get the best start in life. The plan does not seek to capture every service or initiative. Instead, it provides a strategic framework for local activity, setting out our ambition, our shared sense of purpose and direction and will be supplemented by a range of underpinning strategies and action plans and reflected in the plans of partner agencies.

National Context:

This Plan has been written in the context of major reform locally and nationally, which has reshaped the policy and delivery environment for children and young people. This includes:

- A refocus of the safeguarding of vulnerable children and families, and growing understanding of the experiences of young people and the risks they face, such as sexual exploitation and online safety.

- Transformation of the system of support for children and young people with special educational needs and disabilities, aimed at improving the experiences of families with a more joined up and personalised approach to the health, education and care services they receive.

- Major reform of health services included the establishment of Health and Wellbeing Boards, development of GP led Clinical Commissioning Groups and NHS England, and transfer of Public Health Services to Local Authorities with the requirement to address the Public Health Outcomes Framework and other national Frameworks.

- Reduction in public spending in a challenging economic environment, which means that all partners have to take some difficult decisions on priorities.

- A greater focus on helping families earlier, particularly in the early years through initiatives such as free childcare for vulnerable 2 year olds, and those families with multiple and complex needs.

- Changes to the educational system to greater school autonomy, and new education providers such as academies and free schools.

- Enhancing public scrutiny with, for example, the introduction of new Police and Crime Commissioners.

Local Context:

Cheshire East is a generally affluent area, recently announced as the 'best place to live in the North West'[1]. It is a growing borough, with over 370,100 residents in the borough with 74,900 children and young people aged 0-17 in Cheshire East, which is approximately 21% of the total population. It is a borough in which most flourish against the indicators which define a good childhood.

Despite this, some of our neighbourhoods also count among the most deprived, which translate to very real inequalities in the lives of some families. Approximately 12.5% of children under 16 live in poverty, around 8,000 children, mainly around the towns of Crewe and Macclesfield but there are pockets of deprivation in some of the smaller rural areas of the borough. Just under 3,900 (8.6%) of school children are from a minority ethnic group and 16% have some form of special educational need.

Equally, for those who face additional risks and challenges we need to re-double our efforts to effect improvement. This Plan sits alongside our Children's Improvement Plan 2014 and the Cheshire East Safeguarding Children Board Business Plan which together set out our joint priorities, and a system of accountability, to improve the safety of children and young people in the borough.

[1] Annual Halifax Quality of Life Survey

Cheshire East Children and Young People's Plan

Through these Plans we have agreed 3 joint aims which are:

- **Frontline practice is consistently good, effective and outcome focused**
- **Listening to and acting on the voice of children and young people**
- **The partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East**

As a whole partnership we will drive improvement by focusing on these joint priorities. This will ensure that improvements to partnership working are aligned and made across all aspects of children's services from commissioning to delivery, from universal to specialist services.

4. What do children and young people say about growing up in Cheshire East?

In Cheshire East we recognise the value in understanding from young people themselves what life is like and children and young people were invited, through schools, to take part in a *Good Childhood Conversation*. Approximately 2,800 children took part in this survey and 800 were involved in face to face consultations on the key findings of the survey.

In line with the national findings, Cheshire East children and young people confirm that it is the nature and strength of their relationships with their family, friends, school staff and other adults known to them that has the greatest impact on wellbeing.

The survey results indicate that:

Overall wellbeing amongst children in Cheshire East is a little higher than the national average and that whilst there were some differences in results within Cheshire East they were not of any real significance. However the survey shows that for around 10% of children and young people their responses suggest they have low wellbeing. This is in line with the national average.

The key differences are in age and gender. Primary age children are generally happier with life than the national average. This level of happiness drops in line with the national average as children grow older, except for girls the drop is more pronounced and takes their wellbeing below the national average.

The life satisfaction results also show a slightly higher level of satisfaction than the national average.

As with wellbeing, life satisfaction drops as children move into adolescence, this is the case for Cheshire East, which is in line with the national average.

Cheshire East Children and Young People's Plan

There are differences in how children feel about specific areas of their lives.

In most areas of wellbeing boys are happier than girls, particularly at secondary level. The key difference is in how girls feel about their appearance and how much they worry about their looks. The concerns girls have about their appearance is mostly influenced by the comments and judgements they make on each other and particularly by the observations boys make about girls. Consultation suggested that boys are generally unaware or unaccepting of the way their comments affect girls and their self-esteem.

"There is a lot of pressure to look good, you get called names no matter what, people always say stuff behind your back, boys always call you ugly if you have spots, or a slag if you wear makeup" - year 8 girl

"Many girls and boys have started to think it's acceptable to call each other nasty names, but it's horrible" - girl year 8

In most areas of wellbeing, children and young people in Cheshire East had similar or higher scores than the national average. This was significantly higher in how they felt about their possessions and things that they own. In how they felt about their health, they were lower.

"It's not hard to choose between a burger and broccoli – you would choose a burger" - boy year 8

"There are not enough healthy inspired cafés" - year 8

"In my village there are a lot of ways to stay healthy because there are lots of jogging places and walking areas. It is also affordable to be active" - year 7 girl

"Mostly it's very expensive to buy fruit and healthy food. In Bollington there are mainly takeaways" - year 8

On their local area, the desire for more shops and an overall sense of safety was consistent across the authority. At primary age some children were bothered about traffic and cars, they had little sense of what a youth club was or what they offered, and they wanted friendlier adults. At secondary age there was a consensus that more shops meant more places to go, there was little interest in youth clubs and designated youth space and young people generally felt safe and unaffected by crime.

"There are lots of activities I like football at the park" - boy year 8

"There are quite a few fast food places in Poynton. There is a pub so people will smoke and drink" - year 8 girl

"It's boring, there isn't much to do there and they don't open up the hall so we can play football, and it's £2.50" - year 9 boy

"Costa is somewhere to go" - year 7

"It's not safe people come speeding around in cars and it's a rough area there are scary places on the estate" - year 7 boy

On their experience of school, as with the national average, primary age children are more content with school than secondary but in general, children in Cheshire East have average or a little higher than average levels of happiness about school. Girls tend to be less happy than boys.

"I feel sad at school all the time. It is hard to fit in at school because other people make you feel bad/ poo about yourself (especially the populars) There should not be people which think they are better than you. I don't have many friends"- girl year 9

"It's different from primary school; I find it really hard to keep on top of all the homework" - girl year 7

5. What's going well and what do we need to think about?

Our Joint Strategic Needs Assessment (JSNA) confirms that most children and young people do well in Cheshire East with positive outcomes which provide them with the skills and opportunities to progress in adulthood. Across health, attainment, and safety young people's outcomes are generally better that their counterparts nationally and significant progress has been made in areas such as narrowing the gap for children with special educational needs, increasing the numbers of young people who go onto employment, education or training and diverting young people away from the youth justice system.

What's going well?

- ✓ More than 96% of babies are fully immunised during their first year of life 56% children start school with good level of development
- ✓ 81% of pupils leave primary with expected level of achievement
- ✓ 2/3rds young people leave secondary school having a good level of qualification
- ✓ Top quartile nationally for A level
- ✓ Attendance at school is high
- ✓ The gap between Special Educational Needs (SEN) pupils and non-SEN is reducing at secondary and now below the gap nationally
- ✓ Improved quality and timeliness in the planning and assessment for help and protection
- ✓ Improving child centred practice
- ✓ Decrease in the number of inappropriate referrals to children's social care
- ✓ Reducing number of children in care
- ✓ Good health outcomes for cared for children
- ✓ Reduction in the numbers of young people who do not progress into education, employment or training to 3.5%

- ✓ Continued reduction in the teenage conception rate to 23.3 conceptions per 1,000 women aged 15-17 which is significantly better than the England average of 30.7.
- ✓ Significant year on year reduction in the numbers of young people coming into contact with the youth justice system for the first time which now stand at 85.
- ✓ There has been only one ASBO in past three years, less than 1% are convicted of a crime
- ✓ Additional investment in promoting the rights and involvement of children and young people
- ✓ Significant progress made to improve adoption timescale, over 50% of children wait less than 18 months between entering care to moving in with their adoptive parents

What do we need to look at?

In summary, the key issues emerging from the needs assessment as areas for improvement are:

- Children and young people in *particular areas* of Cheshire East do not do as well as their local counterparts across a range of outcomes such as attainment, teenage conceptions and delivery, levels of child protection referrals, youth offending, not in education, employment or training (NEET), breastfeeding continuation levels etc. These tend to cluster most obviously around wards in Crewe and Macclesfield and in small clusters spread out across the borough, both around the main towns and in small rural pockets.

- Variations of experiences and outcomes for children and young people with additional needs, i.e. children with Special Educational Needs or Disability (SEND), long term conditions, cared for children, young carer, offenders and black, minority ethnic (BME) groups do less well. The attainment gap for these particular groups is in some cases bigger than the national gap average.

- Levels of unsafe risk taking behaviour with higher than the national average rates of hospital admissions for alcohol/substance misuse and self-harm.

- High numbers of children and young people on child protection plans for emotional abuse and neglect. Overall the number of Child Protection Plans has

increased significantly since 2011 and the percentage of cases where neglect is a key feature as reduced from a high of 63% to 49%. Despite this neglect remains however, the highest category of referral. Domestic abuse remains a feature for a number of children and young people.

- Accidents and deaths in road traffic accidents are significantly higher than the national average.

- Cared for children who report lower levels of emotional health.

More detailed information can be found in the JSNA.

6. What are our priorities?

The following pages set out the priorities agreed by partners, and each section covers why we have chosen to focus on this issue, what we plan to focus on and how we will assess whether we are making a difference. The priority outcomes for 2014 -18 are:

1. Children and young people will be **actively involved in decisions** that affect their lives and communities

2. Children and young people **feel and are safe**

3. Children and young people experience **good emotional and mental health and wellbeing**

4. Children and young people are **healthy and make positive choices**

5. Children and young people **leave school with the best skills and qualifications they can achieve** and the **life skills they need to thrive** into adulthood

6. Children, young people and young adults with additional needs **have better chances in life**

Underpinning these priority outcomes are our Partnership's 3 aims:

- **Frontline practice is consistently good, effective and outcome focused**
- **Listening to and acting on the voice of children and young people**
- **The partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East**

Cheshire East Children and Young People's Plan

Priority One:

Children and young people will be **actively involved in decisions** that affect their lives and communities

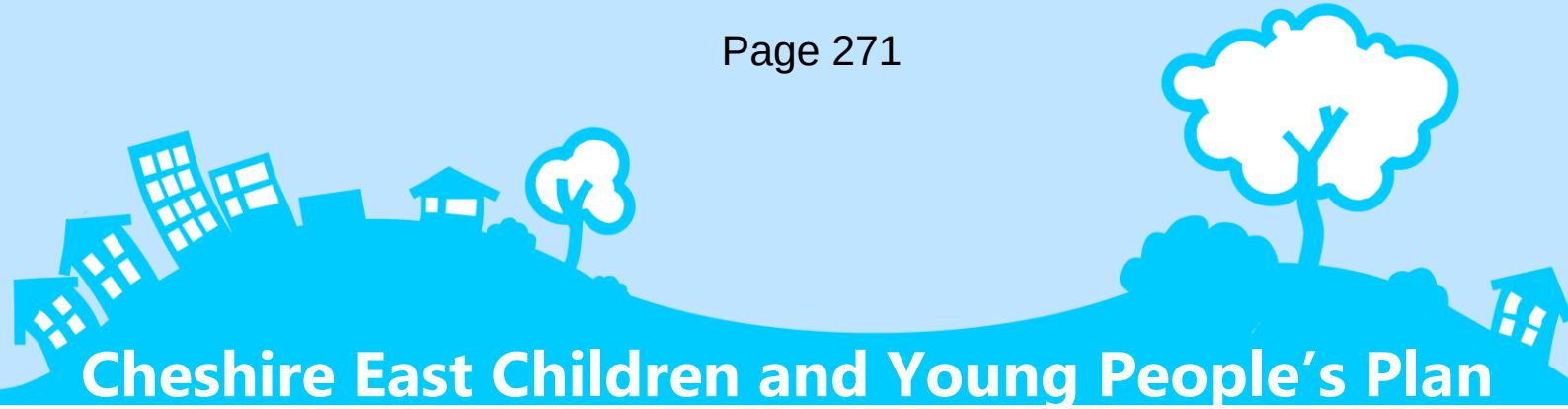
Why is this important in Cheshire East?

Our ambition is for all children and young people to be active citizens who feel they have a voice on the important issues affecting them and their community and can influence decision making and community life. In July 2014, Cheshire East Children and Young People's Trust agreed a strategy which sets out the commitment of partner agencies to respect and champion children's right to have a say.

What will we do:

This priority will focus on:

- ✓ Equipping the children's workforce in Cheshire East with the skills and knowledge needed to support effective engagement and participation
- ✓ Supporting children and young people to develop the skills and confidence to participate
- ✓ Supporting Cheshire East Youth Council to become the credible and democratic forum in the borough with a mandate to speak for all children and young people.
- ✓ Addressing barriers preventing children and young people from participating, particularly those that are rarely heard.
- ✓ Ensure that children and young people have a consistent experience of participation throughout their childhood and adolescence



How will we know we've been successful?

When Children and Young People tell us:

- they have a good understanding of children's rights, according to the United Nation Convention on the Rights of the Child
- they are treated fairly and feel respected
- they have their basic rights met
- they can express their views, feel heard and are actively involved in decisions that affect their lives and they are positive about the impact it has on them as an individual
- there are increasing numbers actively participating, including children and young people from more diverse backgrounds
- more young people are voting in the youth council elections
- the Cheshire East Youth Council is active and represents the views and interests of children and young people in the borough
- they can see their views reflected in strategy, projects, reports etc
- they see positive media stories about how children and young people have taken the lead
- they know the outcomes from their involvement

When adults tell us:

- they have a good understanding of children's rights, according to the United Nation Convention on the Rights of the Child
- participation is the way we do things not seen as an extra or an add on
- they have adopted the Cheshire East 5 Star Participation Standards
- they can evidence improved practice and this is informed by children and young people
- we are seen externally as a place with exemplary practice
- that external inspections and reviews reflect that the voice of the child is consistently gathered and acted on

Cheshire East Children and Young People's Plan

Strategies and Plans

Cheshire East Participation Strategy

Who will be involved?

Children and Young People's Trust Board
Participation Network

Priority Two:

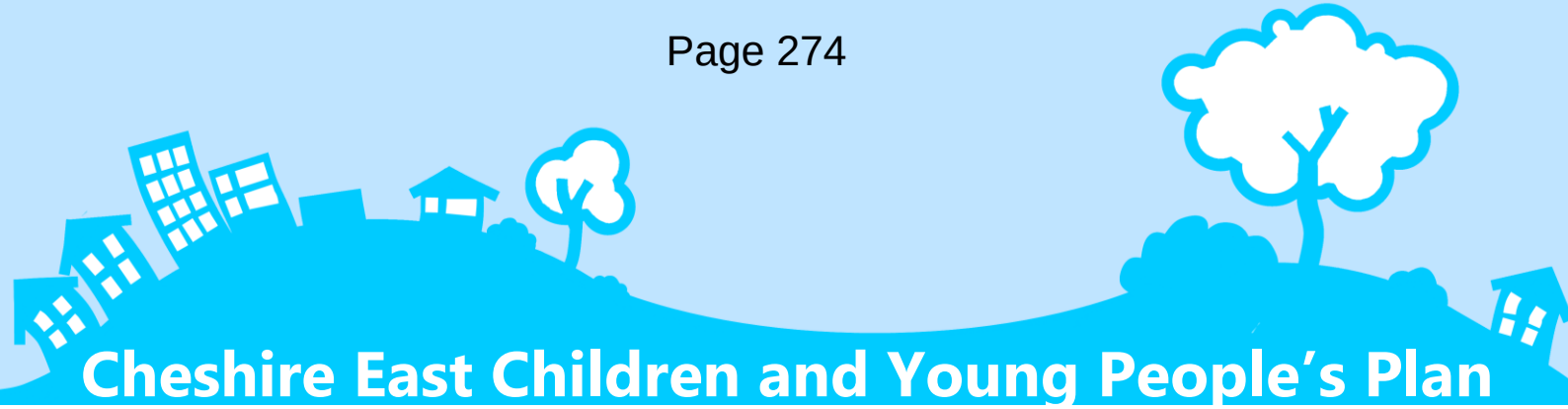
Children and young people **feel and are safe**

Why is this important in Cheshire East?

Most children and young people in Cheshire East grow up in a safe, loving environment, in families who provide them with the care and support they need to thrive, and in communities which support them. For those families where this isn't the case, it is particularly important that we are able to reduce levels of risk to children and help families to reduce the impact of them and to prevent problems from reoccurring. The borough's Early Help Strategy is focussed on targeting families when difficulties emerge in order to prevent problems from becoming entrenched or escalating. Universal services, such as Schools, GPs, Health Visitors, and Children's Centres are critical in helping to identify children early so that help can be offered quickly.

