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Cheshire East Health and Wellbeing Board

Agenda

Date:	**Tuesday, 21st June, 2022**
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 top of each report.

It should be noted that Part 1 items of Cheshire East Council decision making meetings are audio recorded and the recordings will be uploaded to the Council's website

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

1. **Apologies for Absence**

   To receive any 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 Previous meeting** (Pages 3 - 8)

   To approve the minutes of the meeting held on 22 March 2022.

For requests for further information
Contact: Karen Shuker
Tel: 01270 686459
E-Mail: karen.shuker@cheshireeast.gov.uk with any apologies

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

In accordance with paragraph 2.24 of the Council's Committee Procedure Rules and Appendix on Public Speaking, set out in the Constitution, a total period of 15 minutes is allocated for members of the public to put questions to the committee on any matter relating to this agenda. Each member of the public will be allowed up to two minutes each to speak, and the Chair will have discretion to vary this where they consider it appropriate.

Members of the public wishing to speak are required to provide notice of this at least three clear working days' in advance of the meeting.

5. **Cheshire East Safeguarding Children's Partnership Annual Report 2020-2021** (Pages 9 - 34)

To receive the annual report of the Cheshire East Safeguarding Children's Partnership 2020-21

6. **Cheshire East Place Integrated Health and Care Governance proposals** (Pages 35 - 42)

To receive an update on the Cheshire East Place integrated health and care governance proposals.

7. **Cheshire East Place Partnership update**

To receive a verbal update on the work of the Cheshire East Place Partnership.

8. **Cheshire East Integrated Care Partnership Update**

To receive a verbal update on the Cheshire East Integrated Care Partnership.

9. **'All Together Fairer: Health equity and the social determinants of health in Cheshire and Merseyside** (Pages 43 - 64)

To note the report of the All Together Fairer: Health equity and the social determinants of health in Cheshire and Merseyside.

10. **Child Death Overview Panel Annual Report 2020-2021** (Pages 65 - 90)

To consider the annual report of the Child Death Overview Panel.

Membership: L Barry, Councillor C Bulman, H Charlesworth-May, Councillor S Corcoran (Chair), Dr P Kearns, T Knight, S Michael, Dr L O'Donnell, Councillor J Rhodes, Dr M Tyrer, C Watson, J Wilbraham, Dr A Wilson (Vice-Chair), Councillor J Clowes (Associate Non-Voting Member), P Crowcroft (Associate Non-Voting Member), C Hart (Associate Non-Voting Member), J Traverse (Associate Non-Voting Member), C Whitney(Associate Non-Voting Member) and D Woodcock (Associate Non-Voting Member

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 22nd March, 2022 in the The Ballroom, Sandbach Town Hall, High Street, Sandbach, CW11 1AX

PRESENT

Voting Members
Councillor Sam Corcoran (Chair), Cheshire East Council
Councillor Carol Bulman, Cheshire East Council
Councillor Jill Rhodes, Cheshire East Council
Louise Barry, Healthwatch Cheshire
Helen Charlesworth-May, Cheshire East Council
Denise Frodsham, Cheshire East Integrated Care Partnership
Steven Michael, Cheshire East Health and Care Partnership
Dr Matt Tyrer, Director of Public Health

Non-Voting Members
Deborah Woodcock, Cheshire East Council

Associate Non-Voting Members
Councillor Janet Clowes, Cheshire East Council

Cheshire East Officers and Others
Guy Kilminster, Corporate Manager Health Improvement
Sarah Baxter, Democratic Services Officer
Josie Lloyd, Democratic Services Officer
Dr Susie Roberts, Public Health Consultant

48 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Chris Hart, Deborah Nickson, Dr Lorraine O'Donnell, Jayne Traverse, Clare Watson and Caroline Whitney.

49 **DECLARATIONS OF INTEREST**

Councillor S Corcoran declared a non-pecuniary interest by virtue of his wife being a GP.

50 **MINUTES OF PREVIOUS MEETING**

RESOLVED:

That the minutes of the meeting held on 25 January 2022 be confirmed as correct record.

51 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no public speakers.

52 **BETTER CARE FUND END OF YEAR REPORT 2021/22**

The Board considered a report on the performance of the Better Care Fund, including the Improved Better Care Fund in 2021/22. The report included an overview of schemes, expenditure and performance, and a breakdown of the performance of the specific schemes.

The Chair asked for examples of what the £18 million in relation to Homefirst schemes referred to within the report was spent on. The board heard these included items such as community equipment and hospital discharge fund. There was also a request for information in respect of narrative or outcomes on the difference or value that was being made to people's lives in future reports.

RESOLVED:

That the Better Care Fund programme performance for 2021/22 be noted.

(During consideration of the item, Councillor C Bulman arrived to the meeting).

53 **BETTER CARE FUND PLAN 2022/23**

The Board received a report on the Better Care Fund Plan 2022-23 which described the areas of activity and the proposed expenditure for the Better Care Fund covering Cheshire in 2022/23. A number of schemes had been identified and a rationale of how they would meet the needs and demands of the local care and health economy were presented.

The Board asked that a piece of work be undertaken which would look at the metrics, outcomes and the impact of the Better Care Fund schemes identified within the report.

RESOLVED:

That the schemes and plan for 2022/23 be noted.

54 **CHESHIRE & MERSEYSIDE HCP - MARMOT COMMUNITY UPDATE REPORT**

The Board were briefed on the progress at a Cheshire and Merseyside level on developing as a Marmot Community. This would raise the profile of the need to focus upon reducing health inequalities across Cheshire and Merseyside. Cheshire East's health inequalities were highlighted through the Joint Strategic Needs Assessment and the 'Tartan Rug'. By signing up to being a Marmot community would assist in Cheshire East's

efforts to improve the health and wellbeing outcomes for its residents and reduce those inequalities.

RESOLVED:

That the update and draft recommended actions be noted.

55 **PUBLIC HEALTH OUTCOMES FRAMEWORK (TARTAN RUG)**

Consideration was given to a report on the Public Health Outcomes Framework (Tartan Rug). The tartan rug was part of the Joint Strategic Needs Assessment (JSNA) and visually displayed health and wellbeing data by ward, and across Cheshire East as a whole, to highlight inequalities across communities in Cheshire East. The report described the changes to health and wellbeing in Cheshire East as demonstrated by updated national data sources available between November 2017 and February 2021. It was proposed that the latest version of the Tartan Rug be published on the Cheshire East Council website as an interim tool to guide local service development and strategy with a view to updating it again in the next year.

Overall Cheshire East had improved compared to other areas between 2017 and 2021 although inequalities had widened slightly.

It was likely that there would be further dips in performance over the next couple of iterations of the tartan rug due to the impact of COVID- 19 therefore It was likely that the inequalities gap would widen for some areas.

Members of the Board thanked Dr S Roberts and those involved for their hard work.

RESOLVED:

That the update be noted.

56 **INCREASING EQUALITIES COMMISSION UPDATE**

Consideration was given to a report which provided an update in relation to the work of the Commission, established by the Board in October 2020. Since then, the Commission had met seven times. At its March 2021 meeting it was agreed to initially focus on Crewe, where there were the most significant inequalities in the borough. Work was underway to prepare a strategy for reducing inequalities in Crewe. The draft strategy would go out for consultation in spring and then be brought to the Health and Wellbeing board later in 2022. A wide range of partners were directly involved or had contributed to workshops to add to the knowledge base to inform the thinking and strategy development.

In addition, the Commission was taking the lead on the work to support the Cheshire and Merseyside Integrated Care System's ambition to become a Marmot Community (supported by the Health and Wellbeing Board at its meeting in November 2021).

RESOLVED:

(1) That the work of the Increasing Equality Commission to date be noted.
(2) That the Health and Wellbeing Board continue to support the work of the Commission.

57 **TEST, TRACE, CONTAIN, ENABLE UPDATE**

Dr Matt Tyrer gave an update on the Test, Trace, Contain and Enable system. The situation had changed significantly since the previous Health and Wellbeing Board meeting. Case rates were increasing not only in Cheshire East but across the whole country. There had also been an increase in the number of people requiring hospital stays with a small number of people requiring intensive care. This would be monitored closely, along with offering support by way of the Swab Squad and pilot work in collaboration with CWP to help promote the vaccination programme to help in those areas where uptake was lower.

Vaccination rates continued to increase albeit slowly.

RESOLVED:

That the update be noted.

58 **CHESHIRE EAST PLACE PARTNERSHIP UPDATE**

This item and the Cheshire East Integrated Care Partnership update were considered together.

Although there was the willingness to streamline governance as much as possible it was recognised that this was challenging with interim arrangements and other factors to consider, although there was a common understanding of what needed to be done.

The new ICB Place Director had been invited to the next meeting of the Partnership Board. There would be further changes to personnel in the Partnership in the coming months and it was important to keep focus - but solid progress had been made.

It was acknowledged that there was still work to do around the governance as there had not been any confirmation as to what was to be delegated by the Integrated Care Board (ICB), but it seemed that all partners had the same ambition for Place.

There had been a £1.3 million investment into the Rapid Response Two Hour Service which had now gone live and was a seven-day service

Telemedicine was due to go live, focusing on those people with COPD and heart failure. Those people would be monitored so they could have early intervention which all links into programmes discussed earlier in the meeting.

RESOLVED:

That the update be noted.

Following this item there was an announcement in respect of a draft support proposal. Cheshire East had expressed an interest in some bespoke support from the Local Government Association to work with its Health and Wellbeing Board (HWB) to consider its role and responsibilities in the light of the Health and Care Bill 2022 and the Joining Up Care White Paper (9th February 2022).

It was noted that the draft proposal would be circulated to board members following the meeting and they would be invited to comment on the proposals.

RESOLVED

That the LGA review be noted and accepted.

59 **CHESHIRE EAST INTEGRATED CARE PARTNERSHIP UPDATE**

The Managing Director of Cheshire East Integrated Care Partnership provided a verbal update which included an overview of

RESOLVED:

That the verbal update be noted.

The meeting commenced at 2.00 pm and concluded at 3.15 pm

Councillor S Corcoran (Chair)

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Working for a brighter future together

Cheshire East Health and Wellbeing Board

Date of Meeting:	21st June 2022
Report Title:	Cheshire East Safeguarding Children's Partnership Annual Report 2020-21
Report of:	Deborah Woodcock, Executive Director of Children's Services

1. Purpose of the Report

1.1. This report will provide the Health and Wellbeing Board with an update on progress against the Cheshire East Safeguarding Children's Partnership priorities over 2020-21.

1.2. The report was considered and scrutinised in detail at the Children and Families Committee meeting on 10th January 2022.

2. Recommendations

2.1. The Health and Wellbeing Board is asked to note the progress made by the Cheshire East Safeguarding Children's Partnership, and the impact for children and young people; recognising the achievements and progress made, and the ongoing areas for further development.

3. Reasons for Recommendations

3.1. The Cheshire East Safeguarding Children's Partnership priorities contribute to the Council's Corporate Plan aim to 'protect and support our communities and safeguard children from abuse, neglect and exploitation, adults at risk, and families from abuse,' and its objective that 'children receive the right support, by the right people, at the right time, so they are effectively protected from harm, and are supported to stay within their families and communities.'

3.2. It also supports the Cheshire East Health and Care Partnership's key outcome to 'Ensure that children and young people are happy and experience good physical and mental health and wellbeing'.

4. Background

4.1. The statutory guidance 'Working Together' (2018) requires each area to produce and publish an annual report on the effectiveness of the arrangements to safeguard and promote the welfare of children and young people in their local area. The report has been scrutinised by the Cheshire East Safeguarding Children's Partnership statutory representatives from Cheshire East Council, Cheshire Police and Cheshire NHS Clinical Commissioning Group.

5. Implications

5.1. Legal

5.1.1. The Council is defined by Working Together to Safeguard Children 2018 and the Children Act 2004 (as amended by the Children and Social Work Act, 2017) as a safeguarding partner in partnership with the Cheshire NHS clinical commissioning group and chief officer of police for Cheshire. This partnership operates within that guidance.

5.2. Finance

5.2.1. The council, along with other partners, contribute financially to support the partnership's activity. Financial plans are due to be reviewed to ensure that the service can continue to meet the needs of vulnerable children and young people in Cheshire East.

5.3. Policy

5.3.1. Cheshire East is ambitious and committed to ensuring as a partnership, we work together to make Cheshire East a great place to be young.

5.4. Equality

5.4.1. Good quality practice with families ensures that all children and young people's needs are taken into account and supported.

5.5. Human Resources

5.5.1. Developing high quality practitioners and managers is crucial in supporting us to achieve consistently good practice for children and young people. The Cheshire East Safeguarding Children's Partnership provides a training programme and coordinates the development of practice guidance which contributes to this.

5.6. Risk Management

5.6.1. There are reputational and financial risks of not providing good Children's Safeguarding Services, as well as risks to individual children and young people. The council must continue to ensure that these risks are minimised by ensuring effective plans are in place to improve where areas for development are identified.

5.7. Rural Communities

5.7.1. Vulnerable children and young people are present in all communities in Cheshire East.

5.8. Children and Young People/Cared for Children

5.8.1. The partnership's priorities contribute to the Council's Corporate Plan aim to 'protect and support our communities and safeguard children from abuse, neglect and exploitation, adults at risk and families.'

5.9. Public Health

5.9.1. There are no direct implications for public health.

5.10. Climate Change

5.10.1. Children's Services continue to support the council with climate change objectives.

Access to Information	
Contact Officer:	Alistair Jordan CESCP Business Manager Alistair.Jordan@cheshireeast.gov.uk
Appendices:	Appendix 1: Cheshire East Safeguarding Children's Partnership Annual Report 2020-21
Background Papers:	None

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Cheshire East Safeguarding Children's Partnership

Cheshire East Safeguarding Children's Partnership

Annual Report 2020-21

Contents

Foreword from the Partnership Chair

This is the second annual report of the Cheshire East Safeguarding Children's Partnership, it covers the period from 1 April 2020 to 31 March 2021. We want to first recognise that through this period the global pandemic COVID-19 affected everyone in the Cheshire East community.

This report recognises the progress the Cheshire East Safeguarding Children's Partnership has made throughout this most challenging of years and those challenges that remain that we will continue to address in 2021/22.

If you have any questions about the report or the information contained in it, please contact me at CESCP@cheshireeast.gov.uk

Paula Wedd, Chair, Cheshire East Safeguarding Children's Partnership.

Summary

The Cheshire East Safeguarding Children's Partnership has continued to lead the safeguarding work of the borough. Much of this year has been spent building upon the culture that supports the collaborative working arrangements needed to safeguard Cheshire East's vulnerable children and adults to ensure that despite the challenges of the COVID pandemic that safeguarding of children remained a priority for all services.

The Cheshire East Safeguarding Children's Partnership has engaged multi-agency partners in the assurance process associated with delivery of the agreed work programme, encompassing core business and priorities relating to neglect, contextual safeguarding and emotional wellbeing of vulnerable children. This has included partnership scrutiny, and constructive check and challenge. Evidence of actions arising from audits and case reviews have been scrutinised and signed off by the Quality Assurance sub-group. Opportunities for learning and adopting good practice from peers has been reflected in the work programme.

Cheshire East Safeguarding Children's Partnership

The statutory guidance Working Together 2018 (WT18) requires each area to produce and publish an annual report on the effectiveness of the arrangements to safeguard and promote the welfare of children and young people in their local area. This report sets out what we have done over the past year and what we plan to do next year to make Cheshire East a safer place for children and young people.

This report is aimed at everyone involved in safeguarding children, including members of the local community, professionals and volunteers who work with children, young people, and families.

A copy of this report will be sent to senior leaders and stakeholders in our area, including the Chief Executive of the Council, the Leader of the Council, and the Executive Director of Children's Services. The report will also be sent to the Health and Wellbeing Board, Children and Young People's Trust Board, Community Safety Partnership, and the Council's Children and Families Committee. Individual agencies will also be encouraged to present this report through their internal Boards and scrutiny arrangements.

The Partnership

Senior representatives from the statutory partners: Cheshire East Council, Cheshire Clinical Commissioning Group, and Cheshire Police, are the Cheshire East Safeguarding Children's Partnership. Also represented are the Youth Justice Service, National Probation Service, Cheshire and Greater Manchester Community Rehabilitation Company, Public Health, Mid Cheshire Hospitals NHS Foundation Trust and East Cheshire Trust

NHS. These Executive members work together to keep children and young people safe from harm.

The partnership was responsible for scrutinising the work of its partners to ensure that services provided to children and young people make a positive difference.

The main role is to co-ordinate and to ensure the effectiveness of work undertaken by each agency on the board for the purposes of safeguarding and promoting the welfare of children in Cheshire East.

The chair of the partnership was held by Cheshire East Council's Executive Director of People for quarters 1-3 of 2020/21. When the Director of People left the authority the opportunity to rotate the chair to the Clinical Commissioning Group was taken in line with the partnership chairing plan.

Independent Scrutiny

Due to the ongoing challenges of managing services during the COVID crisis the intention to conduct a peer challenge exercise with another Safeguarding Children's Partnership in the region were not realised. It is anticipated that an exercise like this will be conducted in the future.

The partnership commits to active involvement in Cheshire East Council's scrutiny arrangements, including the Chief Executive's quarterly safeguarding review meeting.

The partnership has commissioned two local safeguarding practice reviews led by independent chairs during 2020/21. One of those has concluded its enquiries and the other will do so during 2021/22.

Ofsted and the Care Quality Commission revisited the area of Cheshire East in May 2021 to evaluate whether sufficient progress has been made in addressing the two areas of significant weakness for children and young people with special educational needs and/or disabilities (SEND) detailed in the written statement of action in 2018. They concluded that sufficient progress has been made in addressing all the issues identified at the initial inspection in 2018.

Our Vision for the Children and Young People of Cheshire East

It is the right of every child and young person in Cheshire East to enjoy a healthy and happy childhood, grow up feeling safe from abuse or neglect and thrive in an environment that enables them to fulfil their potential.

We aim to do this through our collective commitment to:

- strategic Leadership across the partnership – to make the safety of children and young people a priority
- challenge – through focused inquiries or investigations into practice or issues based on evidence, practitioner experience and the views of children and young people, for us to improve together
- learning – to achieve the highest standards of development and to ensure all practitioners have the skills and knowledge to be effective.

This will include listening to the voice of children and young people and using what we hear to inform best practice.

The shared values are at the heart of all we do and are actively demonstrated through our behaviours and promoted throughout our respective organisations:

We will:

- Actively involve children and young people and their families, as what they say will shape the way that we work.
- Listen to frontline practitioners and their managers and take their views into account.
- Act in an open and transparent way and foster a culture of challenge, scrutiny, and support across the partnership.

- Ensure that our staff have the skills, support, and supervision to keep children and young people safe.
- Share information and intelligence that will enable us to keep our children and young people safe.
- Celebrate strengths and positive achievement. We are committed to continuously improve.
- Embed the principles of Signs of Safety across our partnership.
- Work with other strategic partnerships in Cheshire East to ensure that our plans are aligned to maximise the opportunities for children and young people.
- Hold multi-agency professional events to update the settings on the work of the partnership but also include them in delivering the key safeguarding objectives.

Children and Young People in Cheshire East - Our Child Population

Cheshire East is a relatively affluent area, and we know that most of our children and families experience good outcomes. However, there are areas where child poverty and associated deprivation is endemic and intergenerational.

