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Cheshire East Council

NHS
Eastern Cheshire
Clinical Commissioning Group

NHS
South Cheshire
Clinical Commissioning Group

Cheshire East Health and Wellbeing Board

Agenda

Date:	**Tuesday, 30th May, 2017**
Time:	**2.00 pm**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

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

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

1. **Appointment of Chairman**

2. **Appointment of Vice-chairman**

3. **Introductions, Welcome and Apologies**

4. **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.

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

5. **Minutes of Previous meeting** (Pages 5 - 10)

To approve the minutes of the meeting held on 28 March 2017.

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

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

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

7. **Evaluation of the Pilot Phase of the Emotionally Healthy Schools Project** (Pages 11 - 70)

To provide the Board with details of the review of the Pilot project.

8. **Children's Improvement Plan, Improvement Plan Progress Report and Improvement Plan Scorecard** (Pages 71 - 124)

To inform the Board of the new Children's Improvement Plan for 2017-18 and allow the Board to scrutinise the progress of Children's Social Care against the Plan.

9. **Better Care Fund 3rd Quarter report 2016 - 2017** (Pages 125 - 132)

To provide the Board with the information on the 3rd Quarter metrics for the Better Care Fund.

10. **Participatory Budgeting** (Pages 133 - 142)

To share the findings from the work to introduce participatory budgeting.

11. **Capped Expenditure Programme**

To receive a verbal report.

12. **Membership Review** (Pages 143 - 148)

To provide the Board with the opportunity to vote on additional associate non-voting members of the Board being appointed.

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 28th March, 2017 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Voting
Councillor Rachel Bailey (Chairman)
Councillor L Durham, Cheshire East Council
Kath O'Dwyer, Executive Director of People, Cheshire East Council
Mark Palethorpe, Strategic Director of Adult Social Care and Health, Cheshire East Council
Jerry Hawker, Eastern Cheshire Clinical Commissioning Group
Paul Bowen, Eastern Cheshire Clinical Commissioning Group
Dr Andrew Wilson, South Cheshire Clinical Commissioning Group
Tracy Bullock, Independent NHS representative
Alison Cullen, Healthwatch (Substitute)

Non-Voting:
Fiona Reynolds, Director of Public Health, Cheshire East Council
Tom Knight, NHS England

Observers:
Councillor P Bates, Cheshire East Council
Councillor S Gardiner, Cheshire East Council
Councillor S Corcoran, Cheshire East Council (Substitute)

Cheshire East Officers/others in attendance:
Deborah Nickson, Legal Services, Cheshire East Council
Guy Kilminster, Corporate Manager Health Improvement, Cheshire East Council
Dr Guy Hayhurst – Consultant of Public Health, Cheshire East Council
Jonathan Potter - Head of Service, Preventative Services, Cheshire East Council
Julie North, Senior Democratic Services Officer, Cheshire East Council
Emma Leigh - Eastern Cheshire CCG
Melanie Brown - South Cheshire CCG

Councillors in Attendance:
Councillor J Saunders, Cheshire East Council
Councillor L Wardlaw, Cheshire East Council

54 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Simon Whitehouse, Mike Suarez, Caroline O' Brien, and Cllr Laura Jeuda.

55 **DECLARATIONS OF INTEREST**

Councillor S Corcoran declared a non-pecuniary interest by virtue of his wife being a GP and a Director of South Cheshire and Vale Royal GP Alliance Ltd.

56 **MINUTES OF PREVIOUS MEETING**

RESOLVED

That the minutes of the meeting held on 31 January 2017 be approved as a correct record.

57 **PUBLIC SPEAKING TIME/OPEN SESSION**

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

58 **UPDATED CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH LOCAL TRANSFORMATION PLAN, 2017/18**

Consideration was given to a report presenting the "Children and Young People's Mental Health Local Transformation Plan" for Cheshire East.NHS England required that each Clinical Commissioning Group refresh the Children and Young People's Mental Health and Wellbeing Local Transformation Plan (LTP), submitted in October 2015. The original LTP had been signed off by the Health and Wellbeing Board at the meeting in December 2015 and then published on both NHS Eastern Cheshire and NHS South Cheshire CCG websites. Since the publication of the first plans in October 2015, collaborative activity had been undertaken to commence the transformation of mental health services for children and young people across Cheshire East. The revised plans had been written following detailed consultation with young people and their families and in partnership with Cheshire East Council, NHS South Cheshire and NHS Eastern Cheshire CCGs and Cheshire and Wirral Partnership NHS Foundation Trust and voluntary and community organisations active in the area of mental health. The Board oversaw the delivery and implementation of the Transformation Plan, alongside the Local Children's Safeguarding Board and the Children's Trust.

Members of the Board asked a number of questions and gave consideration to the recommendations as set out in the report, which had been developed in partnership with the Children and Young people Mental Health Partnership Strategy Group, and following extensive consultation and engagement with children and young people and their families.

RESOLVED

1. That the baseline created and the progress made during 2016 despite challenging financial circumstances within the Cheshire East health economy be noted.

2. That the progress made in increased partnership working to increase the efficiency of mental health provision and to support the governance structure be acknowledged.

3. That the senior executive level recommendations made for 2017/18 be supported.

4. That the following overview of the identified activities that will form the 2017/18 transformation activity within Cheshire East be noted. (It was also noted that these should be considered in the way that they interlinked into wider service delivery across the multiple organisations):-

- Roll out "Tools for Schools" project (previously Emotionally Healthy Schools)
- Roll out "MH Links" project
- THRIVE "Getting Help" pilot
- Development of CYPIAPT Workforce
- Redesign of service specification for CAMHS
- Workforce redesign – including staffing resilience/workforce development
- Development of perinatal mental health pathways from universal services, including acute services
- Development of a single point of contact for information and advice
- Develop access to (online) counselling services
- Implementation of Self Harm pathway
- Review local CYP MH commissioning arrangements – exploring lead commissioner models and mapping against local need
- Comprehensive workforce review as part of Strategic Clinical Network business planning

59 **MENTAL HEALTH IN CHESHIRE EAST - ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2016**

Consideration was given to the Annual Report of the Director of Public Health for 2016, which continued the theme of mental health that had started in the previous year. Although it had adult mental health as its primary focus, the report also covered what had happened since the publication of the previous year's Public Health report "Supporting the Mental Health of Children and Young People".

This was the fourth Annual Report of the Director of Public Health for Cheshire East. In 2013, the report had focussed on premature mortality; in 2014 on the health of children and young people; and in 2015 on the mental health of children and young people. This report focussed on adult mental health, but also referred back to the previous year's report and reported on local progress. The topic of the report reflected the commitment of the Public Health team and Cheshire East Council as a

whole to promoting good mental heath amongst it residents, and that improving mental health was a priority within the Health and Wellbeing Strategy. Proposals were made in the report that would improve the Cheshire East Parenting Journey and achieve better outcomes for pregnant women and their babies, details of which were reported.

The report contained a list of recommendations and it was agreed that these would be considered by the soon to be established Public Health Governance Group.

RESOLVED

That the Annual Report of the Director of Public Health be received and that it be ensured that the recommendations are considered and, where appropriate actioned and that the Public Health Governance Group monitor and report back on progress.

60 **ALCOHOL-RELATED HARM POSITION STATEMENT AND FORWARD PLAN**

Consideration was given to the Alcohol-Related Harm Position Statement and Forward Plan. It was reported that excessive consumption of alcohol continued to cause harm to individuals, families and communities within Cheshire East. The Alcohol-Related Harm Position Statement and Forward Plan, attached at Appendix One of the report and its associated Implementation Plan, at Appendix Two, set out a multiagency response to work in partnership to reduce the impacts and costs associated with excessive consumption.

The Board made a number of comments in respect of the Position Statement and:-

RESOLVED

1. That the Alcohol Harm Position Statement and Forward Plan be adopted and its Implementation Plan supported.

2. That the Alcohol Harm Plan Steering Group transitioning into a formally established Implementation Plan Delivery Group (as a sub-group of the Board) to oversee the delivery of the Plan be approved.

61 **CANCER STRATEGY FOR SOUTH CHESHIRE AND VALE ROYAL**

(Before consideration of this item, Cllr Stewart Gardiner declared that he had worked for David Mowat MP, the Minister responsible for dealing with cancer matters).

Consideration was given to a Cancer Strategy for South Cheshire and Vale Royal (2016-2020), which the Board was asked to note.

It was reported that this local cancer strategy was aligned with and provided a vehicle for the delivery of the national cancer strategy. In July 2015, 'Achieving world-class cancer outcomes: a strategy for England 2015-2020' had been produced by the Independent Cancer taskforce. This was the national cancer strategy. It proposed 6 strategic priorities over a 5 year time period, details of which were reported. At around the same time, an All Party Parliamentary Group Report on Cancer (published June 2015), had highlighted NHS Vale Royal CCG as having the worst 1 year survival from cancer in England in 2012 (63.7% compared to 69.3% for England) and NHS South Cheshire CCG as the fourth lowest 1 year survival for lung, breast and colorectal cancer across England in 2012. The Cancer Commissioning Board had, therefore, taken the decision in December 2015 to re-focus its work programme on early detection of cancer and to develop a local Cancer Strategy that covered the next 5 years, to ensure that the local work programme/action plan not only reflected, but was also in line with the national strategy. In 2016, the Cancer Commissioning Board had been overseeing the implementation of the work plans of four work streams. The aim of the document, as submitted to the Board, was to provide a public facing document which outlined the framework in which Cancer Commissioning Board partners were working to in order to improve cancer outcomes locally.

The Board was asked to note the Strategy.

Jerry Hawker reported that it would be necessary for the CCGs to submit a joint paper to the Board on this issue, to cover the whole population of East Cheshire and stated that East Cheshire had a good rating against the national outcomes framework, although there were some challenges.

The Chairman suggested that it might be appropriate to include more emphasis within the Strategy on the importance of healthy lifestyles.

RESOLVED

That the Cancer Strategy for South Cheshire and Vale Royal be noted.

62 **SUMMARY OF HEALTH PROTECTION FORUM DISCUSSIONS AND ACTIONS 2016**

Consideration was given to a briefing note providing a Summary of the Health Protection Forum Discussions and Actions for 2016.

RESOLVED

That the Summary of the Health Protection Forum Discussions and Actions for 2016 be noted.

63 **UPDATE ON COURT PROCEEDINGS**

The Executive Director of People and Deputy Chief Executive, Cheshire East Council, provided information in respect of a recent court hearing relating to the Council in respect of a social care case, where the judge had found that there had been severe deficiencies and that the assessment of the case had been lacking. She stated that the quality processes had failed and that she wished to give assurance that a root and branch review would be undertaken, in order to obtain a better understanding as to how this had happened and to ensure that it did not happen again. She also wished to assure the Board that appropriate action had been taken.

The meeting commenced at 2.00 am and concluded at 3.45 pm

Councillor Rachel Bailey (Chairman)

NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Evaluation of the Pilot Phase of the Emotionally Healthy Schools Project
Date of meeting:	30th May 2017
Written by:	Jonathan Potter
Contact details:	Jonathan.potter@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Councillor George Hayes

Executive Summary

Is this report for:	Information X	Discussion ☐	Decision ☐
Why is the report being brought to the board?	To provide the Board with details of the review of the Pilot project.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Starting and Developing Well X Living and Working Well ☐ Ageing Well ☐ All of the above ☐		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above X		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	To note the findings of the evaluation and support the continuation of the project and the roll out of Phase 2		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	N/A		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	Staff and young people from the schools involved in the pilot project were invited to complete surveys to inform the evaluation.
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Improved outcomes for children and young people in relation to their mental health and wellbeing.

Evaluating the impact of the Cheshire East Emotionally Health Schools Pilot Project

Research Report

April 2017

This study was carried out by the University of Salford CYP@Salford research group on behalf of Cheshire East Council. The study was funded by Cheshire East Council. The purpose of the study was to identify the outcomes for pupils and staff following the delivery of the Emotional Healthy Schools pilot project into six secondary schools.

The research team acknowledges the support and time given by the staff and pupils of the pilot schools and the EHS project team to make this research possible.

CYP@Salford

Improving Outcomes for Children, Young People and Families

http://www.salford.ac.uk/nmsw/research/children,-young-people-and-families

Our research spans health, social care and education, and focuses on enhancing services, improving outcomes and evidencing impacts on children and families. The research group works closely with colleagues in the NHS, Local Authorities, the Third Sector, and national networks. We have research links with international partners in the Nordic countries, the Middle East, the Far East, Europe and Australia.

Celeste Foster Principal Investigator

Dr Gillian Rayner

Dr Shelly Allen

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Tables and Figures

Research project focus and objectives

The focus of the research study was to evaluate the impact of the Emotionally Healthy Schools (EHS) Project against its intended outcomes as set out within Cheshire East Council's contract specification for the EHS project.

The emotionally healthy schools project (EHS) was developed by Cheshire East Children's Service in order to address priority outcomes in its Children and Young People's Plan, 2015-2018.

http://www.cheshireeast.gov.uk/children_and_families/childrens_trust/childrens_trust.aspx

The EHS project is a local partnership approach between schools, statutory and non-statutory emotional health and wellbeing services; providing a mixture of whole school and targeted interventions for pupils, underpinned by access to mental health and wellbeing training and consultation to school staff. The EHS pilot project was designed in accordance with the principles outlined with the Department of Education's (2015) white paper: "Promoting children and young people's emotional health and wellbeing – A whole school and college approach". The project was piloted in six secondary schools between December 2015 and December 2016. Details of the EHS project can be found in the Emotionally Healthy Schools Service Specification (Kehoe, 2015).

Objectives

To undertake a 12 month mixed methods evaluation of the impact of the EHS project against its intended end of project implementation outcomes:

School Staff Specific:

1. To measure, pre and post project, rate of appropriate and inappropriate referrals to Tier 3 Child and Adolescent Mental Health Services (CAMHS), from participating schools
2. To measure staff knowledge of local service provision available in addition to CAMHS, that can support pupil emotional health and wellbeing
3. To measure confidence of staff to talk to pupils about and help with emotional health and wellbeing issues Pre and post project.

School staff and pupils:

4. To measure pre and post levels of stigma in relation to emotional health and wellbeing
5. To measure pre and post levels of awareness and knowledge of emotional mental health and wellbeing

Pupil Specific

6. To measure pre and post levels of knowledge that young people have about maintaining their emotional wellbeing
7. To measure pre and post whether young people can identify where to go for help if they need it

8. To measure pre and post confidence, school-focused measures self-esteem and resilience levels in young people who have participated in targeted group or participatory activities

Whole School:

9. To provide evidence of a school environment which aims to promote and support the development of self-esteem, confidence and resilience in its pupils.

2. Research Method

A multi methods approach was utilised to evaluate the success of the EHS project in achieving the above objectives. This involved qualitative and quantitative approaches matched to particular elements of the project and their intended outcomes.

Wherever possible data collection instruments were selected from the suite of nationally agreed and validated outcome measures developed by Child Outcome Research Consortium (CORC: http://www.corc.uk.net/resources/measures/) which are now approved to use in universal (e.g. school) and primary care children's services.

Method 1:

(Outcome 1)

Quantitative comparative analysis of aggregated CAMHS service referral data (existing aggregated and anonymised data set, routinely collected by CWP CAMHS service) for the six participating schools for a 6-month period prior to implementation of the EHS project and in the final 6-month period of the 12-month project. Data for referral rates and Tier 3 CAMHS response was analysed using descriptive statistical analysis. The data set for this component was not large enough to warrant inferential statistical analysis.

Method 2

(Outcomes 3, 4, 5 8 and 9)

Online survey design. All staff and all young people in schools participating in the EHS pilot project were invited to participate in an anonymous online survey, administered using Bristol Online Survey system. This system allows for administration to a cohort that is spread across six geographical locations, full anonymity and in-programme collation of data for analysis.

Data collection tool design

There was a separate survey for Staff and for young people. Both instruments were adapted from a method that has been tested and validated in two randomised control trials. This focused on, evaluating the effects of Mental Health First Aid interventions

on levels of understanding of common emotional health difficulties, perceived stigma, and confidence to talk about and help with emotional health needs, in both staff and young people (Svensson and Hansson, 2014; Jorm et al., 2010; Graham, Phelps et al., 2011).

This method is centred around a short vignette and a series of related questions that concern the participant's ability to identify the emotional health issues within the vignette, levels of personally held stigma and perceptions of other's people's levels of stigma. For staff; questions assessed confidence and intention to help. For pupils; questions assessed confidence in the helpfulness of school staff and knowledge of where they could seek help if they or a friend needed it. For each question participants chose from a series of responses that most applied to them, ranked across a Likert scale.

A series of additional questions were added to this basic method, that relate directly to the specific intended project outcomes.

For the staff survey these were:

- To understand local care pathways, sources of help and how to signpost young people
- To identify perceived training needs

For the young people's survey these were survey items that provided a

- A measure of self-esteem
- A measure of resilience

The questions relating to self-esteem and resilience were developed from a review of four validated outcome scales for young people that specifically measure resilience and self-esteem as separate domains from clinical symptomatology in order to be appropriate to the non-clinical population in this study (NPC Wellbeing Measure, http://www.thinknpc.org/our-work/our-services/npcs-well-being-measure-2/; BASC-2, Reynolds and Kamphaus, 2004; Resiliency Scales for Children and Adolescents, Prince-Embury, 2006; Child and Youth Resilience Measure (CYRM) Ungar and Leibenberg, 2009).

Analysis of these validated measures indicated that core domains of resilience are: sense of mastery (optimism, self-efficacy, adaptability) and sense of relatedness. Items selected, assessed self-perception of positive constructs of resilience, rather than questions relating to potential problems associated with resilience and self-esteem. This was to manage the ethical issues that can arise from asking young people to self-report difficulties in an anonymous questionnaire, which does not allow for follow-up of individuals. In particular, 'relatedness' questions connecting to sub-domains of trust, availability of support and tolerance of diversity within the school environment (Reynolds and Kamphaus, 2004), were specifically selected as these provide a concurrent measure of school's provision of a relational environment that supports development of resilience (intended outcome 9). Language, question construction and survey size was informed by the National Children's Bureau Research Centre Guidelines for undertaking research with children and young people (Shaw, Brady and Davey, 2011).

Both surveys were piloted to ensure readability, understanding and usability for the participant to check that questions elicit the intended scope of response, and whether sufficient categories of response were available for closed questions (Kelley et al., 2003). For the staff survey, schoolteacher members of the project steering group were invited to pilot the survey. For the pupil survey, members of the Young Advisor Group (a group of young people who participated in the implementation of the EHS project and who received training and support to take part in the project development alongside professional stakeholders), piloted the study and advised the research team on age/developmentally appropriate use of language and question construction.

Data Analysis

Descriptive statistics were calculated within Bristol Online Survey Software. Degree of change over time was analysed by comparison of proportion of responses, in accordance with calculated margin of error for the sample size at a confidence level of 95%. Where appropriate significance of relationship between variables was analysed using Pearson Chi Squared.

Survey questions that generated free text (qualitative) data were analysed using a content analysis method (Elo and Kyngas, 2007), to code and organise content into ordinal and sub-ordinal categories.

Due to lower than anticipated numbers of participants in the staff survey, the data analysis strategy was amended. Changes in pre and post data were reported as whole numbers or percentage change, and cross-tabulation was used to explore relationships between factors. In addition, a small number (n=5) of anonymised matched pairs were included in the analysis to corroborate emerging trends from comparison of the whole sample group over time.

Method 3

(Outcomes 1, 5 and 6)

Quantitative analysis of impact of targeted interventions, using validated age-appropriate self-report outcome measures pre, mid and post completion of pupil or parent participation.

Data Collection

Data was routinely collected as part of EHS project implementation at the beginning, middle and end of each targeted intervention, using a repeated measures design. Measures were administered and anonymised by the provider organisations, then forwarded to the research team for collation and analysis.

Measures used:

- For targeted group approaches for young people:
    - Measure of impact of intervention upon pupil's wellbeing: Young Person Outcome Rating Scale (ORS)
    - Measure of pupil's satisfaction with the intervention: Session Rating Scale (SRS) (Miller et al., 2003)

- For Parent engagement strategies:
    - Parent Session Feedback Questionnaire (Chorpita, 2003)

The ORS measures 4 dimensions of wellbeing and the combined score can be used to identify those young people who may warrant additional mental health assessment and intervention. Prior to data being anonymised for the Salford research team, the needs of any young person scoring below the combined score cut-off were discussed by the school's EHS project worker with the CAMHS project clinical lead in order to ensure referral to further services where required.

Data analysis

Responses were coded into SPSS (version 23). Scale scores were summed for Outcome rating score (ORS) and satisfaction rating score (SRS) for each participant. Descriptive statistics were calculated. Frequency analysis and mean scores were calculated for both subscales and combined scores within each measure. Inferential statistical analysis to establish levels of statistical significance of change over time was undertaken. As data was not normally distributed, nonparametric tests were selected.

The degree of change between pre and post intervention measures was analysed using a non-parametric Mann Whitney U test to compare means. A nominal statistical significance level was established a priori: P value was set at <0.05.

Method 4

(Outcomes 1,2,3)

Qualitative data analysis generated from CAMHS consultation questionnaire (CAMHS Outcome and Research Consortium (CORC), an instrument designed to measure impact and effectiveness of access to mental health practitioner consultation for teaching and other non-mental health staff. This instrument was routinely administered as part of the EHS project implementation. Data has been subject to frequency counts and thematic analysis of free text, in accordance with the method by Braun and Clarke (2006).

Ethical considerations

Approval, governance and monitoring.

Cheshire East Council retained responsibility for the implementation and governance of the EHS pilot project that the research study was evaluating. Ethical approval was secured from the University of Salford Research Ethical Approval Panel (HSCR15-136). Organisational agreement to undertake the study and the terms and conditions of the supply of services by the research team on behalf of the University of Salford was granted via the research contract; signed by University of Salford Research Contract department and by Cheshire East Council Governance and Legal departments c/o Jonathon Potter. The study was carried out in accordance with the research governance framework for social care research (ESRC 2015).

Information about the evaluation process was distributed to EHS School leads, head teachers and other stakeholders through the EHS pilot steering group, school lead's meeting and EHS newsletter/updates. An information leaflet was provided for all staff, pupils and their parents/carers outlining the overall study, its purpose and the different methods of data collection within it. All data was managed securely in accordance with the Data Protection Act (1998).

Strategy for Recruitment and Seeking Informed Consent

All staff and pupils in the participating schools were invited to take part in the survey. To gain informed consent potential participants were provided with age appropriate participant information and the opportunity to ask the research team questions about the study. Due to the need to seek consent from both young people and their carers in the case of those pupils under the age of 16, a 2-stage process of consent was implemented. As this was an evaluation of a project using a 'whole school' approach, an opt-out process was used for stage 1. The information for parents/carers made it clear that any parent who does not give their consent for their children to be invited to participate in the survey, could complete the withdrawal of consent form. Head teachers or a designated deputy collated withdrawal of consent forms andyoung people whose parents opted were not invited to take part in the survey. At Stage 2 all young people were given their own age appropriate information sheet, and opportunity to answer any questions about the process. Pupils who had not been opted out by their parent's/carers were then invited to participate in the survey. The front page of the survey reiterated the principles of confidentiality, anonymity, voluntariness and the right to withdraw. This was supplemented by an audio file for pupils who prefer to listen rather than read, in order to maximise accessibility. Information was provided about sources of support, should pupils be affected by any of the issues raised in the survey. For students under the age of sixteen the survey was completed in school, in a timetabled classroom in order to ensure that pupils could seek clarification and support if needed.

Participant information clearly stated that participation was voluntary and that participants retained the right to withdraw at any point. Use of a nickname allowed for data to be located and destroyed should any participant who completed the survey then decide to withdraw their consent later.

Confidentiality and anonymity was maintained through the use of a participant selected nickname to enable anonymous matching of participant responses at baseline, mid and post project, for comparison purposes only. No other identifying information was collected.

3. Results

3a. Referral Data

At baseline, prior to the project's commencement, between January–June 2015 across all schools in the East Cheshire Locality there were a recorded 115 referrals to Tier 3 CAMHS. In terms of referrals made to CAMHSEast by the six pilot schools, there was a total of 17 out of 115 (14.8%). Middlewich High School (which depending on pupil address refers to both East Cheshire and West Cheshire CAMHS services), made no referrals to Cheshire East CAMHS, but did make one referral to the neighbouring CAMHS West.

Poynton was the school most likely to refer based on this data. Poynton made over 50% of these (52.9%); Eaton Bank and Macclesfield High School made 17.6% each and Ruskin Sports College 11.8%. Referrals to CAMHS services are recorded according to the school in which the young person is enrolled, therefore explaining why there are no recorded referrals from Oakfield.

Baseline audit data was compared with a further audit undertaken during the final 6 months of the EHS project implementation (ending December 2016). The results of both audit periods are presented in Table 1.

Table 1: Comparison of baseline and post referral data

School	**Eaton Bank**	**Macclesfield Academy**	**Poynton High School**	**Ruskin Sports College**	**Middlewich High School**	**Total**
Number of Referrals						
Pre	3	3	9	2	0 (CAMH East) 1(CAMH West)	18
Post	0	8	1	0	1	10
As a percentage of total CAMHS East referrals from secondary schools						
Pre (n=115)	2.6%	2.6%	7.9%	1.7%	Referral to west Cheshire CAMHS service not included	14.8%
Post (n=155)	0 %	5.2%	0.7%	0%	0.6%	6.5%
Referrals accepted						
Pre	1(33%)	3 (100%)	8 (88.8%)	2(100%)	1 (100%)	15 (83%)
Post	/	8 (100%)	1 (100)	/	0 (0%)	9 (90%)

***Benchmark acceptance rate across all schools in locality:** **Pre = 81%** *(n=93/115)*
Post = 81% *(n=126/155)*

During the post evaluation period, there were 10 referrals made to the CAMHS by the pilot schools. This represents an 8.3% reduction in referrals from across the pilot schools. However, due the overall numbers of referrals being small, the degree to which this result may be to chance is relatively high, and would be best confirmed by re-running the audit at the end of the next sixth month period to see if the trend is sustained over time.

Poynton, which had previously made over 50% of referrals made 10% during the post period. Macclesfield Academy made the majority representing 80% of all referrals to CAMHS at that time. Interestingly, Macclesfield Academy had all referrals accepted at pre and post evaluation period indicating that of those young people identified as having a mental health need, all met the criteria for CAMHS. It can be inferred from this that where awareness of mental health needs and care pathways exists, appropriate action is taken to support the young person.

At the baseline evaluation period Eaton Bank made 3 referrals of which one was accepted (33.3%). Eaton Bank's referred acceptance rate at pre-project implementation is considerably lower than the benchmark average for all schools (81%). However, it is not possible to say whether there have been any changes across the project timeframe given no referrals were made during the post audit period by the school.

This also applies Ruskin Sports College where no referralswere made during the post audit period. Although in contrast to Eaton Bank, both referrals at baseline were accepted to CAMHS. As was the referral made by Middlewich High School, although interestingly this pattern reversed at post evaluation where the one referral was not accepted by CAMHS.As such, there is a mixed pattern of referral and acceptance between schools at pre and post evaluation period.

In summary, there was a clear decrease in referrals post period from 18-10 (-8.3% as a factor of the total number of school referrals received by Tier 3 CAMHS). At first glance, these figures look as though the snap shot audit suggests that the EHS project has produced almost a 50% reduction in referrals. However it must be remembered the reduction refers only to school high school initiated referrals, and so although it is evidence of good impact of the EHS project, it may only make a limited difference to the total number of referrals received by T3 CAMHS overall. At both time points across all pilot schools at both the acceptance rate of referral to CAMHS as above the benchmark of 81%. There was a small increase in the overall number of appropriate referrals from the pilot schools at the end of the project (+7%).Aside from Middlewich High School at post period, each individual school within the pilot study had their referrals accepted by CAMHS at a higher rate than the whole locality average. Caution is urged however in relation to making inferences with regard to Middlewich high school at the post period due to the single referral which may not be representative of a more pervasive pattern.