In Cheshire East approximately 200 children, where there are concerns that there is a risk of harm, are referred to Children's Social Care each month and the borough has 333 children in care, 270 children subject to a child protection plan and 1250 Children in Need. Of these we know that:

- Emotional abuse on average accounts for around 30% of all Child Protection cases. This is in line with our statistical neighbours but slightly lower than the England average of 33%
- Neglect cases, where there is a persistent failure to meet a child's basic physical and /or psychological needs account for 56% of cases on average, which is higher than our statistical neighbours (44% on average) and Northwest (39% on average). This is in line with national patterns
- Currently there are around 120-130 children with Child Protection Plans in place for neglect, with a possible 25% of unidentified need
- The number of children on a Child Sexual Exploitation Plan has increased in Cheshire East since 2012-13.
- Numbers of children subject to a Child Protection Plan have been increasing.
- Numbers of children entering into care are increasing, however, overall the total numbers continue to reduce locally and are low by national rates.



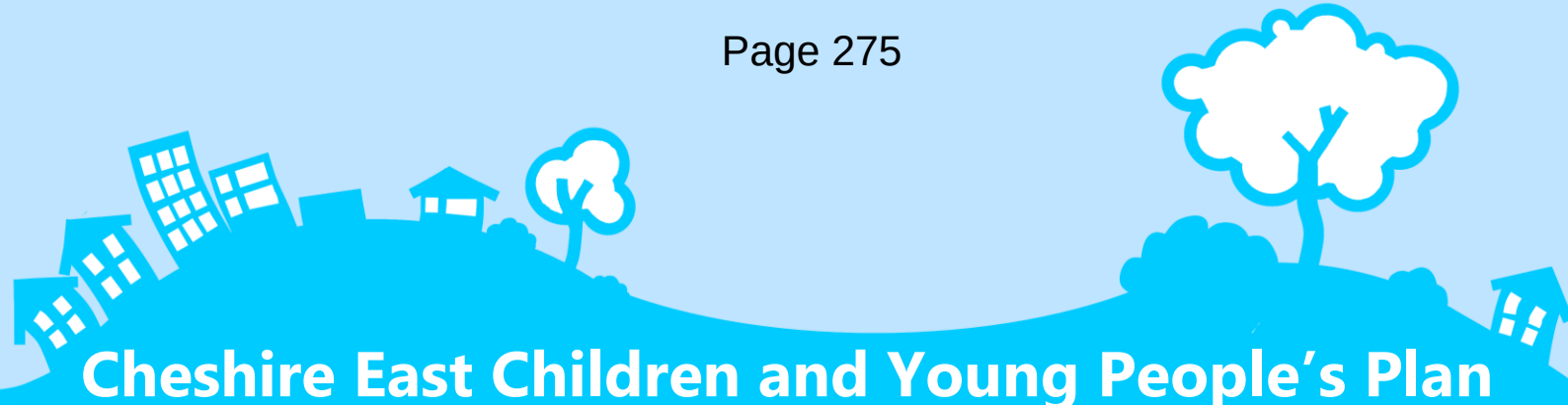
We know that children who are exposed to abusive or violent behaviour may suffer a range of harmful effects and we need to work together as partners to ensure that children are protected from the negative impacts of domestic abuse. Local information tells us that reported incidents of domestic abuse are increasing, with some 350-400 residents are identified annually as being at 'high risk' and meriting proactive safety interventions. High risk cases are believed to represent some 10% of the total number of those who experience abuse or violence. Young women with young children are Cheshire East's largest cohort of high risk families.

Road traffic accidents are an important cause of death or serious injury in children and young people. 60 children were killed or seriously injured on Cheshire East's roads between 2010 and 2012, and the local rate is nearly 50% higher than the national rate.

What will we focus on:

As partners we are clear that supporting the most vulnerable through effective help and protection is a shared responsibility and through this we intend to focus on the following

- ✓ Ensuring that there is a strategic commitment to safeguarding in all agencies and improve communication direct to front line staff
- ✓ Improving the awareness, understanding and recognition of risk
- ✓ Reducing levels of risk to children and young people through early help
- ✓ Improving the effectiveness of interventions to tackle neglect and domestic abuse
- ✓ Re looking at the model of support and intervention for children in need
- ✓ Reviewing actions and interventions to keep children and young people safe on our roads
- ✓ Supporting children and young people to develop skills and knowledge to keep themselves safe
- ✓ Improving destinations for cared for children
- ✓ Improving online safety
- ✓ Working with children and young people to improve our understanding of the safeguarding issues facing children and young people

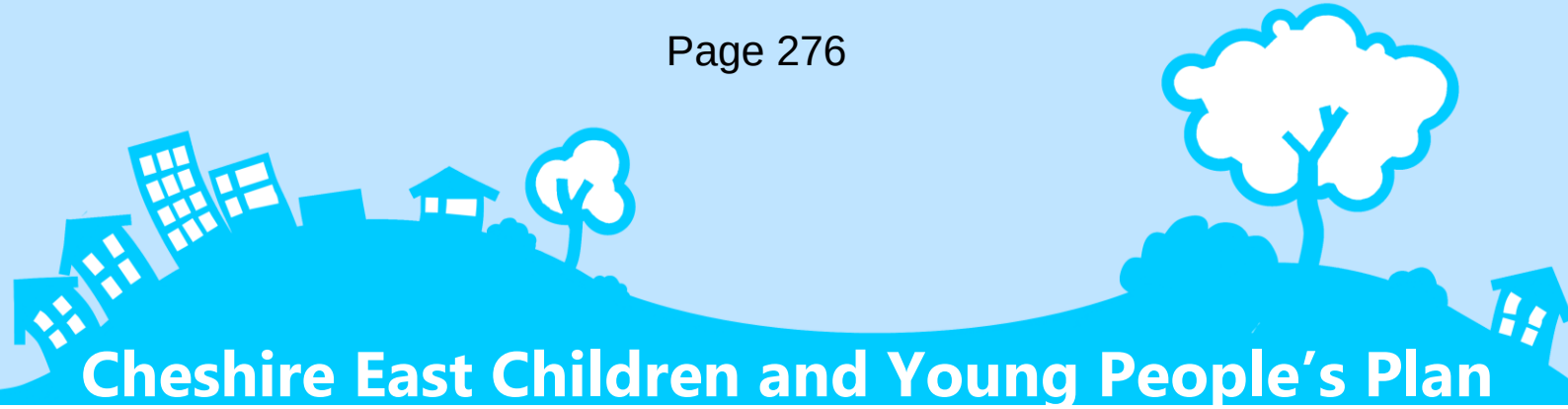


How will we know if we are successful?

- ✓ Less children and young people need to be cared for
- ✓ Children who are cared for will have the right destinations, including more children leaving care to return to their family and friends/wider community or adopted
- ✓ Less children and young people who need protecting
- ✓ Less children and young people killed or injured on Cheshire East roads
- ✓ Reduction in repeat incidents of neglect or domestic abuse.
- ✓ Increase in the number and quality of CAFs across partners
- ✓ Families report that Early Help is timely and effective
- ✓ Children and young people report feeling safer

- ✓ Frontline practice is consistently good, effective and outcome focused
  - All practitioners are skilled in safeguarding practice and can act on children's expressed views
  - Information sharing is effective
  - CAF is embedded across partners.
  - Children and young people are able to build trusting relationships with professionals.
  - Children have access to information, know their rights, have their say and make choices, and understand how decisions about them are being made.

- ✓ Children and young people are listened to and their voice acted on
  - Adults recognise that children and young people have views, wishes and feelings and an interest in their own protection
  - Children are respected as individuals and their voices are heard separately from their parents
  - Workers are skilled at gaining the wishes and feelings of all children and young people and are confident that these are heard and acted on
  - Participation of children and young people is embedded and their experience and insight is used to shape service improvement



Cheshire East Children and Young People's Plan

- ✓ The partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East
  - The LSCB effectively monitors and challenges the role of partners in protecting children from harm or risk of harm
  - Safeguarding and child protection needs are prioritised in relevant Partnership Strategies
  - The Partnership has a clear understanding of the quality of life and wellbeing of children and young people in Cheshire East and the barriers to their potential
  - There is an effective Early Help Offer agreed across partners agencies

Strategies and Plans

Children's Improvement Plan 2014
Cheshire East Safeguarding Board Business Plan 2014
Cheshire East Neglect Strategy
Cheshire East Early Help Strategy
Cheshire East Participation Strategy
Cared for Children Strategy
Domestic Abuse Strategy 2015-17
Health and Wellbeing Strategy

Who will be involved?

Cheshire East Safeguarding Children Board
Safer Cheshire East Partnership
Cheshire East Road Safety Executive
Early Help Children's Trust Sub Group
Youth Management Board

Priority Three:

Children and young people experience **good emotional and mental health and wellbeing**

Why is this important in Cheshire East?

The mental health and emotional wellbeing of children and young people is vitally important to both a good experience of childhood and adolescence and in determining long term health into adulthood. There is a growing body of evidence of increased episodes of young people experiencing poor emotional mental health and wellbeing that are not being addressed appropriately (or at all). It is estimated that between 10 to 15% of children have a mental health problem, which would equate to between 8,000 and 12,000 children and young people in Cheshire East.

Early help is critical. Over half of all adults with mental health problems were diagnosed in childhood but less than half of these received appropriate treatment at that time. The Cheshire East Good Childhood Enquiry 2014 suggests poor levels of self-esteem and confidence affecting 1 in 10 young people, with particular issues for young women. Poor self-image and sense of self-worth can, without the right support, result in a range of negative and dangerous behaviours including self-harm and suicide. As a private act, the extent self-harm is not known, although national estimates suggest that around 1 in 12 children deliberately self-harm. In Cheshire East we know that we have higher than average numbers of hospital admissions for self-harm. There will be many reasons for this and young people tell us that it is important that adults focus on why rather than the act but all forms of abuse will impact hugely upon emotional mental health and wellbeing, as will experiences of neglect, both of which are a feature in the lives of some children and young people in the borough.

Experiences, often beyond your control, can also contribute poor emotional and mental health and wellbeing. Being a young carer or being placed in care can expose a young person to experiences and feelings they are not fully equipped to deal with. Similarly being involved in anti social behaviour or the youth justice system can leave young people vulnerable to poor health outcomes, lack of self-worth and at

risk of isolation. It is so important to identify who these young people are and support them to break the cycle they are in and provide choices and alternative futures.

What young people tell us is that mental health needs to be in the mainstream with more discussion and debate which influence how mental health is perceived.

What will we do:

- ✓ Work with young people to improve resilience.
- ✓ Develop environments which support good emotional health and wellbeing
- ✓ Promote young people led approaches for example peer support/advocacy, peer mentoring.
- ✓ Provide more effective support for children and young people who are at risk of poor emotional or mental health.
- ✓ Improve young people's experience of transition as a key time of risk.
- ✓ Work to reduce the incidence of anti-social behaviour and youth nuisance
- ✓ Undertake a "whole systems" review of the support system, including level, range and variety of provision, accessibility, integrated working high risk cases and crisis care.
- ✓ Joint commissioning of early intervention support.
- ✓ Implement the recommendations from the thematic review into suicide and self-harm by young people in Cheshire East.
- ✓ Improve the capacity and confidence of the children's workforce to support young people with poor emotional health

Cheshire East Children and Young People's Plan

How will we know we've been successful?

- ✓ Increase in the number of young people who report good levels of emotional health
- ✓ Children and young people are aware of what services and support is available
- ✓ Reduction in hospital admissions for self-harm
- ✓ Increase in the number of cared for young people who report good emotional and mental health and wellbeing
- ✓ Number of appropriate referrals to CAMHS and other Tier 3 & 4 services

Strategies/plans:

Health and Wellbeing Strategy
Youth Support Strategy
Early Help Strategy
Young Carers Strategy
CECSB Thematic Review Suicide and Self Harm
Cared for Children Strategy
Domestic Abuse Strategy 2014-16

Who's Involved?

Health and Wellbeing Board
Joint Commissioning Leadership Team
Youth Council
Early Help Children's Trust Sub Group

Priority Four:

Children and young people are **healthy and make positive choices**

Why is this important in Cheshire East?

The first few years of life are a critical period for a child's development and we know that good health begins before birth. The health and wellbeing of an infant is directly related to parental health and health related behaviour. For example, smoking during pregnancy reduces the transfer of oxygen and nutrients between mother and unborn baby. In 2011/12, 15.4% in 2011/12 of Cheshire East women smoked throughout their pregnancy up until the time they delivered their baby, and whilst this has reduced over successive years remains higher than the England averages. Once a baby is born, exposure to second hand smoke significantly increases the risk of Sudden Unexpected Death in Infancy (SUDI) and exacerbates respiratory conditions, such as asthma, resulting in illness and time missed from school.
In Cheshire East approximately 8,000 children live in poverty. Children in poverty are at increased risk of a range of poor health and social outcomes including adverse birth outcomes, obesity, diabetes, asthma, mental health problems and reduced access to healthcare4. Children of persistently poor parents are at risk of becoming poor adults themselves and any children they have are at risk of growing up in poverty.

Breastfeeding is a reliable marker for future health outcomes and has been found to significantly reduce the risk of certain infections as well as reducing the likelihood of childhood obesity and other long term conditions. Breastfeeding initiation rates have improved but disparities exist across the borough with the more deprived areas having the lowest breastfeeding rates. A baby born in Poynton for example is twice as likely to be breastfed than a baby born in Crewe.

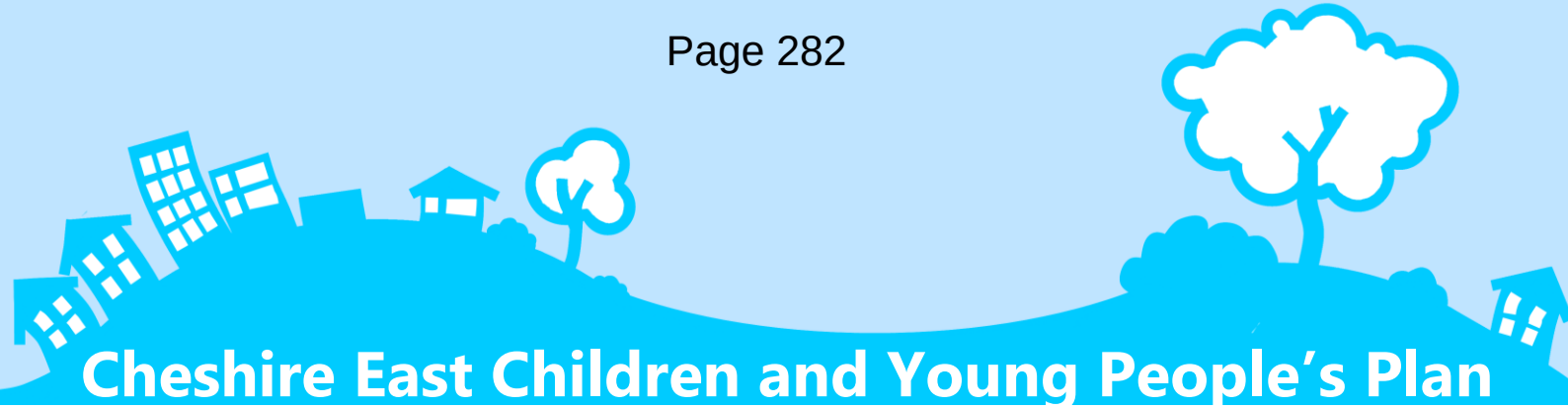
In the case of children's health, good habits adopted early in life clearly have the most long lasting positive impact. Play development not only helps children with physical and social skills and physical activity contributes towards increased self-esteem, confidence and maintaining a healthy weight. Nationally there is concern about excess weight, in both children and adults, so children need to be equipped

with the skills and knowledge to understand and implement good habits such as regular exercise, good nutrition and drinking water which will stand them in good stead to grow into strong, fit and healthy adults. Again there are real variations in the levels of healthy weight across the borough.

In Cheshire East there are around 3,650 children with one or more of the long-term health conditions and in the last five years we have seen a 20% increase in the number of children and young people with chronic respiratory disease. In some areas of the borough unplanned hospital admissions for paediatric asthma, diabetes and epilepsy are above national average figures.

As children develop into young people and then into adults they enjoy greater independence, and in this period of change begin to explore new experiences and lifestyle changes. During this process, young people may begin to engage in risk taking behaviour, and will set lifestyle patterns that may significantly affect their long term health outcomes. These choices are influenced by a wide variety of determinants and are often underpinned by the individual's environment and emotional wellbeing. Alcohol surveys suggest that higher numbers of young people (aged 14-19) in Cheshire East are drinking to harmful levels compared to nationally and there are higher than national rates of young people who we know in some areas the number of teenage conceptions remains high.

All of these areas are important for all children and young people but for some of our young people we need to pay particular attention as they are at times additionally vulnerable. The NSPCC estimates that a quarter of all babies in the UK have a parent affected by domestic violence, mental health issues or drug and alcohol problems. Children who have been in care, young offenders and young carers are all at risk of being exposed to things that do not contribute to good health and making positive choices. It is our collective responsibility to ensure this is not the case.