Cheshire East has 18 areas which are within the top 20% of the most deprived areas in England, affecting 31,600 people or 8.5% of Cheshire East's population. Thirteen of these areas are in Crewe, with two in Macclesfield, one in Wilmslow, one in Alsager, and one in Congleton. Overall, relative deprivation has increased since 2010, as only sixteen areas were previously within the top 20% of most deprived areas.

There are approximately 75,400 children and young people under the age of 18 in Cheshire East, 51% are male and 49% are female. Children and young people make up approximately 20% of the total population.

8.8% of primary pupils are entitled to free school meals (an indicator of deprivation) compared to 14.2% nationally. 8.4% of secondary pupils are entitled to free school meals compared to 13.3% nationally.

Overall, 92% of individuals are of British ethnicity. The biggest minority groups in Cheshire East are 'white other' (2.5%), Asian/ Asian British (2%), and mixed/ multiple ethnicities (2.6%).

The majority of pupils' ethnic backgrounds are reported to be White British (87% of primary pupils and 89% of secondary pupils), albeit the ratio has reduced slightly from last year

There are just under 100 different first languages recorded for primary and secondary pupils, although only 6.9% of primary pupils and 4.7% of secondary pupils have a first language other than English, compared to national figures of 21.2% and 16.6%, respectively, so although increased from last year it is at a lesser rate than the increase nationally.

The Child's Journey in Cheshire East

Cheshire East Consultation Service

The Cheshire East Consultation Service is the 'front door' to access services, support and advice for children, young people, and their families; from early help and support through to safeguarding and child protection. Co-located within the front door are the police, multi-agency Missing from Home Service, Child Exploitation Service and Domestic Abuse Hub.

	Consultation activity	No. converted to referral
2016/17	10,432	3,438 (33%)
2017/18	9,536	2,976 (31%)
2018/19	9,418	2,558 (27%)
2019/20	9,824	2,543 (26%)
2020/21	8,373	2,273 (27%)

Number of consultations over the past four years that resulted in a referral to Children's Social Care

There has been a 15% reduction in consultations activity since last year. Conversion to referral has increased by 1% to 27%.

Early Help

We are increasingly trying to intervene earlier through the partnership work driven forward by the Early Help Together Board and our emerging locality working model. However, we continue to see the issues that families are facing becoming increasingly complex; this was exacerbated by the COVID-19 lockdown and the ability of partners to deliver home-based and school-based work in the first part of 2020/21. The Early Help Brokerage Service is a service with a dedicated team whose aim is the allocation of early help cases. This will provide timely referrals to early help, and identification of the best service to meet the needs of the child or young person and their family.

We have refreshed our Early Help action plan to focus on tackling neglect and understand the mental health challenges that have emerged through lockdown; we intend to skill up our frontline practitioners to better respond to the needs of children and parents particularly those who will struggle to get back to school and college.

The local authority remains committed to continuous improvement and an effective range of services are in place across the continuum to meet need. This includes:

- High quality advice and information through the Family Information Service, support to our partners to engage with and deliver Signs of Wellbeing early help services, and supported access to more targeted services through our Locality Support Officers and the Early Help Brokerage Service.
- The Early Start Service deliver services in the Early Years Foundation Stage, and support families to achieve social mobility and early childhood health, ensuring localised intervention strategies between Children Centres and across our 480 private sector providers and maintained childcare settings with a focus on speech and language and readiness for school and learning.
- Early Start Hubs (clusters of Children's Centres and community venues) embed the Parenting Journey consistently across all centres and we have continued to deliver this as online support throughout the lockdown period.
- Family Support is offered across the continuum of need, and resources are aligned to need across level 2 targeted and level 3 complex caseloads – although we are making positive strides to enable other agencies to lead early help assessments and plans.
- Family Support Services lead the council provision for parenting interventions.
- Supporting young people who are not in education, employment or training (NEET) to access provision post 16 years.

Children in Need and Child Protection

Assessments Completed in 45 days

Local authority	2016-17	2018-19	2019-20	20-21
England	83%	83%	84%	N/A
North West	81%	84%	81%	N/A
Cheshire East	88%	81%	86%	74%
Statistical neighbour	82%	86%	84%	N/A

Assessment timescales

The total number of assessments completed in the year was 3,040 compared to (3,129) last year. 74% of these were completed within 45 days.

Children in Need

A Child in Need is defined as; a child who is unlikely to reach or maintain a satisfactory level of health or development, or whose health or development is likely to be significantly impaired without provision of services from the local authority, or he/she has a disability.

As at the end of the year there were 2,082 children with open episodes – this equates to 269.4 per 10,000 compared to 272.5 last year (our statistical neighbours ranged from 196.7 to 347.2).

Child Protection

When the local authority receives a referral and information has been gathered during an assessment during which a concern arises that a child maybe suffering, or likely to suffer, significant harm, the local authority is required by Section 47 (S47) of the Children Act 1989 to make enquiries.

The number of S47 enquiries initiated within the year was 940. The number of Initial Child Protection Conferences undertaken in the year was 319.

The percentage of S47 enquiries with an outcome of Initial Child Protection Conferences (ICPC) was 44%. The number of child protection plans (CPP) started in the year was 284.

Child Protection Numbers 2017-21

Key Indicators	17-18	18-19	19-20	20-21
CPPs lasting 2 years or more	1.1%	0.3%	0.3%	3.2%
CPP for a second or subsequent time	18%	26%	22%	28%
CP cases reviewed within required timescales	95%	98%	90%	93%
ICPC within 15 days	84%	81%	78%	79%

The data measures in the table above reflects that this year there has been a reduction in achieving the statutory timescales for multi-agency responses for children most at risk. For most children (79%) their needs and risk are considered in a timely way (15 days). We are aware of all the children where this falls outside the statutory timescales and the reasons for this are reported on a weekly basis. The impact for the child is minimised as an immediate temporary safety plan is agreed, and for those subject to a review a plan is already in place. We are not outliers in the national performance framework but would want improvement so that children at risk have the right interventions in a timely way.

The measure for children on second child protection plans is a priority indicator for the partnership as there has been an increase in 2020/21 and this is higher than we want it to be. The impact for children this suggests is that we are not ensuring they remain safe when we remove them from a plan. We know that for most of these children, their risk

relates to neglect. This is a task and finish priority for the partnership this year with the Neglect Strategy being updated.

The figure for child protection plans lasting more than two years has increased. The impact for children is that there are not significant delays for them in the progress of their plan to keep them safe.

Cared for Children

Cared for children are those that are looked after by the local authority either voluntarily or through a statutory order. On the 31 March 2021, 518 children and young people were being cared for by the local authority:

- 20.7 % live outside the local authority area and over 20 miles from home
- 8% live in residential children's homes
- 1% lived in residential specialist schools
- 67% were in foster placements (including friends and family approved foster placements).

On the 31 March 2021, 14 unaccompanied asylum-seeking children were in the care of Cheshire East.

The figures show a number of young people live out of the area; many of these live nearby but across Cheshire East's border. Extensive work is underway to ensure there are sufficient local foster carers in Cheshire East to ensure where possible local placements are made.

In the last 12 months a total of 148 children have ceased to be cared for by the local authority. Of these, 26 children have been adopted; 13 children became subject of special guardianship orders; and 60 individuals have left care due to turning 18.

Care Leavers

On the 31 March 2021 there were 208 care leavers aged 17-21 who we were in touch with and supporting.

Listening to and acting on the voice of children and young people

CAN-DO Conference (Creative Act Now – Directly Online Conference)

Due to COVID restrictions it was not possible to hold the Cheshire East Safeguarding Children's Partnership Act Now Conference which for the previous 5 years had showcased the talent and knowledge of Cheshire East's children. In its stead, the Safeguarding Children in Education Service worked with several schools to develop and successfully deliver a **CAN-DO Conference** (**C**reative **A**ct **N**ow – **D**irectly **O**nline Conference).

This provided the opportunity to feedback to children on actions taken in response to what they had said they were worried about at Act Now 2019 and what they thought we could do better:

- The development of a self-harm pathway that enables schools to be more aware and work with hospitals to offer support and help a young person who has self-harmed to understand what is happening to support them.
- You wanted to know what Children's social Care does:
  - we explained that we use the Signs of Safety approach and what that means including how we use a variety of approaches to communicate with you. This means that that other people know about and understand your problems and families are strengthened and work together meaning they stay together.

Several schools utilised virtual tools to develop presentations on cyber bullying, a real life journey through child sexual exploitation, self-harm,

trauma - how to help us, autism awareness, and a song celebrating how a school keeps it pupils safe. These can be found here.

November Children's Rights Month

November Children's Rights Month is an annual celebration of children's rights across the borough, developed by young people for adults to experience life in their shoes based on the 6 outcomes of the Children and Young People's Plan. Within Cheshire East we worked with Cheshire East Youth Council to make it a celebration of the positive participation of children and young people for services within Cheshire East.

Key events included:

- Loneliness and isolation opportunity - connect with others
- Staying safe online – switch off
- Recognising individual success – positive moments
- Body image and self-esteem – stretch and relax
- Exam stress and transitions – personal achievement
- Being kind and celebrating differences – thinking of others.

Review of Priorities for 2020-21

The following three partnership objectives underpin the Cheshire East Safeguarding Children's Partnership business plan:

- 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 Safeguarding Children's Partnership agreed the following priorities to deliver these objectives in 2020/21:

We will improve frontline multi-agency practice through:

- Improving partnership engagement directly with frontline staff
- Continuing to drive developments around key safeguarding areas including children at risk of contextual safeguarding
- Embedding strengthening families
- Implementing our Neglect Strategy
- Implementing changes around the integrated front door
- Improving safeguarding arrangements for disabled children
- Improving identification and response around children and young people with mental health issues, including self-harming.

We will continue to improve the participation of young people in Cheshire East Safeguarding Children's Partnership business through:

- Ensuring that the voice of children and young people is central to Cheshire East Safeguarding Children's Partnership business.
- Engaging children and young people in co-producing information and support relevant to them.
- Ensuring that the Cheshire East Safeguarding Children's Partnership celebrates children's rights and participation and the contribution of children and young people to safeguarding.
- Ensuring the voice of children and young people is central to the Cheshire East Safeguarding Children's Partnership training programme.

We will strengthen the partnerships through:

- Engaging the community through links with the voluntary and faith sector.
- Improving Cheshire East Safeguarding Children's Partnership role and traction in relation to developing early help.

Improvements against the Priorities

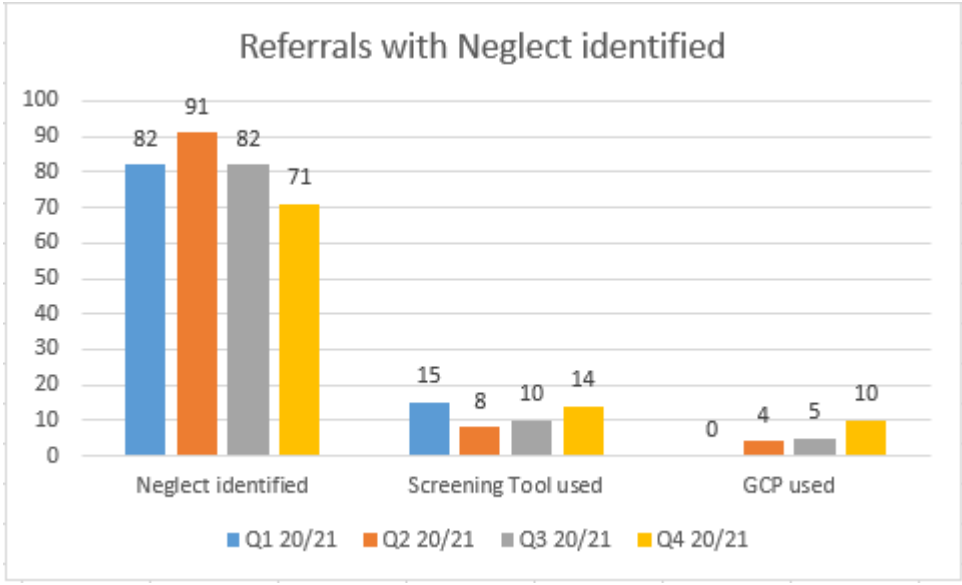
Improving engagement with frontline staff - e-bulletins

Cheshire East Safeguarding Children's Partnership has continued to publish its newsflash and frontline bulletins. The frequency of these was increased due to the need to convey information to practitioners during the challenges of working during the pandemic. They have covered a variety of topics including:

- Child protection conferences and cared for reviews during these challenging times
- Assurance from the Rape and Sexual Abuse Support Centre they are open usual apart from face to face.
- Domestic abuse risks and needs tool
- Foster Care Fortnight
- Safeguarding infants during the coronavirus pandemic: the ICON programme
- COVID-19: Stepped approach to caring for people who lack mental capacity and MCA: Liberty Protection Safeguards
- Safer Sleep
- Key Worker Parent/Carer Information
- Early Help Support
- Training
- Digital safety during COVID-19
- Summer Programme
- Preventative services sessions over the summer holidays to support families with transitioning back into school
- International White Ribbon Day
- COVID-19 safeguarding offer
- Mental Health Service Directory
- Local Safeguarding Adults Board Adult Safeguarding Bulletin
- Food and energy vouchers to support vulnerable children and families over winter
- Missing from Home and Care
- Coronavirus and Bereavement
- Trauma

Feedback from executive members and those participating in the COVID-19 response group has been that this method of communication is effective in supporting them in promoting the partnership and in disseminating safeguarding information within their services.

Neglect



During 2020/21 the Neglect Task and Finish Group developed the Neglect Strategy.

To inform this Strategy we have:

- researched the current partnership awareness and understanding of neglect using a survey
- used this information to develop 3 workstreams to support the development of the strategy as well as the training offer and performance measures

- Neglect is a priority for the Cheshire East Safeguarding Children's Partnership.

To respond we will:

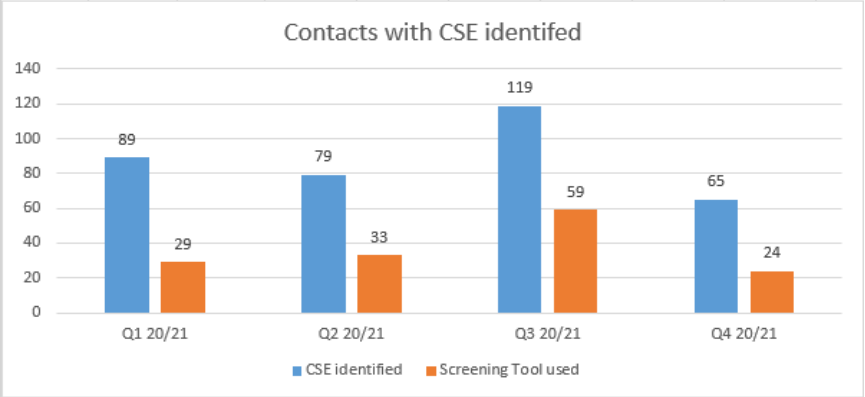
- develop practice guidance for all practitioners working with children and families who experience neglect at all levels of need
- review and launch the Early Help offer across all agencies
- each partner will take ownership and responsibility for promoting the Neglect Strategy within their organisation and embedding the practice
- further develop a partnership data set for neglect to continuously tell us what our picture is in Cheshire East
- develop a Neglect Strategic Board to analyse the data in Cheshire East including national comparators and research
- report findings of the board to the Cheshire East Safeguarding Children's Partnership Quality Assurance Sub-group.

Measures for success – Activity that will tell us of the impact:

- multi-agency auditing regarding all aspects of neglect and the practice delivered to children and families to address neglectful parenting
- regular consultation with children and families regarding the impact of any level of intervention
- regular consultation with frontline practitioners to understand their confidence in practice and their view of their impact.

The Neglect Strategy along with practice guidance for working with children and families who experience neglect was launched in quarter 1 2021/22 and the training offered is being refreshed.

Continuing to drive developments around Child Exploitation



In 2020-21 there were 352 contacts to the front door where child exploitation was a factor affecting either the individual or a family member. This related to 304 separate children. 145 of these (41%) were accompanied by a screening tool. 173 of the contacts resulted in a referral to social care.

In 2020/21 the Child Exploitation Operational Group was established to share information monthly within a multi-agency arena to safeguard and protect children from potential sexual exploitation, criminal exploitation, female genital mutilation, radicalisation and honour-based violence. The meeting provides an arena to share intelligence and knowledge on young people, persons of interest and places/premises where there could be links to such exploitation and/or significant harm beyond a young person home.

In Cheshire East child exploitation is a key priority for action for the next year.

Emotional health and wellbeing of our vulnerable children

Action	Indicator of Success	Progress 20/21	Plan 21/22
Examine the arrangements for, and effectiveness of work to improve the emotional wellbeing and mental health of vulnerable children, those on the edge of care and cared for children.	Development of a multi-agency approach to support children living with mental health issues from vulnerable backgrounds and where safeguarding concerns have been identified. To build on existing and emerging mental health pathways to ensure a comprehensive and responsive offer of support is available for children across the continuum of need framework and ensure that services are better aligned to the range of children and young people's needs.	• Directory of mental health services produced, including both adult and children's mental health. • Details of referrals and criteria for referral are included.	• Monitor number of referrals received to mental health services. • Develop a scorecard to highlight any areas of concern.
Work with partners to understand the mental health needs of children who are out of school/on part-time timetables.	Key partners will understand the needs of these children, specifically those with unmet needs, and the board will have an agreed multi-agency action plan to address these needs.	• Task and finish group established to review current pathways which includes mental health commissioners.	• Multi-agency information sharing pathway will be implemented for children who are out of school or on part-time timetables.
Review the present pathway for sharing information between health and education regarding incidents of children and young people self-harming.	Development of a pathway that ensures there is timely and proportionate sharing between school and health following an incident of self-harm by a child or young person.	• Self-harm notification pathway implemented across Cheshire. • School staff trained in Cheshire East by the Safeguarding Children in Educational Settings (SCiES) team on 'what to do when they receive a notification.' • Development and pilot of a leaflet for children on attendance at hospital on the assessment process by CAMHS, reason for information sharing and who will receive information in school. • Letter sent by all Cheshire East schools advising parents of self-harm notifications being received by schools to support children. • Initial quantitative and qualitative report from the SCiES team completed.	• Audit completed in May 2021 which included number of notifications and evaluation of pathway. Report of findings and recommendations to be finalised. • Continue to monitor number of notifications being received by the SCiES team monthly and identify if there are areas where more awareness raising and training is needed. • Further qualitative report to evidence outcomes for children of the pathway. • Finalise information leaflet and review the final copy with children and young people before use.

Developing our Early Help Strategy

The Cheshire East Early Help Strategy sets out how partners who work with children, young people, their families and carers, will deliver services in a way which enables children to maximise their potential, are kept safe and, where appropriate, prevents escalation of needs that require targeted or intensive interventions from statutory agencies. The strategy sets out the ambition of all the partners in Cheshire East to 'get it right' for children, their families and carers, by providing support and early help that enables children to thrive within their family environment and improve their long-term outcome and goals. The strategy has five priorities:

1. The partnership has the right infrastructure to support the development of early help services
2. Children and families get the right service at the right time: all partners understand levels of need and referral pathways
3. Understand the training need required, to ensure that our practitioners are enabled to co-produce high quality assessments and plans
4. We understand the quality of our services and act on this to improve outcomes for children - in order to respond quickly to any areas for improvement within our services we need to have a comprehensive overview of our partnership offer, which we regularly review
5. We understand the needs of children and families in Cheshire East, and we have the right range of services to meet these that can be accessed locally

There is an action plan that sets out the key actions to achieve the priorities.