Survey Data

3b. Survey Participation Data

Table 2: Staff and pupil participation by School

School	Teaching staff	Teaching assistants and support staff	No teaching staff participants			Pupils	Number opted out	Approx No. eligible to take part	No. Pupil Participants		
			Pre	Mid	Post				Pre	Mid	Post
Middlewich High School:	51	53	27 (26%)	10 (9.6%)	10 (9.6%)	668	20	645	422 (65%)	98 (15%)	138 (21.4%)
Macclesfield Academy	43	18	23 (38%)	0	0	393	16	370	0 (0%)	0 (0%)	1 (<1%)
Oakfields, Cheshire East Pupil Referral Unit	10	8	0	0	0	max 30 places	2	25	0 (0%)	1 (4%)	1 (4%)
EatonBank Academy	approx. 50	?	21 (42)	0	0	approx. 750	16	730	284 (39%)	72 (9.9%)	1 (<1%)
Ruskin	40	36	6 (8%)	0	0	473	20	450	258 (57.3%)	2 (<1%)	0 (0%)
Not specified	-	-	-			-	-	-	23	0	0
Total	194	115	**77** (25%)	**10** (3.3%)	**10** (3.3%)	2315	74 (3.2%)	2220	**995** (45%)	**173** (7.8%)	**141** (6.4%)
	Combined staff total = 310										

Table 3: Breakdown by year group

Time point	Pre	Mid-point	Post	Total
Year 7	277	19	3	299
Year 8	213	8	25	246
Year 9	188	115	42	345
Year 10	186	29	29	244
Year 11 and 12	91	2	41	134
Unspecified	40	0	0	40

Implications for generalisability of the study findings

In the original design the required minimum sample sizes were calculated using 95% confidence level and confidence interval of 5. This means that to be 95% sure that the results would be reflective of the answers picked by the whole population, plus or minus 5%; we would need a sample size of:

- Staff: 172
- Pupil: 328

Pupil participation (995) at baseline far exceeded this minimum requirement and is a testament to the infrastructure support given to schools at the outset of the project. There was a significant level of drop off in participation of young people at the mid and endpoint survey within most schools. However, using a whole sample analysis (rather than school by school), still enables results to be reported at a 95% confidence level, with a margin of error (confidence interval) of +/- 7.5%. This means that results can confidently be assumed to reflect the whole population sampled. In addition, overall the participant rate for young people breaks down to provide even levels of representation across each year group (range 19-23%), allowing for reliable analysis between sub-groups at the mid and post project time points. Although it looks as though no young people from the pupil referral unit participated at the baseline survey, this cannot be assumed: 23 young people assigned informal terms for their school names. This may represent uncertainty for pupils in the PRU (as they remain on role in their original school, whilst attending the PRU), or may indicate residual nervousness regarding their anonymity. Although limited number of schools participated in the mid and endpoint survey, if engagement with all arms of the evaluation are taken as a whole there was representation from all schools. In addition, pupils from a range of the participating schools participated at baseline, midpoint, and endpoint. Therefore, in line with the initial intention of the commissioned evaluation and to maximise use of all data provided by pupils, a whole population approach was utilised across the whole project, rather than a school-by-school matched pair analysis.

The staff response rate at baseline of 77 represents a 25% return rate. This is in line with expected return rate for online survey methods, which are estimated between 21 and 30% (Sax et al., 2003), and comparable with the return rates in previous studies exploring teachers attitudes and beliefs regarding mental health education in school settings (Graham et al., 2011). However, the fall in participation to ten respondents at mid and endpoint, mean that changes reported must be interpreted with considerable caution. To address the challenges raised by having such a small mid and post sample group, an anonymised matched pair analysis of responses of five staff who completed at more than one time point was undertaken. Correlation between trends identified in the matched pair and the whole sample analysis increase the confidence with which results can be asserted as indicators of change,

3c. Pupil Survey Results

Data in the main summary tables (Tables 4 and 6) for both the pupil and staff surveys have been presented in the direction that is most likely to show change over the three time points of the evaluation period. Notable changes (those outside of the 7.5% percentage margin of error, or close to it) have been highlighted in green to depict a change in a positive direction and red to depict a change in a negative direction.

Question responses have been summarised in Table 4 and a narrative is provided in accordance with the intended EHS project outcome that it was designed to measure.

Table 4: Pupil survey outcomes Pre, Mid and Post EHS implementation

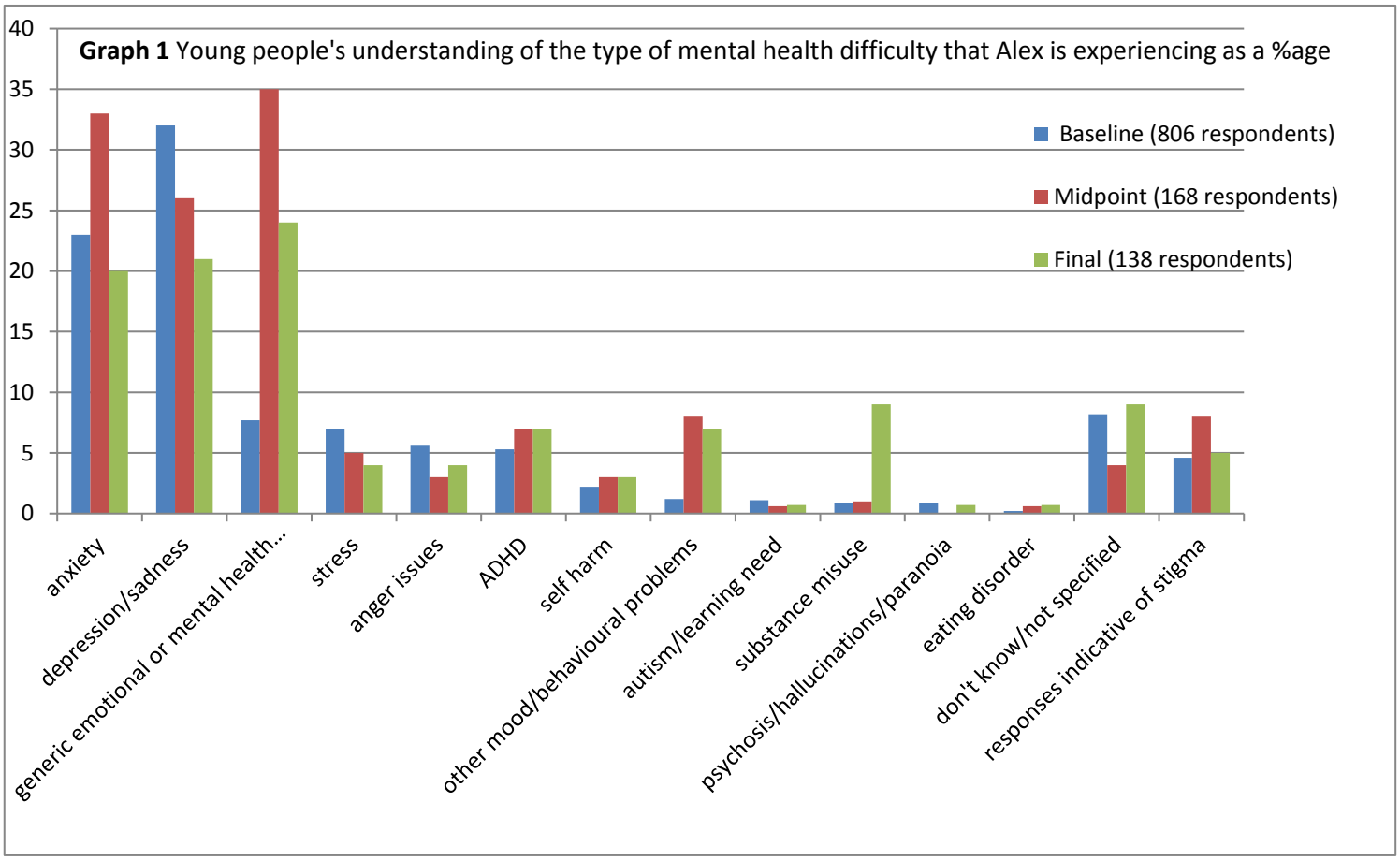
	Baseline	Mid-point	Post-project	% change
Mental health knowledge (%)				
Recognition of mental health issues in the vignette	**79**	**88**	**86**	**+7**
Knowledge of underlying causes	40	31	31.9	**-8.1**
Don't know/non-specific	**15.7**	**12.2**	**9.0**	**-6.7**
Stigmatising responses	4.6	8.0	5.0	+0.4
Personal stigma items: % ≥ *disagree*				
Personal weakness	57.2	74.1	56.5	-0.7
People with those problems are dangerous	47.8	52.9	44.5	-3.3
If they had a problem, they would not tell anyone	87.9	79.1	84.3	-3.6
Excuse for poor behaviour	48.2	57.4	48.6	+0.4
Should be taught alone	40.1	45.5	40	+0.1
Perceived stigma items: % ≥ *disagree*				
Other people believe a sign personal weakness	25.1	17	21.1	-4
Other people believe people with those problems are dangerous	22.4	15.1	18.8	-3.6
Other people would not tell anyone	88.2	83.8	86.3	-1.9
Other people believe it's an excuse for poor behaviour	29.5	26.5	31.5	+2
Other people believe Should be taught alone	23.2	17.0	24.5	+1.3
Confidence in own ability to stay emotionally healthy or help others: % ≥ Quite a bit				
Knowledge of places to get help	37.9	38.4	34.8	-3.1
Knowledge of sources of information	33.5	24	24.7	-8.8
Perception of own ability to generate ideas to stay well	36.9	29.6	31.7	-5.2
Beliefs and intentions about where to seek help: % Yes				
Belief in helpfulness of school staff	83.4	76.4	78.2	-5.2
Talked to a staff member about emotional health issue in the last month	**12.6**	**21.5**	**22**	**+9.4**
School-related indicators of resilience: % ≥ <u>disagree</u>				
I feel confident in school	17.5	22	21.1	+3.5
I feel hopeful that my school can help me achieve	10	11.7	17.8	+7.8
I feel I belong in my school	17.8	24	20.9	+3.1
In my school it feels safe to express difference or uniqueness	32	42.9	39.1	+7.1
Personal indicators of resilience: % ≥ <u>disagree</u>				
I can do things as well as most people	16.3	18.3	17.1	+0.8
When things go wrong I feel as though I can learn and bounce back	17.3	22.9	15.9	- 1.4
I am as good as most other people	18.7	18.2	22.3	+3.6

Pupil Knowledge of mental health difficulties

This was a free text response to the question: 'What do you think is wrong with Alex?'

Pupil answers to this question broadly fell into two types: describing/naming the type of mental health problem and answers that reflected an attempt to consider the possible underlying causes.

TYPE OF MENTAL HEALTH DIFFICULTY



At the baseline 806 responses were given, with anxiety and depression the most common (55% of total responses).79% of responses of this type were appropriate to the symptoms being described. Combined with the range of possible mental health difficulties identified, this shows a very high baseline knowledge of mental health issues in the pupil participants prior to the implementation of the EHS project. 58% and 41% of respondents named anxiety and depression at midpoint and endpoint demonstrating stability in the level of student ability to identify mood related problems across the three time points of the survey. There was a small upward trend towards improved level of knowledge (+7%) in participant responses at the end of the project - see table 4.

Prior to EHS implementation 7.7% of pupil participants were only able to say that Alex had a generic mental health issue of some kind, 8% did not know what was wrong with Alex (though many of these responses indicated that they knew he needed help), and 4.6% gave responses that were indicative of stigma. Only 0.5% of the sample identified that there was nothing wrong with Alex. Given the high level of knowledge across the sample group before project implementation it was these results where we would hope to see a change as the project implementation progressed.

The number of responses indicative of a stigmatising attitude at baseline and end of project remained comparable (4.6% and 5%). However, at midpoint this peaked to 7.7%. Previous research by Jorm et al., (2010) evaluating the impact of mental health first aid training in school settings, found a specific effect impacting on stigma related responses: that students were biased towards giving more socially desirable responses at the baseline or pre-test time point, but that this bias decreased at later assessment points. As such, it is possible that the midpoint responses are a more accurate reflection of levels of stigma held by participants than the baseline survey the result possibly also highlights an opportunity for myth busting and stigma challenging to be concurrently implemented whilst endeavouring to support pupils to develop mental health awareness.

Examples of the kinds of stigmatizing statements given by pupils represented in text box 1.

Box 1: Examples of stigmatizing statements

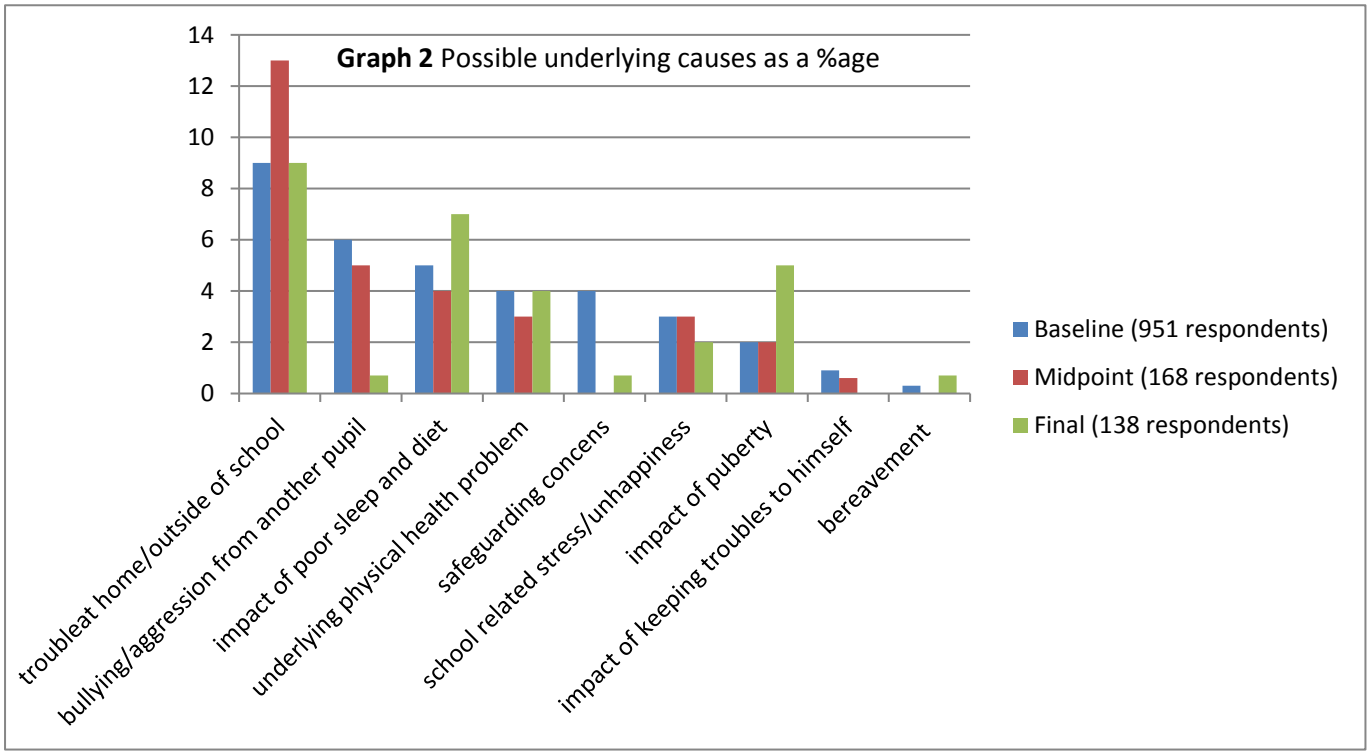
(S)He:

- Is weird
- Has a name like Alex
- Is bad
- Is scruffy
- Is a Schizo
- Is retarded
- Is attention seeking
- Is having a ‘giraffe’ (laugh)
- Is a wimp
- Is on a period
- Is not my problem
- needs to sort himself out

Recognition of the specific mental health difficulties associated with the vignette increased and the response of don’t know/non-specific reduced. This suggests there was an increased awareness relating to identification of mental health difficulties and development of accepted language to describe them. Knowledge of underlying causes decreased but this may be mitigated by answers being more closely associated with specific, named mental health problems such as anxiety and depression.

POSSIBLE UNDERLYING CAUSES

An average of 34% of all student responses at baseline, mid and end-point survey sought to offer a view on the possible underlying causes of Alex's difficulties. These responses are interesting on a number of counts. Firstly, they indicate an accurate understanding within the pupil population of the common statistically significant precipitants of mental distress. Secondly, they reflect an understanding of the relationship between physical and mental ill/health. This is particularly interesting when compared with staff responses, which comparatively do not offer the same attempt to understand 'why as well as 'what'.



These results also highlight that, after problems at home, bullying was the most significant cause for concern for the pupil population prior to the EHS project implementation, but that the number of student respondents who identified bullying as an underlying cause dropped from 6 % to 0.7 % at the project endpoint.

Indicators of personally held stigma and perceived stigma in other, in relation to mental health difficulties

Overall levels of personally owned/expressed stigma in the pupil sample were low. However, levels of perceived stigma in others are notably higher:

At baseline only 26% agreed with the statement that emotional health issues are a sign of weakness but 48% believed that other people would think they were a sign of weakness. At the end of the project the number of pupils agreeing that emotional health issues were a sign of weakness had reduced to 16%, showing a further improvement in personally held attitudes, but perceived levels of stigma in others did not show significant change.

47.8% disagreed with the statement that Alex is dangerous, but only 22.4% felt that other people would also disagree, remaining stable across the 3 survey time points

At baseline only 23.8% agreed that Alex's behaviour was an excuse for poor behaviour, but 44.1% believed that others would see it as poor behaviourindicating a significant expectation that others would judge. Although there was a 10% reduction in the number of pupils who believed that others would evaluate Alex's difficulties as an excuse for poor behaviour at the end point, the shift was from 'agree' to 'neither agree not disagree' rather than indicating confidant change in view of how other's perceive emotional health issues. A third of pupil respondents felt that Alex should be taught alone, but half of them thought that others would believe that they should be taught alone

Across all items relating to perception of stigma what can be said is that approximately twice as many students believe that others have stigmatising attitudes towards those with emotional health needs than report holding these views themselves. Whilst the results do point to some further improvement in the level of personally held stigmatising beliefs, the EHS interventions do not appear to have significantly reduced concerns about the views of others.

However, despite these concerns the likelihood that pupils would seek help if they had problems similar to Alex was high – 85% - with 32% initially agreeing that they would do so within a week of feeling this way, rising to 55% at the end of the project. This statistic can be understood in the context of the responses given regarding perception of staff responses to requests for help, which also shows an improvement over the duration of the project.

Perception of own capacity to stay emotionally health or contribute to emotional health of peers

Overall, pupil perceptions of their own knowledge about where to go to get help or information about mental health issues and of their own capacity to generate ideas about this was consistently rated as good in 75% or above of respondents at each time point. Though it should be noted that 16% of the participant group indicated that they did not think they could do this at all, which in fact rose to around 25% of participants at the end of project survey. Although the proportion of participants showing worsening results is relatively small, it does indicate that a small but

significant group continue to need access to mental health promotion strategies and information, or have struggled to make use of the information that has been provided.

Beliefs and intentions about where to seek help

At baseline 83.4% of pupils felt confident that staff in their school would help them to help another young person they were worried about.This number remained stable at the mid and endpoint surveys (results show negligible reduction within the calculated margin of error)

There was a recorded reduction in the belief that staff could be helpful, however, there was an increase in pupils seeking out members of staff specifically to talk about an emotional issue. This suggests an increased level of confidence that this was acceptable and less of a concern that that such a request may be met unfavourably. As such, it may be reasonable to suggest that young people's knowledge regarding maintaining their emotional wellbeing and identifying where to go for help increased amongst those that staff have sustained and regular contact with.

In order of preference, pupils were likely to seek help from the following:

- 73.2% Parent or Carer
- 63% Pastoral support Team
- 62% School Nurse
- 54% Teacher
- 48.9% School Counsellor (although 10.3% thought this could be harmful)
- 35.8% Alex (27% thought this could be harmful)
- 41.1% Friends (21.5% thought this could be harmful)

The order of preference remained the same at each time point with only very narrow margin of difference in results between timepoints (<3%), indicating that results are very likely to be a good fit with the wider population.

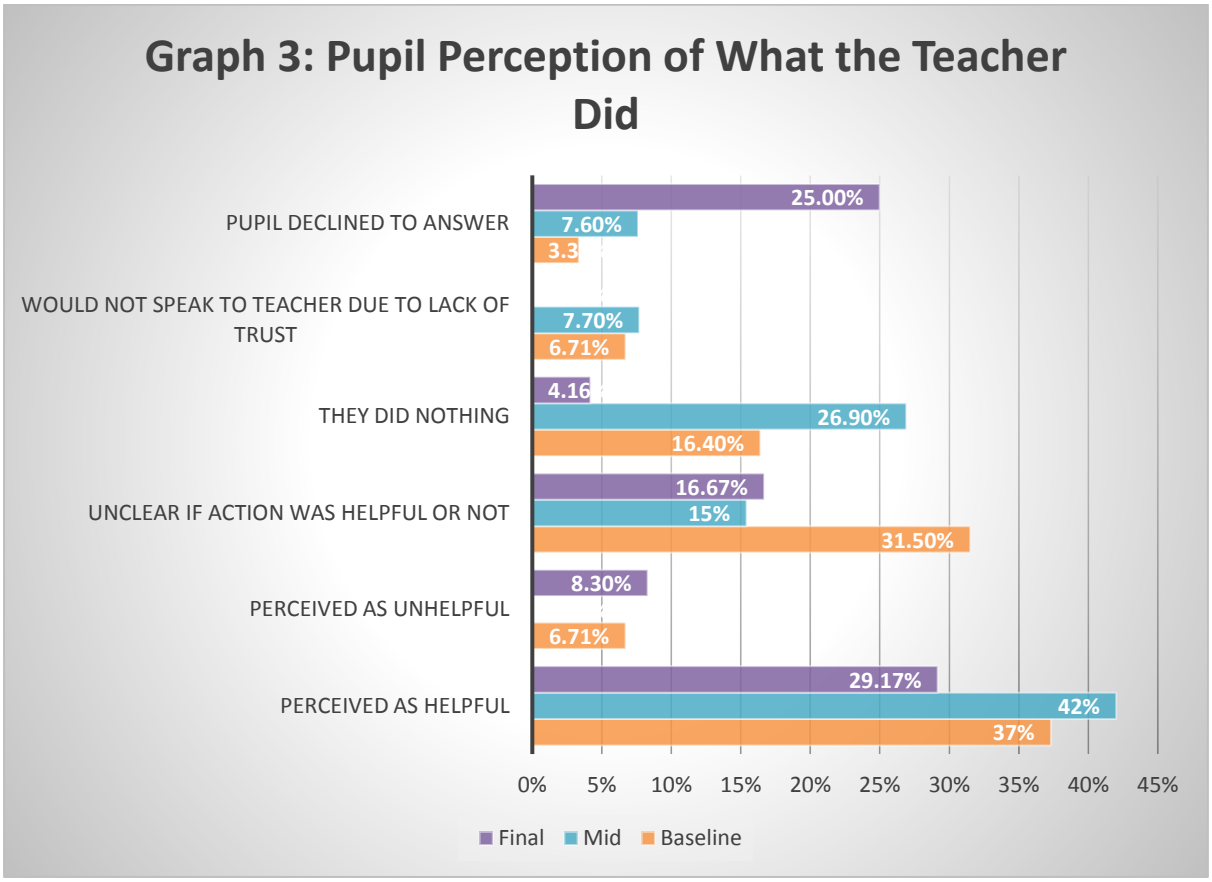
At the end of the project 86% participants identified that speaking to no-one about their concerns would be harmful.

Actual Help received from staff

The number of pupils seeking help for emotional health concerns in the month prior to completing the survey rose by almost 10% across the duration of the EHS project, from 12.6 to 22%. Although the number of young people approaching staff to talk about their emotional health looks relatively low, 12.6 (the baseline number) is actually in line with the expected point prevalence of mental health issues within the 11-17 population (Melzer et al. 2003). Therefore, the rise in numbers of young people seeking help within school is likely to reflect a positive impact of the EHS project on pupil's help-seeking behaviour.

What did the teacher do?

Graph 3 shows a comparison of pupil perceptions of teacher responses at each of the three time points.



Although it looks at first glance as though pupil perception of helpfulness has reduced at the end of project. In fact, this number is skewed by the high number of students declining to answer the question at this time point. If the figures are adjusted for this, then the proportion of respondents reporting helpful teacher responses at the endpoint rises to 39% in line with the other time points. It is also important to note that although the number proportion of respondents who evaluated teacher responses as helpful has reduced very slightly, it remains the most likely response.

Although overall there has not been an increase in the number of participants who appraised teacher responses as positive, there are a number of indicators of positive impact of the EHS project:

At baseline 17.6% of participants indicated that the staff member had done nothing. At the project midpoint the research team recommended work to ensure that staff members go back to young people to let them know what action has been taken. It is notable that only 4.2% of participants in the final survey reported that teachers had done nothing in response to their request for help.

Whilst the number of pupils reporting that they would never confide in a teacher about their mental health concerns due to lack of trust remained small but steady between the baseline and midpoint, the number of students reporting this concern at the end of the project had dropped to zero.

7.2% of responses reported actions that had been actively unhelpful or in the young person's view made things worse, this dipped to zero at midpoint, but then returned to a rate equivalent to the baseline.

Supportive measures included: being listened to, helped to feel safe, being helped to feel calmer, speaking to other people who could help with my problems, comforting me, suggesting ideas to help me get better, asking if I wanted to talk, being helped to consider strategies to help them cope such as problem solving and ideas on coping with anger. Referrals to counselling or CAMH's were seen to be useful with more generic considerations such as making sure they knew what was available that might be helpful.

Where it was unclear if it had been helpful or not, answers included indication that specific people had been involved such as parents, school nurses and specific teachers but it was not clear if this had been a positive or negative intervention, therefore further positive experiences could be hidden in this group. Actively unhelpful responses included being shouted at, being put in detention, breaches of confidence, being laughed at and being given information for which the young person could not see the relevance.

Though it was not directly asked about it is interesting to note, given the degree to which bullying was identified as a precipitant to mental distress in the earlier question, that 9.2% of all baseline responses implied within them that the cause of their distress was related to bullying or negative peer interaction. However, no responses at mid or endpoint carried the same implication.

Although the number of participant responses to this question are very different, at pre (268), mid (31) and final point (27), percentages are useful to seek any changes.

Table 5: Summary of changes in pupil perception of teacher responses to requests for help

Responses	Baseline	Midpoint	Final	Change
Helpful	37%	42%	39%	+5% - +2%
Unclear	31.5%	15%	16.7%	-14.8%
Unhelpful	6.7%	0.0%	8.3%	-6.7% - +1.6%
They did Nothing	16.4%	26.9%	4.16%	-12.24%
Would not speak to a teacher	6.7%	7.7%	0.0%	+1% - -6.7%

Chi Square test (X2) indicates that although results show a trend towards positive change in relation to perception of helpfulness and reduced perception of teachers doing nothing to help, results do meet test for statistical significance (p= 0.58).

School related indicators of resilience

60% of participants reported feeling confident within their school prior to project implementation and this remained stable at project end (-2%).

However, only 54.3% pupils agreed that they feel like they belong within their school, and although there was no change in this figure at the end of the project, the number of pupils who actively disagreed with the statement actually increased by nearly 8%.

Similarly, there was a small but notable reduction in the number of students who agreed with the statement “I feel safe to express things about me that are different” and overall approximately one third of pupil participants did not believe that their school was a safe place to express difference.

This is a domain in which it would be hoped that whole school approaches to building an inclusive culture, which are a constituent part of the EHS project philosophy, would positively impact. However, it is also important to note that these score may also reflect the developmental position of the participants; as adolescence is a time of normative anxieties relating to perceived personal difference from the norm and the impact this has upon inclusion/exclusion within social groups (Briggs, 2009).

Of note, the belief that the school could help pupils achieve actually declined modestly over time. This may relate to specific school activitiesthat tend to increase performance anxiety for pupils taking place during the final survey period (December-January), for example exams. It may prove fruitful for individual schools to explore this as a timeline, to consider targeted support at timely periods where the demands placed upon pupils mean they may require additional input.

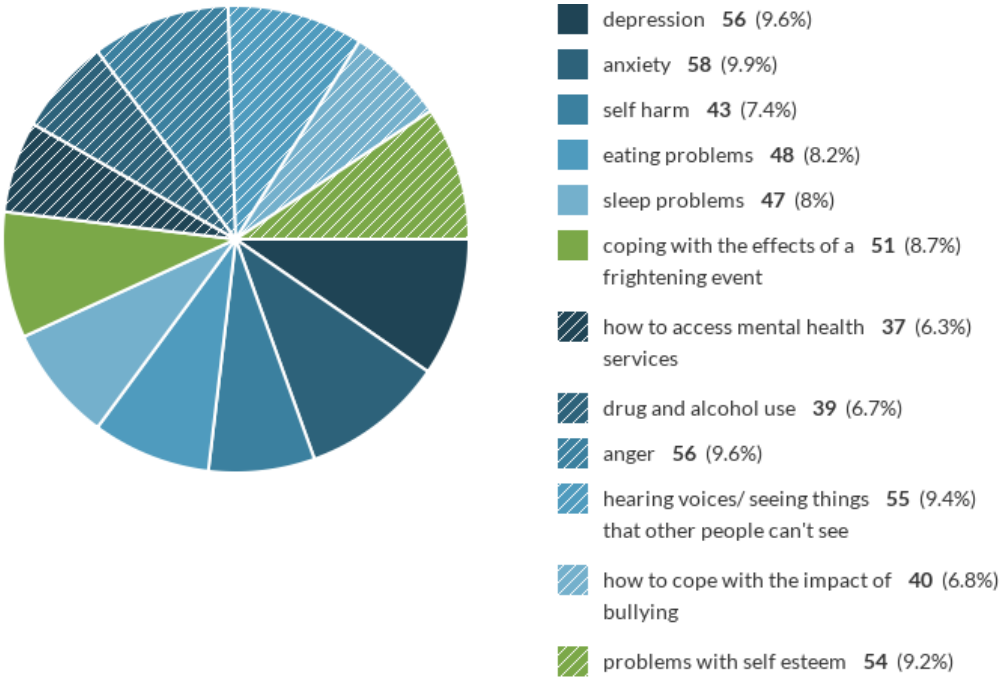
Personal indicators of resilience

It is demonstrated in table 4 that across the questions asking about personal sense of resilience, although overall most pupil responses indicated good levels of personal resilience, a consistent subgroup reported poor indicators of personal resilience (16-18%), which was not impacted upon by the EHS project. This figure is in line with what might typically be expected within the general population of 11-18 year olds, where rates of mental health distress are typically found to be within the range of 15-25%.