What will we do:

- ✓ Develop a 'healthy family' approach
- ✓ Involve young people to ensure existing provision is diverse and appropriate including review of sexual health provision, recommission the school health service to become a 5-19 years healthy child service, and implement the new drug and alcohol services, targeting prevention and awareness raising amongst young people
- ✓ Work with NHS England to re commission the 0–5 years healthy child service and ensure a smooth transition to the council in October 2015
- ✓ Invest in local specialist support to avoid placing young people out of borough whenever possible
- ✓ Develop an Integrated Early Years Pathway with health, early years education and care services working together to ensure a seamless and joined up pathway
- ✓ Work with schools to promote good parenting and health and wellbeing
- ✓ Applying our early help philosophy in service provision for all mums to be
- ✓ Improve young people's experience of young adulthood and improve the transition between children and adult services
- ✓ Involve children and young people and their families/ carers in designing care pathways
- ✓ Reviewing our approaches to healthy weight

How will we know if we are successful?

- ✓ Reduced variations in health inequalities including maternal smoking prevalence, breastfeeding rates and reduced under 18 conception rates in key hot spot areas
- ✓ Reduction in the rates of hospital admissions for alcohol/ substance misuse related harm
- ✓ Reduction in the urgent care attendances for asthma, diabetes and epilepsy
- ✓ A reduction in admissions for asthma, diabetes and epilepsy
- ✓ An increase in the number of children cared for at home with complex health needs
- ✓ Reduction in delayed discharge for babies and children requiring supported care at home
- ✓ Reducing time spent in hospital by people with long-term conditions

- ✓ Preventing lower respiratory tract infections (LRTI) in children from becoming serious
- ✓ Improving the patient experience of children and young people
- ✓ Reduced budget spend on out of borough or private care

Strategies/plans

Early Help Strategy
Health & Wellbeing Strategy
Young Carers Strategy
Healthy Weight Strategy
Domestic Abuse Strategy 2014-16

Who is involved?

Starting Well Programme Board
Cheshire East Health and Wellbeing Board
Early Help Children's Trust Sub Group
Youth Management Board
Cheshire East Domestic Abuse Partnership

Cheshire East Children and Young People's Plan

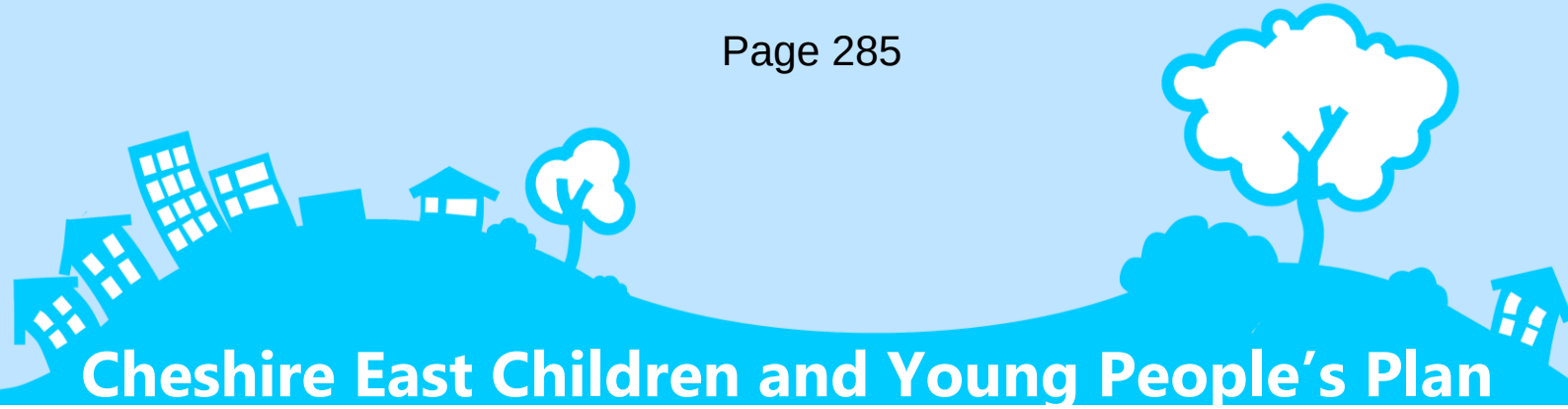
Priority Five:

All children and young people leave school with the **best skills and qualifications they can achieve** and the **life skills they need to thrive** into adulthood

Why is this important in Cheshire East?

In Cheshire East we believe in delivering the best education to give our young people the best chance of succeeding in later life. The majority of children and young people in the borough make good educational progress in schools but we know that geographical differences exist across Cheshire and our positive achievement figures overall mask variations differences across the borough, which perpetuate into adulthood. This gap in achievement starts in the early years and over recent years has widened by the time young people leave school. GCSE achievement by children and young people eligible for Free School Meals has improved but remains below the local and national attainment overall. Although small in number, the gap for our cared for children is wider than their counterparts nationally.

The vast majority of young people in the borough progress in education, employment or training. However, again very real inequalities exist of some young people. In particular wards young people are twice as likely to become NEET and challenges exist for particular vulnerable groups including Care Leavers and Young Offenders and those with complex circumstances such as young people with mental health issues, disability or caring responsibilities. The Raising Achievement Strategy commits to a number of specific objectives to raise levels of achievement to improve overall performance, tackling any inequalities in provision across the Borough to accelerate progress rates for vulnerable groups, placing Cheshire East as one of the highest achieving Authorities in the country.



What will we do?

- ✓ Improve the quality of provision in the Early Years Foundation Stage with effective support in the early years targeted to those children most at risk of underachievement
- ✓ Work with early years providers to ensure that there is sufficient high quality places in order that children eligible for the two year old offer take up their place.
- ✓ Implement an integrated pathway for children in the early years so that young children make good progress in their learning and development and that their families receive the support they need in order to improve outcomes for the lowest achieving at age 5.
- ✓ Further embed our Early Help offer to ensure children and families who require additional support can easily access services
- ✓ Strengthen transition from the Early Years Foundation Stage into Key Stage 1 to maximise achievement at KS1.
- ✓ Build a long term sustainable, education sector led model, securing good teaching practice, leadership and governance across the Cheshire East Education system through effective and creative school partnership arrangements. The role of Teaching Schools is key to the success of school to school support.
- ✓ Work with all schools to ensure an effective use of pupil premium funding in tackling variance in pupil outcomes.
- ✓ Promote digital inclusion.
- ✓ Provide targeted support for young people to secure their engagement and retention in education or training, particularly in light of the raising participation age expectation.
- ✓ Work with education providers and local employers to ensure young people have access to high quality educational provision and appropriate progression into training and employment including work experience opportunities and vocational training.
- ✓ Promote a 'curriculum for life' to improve young people life skills.
- ✓ Improve the range of local learning and progression opportunities to better meet the learning needs of young people with learning difficulties and/or disabilities.
- ✓ Ensure the Borough has sufficient school places and responds to localised demand.

Cheshire East Children and Young People's Plan

How will we know if we are successful?

- ✓ More children are ready for school with good social and emotional development.
- ✓ Increase in the number of schools and settings judged as Good or Outstanding by Ofsted.
- ✓ Children and young people have a positive experience of school
- ✓ More children and young people who experience disadvantage will attain in line with all other children locally and with similar groups nationally at all key stages but particularly at Key Stage 4.
- ✓ Increasing the numbers of young people achieving 5+ A*-C including English & maths and ensuring progress measures are maximised.
- ✓ Educational achievements of our Cared for Children will improve at all Key Stages but especially at Key Stage 4.
- ✓ Increase the numbers of disadvantaged young people who leave compulsory school with the skills needed to realise their particular talents and abilities and move onto meaningful education, employment or training.

Strategies and Plans

Raising Achievement Strategy
Cheshire East Early Help Strategy

Who will be involved?

Cheshire East Education Partnership Board
Youth Management Board
Early Help Children's Trust Sub Group

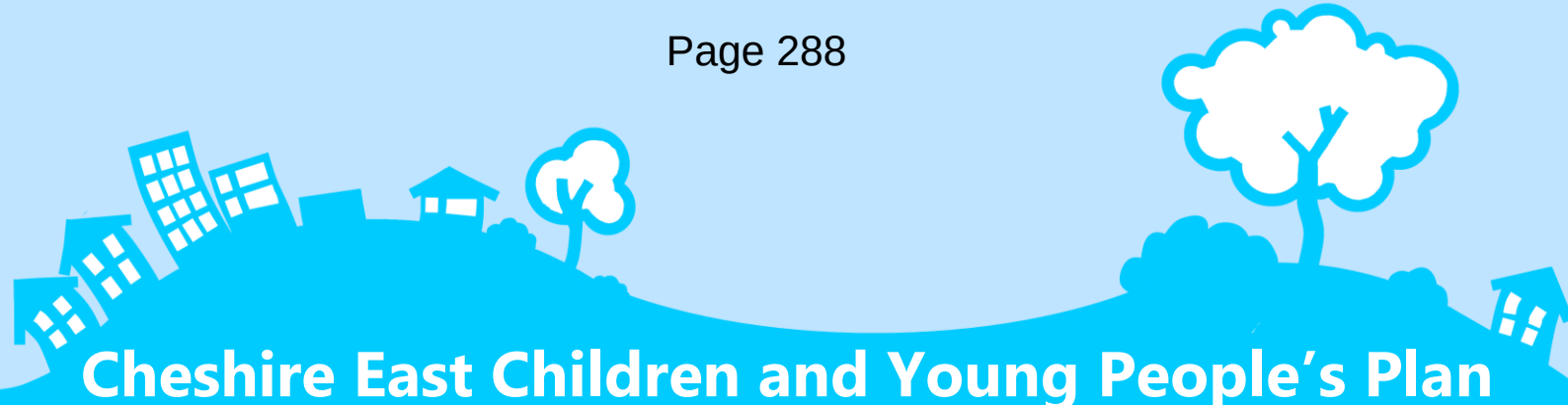
Priority Six:

Children, young people and young adults with additional needs **have better life chances**

Why is this important in Cheshire East?

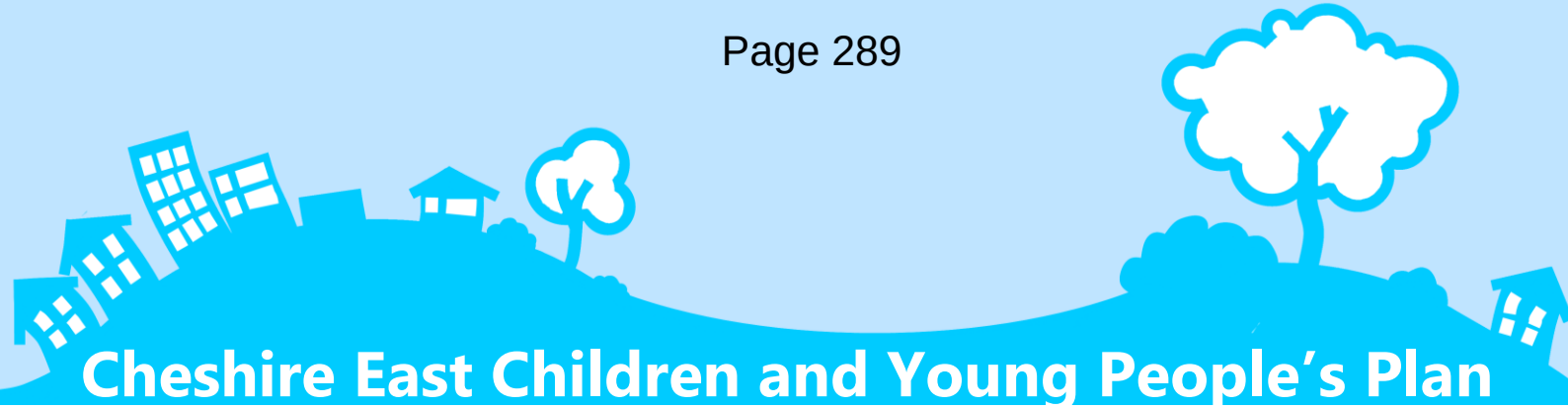
Approximately 16% of children and young people in Cheshire East have Special Educational Needs and/or disabilities (SEND) and we know that these children and young people often face a range of barriers that impact on their quality of life, wellbeing and future prospects. Pupils with SEND demonstrate good progress and achievement [insert XX%] and the gap in attainment compared with pupils who do not have SEND is closing [XX%, showing a X% improvement]. In Cheshire East young people with special educational needs or a disability are disproportionately represented in those who are not in education, employment or training (NEET) and those who come into contact with the youth justice system. We also know that for those with the most complex need who attend independent specialist colleges over the past 4 years, just 44% have achieved positive life outcomes such supported employment, supported living, progressing to further education and taking their place in their community. It is vitally important therefore that children with special educational needs and disabilities have access to greater opportunities and choices that help them achieve their potential as they move into adulthood.

The Children and Families Act 2014 provides us with an opportunity to re look at our approaches to children and young people with special educational needs or a disability. Our local programme aims to create the right culture of improvement and aspiration, shared ownership with children, young people and their families, and being clear about roles & responsibilities and expectations.



What will we do:

- ✓ Work with families to maintain and develop the local offer of support and provision for children and young people who have special educational needs or disabilities and their families
- ✓ Improve the participation of children and young people with special educational needs or a disability, ensuring that they are involved in decisions that affect them
- ✓ Put children, young people and families at the heart of decision making.
- ✓ Implement a multi-agency approach to personalisation for SEND 0-25 and embed the new statutory assessment and Education, Health and Care Plan process.
- ✓ Enable families to have more choice and control through the introduction personal budgets for those who want them for children and young people with a EHC plan
- ✓ Establish joint commissioning arrangements that support the flexible approach of the new statutory assessment and planning process
- ✓ Improve planning and support for transition at all ages and stages
- ✓ Create more choice in post 16 education, employment and training opportunities in 'preparation for adulthood'
- ✓ Improve the capacity of all settings and services to deliver inclusive, holistic and personalised provision and ensure an effective continuum of provision that meets the continuum of needs and secures outstanding outcomes.



Cheshire East Children and Young People's Plan

How will we know we have been successful?

- ✓ Improving progress and achievement for children and young people with SEND and closing attainment gaps.
- ✓ Reduction in number of children and young people with special educational needs or a disability that are NEET
- ✓ Reduction in number of children and young people with special educational needs or a disability that come into contact with the youth justice system
- ✓ Children and young people and their families or carers report improvements in those outcomes identified in their Education, Health and Care Plans
- ✓ Children and young people make expected or better levels of progress and achievement
- ✓ Families report high levels of satisfaction with the Local Offer and they report that information is accessible and helpful. They have more choice and control over services and receive positive experiences.
- ✓ Children and young people with special educational needs or a disability report that they are respected as individuals and their voices are heard separately from their parents
- ✓ Participation of children, young people and families is embedded and report that their experience and insight is used to shape service improvement
- ✓ They report a positive experience of a personalised, joined up approach received from professionals and services
- ✓ The quality of life for people with Long Term conditions is enhanced
- ✓ The quality of life for carers is enhanced
- ✓ Reduction in premature deaths for people with learning disabilities

Strategies and Plans

Implementing a multi-agency approach to personalisation for SEND 0-25
Raising Achievement Strategy

Who will be involved?

Life Course Programme Board
Joint Commissioning Leadership Team (JCLT)
SEND Multi-Agency Managers Group
Parent/Carer Forum

7. How will we make this happen?

This plan sets out how the borough will support young people to get the best start in life, as set out in the Cheshire East Health and Wellbeing Strategy. It outlines how the Children and Young People's Trust aim to deliver these health and wellbeing improvements through our six priority outcomes. This Plan is very much a live document, and we will review its progress over its three year life. The Plan will be monitored by the Children and Young People's Trust Board (CYPT) or Cheshire East Safeguarding Children Board and progress reported to the Health and Wellbeing Board. The Partnership arrangements to deliver on our priorities comprise the following:

- The **Health and Wellbeing Board** provides the vision and coordinated drive to address the health and wellbeing needs of the local population of Cheshire East to reduce unacceptable and avoidable variations in health and healthcare. Children and families services come under the „Starting Well" and „Living Well" priorities of the Health and Wellbeing Board
- The **Children and Young People's Trust** is a partnership Board that aims to improve outcomes for all children and young people in Cheshire East through strategic leadership and decision making, determining joint priorities, joint planning, and ensuring integrated working. The Trust Board is supported by the **Early Help Children's Trust Sub Group and the Youth Management Board**.
- The **Participation Network** is a multi-agency group that brings together engagement and participation workers across the partnership to share and develop good practice and join up services.
- The Cheshire East **Safeguarding Children Board (LSCB)** and its **Executive Group** is an independently chaired statutory partnership board that works together to ensure that where children are harmed, or at risk of harm, all agencies actively cooperate to safeguard them and promote their welfare. The LSCB is supported by an LSCB Executive Group and a number of sub-groups that progress separate work streams of the LSCB Business plan.
- The **Joint Commissioning Leadership Team** brings together commissioning partners from the Local Authority, South Cheshire Clinical Commissioning Group, East Cheshire Clinical Commissioning Group and Public Health England to develop commissioning plans to deliver on shared health and wellbeing priorities.