Learning and Improvement

The Learning and Improvement Sub-group have supported and improved safeguarding practice across agencies and have:

- received the Annual Training Report from the partnership's Training and Development Manager
- agreed an approach for delivering safeguarding training in the 'new normal'
- adapted the training charging policy in response to the COVID pandemic, removed any barriers of cost for all partners
- overseen the work of the task and finish groups working on
  - children living with mental health issues
  - contextual safeguarding
  - implementing the Local Safeguarding Practice Review recommendations actions
  - neglect.

Strengthening Partnerships

We will strengthen relationships with other key partnerships to improve the reporting, accountability and sharing of good practice

Key updates from Children's Services have been scheduled on the forward plan for the Health and Wellbeing Board to ensure they have strategic oversight and scrutiny of the quality of children's services and the key issues for children and young people in Cheshire East.

The Partnership Chairs' Group has continued to meet during the year. It explores cross cutting issues within Business Plans and identifying shared risks.

Performance, Scrutiny and Challenge

Cheshire East Safeguarding Children's Partnership has a comprehensive quality assurance framework, which can be found on our website. In 2020-21 this has provided the partnership with a range of quantitative and qualitative information in relation to the effectiveness of safeguarding in Cheshire East. The partnership has strategic oversight and scrutiny of the quality of children's services and the key issues for children and young people in Cheshire East.

Performance A quarterly picture, showing a clear trajectory of progress. Allowing us to set targets and evaluate our performance against our statistical neighbours.	**Feedback from Children and Young People, Parents and Carers** What children, young people and their families want and is important to them, what their experience is of our services.
Qualitative Information Detailed information on what is working well and areas for improvement for specific services, including what the causes of issues are.	**Feedback from Staff** What staff know would help them to work with families, what is working well, and what could work better.

Quality Assurance Sub-group - Performance Monitoring

A range of quality assurance activity supports performance monitoring. Arrangements for this are robust and support and supplement partnership performance monitoring. This includes the Cheshire East Safeguarding Children's Partnership multi-agency audit programme.

The scorecard covers a range of measures from all partners and is aligned with the areas of focus for the partnership. It provides oversight of safeguarding practice across the partnership.

The Quality Assurance Sub-group is effectively scrutinising and challenging partnership performance and driving improvements to partnership working. The Quality Assurance Subgroup has:

- undertaken audits on contextual safeguarding and vulnerable adolescents
- further developed the audit methodology which is much more comprehensive and inclusive with better practice-based findings and effective multi-agency debate and agreement on findings.
- scrutinised and monitored the progress of agreed actions from audits and reflective reviews
- scrutinised S175 submissions.

Multi-Agency Audit

This audit covered a range of ages and levels of need each time. The agencies audit their own involvement using a common tool. They all make judgements on the quality of partnership working. Agencies then came together to analysis the audits and make recommendations for improvements. The agreed improvements are then tracked to completion by the Learning and Improvement Sub-Group.

Contextual Safeguarding and Vulnerable Adolescents

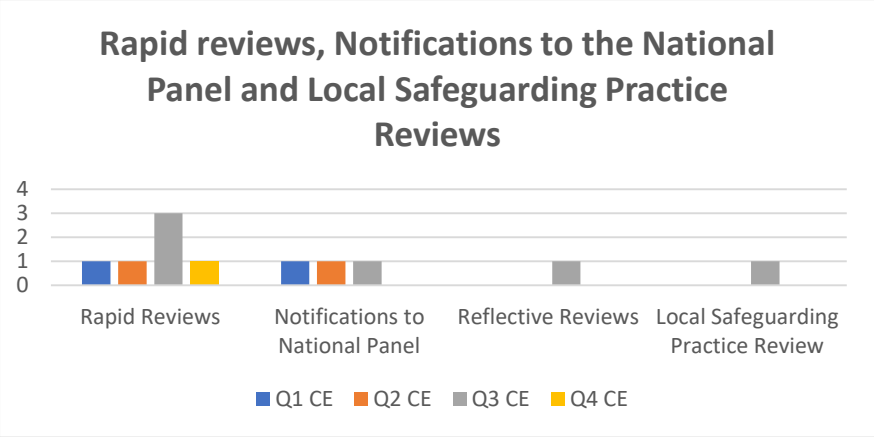
The audit findings are summarised below in terms of strengths and areas for improvement.

What are we worried about?	What's going well?
• Number of professionals involved with each child – Some young people responded well to this, but others didn't. • Not all the information discussed within contextual safeguarding meetings can be recorded on LiquidLogic as it often contains police intelligence although Social Workers do receive the meeting minutes. • There were cases where the escalation process could have been considered. • Neglect features in all cases and there were re-referrals to social care due to a reoccurrence of neglect. • Several of the young people were excluded from school / alternative provisions or were on the verge of being excluded. Understanding on adverse childhood experiences / journey of the child and understanding of the contextual safeguarding issues should inform this process. • Specialist agencies, such as CGL and CAMHS, experiencing non engagement by either children or parents/carers. • Agencies not completing mapping exercises routinely to strengthen information within tools.	• Good communication and information sharing. Good evidence of partnership working. • Use of IOM / complex Youth Police Officers to support plan and young person. • Most agencies have a good understanding of the contextual safeguarding process. • @ct involvement - this acts as an effective disruption tactic in the work that they complete. • Professionals' ability to form good working relationships with young people and families. • Good working relationship with the police. • Evidence of the voice of the child within assessments and plans. • Positive change being evidenced in a lot of the cases audited.
What do we need to do?	
• Be assured by partners that their frontline workers and managers are familiar with the escalation process is and use this when necessary. Assurance is required from CAMHS and CGL on what additional steps to engage are being tried and if consideration of a referral to other services is considered.	

Serious Case Reviews

The Cheshire East Safeguarding Children's Partnership published a Serious Case Review (SCR) that had been delayed awaiting the conclusion of other processes. This is available on the Cheshire East Safeguarding Children's Partnership website.

Rapid reviews, Notifications to the National Panel and Local Safeguarding Practice Reviews



The Rapid Review process has reviewed six cases during 2020/21; three of these resulted in notifications to the National Panel. Two of those progressed to Local Safeguarding Practice Reviews, of these one concluded during the year but could not be published due to ongoing criminal matters, the other was started in quarter 4 of 2020/21 and concluded in 2021. Where possible recommendations from all reviews have been progressed for example:

- dip sampling by health services and joint approach with Children's Social Care implemented for under two year olds known to services
- shared email to practitioners issued highlighting what should be looked for when visiting and not to focus solely on the parent etc.
- new-birth face to face visits taking place since June, parents being given a choice depending on their circumstances.

Implementation was scrutinised by the Quality Assurance sub-group.

Section 175

Due to the impact of the Covid Pandemic on the education system a decision was made by the partnership to delay the request to schools to complete their Section 175 returns. This meant that it was conducted in October 2020 instead of July 2020.

The school's submissions were extremely detailed and gave the partnership a very clear outline of schools safeguarding arrangements and what is under development. It provided the required assurance on safeguarding practice in schools. In addition, it also captured many of the ways in which schools have adapted and enhanced their safeguarding procedures during COVID.

In most primary schools, the Designated Safeguarding Lead is identified as the headteacher. All schools indicated that they have at least one named Deputy Safeguarding Lead. All schools indicated that they have a Designated Safeguarding Governor.

The Safeguarding Children in Educational Settings (SCiES) Team undertook analysis of the submissions and a report was scrutinised by the Quality Assurance Sub-group. SCiES are working with those schools who identified areas for improvement.

Type of setting	% completing S175
Independent School	82%
Primary School	93%
Secondary School	80%
Special School	100%
Colleges	67%
Nursery	100%

Joint Frontline Visits

The Joint Frontline visits during 2021 were completed by representatives of both the Local Safeguarding Adults Board and the Cheshire East Safeguarding Children's Partnership. These visits were undertaken during the COVID-19 pandemic lockdown period and therefore services were operating in a different manner. These visits have all been conducted virtually to comply with Public Health and NHS England guidance relevant at the time the visits took place.

In summary the visits made the following observations on children's multi-agency safeguarding:

What's working well?	What we are worried about?
• Signs of Safety well embedded in partners' practice and assists in embedding a Think Family approach and encourages professional curiosity. • Links with schools and statutory agencies have been strengthened since COVID-19. • Identification of young carers via screening tools. • All partners had a good understanding of the work of the Safeguarding Children's Partnership Board, newsletters, multi-agency communications and awareness raising activity. • Partners are clear regarding when to refer to the Children's Safeguarding Partnership. • Clear evidence of consultation with the child or young person to ensure that their views and wishes are central to safeguarding activity. • Adapting ways of working whilst keeping everyone's safety a priority has been crucial, ensuring appropriate PPE, vaccinations and keeping working/visiting areas as COVID-19 safe as can be.	• Increase in self-harm highlighted by children's practitioners, closely linked to mental health • Difficult to pick up on Signs of Safety during virtual contact with children and young people. • It has been challenging to identify carers due to a lack of visitors to premises such as hospitals and GP surgeries where this would usually be identified. • Further thought required regarding how children's safeguarding information is to reach some adult services. • Children and young people who use services and/or their carers having to repeat their history multiple times which can cause unnecessary distress, which could easily be avoided.
What needs to happen?	
• Needs to be more appropriate methods of sharing information in a sensitive manner, to ensure that children and young people who use services do not have to repeat their history multiple times, as acknowledged that this can be distressing and lead to a lack of engagement. • Training is needed to raise awareness in respect of complex safeguarding, and to ensure that practitioners are aware of local policy and guidance. • Frontline practitioners welcomed frontline visits and felt that this was a useful process, and it would be beneficial to increase the number of visits that are completed next year.	

COVID-19

The initial response of the Safeguarding Children's Partnership was to create a COVID response meeting to which both statutory and relevant partners were invited. This initially sought assurance from all partners that safeguarding children was a priority within the COVID lockdown response. This assurance was provided by all partners.

The terms of reference were established as:

- to ensure that multi-agency working remains effective in safeguarding children at a time when there are challenges to practice and additional vulnerabilities
- to ensure that there is a common understanding and risk assessment across all partner agencies as to the service that is being delivered and how it is delivered to children and families and that there is early notification across the partnership of any area of work that may be compromised for any agency that may impact on children and young people's safeguarding
- To ensure during COVID-19 restrictions that there is fluid coordination of multi-agency resources to ensure the most vulnerable children and families are safeguarded.

The safeguarding partners also agreed measures and plans to reduce the risk of contracting and spreading of the virus to children, young people, and their families and within our multi-agency workforce. A document was also created on our offer to safeguard and support children and families during COVID-19 where services shared their offer during COVID and that has been updated as the situation has evolved.

Amongst other outcomes:

- the partnership created a forum for operational considerations and check/challenge in real time as the COVID situation has evolved
- analysis and challenge of the increasing use of Police Protection Orders in the early lockdown - each was examined and assured that the police had made the correct decisions when utilising this approach
- requested and received assurance regarding mental health provision
- processes have been developed for identifying cohorts of vulnerable children and planning partnership responses
- Child Protection Conferences have virtual and face to face attendance options for parents
- using the learning from first lockdown to inform joint working on further periods of restriction
- Summer 2020 back to school campaign encompassing reduction in anxieties and reluctance to return. Schools identified which children might be at risk of not returning.
- Cafcass and Children's Social Care worked on court listing to agree priority cases.

This meeting continued to meet weekly and then fortnightly through the remainder of 2020/21.

Training and Development

The training year 2020/21 was unprecedented with the impact of COVID on the workplace and how training could be delivered. The training team and training pool responded to ensure that safeguarding training could continue to be delivered to all partners across the children and families workforce. Initially this was one to one activity via Lync and small bespoke

sessions being delivered to partners on request and a particular focus on new starters. Also, a considerable amount of time was devoted to redeveloping the original face to face offer into a virtual delivery model.

With the deployment of Microsoft Teams, and the learning from the initial use of Lync it was possible to deliver all multi-agency safeguarding training courses via Teams. Support to the training pool at this time was another focus to ensure that the considerable benefit to safeguarding training from local safeguarding expertise was sustained. The multi - agency training pool need to be commended as all remained committed to the quality delivery of the safeguarding training program despite having to learn quickly how to use virtual platforms to deliver training.

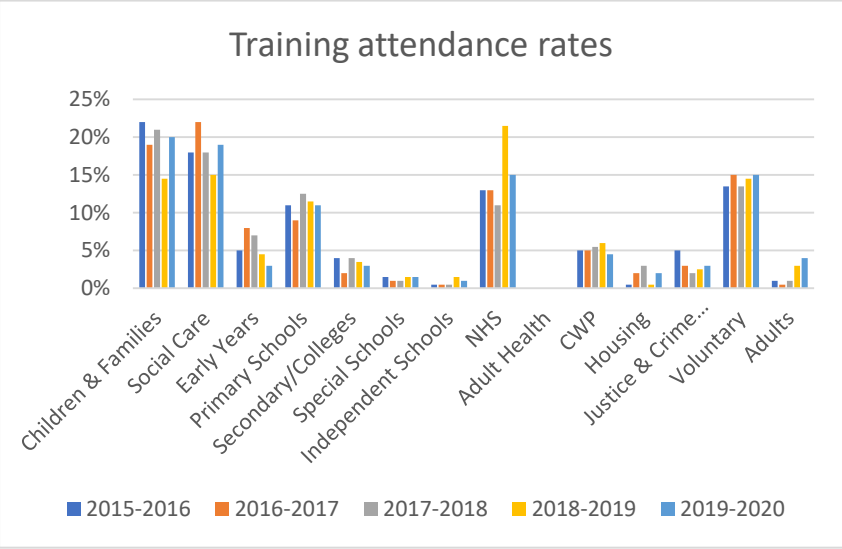
> The information received will be useful to pass on to the families I support and during group facilitation. I have already checked that the ICON information is displayed within the Children's Centre and that my colleagues have completed the training too.

> An informative and useful training session by trainers with exceptional knowledge bases and experience. Thank you.

Summary of the training year

Worries	Working Well	Next Steps
• IT resources including connectivity not being fit for purpose. • Short notice on non-attendance because of the pandemic. • Support to participants when delivering sensitive and highly emotive training more difficult via virtual training delivery methods • Lack of group interactions available as initially IT resources could not facilitate group work easily.	• Bespoke safeguarding learning opportunities were quickly developed to support one to one requests for training. • New starters were supported through Lync during the first four months of the pandemic specifically on Signs of Safety and Graded Care Profile 2 (GCP2). • Successful conversion of all courses to a virtual package. • Signs of Safety two-day course successfully revised to a virtual modular approach which was easier for participants to access. • All members of the training pool have remained available to deliver training • Specific work undertaken with the NSPCC to convert GCP2 face to face training to a virtual delivery method with excellent results which have been commended by the NSPCC. • Evaluation data has been excellent during the transitionary period. • Considerable savings made as no printing, venue, or refreshment costs over the training year.	• Further review of training packages required to establish which courses if any need to revert to a face-to-face model of delivery. • Risk assessment required to ensure resuming any face-to-face delivery of training in the future is safe for participants, trainers, and other venue users. • Review and reintroduction of the charging policy to accommodate non-attendance fees, bespoke design and delivery of single agency courses and support to organisations requesting policy review.

Attendance rates



35 multi-agency courses were delivered in 20/21. 666 participants attended training, whilst this is a decline from last year's activity this can largely be explained by the COVID-19 pandemic, the lack of a platform to confidentially deliver training for the first four months of the training year, the work involved in converting all courses and the additional time and support needed for the training pool. This number does not include any one to one, bespoke or small team sessions which were delivered outside of the formal training program. Two courses are on hold for redevelopment and have not been delivered over the past 16 months.

In addition to the existing training programme the suite of e-Learning courses has been revised and 317 users have completed these, which is an increase on the preceding year.

Really difficult to deliver a full day's training virtually so I was very impressed with how engaging and interactive it was.

The graph demonstrates the attendance percentages over the past five years, we are unable to accurately compare this year's data due to the COVID pandemic.

Attendance is from across all areas of the children's workforce, including health, education, social care, children and families and the voluntary sector. Notable exceptions include Cheshire Fire and Rescue Service and the Northwest Ambulance Service, however given the multi-regional footprint of both organisations it is likely training may be accessed from outside Cheshire East. Attendance by adult practitioners is the highest recorded.

Impact on practice

80% of 2020/21 participants returned the in-course evaluation and indicated high levels of satisfaction for both content and delivery. 24% of post-course evaluations were returned and showed most participants found the training useful practically with children and families.

Grade Care Profile 2 evaluation was conducted separately and 94% of attendants said they would use the tool even if they haven't had the opportunity to date in practice. All participants stated that it will be helpful in their work with families where neglect is a feature. Of the participants who have used the tool, 100% said families liked and understood the assessment. This is consistent with previous years.

Bespoke events, new courses, and development activity

The Training Team has delivered or coordinated the following learning and development processes alongside the existing training programme:

- Development of Grade Care Profile 2 refresher training.
- Support to three new Signs of Safety training pool members.
- Support to all training pool members to deliver courses confidently using virtual methods.
- Contribution to the Neglect Strategy - the Cheshire East Safeguarding Children's Partnership Training Manager has led on the Learning Sub-group for the Strategy.
- Working closely with Workforce Development to ensure courses are accessed appropriately by council staff.
- One to one support to new starters, particularly within the council.
- Support to regional colleagues regarding the harmful sexualised behaviour assessment toolkit.

Key Priorities for 2021-22

The local arrangements for Cheshire East Safeguarding Children's Partnership have been agreed by the partnership and published on its website. Cheshire East Safeguarding Children's Partnership has agreed shared priorities for our partnership and have adopted these as their initial plan for supporting the protection and wellbeing of children and young people in Cheshire East. We will:

Improve frontline multi-agency practice through working on:

- Our approach to contextual safeguarding
- Improving the quality and effectiveness of our approach to neglect
- Emotional health and wellbeing of our vulnerable children
- Embedding the new arrangements.

We aim to do this through our collective commitment to:

- Strategic leadership across the partnership – to make the safety of children and young people a priority.
- Challenge – through focused inquiries or investigations into practice or issues based on evidence, practitioner experience and the views of children and young people, for us to improve together.
- Learning – to achieve the highest standards of development and to ensure all practitioners have the skills and knowledge to be effective. This will include listening to the voice of children and young people and using what we hear to inform best practice.

#BecauseWeCare
Cheshire East Partnership

Governance proposals for the ICS at Place

21 June 2022

Governance/operating model

#BecauseWeCare
Cheshire East Partnership

Strategy, Assurance & Risk, Quality, Monitoring	CE Place Board
Place Leadership	CE Place Leadership Group
Strategic Planning & Transformation	Integrated Planning & Delivery Group
Operational Leadership & Delivery	Whats wrong with me? / Fix Me / Help me stay well / End of Life

Enabler Workstreams

- Comms & Engagement
- Digital
- Business Intel Inc. Population Health
- Estates
- Quality and Safeguarding
- Workforce
- Finance

Care Communities / PCNs

The Place Board –a 'Committee in Common'

#BecauseWeCare
Cheshire East Partnership

- Consultative Forum:-

The part of the Committee which is consulted by the ICB Director/S75 Committee on its financial decisions.

Members can use their own individual delegations to make decisions on behalf of their organisation if they wish.