Further mental health information that pupils would like:

Students were given a choice of 10 aspects of mental health about which they might want further information at the end of the EHS pilot project. The results are presented in graph 4

Graph 4: Mental health topics about which pupils at the end of the project would like more information



At baseline depression self-harm, anxiety and coping with anger were the most frequently selected topics. At end of project it is possible to see that these are still topics of interest but do not stand out amongst other areas of mental health knowledge. This may reflect pupils feeling more knowledgeable about these topics, and/or becoming more aware as the project has progressed of the wider range of emotional health issues they can face. How to cope with bullying was added as a choice to the mid and endpoint surveys, in response to the high priority that bullying was given by participants in the baseline survey.

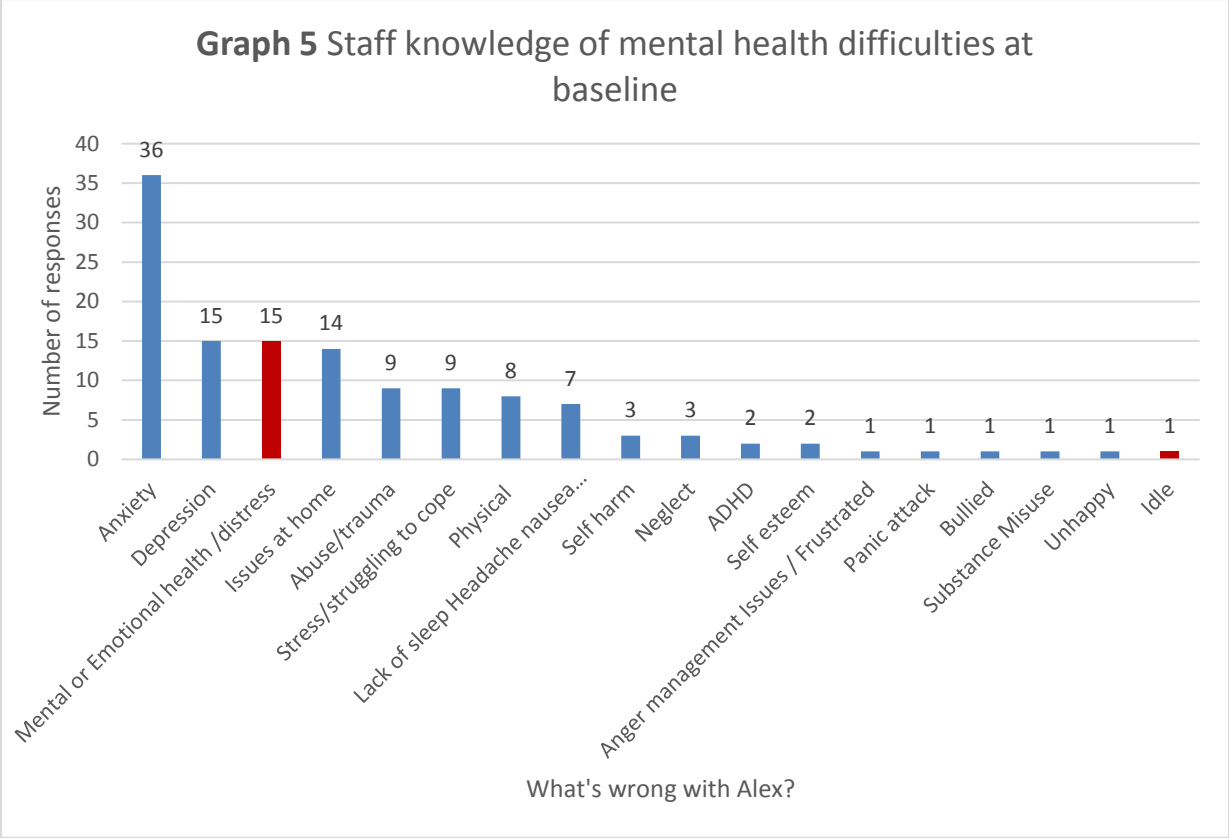
3d. Staff Survey

77 staff members completed the baseline, 10 completed the midpoint and 10 completed the endpoint. (Comprised of 16 different staff members across the last two time points). Results reported as percentages are summarised in table 6, to allow comparison between time points. However low uptake of the survey by staff members means that changes presented need to be interpreted with caution. Results of five anonymised matched pairs have been presented alongside the whole sample data to help confirm reliability of emerging trends.

However, even when the two forms of data analysis corroborate each other's findings, due to low participant numbers, it can still only be asserted that any changes are accurate for those who participated in the evaluation, rather than for the whole population.

Changes in knowledge of mental health difficulties

The baseline survey indicated a good level of knowledge of mental health issues in staff overall (81%).



This level of knowledge remained stable over the 3 time points, with a small increase (+6.5%) in proportion that recognised the mental health issues within the vignette. There was a concurrent small decrease (-5.5%) in the proportion of participants who could not specify the particular kind of emotional health difficulties present in the vignette. It was notable that bullying was almost absent in the staff group as a possible underlying cause at baseline, as compared to the pupil responses. It is also noted that staff members tended to express their understanding of the health difficulties as symptoms of illness, compared to pupils who were much more likely to express their understanding in terms of possible underlying drivers to Alex's distress. No responses indicative of a stigmatising attitude were given by participants at mid and end point.

Table 6: Staff outcomes at pre, mid and post EHS project implementation

	Baseline (n=77)	Mid-point (n=10)	Post-project (n=10)
Mental health knowledge (%)			
Recognition of mental health issues in the vignette	81	77	**87.5**
Knowledge of underlying causes	32	15.4	25
Don't know/non-specific	18	23	**12.5**
Stigmatising responses	<1	0	0
Personal stigma items: % ≥ *disagree*			
Personal weakness	92	90	**100**
People with those problems are dangerous	70	80	60
If they had a problem, they would not tell anyone	95	100	100
Excuse for poor behaviour	72	100	90
Should be taught alone	83	90	**100**
Perceived stigma items: % ≥ *Disagree*			
Other people believe a sign personal weakness	73	44	40
Other people believe People with those problems are dangerous	54	40	20
Other people would not tell anyone	93	100	**100**
Other people believe it's an excuse for poor behaviour	41	55	30
Other people believe Should be taught alone	46	60	**60**
Help given to students: %			
Never	29	40	40
Once	11	0	0
Occasionally	37	40	30
Frequently	24	20	**30**
Confidence level to help: % ≥Quite a bit			
Personally	37	44	40
Perception in others	45	60	40
Confidence in the support of colleagues to support the staff member	60	90	50

Table 7: Summary of change in anonymised matched pairs

Pair No.	Demonstrated level of knowledge	Personally held stigma	Stigma in others	Help seeking	Confidence in colleagues	Self-reported knowledge/ confidence	Actions to help	Signposting
1	↑	↓	↑	↑	↑	--	↑	↑
2	↑	--	↑	↑	--	↑	--	↑
3	--	--	↑	--	--	--	--	↑
4	↑	--	↑	↑	↑	↑	--	↑
5	--	↓	↑	--	↑	↑	↑	↑

Key

↑ = increase ↓ = decrease -- = no change

Questions relating to Stigma

Staff results parallel pupil findings, in that levels of personally held stigma were reported as low at baseline (<10% in relation to emotional health difficulties indicative of personal weakness), with some questions showing that staff who participated in the final survey have even lower levels of personally held stigma. In the five matched pairs, two participants showed a reduction in personally held beliefs of a stigmatising nature and three participants, whose original score indicated very low levels of personally held stigma, remained the same (Table 7).

In contrast, both the comparison of overall survey results at baseline and endpoint, and analysis of the individual matched pairs, show a marked increase in perception of stigmatising beliefs and attitudes in others. As nearly all mental health awareness training includes increasing awareness of stigma and its impact upon those in mental distress, it is possible that engaging with training and talking more explicitly about emotional health issues within in the school environment may have actually increased individual's awareness of and sensitivity towards negative attitudes.

A notable positive change sustained at mid and endpoint is an increase in the speed within which staff respondents reported that they would seek help for an emotional health problem. By the end of the project all participants stated they would seek help, with the majority indicating they would seek help immediately and the rest doing so within a week of onset

Questions relating to confidence

Proportion of participants who felt not at all confident or only a little bit was reduced (-9.3%) at mid and endpoint.

Whole survey comparison shows marked improvement in all three questions relating to perceived confidence at mid-point, with a return to baseline levels at end of project. However, in the matched pair analysis there was a clear increase in self-reported levels of confidence and knowledge as well as in confidence in their colleague's abilities.

Intention to help

Staff were asked to rank which three actions they were most likely to take, if they were to be approached by pupils experiencing emotional health issues:

Rank	Actions	Responses		
		Baseline	Mid	End
1	Discuss with school based health professional	67	10	10
2	Have a conversation with the pupil	55	8	9
3	Discuss with another teacher	39	7	5
4	Referral to CAMHs	23	4	4
5	Contact the family	20	1	2
6	Discuss with a member of the admin team	5	0	0
7	Talk to other students	2	0	0
7	Do nothing	2	0	0

Responses marked in red indicates the baseline responses that we expected to be markers of change at the mid and post-project time points. As can be seen from table there was a positive trend away from discussing student's emotional health issues with their peers, administrative staff, or from doing nothing.

Actual help given to students

At baseline 71% of staff reported speaking to a pupil about their emotional health at least once in the month prior to completing the survey, with 23% indicating that they had done this frequently. Whilst the number of participants who had never spoken with a pupil in the last month increased modestly, there was also an increase in the frequency with which participants spoke with young people about emotional wellbeing issues.

TYPE OF HELP GIVEN:

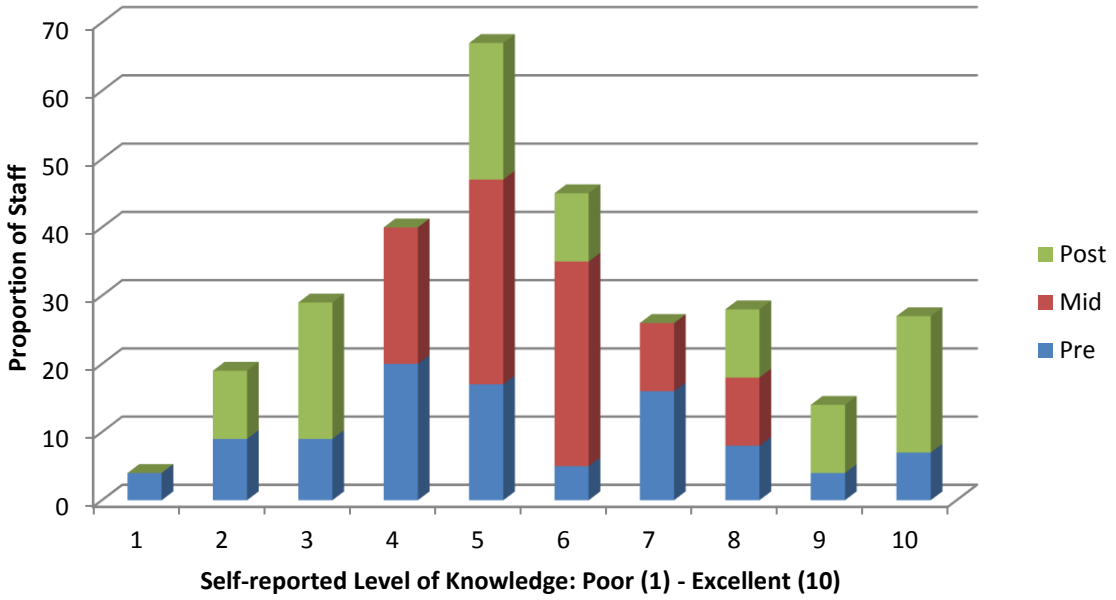
Intervention	**Number of responses**		
	Baseline (n=46	Mid (n=)	End (n=5)
Interpersonal interaction: Discussion Listening Reassurance Time Supported Empathised Mindfulness Total	 17 11 6 3 2 1 40	 2 1 1 0 1 0 5	 1 1 0 1 1 0 1 5
Discussed/referred with safeguard lead, pastoral support/line manager/SENCO	24	3	3
Advice, Sleep, Attend class, strategies	12	1	2
Contacted parents	4	0	2
PHSE sessions	1	0	0
Offered to mediate with parents	1	0	0
Opened a Common Assessment Framework or Individual action plan	1	0	2

It is noteworthy that the responses that relate to personal interaction with the young person correlates highly to the types of response that the pupil respondents have identified as helpful. The matched pair analysis revealed a positive shift over time with participants reporting use of more specific, intentional actions to help at the end point,

Perceived knowledge of sources of help and referral pathways within the locality

Graph 6 displays the distribution of how participants ranked their level of knowledge of sources of help at each time point.

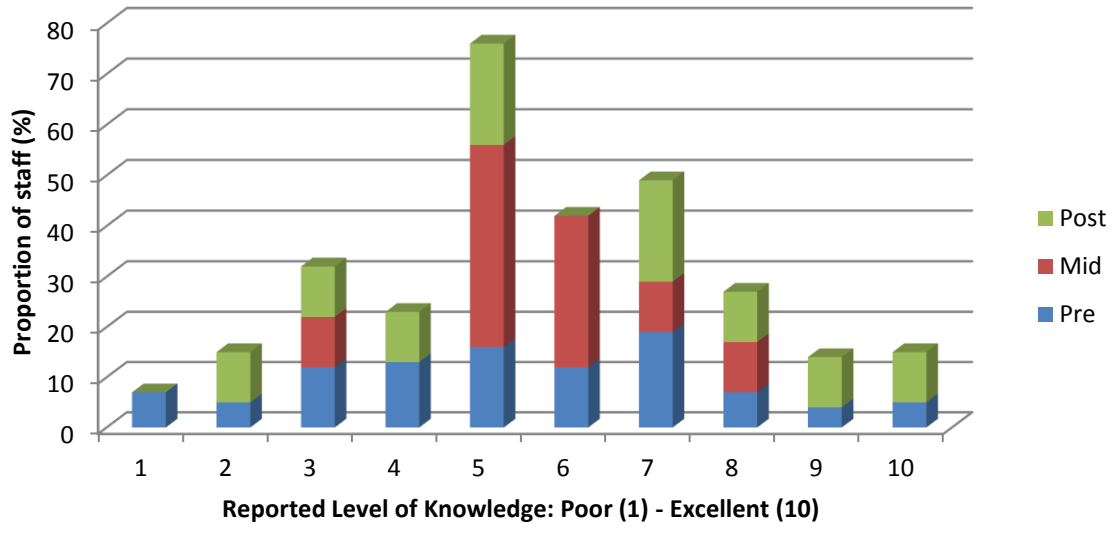
Graph 6: Staff knowledge of sources of help and referral pathways



Staff perception of knowledge of sources of information and advice for young people

Graph 7 presents the distribution of individual's knowledge and awareness of sources of information and advice, to which pupils could be signposted.

Graph 7: Staff knowledge of sources of information and advice to which to direct pupils

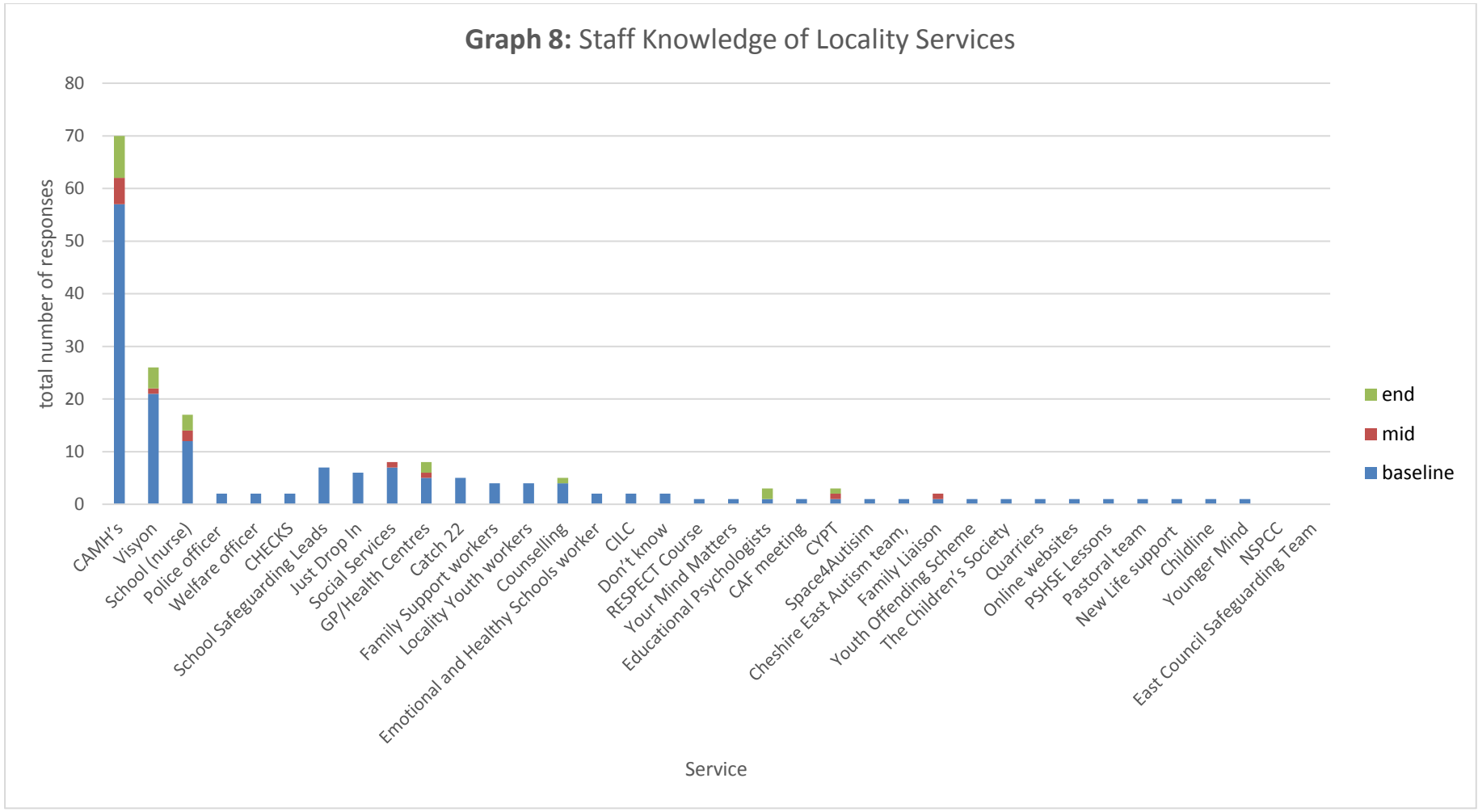


Both graphs show that at baseline respondents ranked themselves across a very broad distribution (indicating high variance in levels of knowledge within the sample). Whereas, at mid-point, responses are clustered around the median in the 2nd and 3rd quartile. At endpoint, although the distribution is broader again, overall, a higher proportion of participants have ranked their level of knowledge in the top quartile. Whilst this shows that participants rated their level of knowledge more highly at the endpoint, it should be noted that the very small sample size means that the effect size of each individual participant's responseis significantly amplified. This means that a marked change in one participant's response can disproportionately affect the overall results.

Knowledge of local services

At each time point staff were asked to list local services that could support children with emotional health needs as a free text response (so as not to prime respondents with the answers). Responses were mapped against a directory of local service provision provided by the EHS clinical lead (Graph 8). This information is not intended to provide a measure of change, but to help identify those areas of service provision that require a higher level of visibility or benefit from greater marketing to school staff going forwards.

Graph 8 clearly demonstrates that three services were well known within the sample group, and that additional marketing and information-giving regarding other services within the Cheshire East locality may be indicated.


Graph 8: Staff Knowledge of Locality Services
total number of responses
80
70
60
50
40
30
20
10
0
CAMH's
Visyon
School (nurse)
Police officer
Welfare officer
CHECKS
School Safeguarding Leads
Just Drop In
Social Services
GP/Health Centres
Catch 22
Family Support workers
Locality Youth workers
Counselling
Emotional and Healthy Schools worker
CILC
Don't know
RESPECT Course
Your Mind Matters
Educational Psychologists
CAF meeting
CYPT
Space4Autisim
Cheshire East Autism team,
Family Liaison
Youth Offending Scheme
The Children's Society
Quarriers
Online websites
PSHSE Lessons
Pastoral team
New Life support
Childline
Younger Mind
NSPCC
East Council Safeguarding Team
Service
end
mid
baseline

Reported impact of EHS pilot project upon knowledge and confidenceand its relationship with engagement with training opportunities

Participants of the end of project survey were asked to rate the extent to which they agreed with the statement: “Overall, I feel the emotionally healthy schools project in my school has positively impacted on my knowledge and confidence in dealing with the emotional health needs of pupils”. Responses were cross-tabulated with participant engagement in training opportunities provided as part of the EHS pilot in order to explore the relationship between the two variables.

Table 8: Relationship between engagement I training and perceived impact of EHS project upon levels of knowledge and confidence

To what extent to you agree with the statement: "Overall I feel the emotionally health schools project in my school has positively impacted on my knowledge and confidence in dealing with the emotional health needs of pupils"	Since the Emotionally Healthy School project began in your school, what training and development opportunities have you taken part in:				No answer	Totals
	MindEd e-learning module(s)	CAMHS Schools Link Training	Training Sessions delivered by Educational Psychologists working with your school	In-school training delivered by Dr Rob Lupton (Emotionally Healthy Schools clinical lead)		
Strongly disagree	0	0	0	0	0	0
Disagree	0	0	0	0	1	1
Neither disagree not agree	1	0	0	0	2	3
Agree	3	0	2	2	0	7
Strongly agree	2	1	0	2	0	5
No answer	0	0	0	0	0	0
Totals	**6**	**1**	**2**	**4**	**3**	**16**

Question	Response count
4	7
14	10

Whilst endpoint sample size means this cannot be generalised to the whole staff population within the pilot school, it can be said categorically that for those staff who completed the endpoint survey, engagement in training was positively correlated with a perceived improvement in levels of knowledge and confidence. Conversely, staff who responses indicated no perceived benefit from the EHS pilot project have engaged in no or little training opportunities.

Further information and training requests

At the project end respondents identified thefollowing areas about which they would like further information and training:

- Self-Harm
- How to support youngpeople with low self-esteem, anxiety and depression
- Understanding psychosis

- How to help young people get back in the classroom
- Updates on latest government initiatives relating to emotional health and wellbeing

Two respondents commented on having recently received a lot of help and information, so whilst not having any specific needs, registered their ongoing openness to further training.

Overall notable themes and changes in staff and pupil survey

Baseline survey responses demonstrated that knowledge of student mental health issue was good in both pupils and staff. Further increases in knowledge were observed in both staff and pupil participants over time. In particular, there was more specific understanding of emotional health issues alongside pupils demonstrating increased knowledge of the of the importance of seeking help and staff showing increased readiness to engage with pupils and improved knowledge of where to refer or signpost.

At baseline pupils and staff reported relatively low levels of personally held stigma, which decreased even further at the end of the project by a small degree. Pupils were up to two times more likely to expect others to think Alex was weak, dangerous, would be considered to have poor behaviour and should be taught away from the class, even though they generally didn't agree with this themselves. So expected stigma from others was more of an issue than judgement or stigma from the pupils themselves. The pattern of perceiving higher levels of stigma in other's attitudes rather than one's own was mirrored in staff survey responses. Although the degree of stigmatising attitudes thought be held by others was less than in the student group, there was a marked increase in levels of perceived stigma in others in staff participants at the endpoint

There were quite good levels of awareness of what to do and where to get information and help, but a consistent percentage of pupils felt they had no abilities in relation to helping themselves and others stay emotionally healthy (16%). This did not alter over time and may reflect the students who would be more likely to require targeted interventions.

Overwhelmingly, pupils would seek external help from staff family or friends if they had a friend like Alex but they were less likely to approach Alex himself, with some children expressed concern regarding the potential harm from speaking with Alex directly or involving counsellors. The likelihood and speed with which both pupils and staff would seek help showed a marked upward trend at the end of the project. For pupils this result is perhaps more important than whether there was a change in their perceived capacity to help themselves, as seeking assistance from an adult is a developmentally appropriate strategy for school age children.

Staff participant's perception of their knowledge, confidence and confidence in their colleagues' ability showed a positive trend over time, alongside an apparent increase in the frequency with which some staff spoke to young people about their emotional

health. This trend is further substantiated by results of the pupil survey which at endpoint showed that pupils were talking to teachers about their emotional health on a more frequent basis and indicated pupil-perceived increase in staff responsiveness.

There was a significant difference between staff and student survey responses in relation to the prominence of bullying as a factor associated with mental health issues, with pupils rating bullying as a much more central factor in their understanding of causes of mental distress at baseline. It is of note that concerns about bullying were much less present in pupil responses at midpoint and endpoint.

School-related resilience scores were good for most pupils, demonstrating confidence in school, that the school can help them to achieve and belong. Lowest scores were around being pupils feeling safe to express things about them that are different, but still 40% could express this. However, the EHS interventions appeared to have little impact upon these domains over time. Across all questions relating to personal indicators of resilience, approximately 17% consistently disagreed or strongly disagreed and this did not alter over time.

Staff and students identified very similar priorities in relation to mental health issues about which they would like more information.Staff awareness of local emotional health and wellbeing services show that there is a significant gap in knowledge of the range of services outside of T3 CAMHS and school-based services

3e. Targeted interventions for pupils

Participating schools selected a menu of targeted programmes to address the needs of particular populations within each school, to implement across the 12-month pilot. These were:

Table 9

Programme name	Schools planning to implement	Year group targeted	Outcome measures completed?
Exam Stress	Middlewich High School Eaton Bank Academy Ruskin High School	10, 11 11	Yes No Yes
Team of Life (using sport for resilience and skill building)	Middlewich High School Oakfield High School Poynton High School Eaton Bank Academy Ruskin High School	7, 8, 9 / 8, 9, 10 / 7, 8, 9,10	Yes No Yes No Yes
Resilience for Life (Resilience building)	The Macclesfield Academy	7, 8, 9	Pre only
Cool Connections (CBT-based programme for increasing understanding of thoughts, feelings and behaviour and effective management)	Ruskin High School	7	Yes
Form Room Mindfulness	The Macclesfield Academy	Not Specified	N
Transition Intervention	Eaton Bank Academy	Not specified	N

Outcome Rating Scale (ORS) measures

The ORS measures 4 dimensions of wellbeing and the combined score can be used to identify those young people who may warrant additional mental health assessment and intervention. The mean ORS scores for each domain at pre, mid and time points are presented by group programme on page 37.

Table 10: Mean ORS Scores for Cool Connections Group

	Personal wellbeing				Interpersonal Wellbeing				Social Wellbeing				Overall Wellbeing				Combined score			
Time points	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value
Pre	2.800	5	.4472		4.200	5	2.2804		1.600	5	.5477		2.900	5	.5477		11.100	5	3.0496	
Mid	4.667	6	2.3381		7.500	6	1.7607		4.833	6	2.4833		4.167	6	1.3292		21.167	6	4.1673	
Post	7.033	6	1.9866	.005	5.800	6	2.5140	.399	5.583	6	1.1035	.005	3.367	6	1.4989	.443	21.783	6	4.2541	.006

Table 11: Mean ORS Scores for Team of Life

	Personal wellbeing				Interpersonalwellbeing				Social wellbeing				Overallwellbeing				Combined score			
Time points	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value
Pre	5.509	33	2.7590		5.161	33	3.0023		5.773	33	2.8203		5.812	33	2.8708		22.882	33	9.0230	
Mid	6.160	15	2.2746		7.013	15	2.9157		6.427	15	1.8281		7.013	15	2.0000		26.947	15	8.4008	
Post	6.496	25	2.4864	.197	6.148	25	2.7467	.254	6.628	25	2.6776	.208	6.508	25	2.4406	.413	25.676	25	9.4790	.388

Table 12: Mean ORS Scores for Exam Stress

	Personal wellbeing				Interpersonalwellbeing				Social wellbeing				Overallwellbeing				Combined score			
Time points	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value	Mean	N	Std. Deviation	P Value
Pre	5.496	23	2.4462		5.926	23	2.7143		6.083	23	2.6198		5.670	23	2.2445		23.000	23	8.6925	
Mid	6.917	6	2.1075	.214	7.167	6	3.0768	.331	6.667	6	2.9609	.608	7.500	6	2.9326	.075	28.250	6	10.7645	.206

Across all groups for which outcome measures were completed, and across all 4dimensions of wellbeing, the standard deviation indicates that the mean is a reliable fit in relation to the whole sample group from which it is derived.

COOL CONNECTIONS

As Cool Connections was a CBT-based group to help young people who were having difficulties understanding and managing their thoughts and feelings, wellbeing scores at baseline were notably lower than for the other groups. This is expected for a group that is providing intervention for pupils experiencing an emotional health problem, rather than focusing on resilience or addressing a specific source of stress.