Cheshire East Children and Young People's Plan

The following organisations are cosignatories to the Children and Young People's Plan, and are committed to ensuring that we achieve the outcomes that we have set out. This could be achieved through single agency activity or through joint working, commissioning or scrutiny, as appropriate.

Cheshire East Youth Council 	Cheshire East Council
Cheshire East Local Safeguarding Children Board	South Cheshire Clinical Commissioning Group
Eastern Cheshire Clinical Commissioning Group	Plus Dane Group
East Cheshire Association of Primary Head Teachers (eCAPH)	Cheshire East Association of Secondary Head Teachers (CEASH)
Cheshire Constabulary	Cheshire Fire and Rescue
Guy Hayhurst Public Health	Cheshire and Wirral Partnership K. Langton-Flint Cheshire and Wirral Partnership
Representing the voluntary, community and faith sector	Representing Colleges

Cheshire East
Children & Young
People's Trust

www.cheshireeast.gov.uk/children_and_families/childrens_trust

email: **childrenstrust@cheshireeast.gov.uk**

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The Children's Society

Cheshire East Good Childhood Report

Measuring children's and young people's well-being in Cheshire East

Photograph modelled for The Children's Society | © Larry Bray

Contents

1. Introduction and summary of key findings

The Cheshire East Survey of Children and Young People 2014 provides a unique insight into the lives of children and young people aged 7 to 17 living in Cheshire East. Over 1,800 children and young people in primary and secondary schools across the area participated in the survey. Previously in 2013 the work had been conducted in Knutsford with 923 children and young people and most of those results are included in this report. This gives a combined sample size of 2,810.

The survey questionnaire covered all the key aspects of children's lives from their feelings about life as a whole, to their relationships with family and friends, and their perspectives on school and the local area. The survey questions were taken from a larger set of questions on children's well-being that have been developed and validated by The Children's Society and the University of York. This means that it is possible to compare many of the answers given by children in Cheshire East with the national picture for England.

The aim of undertaking the survey is to identify the aspects of life where children in Cheshire East are doing well, and those where they are not doing so well, in order to identify potential local priorities for improving well-being.

Following the survey, a series of face to face consultations were carried out with children and young people in order to amplify, illustrate and illuminate the survey findings. These consultations were undertaken by a team from The Children's Society who have conducted similar activities across the country and are able draw comparisons with other areas where this work has been conducted.

Key findings

This report presents the main findings from the survey. A summary of key points is as follows:

- Well-being and life satisfaction for children and young people is in general as good as or often better than the national average
- The differences are in how children and young people feel about their health and how teenage girls feel about their appearance. In both these situations Cheshire East does less well
- Higher levels of satisfaction with things is more about having enough than having a lot

- As with the national findings, it is the nature and strength of children's relationships with their family, friends, school staff and local adults that has the greatest impact on well being
- Young people want more shops and places to hang out, but not youth centres
- There are variations within Cheshire East, but they are not significant
- Although the survey shows most children experiencing average or above average scores for well-being, for around 10% their responses suggest they have low well-being. This is in line with the national average
- The concerns girls have about their appearance is mostly influenced by the comments and judgements they make on each other and particularly by the observations boys make about girls
- Boys are generally unaware or unaccepting of the way their comments effect girls and their self esteem

2. Details about the survey and consultation work

The survey questionnaire was developed by The Children's Society in partnership with the University of York. It covers all of the aspects of children's lives that are included in The Children's Society's Good Childhood Index:

- Feelings about life overall
- Self (appearance)
- Health
- Family relationships
- Friendships
- Home
- School
- Local area
- Money and possessions
- Time use
- Choice and autonomy
- The future

All these topics have been found to be important aspects of how children view, and feel about, their lives[1].

[1] Rees G, Goswami H & Bradshaw J (2010) *Developing an Index of Children's Subjective Wellbeing in England*. London: The Children's Society.

The questionnaire also asked children for information about their age, gender, ethnicity, abilities and living situation.

The survey had been carried out in Knutsford with 920 students in 2012 and some of those results have been included in this report.

Recruitment and administration

All mainstream primary schools, secondary schools/colleges and special schools in Cheshire East were invited to participate in the survey, and 23 elected to take part and involved 1,887 children and young people completing the survey.

In addition, The Children's Society carried out face-to-face consultations with 771 children and young people in primary schools, secondary schools, one special school and with groups of young people who are looked after by the Local Authority (for more details of the consultation, see the next section).

The survey was administered online by The Children's Society. Children and young people were able to access and respond to a secure online questionnaire which varied according to school year to ensure that the content of the questions was age-appropriate.

The survey was conducted in accordance with an ethical protocol approved by The Children's Society's research ethics panel, consisting of internal and external experts.

Data cleaning and statistical analysis of the questionnaire has been conducted by staff in The Children's Society's in-house research team.

Profile of the young people taking part in the survey

The sample was well balanced between females (53%) and males (47%).

The age distribution of participating children and young people are shown in the table below and include the Knutsford survey.

Based upon the low number of children in some age categories in the Cheshire East survey, national comparisons are based on those aged 9-17 only.

8% of participating students said they receive free school meals.

3% of participants said they live in a household where no adult is in paid work, while just under one quarter (22%) live in a household with one adult in paid work.

Presentation of findings

This report presents an overview of findings from the survey as follows. First, we look at children's feelings about their lives as a whole. Then we provide key findings on the different aspects of children's lives covered in the survey.

In each section we make some comparisons within the sample (mainly on the basis of age and gender) and where possible make comparisons with data from nationally representative samples of children and young people in the same age group in England as a whole.

We have used statistical tests to check whether differences between groups within survey (e.g. females and males) are statistically significant. Where we have said that a difference is statistically significant this means that there is less than a 1% likelihood of the difference happening purely by chance. This is a standard threshold used by researchers for surveys of this type.

About the consultation

Following the completion of the survey by over 1,800 children, The Children's Society consulted with 771 children and young people face-to-face on the key issues that emerged from initial analysis of the survey. The aim was to explore and illustrate with children's own words some of the key issues raised by the survey, and specifically the following topics:

- School and relationships with peers and staff in particular
- Thoughts about the future
- Health and appearance
- Local area, and thoughts about improvements
- Possessions and things children and young people own

The Children's Society arranged consultations with primary schools, secondary schools, youth councils and with the children in care group. The school consultations involved classes in year groups 3 to 10. We used a variety of class

activities that allowed children and young people to reflect on the survey findings, consider their own responses and discuss them with their peers. We recorded some of their comments and they provided some written comments through some of the activities.

In this report, we present these written and verbal comments from children and young people from the consultation alongside the main themes of the survey to which they relate.

Our intention is to provide an insight into the types of issues that children and young people raised when we asked them about the key themes emerging from the survey. The comments included here are therefore illustrative rather than representative, and they offer a summary rather than a full discussion of the consultation exercise.

Although we have a record of where the comments were made, we do not identify children to protect their anonymity.

3. Life as a whole

The questionnaire asked children how they felt about their lives as a whole. International research with adult populations indicates that there are different components of 'well-being':

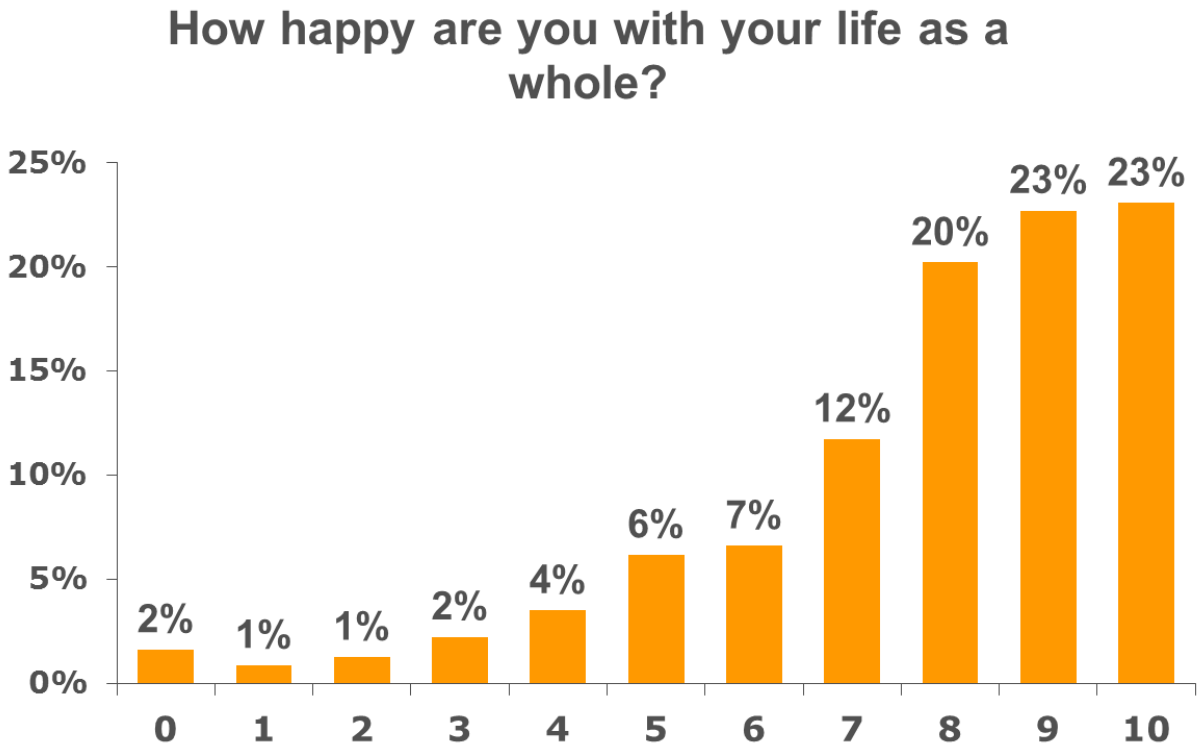
- Levels of happiness, which can vary from day to day or hour to hour
- Cognitive assessments of satisfaction or happiness with life as a whole, which are more stable
- Feelings of personal development or 'flourishing'.

We asked children a question about the second bullet point: how happy they are with their life as a whole. For this question children could respond on a scale from zero to 10 where zero = 'very unhappy' and 10 = 'very happy'.

In response to the questions about how happy children are with their lives and almost a quarter answered very happy with a score of 10 out of 10 and less than 3% answered with very unhappy with a score of zero.

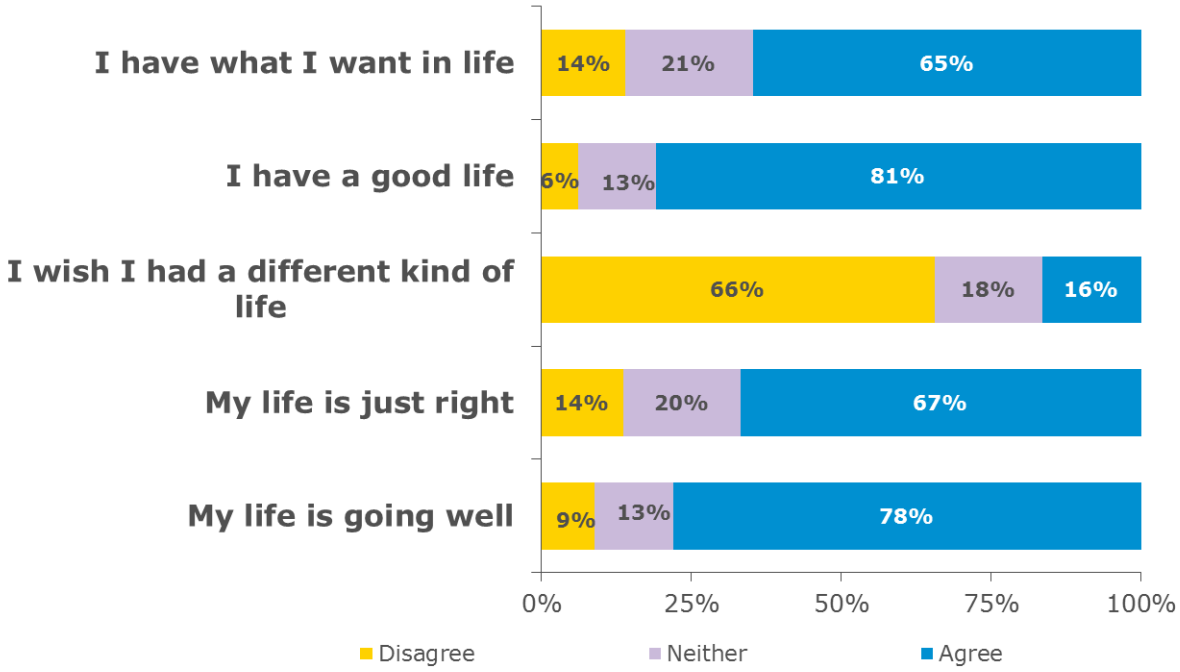
As with the national average most children answered that they were happy with their lives as a whole and this response is generally higher for primary age children than for secondary age. In this respect children and young people in Cheshire East are similar to the national average and if anything indicate slightly higher scores than the national average.

"It is quite easy to be happy because there are nice people and nice friends around and in school"- year 7 girl



The overall score out of 10 for well-being was a little higher than the national average at 7.74

This single-item question about life as a whole is useful for getting a basic picture of how children feel about their lives overall, but we also included another set of questions about children's life satisfaction, which can be used to create a score of children's well-being that is more statistically robust and can be used to compare well-being between different groups of children. These questions are in the form of statements that children are asked how much they agree or disagree with. The statements, and children's responses to them, are shown in the Figure 4 below. This shows that most children agree or strongly agree with all the statements (except for the third statement, which is phrased negatively). Between 6% and 16% respond negatively depending on the question asked.



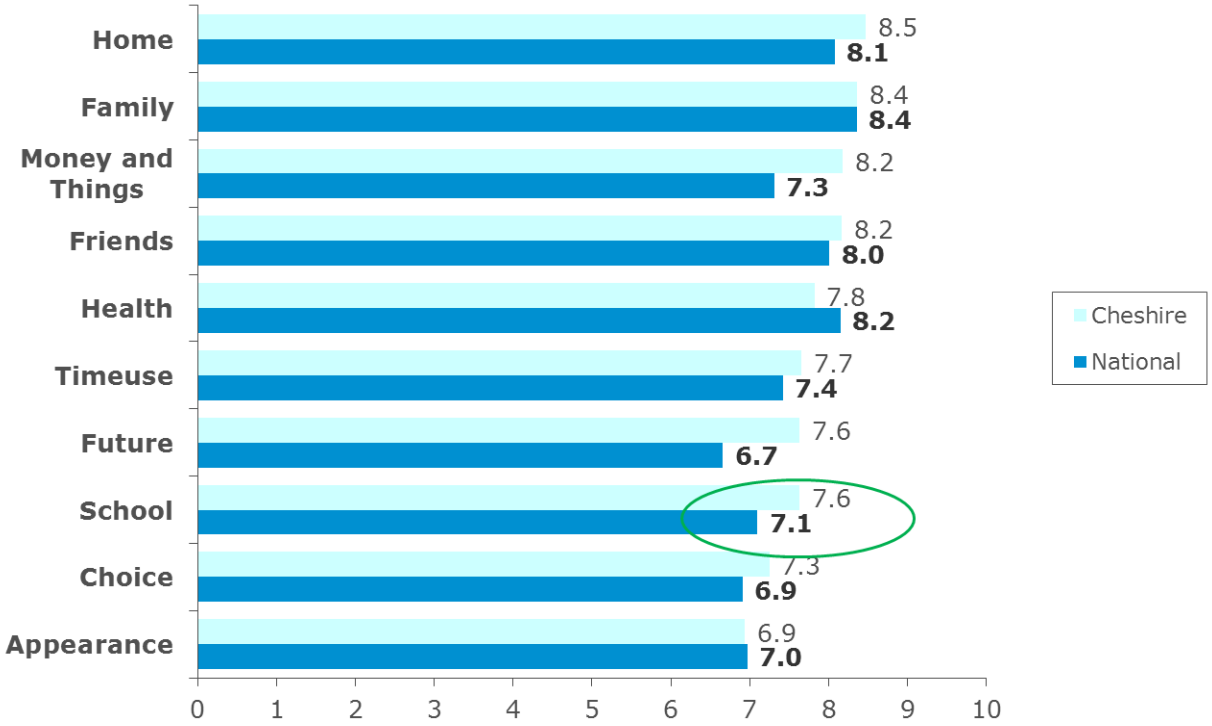
Research shows that answers to these kinds of questions do not reflect a temporary state. For example, our research suggests that around half of children who have low life satisfaction now will still do so in six months' time. International research also suggests that low well-being is linked with a range of other longer-term problems and issues in children's lives. It is therefore important to understand the factors that cause low well-being in order to consider what measures might be taken to provide support to children who are in this situation.

"If I lost my tablet I wouldn't be that bothered but if I lost my cat I would be so sad" - year 5 girl

Surprisingly, the research on well-being indicates that factors that might be expected to explain variations in children's (and adults') well-being such as gender, ethnicity, family structure and economic status are not as important as might be anticipated. There are variations in well-being according to these factors (for example, children in poorer families do tend to have lower well-being than children in richer families). However, these types of factors can only explain a small part of the variations in well-being. Amongst children in England our research suggests that all of these types of factors put together explain less than 10% of the variation in life satisfaction.