Purpose of Place Committee as a whole is oversight and management of an integrated health and social care system through effective collaboration, and to deliver improved health and social care services and outcomes.

Agreed decisions to date – PPB & Place Executive

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Cheshire East Partnership

- Streamlining of meetings
- Consensus decision making
- Behaviours and principles
- Bi-monthly meetings
- Next step – terms of reference to be signed off by Boards (including membership and chair proposals)

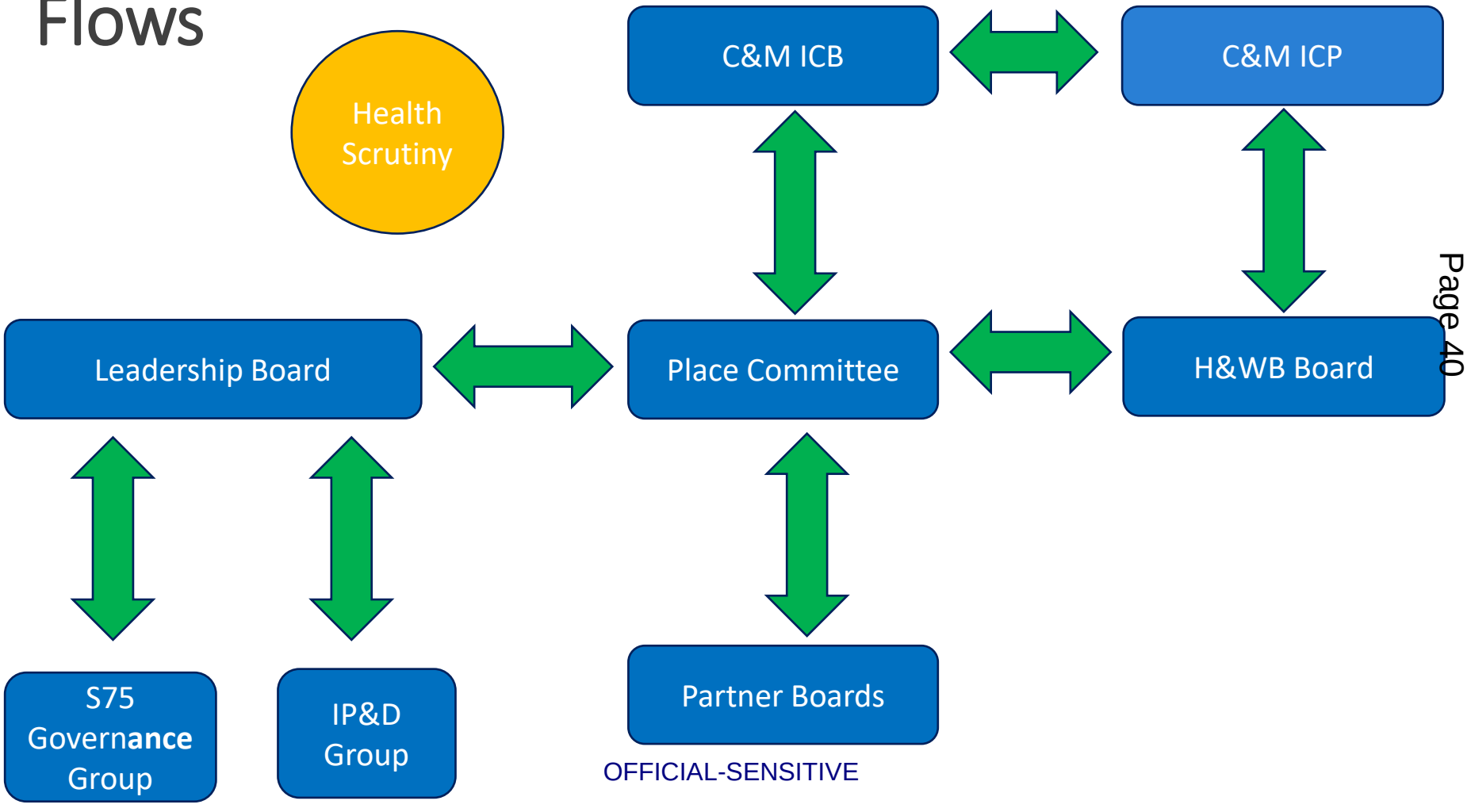
#BecauseWeCare
Cheshire East Partnership

Place Committee sign off - timeline

Partner	Date report needed	Sign off
Cheshire Clinical Commissioning Group	23/06/2022	30/06/2022
East Cheshire NHS Trust	29/06/2022	07/07/2022
Cheshire East Council – Adults and Health Committee	27/06/2022	18/07/2022
Cheshire and Wirral Partnership NHS Foundation Trust	20/07/2022	27/07/2022
Mid Cheshire Hospital NHS Foundation Trust	21/07/2022	28/07/2022

Information Flows

#BecauseWeCare
Cheshire East Partnership



Scheduling proposals for Place Board reporting

#BecauseWeCare
Cheshire East Partnership

- Place Board bi-monthly to fit in with ICB Board
- Chairs report from Place Board to be circulated to all partners/for discussion – but not to align with meetings
- Chairs report from Place Board to align with H&WB Board
- H&WB Board to align with ICP for information flows

Next Steps

#BecauseWeCare
Cheshire East Partnership

- All partners Boards to agree the Place Board terms of reference at the July set of meetings
- Existing Place Partnership Board & Place Executive group to be wound up
- New Place Board to be set up for 1st August
- Timetable to be revised for all meetings once ICB have confirmed their meetings
- Chairs report to be brought to H&WB Board from Place Board meetings

Agenda Item 9

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	All Together Fairer: Health equity and the social determinants of health in Cheshire and Merseyside
Date of meeting:	21st June 2022
Written by:	Guy Kilminster
Contact details:	Guy.kilminster@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Dr Matt Tyrer

Executive Summary

Is this report for:	Information ☐	Discussion X	Decision ☐
Why is the report being brought to the board?	To inform the Board of the publication of 'All Together Fairer' and note that a follow up report will seek endorsement of the recommendations that the Cheshire East Place should prioritise.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Creating a place that supports health and wellbeing for everyone living in Cheshire East ☐ Improving the mental health and wellbeing of people living and working in Cheshire East ☐ Enable more people to live well for longer ☐ All of the above X		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness X Accessibility X Integration X Quality X Sustainability X Safeguarding ☐ All of the above ☐		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	'All Together Fairer' sets out a series of recommendations for the Cheshire and Merseyside health and care system. In addition, it has recommendations for Places and asks that each Place consider these and prioritise those most relevant to them. The Board is asked to note the publication of the report and that a follow up report with proposals as to which of the recommendations to adopt will be forthcoming.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	No, but it will be shared with the Place Partnership Board in due course.		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	Not directly
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	The case for reducing health inequalities is clear, they are unnecessary and unjust, harm individuals, families, communities and place a significant financial burden on services, including the NHS, the voluntary and community sector and on the economy. If the recommendations of 'All Together Fairer' are implemented over an extended period of time, then there is the opportunity to make a fundamental difference to the lives of some of our most vulnerable people.

1 Report Summary

1.1 In November 2008, Professor Sir Michael Marmot was asked by the Government to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The final report, '**Fair Society Healthy Lives**', was published in February 2010, and concluded that reducing health inequalities would require action on six policy objectives:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention.

1.2. The Cheshire and Merseyside Health and Care Partnership has, as one of its priorities, the reduction of health inequalities. Adopting the Marmot principles is regarded as a key step, to focus all partners and all nine Places (including Cheshire East) on this objective. Work has been underway over the last two years to set out how to achieve Marmot Community status (working with the Institute of Health Equity) and their report 'All Together Fairer: health equity and the social determinants of health in Cheshire and Merseyside' was published at the end of May. A dedicated website with the full report and related videos and information can be accessed here Champs | Public Health Collaborative (champspublichealth.com) The Executive Summary is also attached as Appendix One.

1.3. The report sets out the inequalities in health and in the social determinants of health in Cheshire and Merseyside and assesses the impacts of the Covid-19 pandemic. The recommendations made cover the key social determinants of health, arranged to match the eight Marmot principles and with additional proposals to be addressed by stakeholders across the system. There are specific recommendations for Places to consider and prioritise to suit their local needs.

1.4 Within Cheshire East, our own health inequalities are highlighted through the Joint Strategic Needs Assessment and the 'Tartan Rug'. A Place-based approach to the report's recommendations will assist in our efforts to improve the health and wellbeing outcomes for our residents and reduce those inequalities.

2 Recommendations

2.1 That the Cheshire East Health and Wellbeing Board note the publication of ‘All Together Fairer: health equity and the social determinants of health in Cheshire and Merseyside’.

2.2 That the Cheshire East Health and Wellbeing Board receive a report at a future meeting to approve the priorities that will be proposed as being most relevant to the Cheshire East Place.

3 Reasons for Recommendations

3.1 To ensure the Cheshire East Health and Wellbeing Board is aware of and supports the ‘All Together Fairer’ proposals.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 Reducing inequalities is a priority within the Cheshire East Health and Wellbeing Strategy and the Cheshire East Place Five Year Plan.

5 Background and Options

5.1 ‘All Together Fairer: Health equity and the social determinants of health in Cheshire and Merseyside’ was published and launched at the end of May. The report had been commissioned by the Cheshire and Merseyside Health and Care Partnership from the Institute of Health Equity following a decision in 2019 to seek to achieve ‘Marmot Community’ status.

5.2 The work to research and produce the report was supported by a Champs Public Health working group with representation from each Place in Cheshire and Merseyside. Working with the Institute’s academics and research team a detailed analysis of the current situation in relation to health inequalities and the social determinants of health was undertaken. Through a series of Place-based workshops in October - November 2021 the evidence base was tested with local representatives and case studies identified to include within the report.

5.3 The report sets out recommendations at two levels: those for the Cheshire and Merseyside System to address and those that Places should take the lead on. These are further sub-divided not current year recommendations and longer term (2023-2027) recommendations.

5.4 The report acknowledges that Places will not be in a position to respond to all of the recommendations, so it suggests that each Place identify those most relevant to their local circumstances. A piece of work is underway to review and map the recommendations against the Cheshire East Health and Wellbeing and Place priorities. This will inform a follow up report to the Board that will propose a suite of recommendations that the Cheshire East Place should focus upon.

5.5 A series of ‘Marmot Beacon Indicators’ are to be used to measure progress across Cheshire and Merseyside and these are set out in the report. The Public Health and

Corporate Business Intelligence teams will work with Cheshire and Merseyside colleagues to ensure that we are able to provide the data required in relation to these.

6 Access to Information

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

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Designation: Corporate Manager Health Improvement
Tel No: 07795 617363
Email: guy.kilminster@cheshireeast.gov.uk

EXECUTIVE SUMMARY

INSTITUTE of HEALTH EQUITY

ALL TOGETHER FAIRER: HEALTH EQUITY AND THE SOCIAL DETERMINANTS OF HEALTH IN CHESHIRE AND MERSEYSIDE

In 2021 the Institute of Health Equity (IHE) was commissioned by the Population Health Board of the Cheshire and Merseyside Health and Care Partnership (HCP) to support work to reduce health inequalities in the region through action on the social determinants of health and to build back fairer from COVID-19.

The report's approach reflects the views of many we heard from in Cheshire and Merseyside since we began work in July 2021. "We need to do something different or nothing will change", "If we keep doing what we've done in the past, inequalities will continue to worsen".

The case for reducing health inequalities is clear - they are unnecessary and unjust, harm individuals, families, communities and place a huge financial burden on services, including the NHS, the voluntary and community sector and on the economy. Health inequalities are remediable by reasonable means and, even without national government support, are remediable to some extent. Despite deteriorating health and widening inequalities across the country and in Cheshire and Merseyside, there is scope for local areas to make a real difference. Changes in approach, allocation of resources and strengthened partnerships are essential.

The report sets out inequalities in health and in the social determinants of health in Cheshire and Merseyside and assesses the impacts of the COVID-19 pandemic on health inequalities and the social determinants. It points to the role of austerity policies and associated funding cuts between 2010-20 in driving these inequalities.

The recommendations made in the report cover the key social determinants of health – the eight Marmot principles and seven actions across for the Cheshire and Merseyside stakeholders and system. The recommendations are classified in two categories: Year 1 (2022-23) and Years 2-5 (2023-27) and they challenge the region to take actions on the social determinants of health, develop a regional system to take forward these actions and develop a healthier and more equitable region.

THE REGION

The Cheshire and Merseyside region is home to more than two and a half million people across nine boroughs. The region has areas of substantial wealth and substantial deprivation.

Overall a third (33 percent) of Cheshire and Merseyside population live in the most deprived 20 percent of neighbourhoods in England, with significant negative implications for health (1). The average Index of Multiple Deprivation score in Cheshire and Merseyside is 28.6 compared to 19.6 in England (2).

The Index of Multiple Deprivation shows that Knowsley is the second most deprived borough in England, Liverpool the third. Knowsley has the highest proportion of its population living in income deprived households in England (tied with Middlesborough), equating to one in four of all households. Liverpool has the fourth highest proportion, with 24 percent living in income deprived households (2). Even within the wealthier areas in the region, there is substantial deprivation and associated poor health – while 31 percent of neighbourhoods in Cheshire West and Chester are in the top two income deciles, compared to an England average of 20 percent, 16 percent of neighbourhoods in Cheshire West and Chester are in the lowest income deciles (2).

Extensive cuts to local authority budgets and increasing inflation has resulted in many of the social determinants of health – housing, education, early years, youth services, legal aid and police, the services offered by the voluntary, community, faith and social enterprise sector – to suffer real cuts for many years. The Public Health Grant fell by 22 percent between 2015-16 and 2020-22. Knowsley, the most deprived local authority in the HCP, had the highest spending cuts in the region at £725 per head of population (3).

The 2022 Levelling Up white paper is unlikely to provide sufficient funding to address health inequalities across all of Cheshire and Merseyside. Again, Knowsley, despite its high level of deprivation, received no funding from these Levelling Up funds whilst a number of areas that are the wealthiest in England received over £100 a head (4).

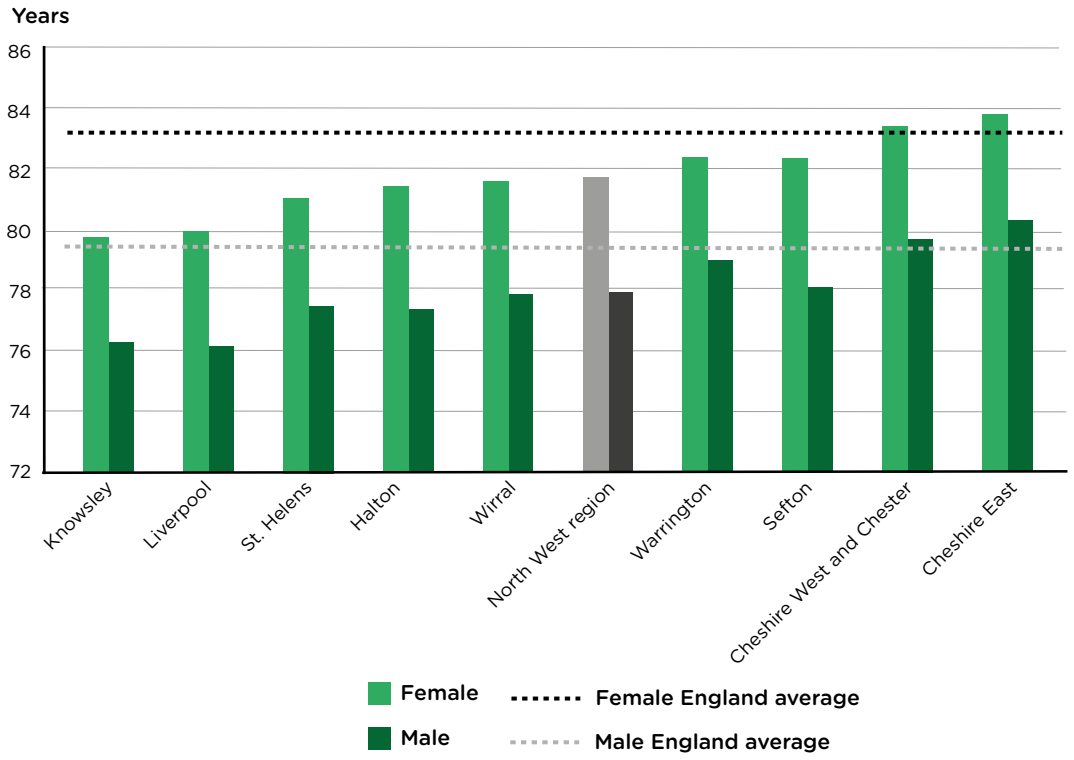
EVIDENCE

LIFE EXPECTANCY

Austerity policies from 2010-20 in England have had substantial impacts on services offered and subsequently on health and inequalities. Across England, life expectancy for the most deprived areas outside London declined, even before the pandemic and this is likely a direct result of cuts to public services and local government, reductions in benefits and low-quality work and low pay.

Within Cheshire and Merseyside life expectancy is generally below the average for England, except in Cheshire West and Chester and Cheshire East.

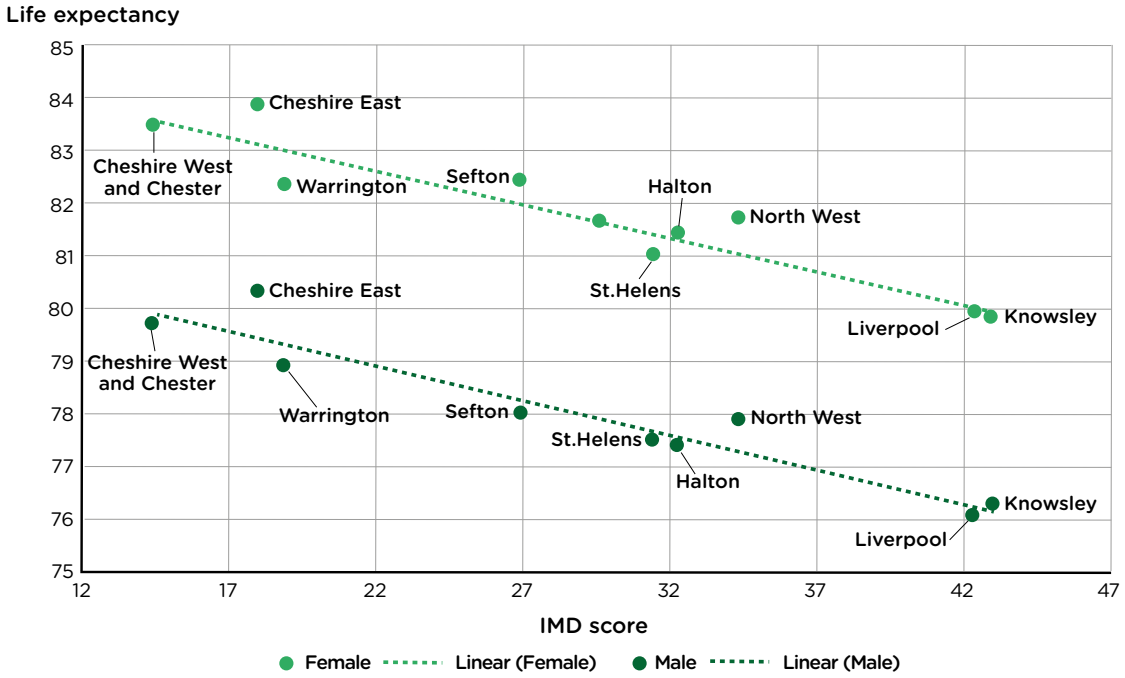
Estimated male and female life expectancy at birth, Cheshire and Merseyside lower tier local authorities, North West region, and England, 2018–2020



Source: *Office for National Statistics. (5)*

Women living in the most deprived areas live 12 years less than those in the least deprived areas, and for men, the difference is 13 years. Within local authorities there are even greater inequalities in life expectancy closely related to level of deprivation.