Cool connections showed the greatest level of improvement over time, with scores improving in each of the four domains at mid and endpoint. A Mann Whitney U test revealed that the degree of change between pre and post scores was statistically significant in the domains of personal wellbeing ($U=.00$, $p<0.01$), social wellbeing ($U=.00$, $p<0.01$) and for the combined score ($U=.00$, $p<0.01$). Analysis of inferential statistics revealed that the degree of improvement in combined score at midpoint was also statistically significant ($U=.00$, $p=0.006$). Highlighting that the positive effects of the cool connections programme begin to take hold early in the intervention.

EXAM STRESS

ORS measures were administered for pre and mid-point only bythe locality team. However, there was an improvement in the mean of all 4 sub-scores and the combined scores at the mid-point. The mean combined score at midpoint shows an improvement. of 20%. A Mann Whitney U test showed that the level of change did not meet statistical significance in any of the domains. This is to be expected given that outcome measures taken before completion of the programme. However, the level of change in overall wellbeing did approach statistical significance ($U=36.00$), $p=0.075$), and the trend towards improvement at mid-point indicates that levels of improvement may have tended toward the level of statistical significance had outcome measures been administered at the actual end-point.

TEAM OF LIFE

Again, positive improvements in mean scores at mid and post time points are seen in all sub-scores and the combined score for the team of life programme. However, in this sample the level of improvement did not reach statistical significance.

DIFFERENCES BY GENDER AND YEAR

Results for all three groups were analysed to establish if there were any notable differences in outcomes based on gender or year group. Only the Team of Life group showed statistical difference between scores by gender. Analysis highlighted that this related to differences in how participants scored themselves at each time point (with girls tending to score themselves proportionately lower than boys on each sub-score). It did not show any difference in levels of improvement between boys and girls.

In relation to differences between year groups, again, only Team of Life showed any notable difference. The degree of improvement in sense of overall wellbeing was smaller in years 9 and 10, compared to other years. In the year 9 group, the mean combined score actually reduced at midpoint, compared with baseline and then showed improvement at the endpoint. However, the larger standard deviation in this group's scores (SD= 6.7), which shows a greater variance of score between individual group members, combined with the smaller number of participants within the subgroup, indicates that this result is likely to be a result of the increased effect size of individual participant scores on the group mean.

Session Rating Scales (SRS)

SRS is a measure of participant satisfaction with the delivery of the intervention and its 'fit' with the pupil's perceived areas of difficulty or priority. Satisfaction is rated in relation tothedegree to which the pupil feels:

- Relationship: Listened to, respected and understood
- Goals and Topic: The session topic or goals fit with their needs
- Method: The facilitator's approach is a good fit for them
- Overall: The session was useful overall

123 SRS forms have been completed by pupils attending groups over the course of the EHS pilot project.

The mean satisfaction scores for each domain by programme/group are presented in Table 11.

Low standard deviation scores indicate that the mean score is a good representative of the whole data set. However, a conservative approach to interpreting the results should still be taken as once broken down by group, the sample sizes are relatively small and there is significant range within all groups.

The mean SRS scores for Team of Life, Exam Stress and Resilience for Life groups are uniformly in the top quartile, indicating a very high satisfaction rating. Although overall the SRS scores still indicate a good level of satisfaction, Cool Connections received the most mixed evaluation from participants, despite it having the most significant impact upon participant levels of wellbeing (as measured by ORS scores). In particular, perceived satisfaction with the fit of the session goals and topic were in the second quartile. This may be understood in terms of difference in focus of Cool connections, where the alignment of pupil worries and the stated focus may not be as transparent as for example an exam stress group. Participants in Cool Connections also had significantly lower wellbeing scores at commencement of the programme. Lower mood and wellbeing can have a negative impact upon the degree of hopefulness individuals have in relation to the intervention they are engaged in effectively meeting their needs (Salovey and Birnbaum, 1989)

Analysis of SRS scores by year group as well as programme revealed notable differences in the degree of satisfaction reported by Year 11 and Year 10 pupils undertaking the exam stress group. Year 11 pupils reported a higher satisfaction rating across all scores compared to Year 10. It is possible to assume that the degree of urgency and relevance of this group to Year 11 pupils may account for the difference. No other significant differences in satisfaction rating were noted between year group.

Analysis of difference by gender groups highlighted one significant difference ($p<0.05$) between boy's and girl's rating of Relationship (degree to which they felt respected and understood) within the resilience for life group. Female participants mean score for relationship was almost 3 points lower than the male participants (although still good). As this group only took place in one school, it is reasonable to assume that the difference is related to gender rather than other confounding variables. This finding indicates that further work considering the impact of gender difference in facilitator and participant engagement style may help to augment the effectiveness of targeted group for participants of both gender.

Table 13: Mean SRS Scores by Group

type of group attended		Relationship	Goals and Topic	Method	Overall
Exam stress	Mean	8.378	7.991	8.661	8.313
	N	23	23	23	23
	Std. Deviation	1.4777	1.5288	1.4099	1.3818
Team of Life	Mean	7.781	7.948	8.571	8.300
	N	48	48	48	48
	Std. Deviation	2.2689	2.1319	1.6238	1.7629
Resilience for Life	Mean	8.082	7.579	8.504	8.171
	N	28	28	28	28
	Std. Deviation	2.7217	2.4426	2.2240	2.4396
Cool Connections	Mean	7.263	5.904	7.717	7.058
	N	24	24	23	24
	Std. Deviation	2.3717	2.2027	1.9722	2.2177
Total	Mean	7.860	7.473	8.411	8.031
	N	123	123	122	123
	Std. Deviation	2.2829	2.2436	1.8199	2.0050

3f. Summary of the CORC Consultation feedback questionnaire.

62 feedback forms were received at final point of the project from staff who had been in receipt of consultation with the EHS clinical lead for CAMHS. Respondents were in a variety of academic and student support posts.

Nature of the consultation	**Number of respondents**
A one off	3
A one to one	0
Over the telephone	0
One of a series of planned consultations	40
Group	18
Face to face	9

the feedback reported as follows;

Concern of the consultation (In terms of who the consultation concerned)	**Number of respondents**
An individual child	51
A group of children	10
An organisational issue	19

What respondents wanted from the consultation is illustrated below

Aim of the consultation	**Number of respondents**
Answers to questions on practice in general	27
Help to think about what to do next with this child	40
Help with assessment	10
Help with interventions	36
Help to think through my worries about this child or group of children	28
Help to increase my confidence in managing the situation	35
Other (communication) support for the parent x1	3

The highest agreement being that the consultation helped people think what to do next with this child. The second highest statement was that the consultation helped with interventions and increased confidence was third highest.

Nature of the Outcome	Number of respondents
A referral to specialist CAMH's	4 existing: contact not a new referral 1 new referral 2 spoke with CAMHS
Child redirected to alternative services	1
Help to manage with no referral or redirection	32
other (text listed below) Action plan for school Students to be monitored, Meeting with CAMHS medical practitioner. To seek advice from Youth Forum Training completed Group discussion/reflection with Nick Change to intervention Proposal for professionals meeting Advice given	14 1 2 1 1 6 1 1 1

Based on this, there was only one new referral to CAMHS over the length of the project, four pupils had already been referred and the consultation helped staff members to manage the presenting issues. The highest scores were that the consultation helped them to manage with no referral or redirection.

Reduction in concerns	Number of respondents
A lot	20
A bit	16
Not at all	21

At the final point of the project, 54 (87%) participants were happy with the outcome of the consultation and their concerns were thought to have been managed as above. One person at mid-point was not happy with the outcome, stating there was "no real conclusions for this one"

Ease to arrange consultation	Number of respondents
Not so easy	0
Easy	24
Very easy	16

At the first report, the proposed improvements to the consultation service section was mainly left blank but suggestions were that additional training had been useful and

Wednesdays were a challenge for one respondent due to competing activities on that day.

For the midpoint collection, there were no reported issues with the above. One person stated they wanted more time to prepare. Two people stated that they found the sessions really useful and would like these to continue. All other forms were left blank.

By the final collection, the only thing reported by one participant was that the staff attending the consultation could have improved in their planning. Otherwise there were no other reported improvements.

4. Key messages and findings in relation to the EHS Pilot Project intended outcomes

An important finding of this evaluation is that baseline data indicated that prior to any of the EHS strategies being implemented, overall the pilot schools were doing a good job in relation to supporting emotional health and wellbeing. Pupil levels of knowledge and confidence in their school to support them were already high and staff levels of knowledge and attitudes overall were good. This creates a ceiling effect, where any changes as a result of the EHS project implementation will therefore be likely to be of small magnitude (Svensson and Hansson, 2014).

Despite this phenomenon, there are a number of distinct indicators of positive changes because of the EHS pilot project. These are summarised in the relation to the EHS project's intended outcomes

Reduction in inappropriate referrals to CAMHS and an increase in appropriate referrals

Analysis of referral data, pre and post project implementation combined with CORC consultation evaluation outcomes demonstrated that access to a Tier 3 CAMH clinician for consultation; delivery of targeted interventions for pupils at risk within the school setting; and whole school approaches, combined to positively impact upon rates of CAMHS referrals made by the schools, and on how appropriate those referrals were.

Reduction in stigma around emotional health and wellbeing

The results present a complex picture in relation to this intended outcome. Perceived stigma from others was a concern for participants at baseline and remained so at the end of the project, with staff participants showing an increase in perceived stigma in others. However, personally held stigmatising attitudes were low in staff and pupils and reduced further over the project period.

These findings are in keeping with prior research studies. Research participants typically assess themselves as less stigmatising than others and personally held views have been shown to be more sensitive to change following interventions aimed at reducing stigma (Quinn et al., 2011). Jorm et al. (2010) found that very few student-focused outcomes showed positive impact of a staff mental health training programme and showed increase in perception of stigma within others.

Despite the challenges of finding anti-stigma strategies that are effective at reducing perceived stigma, this is an important area on which to focus future school-based strategies. Perceived stigmatising views of others has been shown to act as a deterrent to help seeking and to have a disproportionately high impact upon young people (Clement et al., 2015). Focus on giving pupils clear and congruent messages

(direct and in direct), about the accepting and receptive nature of their school and the staff within it may be more effective use of resources than approaches that seek to further increase pupil level of knowledge. It is also important to hold in mind that changes in culture, attitude and belief are often longer-term outcomes of intervention. The relatively short evaluation period of this study may not have captured the full extent of the impact of EHS strategies, which may continue beyond the length of the study period, indicating the need evaluation of medium and long-term impacts (Mehta et al., 2015).

Increase in awareness and knowledge of emotional mental health and wellbeing

Baseline knowledge in young people was demonstrated to be good and sophisticated. Construction of mental distress in staff ran more along the line of naming symptoms within a biomedical framework (as is the case in the adult population generally). Whereas, pupils were more likely to construct mental distress in relation to possible underlying external causes (systemic, environmental and social factors)

There was a moderate improvement in demonstrated knowledge in both groups and self-reported improvement in knowledge in staff respondents at the end of the project. In young people, this related to more specific knowledge and availability of a mental health language with which to describe what they were seeing

There was a marked increase in the degree to which pupil participants understood the importance of seeking help alongside the potential harm of doing nothing or keeping troubles to themselves.

Increased confidence of staff and pupils relating to emotional health and wellbeing

Staff respondents demonstrated an improvement in their perceived confidence and knowledge about referral, signposting and also in their colleagues' capacity to help. This was mirrored in pupil reports of increased frequency with which they had spoken with a member of staff about emotional health concerns in the month prior to the final survey and the pupil's perception of increased responsiveness of staff when they did seek help.

For the staff who participated in the research there was a clear relationship between engagement in training opportunities provided and a positive perception of the impact of the EHS pilot project upon their knowledge and confidence levels to young people.

Young people having and keeping mentally healthy with the knowledge of what is required to maintain this and knowing where to go for help if they need it

The most important changing trend highlighted by a number of measures in this study was the increase in the number of pupil who would seek help, the speed with which they thought they would seek help, and the number of pupils actually talking to teachers about their concerns.

At all time points approximately 16% of pupil participants felt they had no abilities to help themselves stay well. This percentage perhaps reflects the cohort of pupils who need targeted interventions, and is positively mitigated by pupil increase in capacity and tendency to seek the help of a staff member.

Better understanding by of what provision is available additional to CAMHS

Staff participants reported an increase in confidence and perceived knowledge of sources of referral and help. The objective measure indicated that knowledge of services external to the school still fell within the narrow range of CAMHS and the voluntary sector provider working with their specific school. Greater awareness-raising of the range of support services and agencies within the locality is indicated.

Increased confidence, school-focused measures self-esteem and resilience levels in young people who have participated in targeted group or participatory activities

All targeted interventions for children identified as at risk of mental distress or in need of help with specific stressors, that this study assessed, demonstrated marked improvement in all measures of wellbeing, self-esteem and resilience for participating pupils. Cool Connections in particular demonstrated a statistically significant level of improvement for a group of pupils who presented with very low levels of wellbeing prior to intervention. Pupil evaluation of suitability and acceptability of all three interventions were uniformly in the top quartile showing a high level of satisfaction. These findings are in line with previous research studies investigating the impact of school-based mental health strategies, which not surprisingly show that targetted interventions tends to have a more measurable impact than whole school approaches. This is partly because most children within the school environment are not in need of additional emotional wellbeing support and those who do are a much smaller group hidden within the whole population. This makes measuring statistically significant change at a whole pupil population difficult (Spence, 2014).

A School environment that promotes and sustains pupil resilience, sense of worth and esteem

Pupil sense of confidence in their school remained stable at all time points. There was a small reduction in pupil's sense of their school's ability to help them achieve,

which may be related to timing of the final survey at a time of high performance demand (e.g. exams). The percentage of pupils with markers of low resilience rmained stable over time (approx 16%) and access to targeted interventions are more likely to be effective for this cohort.

Relatively low levels of pupils who participated reported feeling comfortable to express aspects of their identity that were different or unique within their school setting. Although it can be predicted that the nature of ordinary adolescent preoccupation with fitting in with their peer group will place a ceiling on how much this could be improved, this finding also needs to be considered alongside the higher level of concern about stigmatising attitudes in others. Any activities that create a greater sense of acceptance of all forms of difference are also likely to improve concerns about being judged for having emotional health difficulties.

Bullying was high on pupils' agenda of emotional health related concerns. However, this was not reciprocated in the information captured from staff groups. Graham et al. (2011) have highlighted the importance of understanding teachers' perceptions and awareness of the events and situation that impact on students' emotional wellbeing and how they align (or not) with student priorities, as they inform teachers' ability to respond appropriately in classroom contexts. The effects of being both a victim and perpetrator of bullying have been shown to be directly associated with rates of depression, anxiety, self-harm and suicidality in childhood, and to last into early adulthood (Copeland et al., 2013). Given the strength of this correlation within published evidence, and that both pupils and staff rate anxiety, depression and self-harm as primary areas about which they would want further information and training, the potential suitability and feasibility of evidence-based whole school anti-bullying measures and programmes could be explored. As a starting point, an example of such a programme is KiVa (http://www.kivaprogram.net/), which has been successfully piloted and evaluated within the UK school setting (Hutchings and Clarkson, 2015).

It is of note that whilst staff were less likely to consider bullying as a high priority issue, engagement with School Leads for the EHS pilot project did highlight that broader problems with interpersonal effectiveness within peer relationships was highlighted by staff as a priority and that whole school approaches were being put in place to support students in this domain. Within the pupil survey results, concern with bullying reduced at mid-point and was not reported at all by the endpoint participants.

Overall, the results of the EHS pilot project evaluation are in line with trends identified within other published research studies investigating the effectiveness of mental health awareness and promotion in school settings. These show highest rates of effectiveness in targeted interventions for pupils and staff, identify the

greatest level of impact of whole school approaches upon levels of knowledge and readiness to help or seek help, and show limited or mixed impact upon staff and pupil attitudes (Svensson and Hansson, 2014; Quinn et al., 2011, Jorm et al., 2010).

Recommendations

1) School-located, targeted interventions for pupils identified as at risk and school-located access to consultation from a CAMHS practitioner have been demonstrated to be effective strategies for improving identification, support and access to early help for pupils who are raising concern but may not yet meet the threshold for secondary mental health services.

    a. Ongoing use of routine outcome measures (ORS and SRS) to monitor impact of targeted interventions may provide important information regarding any emerging gender differences in experience of and in response to particular programmes.

2) Future activities to include a focus on working to break down concern about stigmatizing attitudes of others as a barrier for helpseeking.

    a. Given the relatively low level of perceived safety to express differences reported in the participant group, adopting approaches that promote inclusivity and celebration of difference more broadly, rather than focusing on mental wellbeing specifically, may be more likely to have impact.

3) Consideration of pilot implementation of evidence-based whole school programme for prevention of bullying.

4) Follow-up assessment of the longer-term impact of the EHS pilot project is warranted to identify any further improvements over time and to establish if positive changes identified within this study have been sustained over time.

5. Strengths, limitations and learning from the evaluation process

There are a number of factors that impacted on the final analysis of the project due to data collection challenges and levels of individual school engagement with different components of the evaluation. These are useful to consider from a position of learning from the process and informing future activities.

As illustrated in the report, individual schools were able to be active participants in different components for the evaluation strategy, but few pilot schools were able to engage in all evaluation methods. Enabling students to participate in the mid and endpoint survey appeared to be particularly challenging for a number of schools. As the EHS project progressed EHS School Leads reported that there were multiple evaluation projects using survey methods happening concurrently. Whilst some schools managed this and were able to support the data collection process, for others capacity to enable students to complete the survey was significantly impacted upon. Given this, it may be reasonable to suggest that survey fatigue and lack of clarity with regard to what was being measured, how and why, were interfering factors.

With this in mind, future project evaluation would be served well if this was organised across specific timeframes to avoid the clumping together of numerous forms of data collection. This may assist in the reducing the issues mentioned above and may also positively impact on how confidently the results for a particular project may be reported.

The evaluation depended on being able to collect data at three fixed project points, pre mid and final. These were negotiated with schools in an attempt to enhance engagement and to gain as informed a view as possible of the progression of the project. The mid and final project points for data collection fell at challenging times in the school year, these being the end of the academic year and Christmas/January. Whilst there is never an ideal time given that the primary task in schools is the education of its pupils and evaluation of projects must give way to this, the level of participation compared to baseline measures is noticeably reduced and warrants consideration. Aside from the challenges of school priorities, it is clear that when administrative support for the evaluation process, as well as project delivery within the locality was in place, this was highly instrumental in ensuring data collection. As the project progressed identified administrative support for evaluation data collection was lost and its impact was experienced significantly.

Similarly, having a designated project manager, supported by prioritisation of some of the EHS project administrative time to implementation of the evaluation, at the beginning of the project was crucial in ensuring the recruitment and consent process was undertaken in an ethical and informed way. It also enabled a clear point of contact between the commissioned research team and the EHS project delivery steering group, for brokering pragmatic solutions to emerging logistical problems. This is in keeping with findings from similar types of interdisciplinary collaborations that have highlighted local project manager oversight as an effective means of

improving and project effectiveness and outcome (Foster et al., 2015; Ranade and Hudson, 2003).

The timing of the financial incentive provided to schools who engaged with the EHS project and its evaluation warrants consideration. This was provided in its entirety early in the life of the EHS pilot delivery and potentially meant that there was little incentive for persisting with the evaluation process. This was particularly apparent given the sustainment of the project constituted additional work and logistical organisation within schools and which was in addition to the usual demands within busy secondary schools. It may be reasonable to consider whether future projects of this type use pre and final points as an appropriate time to release any financial incentives to assist with this issue.

The design of the evaluation project could have taken a cross sectional approach to avoid some of the issues with participation. However, this is not an appropriate method for measuring impact over time against project objectives. With this in mind, it may be prudent to build a longer run-in period to any future evaluation where staff are more actively engaged to understand the nature of studies using repeated measures at pre and post intervals. This is more likely to ensure buy in and is particularly important given that staff were not just participants in their own right, but also the gate keepers for pupil participation.

The successful implementation of any project depends on the drivers and infrastructure which support them. In this respect staff on the steering group were highly committed to improving emotional wellbeing and de-stigmatising in their approach, this translated to the project aims and objectives and therefore underpinned the entire project.

Given the nature of the aim and objectives set out in the evaluation, multi methods were useful to tailor make the research strategy to address these in an informed way and which makes for a more holistic evaluation then might otherwise have been conducted using a single methodology.

Before the survey data collection instruments were disseminated for use, feedback from young advisors who piloted the survey was invaluable. This enabled adjustment to be made prior to administration to the whole pupil population which enhanced the survey's usability for a variety of people and age groups in terms of language, clarity and expedient completion. The use of a video/audio clip to engage pupil participants in the process of informed consent derived from the young advisor's feedback and was an informed addition to the recruitment process. What could not be tested was the usability of free text responses in the survey data analysis process. However, learning from the baseline survey data analysis allowed for a number of small changes to be made in the mid and endpoint survey structure in order to mitigate any problems highlighted at baseline.

As with any method of data collection there are strengths and limitations. The online survey method was useful in that it made participation possible for all pupils across multiple sites, but it was difficult to sustain the logistical organisation needed in schools to administer it to pupils and this affected the number of respondents at mid

and final project points. In contrast, where questionnaires were used to evaluate the CORC sessions as hard copies at the end of the sessions, this was more laborious from a data collection and analysis point of view but provided a very reliable data source. Relying on locality project staff to oversee data collection contributed to overall value for money of the commissioned research evaluation. Contracting the commissioned research team to manage and drive data collection processes in each school site would have likely improved participation rates, but would have been much less cost-effective for Cheshire East Council as commissioners. Overall, the use of a multi-methods approach allowed for comparison, corroboration and integration of emerging trends from the data that was collected to overcome the challenges highlighted and ensure that a balanced and reliable appraisal of the impact of the EHS project upon each intended outcome could be provided.

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Evaluating the impact of the Cheshire East Emotionally Health Schools Pilot Project

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Agenda Item 8

NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Children's Improvement Plan, Improvement Plan Progress Report, and Improvement Plan Scorecard
Date of meeting:	30th May 2017
Written by:	Nigel Moorhouse
Contact details:	Nigel.moorhouse@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Mark Palethorpe

Executive Summary

Is this report for:	Information ☒	Discussion ☒	Decision ☐
Why is the report being brought to the board?	To inform the board of the new Children's Improvement Plan for 2017-18, and allow the board to scrutinise the progress of Children's Social Care against the plan.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Starting and Developing Well ☒ Living and Working Well ☐ Ageing Well ☐ All of the above ☐		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☒ Accessibility ☐ Integration ☐ Quality ☒ Sustainability ☒ Safeguarding ☒ All of the above ☐		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The board to scrutinise progress against the plan.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The Council's Corporate Leadership Team Meeting The LSCB		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	Yes, the plan was developed in consultation with children and families, frontline practitioners, and LSCB partners. The progress report includes evidence from these key stakeholders to support our evidence of progress to date.
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	The Children's Improvement Plan aims to improve outcomes for our most vulnerable children and young people through improving the quality of our Children's Social Care services. By scrutinising progress against the plan, challenging Children's Social Care and holding them to account, Health and Wellbeing Board members are ensuring we continue to improve how we safeguard children and young people.

Putting Children and Young People **First**

Our Service Improvement Plan for Children's Social Care

Cheshire East Council

January 2017-2018

About our Plan

We want all our children and young people to be happy, healthy, and safe, and to be able to live a life that is full of fun and opportunities to learn and develop. Where possible, we want to support our children and young people to remain with their families within a loving, caring, safe and stable environment. When children are unable to remain in the care of the families, we want to ensure they receive a permanent loving home as soon as possible.

Children, young people, parents and carers have told us they want:

- **To be listened to**
- **To be included in their plans**, and **understand what the concerns are** and why they need a plan
- For **professionals to be clear with them** about what is going to, or could happen

This is our plan for how we in Children's Social Care Services, **will put the needs of our children and young people first and foremost in everything we do**, and deliver the very best service to all families that need our support.

Our service exists to support families at the times when they are most in need. The people who are best placed to tell us what they need, and how we can best offer support, are the families we work with, which is why involving children, young people, parents, carers and other family members is a large part of our plan.

Our plan focuses on the four key things we think **will make the most difference** to improving the lives of our children and young people. If we can consistently live, breathe and deliver these four priorities, the quality of our service and the outcomes for our children, young people and families will significantly improve:

1. We **always** put children and young people **first**
2. We understand **what impact** the situation is having on the child or young person
3. We **take action** to make positive change a reality
4. We work **with** families to achieve long lasting change. Children and young people get the **right service** for them, at the **right time**

In developing this plan, we have considered a range of sources that tell us how well our service is performing. This has included performance reports, audits on our work with families, the views of children, young people and families we work with, the views of our professionals, and the findings of the Ofsted safeguarding inspection which was carried out in July 2015. This plan addresses the areas we want to improve, but also recognises and builds on the strengths we have within our services.

We have a lot of strengths in Cheshire East; the most important of these is the passion, dedication, enthusiasm and creativity of our professionals. Therefore we will continue to invest in developing, supporting and empowering our workforce at every level in our new plan.

What we will do

This year we will be **changing how we deliver our services** to put the needs of our children and young people right at the heart of our service, and to support our families to develop long lasting, sustainable solutions. We will be adopting Signs of Safety as our new approach to working with families. This approach focuses on listening to the views of children and young people, and using these to show parents and carers what needs to change. It also focuses on working **with** parents and carers, and extended family members, recognising their strengths as a family, being very clear about what we want to achieve, why and by when, and supporting families to determine how they will make this happen.

This approach will:

- Put the needs of children and young people first
- Focus our work on the key issues for families
- Support us to build relationships with families and work together to achieve better outcomes for children and young people, so that families are involved in their plans and understand professional concerns and what safety looks like
- Recognise the strengths within families
- Support and empower families to create their own solutions
- Develop a shared language and understanding between families and professionals
- Deliver good outcomes for families that are sustainable in the long term.

We will also ensure our professionals have the **right support and tools in place** to enable them to conduct high quality work. This includes management support, training and development opportunities, effective caseload management, policies, procedures and practice guidance, tools for working with families, the child's record system and ICT support and equipment.

We will align our audit and quality assurance process with the Signs of Safety approach. Audits will be completed by team managers **with** social workers, recognising their strengths, and supporting them to reflect on the quality of their work and identify areas they can learn from and improve on in future work. Our model of supervision will also be changed to reflect the Signs of Safety approach and will include group supervision to develop strong team working, sharing good practice and learning.

We will be offering **'Master Classes' - specific in-depth training available to all social work staff** on a monthly basis. The topics of the Master Classes will change each month and these sessions will cover areas of practice that we know we need to improve. These sessions will be responsive to findings from our audits and to feedback from staff on the areas they would like to feel more confident about or would like more support with.

We will also be working closely with our partners to ensure we have a joined up approach to working with families. Partners will receive briefings on the Signs of Safety approach, and we are implementing a **campaign for change across the partnership** to develop a shared culture and ambition for children and young people in Cheshire East, and improve the quality, consistency and ownership of partnership work. This approach will focus on key practice areas to raise awareness of good practice and expectations, and provide professionals with the mandate and support to challenge instances of poor practice.

Making Change a Reality

We have already established successful ways of driving improvements to our practice, and we will continue to use these this year. This includes but is not limited to:

- **Listening to the views of children, young people and parents** as part of our audit process, feedback surveys, and through our compliments, complaints and comments process
- **Involving children and young people in service design** and development through the work of our partnership boards
- **A coaching approach in our audits**, supporting professionals to reflect on their practice
- Communicating the **key messages from our audits in a newsletter to all our professionals**
- **Practice Challenge sessions**, where performance is scrutinised down to individual practitioner level to ensure we are focused on achieving good outcomes for children and young people
- **Practice and Performance Workshop**s, where professionals are involved in developing our service and good practice is shared
- **Practice Champions**, who champion good practice within their teams, develop resources for professionals and troubleshoot and respond to issues raised by professionals.
- Actively seeking and developing our service in response to

feedback from our professionals through the **Annual Social Work Staff Survey**
- Our **IRO Practice Alerts**, which challenge poor practice, including partnership practice, and recognise good practice
- Our successful **Recruitment and Retention Strategy** and steering group which has supported us to build a stable workforce.

Progress against our plan will be reviewed and scrutinised by senior managers, including the Executive Director of People's Services and Deputy Chief Executive, Kath O'Dwyer, on a quarterly basis to make sure we are on track and we achieve what we have set out in this plan. The sources we will use to evaluate whether we have made a difference are outlined against each of our priorities.