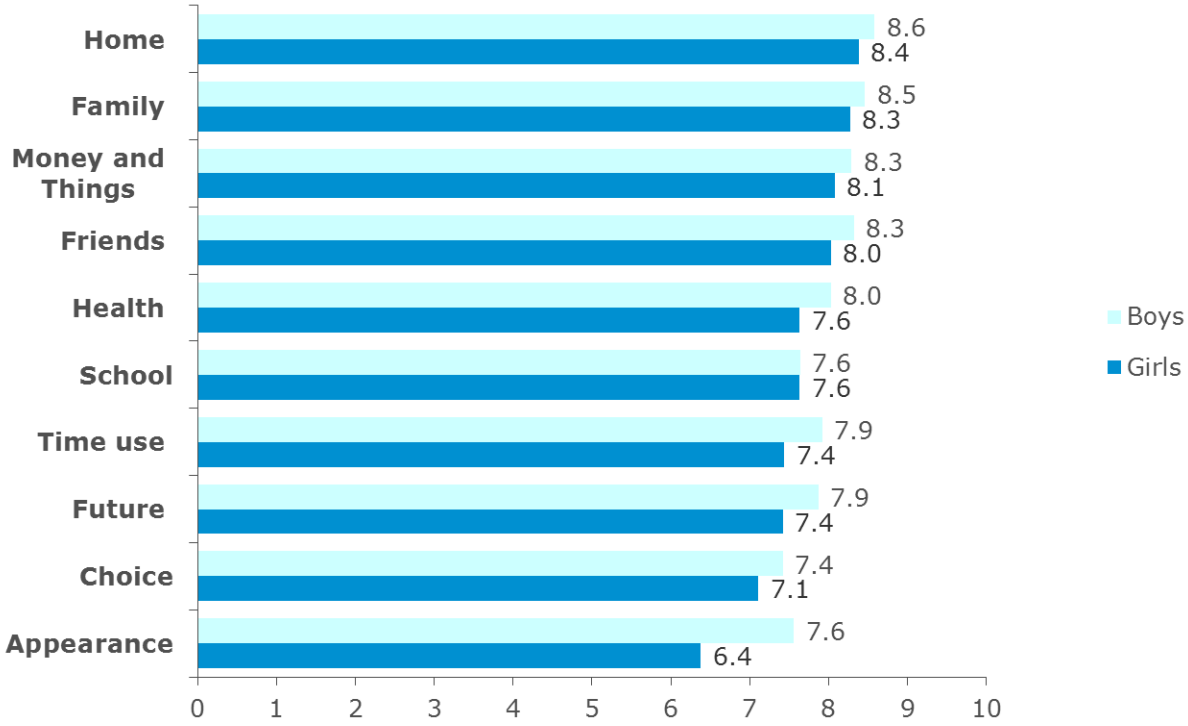
4. Feelings about different aspects of life

In the survey we used questions from our Good Childhood Index which ask children how happy they feel with different aspects of their lives. Children were asked to rate each aspect from zero to 10 where zero = 'very unhappy', five = 'neither happy or unhappy' and 10 = 'very happy'. The mean scores for children's responses to these questions in comparison to the national average are shown below.



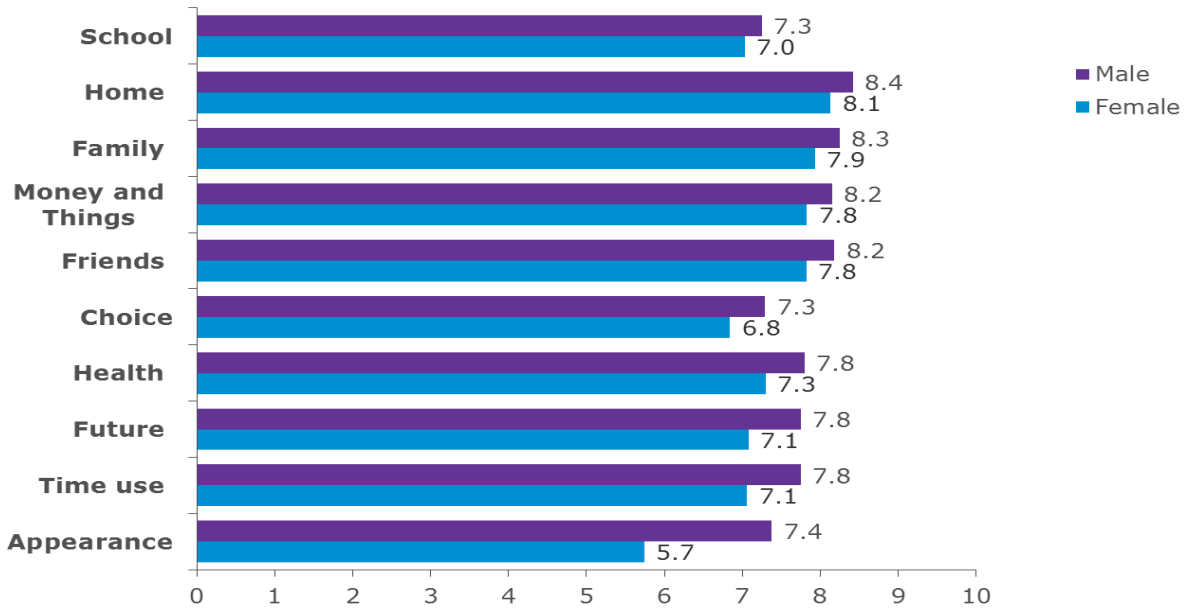
The results for Cheshire East show that in most domains children and young people are scoring higher than the national average, for example the response for how happy children are with school is 7.6 compared to 7.1 nationally.

Where children and young people score below the national average is in how they feel about their health and to a lesser extent their appearance. This is for the whole sample of children and young people. When age and gender is taken into account the results are more pronounced.



Boys are scoring higher than girls in all domains apart from school where they are equal. How girls feel about their appearance is significantly different for girls.

But when age is taken into account it is apparent that the difference increases as children grow older. The figure below is for **secondary age** only.



5. Appearance

In the consultations with children and young people there were indications from the primary age girls that they were already thinking about their appearance and looks.

"It's pants being a girl because you have got to mess around looking nice and doing make up, plus hair" - year 6 girl

Girls in year 5 and 6 were not necessarily unhappy about their looks but in activities where they were given the opportunity to reflect on themselves they were more likely to focus on appearance.

"I love being a girl because they have more fashion sense, you can wear make up, you can wear high heels" - Year 6 girl

But for most of the consultations with girls in secondary schools their reflections were more negative and were largely concerned with how boys and girls comment on physical appearance. Their sense was that most comments were critical and that the boys in particular were insensitive to the impact that had on them.

"There is a lot of pressure to look good, you get called names no matter what, people always say stuff behind your back, boys always call you ugly if you have spots, or a slag if you wear makeup" - year 8 girl

"Boys judge you and they expect perfection from you. It only started in High school because in primary they didn't really care" - year 7 girl

"Because boys only want a real life Barbie" - year 9 girl

"Girls can't go out the house without make up looking good. Boys are mainly the ones that criticise girls for their looks, boobs or bums. Then girls feel insecure and threatened" - year 8 girl

There was little evidence in the consultations that boys were either aware of the impact they were having or particularly cared about that impact.

"Boys don't mind as much about how they look, but girls always want to look good" - year 8 boy

"They might be ugly, they look bad with lots of make up on" - year 9 boy

"Most of them are minters anyway, so why shouldn't they know?" - year 9 boy

The consultations with young people suggested that for some girls the concerns they had about their appearance and how critical they were of each other was making them feel anxious and unhappy. Some girls were able to brush off the concerns but it is clear that this is a major issue for teenage girls and that it is most influenced by the way they make observations of each other.

5. Health

Health was the other area where both boys and girls scored below the national average although again the scores for girls were lower than for boys. In the consultations boys and girls were asked to reflect on different aspects of health and consider what effected whether they felt healthy or not. In many cases children struggled to identify what they thought constituted good or poor health. But their main reflections were around diet, exercise and emotional well-being.

"It's not hard to choose between a burger and broccoli – you would choose a burger" - boy year 8

"There are lots of activities I like football at the park" - boy year 8

"There are quite a few fast food places in Poynton. There is a pub so people will smoke and drink" - year 8 girl

"There are not enough healthy inspired café's" - year 8

"In my village there are a lot of ways to stay healthy because there are lots of jogging places and walking areas. It is also affordable to be active" - year 7 girl

"Mostly it's very expensive to buy fruit and healthy food. In Bollington there are mainly takeaways" - year 8

"It depends how people around me feel because that massively effects how I feel" - year 8 girl

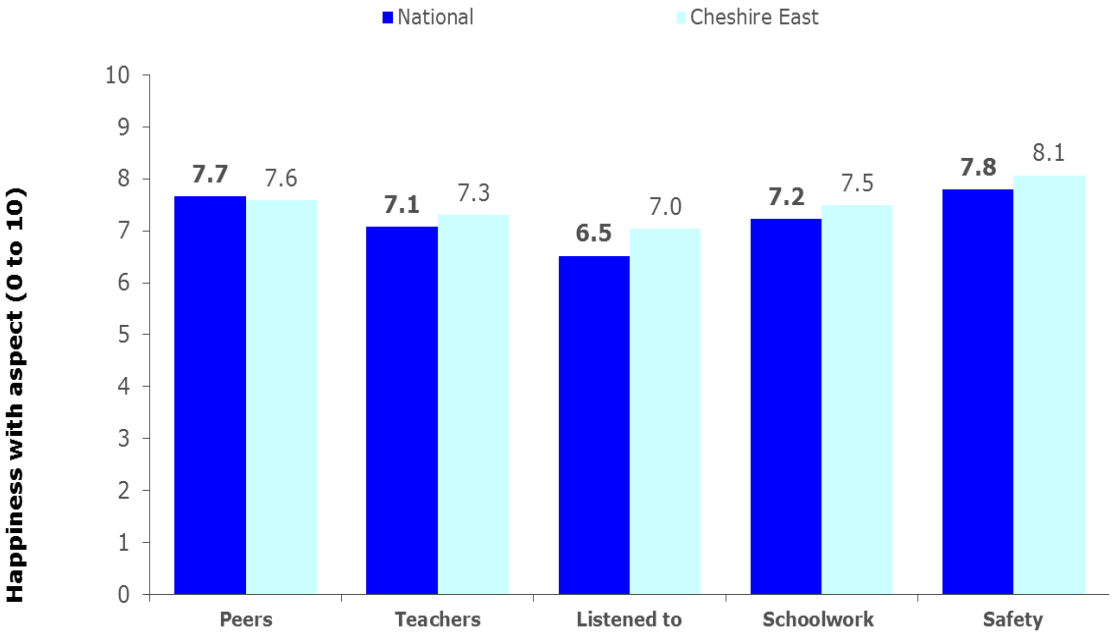
It is hard to generalise the views of young people regarding health because there were differences in attitudes according to the options young people had. In some areas young people talked about the opportunities to be involved in sport and outdoor activity that were free or simply accessible. In other areas young people felt they had limited options or what was available was too expensive to use.

Equally in terms of diet and health many young people referred to the ready availability of fast food but there was a greater variance in terms of how accessible and affordable healthy food was to them. For some boys there was an understanding that fast food wasn't particularly healthy but that they enjoyed it anyway. Knowing what healthy food is but not eating it may contribute to how healthy young people feel.

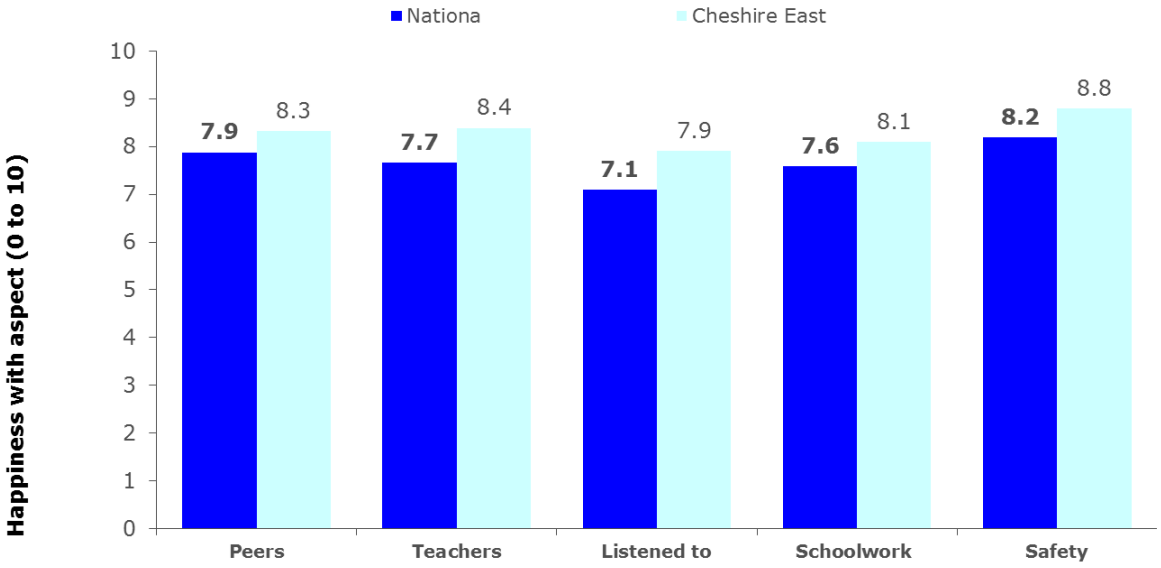
Being happy was a feature of good health particularly for the girls and being happy was associated mostly with good relationships, with friends as well as family. The connection with concerns about appearance and feeling happy and healthy was made by a number of the girls who recognised that many of the comments they received were about their physical appearance and body shape.

6. School

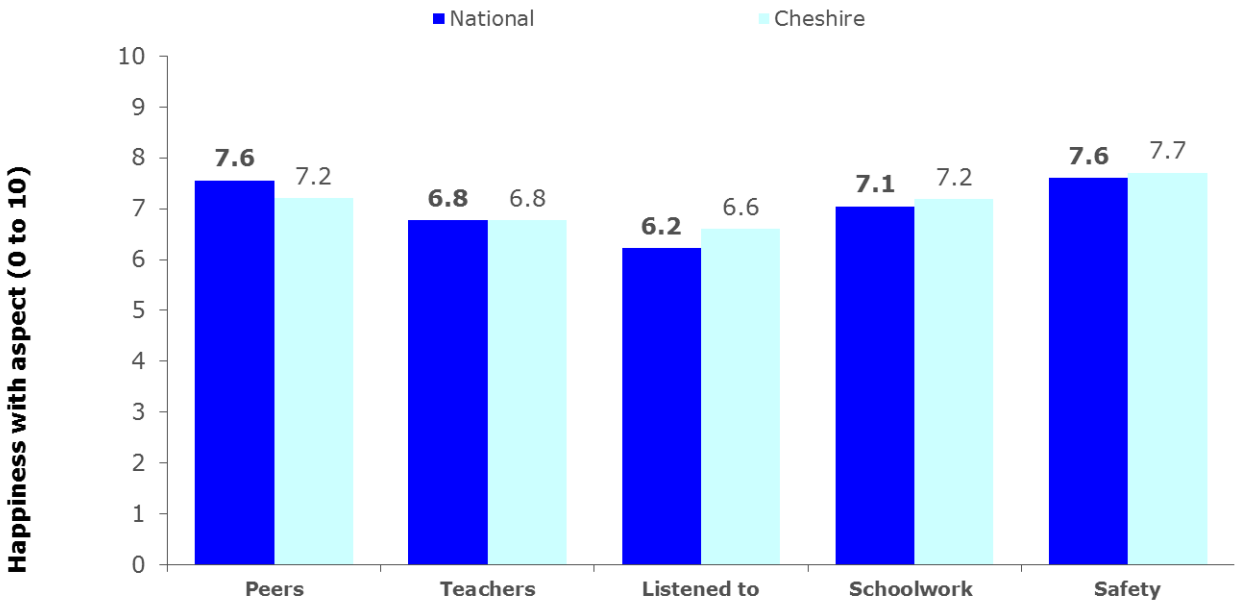
The overall results for how children and young people feel about their school experience suggests that children in the area have similar levels of happiness as the national average. In most domains their happiness with school is a little higher than the national average with the exception of how they happy they are with their peers. For all ages the results are:



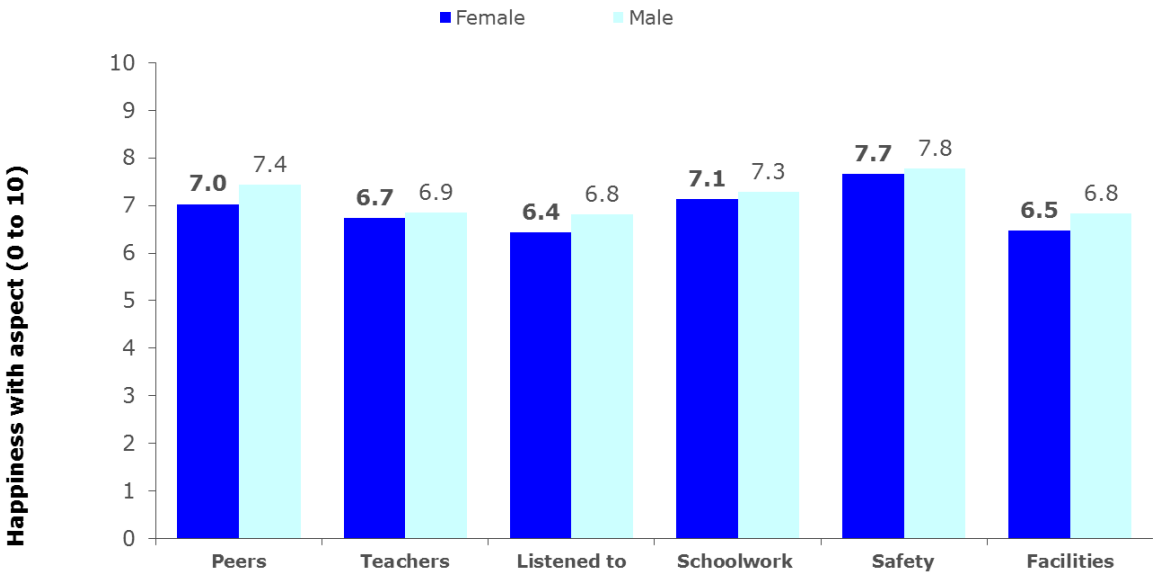
But for children in primary school the children in Cheshire East indicate higher levels of happiness than the national average in all domains.