Estimated male and female life expectancy at birth by deprivation (IMD 2019), Cheshire and Merseyside lower-tier local authorities, 2018-20



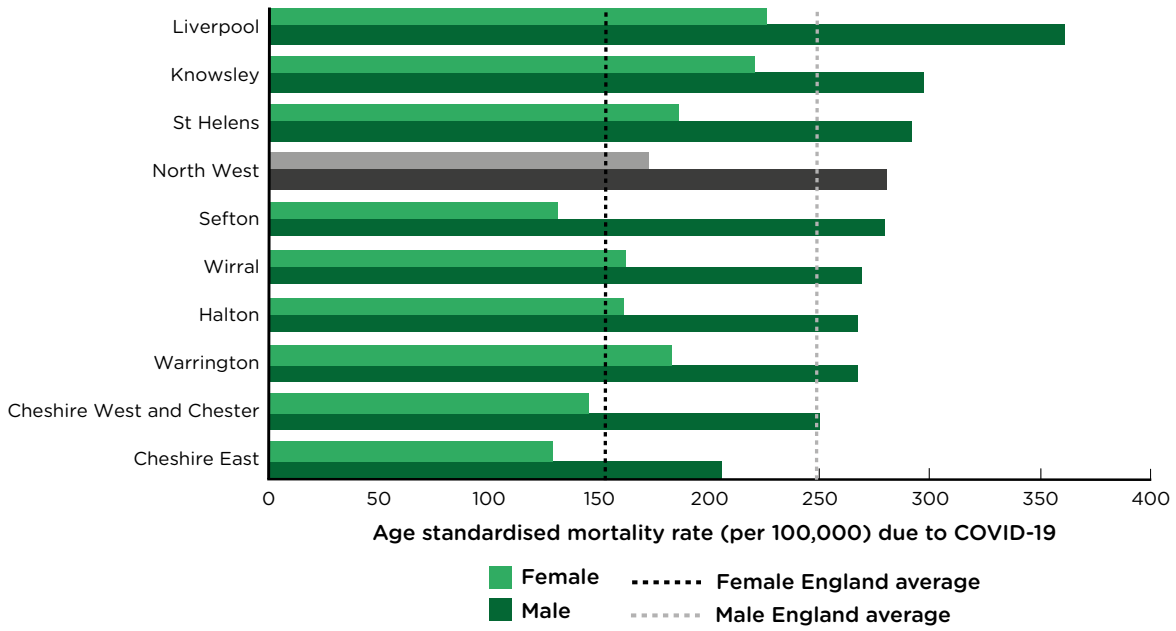
Source: *Office for National Statistics. (5)*

Healthy life expectancy (how long one can expect to live in good health) is also below the England average in Halton, Liverpool, Knowsley, St Helens and for men in Wirral.

The COVID-19 mortality rate in Cheshire and Merseyside has been high (5 percent higher than the England and Wales average between March 2020 and April 2021) and the pandemic has exposed and amplified inequalities.

In the four least deprived areas (measured by the Index of Multiple Deprivation), mortality from COVID-19 was lower than the England and Wales average over the same period, but in the other six deciles, COVID-19 mortality in Cheshire and Merseyside was greater than the England and Wales average. For the most deprived decile in Cheshire and Merseyside, the mortality ratio was 2.23 times higher than that of the least deprived decile.

Age-standardised COVID-19 mortality per 100,000, Cheshire, and Merseyside lower-tier local authorities, North West region, and England, 14-month total, March 2020 to April 2021



Notes: *Deaths 'due to COVID-19' only include deaths where coronavirus (COVID-19) was the underlying (main) cause.*
Source: *Office for National Statistics (6)*

THE SOCIAL DETERMINANTS OF HEALTH

Health is largely shaped by the social, economic and environmental conditions in which people are born, grow, live, work and age known as the social determinants of health. The social determinants of health are encompassed by the Marmot 8 principles, which are the basis for the analysis in the report and the recommendations (6) (7).

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill-health prevention.
7. Tackle racism, discrimination and their outcomes.
8. Pursue environmental sustainability and health equity together.

BEST START IN LIFE AND EARLY YEARS AND MAXIMISING CAPABILITIES FOR YOUNG PEOPLE

Experiences during the early years and in education are particularly important for immediate and longer-term health and outcomes in other social determinants of health such as education and income (8) (9).

Marked inequalities between children eligible for free school meals and those who are not eligible are already apparent at the age of five years in Cheshire and Merseyside. Levels of school readiness at the end of reception are lower for pupils eligible for free school meals compared to more affluent children and these lower levels of school readiness in pupils eligible for free school meals continues into primary and secondary school. Reductions in attainment and development associated with the pandemic have been worse in pupils eligible for free school meals.

Improving outcomes in the early years and in schools requires collaborations between early years providers, schools, employers and youth services working together with communities and families. All have been hit hard by recent funding cuts child poverty is increasing, harming development and outcomes still further. The NHS also has a role to play in supporting better conditions for children and young people – even beyond improving access to relevant services.

Actions addressing the social determinants of health in hospitals

At Alder Hey Children's Hospital a team of respiratory paediatricians, specialist nurses, and Allied Health professionals are working together with families to improve children's lung health. The team regularly phone landlords, housing agencies, and the council directly, explaining the urgency of good housing for children with respiratory problems. Their clinics focus on empowering parents – at one level to use their house better (with advice about cooking oils and kitchen extractor fans, home ventilation, where to place furniture, and how to dry clothes to reduce humidity and so on); and empowering families to help them advocate for better housing for themselves.

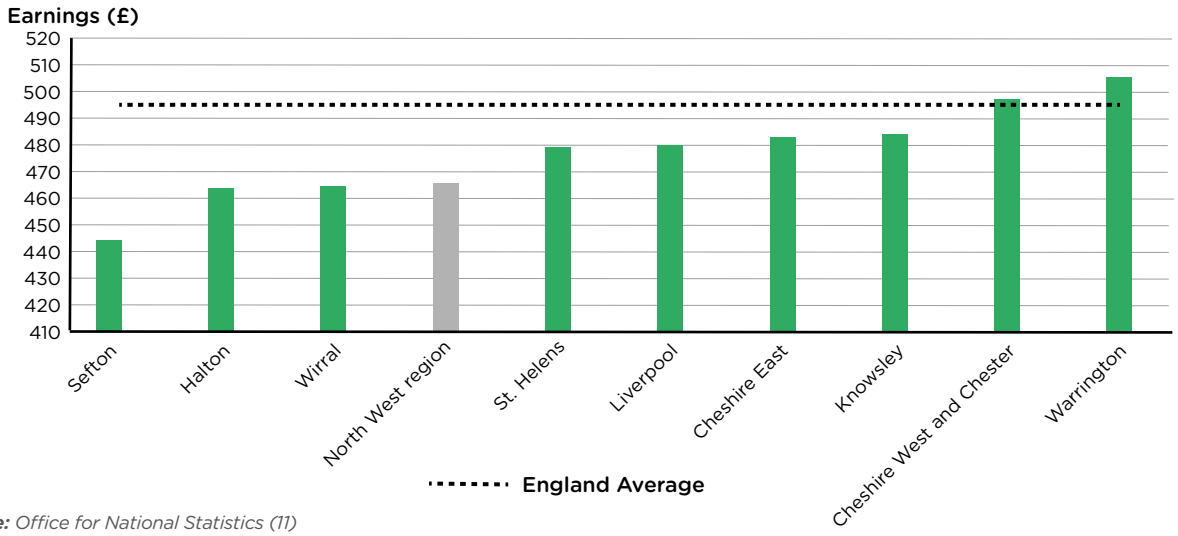
EMPLOYMENT AND INCOME

Good quality work is beneficial to the health of employees and also beneficial to employers as it increases productivity, retention and reduces the amount of sick pay required. Businesses can have both positive and negative impacts on health through employment practices; through goods, services and investments; and through their impacts on communities and the environment. Reducing the harmful impact of business and enhancing the positive contribution is vital for health and wellbeing and reducing inequalities. There is great potential for businesses in the region to improve the health of their employees and communities more broadly.

People with long-term health conditions have lower rates of employment but many still want to work; compared to the England average, six of Cheshire and Merseyside's nine areas have a higher gap in the employment rate between those with a long-term health condition and those without.

Despite the introduction of the minimum and living wages, wage growth in the UK since 2010 has been low and rates of in-work poverty have increased. In the UK three-fifths of working-age adults who live in poverty are either in work or live with someone who is in work. In 2020 only Cheshire East and Cheshire West had average earnings above the England average in the region. Sefton's average weekly earnings in 2020 were £51 below the England average (£496 versus £445).

Average weekly earnings, (aged 16 and over), pounds (£), Cheshire and Merseyside lower-tier local authorities, North West region and England, 2020



Source: *Office for National Statistics (11)*

A third of Cheshire and Merseyside's residents live in the most deprived 20 percent of neighbourhoods in England, 15 percent of children live in absolute poverty households and 18 percent of children live in relative poverty households, compared to 19 percent in England (12). Poverty is not only about money: poverty affects control over one's life which is critical to health and wellbeing and the ability to lead a dignified life. The average cost of living is increasing in the UK and these increases, alongside increasing in flation, will lead to increases in poverty.

Actions to improve health inequalities are challenging understandings of poverty

The Cheshire West and Chester Poverty Truth Commissions, held in 2017 and 2020, aimed to tackle the root causes of poverty and reduce gaps in services across the borough. Community inspirers, volunteers with lived and living experience of poverty, shared their stories of the effect poverty had on them and their families. Through true listening and collaboration, members of the commissions reflected on how systems and processes could better support local people. As a result of the commissions, there has been more collaborative and partnership working across a number of agencies and new support for front line staff. The approach has been mainstreamed, all poverty work across the council and with local partner agencies, will put people at the heart of policy development and service design.

PLACE AND ENVIRONMENT

One of the most significant ways that healthy and sustainable places and communities can be forged is through good quality housing and safe environments with good access to services, shops, community facilities, leisure and entertainment and good quality natural environments.

A quarter of privately rented homes in England do not meet the decent homes standard. In the North in 2018, close to 1 million owner-occupied homes (24 percent of Northern households compared to 20 percent in England) and 354,000 private rented homes (26 percent of Northern households) did not meet the 'decent homes standard' and rates are increasing (13). Levels of rough sleeping dropped dramatically during the first months of the COVID-19 pandemic when local councils were provided with additional funding.

PUBLIC HEALTH, HEALTH AND THE SOCIAL DETERMINANTS

Shifting to a social determinants of health approach means taking action in the drivers of ill health as well as treating ill health when it is presented in healthcare settings: the prevention agenda must focus on improving living and working conditions, and reducing poverty – as well as focussing on healthy behaviours. As set out in the report, it is almost impossible to live healthily when in poverty.

Six of Cheshire and Merseyside's local authorities have alcohol-related mortality rates above the England average and six also have above average deaths related to drug misuse. Prior to the pandemic overall prevalence of obesity was increasing in Cheshire and Merseyside; Halton's rate of overweight or obesity, 78 percent, is the highest in the region (14). Analysis shows each 10 percent spending cut for early years services was associated with a 0.34 percent relative increase in obesity prevalence the following year (10).

NHS AS AN ANCHOR INSTITUTION

Many local authorities in the region have already committed to being anchor institutions and work is occurring in many NHS institutions to integrate the concept into future planning. There is greater scope to expand the role of anchor institutions in improving health in local areas, particularly in the most deprived areas. Being a good employer is part of being an anchor. The NHS should be offering the real living wage; all contracts with minimum hours and minimal use of zero-hour contracts (unless in agreement with employees); all employees offered training and development opportunities. Beyond improving conditions for employees, anchor organisations can work to build health in local communities through buying locally, supporting and advocating for communities and investing to reduce inequality.

TACKLING RACISM AND DISCRIMINATION

Ethnic minority groups often experience worse outcomes in the social determinants of health, such as income, quality of employment and housing conditions – this relates to experiences of discrimination and exclusion. Ethnic minority populations are more likely to report being in poor health and have poor experiences using health services than the White British population. The COVID-19 pandemic has revealed the stark inequalities in health and economic and social inequalities for many of the UK's ethnic minority communities.

Actions to improve health inequalities are being led by the VCFSE sector

Merseyside Sport Partnership (MSP) is working with the Wirral Deen Centre, a mosque and community centre in Birkenhead and Tranmere. The project works with women who do not speak English as a first language, who have difficulties accessing, or even knowing about, local services. The charity identified that appropriate clothing for exercise and money to travel were barriers for women who wanted to become physically active. Many of the women had minimal spoken English, which meant accessing services was more difficult, especially for those who wanted women's-only gym or swimming sessions. MSP helped the Wirral Deen Centre secure funding to subsidise transport costs, purchase gym clothing and paid for exclusive access for a group of women to access a nearby gym.

CLIMATE CHANGE

It is estimated that in the North West region, under a medium greenhouse gas emissions scenario, in the 2080s the North West will have summer temperatures increasing by 3.7 degrees; 21 percent less rainfall in the summer and 16 percent more rainfall in the winter. Harm to health from climate change will worsen as the climate warms and precipitation increases and this harm will be more substantial for those who live in the most deprived areas.

Many of the actions to reduce greenhouse gas emissions and mitigate impacts can also improve health and reduce health inequalities but there is also potential that interventions will widen inequalities. Active travel is central to reducing these emissions. In Cheshire and Merseyside, except for Liverpool, adults walk and travel less than the average for England.

TAKING ACTION IN CHESHIRE AND MERSEYSIDE

Local authorities and/or the NHS cannot take on the required actions to reduce health inequalities alone; many lie outside their direct remit and they do not have sufficient resources, capacity and levers to achieve that. It is important that the HCP and ICPs embed partnerships with the VCFSE sector, other public services, local authorities and businesses to influence these wider conditions which shape health.

IHE proposes recommendations covering each of the Marmot 8 themes and the following system-wide recommendations for action across the Cheshire and Merseyside system.

1. **Increase and make equitable funding for social determinants of health and prevention.**
2. **Strengthen partnerships for health equity.**
3. **Create stronger leadership and workforce for health equity.**
4. **Co-create interventions and actions with communities.**
5. **Strengthen the role of business and the economic sector in reducing health inequalities.**
6. **Extend social value and anchor organisations across the NHS, public services and local authorities.**
7. **Develop social determinants of health in all policies and implement Marmot Beacon indicators.**

A set of local Marmot Beacon indicators, developed in partnership with hundreds of local stakeholders, will monitor actions on the social determinants of health in Cheshire and Merseyside.

The report proposes the following 22 indicators, aligned with the 8 Marmot themes, covering areas which are considered critical in reducing health inequalities. This social determinants indicator set was co-created with Cheshire and Merseyside and will be monitored by the Combined Intelligence for Population Health Action (CIPHA) programme.

Life expectancy		Frequency	Level	Disagg.	Source
1	Life expectancy, female, male	Yearly	LSOA	IMD	ONS
2	Healthy life expectancy, female, male	Yearly	LA	IMD	ONS
Give every child the best start in life					
3	Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development)*	Yearly	LA	NA	DfE
4	Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception)	Yearly	LA	FSM status	DfE
Enable all children, young people and adults to maximise their capabilities and have control over their lives					
5	Average Progress 8 score**	Yearly	LA	FSM status	DfE
6	Average Attainment 8 score**	Yearly	LA	FSM status	DfE
7	Hospital admissions as a result of self-harm (15-19 years)	Yearly	LA	NA	Fingertips, OHID
8	NEETS (18 to 24 years)	Yearly	LA	NA	ONS
9	Pupils who go on to achieve a level 2 qualification at 19	Yearly	LA	FSM status	DfE
Create fair employment and good work for all					
10	Percentage unemployed (aged 16-64 years)	Yearly	LSOA	NA	LFS
11	Proportion of employed in permanent and non-permanent employment	Yearly	LA	NA	LFS
12	Percentage of employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter***	-	-	-	NHS, local government
13	Percentage of employees earning below real living wage	Yearly	LA	NA	ONS
Ensure a healthy standard of living for all					
14	Proportion of children in workless households	Yearly	LA	NA	ONS
15	Percentage of individuals in absolute poverty, after housing costs	Yearly	LA	NA	DWP
16	Percentage of households in fuel poverty	Yearly	LA	NA	Fingertips OHID
Create and develop healthy and sustainable places and communities					
17	Households in temporary accommodation****	Yearly	LA	NA	MHCLG / DLUHC
Strengthen the role and impact of ill health prevention					
18	Activity levels	Yearly	LA	IMD	Active lives survey
19	Percentage of loneliness	Yearly	LA	IMD	Active lives survey
Tackle racism, discrimination and their outcomes					
20	Percentage of employees who are from ethnic minority background and band/level***	-	-	-	NHS, local government
Pursue environmental sustainability and health equity together					
21	Percentage (£) spent in local supply chain through contracts***	-	-	-	NHS, local government
22	Cycling or walking for travel (3 to 5 times per week)~	Yearly	LA	IMD	Active lives survey

** Children achieving a good level of development are those achieving at least the expected level within the following areas of learning: communication and language; physical development; personal, social and emotional development; literacy; and mathematics.*

*** Both the Progress 8 and Attainment 8 scores are proposed for inclusion. Progress 8 scores at local authority level demonstrate that schools with a negative average score require systematic intervention. Attainment 8 shows the percentage achievement of school-leavers and is a more sensitive measure of annual change within schools.*

**** These indicators will require the NHS and local authorities to establish new data recording and collection methods. We have factored the social value indicators into the 2022/23 work programme to align with the rollout of the Anchor Institute Charter. It will also require definitions of "local" in both the local supply chain and employment. All contracts, direct and subcontracted, should be analysed and included. This should be reviewed after the first year of implementation. Collecting ethnicity data related to employment should also be reviewed after the first year of implementation.*

***** To be used to demonstrate annual changes, interpretation to factor in population changes.*

~ Active Lives Survey states the length of continuous activity is at least 10 minutes.

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INSTITUTE of HEALTH EQUITY

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#BecauseW
Cheshire East P

All Together Fairer: health equity and the social determinants of health in Cheshire and Merseyside

21st June 2022

All Together Fairer

Champs | Public Health Collaborative (champspublichealth.com)

#BecauseWeCare
Cheshire East Partn

- Launched end of May
- Commissioned from the Institute of Health Equity
- Supported by a Champs Public Health working group with representation from each Place
- Informed by workshops held in each Place in November 2021
- Detailed analysis of current state of play in relation to inequalities in C&M
- Sets out recommendations for the C&M System and Places
- Marmot Beacon Indicators to be used to measure progress

System recommendations

#BecauseWeCare
Cheshire East Partnership

IHE proposes recommendations covering each of the Marmot 8 themes and the following system-wide recommendations for action across the Cheshire and Merseyside system.