Nigel Moorhouse
Director of Children's Social Care and Deputy Director of Children's Services, Cheshire East Council

We **always** put children and young people **first**

Ref	What we will do:	When will we see an impact?	Who's responsible:
1	We will introduce Signs of Safety as our approach to working **with** families to put the needs of their children and young people **first.** This approach is focused on capturing the voice of children and young people, and using their worries, hopes, and good things they appreciate within the family to motivate families to make changes to improve their lives. The approach involves developing a supportive culture of honesty and transparency, and shared reflective practice and continual learning. Our implementation of this approach will include a review of our processes to ensure they are centred around the needs of children and young people, support best practice, and make the most efficient use of professionals' time so they can maximise their time with families. We will embed this as our way of working through: • Complete commitment to the approach as our way of working from senior leaders, who will also be trained in the model • Involving families in the development of the approach, including co-developing communication materials for families on what the approach involves • Involving professionals in the development of the approach, including the production of good practice examples • Training all children's social care staff in the approach, including advanced training for Practice Leaders, our Team Managers, who will champion and support the approach within teams. Frontline partnership staff will also receive half day workshops on the approach so they understand their roles • Introducing supervision in line with the model, including reflective group supervision • Introducing direct work tools to capture the views, wishes and worries of children and young people in line with the model • Introducing a quality assurance framework and audit process that evaluates the impact on children and young people and supports reflective practice • Aligning our policies and procedures and practice guidance with Signs of Safety • Aligning the child's record system with Signs of Safety	September 2017	Lauren Conway, Project Manager

Ref	What we will do:	When will we see an impact?	Who's responsible:
2	We will develop bespoke management training for team managers to ensure they have the skills and knowledge they need to support, inspire and challenge their teams to always put children and young people first	March 2017	Jacquie Sims and Pete Lambert, Heads of Service
3	We will implement a new way of gaining feedback from children, young people, parents and carers on a routine basis across children's social care – to be coproduced with children, young people and parents and carers who are using our services. Findings will be shared with professionals through e-bulletins, team meetings and Practice and Performance Workshops.	September 2017	Lauren Conway, Project Manager
4	A Business Improvement review will be completed of the Child in Need and Child Protection Team in Crewe to identify areas for improvement in order to enhance the experience of families, improve our interactions with other services and partners, and improve service efficiency.	October 2017	Glynis Caulfield, Senior Business Improvement Analyst
5	All Independent Reviewing Officer (IRO) Child Protection Chairs will ensure that: • they understand the views of child or young person • all child protection plans have the child or young person at the centre • all child protection plans are SMART (specific, measurable, achievable, realistic and timely), and are focused on achieving positive change for the child or young person Child Protection IROs will develop strategies to better prepare children, young people and parents for initial and review conferences and increase their understanding of the child protection process prior to their first conference.	July 2017	Susanne Leece, Safeguarding Manager for Child Protection Independent Reviewing Officers
6	All cared for IROs will ensure that our cared for children and young people's views are needs are at the heart of all their reviews, and that the right children and young people have an Independent Visitor. This will be measured through: • An increase in the number of children and young people who chair their reviews • All children and young people participating in their reviews • An increase in the number of young people participating in the review of their pathway plans Cared for IROs will send a personalised response to all children and young people following their review which sets out their plan in terms of the issues that are important to them. Children and young people's views on how to improve the service will be sought through joint audits with young people of care and pathway plans.	April 2017	Anna Connelly, Safeguarding Manager for Cared for Independent Reviewing Officers

Ref	What we will do:	When will we see an impact?	Who's responsible:
7	The Care Leavers' service will establish close working relationships with the Care Leavers' Forum to ensure our services develop with young people at the core. We will publish our offer to Care Leavers to make our commitments to them clear.	December 2017 March 2017	Peter Lambert, Head of Service for Cared for Children and Anji Reynolds, Service Manager for Permanence and Through Care
8	Services to children with disabilities will be developed further, alongside early help and special educational needs services, to ensure the child is always at the centre of our provision.	April 2017	Peter Lambert, Head of Service for Cared for Children, Ian Donegani, Head of Service for Special Educational Needs and Disabilities, and Keith Martin, Service Manager for Children with Disabilities Team
9	We will facilitate the growth of the fostering service, via innovation and working in partnership with other local authorities, to ensure children can be matched with the best placements to support placement stability.	July 2017	Pete Lambert Head of Service for Cared for Children, and Gill Brookes, Service Manager for Fostering and Adoption
10	All teams will celebrate the importance of involving children and young people in decision making throughout November as part of November Children's Rights Month	November 2017	All Teams

How will we know if we've made a difference?

Measuring our performance	Thresholds		
	Requires Improvement	Good	Outstanding
Activity has improved outcomes for the child or young person (audit measure)	60-69%	70-79%	80-100%

Evaluating how well we did it	Is anyone better off?		
	Feedback from Children and Young People, Parents and Carers	Feedback from Staff	Feedback from Partners
Audit Reports show that children and young people's needs are understood and are the focus of the plan, and that timely action is taken to achieve the best outcome for children and young people	**Compliments, Comments and Complaints Report and feedback surveys from children, young people, parents and carers** show that families feel listened to by professionals, and received a service that helped them	**Annual Social Work Staff Survey, Practice Champions Group and feedback from the Practice and Performance Workshops** shows professionals live and breathe our values and are committed to putting children and young people first. Professionals report that they are supported by managers at all levels to put this into practice and can see the positive impact this has on outcomes for our children and young people.	Feedback from Partners from our **Multi-Agency audits, the LSCB Board, Quality and Outcomes Sub Group, and the Safeguarding Children Operational Group** shows that professionals live and breathe our values and are committed to putting children and young people first.

We understand **what impact** the situation is having on the child or young person

Ref	What we will do:	When will we see an impact?	Who's responsible:
11	We will deliver 'Master Classes' – specific in-depth training in response to our areas for improvement. These sessions will be delivered on a monthly basis and will be open to all children's social care staff. Master Classes are currently planned on the following topics: • Assessing Parental Capacity to Change • Exercising Professional Judgement • Parenting Assessments • Placement Planning • Leading and Chairing Effective Multi-Agency Meetings • Child Sexual Exploitation and Missing from Home and Care Future sessions will continue to respond to findings from audit and staff suggestions.	March 2017	Jacquie Sims, Head of Service for Child in Need and Child Protection
12	The assessment, plan and review document for work with cared for children will be aligned into one document to streamline work for practitioners, ensure the information in each documents informs each other, and that are all reviewed regularly at the young person's review meeting.	March 2017	Pete Lambert, Head of Service for Cared for Children
13	We will adopt Signs of Safety as our way of working, which will support a continual questioning approach to explore and understand the strengths and risks within families. The approach includes capturing the child or young person's thoughts, worries and wishes, and this underpins and drives all the work with the family. We will implement the use of genograms as a direct work tool with children, young people and parents to inform Signs of Safety planning and identifying a safety network of people to support the family	September 2017	Lauren Conway, Project Manager
14	We will produce good practice examples of assessments evidencing analysis and rationale for decisions to support professionals.	April 2017	Practice Champions

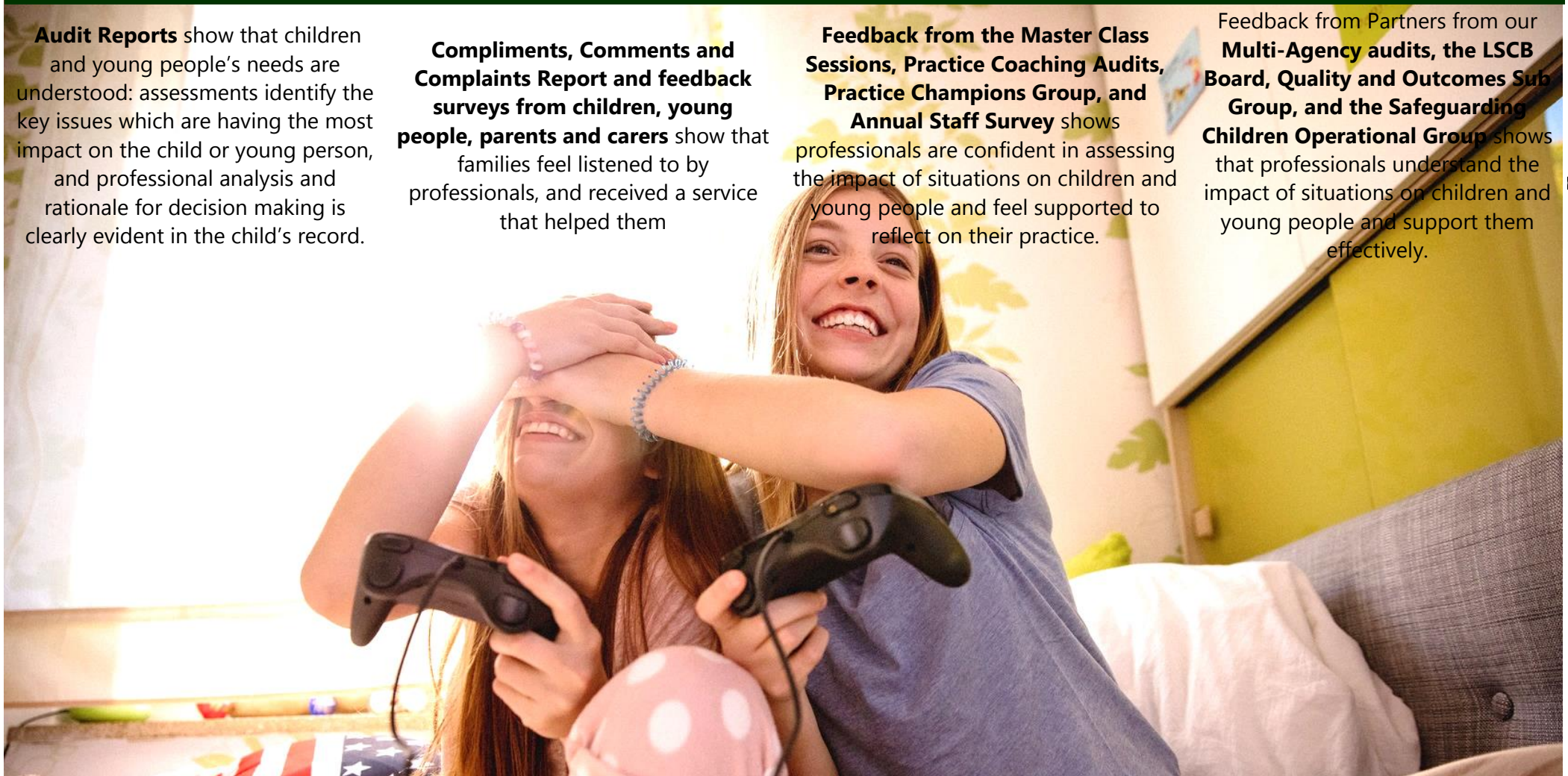
Ref	What we will do:	When will we see an impact?	Who's responsible:
15	The audit process will be redesigned to focus on the quality of the outcomes achieved for the child or young person to drive improvement and recognise and embed good practice.	April 2017	Kate Rose, Head of Service for Children's Safeguarding and Jacquie Sims, Head of Service for Child in Need and Child Protection
16	All Child Protection Independent Reviewing Officers (IROs) will ensure the daily lived experience of children and young people is clearly understood by everyone at Conference, that the plan addresses the key areas that need to change, and contains measurable outcomes for children and young people. Child Protection IROs will lead Pan Cheshire workshops on understanding the impact on children and young people to share and develop good practice. A peer review in April 2017 will provide external validation of our progress in this area.	April 2017	Susanne Leece, Safeguarding Manager for Cared for Independent Reviewing Officers
17	The IRO Service will lead a cross-departmental task and finish group to develop a clear RAG (red, amber, green) rating tool to evaluate the quality of assessments. This will allow good practice to be recognised, and will increase awareness of good practice and drive up standards. It will support comprehensive information gathering and evidence based risk and needs analysis, alongside evidence of the child/ young person, and parent, carers and family participation in the assessment.	March 2017	Anna Connelly, Safeguarding Manager for Cared for Independent Reviewing Officers
18	All Cared for IROs will ensure that their recommendations from reviews are clearly linked to how this will positively impact on the child or young person. Biannual audits will be completed to support strong practice in this area.	February 2017	Anna Connelly, Safeguarding Manager for Cared for Independent Reviewing Officers
19	We will hold a Teaching Partnership annual conference for children's care professionals with key note speakers which celebrates social work practice and raises the profile of making professional judgements as social workers	December 2017	Sarah Flint, Practice Development Manager
20	We will revise and relaunch our strategy to tackle neglect, which will include: • completing a training needs analysis on neglect to ensure training can be tailored to meet partnership needs • adopting the updated and improved version of the graded care profile - graded care profile 2 • working with young people to better understand neglect from their perspective	June 2017	Nigel Moorhouse, Director of Children's Social Care and Deputy Director of Children's Services

Ref	What we will do:	When will we see an impact?	Who's responsible:
	• promoting the 'Act on Neglect' Campaign across the partnership, and raising awareness with multi-agency professionals that all professionals can use, and are expected to use, the graded care profile in neglect cases to assess and evaluate the impact of neglect on the child or young person • developing good practice examples • revising the neglect scorecard to incorporate more targets on which to measure success		
21	We will introduce 'Lessons Learned' meetings between children's social care and legal services to review key cases where the outcome we expected in court was not achieved to identify learning and any areas for improvement	June 2017	Jacquie Sims, Head of Service for Child in Need and Child Protection
22	We will develop and implement standardised tools that will support IRO scrutiny of the quality of consultation with children, young people, parents and carers when managing risk plans at trigger Level 1 and Level 2 missing from home and care meetings	February 2017	Anna Connelly, Safeguarding Manager for Cared for Independent Reviewing Officers

How will we know if we've made a difference?

Measuring our performance	Thresholds		
	Requires Improvement	Good	Outstanding
Social worker identified and challenged safeguarding concerns (audit measure)	60-69%	70-79%	80-100%
Percentage of good or better quality combined assessments (audit measure)			
Percentage of good or better quality assessments for cared for children (audit measure)			

Evaluating how well we did it	Is anyone better off?		
	Feedback from Children and Young People, Parents and Carers	Feedback from Staff	Feedback from Partners
Audit Reports show that children and young people's needs are understood: assessments identify the key issues which are having the most impact on the child or young person, and professional analysis and rationale for decision making is clearly evident in the child's record.	**Compliments, Comments and Complaints Report and feedback surveys from children, young people, parents and carers** show that families feel listened to by professionals, and received a service that helped them	**Feedback from the Master Class Sessions, Practice Coaching Audits, Practice Champions Group, and Annual Staff Survey** shows professionals are confident in assessing the impact of situations on children and young people and feel supported to reflect on their practice.	Feedback from Partners from our **Multi-Agency audits, the LSCB Board, Quality and Outcomes Sub Group, and the Safeguarding Children Operational Group** shows that professionals understand the impact of situations on children and young people and support them effectively.



We **take action** to make positive change a reality

Ref	What we will do:	When will we see an impact?	Who's responsible:
23	We will undertake a review of the front door to early help services, and map the pathways from referral to allocation to ensure families receive a timely service	February 2017	Tracy Ryan, Director of Prevention and Support, Lindsay Thompson, Service Manager for Family Focus and Jacquie Sims, Head of Service for Child in Need and Child Protection
24	We will complete a deep dive investigation on children seen within 10 days of the assessment to understand and address the areas for improvement	February 2017	Jacquie Sims, Head of Service for Child in Need and Child Protection
25	A core aspect of the Signs of Safety approach is identifying the timescale for when change should be achieved for every plan, which makes plans more timely. The risk for the child or young person is evaluated at every planning meeting which requires that all professionals reflect on the progress achieved so far.	September 2017	Lauren Conway, Project Manager
26	Child Protection Independent Reviewing Officers (IROs) will support timely action for children and young people through ensuring all child protection plans are SMART (specific, measurable, achievable, realistic and timely) and contain strong contingency plans. IROs will robustly challenge any incidences of drift and delay.	February 2017	Susanne Leece, Safeguarding Manager for Child Protection Independent Reviewing Officers
27	Cared for IROs will continue to actively track the progress of children's care plans, particularly when they are in care proceedings, and will appropriately escalate any cases that are not progressing within the child's timescale. Biannual audits will assess progress and support learning within this area.	February 2017	Anna Connelly Safeguarding Manager for Cared for Independent Reviewing Officers
28	The IRO Service will produce quarterly data reports on Practice Alerts, the formal dispute resolution process, and Partnership Alerts. These reports to be presented at Service Managers' meetings for discussion, reflection and agreeing action in response to any areas for improvement. Themes from the annual report will be shared with all children's social care professionals at the Practice and Performance workshops.	May 2017	Anna Connelly and Susanne Leece, Safeguarding Managers

Ref	What we will do:	When will we see an impact?	Who's responsible:
29	We will develop a robust system to ensure there is effective management oversight, at all levels across the service, of children and young people where improved outcomes are not being achieved within the child or young person's timescale. We will review Performance Challenge Sessions to ensure they focus on the quality of our services, and the impact on children and young people, and that they drive improved outcomes to high risk children and young people.	May 2017	Jacquie Sims and Pete Lambert, Heads of Service
30	Drift and delay for children and young people will be challenged within audits, and timely practice will be recognised and celebrated to drive improved outcomes for children and young people	March 2017	Auditors and Team Managers
31	We will update the policy and procedure for private fostering arrangements to ensure the process and expectations on timescales are clear	June 2017	Jacquie Sims, Head of Service for Child in Need and Child Protection
32	The process within the child's record system for private fostering will be streamlined to ensure the system supports efficient and timely practice	April 2017	Jacquie Sims, Head of Service for Child in Need and Child Protection
33	We will hold a workshop on improving our processes around Public Law Proceedings to make our action more timely for children and young people, and establish an action plan, which will be delivered by task and finish groups.	May 2017	Jacquie Sims, Head of Service for Child in Need and Child Protection
34	We will develop performance reports and a tracker for court work to support monitoring of timeliness for pre-proceedings and Legal Advice Meetings which will be scrutinised at monthly legal liaison meetings. Cared for IROs will actively track the progress of children where there is a court timetable and escalate where there is delay. Use of the Permanence Tracker will continue to support the timeliness of placement planning.	May 2017	Jacquie Sims, Head of Service for CIN&CP and Anna Connelly, Cared for IRO Manager, Pete Lambert, Head of Service for Cared for Children
35	We will ensure that all social workers receive regular, good quality supervision which supports reflection and learning so we can effectively support our children and young people. We will do this through tracking the frequency of supervisions and monitoring and challenging this in Performance Challenge Sessions, and completing a six monthly deep dive audit on the quality of supervision to identify and address any areas for improvement.	February 2017	Jacquie Sims and Pete Lambert, Heads of Service
36	We will embed good quality Pathway Plans to ensure best outcomes for care leavers. This will be achieved via team audits and team learning events.	April 2017	Pete Lambert, Head of Service for Cared for Children

How will we know if we've made a difference?

Measuring our performance	Thresholds		
	Requires Improvement	Good	Outstanding
No drift or delay in actions being completed (audit measure)	60-69%	70-79%	80-100%

Evaluating how well we did it	Is anyone better off?		
	Feedback from Children and Young People, Parents and Carers	Feedback from Staff	Feedback from Partners
Audit Reports show that timely action is taken to achieve the best outcome for children and young people **Supervision Audit Report** shows that staff receive regular supervision and good quality support which supports improved outcomes for children	**Compliments, Comments and Complaints Report and feedback surveys from children, young people, parents and carers** show that families received a responsive and timely service that helped them	**Feedback from the Annual Staff Survey and Practice Coaching Audits** shows that professionals feel supported and challenged to take timely action for children and young people	Feedback from Partners from our **Multi-Agency audits, the LSCB Board, Quality and Outcomes Sub Group, and the Safeguarding Children Operational Group** shows that professionals are responsive to children's needs, taking action in a timely way

We work **with** families to achieve long lasting change. Children and young people get the **right service** at the **right time**

Ref	What we will do:	When will we see an impact?	Who's responsible:
37	We will develop and implement a work plan for the LSCB Early Help Sub Group to drive developments across the partnership and ensure we support families at the earliest possible stage	March 2017	Tracy Ryan, Director of Prevention and Support
38	We will carry out a deep dive analysis of Child in Need cases to ensure they are at the right level of need	May 2017	Jacquie Sims, Head of Service for Child in Need and Child Protection
39	We will review the role of the Family Support Service to ensure they are working at the right level of need, and review the timeliness of step up to social care	June 2017	Jacquie Sims and Jonathan Potter, Heads of Service
40	We will review and revise the step down process, ensuring that step down requires that strong contingency plans are in place	June 2017	Jacquie Sims and Jonathan Potter, Heads of Service
41	We will launch 'Project Macc' as part of our demand management strategy. Project Macc will mirror our successful Project Crewe service, working intensively with low level children in need cases to achieve sustainable change for families.	August 2017	Jacquie Sims, Head of Service for Child in Need and Child Protection
42	We will complete an early help needs analysis for Cheshire East	March 2017	Jonathan Potter, Head of Service for Prevention
43	We will map the full range of early help services and undertake a demand-led review of future provision requirements	July 2017	Tracy Ryan, Director of Prevention and Support and Jonathan Potter, Head of Service for Prevention
44	We will develop a demand management strategy for Children's Social Care services	March 2017	Jacquie Sims, Head of Service for Child in Need and Child Protection

Ref	What we will do:	When will we see an impact?	Who's responsible:
45	The Signs of Safety approach will focus on identifying the key risks ('danger statements') which parents need to address to keep their children safe. The work in the plan will be focused around addresses these issues. Signs of Safety focuses on parents and carers identifying and demonstrating change, including a safety network of people that will monitor and support the family once services are no longer involved, which supports sustainable change.	September 2017	Lauren Conway, Project Manager
46	Regular CAF (Common Assessment Framework) audits will be instated and reported to the Local Safeguarding Child Board (LSCB) to identify areas for partnership improvement.	March 2017	Lindsay Thompson, Service Manager for Family Focus
47	We will improve reporting around step down and CAF take up in order to drive effective challenge within the LSCB on partnership working, and establish an Early Help Performance Management Framework.	June 2017	Tracy Ryan, Director of Prevention and Support, and Lindsay Thompson, Service Manager for Family Focus
48	We will re-establish the CAF team, CAF training, and relaunch this with partners.	July 2017	Tracy Ryan, Director of Prevention and Support, and Lindsay Thompson, Service Manager for Family Focus
49	We will agree as a partnership how the Signs of Safety framework will be applied to our thresholds, and review, revise and relaunch the thresholds of need	August 2017	LSCB Early Help Sub Group
50	Child Protection Independent Reviewing Officers (IROs) will ensure that parental motivation and capacity to change is a central consideration in all Child Protection Conferences and planning, and positive change for the child or young person, and that the family can sustain this, is clearly evidenced where cases are stepped down. IROs will track and provide additional scrutiny for children and young people who are on a second or subsequent plan through: • Audits to identify learning points • Effective gatekeeping at the point of conference request • Robust contingency planning	March 2017	Susanne Leece, Safeguarding Manager for Child Protection Independent Reviewing Officers

Ref	What we will do:	When will we see an impact?	Who's responsible:
	• Appropriate escalation IROs will ensure that there are clear contingency plans in place when cases are stepped down from child protection to ensure that the right action is taken immediately if outcomes for the child or young person start to deteriorate.		
51	Cared for IROs will track the effectiveness of services provided to our cared for children and young people to promote achieving the very best outcomes for them	April 2017	Anna Connelly, Safeguarding Manager for Cared for Independent Reviewing Officers
52	We will ensure that the move into the Regional Adoption Agency realises best outcomes for our children in care by effective and prompt planning for adoption including best practice for concurrency planning and foster to adopt.	April 2017	Pete Lambert, Head of Service for Cared for Children

How will we know if we've made a difference?

Measuring our performance	Thresholds		
	Requires Improvement	Good	Outstanding
The social worker took the right action at the right time to protect the child or young person and their siblings (audit measure)	60-69%	70-79%	80-100%

Evaluating how well we did it	Is anyone better off?		
	Feedback from Children and Young People, Parents and Carers	Feedback from Staff	Feedback from Partners
Audit Reports show that children and young people's needs are met at the right level at the right time, and that step up and step down to services is robust	**Feedback surveys from children, young people, parents and carers** show that families received a service that helped them and they feel they can sustain the outcomes they have achieved in the long term	**Annual Social Work Staff Survey and feedback from the Practice Champions Group** shows professionals report that step up and step down is robust and there is a joint understanding and application of thresholds across the partnership	Feedback from Partners from our **Multi-Agency audits, the LSCB Board, Quality and Outcomes Sub Group, and the Safeguarding Children Operational Group** shows that step up and step down arrangements are robust and there is a joint understanding and application of thresholds across the partnership

Your thoughts matter

If you have any thoughts or views on this plan, or how well we are progressing, please do contact us at **ChildrensImprovement@cheshireeast.gov.uk**

Cheshire East Council

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Improvement Plan Monitoring Quarter 3

Progress Report

Overview

This report reviews our activity and progress to date against our Service Improvement Plan for Children's Social Care.

Our priorities are:

1. We **always** put children and young people **first**
2. We understand **what impact** the situation is having on the child or young person
3. We **take action** to make positive change a reality
4. We work **with** families to achieve **long lasting** change. Children and young people get the **right service** for them, at the **right time**

This report details:

- Our achievements
- Key areas for improvement
- Improvements to services
- Quality of our services
- Planned future improvements

Executive Summary

There has been an **increase in good quality practice** taking place with families. Children and young people receive the right service for their needs and are experiencing **improved outcomes** as a result of intervention.

Children, young people and parents are positive about their relationships with their workers. Children and young people's views and wishes are sought, and reflected in multi-agency meetings, assessments and plans. Families are involved in planning, and understand why they have a plan.

Considerable service improvement activity has taken place to support professionals to deliver best practice, improve multi-agency working, increase scrutiny, ensure services are child-focused, and ultimately to improve outcomes for children.

We know ourselves well, and detailed knowledge of the quality of our services and areas for improvement is supporting senior managers to effectively drive improvements. Service improvements have resulted in better quality services and improved decision making which has been confirmed through repeat audit. Significant improvements have been achieved.

Although the quality of practice continues to improve, the majority of practice requires improvement, and is not yet at the quality and consistency we want for our children and

young people. Long-lasting change is not always achieved within children's timescales, and will still have more to do to ensure our work is truly child-focused.

Large scale changes are planned to drive further improvements, including the adoption of Signs of Safety as our way of working with families. This will support our practice and our organisation to be child-focused, solution-orientated, and respectful and inclusive of families.

Achievements

Significant Improvements Achieved

- There has been an **increase in good quality practice** taking place with families. Overall judgements show **an increase in the percentage of cases considered to be good and outstanding** (42% cases), along with a 17% decrease in those cases judged to be inadequate or requiring improvement. This continues to build on the increase in good practice achieved in Q2 and shows a positive trajectory in improvements to practice.
- The Making Children Safer Conference model has been shown to support **more evidenced decision making and SMARTer Child Protection Plans.** Initial evidence suggests that this model is having a positive impact on the effectiveness of plans and is reducing the number of children and young people subject to repeat plans. Through using this model, **Child Protection IRO's, Social Workers and partners are becoming more skilled at developing effective Child Protection plans and measuring their impact on children and young people.** This demonstrates the impact that Signs of Safety practice has made to children and young people and indicates the further scope for improvements to the quality of our practice once we adopt this approach across all of our practice.
- **Children on a child protection plan for a second or subsequent time** (within 2 years) **is showing a reduction over the last quarter,** which suggests that we may now be seeing the benefit of improved planning over the last two years, resulting in more sustainable changes achieved for families.
- **Improvements made to services in response to previous themed audits has resulted in better quality services and improved decision making:**
  - Awareness raising and communication with teams and partners following a previous audit which showed inappropriate use of the category for emotional abuse has resulted in a **decrease of 10% of plans in this category.** There will be a further audit in 2017 to assess progress in this area and the appropriate use of categories.
  - **Work around strategy discussions has significantly improved. Decisions to proceed to a Strategy Discussion are more considered**. There has been a decrease in follow up strategy meetings and an increase in the proportion of cases progressing to a section 47 enquiry. The percentage of section 47s that led to an initial child protection conference has increased from 45% in Q2 to 60% in Q3. **Multi-agency involvement in Strategy Discussions has also significantly improved**; 55% of cases in September/October 2016 involved participants from at least one other agency apart from the Police, whereas in January 2016 this was true in only 12.5% of cases. This is following the considerable awareness raising work completed in response to the areas for improvement from the

IRO strategy discussion audit in January 2016. The quality of S47s and strategy discussions has improved with 63% of these being judged to be good quality

- **Performance on requests for initial health assessments within 48 hours of a child coming into care has significantly improved** from 65% in Q2 to 87% in Q3. This is from a low of 4% in Q3 last year, and is a result of significant improvement activity in this area.
- **Children receive the right service to meet their needs.** Step up and step down was appropriate for the vast majority of case (91%), and the need for a section 47 investigation was identified in all relevant cases.
- The average number of days for 2016/17 **between entering care and moving in with an adoptive family has reduced from 936 in Quarter 1 to 556 days to date** (March 2017) – a 41% reduction. The average number of days **between a placement order and match with an adoptive family has also decreased** to 66 days from 70 in Q2 and Q3. This is against a national target of 121 days so is very good performance.
- **All cases met the practice standard for the quality of case recording** in the Q3 audit, which is a significant achievement
- **Plans for cared for children are SMART (80%),** the Q3 audit demonstrated further improvement in this area.
- The percentage of **children on a plan for neglect with a completed graded care profile has increased significantly** from 43% in November 2016 to 60% in January 2017.
- **Submission of GP reports to Child Protection Conferences has significantly improved**, from 54% in Q2 to 83% for Q3 for initial conferences. This is from a low of 35% in Q4 2015/16. Reports to reviews have also improved up to 64% in Q3 from 51% in Q2, from a low of 7% in Q2 2015/16. The Named GP is driving improvements in this area with real passion and dedication which is resulting in significant improvements.
- **There were 6 good practice notifications raised to recognise good practice this quarter.**
- There has there has been a **significant improvement in senior management oversight of children at risk of drift and delay** leading to improvements in planning to ensure that children are safe and achieve permanency within timescales that meet their needs.