We know from our national data that children become less happy with their school experience as they move from primary to secondary school and that is no different in Cheshire East. Overall at secondary school age young people are still as happy as the national average or a little higher with the exception of levels of happiness with their peers where it is a little less.



This difference is not particularly significant except that it is girls whose experience lowers the score at secondary age.



In the consultations with children and young people we explored how young people felt about the different aspects of school life and as with the survey findings it was the girls who had the lesser experiences.

"I feel sad at school all the time. It is hard to fit in at school because other people make you feel bad/poo about yourself (especially the popular's) There should not be people which think they are better than you. I don't have many friends"- girl year 9

"Many girls and boys have started to think it's acceptable to call each other nasty names, but it's horrible" - girl year 8

"It's different from primary school; I find it really hard to keep on top of all the homework" - girl year 7

Typically a lot of the comments about school related to work, homework and individual teachers. But for the girls there was a continuing thread of comments that connected with issues of appearance and how boys and girls comment on each other. There was little evidence to suggest this was happening on line specifically but was reflected time and again by girls about people talking about them directly or indirectly in ways that made them feel uncomfortable and unhappy.

7. Possessions and things children own

The survey suggested that children and young people in Cheshire East were happier than the national average in relation to the things and possessions that they own. This was true for both boys and girls and they had broadly equal levels of satisfaction. When exploring this issue in other areas we have found that this result does not necessarily reflect a high level of material possession but rather a level of satisfaction with what is personally owned.

In consultations with children and young people in Cheshire East on this theme we formed the following key conclusions:

- Primary age children value their pets as much as any toy or game
- Sports equipment such as a bike or football was regarded by many as a priority item to own
- Few children and young people put much value on having a television
- A smart phone gives young people access to music, games, the internet and a means of keeping in touch with friends and family. As such it is often all young people need

- Boys up to the age of 14 are likely to prioritise games consoles above many other items
- Few children and young people thought that it was important to have a lot of pocket money or designer clothes

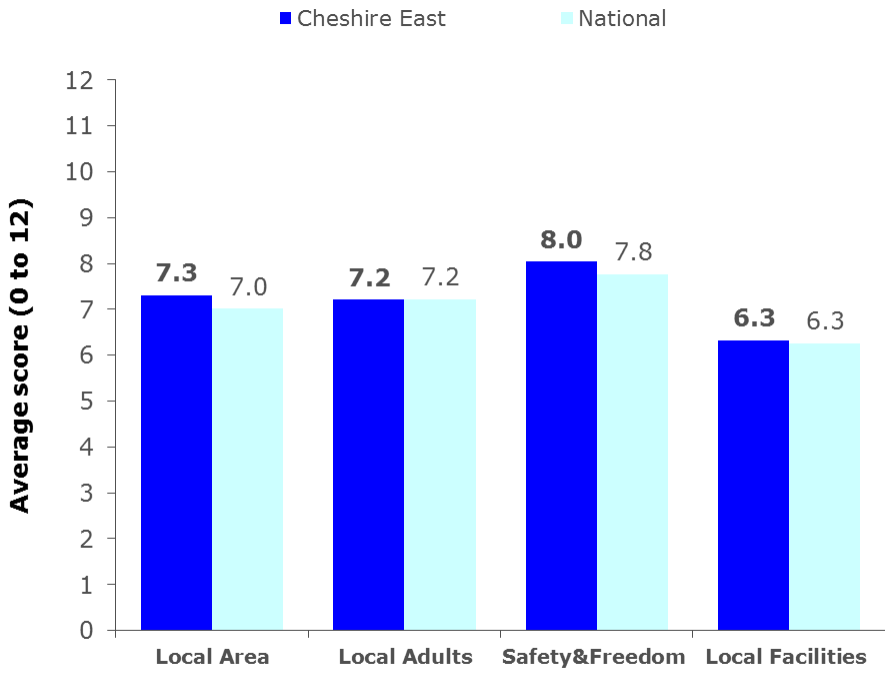
"My cat is epic" - year 5

As with the findings of our national well-being work what we find is that what matters most to children and young people is that they have a similar amount of things to their peers. In part this is why a smart phone seems to be all that is needed as most have one even if the contract or value of the phone itself may differ.

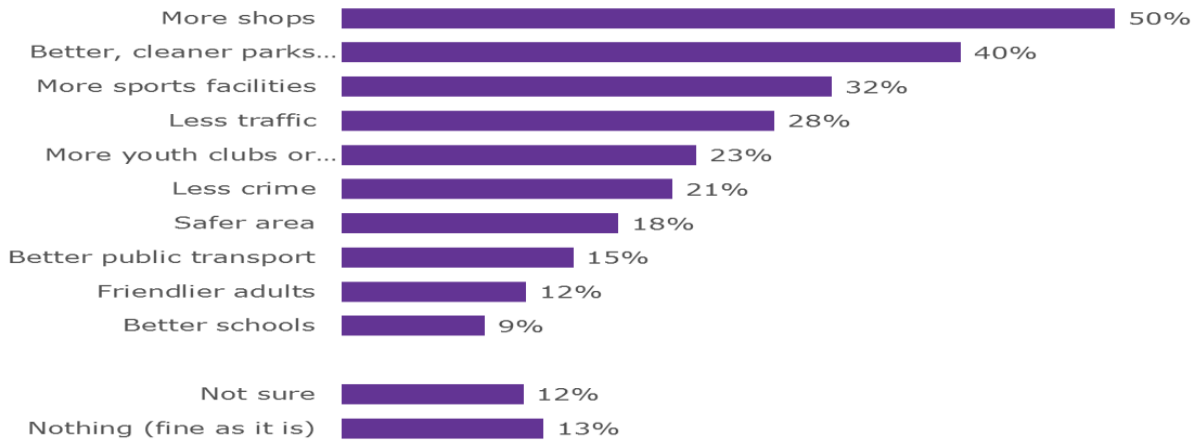
8. The local area

It is an important element of the survey that children and young people's views about their local area are sought. How they experience the neighbourhood they live in and go to school in makes a difference to their overall well-being. The survey asked children and young people to reflect on how happy they were with local facilities, their safety and freedom in their neighbourhood and local adults.

The results for Cheshire East are in line with the national average.



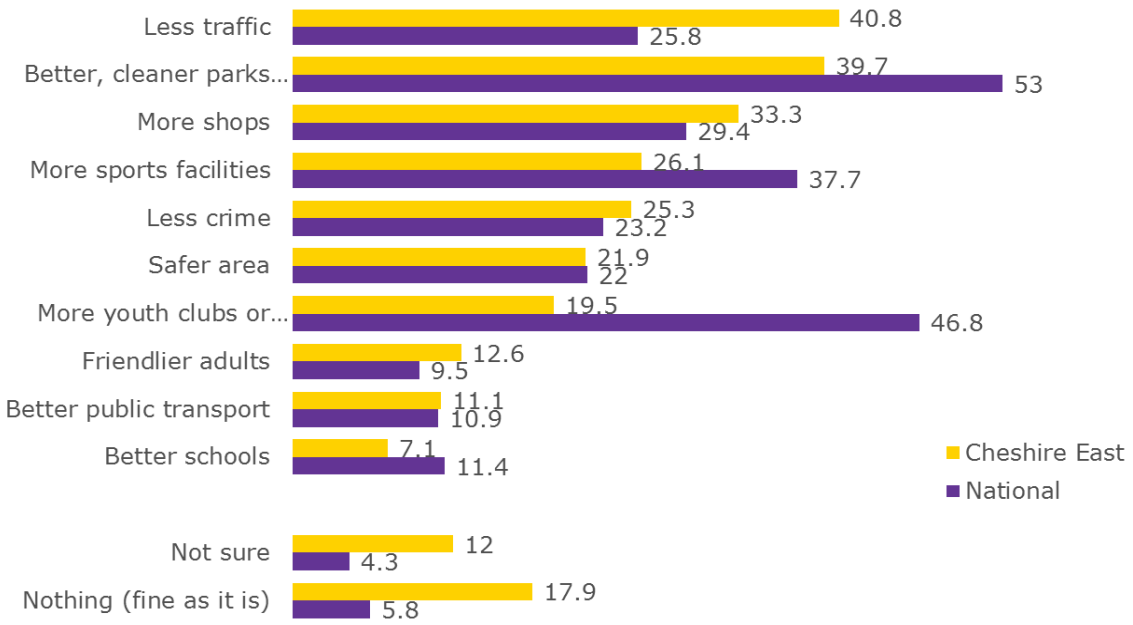
In the consultations with children and young people it was recognised that the neighbourhoods they lived in varied considerably. Some live in rural communities and villages and others in urban towns with equally varying features. Consequently the focus of the consultations was on what children and young people said they thought would most improve the area they live in. The results for Cheshire East for all ages are in the figure below.



By far the biggest single improvement children and young people were looking for is more shops. The proportion of children and young people who said there was nothing wrong with their area was higher than the national average and in consultations with children and young people there were many who were quite satisfied. But the key differences between Cheshire East and the national average are more clearly seen in the results broken down by age.

Primary school age children did put a higher priority on more shops than the national average and on wanting friendlier adults. But it is their concern about traffic that stands out and their lack of wanting more youth clubs.

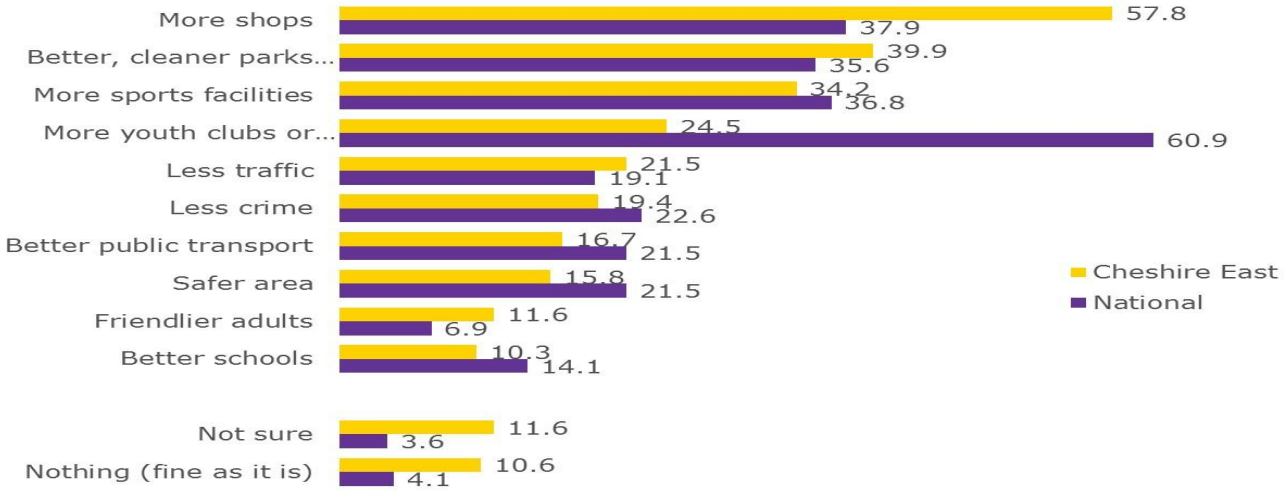
"Our streets nice, there's a big field at the bottom where kids play"- year 5



In exploring the theme of traffic children of this age group reflected on the speed of traffic as much as the volume of traffic and this seemed to relate more to children in rural areas.

In most cases children in this age group expressed limited knowledge and understanding about what a youth club was and few had any experience of one. That might go some way to explaining why they did not put a greater emphasis on seeing more provided. Crime and safety are in line with the national average for this age group and other than some fears and perceptions of crime few children could specify any experiences.

For secondary age young people there were one or two stand out responses.



More shops is the biggest priority for young people and conversely more youth clubs is the least of their priorities in comparison to the national average. Again as with the primary age children this may reflect the general lack of understanding and experience of youth clubs.

"what's a youth club?"- year 7 boy

"I don't actually know what a youth centre is" - year 9 boy

But those who did know about youth clubs and youth centres had a fairly negative view of them.

"Sometimes like there is too many they (young people) hang around outside and I feel a bit intimidated" - year 7 boy

"It just reminds you of old people's homes"- year 8

"It's boring, there isn't much to do there and they don't open up the hall so we can play football, and it's £2.50" - year 9 boy

"There are too many adults" - year 7

The last comment reflects what many young people thought about organised youth provision, in that it is supervised by adults. Whereas shops, and coffee shops in particular, have the appeal of being an adult space that is legitimate for young people to spend time in.

"Costa is somewhere to go" - year 7

"There's nothing to do where I live, I live in the middle of nowhere in between Sandbach and Middlewich" - year 7 boy

As with our experience in other parts of the country young people talked about shops as places to go rather than a place to spend money. That said, many of the girls would prefer to have access to New Look or Primark.

There was a varied response to the issue of public transport but few young people made it a priority as many seemed to have access to affordable transport to go to places of interest to them.

"I can get the train to Manchester for £2.10" - year 8

For some young people however they had comments about their area that reflect their unhappiness with where they live even if most are happy.

"The place I live has a lot of litter/mess, takeaways, rundown buildings, graffiti, and pubs. I don't feel safe in my area because there are a lot of intimidating people who hang around" - year 7

"There are a lot of people who smoke near where I live – they are not nice people. There is a lot of dog poo. I feel ashamed to live where I live"- year 8

Cheshire East is a varied area with rural, suburban and urban neighbourhoods and in close proximity to major conurbations. There is affluence and poverty and some communities are well served while others offer limited provision for young people. Consultations with young people in Crewe did produce more evidence that young people would like more youth provision and in some of the rural locations the lack of public transport was an issue.

"Well, we've got the swimming baths, Maccies (MacDonalds), we got a bike track, a Subway, a big Morrisons, a big ASDA, Aldi, we've got Doctors and dentists, we've got an indoor shopping area and Specsavers"-year 9 boy, Winsford

"I live so far away from my friends so I can't really like see them" - year 7 girl

"I've got my horse" - year 7 girl

"It's not safe people come speeding around in cars and it's a rough area there are scary places on the estate" - year 7 boy

Even with this diversity it was apparent both in the survey and in the consultations that young people are looking for opportunities to meet informally with friends and that youth friendly shops and cafés are preferred. The lack of emphasis on designated youth services may be influenced by a lack of knowledge but there is no doubt that it does not register as a priority for most young people.

9. Conclusions

With the previous survey in Knutsford more than 2,800 children and young people in Cheshire East have given their perspective on well-being and happiness. The qualitative consultations with nearly 800 children and young people has amplified and explained the results of the survey to produce a comprehensive and unique insight into the well-being of children and young people living in the area.

Overall the picture is good. Compared to the national average most children in Cheshire East have a level of well-being that is equal and often higher than the national average. Equally the numbers of children who have low well-being is also in line with the national average and their needs and circumstances should not be lost in the focus on the majority. Our national research indicates that children with low well-being are most likely to be children who do not live with their family, have repeat experience of being bullied or have difficulties with learning.

Within Cheshire East the experience of children at primary school suggests they are happier than the national average but this higher than average experience is not sustained at the same level when they move to secondary school. But the key issue is the way in which girls become less happy than boys and less happy than the national average as they move into adolescence. How they feel about their appearance and the worry they express about their looks has an impact on their overall well-being. Nor is that worry and concern driven by the media or images of skinny models. It is the way in which boys and girls relate to each other and make observations and criticisms of each other, specifically it is the way boys talk to girls about their physical appearance.

Social media may provide another medium for this to happen, but it is not the source of the issue. There are issues of respect, understanding, self-worth, realism and confidence that need to be explored with young people and for that to happen with younger children as well as young people. Of course this already happens in many ways but the evidence from this survey and consultation is that it is not having the desired impact and more needs to be done.