1. Increase and make equitable funding for social determinants of health and prevention.

2. Strengthen partnerships for health equity.

3. Create stronger leadership and workforce for health equity.

4. Co-create interventions and actions with communities.

5. Strengthen the role of business and the economic sector in reducing health inequalities.

6. Extend social value and anchor organisations across the NHS, public services and local authorities.

7. Develop social determinants of health in all policies and implement Marmot Beacon indicators.

Place recommendations

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Cheshire East Partnership

- Incorporates a series of recommendations mapped to the Marmot principles
- Recognises that Places will not have capacity to deliver against all - so suggest that Places review and choose those deemed most relevant to their Place
- Suggested that a mapping against our existing priorities is undertaken (against Five Year Plan, Health and Wellbeing Strategy, ICP Strategy, corporate plans etc) to inform the recommendations that we should focus upon
- Place Partnership Board to consider and Health and Wellbeing Board to endorse.

Example of recommendations

1. GIVE EVERY CHILD THE BEST START IN LIFE		
2022/23	**2023/27**	**RELATED MARMOT INDICATOR**
Responsible: Place • Review inequitable outcomes in early years and bring systems together within each place to ensure equitable early intervention, involving all partners (such as education, social care - children's services, communities and the VCFSE sector, children's boards, public services, NHS, local authorities). • Assess early years provision and parental support within each place and provide further support for early years settings in more deprived areas and in collaboration with communities in these areas and / or families with disabilities, or English as a second language for example. • Assess how the ACEs agenda links to the early years approach in Cheshire and Merseyside and ensure families' voices are included in this agenda.	**Responsible: Place** • Work in partnership to improve school readiness for all and reduce inequalities between children eligible and not eligible for free school meals. Ensure support is focussed to develop children's early learning, especially with regard to speech and language skills and the ACEs agenda. • Ensure shared accountability across the system and within each place to give every child the best start in Cheshire and Merseyside (include children's public health, early years and wider family services including education and VCFSE sector).	**3** Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development). **4** Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception).
Responsible: Cheshire and Merseyside System • Assess maternity leave policies and support for child care by all employers, including private business.	**Responsible: Cheshire and Merseyside System** • Develop a region-wide childcare workforce standard, which includes training and qualifications on the job to a higher standard and pay than national requirements.	

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Marmot Beacon Indicators

Life expectancy		Frequency	Level	Disagg.	Source
1	Life expectancy, female, male	Yearly	LSOA	IMD	ONS
2	Healthy life expectancy, female, male	Yearly	LA	IMD	ONS
Give every child the best start in life					
3	Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development)*	Yearly	LA	NA	DfE
4	Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception)	Yearly	LA	FSM status	DfE
Enable all children, young people and adults to maximise their capabilities and have control over their lives					
5	Average Progress 8 score**	Yearly	LA	FSM status	DfE
6	Average Attainment 8 score**	Yearly	LA	FSM status	DfE
7	Hospital admissions as a result of self-harm (15-19 years)	Yearly	LA	NA	Fingertips, OHID
8	NEETS (18 to 24 years)	Yearly	LA	NA	ONS
9	Pupils who go on to achieve a level 2 qualification at 19	Yearly	LA	FSM status	DfE
Create fair employment and good work for all					
10	Percentage unemployed (aged 16-64 years)	Yearly	LSOA	NA	LFS
11	Proportion of employed in permanent and non-permanent employment	Yearly	LA	NA	LFS
12	Percentage of employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter***	-	-	-	NHS, local government
13	Percentage of employees earning below real living wage	Yearly	LA	NA	ONS
Ensure a healthy standard of living for all					
14	Proportion of children in workless households	Yearly	LA	NA	ONS
15	Percentage of individuals in absolute poverty, after housing costs	Yearly	LA	NA	DWP
16	Percentage of households in fuel poverty	Yearly	LA	NA	Fingertips OHID
Create and develop healthy and sustainable places and communities					
17	Households in temporary accommodation****	Yearly	LA	NA	MHCLG / DLUHC
Strengthen the role and impact of ill health prevention					
18	Activity levels	Yearly	LA	IMD	Active lives survey
19	Percentage of loneliness	Yearly	LA	IMD	Active lives survey
Tackle racism, discrimination and their outcomes					
20	Percentage of employees who are from ethnic minority background and band/level***	-	-	-	NHS, local government
Pursue environmental sustainability and health equity together					
21	Percentage (£) spent in local supply chain through contracts***	-	-	-	NHS, local government
22	Cycling or walking for travel (3 to 5 times per week)-	Yearly	LA	IMD	Active lives survey

#BecauseWeCare
Cheshire East Partners

Pan-Cheshire Child Death Overview Panel

Annual Report

1st April 2020 – 31st March 2021

Forward

Section 1:

Executive Summary

Section 2:

Overview and Processes:

Section 3:

Data and Analysis

Mike Leaf
Independent Chair
Pan-Cheshire CDOP

Forward from the Independent CDOP Chair

This is my fifth report as Independent Chair for the Pan-Cheshire CDOP, and reflects an historical year in which we have had to deal with the pressures of managing a global pandemic, which left no-one unaffected. All of the public sector were directly involved in responding to unprecedented demands and changes in roles, which was clearly going to have an impact on child death review processes, and this has resulted in a significant drop in cases being brought to panel. Only 28 cases were considered, so care needs to be taken in making too many conclusions from a single year. As always, we try and look at trends over several years, although 2020-21 was unusual for many reasons, but all related to the pandemic. CDOP is the last part of the child death review process and can only usefully review a child death once all other enquiries/ reviews have been completed. These include:

- Coroners inquests (temporarily suspended during the covid pandemic during 2020-21)
- Criminal enquiries (delayed through covid pandemic during 2020-21)
- Internal reviews including Root Cause Analysis, Perinatal Mortality Reviews (PMRT), Health Safety Investigation Board (HSIB) reviews, Child Death Review Meetings (CDRMs)
- Peer reviews including the NW Neonatal Operational Delivery Network (NWNODN)

During 2020-21 covid had a significant impact on all of these processes. Figure 7 in this report illustrates this shift in the time taken to review cases.
In terms of how we will deal with the backlog, I am recommending that we put on some additional panels once we are clear that we have all the necessary information to complete the reviews.

The report aims to not only reflect the cases the panel has considered throughout 2020/21, but also the achievements of the partnership, future priorities for action, and issues related to the implementing the statutory child death review processes, during a year affected by Covid 19.

A Memorandum of Understanding between CDOP and the statutory partners for child death review (Local Authorities and Clinical Commissioning Groups) clarifies the respective expectations of each partner for appropriate effective delivery and oversight of effective child death review system. As Chair, it will be my responsibility to ensure that CDOP provides oversight and assurance of the child deaths review processes, to the statutory partners.

I would like to thank all the Panel members, for their continued commitment and hard work, and in particular to how they switched swiftly to virtual working, without compromising the quality of the panel meetings. I would like to thank all the Panel members, for their continued commitment and hard work, and in particular, to Anne Barber for the hard work that goes on behind the scenes to ensure that the Panel runs smoothly, and keeps pace with the changing landscape, particularly during a year when this has meant her often working in isolation.

Mike Leaf, Independent Chair

Pan-Cheshire CDOP, Autumn, 2021

Section 1:
Executive Summary

There is a statutory requirement for the statutory partners to *make arrangements to carry out child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), or equivalent, to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children*.
Responsibility for reviewing child deaths no longer sits with local safeguarding arrangements and sits with the following:
Halton Borough Council
Warrington Borough Council
Cheshire East Borough Council
Cheshire West and Chester Council
Eastern Cheshire Clinical Commissioning Group (CCG)
South Cheshire CCG
Vale Royal CCG
West Cheshire CCG
Halton CCG
Warrington CCG

It has been agreed that Pan-Cheshire CDOP will:

- provide oversight and assurance of the new Child Death Review processes and ensure that it meets the required statutory standards.
- review all infant and child deaths under 18 years of age. This includes neonates where a death certificate has been issued, irrespective of gestational age.
- identify and highlight any modifiable factors, and bring these to the attention of strategic partners, including Health and Wellbeing Boards, Multi-Agency Safeguarding Arrangements and Community Safety Partnerships where necessary in order to inform their preventative planning and commissioning arrangements.

The purpose of this Annual Report is to:

- Clarify and outline the processes adopted by the Pan-Cheshire CDOP
- Assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Cheshire, which meets national guidance
- Provide an overview of information on trends and patterns in child deaths reviewed across Cheshire during the last reporting year (2020-21)
- Highlight issues arising from the child deaths reviewed
- Report on achievements and progress from last year's annual report
- Make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across Cheshire

Achievements and impact during 2020-21

- ✓ Managed and modified oversight of the Child Death Review processes
- ✓ Engaged with other CDOPs across the NW and nationally, and sharing good practice
- ✓ CDOP Study/ Development day delivered on post-mortems
- ✓ ICON[11] – CDOP has supported the Implementation of the ICON Programme throughout Pan Cheshire. This is an evidenced programme that is has been designed by to reduce Abusive Infant Head Trauma through primary prevention interventions, population based awareness, raising public health interventions and secondary prevention interventions. Several key members of the CDR Panel have been key members of the Steering Group and have been involved in the co-ordination and implementation.
- ✓ Switched to virtual working and maintained functionality
- ✓ Circulated good practice, learning and tools across Cheshire
- ✓ Challenged and sought assurance from providers on elements of inadequate care / deviation from protocols arising from case reviews at panel, to assure quality
- ✓ Provided support and guidance to local providers on new processes
- ✓ Ensured that exceptional care is recognised by writing to providers where care has gone beyond that which might be expected.
- ✓ Updated Sudden Unexpected Death protocol
- ✓ Quarterly liaison meetings with child death review partners in Wales have been established to explore cross-border issues, due to the different child death review processes

Summary of key points and themes:

Of those deaths reviewed [2019-20 percentage in square brackets]:

- 49% of the deaths occurred before the child reached 28 days (20 deaths)[44.4%]
- 68% of the deaths occurred before the child reached one year of age (29 deaths)[64.4%]
- 11% of the deaths occurred in Children aged 1 year to 4 year (5 deaths) [11.1%]
- 5% of the deaths occurred in Children aged 5 years to 9 years (3 deaths) [6.6%]
- 12% of the deaths occurred in Children aged 10 years to 14 years (5 deaths)[11.1%]
- 5% of the deaths occurred in Children aged 15 years to 17 years (3 deaths) [6.6%]
- 46% of the deaths were male (13 deaths) [51%]
- 39.3% were Perinatal/Neonatal events (11 Deaths) [24.4%]
- 50% of deaths reviewed had 'modifiable factors' (14 deaths) [38%]
- 61% deaths were classified as 'unexpected' [40%]
- 50% of cases reviewed had modifiable factors. Of these, 64.3% were linked to deaths under one year of age, which was similar to the previous year (64.7%).

[1] **ICON -** Infant crying is normal; C –Comforting methods can help; O – It's OK to walk away; N – Never, ever shake a baby

A modifiable factor is one *which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths*. Modifiable factors identified for Cheshire during 2020-21 (in order of prevalence) include [last year's %]. As some cases will have more than one modifiable factor, the total percentages can add up to more than 100%:

- Mental health issues (parent or child) (27% of all deaths [17.8%])
- Alcohol / substance misuse (parent/child) (9% of all deaths [13.3%])
- Smoking by the mother/ parent/ or carer during pregnancy or in the first few years of a child's life (30% of all deaths under one (19.2%))
- High maternal body mass index (BMI) (9 % of all deaths under one (15.4%))
- Domestic Violence 6%
- Unsafe sleeping (6% of all deaths under one (11.5%))
- Faulty Trans Warmer
- Bike not road worthy as seat & brakes removed

Update on priorities 2020-21

- ✓ Agree future funding formula for CDOP and broader Child Death Review processes including funding for training and development and streamline the arrangements.
  A funding formula has been agreed across all partners which includes training and development
- ✓ Through the monitoring of the self-assessment framework and risk register, ensure that any elements of non-compliance are managed or escalated to appropriate partners.
  Whilst the self-assessment framework has been considered at the business meeting, no updates have been requested throughout the year in view of the pressures faced by the partners in their response to covid. This will be picked up again through 2021-22 dependent on service demands caused by covid.
- ✓ Ensure that CDOP receives the necessary documentation from Child Death Review meetings.
  Whilst there have been noticeable improvements, there are still areas for more improvement particularly general practice and tertiary centres. This will be followed up throughout 2021-22.
- ✓ Advocate with other CDOPs for NCMD to produce national comparative data to facilitate better benchmarking, help set standards and help drive CDOP performance in terms of "completeness" and "timeliness" of child death reviews in the country.
  CDOP has liaised with the NCMD who have confirmed that the opportunity for national benchmarking will be enhanced as each year passes due to the increased data being held.
- ✓ Strengthen the governance relationship with the local Health and Wellbeing Boards.
  Relations with health and wellbeing boards continue to develop through the partners involved in both child deaths and health and wellbeing.

- ✓ Review any Evaluation/outcome reports of ICON implementation
  Whilst CDOP Business meetings have received verbal updates on the implementation of the programme, no formal evaluation of the programme has been presented.
- ✓ CDOP response to the recent report *A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm (July 2020):* https://www.gov.uk/government/publications/safeguarding-children-at-risk-from-sudden-unexpected-infant-death
  This report reinforces the key messages CDOP has been promoting:

- *promoting consistent information for practitioners about the factors associated with SUDI, based on current national and international evidence*
- *developing the knowledge and skills of practitioners to engage families in healthy lifestyle changes and parenting practices*
- *supporting effective safer sleep conversations, in which risk tools enable parents to assess the risk factors associated with their particular circumstances and make safe and appropriate decisions about the sleep environment*
- *outlining how individual organisations can promote safer sleep messages as part of their everyday work with families, with role-specifc guidance for practitioners*

✓ Support the review of the CDOP Nurse specialist role in relation to developing Cheshire CCG arrangements

CDOP representatives have been liaising with leaders in the emerging CCG for Cheshire to ensure that appropriate structures and staff are in place to service the needs of child death review demands. This will continue throughout 2021-22 as new NHS governance arrangements develop.

✓ Ensure CDOP has a formal set of accounts

Balance sheets feature as a standard agenda item at CDOP business meetings

Priorities for 2021-22:

- ✓ Implement the eCDOP programme across Cheshire, to improve processes and minimise additional administrative burdens;
- ✓ Analyse the data on Adverse Childhood Experiences (ACEs) and report on the findings next year.
- ✓ Through the monitoring of the self-assessment framework and risk register, ensure that any elements of non-compliance are managed or escalated to appropriate partners.
- ✓ Ensure that CDOP receives the necessary documentation from Child Death Review meetings.
- ✓ Improve the scores on the notification and reporting fields highlighted by the National Child Mortality Database [NCMD] report.
- ✓ Clarify the governance arrangements and implications of the emerging NHS re-organisation
- ✓ Review any Evaluation/outcome reports of ICON implementation
- ✓ Ensure that there are opportunities for parents to access non-digital versions of *"When a Child Dies"* leaflet which provides a detailed explanation of many of the processes associated with a child's death.
- ✓ Catch up on the delayed cases coming to panel as a result of covid

Recommendations for Local Strategic Partners
Local Strategic Partners are asked to:

1. Note the contents of this report
2. Children's Safeguarding and Health and Wellbeing partners should clarify and monitor interagency initiatives are required to reduce the prevalence of modifiable factors identified in the under one population including:
   - Safe sleeping
   - Risk factors for reducing premature births including:
     - High BMI (including healthy diet and physical activity)

- High blood pressure (linked to high BMI)
- Smoking
- Alcohol use
- Substance misuse
- Domestic violence
- Mental health
- Diabetes (often linked to BMI)
- Lack of physical activity

Mike Leaf
Independent Chair
Pan-Cheshire CDOP
Autumn 2021

Overview and Processes

CDOP Panel Meetings

CDOP Membership

Pan-Cheshire CDOP's core membership comprised of:

- Independent Chair
- CDOP Coordinator
- Designated Nurse for Safeguarding Children (Warrington and Halton)
- CDOP Nurses x 3 (Cheshire East, Cheshire West and Warrington/Halton)
- Specialist Midwife
- Public Health
- Coroner's officer
- Designated Doctor for Child deaths x 3 (Cheshire East, Cheshire West, Warrington/Halton)
- Police Representative from PPU Directorate
- Local Authority Head of Service, Safeguarding and Quality Assurance Unit
- Local Authority Service Manager, Children's Social Care
- Education Representative from Safeguarding in Education Team.
- Local Safeguarding Children Partnerships
- Co-opted Advisory Member (Paediatrician/Deputy Coroner)
- North West Ambulance Service (where needed in cases of unexpected deaths)

The Pan-Cheshire CDOP has permanent representatives drawn from the key professionals who have an interest in children's health and safeguarding, and statutory partners. Members are not there to represent their individual organisations, but to represent a professional perspective/ insight to the cases presented. In addition to the specific roles identified below, all members of CCDOP are expected to:

- Ensure that they are fully prepared to contribute at each meeting by reading through the papers, and consulting colleagues where necessary beforehand.
- Ensure that there is a suitable alternative replacement to attend if it is not possible to attend
- Take away action points to their specific geography, agency or professional groups, and ensure that the action is undertaken within the required timescales

Frequency of Meetings

The panel currently meet on a quarterly basis and for a whole day. It has been agreed that this frequency will remain unless there was a significant number of cases to review. The business meeting will follow the panel meeting. At the time of writing, virtual meetings are in place as a result of the Covid 19 pandemic.

Agency Representation at Panel Meetings

The Pan-Cheshire CDOP met on five occasions between April 2020 and March 2021, although this was virtual. Attendance is monitored on a regular basis to ensure quoracy and effective representation.

On occasions there are times where professional demands must take priority. Representation has been consistent throughout the year.

Table 1: Agency representation

Sector	Role
Chair	Independent CDOP Chair
Health	Designated Doctor CE
	Designated Doctor CWAC
	Cheshire East Specialist CDOP Nurse
	Cheshire West Specialist CDOP Nurse
	Warrington Designated Nurse Safeguarding
	Designated Nurse Halton CCG
	Supervisor of Midwives CWAC
	Warrington Safeguarding Nurse
Local Authority	Coroner Officer
	Cheshire East Head of Service – Children's Safeguarding
	Public Health Consultant (Cheshire W. and Chester)
	Local Authority Safeguarding Children Partnerhip Business Manager for Warrington Borough Council
Police	Public Protection Unit

Processes/ Networks/ Reviews and Sub-groups

Notification Process

The notification process via paediatric liaison and hospital/hospice staff functions well. By cross-referencing with the annual NHS England return (regarding notifications from Registrars to NHS England), CDOP is confident that it is notified of all child deaths. When Cheshire child deaths occur out of area, CDOP is often notified by Cheshire agencies, as well as by the CDOP contact in the respective area where the death occurred. This demonstrates effective communication between local organisations and CDOP.

SUDiC Guidance

The Pan-Cheshire SUDiC guidance has been updated and widely circulated, and aligned to the national Statutory and Operational Child Death Review Guidance.

Links to Coroners and Registrars

Within Cheshire there is an excellent working relationship with the Coroners offices, with senior coroner's officer representation.