Other Achievements

- To date (March 2017) for 2016-17 **25 children have achieved permanence through adoption.**
- **Our Social Work workforce has stabilised and turnover has continued to reduce.** We have seen an increase in enquiries and applications as well as in the appointments of experienced workers, including the permanent appointment of two experienced Child Protection Managers to the Child in Need and Child Protection Team in Crewe. Crewe is now fully staffed with all permanent Team Managers.
- **Cheshire East's Social Worker Recruitment Strategy 'Where Social Work Works' received a high commendation in the Children & Young People Now Awards in November 2016.**

- Cheshire East has received **positive feedback from accommodation providers and education establishments on our care plans for unaccompanied asylum seeking children**. Prior to Christmas, Cheshire East accommodated two 17 year old girls under the Lord Dubs amendment. The girls have settled very well and are making good progress.

Key Areas for Improvement

- Although the quality of practice continues to improve, **the majority of practice still requires improvement** (51%), and is not yet at the quality and consistency we want for our children and young people
- **Too many children and young people experience drift and delay**. Some drift and delay was evident in the majority of cases (69%). Permanency needs to be a key consideration in planning from a much earlier stage, and professionals need to be clear when a lack of progress in neglect cases should result in escalation. Some children and young people experience delays around good quality assessments first time informing Legal Advice Meetings (LAM) and pre-proceedings.
- **We still have more to do to ensure our work is truly child-focused,** and the lived experience of children and young people is at the heart of all our work
- **The quality of assessments requires improvement –** assessments can be lacking in depth and analysis, and can be too descriptive, and do not always consider the parents' motivation and capacity to change. **Assessments and plans do not always evaluate or address all the known risks** within families, such as disguised compliance, which limits their ability to support sustainable change
- **Plans still need to be SMARTer, and all plans need to include clear contingencies. Child protection plans are not always categorised correctly,** which limits the effectiveness of the plan
- **The progress of plans is not always evaluated by the impact on the child.** In some cases professionals showed **over-optimism of parents' abilities** to create and sustain long-lasting change for their children
- There is further work to do to ensure that **all partners know what good looks like, take responsibility for outcomes for children,** and provide **effective and robust partnership challenge**
- **Use of the Graded Care Profile** to inform assessment and evaluation of progress in neglect cases remains an area for improvement for the partnership – although recent performance for January 2017 shows this has increased.
- **Multi-agency involvement in strategy discussions** has improved from previous performance but still requires further improvement
- The percentage of **initial health assessments (IHAs) completed by paediatricians** within 20 days has been at an unacceptable level for some time and continues to be so (Q3, 36%). A root cause analysis has been undertaken by both CCGs and will be reported to the LSCB Quality and Outcomes Sub Group for partnership scrutiny. There will be dedicated IHA clinics in South CCG from March 2017 (these already exist in the Eastern CCG.) A thorough analysis of all late compliance will be made by Designated Professionals in Q4. It is of note

that a number of requests were made out of area in Q3 which did affect compliance as did some delays related to arrangements for unaccompanied asylum seeking children (UASC).

Improvements to Services

Training to support best practice

- **Masterclasses continue to be offered on a monthly basis**, these have been well attended so far. Masterclass workshops have been held on:
  - **Assessing Parental Capacity to Change**
  - **Exercising Professional Judgement**
  - **Parenting Assessments**
- **Social Workers' confidence and skills in chairing multi agency meetings are being developed** through the 'Masterclass' offer, with the latest sessions in February and March 2017 focusing on chairing multi-agency meetings effectively, which responds to findings from the audit of core group effectiveness. **Further sessions are planned on:**
  - **Engaging with birth fathers**
  - **Permanency Planning**
  - **Children with SEND**
- **A workshop on Reflective Practice for Managers will take place in March 2017** which includes reflective supervision and developing reflective teams.
- **We have adopted the Graded Care Profile 2,** a much improved version of the graded care profile which is used to assess and evaluate the extent and impact of neglect. Initial feedback on the tool has been very positive. Training is currently being rolled out across the partnership, targeted to specific groups of practitioners in areas where there are high referrals for neglect. Since adoption in November 2016 we have trained 180 practitioners.
- **The Cared for IROs held a development day in December 2016** which was focused on engagement and direct consultation with children and young people, including young children.
- **A leadership and management session was held with Children's Social Care Managers** in February 2017 to support the development of connected leadership delivering to the service and Council priorities.
- **Two joint training workshops with Childrens' and Adults' social workers** will be held in March 2017 as part of celebrating World Social Work Day. These workshops will establish shared values for both services, celebrate social work practice, and support the development of good working relationships and increased integration. One session is a dedicated workshop for ASYEs.

Tools to support practitioners

- A **revised care plan document** was introduced in February 2017. This new combined document supports social workers to improve the quality and timeliness of assessments, review reports and care plans as these are all now streamlined together in one form.

- A **new pathway plan** went live in January 2017 which was developed with Social Finance.
- The LSCB will launch **assessment tools for the toxic trio** in March 2017 which will support practitioners to reflect on the lived experience of children at risk from the toxic trio, including adult focused workers. This was identified as a gap in previous LSCB audits.
- The Children with Disabilities Team has developed **guidance for social workers on the completion of the social care element of Education, Health and Care Plans** and raised awareness of responsibilities within Practice and Performance workshops. This includes specific guidance for cared for children and this is now being used across the Children with Disabilities and other social work teams
- **Good practice examples** are being collated from Cheshire East practice, including examples of effective assessments that evidence good quality analysis. These will be available on Centranet to support practitioners from April 2017.
- A new policy and procedure has been developed on **'Preparing for Adulthood'** for young people with Special Educational Needs and Disabilities. This policy and procedure outlines the statutory duties placed upon the Local Authority and informs staff across the People's Directorate of their specific responsibilities towards young people aged 14-25, including a detailed reference section for tasks required for children of certain ages, and is **designed to promote the earlier development of transition planning**. The following principles are central to the policy: planning early, involving the young person and having a person-centred strengths-based approach.

Supporting effective partnership working

- **'Time to Share' workshops** are established, theme-led, discussion forums facilitated by multi-agency practitioners, who work with Cared for Children and Care Leavers. Based on a solution-focused model, the forums provide multi-agency practitioners with an opportunity to share good practice and practice issues, and discuss solutions. Some of the previous themes considered by the group include: out of area placements; resilience; relationships; our services for disabled young people; diverting our young people from offending; the cost of not being cared for; and young people with no recourse to public funds.

  This forum has brought together different agencies to share good practice, such as the Children's Society, the @ct team, residential workers, fostering, therapeutic team, social workers, family support workers, housing, disability and SEN workers. This has contributed to the use of common tools to reduce criminalisation and a multi-systemic view to working with Cared For children and Care Leavers.

  The group has also identified gaps in our services; a theme focussed on unaccompanied asylum seeking young people and other cared for/care leavers with no recourse to public funds identified the need for a Corporate Parenting Strategy in meeting the needs of the above. It also brought together the housing sector alongside the other professionals in finding a solution to these issues.

  ASYE's and newly qualified social workers have used this forum for personal development.

  The Final quarter of 2017 will see peer evaluation utilised to measure the impact of Time to Share on outcomes for cared for children and care leavers.

- **Child Protection IROs have completed training with school nurses to develop their ability and confidence to challenge,** particularly in cases where the child does not have any significant health issues and school nurses have previously felt that they have not had an active role in the plan.
- **Single agency reports to review child protection conferences were introduced in February 2017** in response to an IRO audit that highlighted issues in quality and multi-agency contribution to combined reports. A new report template has been developed which will be used for both initial and review conferences. The template has been developed in consultation with operational managers from across the partnership and it also complements the Cheshire East Making Children Safer conference model and Signs of Safety. **The quality of police reports to conference has improved significantly following challenge.**
- A process to support **good practice notifications to partners** has been developed, allowing alerts to be issued from January 2017. This will support good practice development across the partnership.
- There is ongoing activity to improve the **inclusion of multi-agency practitioners within strategy discussions** and this is supported by a work stream of the Safeguarding Children Operational Group. A Task and Finish Group has been established where they have considered the current process and obstacles in achieving multi-agency meetings. An action plan has been developed to address this including a new process for referrals to partners when a strategy meeting is called.
- **In response to the findings from the IRO audit on Core Group Effectiveness**, the LSCB Safeguarding Children Operational Group has established a task and finish group to:
  - **agree the shared roles, responsibilities and expectations of Core Group members**
  - **develop a standard agenda for Core Group meetings to provide a clear structure**
  - **develop a standard minute template to enable effective sharing of the minute taking role**

  This work is currently underway. A deep dive enquiry on core group effectiveness was undertaken by the LSCB Quality and Outcomes Sub Group in February 2017 to drive improvement in this area which revealed a skill gap for practitioners in relation to chairing children's meetings. Plans are in place to meet this need through inclusion of these aspects within the current LSCB multi-agency training on child protection. The roles and responsibilities for Core Group members will be incorporated within LSCB training to embed this.
- **The LSCB Quality and Outcomes Sub Group will be undertaking deep dive investigations into partnership practice to drive service improvements**. The first of these was on core group effectiveness. The next area of focus will be neglect in May 2017, which will include the use of the screening tool and the Graded Care Profile. Single agency reports for CP conferences were introduced in February 2017 and a summary report on progress of implementation will also be submitted at the next meeting of the group in May.
- The LSCB Partnership newsletters, **Changing Practice Together,** continue to focus on key areas of practice for the partnership to communicate shared expectations on good practice. A practitioner feedback survey was carried out in December 2016 - January 2017 which has informed changes to the newsletter. The newsletter focused on listening to children and young people in November, using the right tools – for example the graded care profile,

throughout December, assessment and analysis in January, and Domestic Abuse in February and March. The themes for this newsletter going forward have been agreed to align with the LSCB priority areas and focus of the multi-agency audits, and will be Neglect for Q1, Signs of Safety and a shared culture and language in Q2, and early help and robust step up and step down in Q3.

Child-centred processes

- **A review of our processes around Public Law Proceedings is underway** to support good quality court work that achieves positive outcomes for children, and ensures decisions are made within children's timescales. An action plan has been established and is being delivered by task and finish groups. Work is expected to be completed by May 2017. **We have already received an increase in compliments with regards to our court work from court, CAFCASS and legal services.**

> "I do believe that the successful reunification of A was mainly due to the allocated social worker, who I believe worked tirelessly with the couple. The support plan prepared was highly detailed and provided for the family to have continued professional support in order to maintain the placement was in A's best interest"

Part of this work will involve the introduction of 'Lessons Learned' meetings between children's social care and legal services. These meetings will review key cases where the outcome we expected in court was not achieved, as well as identify learning and any areas for improvement.

In addition, the court tracker has been updated and now includes dashboard information that is able to track workload across the teams, timeliness and outcomes for children subject to the PLO process. Through close cooperation with the legal department, **timely notifications and sharing of court documents and orders has now much improved.**

- **Our offer to Care Leavers has been refreshed and is set out in the Care Leavers' Policy.**

Robust scrutiny and drive for improvement

- **Increased scrutiny has been put in place to drive improved outcomes for children who are at risk of drift and delay**. All children who have been on Child Protection Plans for over 12 months, are subject to repeat CP planning, or have been involved in the pre-proceedings process for over 6 months are reviewed by a Service Manager or Head of Service on a monthly basis. The expectation is that the number of children within these categories will reduce significantly over the next three months as a result of this increased focus. More robust systems for identifying children and young people at risk of drift and delay will be developed to support early identification and action.

As a result of this increased management oversight, **a number of children who were not achieving positive outcomes in a timely way now have clear plans in place with appropriate timescales**. This has caused an increase in applications to Court and, although

this is anticipated to continue for the next three months, numbers should then reduce to expected levels.

- **All children with two or more placements are now tracked and monitored at the Permanence Tracking Panel** to ensure we achieve permanency and placement stability for these children. A placement stability working group has also been established with Head of Service oversight to review the issue and identify solutions.
- **Children Causing Concern** is a relatively new panel whose purpose is to track children and young people who have 3 or more placement moves, low school attendance or are young offenders. The aim being that by identifying some of the children who may not have complex or high costs but are meeting some of the indicators that we know are likely to lead to poor outcomes – such as low educational attainment and becoming NEET – that we can better understand some of the contributors to these issues and find ways to address them.
- A **draft new Children's Social Care Audit Tool** has been approved by Heads of Service across Children's Social Care in anticipation of the introduction of the Signs of Safety model. The audit tool is intended to be used for all audit streams, in particular those undertaken by Team Managers and for Social Care Practice Audits. It will continue the emphasis of change away from quantifying compliance to judging the quality of our interventions and our impact on children and young people. It is currently being piloted and will be refined following feedback.
- **Independent Auditors are continuing to work with Team Managers to support a coaching approach and ensure Team Management audits are fully embedded**.
- The **LSCB Multi-agency Audit Process** has also been reviewed. There will be three LSCB multi-agency audits each year based on agreed themes, with a 12 month follow up to evaluate progress. The next themed audit is to be on Neglect in preparation for the possible JTAI and to support the launch of the Neglect Strategy 2017-19. Subsequent LSCB multi-agency audits will be:
  - June 2017 – Child Protection Conferences
  - October 2017 – Effectiveness of the Integrated Front Door, including Early Help
  - February 2018 – Neglect
- **The CAF partnership audit process has been redesigned** using Norfolk's Signs of Safety audit process. This was considered by the LSCB Early Help Group in February 2017 and audits will take place in March/April 2017. As this becomes embedded the audit streams will be brought together to provide evidence of the quality of practice irrespective of where in the system the child receives a service.
- A **deep dive investigation on children seen within 10 days of the assessment** has been completed to understand and address areas for improvement. It showed that the timeliness of children seen was 77-79%. A more accurate performance report has now been developed and this information will be included in Performance Challenge so this figure can be further improved.
- **Performance Challenge Sessions have been reviewed** and there are plans for the Child in Need and Child Protection Teams and the Safeguarding Unit to have joint sessions that will enable a focus on the progress of individual children and families.

- A **Supervision Tracker** is now in place to monitor the frequency of social workers' supervisions, which can be challenged through the Performance Challenge Sessions. Supervision audits are being completed on a quarterly basis to monitor and inform improvements to the quality of supervision
- **Our offer to care leavers beyond 21 years is now supported on Liquid Logic**. The Business Intelligence Team are currently producing reports against this offer so we can monitor and evidence our provision.

Co-producing services with children and young people

- **Ignition** is an innovative project that has been established to support young people to have the best, most appropriate transition for when they leave care. It is available to young people aged over 15½ years who are thinking about where and how they would like to live when they leave care. Once a referral is made the details are passed to Voice for Children or Crewe YMCA who each have identified people who will meet with the young person to discuss their aspirations. A panel discussion will take place incorporating these views, which the young person is welcome to attend, and an action plan is developed, that will help the young person to achieve their future living goals.
- **New in 2017, there is a pre-arranged Children's Society 'drop in' at Cledford House to speak to staff about cared for children's views raised within the Children in Care Council.** The Team Manager for the Care Leavers' Service has now attended the Care Leavers Forum twice in the past six months to obtain their views on services. Over 2017 a survey will be undertaken to obtain feedback from all care leavers we are working with.
- A **shadow Young People's Committee** for the Corporate Parenting Committee has been established to increase the participation of cared for children and care leavers in developing services and the operation of the Committee. Both the Corporate Parenting Committee Chair and Vice Chair attended the first shadow committee meeting in January 2017.
- **Work has been completed with young people to better understand neglect from their perspective,** and their views have shaped the development of the neglect communication campaign.
- **Standardised tools that will support IRO scrutiny of the quality of consultation with children, young people, parents and carers** when managing risk plans at trigger Level 1 and Level 2 missing from home and care meetings have been developed and are currently under consultation with a group of young people.

Strategic developments

- **Our regional foster carer recruitment campaign called 'You Can Foster' launched in September 2016.** The theme of the campaign was 'Ambition' focussing on the important role foster carers play in supporting children and young people and helping them to realise their dreams. The campaign has featured on regional TV and radio as well as online via social media channels such as Facebook. Cheshire East also launched a new 'Net Natives' campaign in October 2016, which generated new enquires. Work is being undertaken to

improve the progression of enquiries, the Fostering Team are working closely with the other regional teams.

- Discussions have commenced with regional partners (Cheshire West and Chester, Warrington and Halton) to identify **opportunities for fostering services to work together** on key areas. The aim is to increase our ability to compete with private sector providers whilst also seeking efficiencies in how services are provided. The proposals being considered focus on the following key areas in the first phase:
  - Fostering recruitment - shared referral / front door services
  - Marketing - shared strategies and media work
  - Training of foster carers - access to pooled training programmes
- **Work-streams have been created around the Care Leavers Strategy** to focus on improving outcomes in the key areas of Education, Health, Independence, Financial Stability and Housing. Champion Personal Advisor roles are being created to take the lead in these areas and they will work closely with the Team Manager to co-ordinate the work streams, develop resources, produce a quarterly report and work closely with care leavers so focus of the work is shaped by their needs and their feedback.

  Care Leavers are also being allocated with a Personal Advisor at an earlier time compared to last year as more resources are available to meet the growing demands of the service. Work has been undertaken to raise the profile of work with Care Leavers; staff have delivered a number of presentations about the service at the Practice and Performance Workshops, Fostering Forum and to the 'Skills for Fostering' training programme. These events were all well received.
- **The CCGs have commissioned research into children's emotional and mental health needs at the point of placement** with the aim of ensuring that children placed for adoption in Cheshire East receive appropriate services in relation to their emotional and mental health. The report which has recently been published will be reported to the Health and Wellbeing Board and actions required are being developed in conjunction with the Cheshire East Adoption Team.
- The **Child Protection Information Sharing Project (CP-IS) has gone live in Cheshire East**. This is a nationwide system that enables child protection information to be shared securely between local authorities and NHS trusts across England. This project will improve our information sharing with partners. Sharing information effectively across health and care settings is vital in protecting vulnerable children and young people to prevent further harm. CP-IS connects Liquid Logic with systems used by NHS unscheduled care settings, such as Accident and Emergency, walk-in centres and maternity units. It helps ensure that health and care professionals are notified when a child or unborn baby with a child protection plan or cared for child is treated.
- **Work to support Signs of Safety implementation is well underway:**
  - **Governance arrangements** to support implementation have been agreed, and the Signs of Safety Project Board was established in January 2017. This board is meeting monthly initially to ensure arrangements are in place for implementation. Members of the Practice Champions Group have been identified to support the work streams and ensure service development is driven and owned by those closest to the practice.
  - **Engagement with key stakeholders** has taken place, including but not limited to the key children's partnership boards, Practice Champions, children's social care staff within

Practice and Performance Workshops, Children's Social Care Management meetings and early help team development sessions. A newsletter on the bid and Signs of Safety FAQ was released to all Children and Families staff in January 2017. Continued communication and engagement activity has been planned by the Project Board.

- The **LSCB are committed to adopting the approach as a whole partnership culture** and way of working with families. The LSCB will be included within the development of the strategic plan and within the initial leadership briefings. A report on culture and leadership will go to the Board in May 2017.
- **Research and engagement with other LAs** that have adopted Signs of Safety has been undertaken. A visit to North Yorkshire who have fully embedded Signs of Safety across their services, and are a member of the DfE's Partners in Practice scheme, will be completed in April to observe their services and understand what support they can offer us under this scheme.

- **The membership of the Practice Champions Group has been fully refreshed** to ensure that it consists of those people who are keen to lead, develop and drive service development with enthusiasm. Skills and interests in the different work streams for this group were canvassed in January 2017.
- **'Project Macc'** will be launched in April 2017 which will mirror our successful Project Crewe service, working intensively with low level children in need cases to achieve sustainable change for families. Project Macc and Project Crewe will be co-located within the Child in Need and Child Protection Teams to promote effective working relationships.

Recruitment and Retention

- **Turnover has continued to reduce and the workforce has stabilised.** This has allowed us to cease our programme of rolling recruitment and move to a more targeted approach as individual vacancies in the service arise.
- There has been **an increase in enquiries and applications as well as in the appointments of experienced workers.** In 2016 we recruited 18 permanent full-time social workers, 11 of these had practised elsewhere, and of these, 7 joined our Child Protection Teams.
- In addition, **we have appointed four Supervising Social Workers to the Fostering Service and two Social Workers to the Emergency Duty Team.**
- **The permanent appointment of two experienced Child Protection Managers to the Child in Need and Child Protection Team in Crewe has also had a significant impact on stability and morale.** All permanent Team Manager posts in Crewe are now filled.
- Feedback about our recruitment activity continues to be positive and we received wider recognition in a **high commendation at the Children & Young People Now Annual Awards** in the category of Recruitment and Professional Development.
- On-going activity includes a continued focus on advertising through social media to support our recruitment programme, keeping the recruitment microsite up-to-date, **participation in two Government schemes to attract and assist people into careers in social work**, and the establishment of an Advanced Practitioner role.

- We have joined the **North-West Midlands Social Work Teaching Partnership**, which is coordinated through Keele University, and we anticipate this will assist our recruitment programme as well as offer opportunities to better support existing employees with their continuing professional development.
- **Securing the whole IRO team in permanent posts**, which has been one of the team's strategic targets, directly linked to children benefitting from stable, reliable, trusting relationships with their IROs, is becoming a reality now.

Quality of Services

What our performance tells us

- **Performance on requests for initial health assessments within 48 hours of a child coming into care has significantly improved** from 65% in Q2 to 87% in Q3. This is from a low of 4% in Q3 last year, and is a result of significant improvement activity in this area.
- The percentage of **children on a plan for neglect with a completed graded care profile has increased significantly** from 43% in November 2016 to 60% in January 2017.
- **Submission of GP reports to Child Protection Conferences has significantly improved**, from 54% in Q2 to 83% for Q3 for initial conferences. This is from a low of 35% in Q4 2015/16. Reports to reviews have also improved up to 64% in Q3 from 51% in Q2, from a low of 7% in Q2 2015/16. The Named GP is driving improvements in this area with real passion and dedication which is resulting in significant improvements. GPs have also recently received training from the IRO's in January 2017 to increase awareness of their safeguarding responsibilities and develop good working relationships.
- **Children and young people's views continue to be heard at conference (99%) –** performance on this measure continues to be strong
- **Parents and carers are attending conferences** (100% of initial conferences and 93% of reviews)
- **The average caseload for social workers has reduced from 23 in Q2 to 19 in Q3**
- **Initial and Review Conferences and Cared for reviews are completed within timescale**

However:

- **Too many children have been on a Child Protection plan for an extended period** – 31 have been on a plan for more than 15 months. This is due to some large families (65% of these young people are from just 6 families out of a total of 17 families) - however this is still too high. Support for these children is closely scrutinised to ensure the appropriate action is being taken and increased senior management scrutiny has been put in place which expected to achieve a significant reduction in the number of children on plans for an extended time.
- The percentage of **initial health assessments (IHAs) completed by paediatricians** within 20 days has been at an unacceptable level for some time and continues to be so (Q3, 36%). A root cause analysis has been undertaken by both CCGs and will be reported to the LSCB Quality and Outcomes Sub Group for partnership scrutiny. There will be dedicated IHA

clinics in South CCG from March 2017 (these already exist in the Eastern CCG.) A thorough analysis of all late compliance will be made by Designated Professionals in Q4. It is of note that a number of requests were made out of area in Q3 which did affect compliance as did some delays related to arrangements for unaccompanied asylum seeking children (UASC).

- There has been a **decrease in the number of assessments completed within 15, 35 and 45 days** during January 2017. Despite an increase in the percentage of assessments completed within 15 days from 26% in September 2016 to 37% in December 2016, suggesting we are making more timely and focused decisions and putting in an appropriate support package as soon as possible, this has decreased in January 2017 to 19%. The overall year to date position for assessments completed within 35 days has nevertheless increased to 70% and the completion rate within 45 days remains high; 84% in January 2017 and 85% in the year to date.

Please see our Improvement Plan Performance Scorecard for all the performance and audit measures for our progress.

What audit and quality assurance reports tell us

- Children and young people are experiencing **improved outcomes** as a result of intervention (90%)
- There has been an **increase in good quality practice** taking place with families. Overall judgements show **an increase in the percentage of cases considered to be good and outstanding** (42% cases) along with a 17% decrease in those cases judged to be inadequate or requiring improvement. This continues to build on the increase in good practice achieved in Q2 and shows a positive trajectory in improvements to practice.
- **Identification, challenge and timely response to concerns were evident. Social workers are effectively identifying and challenging safeguarding concerns** (92%), and taking **the right action at the right time to protect children** (88%).
- **Children and young people's views and wishes are sought**, and reflected in multi-agency meetings, assessments and plans
- **Families are involved in planning**, and understand why they have a plan. Views of absent parents are sought
- **Children and young people receive the right service for their needs**. Step up and step down was appropriate for the vast majority of case (91%), and the need for a section 47 investigation was identified in all relevant cases
- **There is good quality work at the front door.** 50% work was good quality. Decision making is sound (100%), informed by information from partners (70%) and family history (100%), and result in the right outcome for children (90%).
- **Managers are scrutinising work** and driving improved outcomes for children. Management decision making met the Practice Standard for all cases within ChECS and Permanence and Throughcare, and 67% CIN/CP cases.
- **All cases met the practice standard for recording** – which is a significant achievement

- **Plans for cared for children are SMART (80%)** – audit has demonstrated further improvement in this area.
- **Work around strategy discussions has significantly improved. Decisions to proceed to a Strategy Discussion are more considered**. There has been a decrease in follow up strategy meetings and an increase in the proportion of cases progressing to a S47 enquiry. The percentage of section 47s that led to an initial child protection conference has increased from 45% in Q2 to 60% in Q3. **Multi-agency involvement in Strategy Discussions has also significantly improved**; 55% of cases in September/October 2016 involved participants from at least one other agency apart from the Police, whereas in January 2016 this was true in only 12.5% of cases. This is following the considerable awareness raising work completed in response to the areas for improvement from the IRO strategy discussion audit in January 2016. The quality of S47s and strategy discussions has improved with 63% of these being judged to be good quality
- An evaluation of our Child Protection Conference model, 'Making Children Safer', was completed in August 2016. **The model has received positive feedback from both parents and professionals; conferences are more risk focussed, with an emphasis on planning** rather than information sharing, the quality of parent and child participation has increased, plans are becoming SMARTer, the child's lived experience and the impact of the child protection plan is more easily identifiable, and decisions within conference are therefore more evidence based. Initial evidence indicates that use of this model may be reducing repeat plans.

However:

- Although the quality of practice continues to improve, **the majority of practice still requires improvement** (51%), and is not yet at the quality and consistency we want for our children and young people
- **Too many children and young people experience drift and delay**. Some drift and delay was evident in the majority of cases (69%). Permanency needs to be a key consideration in planning from a much earlier stage, and professionals need to be clear when a lack of progress in neglect cases should result in escalation. Some children and young people experience delays around Legal Advice Meetings (LAM) and pre-proceedings.
- **We still have more to do to ensure our work is truly child-focused,** and the lived experience of children and young people is at the heart of all our work
- **The quality of assessments requires improvement –** assessments can be lacking in depth and analysis, and can be too descriptive, and do not always consider the parents' motivation and capacity to change. **Assessments and plans do not always evaluate or address all the known risks** within families, such as disguised compliance, which limits their ability to support sustainable change
- **Plans still need to be SMARTer, and all plans need to include clear contingencies. Child protection plans are not always categorised correctly,** which limits the effectiveness of the plan
- **The progress of plans is not always evaluated by the impact on the child.** In some cases professionals showed **over-optimism of parents' abilities** to create and sustain long-lasting change for their children

- There is further work to do to ensure that **all partners know what good looks like, take responsibility for outcomes for children,** and provide **effective and robust partnership challenge**
- **Use of the Graded Care Profile** to inform assessment and evaluation of progress in neglect cases remains an area for improvement for the partnership – although recent performance for January 2017 shows this has increased.
- There is still work to do with regards to the **timeliness of initial child protection conferences**, although there is an improving picture. In October 2016, 54% of initial conferences were held within the 15 working days and this had increased to 94% in November and 100% in December, but has dropped back to 83% in January 2017.
- **Multi-agency involvement in strategy discussions** has improved from previous performance but still requires further improvement

For more detail please see the supporting audit summary report.

What children, young people, parents and carers tell us

- Children, young people and parents' views are sought through our audits. **Children, young people and parents are positive about their relationships with their workers.** They value the openness and honesty of workers, and identified good examples of when their workers were open and honest with them. They reported that they were aware of the reasons for social care involvement and were kept informed for what actions were being taken. Social workers visited often, and families were able to attend and contribute to meetings and plans. Plans were clear about what was expected of them and the professionals involved, and were regularly reviewed to help to keep everyone on track.
- **Families feel supported and listened to by their social workers.** There were 26 Child in Need Feedback Surveys completed and returned this quarter, which contained positive feedback about family's experiences and the support they received (figures represent those who agreed or strongly agreed):
  - **100% said their Social Worker was easy to talk to and understood their situation**
  - **92% said that their Social Worker listened to their views,** with 93% feeling they were given opportunity to share their views when attending meetings
  - **96% felt their Social Worker was reliable and did what they said they would do**
  - **77% felt the CiN Plan had helped them and their family**

"Getting people to understand how hard days can be is hard. I understand why you were called but fear no-one is listening to us"

"I was always listened to and got to explain problems/ issues etc."

Parent

- **Parents were very positive about the Making Children Safer Conference model.** 93% rated the conferences as good or outstanding. 98% said the conference had increased their understanding of the concerns.

"This was great and less intimidating"

- **Adoption Panels are working well.** Feedback from Adopters and Prospective Adopters attending Adoption Panels was that staff were welcoming, as was the venue, that their views were taken into account, and that panel members were engaged and interested in what they had to say. **In the last 6 months, all the feedback survey responses have been wholly positive.**
- **29 complaints were received this quarter** which is consistent with previous performance. Complaints from parents are carers covered the following areas which are consistent with previous quarters:
  - Factual errors and inaccuracies in assessments
  - Phone calls not returned, and a lack of communication
  - Reduction in Special Guardianship Allowance
  - The content of assessments
  - Issues with contact arrangements and lack of contact with their children
- **9 compliments were received** from parents, grandparents, foster carers, a teacher, a child's guardian and a thank you card from two children to their social worker.

"The professionalism I have been shown was exemplary"
Parent

"Thank you for all your help and getting us happy again"
Two children to their social worker

What our staff and partners tell us

- **Children's Social Care practitioners were asked for their views on our services** and adopting Signs of Safety in Practice and Performance Workshops in September 2016 under the Signs of Safety three houses model, which is summarised overleaf. This confirms what we know through audit and other quality assurance information, that practice is increasingly good, multi-agency challenge has increased, that staff value the support from their managers, and teams are increasing stable. It also reflects that practitioners share the same aspirations for children and young people and our service.
- **Feedback from 563 partners on the Making Children Safer model has been overwhelming positive** – all of them rated them good (47%) or outstanding (53%)

"Well organised, clear, thorough and very collaborative. Also allowed for warmth/ humanity to enable engagement with young people – not often done. Great!"

"This is by far the best CP conference I have attended"

- **Adoption Panels are working well.** Attending Social Workers from Cheshire East and external Adoption Agencies reported that panel members had clearly read paperwork and asked relevant questions, that the panel itself ran smoothly and that all were made to feel welcome and that their contribution was valued.
- Practitioners' views on the Changing Practice Together newsletter were sought through a feedback survey which was carried in December 2016-January 2017. A total of 109

responses were received. The majority of the comments were positive, most people reported that they found the newsletter informative and useful to their practice:

- **56% respondents said they had reflected on their practice** as a result of the newsletter, and **just under a quarter of respondents, 23%, reported having changed their practice as a result of the newsletter**
- 78% of respondents stated that the Newsletter is "relevant" or "very relevant" to their organisation
- Examples practitioners gave of how they had changed their practice included:
  - "involving the 'absent parent' more, particularly fathers"
  - "making sure my plans are SMART"
  - "go back over the voice of the child before completing assessments. Review with child more frequently"
  - "offering rationale in my record keeping for decisions made"

"Really helpful in keeping the focus on children"

"Very effective tool to update and reach out across all agencies and frontline workers, please continue with it"

Feedback from Practitioners in Children's Social Care

What we want to improve	What's working well	Our dream service
More time to build quality relationships with families We want to make sure we have the tools and support to make Signs of Safety a Success. ICT infrastructure needs to support our practice Want to make sure partners buy into Signs of Safety and get a common understanding and approach across all professionals Workload – worried about additional demands due to changes to services Paperwork needs to be more child-friendly. We need to reduce duplication in recording Recruitment and retention Partners need to have shared responsibility Step down – need clear guidance and thresholds for professionals. Partner agencies want us to hold cases for longer instead of stepping them down Some people won't embrace the possibility that there are other ways of practising	We are achieving better outcomes for children and we are keeping children safe. Children are being adopted/achieving permanence quicker Children's voices are heard – good engagement with children, young people, parents and carers, good direct work with children. Children give positive feedback about their social workers - fewer complaints and more compliments. CP conferences are working better – feedback from parents is positive Quality of practice is improving. Pride in what we've already achieved on our improvement journey – we identify what's working well. More clear, concise and succinct CP Plans Our culture is child focused - people work hard and go the extra mile for children and young people. People aren't set in their ways – flexible and innovative workforce. Culture of improvement Management support and visibility. Open door policy. Can offload worries safely with managers and colleagues. Senior management is visible. Pod approach – Family support worker and social worker roles. Better collaborative working between teams. Multi-agency working has improved – willingness to challenge and change Simplification of assessments – now there is less repetition. Electronic record working to improve processes and quality. Services**:** Children's Disability Team, @ct team, Project Crewe, Foster to adopt, dedicated PA for NEET, DAFSU, range of additional support services for families, good EDT, Front door – fast response, Operation encompass Good training and learning opportunities Signs of Safety - glad to be investing in this as a whole service approach Workloads - Caseloads reducing. Recruitment and retention of permanent staff and managers - increased team stability. Staff turnover is decreasing – people want to come and work for Cheshire East Council. Massive improvement in Crewe CIN/CP – feels calm and a positive place to work	Outstanding and sustainable outcomes achieved for children and young people and families. Children are safe at home with their families. Less children in care, at child protection, children in need and in the criminal justice system Families understand why there is intervention and what we want to achieve. Individuals feel valued, listened to, and involved in their plans. Families take ownership of their own plan. Involve families as much as possible in identifying what works Improved life choices for children with disabilities on a long term basis and moving into adulthood Our Workforce and culture is driven by the needs of children and young people (not staff). Confident workforce. Positivity on all levels – embracing opportunity. Consistency for children and families - building more trusting relationships. Experienced and stable workforce. Happy workforce - no stress. Spending more time with families. Cheshire East leads other authorities in terms of best practice Wholesale responsibility and ownership from all agencies. Consistency across services. Collective decisions Focused and structured work. Efficient service. Locality working Good early help Good quality supervision and management Good quality training for everyone across teams

Planned Future Improvements

- The **LSCB Neglect Sub Group is working on a new Neglect Strategy 2017-19** and this will be launched in April 2017 alongside a communication campaign which has been developed with young people. The 'Act on Neglect' Campaign will launch across the partnership and in universal settings to increase the identification and response to neglect, particularly where it is less recognised, for example in adolescents.
- A **Neglect Operational Group will be piloted** whereby practitioners can share concerns and advice on neglect cases.
- An **analysis of Child in Need cases** is currently underway through an audit of assessments that had an outcome of no further action and re-referrals. This is due to be completed by the end of March 2017 and will inform our demand management strategy.
- **Private Fostering policies and procedures are currently being reviewed** and are on track to be completed by June 2017. Work is currently underway to streamline the processes within the children's record system, which is expected to be completed by March 2017.
- **The Early Help Strategy and needs analysis** are being developed and the drafts were considered by the LSCB Early Help Sub Group in February 2017. CAF Audits are due to be relaunched in March 2017.
- Plans are progressing as expected for Cheshire East to move into the **Regional Adoption Agency**, which should be operational from April 2017. 'Adoption Counts' has been agreed as the name for the Regional Adoption Agency and branding is currently being prepared. Strong family finding processes have been mapped to ensure good, effective care planning from the earliest point is realised.
- A **new team structure for the Integrated Front-Door has been designed and new processes agreed** in line with the Business Improvement Review completed in December 2016. Staff consultation on the changes is due to take place during March 2017 with full implementation by May 2017.
- **Bespoke management training for Team Managers** is being developed to ensure they have the skills and knowledge they need to support, inspire and challenge their teams to always put children and young people first and this is to be rolled out in two sessions to be held in April and June 2017.
- **We will be adopting Signs of Safety** to ensure all our practice and our organisation is child–focused, solution orientated, and respectful and inclusive of families.
- Workshops are planned during 2016/2017 to support our workforce to achieve **high quality referral requests and clear and concise Individual Placement Agreements** for our children and young people. The IPA is the only legally binding document the local authority has with the provider that specifies agreed outcomes and financial detail such as pocket money and savings. Being clear at the start of the placement about what is expected to be achieved ensures everyone knows what they are working towards.
- Cheshire East has joined an innovation bid with Stoke to run **the 'House Project'**; this involves setting up a company with children in care and care leavers to recycle derelict houses and is intended to develop young people's ownership and participation skills.

- A project is being undertaken during 2016-17 in relation to the **emotional and mental health needs of Cared for Children.** This project will involve the participation of Cared for Children in activities related to positive mental health and in a multi-agency conference in spring 2017. This project is important in giving children a voice and raising the awareness of multi-agency managers, practitioners, councillors and carers regarding the emotional and mental health needs of Cared for Children.
- **Placement stability is an area of focus** as there appears to be a growing number of children who are experiencing three or more placements in the course of a year. A cross service working group has been established to identify themes for learning and development. The issue is also being addressed through the Permanence Tracking Panel and has added to the forward plan for our Social Care Leadership Team.

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Quarterly Improvement Plan Performance Scorecard - Q3 2016-17

*Audit measures are indicated in blue

No	Measure	Thresholds			Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Exception Commentary
		RI	Good	Outs.								
We always put children and young people first												
1	Activity has improved outcomes for the child or young person	60-69	70-79	80-100				86%	76%	83%	90%	
2	Standard for management decision making and recording met at ChECS	60-69	70-79	80-100	100%		93%	100%	100%	100%	100%	
3	Standard for management decision making and recording met -CIN/CP	60-69	70-79	80-100	79%	78%	81%	59%	61%	89%	67%	Crewe CIN/CP now has all permanent team managers. As these posts embed we expect this measure to improve. A management development session was held in February to support managers to become leaders for their service areas. A workshop on reflective practice for managers will take place in March 2017.
4	Standard for management decision making and recording met - Cared for	60-69	70-79	80-100	75%	45%	67%	80%	80%	80%	100%	
We understand what impact the situation is having on the child or young person												
5	Social Worker identified and challenged safeguarding concerns	60-69	70-79	80-100				95%	89%	98%	92%	
6	Sufficient information gathered at ChECS	60-69	70-79	80-100	73%		93%	80%	100%	80%	70%	As this measure is from audit we would expect a degree of variation in performance due to the smaller cohorts involved. The total cohort was 10 cases. ChECS experienced a high workload during December 2016 which may have impacted on performance in this area.
7	History considered at ChECS	60-69	70-79	80-100	100%		87%	100%	70%	100%	100%	
8	Incorporating and recording the views and wishes of children and young people at CIN/CP	60-69	70-79	80-100	77%	79%	86%	70%	42%	79%	83%	
9	Incorporating and recording the views and wishes of children and young people - Cared for	60-69	70-79	80-100	82%	90%	92%	89%	78%	75%	100%	

10	Neglect cases using the graded care profile	60-69	70-79	80-100				50%	29%	17%	0%	There were only 2 neglect cases audited this quarter, and neither included the use of the Graded Care Profile. Performance monitoring reports show that the graded care profile was completed for 60% neglect cases in December 2016. The LSCB Neglect Sub Group is working on a new Neglect Strategy 2017-19 and this will be launched in April 2017 alongside a communication campaign which has been developed with young people. The 'Act on Neglect' Campaign will launch across the partnership and in universal settings to increase the identification and response to neglect, particularly where it is less recognised, for example in adolescents. Training on the grade care profile 2 is currently being rolled out across the partnership, targeted to specific groups of practitioners in areas where there are high referrals for neglect. The LSCB Partnership newsletters Changing Practice Together in December 2016 raised awareness that completion of the graded care profile is the responsibility of all partners and shared the IRO neglect audit findings.
11	Up to date assessment (within 12 months) - Cared for	60-69	70-79	80-100	67%	50%	27%	65%	50%	13%	0%	A total of 5 cases were audited from the P&TC teams this quarter, none of them had an up-to-date assessment. As this is the second quarter with a drop in performance in relation to timely assessments in P&TC the Auditors dip sampled an additional 46 cases. Within this random sample there were 21 cases (46%) without an up-to-date assessment and 25 that did have one (54%). A revised care plan document was introduced in February 2017. This new combined document will support social workers to improve the quality and timeliness of assessments, review reports and care plans.
12	Quality of case recording - CIN/CP	60-69	70-79	80-100				78%	83%	83%	100%	
13	Quality of case recording - Cared for	60-69	70-79	80-100				83%	90%	100%	100%	
14	Strategy discussions with multi-agency contribution	60-69	70-79	80-100			22%	50%	18%	62%	50%	There were 4 cases audited where there were strategy discussions. There is ongoing activity to improve the inclusion of multi-agency practitioners within strategy discussions and this is supported by a work stream of the Safeguarding Children Operational Group. A Task and Finish Group has been established where they have considered the current process and obstacles in achieving multi-agency meetings. An action plan has been developed to address this including a new process for referrals to partners when a strategy meeting is called.
15	Completion of CSE screening tools	60-69	70-79	80-100				N/A	N/A	100%	N/A	There were no CSE cases in the audit this quarter.
16	Updated CSE screening tool on step down	60-69	70-79	80-100				N/A	N/A	N/A	N/A	
17	Return home interviews informing the plan	60-69	70-79	80-100				80%	25%	67%	N/A	

18	Updated risk assessment following MFH&C	60-69	70-79	80-100				25%	0%	67%	N/A	There were no Missing from Home or Care cases in the audit this quarter.
19	Quality of return home interviews	60-69	70-79	80-100				60%	25%	67%	N/A	

We **take action** to make positive change a reality												
20	No drift/delay in actions being completed	60-69	70-79	80-100				58%	36%	60%	31%	All children who have been on Child Protection Plans for over 12 months, are subject to repeat CP planning, or have been involved in the pre-proceedings process for over 6 months will be reviewed by a Service Manager or Head of Service on a monthly basis. The expectation is that the number of children within these categories will reduce significantly as a result of this increased focus. More robust systems for identifying children and young people at risk of drift and delay will be developed to support early identification and action.
21	Number of children and young people on a CP plan for more than 15 months	21-25	11-20	0-10	21	16	15	16	19	23	31	Q3 equates to 17 families, however 20 individuals (65%) come from only 6 families. It is therefore important to view this in the context that 2 large families can make a considerable impact on this indicator.
22	Plans are SMART - CIN/CP	60-69	70-79	80-100				67%	44%	61%	44%	A total of 9 cases were audited from the CIN/CP teams this quarter. SMART planning continues to be an area of focus across the partnership, and improvements in this area will be supported by the adoption of Signs of Safety.
23	Plans are SMART - Cared for	60-69	70-79	80-100					60%	70%	80%	A total of 5 cases were audited from the P&TC teams this quarter
24	Plans have clear contingencies - CIN/CP	60-69	70-79	80-100				48%	33%	72%	56%	This performance reflects that this is an area we need to continue to improve alongside SMART planning.
25	Plans have clear contingencies - Cared for	60-69	70-79	80-100					40%	40%	20%	A total of 5 cases were audited from the P&TC teams this quarter. Within the new Care Plan document is a clearer expectation to outline contingency plans. This document was introduced in February 2017.
26	Percentage of decisions at Early Help Brokerage made within 3 working days	70-80	81-90	91-100						95%	83%	Although there has been a drop in performance it still remains good. This decline is due to process changes, identified as part of the front door review and designed for implementation following the outcome of the consultation, which were implemented in mid November 2016. These changes result in more of the triage function taking place in EHB rather than in ChECS. This was designed for a period when additional staff would be in post, but is currently being managed without additional staffing capacity. The monthly figures for Q3 break down as follows October – 92% in timescale November – 82% in timescale December – 76% in timescale
27	Percentage of children and young people seen within 10 days of the combined assessment start date	75-84	85-94	95-100	62%	75%	81%	75%	78%	77%	78%	This indicator has been reworked to ensure data reporting is producing a reliable picture. The data has been retrospectively reworked from Q1 15/16.

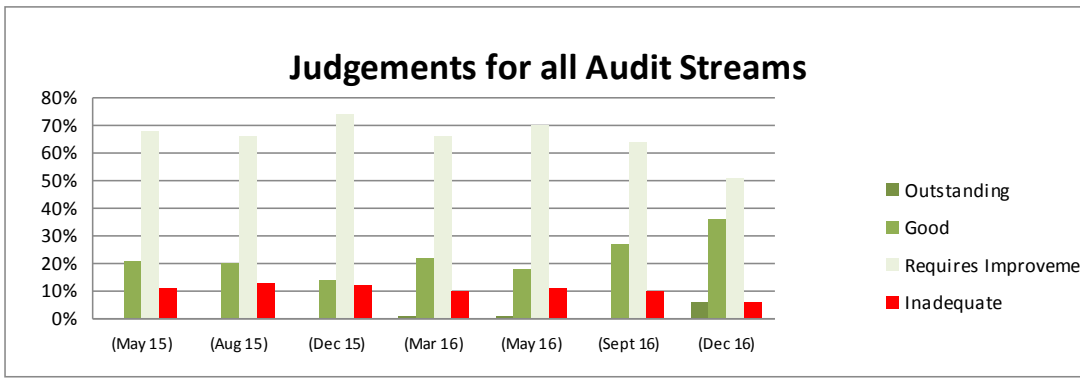
28	Children seen within 24 hours of S47	60-69	70-79	80-100	42%	62%	67%	40%	44%	45%	75%	There were 3 CIN/CP cases audited this quarter where this was relevant and one cared for case. The cared for child was not seen within 24 hours. The SM has reviewed the PTC case and it is clear the child was seen within 24 hours of the (historic) allegation and regularly thereafter. The strategy meeting was delayed but this did not impact on the quality of the work carried out by the SW in a timely way with the child.
29	CIN plans completed within 35 days	60-69	70-79	80-100	42%	59%	67%	44%	64%	69%	50%	This cohort consisted of 6 CiN cases.
30	Regularity of visits to CIN	60-69	70-79	80-100	79%	78%	67%	81%	83%	72%	78%	
31	Regularity of visits to cared for children	60-69	70-79	80-100	82%	90%	92%	80%	70%	50%	60%	Performance challenge sessions support the view that statutory visits are undertaken within the timescales relevant for the child but that recording can sometimes be delayed.
32	Percentage of initial health assessments requested within 48 hours of coming into care	70-80	81-90	91-100	16%	4%	4%	20%	73%	65%	87%	
33	Percentage of initial health assessments completed by paediatricians within 20 days	70-80	81-90	91-100	41%	32%	29%	12%	38%	33%	36%	The overall position for the 9 months to date is 36% - this is still way short of an acceptable performance. A root cause analysis has been undertaken by both CCG's. There will be dedicated IHA clinics in South CCG from March 2017 (these already exist in Eastern CCG.) A thorough analysis of all late compliance will be made by Designated Professionals in Q4. It is of note that a number of requests were made out of area in Q3 which did affect compliance as did some delays related to arrangements for unaccompanied asylum seeking children (UASC).
34	Percentage of Private Fostering cases visited in timescales	80-89	90-94	95-100	100%	67%	83%	93%	96%	88%	100%	
We work **with** families to achieve long lasting change. Children and young people get the right service at the **right time**												
35	Social Worker took the right action at right time to protect child and siblings	60-69	70-79	80-100				94%	98%	92%	88%	
36	Thresholds applied appropriately by ChECS	80-84	85-94	95-100				97%	90%	80%	90%	From the 10 cases there was 1 case where the auditor did not agree with the outcome. The auditor considered that checks should have been made with the Health Visitor as a minimum, given the circumstances and the age of the baby.
37	Appropriate step up/down	60-69	70-79	80-100				67%	83%	84%	91%	
38	CIN cases where S47 was appropriately identified	60-69	70-79	80-100	100%	97%	100%	96%	100%	94%	100%	
39	Percentage of children and young people subject to a child protection plan for a second or subsequent time (cumulative)	15-20	10-14	5-9	23%	21%	21%	19%	23%	24%	18%	
40	Percentage of repeat referrals (cumulative over a 12 Month Period)	25-30	20-24	Below 20	25%	22%	22%	22%	25%	25%	24%	

41	FGC held prior to escalation to ICPC	60-69	70-79	80-100				0%				This service has been reviewed and the decision has been taken that this provision will be brought in house. This work is currently underway
42	FGC held prior to child returning home	60-69	70-79	80-100				0%				

Audit Judgements

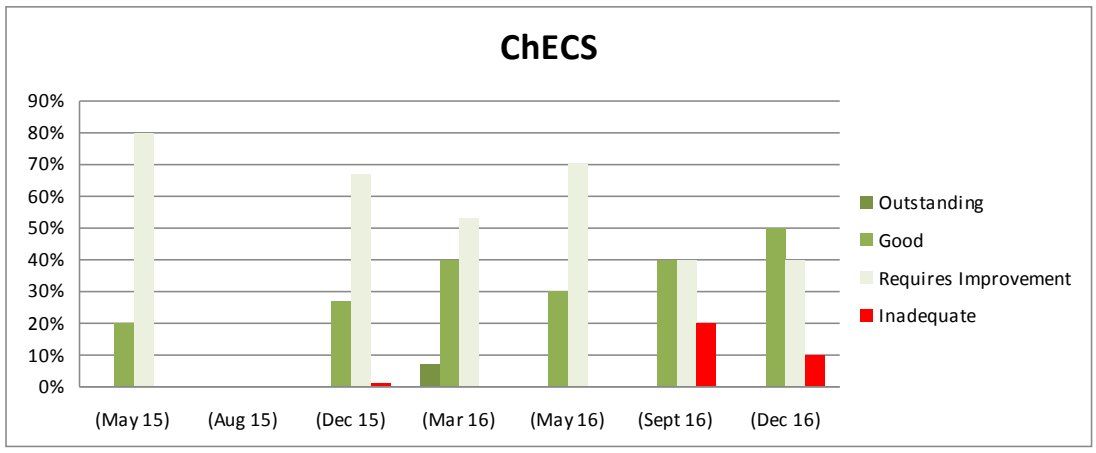
All Audit Streams

	Q1 (May 15)	Q2 (Aug 15)	Q3 (Dec 15)	Q4 (Mar 16)	Q1 (May 16)	Q2 (Sept 16)	Q3 (Dec 16)	Trend
Outstanding	0%	0%	0%	1%	0.8%	0%	6%	↑
Good	21%	20%	14%	22%	18%	27%	36%	↑
Requires Improvement	68%	66%	74%	66%	70%	64%	51%	↓
Inadequate	11%	13%	12%	10%	11%	10%	6%	↓



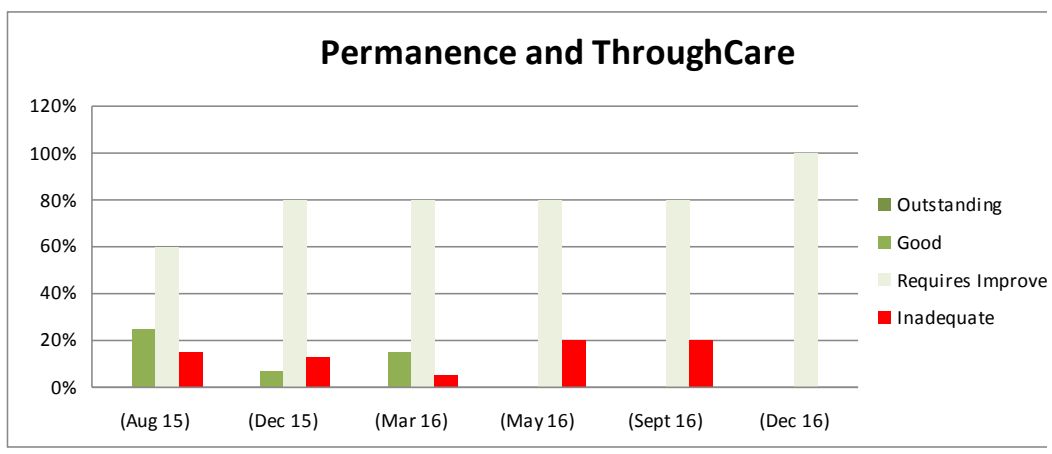
ChECS

	Q1 (May 15)	Q2 (Aug 15)	Q3 (Dec 15)	Q4 (Mar 16)	Q1 (May 16)	Q2 (Sept 16)	Q3 (Dec 16)	Trend
Outstanding	0%	0%	0%	7%	0%	0%	0%	=
Good	20%	0%	27%	40%	30%	40%	50%	↑
Requires Improvement	80%	0%	67%	53%	70%	40%	40%	=
Inadequate	0%	0%	1%	0%	0%	20%	10%	↓



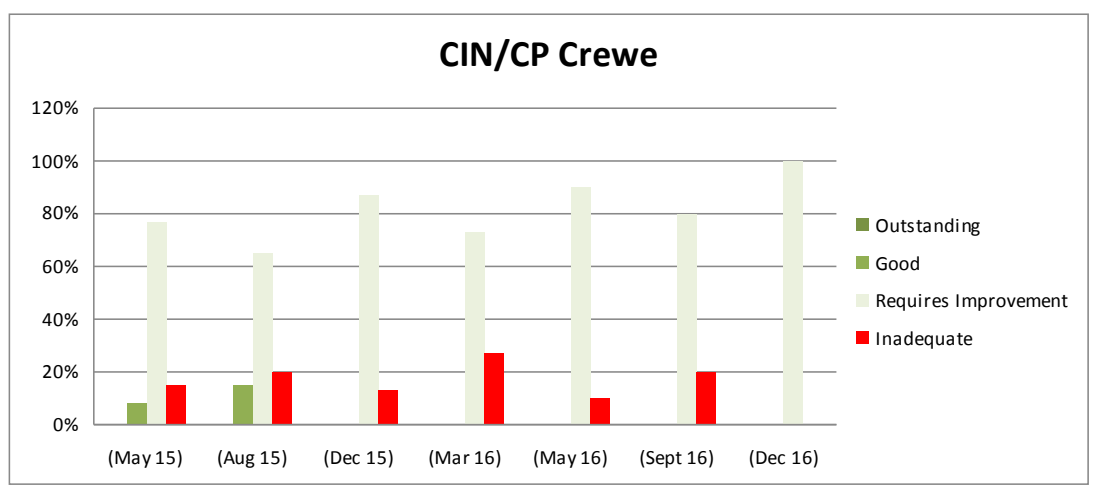
Permanence and ThroughCare

	Q1 (May 15)	Q2 (Aug 15)	Q3 (Dec 15)	Q4 (Mar 16)	Q1 (May 16)	Q2 (Sept 16)	Q3 (Dec 16)	Trend
Outstanding	0%	0%	0%	0%	0%	0%	0%	=
Good	17%	25%	7%	15%	0%	0%	0%	=
Requires Improvement	50%	60%	80%	80%	80%	80%	100%	↑
Inadequate	33%	15%	13%	5%	20%	20%	0%	↓



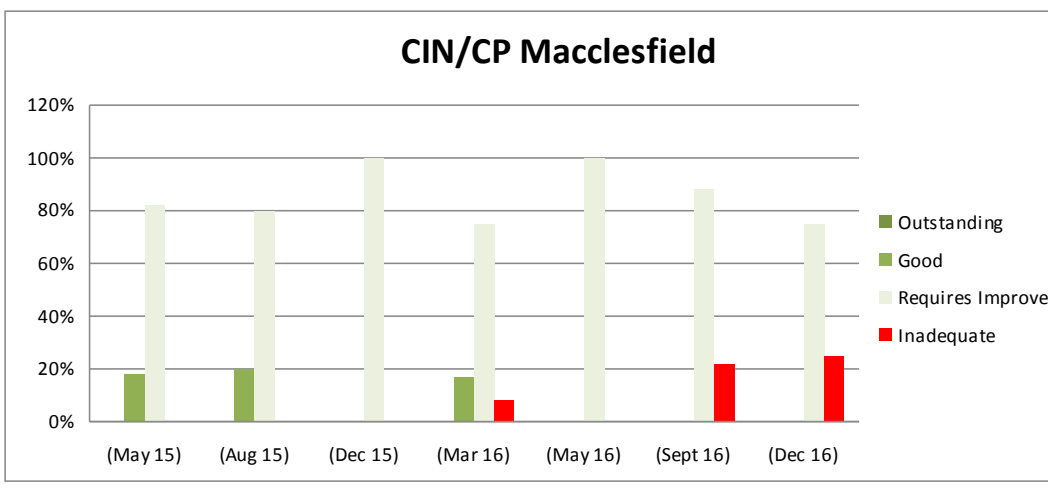
CIN/CP Crewe

	Q1 (May 15)	Q2 (Aug 15)	Q3 (Dec 15)	Q4 (Mar 16)	Q1 (May 16)	Q2 (Sept 16)	Q3 (Dec 16)	Trend
Outstanding	0%	0%	0%	0%	0%	0%	0%	=
Good	8%	15%	0%	0%	0%	0%	0%	=
Requires Improvement	77%	65%	87%	73%	90%	80%	100%	↑
Inadequate	15%	20%	13%	27%	10%	20%	0%	↓



CIN/CP Macc

	Q1 (May 15)	Q2 (Aug 15)	Q3 (Dec 15)	Q4 (Mar 16)	Q1 (May 16)	Q2 (Sept 16)	Q3 (Dec 16)	Trend
Outstanding	0%	0%	0%	0%	0%	0%	0%	=
Good	18%	20%	0%	17%	0%	0%	0%	=
Requires Improvement	82%	80%	100%	75%	100%	88%	75%	↓
Inadequate	0%	0%	0%	8%	0%	22%	25%	↑



Quality of Work - Judgements from Team Managers' Audits and Practice Audits

Referral

	Q4 (Mar 16)	Q1 (May 16)	Q2 (Sept 16)	Q3 (Dec 16)	Trend
Outstanding	8% (2)	4%(2)	0%	4% (1)	↑
Good	58% (14)	51%(27)	57% (27)	58% (15)	↑
Requires Improvement	29% (7)	42%(22)	40% (19)	35% (9)	↓
Inadequate	4% (1)	4%(2)	2% (1)	4% (1)	=

Visits to Cared for Children

	Q4 (Mar 16)	Q1 (May 16)	Q2 (Sept 16)	Q3 (Dec 16)	Trend
Outstanding	0%	0%	0%	0%	=
Good	57%(17)	50%(12)	50% (13)	52% (11)	=
Requires Improvement	37%(11)	33%(8)	38% (10)	43% (9)	=
Inadequate	7%(2)	17%(4)	12% (3)	5% (1)	↓

Combined Assessment

	Q4 (Mar 16)	Q1 (May 16)	Q2 (Sept 16)	Q3 (Dec 16)	Trend
Outstanding	0%	0%	0%	0%	=
Good	37% (11)	44%(21)	31% (11)	32% (7)	=
Requires Improvement	46% (14)	56% (27)	60% (21)	55% (12)	↓
Inadequate	16%(5)	0%	9% (3)	14% (3)	↑

Cared for Assessments

	Q4 (Mar 16)	Q1 (May 16)	Q2 (Sept 16)	Q3 (Dec 16)	Trend
Outstanding	0%	0%	0%	0%	=
Good	40%(10)	33% (8)	42% (11)	50% (10)	↑
Requires Improvement	52%(13)	46%(11)	46% (12)	20% (4)	↓
Inadequate	8%(2)	21%(5)	12% (3)	30% (6)	↑

Child in Need Plans

	Q4 (Mar 16)	Q1 (May 16)	Q2 (Sept 16)	Q3 (Dec 16)	Trend
Outstanding	0%	0%	0%	0%	=
Good	30% (7)	24%(5)	50% (12)	17% (3)	↓
Requires Improvement	57%(13)	66%(14)	33% (8)	78% (14)	↑
Inadequate	13%(3)	10%(2)	17% (4)	6% (1)	↓

Cared for Children's Plans

	Q4 (Mar 16)	Q1 (May 16)	Q2 (Sept 16)	Q3 (Dec 16)	Trend
Outstanding	0%	0%	0%	0%	=
Good	46%(12)	38%(8)	41% (11)	30% (6)	↓
Requires Improvement	50%(13)	57%(12)	48% (13)	55% (11)	↑
Inadequate	4%(1)	5%(1)	11% (3)	15% (3)	↑

Child Protection Plans

	Q4 (Mar 16)	Q1 (May 16)	Q2 (Sept 16)	Q3 (Dec 16)	Trend
Outstanding	0%	0%	0%	0%	=
Good	64%(7)	38%(5)	64% (9)	33% (3)	↓
Requires Improvement	27%(3)	62%(8)	29% (4)	67% (6)	↑
Inadequate	9%(1)	0%	7% (1)	0%	↓

Strategy Meetings and Sec 47

	Q4 (Mar 16)	Q1 (May 16)	Q2 (Sept 16)	Q3 (Dec 16)	Trend
Outstanding	0%	0%	0%	0%	=
Good	50%(6)	33%(6)	38% (6)	63% (5)	↑
Requires Improvement	50%(6)	48%(10)	63% (10)	38% (3)	↓
Inadequate	0%	11%(2)	0%	0%	=

NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund 2016/17 – Q3 report
Date of meeting:	30th May 2017
Written by:	Emma Leigh
Contact details:	Emma.leigh@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Cllr Janet Clowes (Adults and Integration) Cllr Liz Wardlaw (Health)

Executive Summary

Is this report for:	Information X	Discussion ☐	Decision ☐
Why is the report being brought to the board?	To provide the Board with the information on the 3rd Quarter metrics for the Better Care Fund.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Starting and Developing Well ☐ Living and Working Well X Ageing Well X All of the above ☐		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above X		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The Better Care Fund Plan for 2017 – 2018 will need to be informed by performance in 2016 – 2017.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	N/A		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	N/A
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	The schemes funded through the Better Care Fund are designed to improve the health and wellbeing outcomes for people in the health and care system and to better manage the demands on the system.

Cheshire East Council

DRAFT Health & Wellbeing Board

Date of Meeting: **30th May 2017**

Report of: **Mark Palethorpe (Acting Executive Director of People)**

Subject/Title: **Better Care Fund 2016/17 – Q3 report**

Portfolio Holder: **Cllr Janet Clowes (Adults and Integration)**
Cllr Liz Wardlaw (Health)

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1 Introduction

1.1 On 9th March 2017, Cheshire East submitted the 2016/17 quarter 3 Better Care Fund (BCF) return. The complete submission is attached to this paper. This return was signed-off by Cllr Rachel Bailey as Chair of the Health & Wellbeing Board.

1.2 The Better Care Fund Q4 report will be provided for the July Health and Wellbeing Board as the year end data required for this has only been published on 11 May 17 and therefore could not be analysed in time for this report.

1.3 The purpose of this paper is to provide Health & Wellbeing Board (HWB) with a summary of the key points arising from the return, and to recommend next steps to improve performance within the Cheshire East health and social care system.

1.4 The paper will look at the following in turn:

- Income and expenditure
- Metrics
- Next steps

2 Recommendations

2.1 The following recommendations are made:

2.1.1 HWB is asked to note the contents of the quarter 3 BCF report

2.1.4 HWB is asked to note the introduction of the Improved Better Care Fund (IBCF) forthcoming requirements of the 2017-19 plan.

3 Income and Expenditure

3.1 The total BCF budget in 2016/17 is £25.51 million.

3.2 The overall income in quarter 3 was £5.97million, £0.5 million less than expected. The reason for the variation was that the whole Disabled Facilities Grant was received by the council in quarter 1, rather than on a quarterly basis as expected.

3.3 Actual expenditure at Q3 is slightly lower than expected, but expected to increase during Q4. A Forecast underspend of £472k has been identified by South CCG at Q3.

4 Metrics

4.1 Non-Elective Admissions (NELs): There were 10,985 NELs in Cheshire East in Quarter 3. This is 508 more than the target for Q3. Overall there is a slight improvement on the in-year position from 2015/16... Going into Q4 an overall reduction on NELs can be seen.

4.2 Delayed Transfers of Care (DTOCs): DTOCs continue to be a significant challenge in Cheshire East. Following a significant decrease in Q2, there has been a sustained increase during Q3. However going into Q4 these numbers have plateaued, so full year analysis is required to determine the end of year position for Q4.

4.3 Injuries Due to Falls in People Aged 65+: The trend in Q3 is that whilst there is an overall reduction in those falling the trend remains static. Going into Q4, it is not likely that the target for falls will be met for 2015/16.

4.4 People who Feel Supported to Manage Long-Term Conditions: Results show a slight improvement since the Q1 across the domains of, ‘Do you have a written care plan, and did you get help to put your care plan together?’ However there was a slight decrease in the reported satisfaction levels of care plans being reviewed regularly.

4.5 Admissions to Residential Care: Q3 has seen an increase in admissions to residential care, which means that year to date performance so far, would not be an improvement. This ASCOF figure is only finally verified after the year-end. Q3 is the winter quarter and it would be anticipated that demand is greater than in the summer months of Q2. Until the full year comparison can

be made between 15/15 and 16/17 it is unclear whether this increase is a permanent trend or a seasonal feature.

4.6 Reablement: There is no further data since Q2 reporting. The final ASCOF figure will be reported in Q4, performance is anticipated to have improved since 15/16.

6 Next Steps

6.1 The BCF Governance Group is finalising the evaluation of all BCF funded schemes. The findings of this will inform the BCF plan for 2017/19 in Cheshire East.

6.2 Work is commencing to appraise national evidence based practice to ensure local delivery is best placed to achieve the 4 national conditions in 2017/18.

7 BCF 2017/19

7.1 The draft guidance for the Integration and Better Care Fund planning requirements for 2017-19 has been published but has not been finalised by NHS England and the LGA as at 11 May 2017. This impacts on the timeline for a new plan to be developed; it is likely now to be the September Health and Well-being Board for a report on the new plan.

7.2 Key changes to the policy framework since 2016-17 include:

- A requirement for plans to be developed for the two-year period 2017-2019, rather than a single year; and
- The number of national conditions which local areas will need to meet through the planning process in order to access the funding has been reduced from eight to four.

7.3 The four national conditions require:

1. That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the HWB, and by the constituent LAs and CCGs;
2. A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;
3. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement;

4. All areas to implement the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care.

7.5 The reduction in national conditions is intended to focus the conditionality of the BCF, but does not diminish the importance of the issues that were previously subject to conditions.

7.6 These remain key enablers of integration. Narrative plans should describe how partners will continue to build on improvements locally against these formal conditions to:

- develop delivery of seven day services across health and social care;
- improve data sharing between health and social care and
- ensure a joint approach to assessments and care planning.

7.7 By 2020, health and social care will be integrated across England. Narrative plans should set out the joint vision and approach for integration, including how the work in the BCF plan complements the direction set in the Next Steps on the NHS Five Year Forward View, the development of Sustainability and Transformation Partnerships (STPs), the requirements of the Care Act (2014) and wider local government transformation in the area covered by the plan.

7.8 Overall plans will be approved and permission to spend the CCG minimum contribution to the BCF will be given once NHS England and the Integration Partnership Board have agreed that the conditions attached to that funding have been met. For the first time BCF plans will be agreed for a two year period. Arrangements for refreshing or updating plans for 2018-19, for instance to take account of progress against metrics, will be set out in separate operating guidance, which will be published later in the year.

7.9 New IBCF grant

It is subject to the joint NHS England and local government assurance process, which will include consideration of compliance with the grant conditions.

7.10 The Government has made clear in the draft guidance that part of this social care grant funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems.

7.11 DH and DCLG have made clear in their letter to LA chief executives that the grant conditions include three purposes for the funding, including that LAs work with NHS partners to reduce pressures on the NHS. Where areas agree this local investment, it is expected that it will contribute to meeting the NHS ambition in the 2017-18 NHS England Mandate for NHS organisations to reduce delayed transfers of care (DToC) to no more than 3.5% of hospital bed days. This joint work would also contribute to the NHS ambition of freeing up 2000 – 3000 hospital beds.

7.12 Disabled Facilities Grant

Following the approach taken in previous years, the DFG will continue to be allocated through the BCF. This is to encourage areas to think strategically about the use of home adaptations, use of technologies to support people to live independently in their own homes for longer, and to take a joined-up approach to improving outcomes across health, social care and housing. Innovation in this area could include combining DFG and other funding sources to create fast-track delivery systems, alongside information and advice services about local housing options.

7.12.1 In 2016-17, the housing element was strengthened through the national conditions, with local housing authority representatives required to be involved in developing and agreeing BCF plans. This has been retained for 2017-19.

7.12.2 The Care Act also requires LAs to establish and maintain an information and advice service in their area. The BCF plan should consider the contribution that can be made by the housing authority and local Home Improvement Agency to the provision of information and advice, particularly around housing issues.

7.13 Former Carers' Break Funding

Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes. In doing so, local areas may wish to make use of An Integrated Approach to Identifying and Assessing Carer Health & Wellbeing, an NHS England resource that promotes and supports joint working between Adult Social Care services, NHS commissioners and providers, and third sector organisations.

7.14 Reablement Funding

Maintain current reablement capacity in LAs, community health services, and the independent and voluntary sectors to help people regain their independence and reduce the need for ongoing care.

7.15 National conditions

A clearly articulated plan for meeting each national condition in their BCF narrative, as set out in the policy framework and operationalised by the guidance contained in this document, as well as in the scheme details entered in the planning template. This should include clear links to other relevant programmes or streams of work in place locally to deliver these priorities.

8 Summary

8.1 BCF will continue for at least two more years in Cheshire East, with a 2-year planning cycle for 2017-2019.

8.2 The HWB is asked to note that there is a clear expectation that both the vision for integrated health and social care for and method for achieving this will is required for the 2017-19 narrative plan and submission.

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

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NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Participatory Budgeting: Public Health Outcomes
Date of meeting:	10th May 2017
Written by:	Shelley Brough
Contact details:	Shelley.brough@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Fiona Reynolds

Executive Summary

Is this report for:	Information ☒	Discussion ☐	Decision ☐
Why is the report being brought to the board?	To share the findings from the work to introduce participatory budgeting.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Starting and Developing Well ☐ Living and Working Well ☐ Ageing Well ☐ All of the above ☒		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☒ Accessibility ☒ Integration ☐ Quality ☐ Sustainability ☒ Safeguarding ☐ All of the above ☐		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	To use the learning and evidence from the PB project to inform the development of guidance toolkits and best practice for community based commissioning across Cheshire East. That commissioners should recognise PB as an option for future commissioning activities.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The PB process was approved as part of the One You Commissioning process via Cheshire East Council Cabinet.		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	Yes via the PB steering group and Local Community Networks, the development and review of the local PB process has been fully co-produced with local communities.
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	- Reduced health inequalities - Increased community engagement - Increased community empowerment and democracy - Increased community capacity - Better understanding of the complexities of setting public budgets and choosing between competing priorities - More connected communities (see the Connected communities strategy)

NHS South Cheshire Clinical Commissioning Group | NHS Eastern Cheshire Clinical Commissioning Group | Cheshire East Council

REPORT TO: Health and Wellbeing Board

Date of Meeting: 10th May 2017
Report of: Fiona Reynolds (Director of Public Health)
Subject/Title: Participatory Budgeting: Public Health Outcomes

1 Report Summary

1.1 Cheshire East Council Public Health Team and Communities Team have worked together to **coproduce** a local **Participatory Budgeting (PB)** model **with our communities**, which aims to co-commission 'community based' early intervention and prevention activities to improve public health outcomes. Our PB approach which was branded by our local communities themselves as **'You Decide'** also aims to empower, connect and build capacity within our local communities through the development of sustainable 'Local Community Networks'. The critical factor is that **our local communities have been given the power** to **make the decisions** regarding how our £400,000 grant funding has been spent.

1.2 During the development of our Public Health Lifestyles Commissioning programme 'One You', we recognised that not all providers and communities may be in a position to respond to large scale tender processes. Our ambition was to therefore work in partnership with our local communities to ensure that we could empower them to develop and deliver health enhancing services in response to local needs, by building on our local assets. Our local Participatory Budgeting (PB) development was also aligned to the Cheshire East Connecting Communities Strategy.

1.3 PB directly engages and empowers local people in making decisions on the spending priorities for a defined public budget. In Cheshire East the defined budget was £400,000 specifically for reduced health inequalities, improved Public Health outcomes and to support the development of sustainable 'Local Community Networks'. We have engaged local residents and community groups in Cheshire East, who have co-designed the local model/processes, discussed spending priorities, made spending proposals (project applications) and have voted on the projects which they feel most meet their local needs. It has also given local residents a role in the scrutiny and monitoring of the process.

2 Recommendations

2.1 To use the learning and evidence from the PB project to inform the development of guidance toolkits and best practice for community based commissioning across Cheshire East.

2.2 That commissioners should recognise PB as an option for future commissioning activities.

3 Reasons for Recommendations

3.1 The PB project is aligned to priorities and recommendations within the Connected Communities Strategy.

3.2 It supports capacity building for smaller organisations and Voluntary and Community Groups /Organisations (VCOs) across Cheshire East.

3.3 To provide a framework for increased community engagement, empowerment and democracy.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 Outcomes for Cheshire East Communities for Cheshire East Communities

All applications made to the PB process were required to achieve one or more of the following outcomes which are aligned to the 'One You Cheshire East' Public Health outcomes:

- Increased physical activity
- Increased levels of healthy eating
- Reduced levels of obesity
- Reduced smoking prevalence
- Reduced levels of harmful drinking and binge drinking
- Improved emotional health and wellbeing

Reduced health inequalities: The total funding of £400,000 was targeted at communities in Cheshire East with highest levels of health inequalities, with the aim of reducing disparity in the following areas: Crewe, Macclesfield, Wilmslow, Poynton, Knutsford, Congleton, Alsager, Haslington, Middlewich, Holmes Chapel, Sandbach.

Increased community engagement: Our communities have been engaged in the whole process which included:

- Co-designing our local PB model 'You Decide'
- Developing local project proposals to meet local needs and to build on our local assets
- Presenting project proposals to local residents and communities during Decision Days
- Voting on projects which most meet local need
- Playing a role in the monitoring and evaluation of commissioned projects.

Increased community empowerment and democracy: Our communities/residents have been given the power to make funding decisions based on their perceptions of local need. As such PB has encouraged more people to take an active part in their community, therefore, offering greater community cohesion, as diverse people, sometimes meeting for the first time, make decisions together. This in turn empowers them to take positive action themselves e.g. by developing their own projects, resulting in greater ownership by the community over their area.

Increased community capacity: The PB process has provided resources and supported the development of activities, which have strengthened the skills, abilities and confidence of our residents and local community groups to take effective action and leading roles in the development of:

- the Cheshire East PB model
- community based public health projects
- and LCNs.

Ultimately, communities with capacity are more confident, organised, cohesive and influential, and mean that community members are likely to enjoy a better quality of life.

This means Cheshire East communities will:

- work more effectively with public bodies to come up with solutions to problems or opportunities
- do more to set up and run projects or initiatives
- encourage people to support each other.

Better understanding of the complexities of setting public budgets and choosing between competing priorities, in a time of financial restraint and tough budget choices. PB can be used to prioritise budgets and target resources more effectively at key services. Involving the community not only gives them greater understanding of the financial situation, but enables them to be part of the solution.

Connected communities: A key area of feedback that we have received from our local residents is that they feel more connected as a result of attending Decision Days in their communities. PB has enabled residents to understand more about what assets are available locally, including projects, organisations, facilities, services, people etc.

4.2 Outcomes for smaller organisations and VCOs

Capacity building for smaller VCOs: Supporting groups and organisations who don't have the capacity and infrastructure to participate in a higher tier of commissioning and more formal tender processes. Access to PB Grants has enabled VCOs to grow, develop and potentially be able to access and participate in wider

commissioning opportunities in the future. Monthly support sessions have been established in some areas to support development of VCO with governance, funding etc. Already a number of new groups have benefitted from these drop in sessions run in partnership with CDOs and CVS. Further capacity building activity has included:

4.3 Outcomes for Councillors

Strengthening and renewing democracy: PB builds relationships between residents, councillors and officers; providing a stronger role for councillors as community leaders and demonstrating transparency and accountability to local people. This in turn develops mutual trust and confidence in representative democracy and encourages more people to take an active part in their community.

4.4 Outcomes for Commissioners

Increased insight and understanding of local needs via 'meaningful' consultation and engagement: through closer relationships and engagement with local residents and communities, especially with expenditure cuts requiring difficult decisions to be taken. PB techniques can be valuable in determining the opinions of residents, business or other stakeholders.

Asset Mapping: Commissioners now have a greater knowledge and understanding of local assets, with closer relationships with the market, particularly smaller VCOs who have less capacity to engage in formal procurement/tender processes.

Market Development: Capacity building for VCOs supports them to become commission ready, and more able to partner with larger infrastructure organisations or lead tenders themselves. This creates greater competition in the market, higher quality tender submissions, and therefore higher quality service provision. This also supports commissioning requirements of the Social Value Act in terms of building the local market, employment, and local CVOs etc.

Community Based Commissioning Guidance: The PB programme is a key element of the Cheshire East Connecting Communities Strategy, and plans are in place to use the learning from PB to inform the development of a Community Based Commissioning Guidance. Learning from the local PB programme is currently being used to develop plans to engage communities in the decision making processes for the re-commissioning of tendered Substance Misuse Services.

5 Background and Options

5.1 Outputs

- Total number of applications made: 251
- Total numbers of presentations delivered across the areas: 134
- Total number of successful bids across the area: 103
- Total number of voters (members of the community) who attended the events: 537

5.2 We have worked in **partnership** and **engaged** with our local communities to **co-design** a local PB model using the following approaches:

Training and support - A specialist organisation in PB approaches (Mutual Gain) were commissioned to deliver PB training across the 8 Local Community Networks. The PB training aimed to increase knowledge and skills within our communities to develop local PB approaches across Cheshire East.
A Core Community Steering Group (CCSG) was developed to lead on the development of local PB processes, including the criteria, communications, marketing, branding, application forms and voting systems etc. Members of the CCSG have a range of skills and expertise to offer, for example one member has designed a Facebook page in his own time, to promote the Cheshire East PB Grants using the branding also designed by the Steering Group 'You Decide'.
8 Local Community Networks (LCN) The LCNs (supported by Community Development Officers - CDOs) have used the tools and templates developed by the Core Steering Group, and adapted them for their localities. The LCNs have developed their own local timeline for the delivery of local PB approaches.
Community Drop In Sessions have been developed by the LCNs to provide information, support and guidance for groups and organisations to submit an application to the PB Grants process. Members of the community have given their time to support and facilitate Drop In Sessions in their local areas. Individuals, groups and organisations have received information and support to help, ranging from how to complete application forms, how to develop presentations and even opportunities for small groups to 'buddy up' with larger organisation.
Phase 1 (Application Form) The application form was developed and designed by the CCSG. Representatives from each of the 8 LCNs agreed to give their time to review and evaluate which applications met the criteria and would therefore be invited to present their project during a local 'Decision Day'.
Phase 2 (Decision Days) All applications who are successful in Phase 1 were invited to give a short presentation to their local community who voted for the projects that they felt should receive funding. The Decision Days were a real opportunity celebrate our local communities and to bring citizens together for the mutual purpose of improving health and

wellbeing in their communities. It was also an opportunity for organisations to promote their work even if they are not successful in achieving funding.
Presentations Training - Some individuals and groups expressed that they felt that they do not have the skills to deliver presentations. Therefore, in response to this we worked with our local CVS who then delivered a number of training sessions to build skills and confidence.
Understanding of Health and Wellbeing - In response to our communities, who requested information to help them to understand more about Public Health Outcomes and what they look like at a local level, we developed Local Community Health Maps for each of the 8 areas. Communities requested this information to support them with their local decision making processes.
Communications and Marketing - Local communities have rallied together to promote the PB Grants process. Members of the community have used a wide range of opportunities including posters, flyers, talks, meetings, videos and social media to spread the word about the opportunity to be involved in PB, either to submit an application or to attend their local decision day to vote for the projects that they feel deserve to be successful in receiving funding.
Mentors Scheme - The monitoring and evaluation will be taken on by the mentors (Steering Group Partners). Outputs, Outcome and Impact training will be delivered to all successful projects. The cost Benefit Analysis training to be offered to all successful projects (March 2017). All organisations will have shared referral routes in to projects (Good News Brochures).
Follow up Drop Ins Sessions and Showcase Days - Sessions have been provided for successful, unsuccessful and new groups across the area to have access to CVS and CDOs to **develop, sustain or create new projects.** The sessions also helped to raise awareness of the projects that have received funding.

5.3 Qualitative Feedback

"What a fantastic fascinating day I have never experienced an event like it".
Senior Forum

"The day was a great opportunity for local people to communicate with local providers about what they think should be delivered in their community." Healthbox

"4 hours seemed like a lifetime before the event but amazingly it went so fast and time was well spent – lots to do, very interesting, many people to seek out and chat

to that I hadn't met before, many opportunities for partnership work – a really worthwhile day." Wishing Well

"The day was enjoyable from start to finish and was extremely well organised" Living Well Dying Well

"My first ever experience of an event like this and it was an enjoyable one." Survive

"Very professional, informative day. An enjoyable and rewarding experience thank you " Parchment PALS

"I am so pleased for many of the winners on the day – very well deserving." Beechmere

"The whole day was a great success – from meeting other like-minded organisations and individuals to receiving the support we needed to bring our Deafness & Dementia Project to the people of Crewe." Deafness Support Network

"Barnies Community Hub supports the whole community getting involved in PB Funding opportunities." EEA

"It was inspiring to hear about the variety and extent of really worthwhile organisations, projects and activities who are working to make a difference in Crewe. Whether funded on the day or not, I hope all the projects can find the means to develop and grow!" Cheshire Dance

"We were really delighted to be awarded a grant from the Crewe 'You Decide' event for our Turntable lunch club project. This will make a huge difference to those in our local community who face issues of food poverty and isolation. We look forward to reporting on our progress to our broader community and to all those who voted for us – thank you from all at St Andrew's and from all those who will benefit from the Lunch Club" Rev Lynne Cullens

"I attended the above session last Saturday and was very impressed by the whole event. In particular, the Introduction to the process was very clear and informative. The timing was immaculate The presentations were of a high standard, but the Time Out Group presentation was outstanding in every respect. The voting system worked for me. The presentation of cheques to those who were chosen was a very good way closing the event. Well done Cheshire East." Member of the Community

6 Access to Information

6.1 Connected Communities Strategy
http://moderngov.cheshireeast.gov.uk/ecminutes/documents/s51805/Connected%20Communities%20-%20appendix.pdf

6.2 One You Cheshire East https://www.oneyoucheshireeast.org/

6.2 Participatory Budgeting Film https://www.youtube.com/watch?v=sU-_cChVi4g&t=2s

The background papers relating to this report can be inspected by contacting the report writer:
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NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Health and Wellbeing Board Annual Membership Review
Date of meeting:	30th May 2017
Written by:	Guy Kilminster
Contact details:	Guy.kilminster@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Councillor Rachel Bailey

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision X
Why is the report being brought to the board?	To provide the Board with the opportunity to vote on additional associate non-voting members of the Board being appointed.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Starting and Developing Well ☐ Living and Working Well ☐ Ageing Well ☐ All of the above X		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above X		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	To consider and vote upon the proposal that the following three organisations be appointed as non voting associate members of the Board for one year: • Cheshire Police and Crime Commissioner's Office • Cheshire Fire and Rescue service • CVS Cheshire East		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	N/A		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	N/A
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	The organisations proposed as additional members of the Board are all contributing to improved health and wellbeing of the Cheshire east population through their ongoing work. Their membership of the Board will allow for a more effective strategic 'fit' and bring their valuable experience and knowledge to the Board, enhancing its strategic planning, decision making and on the ground implementation.

NHS South Cheshire Clinical Commissioning Group | NHS Eastern Cheshire Clinical Commissioning Group | Cheshire East Council

REPORT TO: Health and Wellbeing Board

Date of Meeting: 30th May 2017
Report of: Guy Kilminster, Corporate Manager Health Improvement
Subject/Title: Health and Wellbeing Board Annual Membership Review

1 Report Summary

1.1 In line with the Terms of Reference there is an opportunity at the Annual General Meeting to consider the membership of the Health and Wellbeing Board and whether to appoint additional voting or non voting associate members.

1.2 The Board are asked to consider the appointment of individual representatives of the Police and Crime Commissioner's Office, the Cheshire Fire and Rescue Service and the CVS Cheshire East as non-voting associate members, for a period of one year.

2 Recommendations

2.1 That in line with para 5.3 of the Cheshire East Health and Wellbeing Board Terms of Reference, the Board consider and vote on the appointment of an additional non-voting associate member of the Board for a period of one year (for review at the next AGM) from the following three organisations:

- The Cheshire Police and Crime Commissioner's Office
- The Cheshire Fire and Rescue Service
- CVS Cheshire East

3 Reasons for Recommendations

3.1 The appointment of the proposed additional members will add value to the work of the Board, particularly in relation to improving the health and wellbeing of the population through the work undertaken by the three organisations.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The organisations proposed as additional members of the Board are all contributing to the priorities of the Health and Wellbeing Strategy through their ongoing work. This includes activity in relation to mental health, helping people stay independent and well, reducing social isolation and loneliness and supporting children and young people. The breadth of activity provides real opportunities to more effectively join up work with other partners to deliver improved outcomes more effectively and efficiently. Having the organisations represented at the Health and Wellbeing Board will provide a forum to enable that to happen.

5 Background and Options

5.1 The Terms of Reference of the Cheshire East Health and Wellbeing Board, offer the Board the opportunity to review its membership on an annual basis. This is particularly in relation to proposed Associate Members being able to assist the Board in achieving the priorities agreed within the Joint Health and Wellbeing Strategy.

5.2 The Cheshire Police and Crime Commissioner, the Cheshire Fire and Rescue Service and CVS Cheshire East, are all actively involved in work that is contributing to the Health and Wellbeing Strategy priorities. Very often this is already being done in partnership with the Local Authority or Health partners through other collaborative arrangements.

5.3 However, there is an opportunity to improve the strategic engagement of the three organisations and to ensure a more effective and co-ordinated response to improving the health and wellbeing of the population of Cheshire East, if they are represented on the Board.

5.4 It is proposed that in line with the Terms of Reference, the three organisations are appointed as non voting members of the Board for a period of one year, and invited to nominate a representative of their organisation to take up the place on the Board.

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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