It is an area that would benefit from further consultation and exploration with young people and relates to how young people experience school as much as any other aspect of their lives.

About us

The most disadvantaged children rarely suffer on just one front. We work directly with these children, many of whom have nowhere else to turn, to ensure that they are loved, valued and listened to. With them we fight childhood poverty, harm and neglect.

Our network of programmes includes drop-in services for runaways, as well as children's centres and support for young carers. We support children who are refugees from violence, and we give those in care a voice. We transform the lives of many more children by pressurising government and local authorities to change policy and practice to protect them, and we challenge the negative attitudes that perpetuate harm and injustice.

In hard times, children are among the hardest hit.

We don't just help them survive - we support them to flourish.

CHESHIRE EAST COUNCIL

REPORT TO: Health and Wellbeing Board

Date of Meeting: 18 November 2014
Report of: Lorraine Butcher, Chair of Pan Cheshire Mental Health Group
Subject/Title: Mental Health Crisis Concordat

1 Background

1.1 On the 27 January 2014, the Mental Health Crisis Concordat was launched. It is a joint statement written and agreed by a range of national organisations to describe what people experiencing mental health crisis should be able to expect in terms of service support.

1.2 The high level principles within the document are to be underpinned at a local level by the formation of a local declaration statement and action plan setting out how agencies will deliver the commitments of the Concordat at a local level.

1.3 The Cheshire, Halton and Warrington area (Cheshire) Sub-Regional Leaders Board agreed to the proposal from the Police and Crime Commissioner for Cheshire that he would take the lead and that the Pan-Cheshire Strategic Mental Health Board would oversee delivery.

1.4 The Pan Cheshire Strategic Mental Health Board comprises senior leaders from across the range of commissioner and provider agencies involved in mental health across the Cheshire sub-region.

1.5 A national template has been published to aid areas in creating a local declaration statement. It is recommended that this is used in Cheshire, and attached, as appendix 1, is both the declaration and the organisations that have indicated their support for a single declaration across Cheshire. It is the intention that at forthcoming meetings of the Sub-Regional Management Board and Sub-Regional Leaders Board, that the Declaration Statement is formally adopted within the Cheshire sub-region.

1.6 In addition to supporting a single declaration work is underway to identify key actions across Cheshire that it is recommended should be undertaken on a combined basis. A list of potential joint actions is currently being considered (attached as appendix 2) with the intention that, once agreed a Delivery Plan is shaped for implementation. The Joint Action Plan will then complement identified actions agreed at the local level by Health and Well Being Boards.

1.7 This report therefore seeks to advise Health and Well Being Boards across Cheshire on the developing Pan-Cheshire approach to implementing the Mental Health Crisis Concordat.

2 Recommendations

2.1 That the Health and Well Being Boards in each area note the adoption of the Cheshire, Halton and Warrington Declaration Statement and recommend its endorsement by the Sub Regional Leaders Board.

2.2 That the Health and Well Being Boards support the development of the Joint Action Plan.

2.3 That the Health and Well Being Boards note and monitor the development of local actions.

2.4 That future reports are received updating the Boards on progess towards implementation of the Pan Cheshire Plan.

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

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Designation: Chair of Pan Cheshire Mental Health Group
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Email: lorraine.butcher@cheshireeast.gov.uk

Crisis Care Concordat
Mental Health

Cheshire, Halton and Warrington's Declaration statement

APPENDIX 1

The Mental Health Crisis Care Concordat is a national joint statement published by the Government and signed by senior representatives from organisations committed to improving mental health care. In addition to listing a set of core principles, the document includes a national action plan agreed by the organisations who have signed the Concordat.

Each region has committed to the national agreement by signing a local declaration and developing a country-wide action plan. This is Cheshire, Halton and Warrington's (Cheshire) declaration:

The 2014 Cheshire Declaration on improving outcomes for people experiencing mental health crisis November 2014.

We, as partner organisations in Cheshire, will work together to put in place the principles of the national **Concordat** to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will support them to find the help they need − whatever the circumstances − from whichever of our services they turn to first.

We will work together to prevent crises happening whenever possible, through intervening at an early stage, and supporting individuals to manage their recovery and avoid relapse

We will make sure we meet the needs of vulnerable people in urgent crisis, getting the right care at the right time from the right people to make sure of the best outcomes.

We will strive to ensure that all relevant public services, voluntary and private sector partners support people with a mental health problem to help them recover. Everybody who signs this declaration will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.

We are responsible for delivering this commitment in Cheshire by putting in place, reviewing and regularly updating local action plans.

This declaration supports 'parity of esteem' (see the glossary) between physical and mental health care in the following ways:

- Through everyone agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in Cheshire for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, provide advice and support for their carers, and make sure that services work together safely and effectively.
- Through agencies working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.
- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.

- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to staff, carers, patients and service users or the wider community and to support people's recovery and wellbeing.

We, the organisations listed below, support this Declaration. We are committed to working together to continue to improve crisis care for people with mental health needs in Cheshire.

Who should sign a local Declaration?

Many local organisations want to support the Declaration because of their commitment to improve mental health care and may want to make a specific contribution within the action plan for continuous improvements.

In addition, certain organisations have a formal (statutory) responsibility and/or a professional duty of care regarding people presenting in mental health crisis.

The signatories are:

- Office of the Police & Crime Commissioner for Cheshire
- Cheshire Constabulary
- North West Ambulance
- Cheshire Fire and Rescue Service
- Cheshire East Council
- Cheshire West & Chester Council
- Halton Borough Council
- Warrington Borough Council
- NHS England
- Mid-Cheshire MIND
- Cheshire and Merseyside Strategic Clinical Network
- NHS Eastern Cheshire Clinical Commissioning Group
- NHS Halton Clinical Commissioning Group
- NHS South Cheshire Clinical Commissioning Group
- NHS Vale Royal Clinical Commissioning Group
- NHS Warrington Clinical Commissioning Group
- NHS West Cheshire Clinical Commissioning Group
- Cheshire and Wirral Partnership NHS Trust
- 5 Boroughs Partnership NHS Foundation Trust
- East Cheshire NHS Trust
- Countess of Chester Hospital NHS Foundation Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- Warrington and Halton Hospitals NHS Foundation Trust

Glossary of terms used in this declaration

Concordat	A document published by the Government. The Concordat is a shared, agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental-health crisis need help. It contains a set of agreements made between national organisations, each of which has a formal responsibility of some kind towards people who need help. It also contains an action plan agreed between the organisations who have signed the Concordat. Title: Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis Author: Department of Health and Concordat signatories Document purpose: Guidance Publication date: 18th February 2014 Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf
Mental health crisis	When people – of all ages – with mental health problems urgently need help because of their suicidal behaviour, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control or irrational and likely to put the person (or other people) in danger.
Parity of esteem	Parity of esteem is when mental health is valued equally with physical health. If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses. Further information: http://www.england.nhs.uk/ourwork/qual-clin-lead/pe

Recovery	One definition of Recovery within the context of mental health is from Dr. William Anthony: "Recovery is a deeply personal, unique process changing one's attitude, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability" (Anthony, 1993) Further information http://www.imroc.org/

APPENDIX 2

PAN CHESHIRE

Mental Health Crisis Concordat Declaration

- CHESHIRE EAST
- CHESHIRE WEST
- HALTON
- WARRINGTON
- NHS ENGLAND/STRATEGIC NETWORKS
- POLICE
- AMBULANCE

PAN CHESHIRE - Joint Actions

Objective 1 – Matching need with a suitable range of services

- Comprehensive data/information sharing agreements across public sector.
- Systematic data analysis to map need and inform joint. commissioning possibilities and future planning.
- Establish pan Cheshire s135/136 group.
- Map and disseminate good practice on needs assessment.

Objective 2- Improving MH Crisis Services

- Identify models of good practice nationally and internationally
- Pan Cheshire gap analysis of service provision
- Identify potential areas for joint commissioning e.g Street triage.

Objective 3 – Workforce Development- Ensuring the right numbers of high quality staff

- Mapping of current workforce numbers, gap analysis
- Development of comprehensive awareness of appropriate Mgt of MH crisis across public sector partners
- GP knowledge and experience?
- Map pan-Cheshire attendance at national development programme for CCG GP

Objective 4 – Improved Partnerships

- Establish a pan-Cheshire web portal
- Establish an improvement collaborative

Objective 5 – Improve quality of response s135/136

- Audit current response
- Develop model for more effective joint agency arrangements

Objective 6 – Joint planning for Preventing Crisis

- Development of pan-Cheshire good practice guidance
- Improve information and advice available to front line staff to enable better response to individuals

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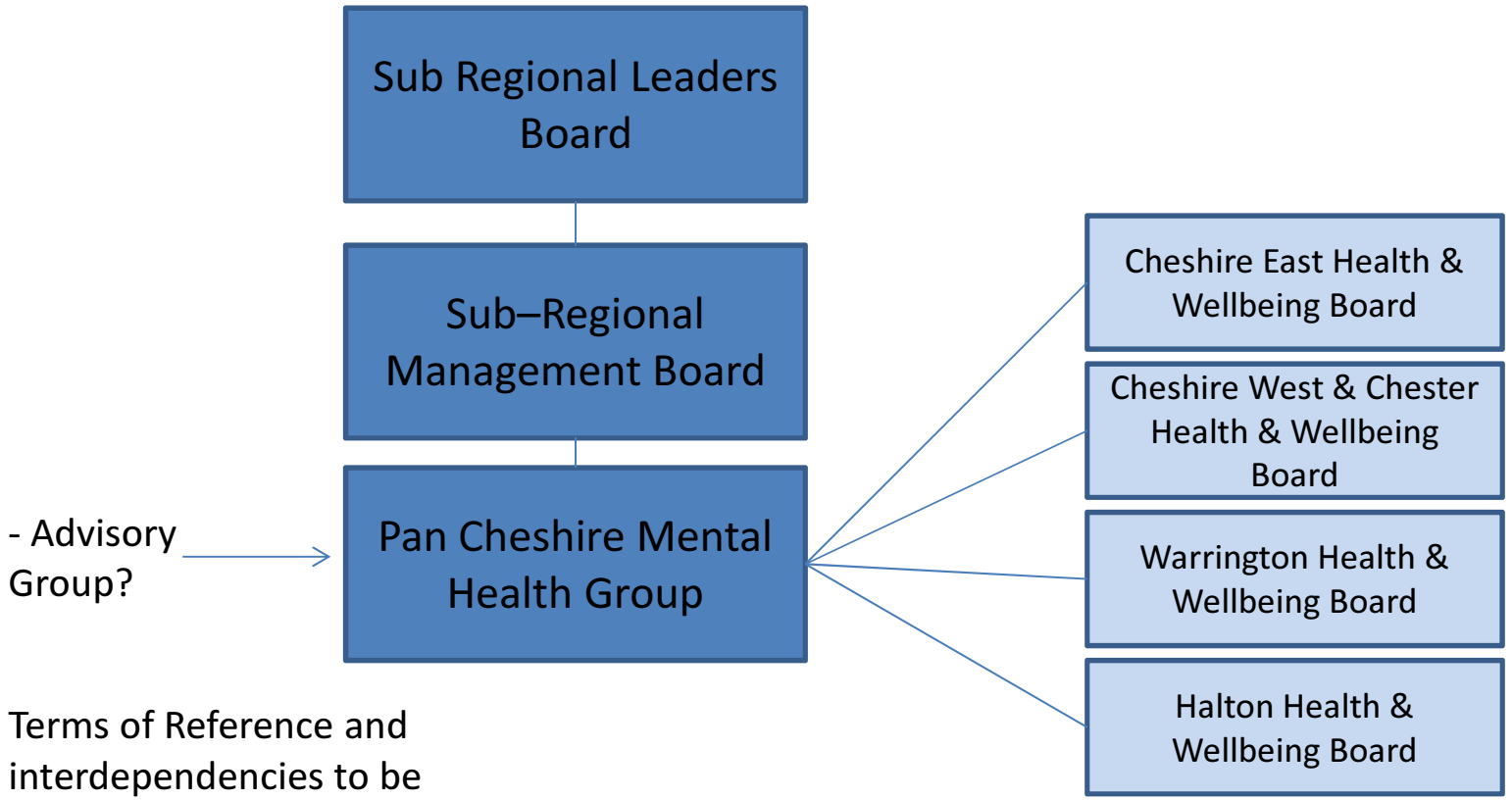
MENTAL HEALTH CRISIS CONCORDAT GOVERNANCE



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CHESHIRE EAST COUNCIL

REPORT TO: Cheshire East Health and Wellbeing Board

Date of Meeting:	18th November 2014
Report of:	Lorraine Butcher, Executive Director of Strategic Commissioning
Title:	Better Care Fund Update
Portfolio Holder:	Councillor Janet Clowes – Health and Social Care

1.0 Report Summary

1.1 To update the Cheshire East Health and Wellbeing Board on the progress of the Cheshire East Better Care Fund plan and to advise on the next stages of delivery towards the implementation date of 1st April 2015.

1.2 The Better Care Fund is being driven nationally by the Department of Health and is a key part of Public Sector reform supporting the integration of Health and Social Care. The Better Care Fund is a national pooling of £3.8bn from a variety of existing funding sources within the health and social care system, with £23.9m being pooled locally within the Cheshire East Health and Wellbeing Board area. The local pooling is made up of Local Authority funding from the Disabled Facilities Grant and Capital Allocation for Adult Social Care of £1.8m, South Cheshire CCG funding of £10.5m and Eastern Cheshire CCG of £11.6m.

1.3 The Better Care Fund requires a pooled budget to be entered into with governance and monitoring arrangements to be formalised under a section 75 agreement. It is anticipated that the Council will host the s75 pooled budget arrangement. The draft s75 agreement needs to be completed and approved during early 2015 to meet the reporting and governance arrangements of respective organisations to ensure that an approved s75 agreement is in operation from April 2015.

1.4 The Cheshire East Health and Wellbeing Board are responsible for the oversight of the Better Care Fund plan and have approved the 19th September 2014 submitted plan.

1.5 The outcomes of the implementation of the Better Care Fund Plan will see improved, integrated health and social care for the residents of Cheshire East.

2.0 Recommendation

2.1 Members of the Cheshire East Health and Wellbeing Board are asked to note:

i) the submission of the revised Cheshire East Better Care Fund plan on Friday 19th September 2014

ii) the National Consistent Assurance Review (NCAR) process carried out on behalf of the Department of Health has given approval for the plan to proceed with a category of *'Approved with Support'*, Appendix 1 has a summary and explanation of the categories

iii) the work underway to progress governance, delivery and risk sharing arrangements across partners as part of the development of the s75 partnership agreement

2.2 Members of the Health and Wellbeing Board are requested to provide a steer in relation to the options for the s75 agreement.

3.0 Reasons for Recommendation

3.1 The Better Care Fund is a national initiative overseen by the Department of Health and locally by the Cheshire East Health and Wellbeing Board and partner organisations.

3.2 The governance arrangements supporting the s75 Better Care Fund pooled budget arrangement are fundamental to the smooth delivery of the expected changes and ensuring the level of risk both financial and non-financial the council, partner organisations and providers are exposed to.

4.0 Wards Affected

4.1 All wards.

5.0 Local Wards Affected

5.1 Not applicable.

6.0 Policy Implications

6.1 Health and Social Care integration is a key element of public sector reform. The Better Care Fund formalises these joint initiatives during 2015/16.

6.2 Elements of the Better Care Fund funding are linked to the implementation of the Social Care Act, in particular carers, safeguarding boards and maintaining eligibility criteria.

7.0 Financial Implications (Authorised by the Chief Operating Officer)

7.1 The Better Care Fund is a national pooling of £3.8bn from a variety of existing funding sources within the health and social care system, with £23.9m being pooled locally within the Cheshire East Health and Wellbeing Board area. The local pooling is made up of Local Authority funding from the Disabled Facilities Grant and Capital Allocation for Adult Social Care of £1.8m, South Cheshire CCG funding of £10.5m and Eastern Cheshire CCG of £11.6m. The local health and social care economy will work together to deliver better care arrangements for its population, seeking to keep individuals within the community, avoiding hospital/residential nursing care.

7.2 The revised guidance in July 2014 introduced a payment for performance element related to the reduction in Non Elective Admissions (these are unplanned, often urgent admissions mainly via Accident & Emergency). The potential performance payment for Cheshire East is £2.11m and this is based on a 3.5% reduction in Non Elective Admissions.

7.3 The Better Care Fund requires a pooled budget to be entered into with governance and monitoring arrangements to be formalised under a s75 agreement. A breakdown of the Cheshire East BCF pooled budget of £23.9m by scheme area is available at Appendix 2.

7.4 It is anticipated that Cheshire East Council will host the s75 pooled budget arrangement. The draft s75 agreement needs to be completed and approved during early 2015 to meet the reporting and governance arrangements of respective organisations to ensure that an approved s75 agreement is in operation from April 2015.