Deaths of Children Living Outside Cheshire

Whilst CDOP is responsible for the review of child deaths resident in Cheshire, there is an expectation that it should receive notification of child deaths for children who live out of area, but have died within the boundary. As Cheshire borders Wales, where there is a different process for reviewing child deaths, the numbers of these children may be significant. Quarterly liaison meetings with child

death review partners in Wales have been established to explore cross-border issues, due to the different child death review processes.
CDOPs across the country should routinely notify the CDOP where the child died, and visa versa. Any deviations from this process are followed up. In the future, some deaths may be reviewed of non-resident children where there is local learning to be uncovered, but this will be discussed with the CDOP of the child's residency. This will be done on a case by case basis. Professionals have a responsibility to notify the CDOP administrator if they learn of the death abroad of a either a child or an infant born to a mother who normally resides in the Cheshire area so that the death may be verified, SUDIC procedures implemented and a JAR initiated.

Communicating with Parents, Families and Carers

Leaflets and a letter are made available to any parent following the death of a child. A new NHS England leaflet has been produced for use locally. *"When a Child Dies"* provides a detailed explanation of many of the processes associated with a child's death. Parents are invited to contribute any comments to the review of their child's death, and CDOP will monitor this.

Deaths involving other reviews and investigations

Child deaths are considered at panel once all relevant investigations and reports have been completed. These include any Children's Safeguarding Practice Review, Coroners enquiry, Healthcare Safety Investigation Board review, criminal enquiry, or internal review. This approach is consistent with that undertaken across the North-West and much of England, and will continue under the new local and national procedures. This may, on occasions, result in a delay between notification and review completion and CDOP will continue to monitor this process and any delays. This explains why there is often a difference between the number of death notifications, and the number of reviewed cases. In 2020/21, there was a large difference between the number of child death notifications (57) and the cases considered at CDOP (28), largely due to processes affected by Covid 19.

Regional/ National Links/ Updates:

North-West meetings
Pan-Cheshire CDOP continues to be represented at the north-west CDOP meetings. A common dataset was agreed for all North-West annual reports to allow for the compilation of an overview report covering the area. A North-West CDOP report is produced annually, although this has not been possible during Covid.

National Network
Some Cheshire CDOP members form part of the national network group which advises on issues of national interest, together with flagging issues with the National Child Mortality Database (NCMD).

Issues Identified

Missing Data
There has been an improvement on the details provided on the forms, but the failure to provide consistent information can create issues. For example, the lack of details of the father/significant male/other parent in the family, is particularly relevant in relation to necessary checks regarding domestic violence. This forms part of an ongoing dialogue with representatives and remains under scrutiny. These processes will be strengthened with the new child death review processes as there is

a legal responsibility for organisations to provide information. CDOP will continue to monitor and remind partners of this obligation. Where the panel have insufficient information to make a decision, further details are sought, and the case postponed.

National annual statistical data

All data from CDOPs in England is now incorporated into the National Child Mortality Database which receives timely information from all areas. NCMD produces quarterly reports, together with an annual report for each CDOP. This report forms the basis of the Pan-Cheshire CDOP report contained in Appendix I.

Priorities for 2021-22:

- ✓ Implement the eCDOP programme across Cheshire, to improve processes and minimise additional administrative burdens;
- ✓ Analyse the data on Adverse Childhood Experiences (ACEs) and report on the findings next year.
- ✓ Through the monitoring of the self-assessment framework and risk register, ensure that any elements of non-compliance are managed or escalated to appropriate partners.
- ✓ Ensure that CDOP receives the necessary documentation from Child Death Review meetings.
- ✓ Clarify the governance arrangements and implications of the emerging NHS re-organisation
- ✓ Review any Evaluation/outcome reports of ICON implementation
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    - Safe sleeping
    - Risk factors for reducing premature births including:
        - High BMI (including healthy diet and physical activity)
        - High blood pressure (linked to high BMI)
        - Smoking
        - Alcohol use
        - Substance misuse
        - Domestic violence
        - Mental health
        - Diabetes (often linked to BMI)
        - Lack of physical activity

Section 3:

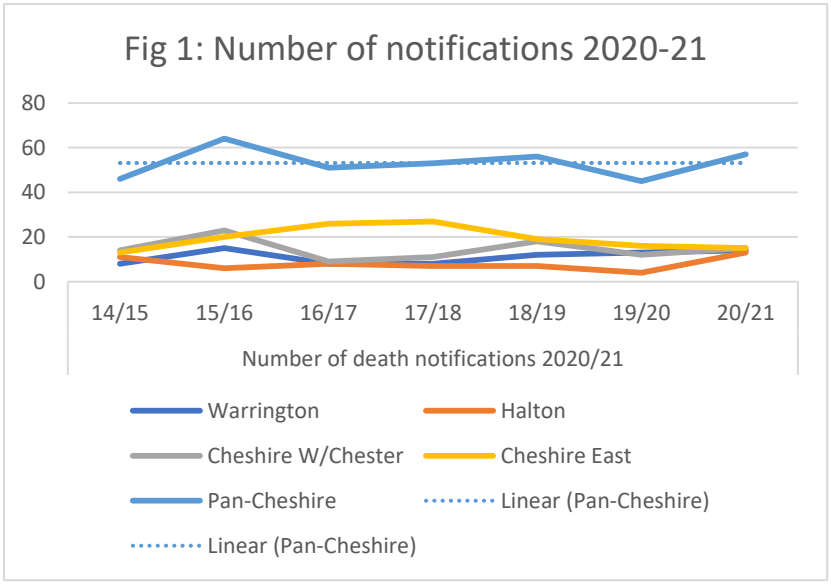
Data and Analysis

It should be noted that it is often difficult to make clear conclusions from analysing data from a relatively small number of cases reviewed each year. The learning from each individual case is noted at each CDOP meeting, with the appropriate action taken at that time. Where reviews have already been undertaken e.g. hospital mortality reviews, action has usually already been taken. Cheshire's figures are amalgamated with other CDOP data across the NW to provide opportunities for identifying more reliable trends. Notified deaths are categorised according to place of residency using postcodes.

This section differs from previous years in that the first part (a) describes Cheshire trends over several years, followed by (b) the narrative to accompany the National Child Mortality Database (NCMD) data contained in Appendix I, which is its first annual data output.

(a) Trends

When dealing with relatively small numbers, there can be wide fluctuations year on year. By considering numbers over time, one can look at trends in the figures.



Child death notifications over time

Encouragingly, Figure 1 shows a slight downward trend in child death notifications per year for Cheshire (see trend line). The mean average number of notifications over the last 5 years is 54.3, which is slightly below the recommended lower limit of 60 deaths per year by NHSE.

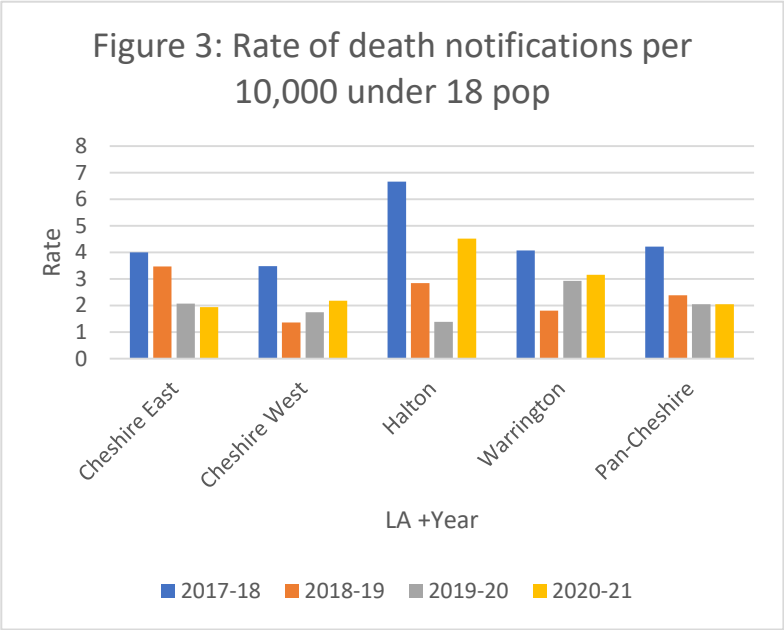
Child Population

The child population estimates in each of the four Local Authority areas are detailed in the following Figure 2.

Figure 2: Child Populations by local authority

LSCB area	Child population size* (0-17 years)
Cheshire East	77,290
Cheshire West & Chester	68,656
Halton	28,770
Warrington	44,391
Pan Cheshire	219,107

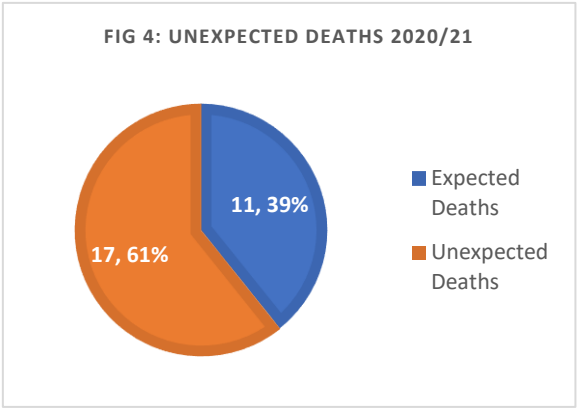
* Source: ONS mid-Year Population Estimates, 2019



Local child populations are useful when comparing local areas. Normally, one would expect to see the numbers of deaths in each geography, to be proportionate to the number of under 18-year olds living in each, but there may be differences according to deprivation levels. Figure 3 shows the rate of deaths per 10,000 under 18 population over the last 4 years, and highlights a gradual reduction in the rate amongst all areas. The most current ONS Mid-year estimate was used for each year.

Expected / Unexpected deaths

An expected death refers to *a death that could reasonably been foreseen by clinicians for a period of at least 24 hours before it occurred. An unexpected death is then defined as the death of an infant or child which was not anticipated as a significant possiblity 24 hours before the death or, where there was was an unexpected collapse or incident precipitating the events that led to that death.* During 2020/21, 17 (61%) deaths were classified as 'unexpected' (Fig 4).



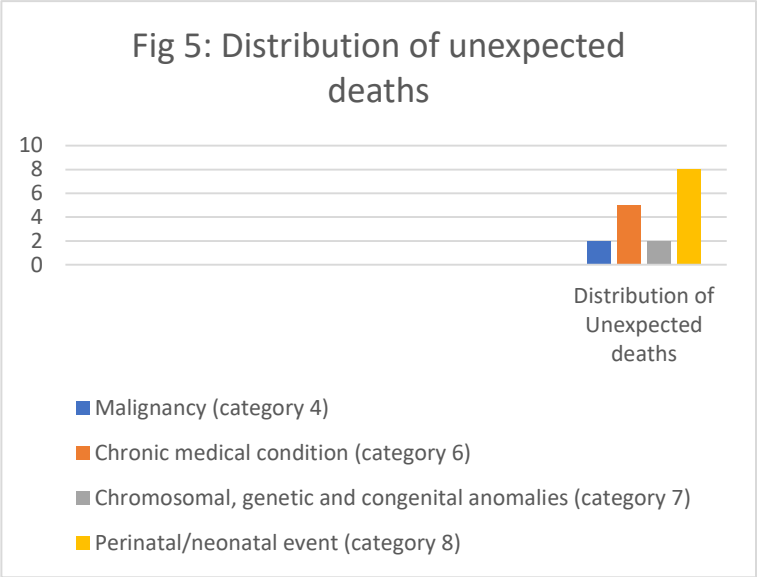


Fig 5 shows the distribution of unexpected deaths by category of death. The biggest proportion of the unexpected deaths occurred in the Perinatal/ neonatal category.

(b) National Child Mortality Database (NCMD) data (Appendix I)

The following narrative describes the various elements contained in Appendix I which is the first report from the NCMD.

Deaths and Case Completions (Table A; Tables 1-4 – Appendix I)

There was a total of 57 deaths notified during the last year, and 28 cases closed (completed by Pan-Cheshire CDOP). 60 deaths were registered with NCMD during the last delivery year, some outstanding from the previous year. At 31st March 2021, 60 cases were ongoing, **Table 2** highlighting the breakdown of closed and open cases by local authority area. The number of closed/ open cases by age group is covered in **Table 3** which broadly reflects the expected distribution of deaths by age, with the majority occurring under the age of one year old, which follows the national pattern. **Table 4** provides a breakdown of cases completed by local authority areas. The proportion of cases completed broadly follows the split of local authority under 18 populations.

Deaths by gender (Table 5)

From April 2020 – March 2021 of the 28 child deaths reviewed by the CDOP, 13 were male or 46% (49% previous year) and 15 or 54% were female (51% previous year).

Completed reviews by primary category of death and by age (Tables 6-7)

The majority of all deaths (54%) had a cause associated with chromosomal, genetic, congenital anomaly or as a result perinatal/neonatal event **(Table 6)**, and 64% of all deaths occurring under the age of one year **(Table 7).** There was 1 instance where death was attributed to deliberately inflicted injury, abuse or neglect.

Completed reviews by place of death and onset of illness/incident (Tables 8-9)

As one might expect, most deaths (82%) occur with a hospital **(Table 8)** and of those who died in hospital, 74% (17) died in the perinatal/neonatal/maternity/labour units. **Table 9** provides the breakdown of where the onset of illness or incident occurred.

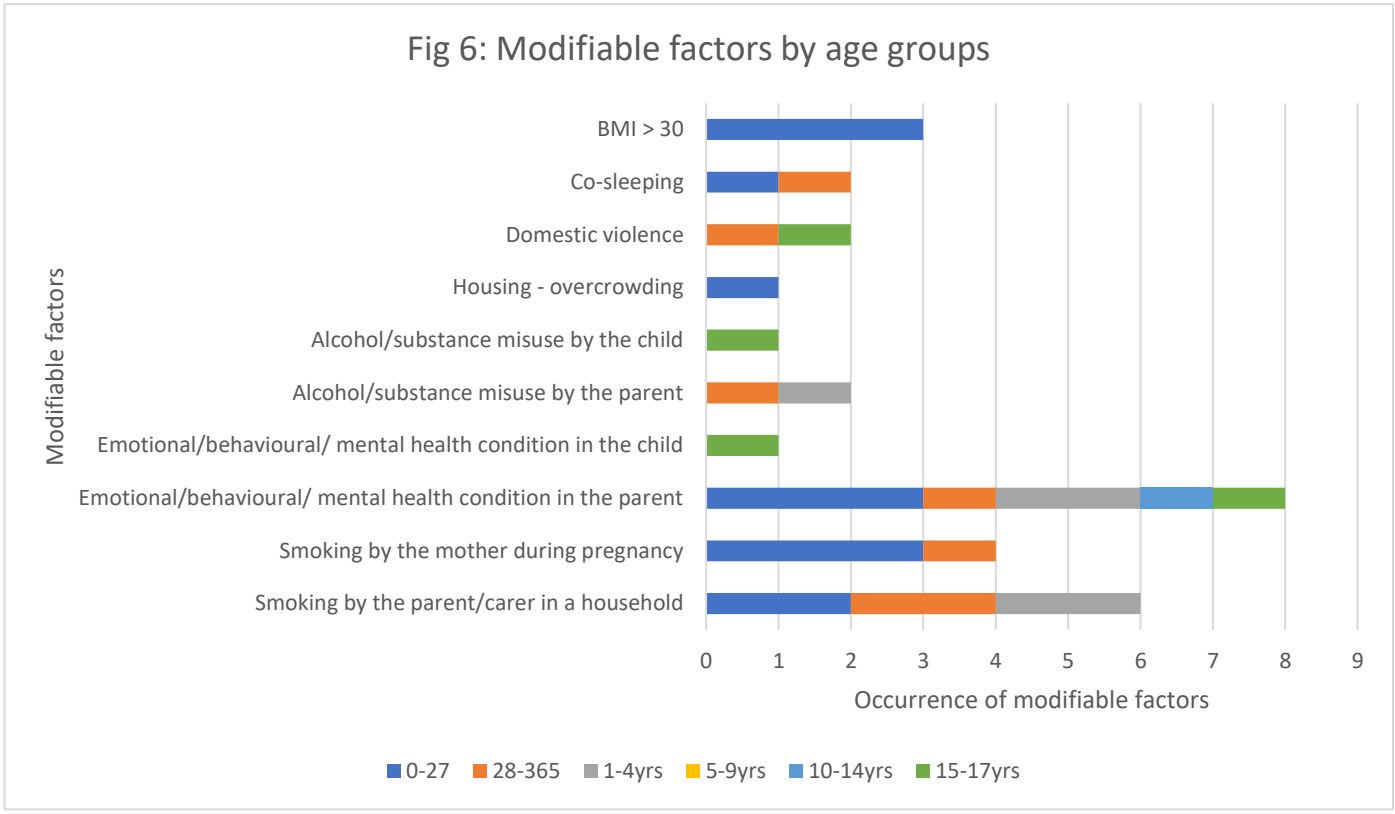
Ethnic groups and category of death (Tables 10-11)

90% (25) of those children who died where categorised as white **(Table 10). Table 11** shows the primary category of death by ethnicity. There are no specific patterns in relation to ethnicity, particularly having reviewed only 28 cases.

Deaths reviewed by CDOP with modifiable factors (Tables 12-15)

A modifiable factor is one *which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths*.

It can be seen that from **Table 12**, 50% of cases reviewed (14) had identifiable modifiable factors, which is higher than the national average of 34%. Of these (7), 58% were linked to deaths under one year of age **(Table 14).** For all categories except chromosomal, genetic and congenital anomalies;



chronic medical condition; infection; and malignancy, modifiable factors where identified in all cases reviewed **(Table 13)**.

Fig 6 gives a breakdown of the modifiable factors identified by age (in order of prevalence) [last year's %]:

- Mental health issues (parent or child) (32.1% of all deaths [17.8%])
- Alcohol / substance misuse (parent/child) (12.5% of all deaths [13.3%])
- Smoking by the mother/ parent/ or carer during pregnancy or in the first four years of a child's life 43.1% (44.4% of all deaths under one [19.2%])
- High maternal body mass index (BMI) (23% of all deaths under 28 days)
- Domestic Violence
- Unsafe sleeping
- Child Abuse or Neglect
- Housing overcrowding

- Failure by parents to access services when child had long term symptoms

The highest annual number of deaths occur neonatally (under 28 days), often as a result of complications through prematurity. Smoking, alcohol consumption, high maternal BMI, and domestic abuse all are known to increase the risk of prematurity and low birth weight, resulting in an increased level of vulnerability and risk of early infant death. It is important that all parts of the health and social care system reinforce messages that reduce risk of prematurity and low birth weight, especially during pregnancy.

Death notifications (Tables 16 – 20)
CDOP can be notified of the death of a child by any organisation or an individual. CDOP may receive several notifications for the same child, but where this occurs, it will be classified as a single notification. A breakdown of notifications by Local Authority area is provided in **Table 16** which broadly correlates to the relevant under 18 populations in each area.

Table 17 shows the number of Joint Agency Responses (JARs) undertaken. A JAR is a coordinated multi-agency response which is triggered if a child's death:
• is or could be due to external causes;
• is sudden and there is no immediately apparent cause (including SUDI/C);
• occurs in custody, or where the child was detained under the Mental Health Act;
• where the initial circumstances raise any suspicions that the death may not have been natural; or
• in the case of a stillbirth where no healthcare professional was in attendance.

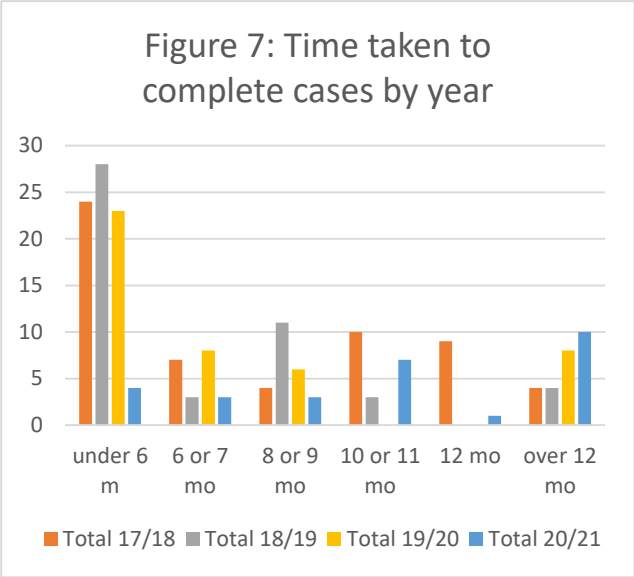
In Cheshire, 49% of death notifications did not indicate whether a JAR had been undertaken or not. This may partly be down to the person completing the form at the time, not knowing whether a JAR had been instigated, but this should be corrected further into the process once SUDC processes are activated. The reasons for this will be explored by CDOP Business group.

Table 18 shows death notifications by month/age, where it can be seen that the highest number of notifications occurred in August. This Table will become more useful when we can see trends from year to year and national comparisons. Notifications by age group feature in **Table 19** which clearly indicates that the majority of deaths occur in the first year of life (67%) compared to 65% nationally. Deaths in childhood occur during the first year of a child's life, and are strongly influenced by pre-term delivery and low birth weight; with risk factors including maternal age, smoking and disadvantaged circumstances (Wolfe and Macfarlan, 2015). **Table 20** shows death notifications by place of death.

Data completeness- Notifications and Completed Reviews (Tables 21-24)

The NCMD Report is a national repository for data from all CDOPs across England, and consequently provided an opportunity to provide comparative data. Clearly, there will be longer term benefits each year new data is gathered. In the first report, there has been an attempt to established national standards for completion of certain information. Reliable comparisons can only be made if all CDOPs collect and provide the same information. **Tables 21, 22 and 23** highlight that in the first year of collecting information, Pan-Cheshire CDOP has under-reported on :

- ✓ Joint Agency Responses (mentioned above)
- ✓ Cases discussed with the medical examiner (relatively new role).



Pan-Cheshire CDOP tends to take marginally less time to bring cases to panel from initial notification compared to national figures (315 days compared to 333 **Table 25).** (Figure 7 provides a breakdown of the time taken to complete the reviews over the last 4 years. It shows that during 2020-21, only 14% of reviews were completed within 6 months compared to 51% the previous year, and 36% took more than 12 months to review, compared to 18% in the previous year. Some of these delays have been as a result of delays from the North West Neonatal Operational Delivery Network (NWNODN) reviews, which has also been impacted by the Covid 19 pandemic.

Category of Child Death

The CDOP panel is required to record each death against 1 of 10 nationally-set categories as follows:

Category 1: Deliberately inflicted injury, abuse or neglect (1)
Category 2: Suicide or deliberate self-inflicted harm (1)
Category 3: Trauma and other external factors (2)
Category 4: Malignancy (2)
Category 5: Acute medical or surgical condition (1)
Category 6: Chronic medical condition (4)
Category 7: Chromosomal, genetic and congenital anomalies (4)
Category 8: Perinatal/neonatal event (1)
Category 9: Infection (1)
Category 10: Sudden unexpected, unexplained death (2)

Acknowledgements

As noted in the foreword much of the business of the CDOP is dependent on the continued support of panel members and the administrative support. I would like to take this opportunity to thank the panel members for their continued support and especially Anne Barber who ensures the panel runs smoothly.

Mike Leaf
Independent CDOP Chair
Autumn 2021

Glossary of Terms

Term	Meaning
Child	A person aged 0-18th birthday

Expected death	A death that could have been reasonably predicted 24 hours before the death occurred or 24 hours before the immediate events leading to the death occurred
Infant	Aged less than 1 year of age
Modifiable factors	Factors associated with a death which by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths
Neonatal period	From birth until 28 days of life
Perinatal period	From viable gestation (around 23 weeks of pregnancy) until 7 days following birth
Unexpected death	A death that could not have been reasonably foreseen 24 hours before it occurs – or where there was an unexpected collapse or precipitating events leading to the death

Abbreviations

CDOP – Child Death Overview Panel

SUDI – Sudden Unexplained Death in Infants

LSCB – Local Safeguarding Children Board

APPENDIX I

NCMD
National Child Mortality Database

NCMD Monitoring Report for CDOPs

Pan Cheshire CDOP

Report created on: 12/05/2021

Quarter 4 2020/21

This report contains confidential information which is intended for use by the CDOP named above for monitoring and data quality purposes. **This report must not be shared with anyone who does not have a role within the CDOP**. All data presented within this report is unvalidated and therefore should be interpreted with caution. Only data which has been submitted to NCMD is included within this report and therefore may not be representative of all child deaths within the area.

Produced by National Child Mortality Database Programme Team. If you have any queries please contact ncmd-programme@bristol.ac.uk

Overview

Data on this page relates to deaths after 01/04/20 or where CDOP review was outstanding at 01/04/20, up to and including 31st March 2021

NCMD
National Child Mortality Database

Number of cases reviewed 20/21:	Total cases with review ongoing:
28	60

Number of deaths during 20/21:
57

Table A

Number of ongoing cases entered by LSCB

LSCB name	Cases
Cheshire East	15
Chester and Cheshire West	19
Halton	14
Warrington	12
Total	**60**

Table 2

Number of ongoing cases by year of death and status of case

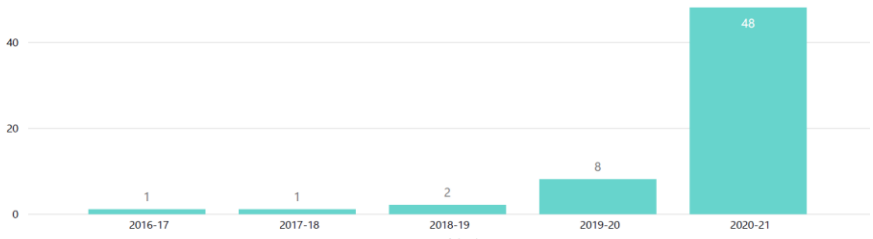


Table 1

Number of ongoing cases by age group and status of case

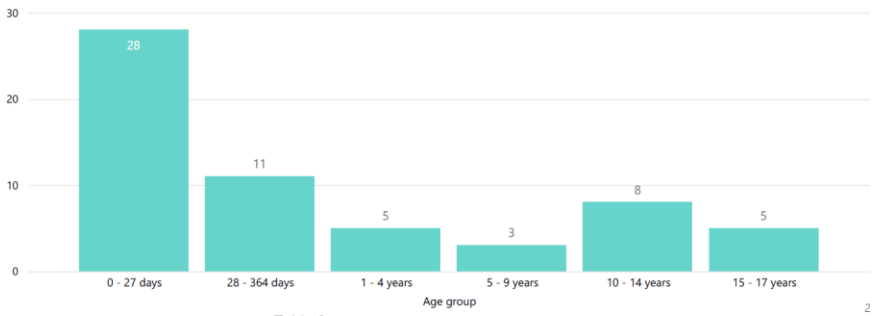


Table 3

Completed Reviews - Overview 1

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2020 and 31st March 2021

NCMD National Child Mortality Database

Number of cases reviewed 20/21:

28

Completed CDOP Reviews by LSCB

LSCB name	Cases
Cheshire East	10
Chester and Cheshire West	6
Halton	1
Warrington	11
Total	**28**

Completed CDOP Reviews by year of death

Year of death	Cases
2018-19	5
2019-20	14
2020-21	9
Total	**28**

Table 4

Completed CDOP reviews by gender

Table 5

Completed CDOP reviews by primary category of death

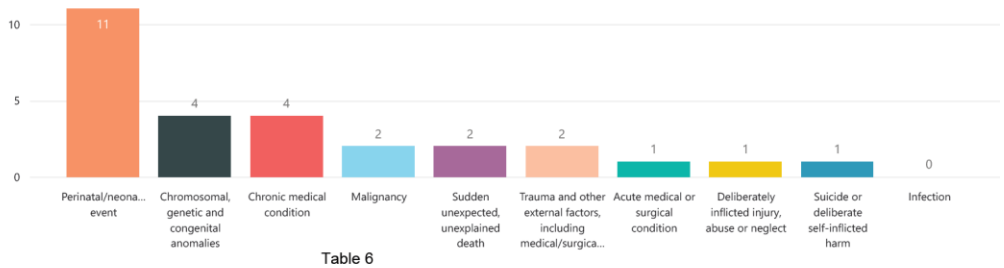


Table 6

Completed CDOP reviews by age group

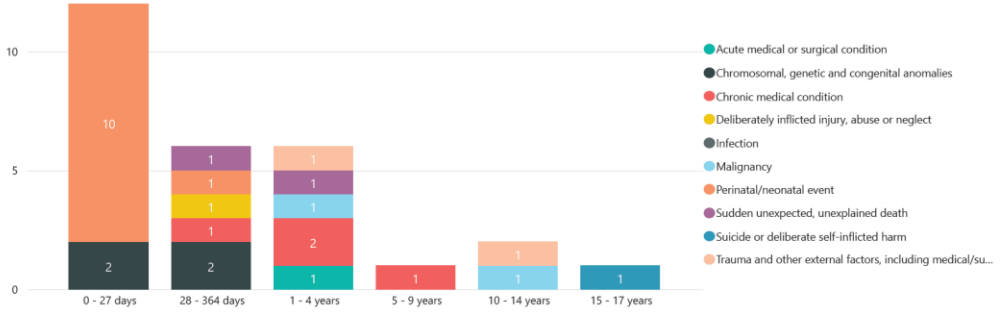


Table 7

Completed Reviews - Overview 2

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2020 and 31st March 2021

NCMD National Child Mortality Database

Number of cases reviewed 20/21:

28

Completed CDOP reviews by place of onset of illness/incident

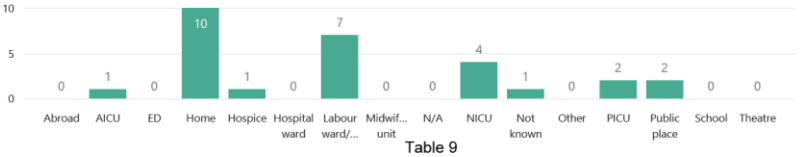


Table 9

Completed CDOP reviews by place of death

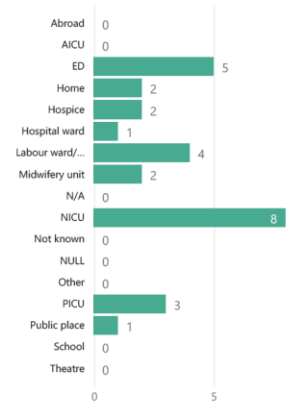


Table 8

Completed CDOP reviews by ethnic group and age group

Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	12	5	5	1	2	0	25
Unknown	0	1	0	0	0	0	1
Other	0	0	1	0	0	0	1
Mixed	0	0	0	0	0	0	0
Black or Black British	0	0	0	0	0	0	0
Asian or Asian British	0	0	0	0	0	1	1
Total	**12**	**6**	**6**	**1**	**2**	**1**	**28**

Table 10

Completed CDOP reviews by ethnic group and primary category of death

Ethnic Group	Acute medical or surgical condition	Chromosomal, genetic and congenital anomalies	Chronic medical condition	Deliberately inflicted injury, abuse or neglect	Infection	Malignancy	Perinatal/neonatal event	Sudden unexpected, unexplained death	Suicide or deliberate self-inflicted harm	Trauma and other external factors, including medical/surgical complications/error	Total
White	1	4	2	1	0	2	11	2	0	2	25
Unknown	0	0	1	0	0	0	0	0	0	0	1
Other	0	0	1	0	0	0	0	0	0	0	1
Mixed	0	0	0	0	0	0	0	0	0	0	0
Black or Black British	0	0	0	0	0	0	0	0	0	0	0
Asian or Asian British	0	0	0	0	0	0	0	0	1	0	1
Total	**1**	**4**	**4**	**1**	**0**	**2**	**11**	**2**	**1**	**2**	**28**

Table 11

Completed Reviews - Modifiable Factors

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2020 and 31st March 2021

NCMD National Child Mortality Database

Number of cases reviewed 20/21: **28**

% cases with modifiable factors (CDOP): **50%**

% cases with modifiable factors (England): **34%**

Were any modifiable factors identified?

Table 12

% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	12	7	58%
28 - 364 days	6	2	33%
1 - 4 years	6	3	50%
5 - 9 years	1	0	0%
10 - 14 years	2	1	50%
15 - 17 years	1	1	100%
Total	**28**	**14**	**50%**

Table 14

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

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Acute medical or surgical condition	1	1	100%
Chromosomal, genetic and congenital anomalies	4	0	0%
Chronic medical condition	4	0	0%
Deliberately inflicted injury, abuse or neglect	1	1	100%
Infection	0	0	0%
Malignancy	2	0	0%
Perinatal/neonatal event	11	8	73%
Sudden unexpected, unexplained death	2	1	50%
Suicide or deliberate self-inflicted harm	1	1	100%
Trauma and other external factors, including medical/surgical complications/error	2	2	100%
Total	**28**	**14**	**50%**

Table 13

% of cases where modifiable factors were identified by ethnic group

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Asian or Asian British	1	1	100%
Black or Black British	0	0	0%
Mixed	0	0	0%
Other	1	0	0%
Unknown	1	0	0%
White	25	13	52%
Total	**28**	**14**	**50%**

Table 15

Notifications during 2020/21

Data on this page relates to cases with a date of death between 1st April 2020 and 31st March 2021

NCMD National Child Mortality Database

Number of deaths during 20/21: **57**

Death notifications by month

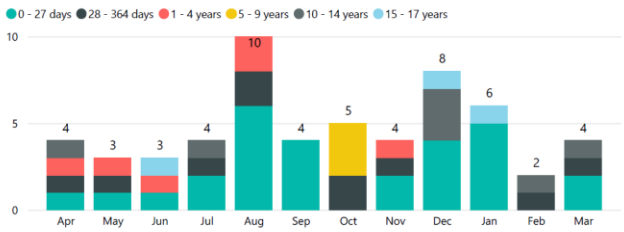


Table 18

Death notifications by place of death

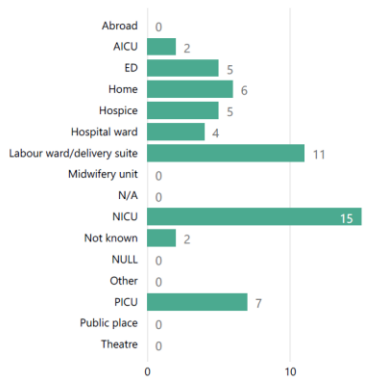


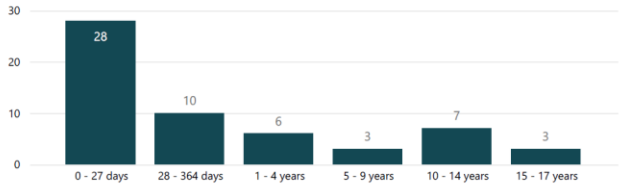
Table 20

Death notifications by LSCB

LSCB name	Cases
Cheshire East	15
Chester and Cheshire West	15
Halton	13
Warrington	14
Total	**57**

Table 16

Death notifications by age group



% of death notifications by age group - CDOP

% of death notifications by age group - National (England)

Table 19

Is there to be a Joint Agency Response?

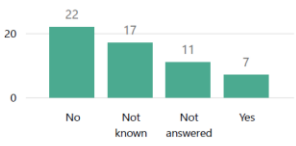


Table 17

Data Completeness - 2020/21 Notifications

Data on this page relates to cases with a date of death between 1st April 2020 and 31st March 2021

NCMD National Child Mortality Database

Potential duplicates:	Cases with DoB/DoD errors:	Cases with CDOP meeting date not yet closed:
1	0	0

90 - 100% Good level of data completeness
< 90% Data completeness requires improvement

Notification fields - % completion of fields (2020/21 notifications)

CDOP Name	Cases	NHS No	DoD	Gender	Postcode	Suspected CoD	Place of Death	Hospital specified^	Joint agency response	Notification Details	Ethnicity
Pan Cheshire	57	98%	100%	100%	93%	100%	100%	100%	81%	100%	100%

Table 21

Data Completeness - Completed Reviews

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2020 and 31st March 2021

NCMD National Child Mortality Database

Potential duplicates:	Cases with DoB/DoD errors:	Cases with CDOP meeting date not yet closed:
1	0	0

90 - 100% Good level of data completeness
< 90% Data completeness requires improvement

Notification fields - % completion of fields

CDOP Name	Cases	NHS No	DoD	Gender	Postcode	Suspected CoD	Place of Death	Hospital specified^	Joint agency response	Notification Details	Investigated by Coroner	Discussed with medical examiner	Post Mortem
Pan Cheshire	28	100%	100%	100%	96%	100%	100%	100%	61%	100%	93%	61%	100%

Table 22

Reporting fields - % completion of fields

CDOP Name	Cases	Events occurred selection	Ethnicity	Circumstances of Death	Where at onset of illness	Formal serious investigation	Known to social care*	Subject to SCR
Pan Cheshire	28	100%	100%	100%	100%	93%	96%	100%

Table 23

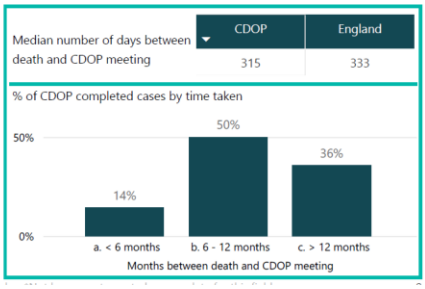
Analysis fields - % completion of fields

CDOP Name	Cases	CDOP category of death	CDOP meeting date	Cause of death	Domain factors recorded (at least 1)	Modifiable factors selection	Learning points text	Actions text
Pan Cheshire	28	100%	100%	100%	100%	100%	100%	100%

Table 24

Table 25

Median number of days between death and CDOP meeting	CDOP	England
	315	333



Notifications - Annual comparison

Data on this page relates to cases with a date of death between 1st April and 31st March for all years, unless otherwise stated.

NCMD National Child Mortality Database

Death notifications by LSCB and year

LSCB name	2019-20	2020-21
Cheshire East	16	15
Chester and Cheshire West	11	15
Halton	4	13
Warrington	14	14
Total	**45**	**57**

Table 26

Death notifications by age group and year

Age group	2019-20	2020-21
0 - 27 days	19	28
28 - 364 days	10	10
1 - 4 years	5	6
5 - 9 years	3	3
10 - 14 years	5	7
15 - 17 years	3	3
Total	**45**	**57**

Table 27

All death notifications from 01/04/19 by month and year

Month of death	2019-20	2020-21
Apr	7	4
May	6	3
Jun	3	3
Jul	3	4
Aug	7	10
Sep	3	4
Oct	6	5
Nov	2	4
Dec	5	8
Jan	1	6
Feb		2
Mar	2	4
Total	**45**	**57**

Table 28

Appendix II: Classification of Death

This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list should be marked.

Category	Name & description of category	Tick box below
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	☐
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	☐
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect. (category 1).	☐
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	☐
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	☐
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.	☐
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.	☐
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	☐
9	**Infection** Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	☐
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	☐

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