7.5 The proposed contingency plans and risk sharing arrangements between partner organisations included in the Better Care Fund plan are being reviewed following feedback as part of the NCAR process and will be confirmed as part of the action plan to progress the plan from *'Approved with Support'* status to *'Approved'.* It is the aim of all partner organisations to limit exposure to the risk of financial pressures as part of the delivery of the Better Care Fund and robust financial management and monitoring will be key and the design of the s75 agreement will reflect this.

8.0 Legal Implications (Authorised by the Head of Legal Services)

8.1 S141 of the Care Act 2014 provides for the Better Care Fund Pooled Funds to be held under and governed by an overarching s75 National Health Service Act 2006 Partnership Agreement.

8.2 NHS England has provided a template overarching s75 Agreement which is in the process of being reviewed. The overarching Section 75 Agreement is intended to allow each specific initiative that will be delivered under the Better

Care Fund to be governed through an arrangement most suitable to the individual circumstances of that initiative.

8.3 The template document is in the process of being reviewed by the Cheshire East Council and separately by Eastern Clinical Commissioning Group and South Cheshire Clinical Commissioning Group.

8.4 Consideration needs to be given (together with partners) as to how to discharge this duty to consult. Partner organisations have a duty to involve (Section 14Z(2) of the Health and Social care Act 2012). The duty to consult may also arise due to the need to adequately consider equality matters or due to the service integration/reconfiguration having a significant impact on a particular group (such as users) which gives rise to a legitimate expectation that consultation will occur.

9 Risk Assessment

9.1 The Better Care Fund plan includes a risk register and it is recommended that each work stream develops its own risk register. It is proposed that these risks are monitored by the Joint Commissioning Leadership Team pending discussions about the ongoing Governance arrangements supporting the delivery and monitoring of the Better Care Fund and that the corporate risk registers for respective organisations incorporates significant risks relating to BCF.

9.2 The most significant risks in the plan are as follows:

- The funding for Social Care Act responsibilities funded from the Better Care Fund, including carers assessment and support packages; advocacy and information and advice is not sufficient to cope with the statutory duties.

- The investment in community based interventions does not deliver the expected benefits in reducing Non Elective Admissions this may lead to cost pressures within the acute sector and the performance payment is not released.

- Governance and decision making arrangements supporting the Better Care Fund are not clear and this may lead to delays with decision making; decisions not being made and decisions being made that are not aligned with the overall vision of the Better Care Fund plan.

9.3 These risks will be managed as part of the delivery of the Better Care Fund plan.

10 Background

10.1 The Better Care Fund was originally announced in June 2013 as part of the Government's spending review and is due to implemented from April 2015. The Better Care Fund supports the acceleration of the integration of Health and Social Care services particularly in the Community. Locally, there are two health and social care transformational programmes called Connecting Care (South Clinical Commissioning Group) and Caring Together (Eastern Cheshire Clinical Commissioning Group).

10.2 The Cheshire East Health and Wellbeing Board are responsible for the oversight of the Better Care Fund plan and approved the April 2014 plan and this was submitted to the Department of Health for review and approval.

10.3 The Better Care Fund plan is aligned with the two respective health and social care transformation programmes: Caring Together (Eastern Cheshire CCG and Cheshire East Council) and Connecting Care (South Cheshire CCG, Vale Royal CCG, Cheshire East Council and Cheshire West and Chester Council). As part of the delivery of the Better Care Fund, options are currently being considered at a strategic level as to whether the s75 agreements are set up to reflect the respective transformation programmes.

Summary of Activity (July 2014 to September 2014)

10.4 Following the release of the revised Better Care Fund guidance from NHS England in July 2014, a cross partner working group focused on updating and strengthening the original plan submission. In particular focus was given to

- Evidencing the case for change including understanding the risk stratification for the Cheshire East population
- Strengthening the narrative to meet the revised guidance and cross referencing the narrative to the costs/benefits
- Incorporating the performance payment linked to the reduction of non elective admissions into the plan and understanding the implication on the acute providers capacity
- Aligning the Better Care Fund plan with the 2 year operational and 5 year strategic plans of the Clinical Commissioning Group
- Updated and revised risk register to recognise the risk across a range of stakeholders, including service users, hospitals and GP's
- Reflecting the implications of funding elements of the Social Care Act
- Further developing the scheme specifications to provide more detail and including reference to the evidence base

10.5 The final Cheshire East Better Care Fund Plan was submitted on Friday 19th September 2014, this was following agreement and consultation with the Health and Wellbeing Board and sign off with partners including acute providers.

10.6 Following the submission of the plans there has been a National Consistent Assurance Review process, to review, validate and provide assurance on the plans on a consistent basis. On 29th October 2014, the Cheshire East plan was assessed as '*Approved with Support',* from the four available categories of:

1. Approved
2. Approved with support
3. Approved with conditions
4. Not approved

10.7 This means that the plan will be approved and the BCF funding will be made available subject to the following standard conditions which apply to all BCF plans:

- That we complete the agreed actions from the NCAR in the timescales agreed with NHS England;
- The Fund being used in accordance with our final approved plan and through a section 75 agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[1]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance.

Options for s75 Agreement

10.8 The Better Care Fund is underpinned by a s75 agreement and local discussions following the development of the Better Care Fund plan have indicated that there are a number of options as to how to implement and operate the s75 agreement.

10.9 Given the multiple governance arrangements that are currently in operation across partner organisations, the intention is to utilise existing governance arrangements and to incorporate the Better Care Fund governance into existing arrangements.

10.10 The following three options are currently being considered:

Option 1: An overarching s75 Agreement between the Council and the two Clinical Commissioning Groups , potentially with subsidiary agreements for each CCG. This would be overseen by the Cheshire East Health & Wellbeing Board.

Option 2: Two Separate s75 Agreements between the Council and the two CCGs again both overseen by the Cheshire East Health and Wellbeing Board.

Option 3: A total of three section 75 agreements across the Cheshire footprint. Whereby Cheshire East would be party to two of the s75 agreements:

s75 Agreement 1: Cheshire East Council and Eastern Cheshire CCG reflecting the 'Caring Together' footprint, overseen by Cheshire East Health and Wellbeing Board.

s75 Agreement 2: Cheshire East Council and South Cheshire CCG that is also signed up to by Cheshire West and Chester Council and Vale Royal CCG to reflect the 'Connecting Care' footprint.

This would require the Cheshire East Council / Eastern Cheshire CCG Agreement to be overseen by the Cheshire East Health & Wellbeing Board and the West/East/South/Vale Royal Agreement being overseen by the two Health and Wellbeing Boards or a possibly by a Joint sub-committee of the Boards

s75 Agreement 3: Cheshire West and Chester Council and Western Cheshire CCG. Overseen by the Cheshire West Health and Wellbeing Board.

Next Steps

10.11 As a priority the action plan included in the NCAR process will be actioned and submitted to NHS England by 28th November. The areas highlighted for action can be progressed relatively quickly and the NCAR review has established that 'no showstoppers' have been identified.

10.12 Over the coming months there will be a significant amount of work involved in progressing and implementing the Better Care Fund plan. The next stage of delivering the Better Care Fund plan will focus on developing and implementing the proposed schemes and developing the s75 agreement. The Joint Commissioning Leadership Team are currently reviewing the following:

- Governance and Commissioning Arrangements
- Implementation and Delivery
- Risk management and risk sharing
- Ongoing management of the pooled budget following implementation on 1st April 2015

Resources are being identified to support the development of the s75 agreement and a plan is being developed to ensure that key milestones are identified and monitored.

A lead officer will be identified for the schemes to ensure that there is an accountable officer who is responsible for progressing the implementation and delivery of schemes.

11 Access to information

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

Name: Lorraine Butcher
Designation: Executive Director, Strategic Commissioning
Tel No: 01270 686021
Email: Lorraine.Butcher@CheshireEast.gov.uk

Appendix 1: National Consistent Assurance Review, Rating Summary (extracted from Better Care Fund Weekly update from Andrew Ridley)

Approved

The aim is for all plans to have reached this standard by April. If your plan is 'Approved' following the NCAR process at the end of October, the regional and national team will request to work with you in order to provide support as you prepare for delivery.

Approved with Support

This means that overall the review team and the moderation panel have confidence in your plan. However, there may be some items of evidence or information that will need to be submitted to provide full assurance. The team will want to review these before your plan can be fully approved. Areas in this category will be assigned a relationship manager from the task force to agree a plan to provide the further information identified through the NCAR process – this will be a straightforward and light-touch process and we would aim for all HWBs in this category to be fully approved before December.

Approved subject to Conditions

If your plan is approved subject to conditions, it means there are some substantial issues or risks in your plan without enough demonstration of how these will be mitigated. Areas in this category will not be able to progress to implementation for the aspects of their plan affected by the conditions placed on them. They will be assigned a relationship manager who will work with the local team to agree an action plan to address areas of weakness identified through NCAR, access available support and agree the level of resubmission required to secure removal of conditions. The aim is to have these areas fully approved before January.

Not Approved

Areas in this category will not be given approval for their plan, and will not be able to progress to implementation until their plan is approved. They will be assigned a relationship manager and will be required to work closely with them to agree an action plan that will ensure they submit a fully revised plan in January so they are approved in time to begin implementation. Areas in this category will receive more intensive support to help them improve their plan. These areas will be required to resubmit a full plan for a further NCAR assessment process at the end of January.

Appendix 2: Breakdown of Cheshire East Better Care Fund Schemes

Ref	Scheme	Funding
1	**Self care and self management**	
BCF1 (1a)	**Supporting Empowerment – Information, advice, prevention and early intervention** The principle of the 'Empowered Person' has been one of the key underpinning principles of the whole system redesign in both Caring Together and Connecting Care programmes. It focuses on the cultural shift required to further enable individuals to take responsibility for their own health and wellbeing by ensuring that they have access to a range of information advice and support to do this effectively. The planning is further enhanced by the requirements for this scheme within the Care Act 2014 to ensure that information and advice is made available to those individuals who may need to access social care support. The strategic objective of this scheme is to reduce the demand on health and social care services over the longer term by ensuring access to information and advice at an early stage in order to increase the chance of prevention or delays in deterioration of health conditions. (Includes care navigation services)	£604,000
BCF2 (1b)	**Universal Access to low level assistive technology, occupational therapy advice and assessment** To support and enable people to access early practical help to support them with health and social care related problems. Utilising evidence-based practice principles relating to early help to maintain independence and self reliance. It is intended that this initiative will encourage individuals to access support in a variety of community settings where they can have low level assessment which would indicate a range of assistive technology solutions and/or low level equipment, together with advice regarding self heal and self care support. This meets the objectives in the prevention and early intervention agenda. It builds on the premise that individuals want to remain in control and to have the low level support/tools to do this allowing the self care/self management principles to be encouraged and maintained.	£552,000
BCF3 (1c)	**Assistive Technology Pilot for adults with a learning disability** To pilot the use of Assistive Technology options within 24 hour supported tenancy based schemes and individuals living in their own	£743,000

Ref	Scheme	Funding
	homes. The objective is to primarily seek out solutions to provide access to support and assistance without the need for continued staff supervision. The long-term objective is to respect individuals' rights to privacy at the same time as ensuring safety and risk management is maintained.	
BCF4 (1d)	**Facilitating Early Discharge** To provide a service that prevents Delayed Discharge from Hospital.	£228,000
BCF5 (1e)	**Disabled Facilities Grant funded service** A suitable, well adapted home can be the defining factor in enabling a disabled person to live well and independently. The Disabled Facilities Grant scheme forms part of the vision for health and social care services by increasing opportunities for frail older people and disabled people to take control of their own care and support, increasing their independence and enabling them to remain in the home their choice. There is a growing number of older people in Cheshire East, and an increasing number of non-elective admissions to hospital services, which is putting unsustainable financial pressure on acute services. Home adaptations have the potential to deliver dividends in terms of both social and financial outcomes, enabling care to be delivered in the patient / service user's own home, and maintaining their safety and independence to prevent unnecessary hospital admissions.	£990,000,
BCF6 (1f)	**Carer's Assessment and Support** • Develop revised guidance for carer's eligibility criteria which is aligned with the social care act. • To effectively commission carers support services across Cheshire East across the health and social care boundary. • To ensure Cheshire East Council meets its duties under the Social Care Act to provide assessment and support planning to Carers, and further, to ensure assessment and support planning are truly personalised and provided by skilled staff. • Increase the number of carers assessments performed and to develop a clearer understanding of residents who rely on carer support.	£743,000
2	**Integrated community services**	
BCF7 (2a)	**Dementia Reablement** To pilot a Dementia Reablement service with a view to providing early help to newly diagnosed patients and those in the early stages of Dementia.	£637,000

Ref	Scheme	Funding
	The aim of the service is to pilot and test the principles of reablement to focus on learning new skills/techniques to retain memory and delay memory impairment. Drawing on a range of evidence, the pilot will utilise techniques where patients can use practical measures to assist them in maintaining daily living skills and support family/carers to promote independence and positive risk taking.	
BCF8 2b	**Community based co-ordinated care** The Community Based Co-ordinated Care delivered by integrated health and social care teams has been designed to provide joined up care for the wellbeing of people with the most complex needs. Its purpose is to proactively work with people identified through a risk stratification approach and their carers to identify their individual needs and goals, design a personal care plan and support their long term care needs by a dedicated care co-ordinator.	£3,019,000
BCF 9 2c	**Integrated Community Service Model – Connecting Care** Community Based Co-ordinated Care will be delivered by integrated health and social care teams which have been designed to provide joined up care for the wellbeing of people with the more complex needs. Its purpose is to proactively work with people identified through a risk stratification approach and their carers to identify their individual needs and goals, design a personal care plan and support their long term care needs by a dedicated care co-ordinator. This means that instead of citizens trying to navigate their way around the multitude of health and social care services, we are redesigning services to fit around their needs. We want to reduce duplication of care, prevent people having to tell their story multiple times and to minimise waste across care settings.	£3,029,000
3	**Community based urgent care/rapid response**	
BCF10 3a	**Implementing a Short Term Assessment Intervention recovery & Rehabilitation Service (STAIRRS)** The need for an integrated community rapid response service has been identified in both Caring Together and Connecting care. Whilst the core objectives and overarching ambition for this service is shared across the two health economies, the delivery model will differ, to take account of the local context and population need	£12,293,000
4	**Social Care Capital and Programme Enablers**	
BCF11 4a	To utilise the social care capital grant (former Community Capacity Grant) to support development in three key areas:	£1,053,000

Ref	Scheme	Funding
	1. Personalisation 2. Reform 3. Efficiency To provide enabling support to the Better Care Fund programme, through programme management support; developing governance arrangement including the s75 agreement and commissioning capacity.	
		£23,891,000

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Publications Gateway Ref. No. 02396

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To:
Cheshire East Health and Wellbeing Board
NHS Eastern Cheshire CCG
NHS South Cheshire CCG

29th October 2014

Copy to:
Cheshire East Council

Dear colleague,

Thank you for submitting your revised Better Care Fund (BCF) plan. We know that the BCF is an ambitious programme and preparing the plans at pace has proved an immensely challenging task. However, your plan is now part of an ongoing process to transform local services and improve the lives of people in your community.

It is clear that your team and partners have worked very hard over the summer, testing out ways of working and finding innovative solutions to some of the challenges our services face in order to improve people's care.

NHS England is able to finally approve plans once the 2015/16 Mandate is published. I am pleased to let you know that, following the Nationally Consistent Assurance Review (NCAR) process, provided there is no material change in circumstance and the 15/16 Mandate is published as expected, your plan will be classified as **'Approved with Support'** once the 15/16 Mandate has been published. This recognises that whilst your plan is strong the review process identified a number of areas for improvement which once addressed will enable you to move to a fully approved status. This category means that your plan will be approved and your BCF funding will be made available to you subject to the following standard conditions which apply to all BCF plans:

- That you complete the agreed actions from the NCAR in the timescales agreed with NHS England;
- The Fund being used in accordance with your final approved plan and through a section 75 agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[1]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released

into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance.

The conditions are being imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These allow NHS England to make payment of the BCF allocation subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG that it be spent in a particular way.

Appended to this letter is your NCAR Outcome Report which documents the agreed actions. Please work with your Area Team Lead Alison Tonge (a.tonge@nhs.net) to agree a timetable for when you will submit the additional information/evidence required on the back of the NCAR report.

We are confident that there were no areas of high risk in your plan and as such you should progress with your plans for implementation. Although the areas of support the review identified are essential to successful delivery in the medium term we do not consider them as material at this stage.

Any ongoing support and oversight with your BCF plan will be led by NHS England Regional/Area Team along with your Local Government Regional peer rather than the BCF Taskforce from this point onwards.

Non-elective (general and acute) admissions reductions ambition

As there is a considerable amount of time between the submission of BCF plans and their implementation from April 2015, we recognise that some areas may want to revisit their ambitions for the level of reduction of non-elective admissions, in light of their experience of actual performance over the winter, and as they become more confident of the 2014/15 outturn, and firm-up their plans to inform the 2015/16 contracting round. Any such review should include appropriate involvement from local authorities and be approved by HWBs. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans.

Once again, thank you for your work and we look forward to the next stage.

Yours sincerely,

Dame Barbara Hakin
National Director: Commissioning Operations
NHS England

[1] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf