Cheshire East
Health and Wellbeing Board

Agenda

Date:	**Tuesday 28th January 2020**
Time:	**2.00 pm**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

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

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

1. **Apologies for Absence**

2. **Declarations of Interest**

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

3. **Minutes of Previous Meeting** (Pages 3 - 8)

   To approve the minutes of the meeting held on 26 November 2019.

For requests for further information
Contact: Rachel Graves
Tel: 01270 686473
E-Mail: rachel.graves@cheshireeast.gov.uk with any apologies

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

In accordance with paragraph 2.32 of the Committee Procedural Rules and Appendix 7 to the Rules 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.

5. **Better Care Fund Plan 2019 - 2020** (Pages 9 - 22)

To consider a report on the Better Care Fund plan 2019-20.

6. **Better Care Fund Quarter 2 Update** (Pages 23 - 34)

To consider a report on the progress made during Quarter 2 2019/20 of the Better Care Fund.

7. **Pan-Cheshire Child Death Overview Panel Annual Report** (Pages 35 - 56)

To consider the annual report of the Pan-Cheshire Child Death Overview Panel.

8. **Cheshire East Local Safeguarding Children Board Annual Report** (Pages 57 - 100)

To consider the annual report of the Local Safeguarding Children Board

9. **Mental Wellbeing Strategy - Heading in the Right Direction** (Pages 101 - 140)

To consider the Mental Health Wellbeing Strategy.

10. **Cheshire East Partnership Transformation Update**

To receive a verbal update on the Cheshire East Partnership Transformation.

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 26th November, 2019 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Voting Members

Councillor Sam Corcoran, Cheshire East Council (Chairman)
Councillors Laura Jeuda, Cheshire East Council
Linda Couchman, Cheshire East Council
Mark Palethorpe, Cheshire East Council
Louise Barry, Healthwatch
Clare Watson, Cheshire CCGs

Non-Voting Members
Matt Tryer, Cheshire East Council
Superintendent Peter Crowcroft, Cheshire Police
Mike Larking, Cheshire Fire and Rescue
Councillor Jill Rhodes, Cheshire East Council

Observer
Councillor Janet Clowes, Cheshire East Council

Councillors in Attendance
Councillor Jos Saunders
Councillor Liz Wardlaw

Cheshire East Officers/Others in Attendance
Guy Kilminster, Cheshire East Council
Rachel Graves, Cheshire East Council
Ali Stathers-Tracey, Cheshire East Council
David Leadbetter, Cheshire East Council
Nik Darwin, Cheshire East Council
Mark Groves, Healthwatch

24 APOLOGIES FOR ABSENCE

Apologies were received from Dr Andrew Wilson (Eastern Cheshire and South Cheshire CCG), Councillor Dorothy Flude (Cheshire East Council), John Wilbraham (East Cheshire NHS Trust), Tom Knight (NHS England), Kath O'Dwyer (Cheshire East Council) and Caroline Whitney (CVS).

25 DECLARATIONS OF INTEREST

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

26 **MINUTES OF PREVIOUS MEETING**

RESOLVED:

That the minutes of the meeting held on 24 September 2019 be confirmed as correct record.

27 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no members of the public present.

28 **CHILDREN & FAMILIES LOCALITY WORKING MODEL UPDATE**

The Board considered a report on the progress with creating a new way of working called 'Together in Communities' across agencies working with Children and Families in Cheshire East.

A locality working model was being adopted to bring together services to work more efficiently to best meet needs and improve outcomes for children, young people and their families. The services in Cheshire East would be grouped into three areas to reflect North, South and Middle communities.

A number of workshops had been held with Managers, Operational Staff and Young People to help design how the model would work operationally. Further workshops would be held to bring together partner agencies to help build relationships to ensure the success of the locality working model.

The Early Help Together Strategy set out the intended improvements and impact of moving to an integrated delivery model based on the community configuration.

RESOLVED: That

1 the Board endorse and promote a refreshed locality working model for Children and Families Service, that young people have chosen to brand "Together in Communities"; and

2 the Board promote attendance at February Locality Workshops to further endorse the new ways of working, building upon Signs of Safety and creating 'virtual' team working across communities.

29 **APPOINTMENT OF NON-VOTING ASSOCIATE MEMBER OF THE BOARD**

It was proposed that Councillor Jill Rhodes, Portfolio Holder for Public Health and Corporate Services, be made a non-voting Associate Member of the Health and Wellbeing Board.

RESOLVED:

That Councillor Jill Rhodes, Portfolio Holder for Public Health and Corporate Services, become a non-voting Associate Member of the Health and Wellbeing Board.

30 **CHESHIRE EAST SAFEGUARDING ADULTS BOARD ANNUAL REPORT**

The Board considered the Annual Report of Safeguarding Adults Board 2018/19, in order to keep the Board informed of the work of the Safeguarding Adults Board. Geoffrey Appleton, Independent Chair of Cheshire East Safeguarding Adults Board, was in attendance at the meeting to present the report.

Highlights from the report included the successful Safeguarding Awards event, undertaken with the Children's Safeguarding Board, to celebrate and recognise good practice; the hosting of a Hoarding Conference to highlight the growing need to expand services to give individuals affected the necessary support, and the launch of a three year Strategy Plan.

RESOLVED:

That the Annual Report of Safeguarding Adults Board 2018/19 be received and noted.

31 **PUBLIC HEALTH - ANNUAL REPORT 2018**

The Board considered the Annual Report for 2018 prepared by the Director of Public Health.

The Report provided a brief overview of the wide range of a wide range of issues affected people's health in Cheshire East and also highlighted work across the Place Service that addresses these and identified actions that individuals could undertake to benefit their own and families health.

RESOLVED

That the Public Health Annual Report 2018 be received and noted.

32 **HEALTHWATCH CHESHIRE EAST ANNUAL REPORT 2018/19**

The Board received the Annual Report 2018/19 for Healthwatch Cheshire East.

Healthwatch Cheshire East had been jointly commissioned by Cheshire East Council and Cheshire West and Chester Council to deliver Healthwatch services and also to deliver the Independent NHS Complaints Advocacy Service across Cheshire. A short video was shown to the

Board which explained the work of Healthwatch and was available to watch on their website: - https://healthwatchcheshireeast.org.uk/

The Annual Report detailed the work undertaken during 2018/19, which included visiting local services and health and wellbeing events, undertaking regular A&E Watch activities, conducting Enter and View visits and involvement in a number of projects on issues raised by residents in Cheshire East.

RESOLVED:

That the Healthwatch Cheshire East Annual Report 2018/19 be received and noted.

33 **CHESHIRE EAST ALL AGE AUTISM STRATEGY 2020-2023**

The Board considered the All Age Autism Strategy 2020-2023.

The All Age Autism Strategy had been co-produced through the collective working of Cheshire East Council, Eastern Cheshire Clinical Commissioning Group, South Cheshire Clinical Commissioning Group, Cheshire and Wirral Partnership and the direct involvement of people who experience autism, their families, carers and other stakeholders.

RESOLVED:

That the Board endorse the Cheshire East All Age Autism Strategy 2020 to 2023.

34 **FALLS PREVENTION STRATEGY**

The Board considered the Falls Prevention Strategy.

The Falls Prevention Strategy aimed to reduce the number of serious injuries that result from falls; reduce the number of falls affecting older people and those at higher risk of falling; commission on the basis of an integrated, evidence-based falls prevention pathway across Cheshire East, and reduce the fear of falling amongst older people.

RESOLVED:

That the Board endorse the adoption of the Cheshire East Falls Prevention Strategy following completion of the consultation process.

35 **CHESHIRE EAST PARTNERSHIP TRANSFORMATION UPDATE**

The Board received an update on the Cheshire East Partnership Transformation.

It was reported that the 5 Year Place Plan had been published and an Action Plan was being developed for delivery of the Plan.

It was noted that the merger of the four Cheshire Clinical Commission Groups had been approved and discussions were taking place on how the new Clinical Commissioning Group would operate.

RESOLVED

That the update be noted.

The meeting commenced at 2.00 pm and concluded at 3.40 pm

Councillor S Corcoran (Chairman)

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Agenda Item 5

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 Plan 2019 – 2020
Date of meeting:	28/01/2020
Written by:	Alex Jones
Contact details:	Alex.T.Jones@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Cllr. Laura Jeuda (Adults Social Care and Health)

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision x
Why is the report being brought to the board?	This report provides an overview of the Better Care Fund plan 2019-20. The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group allocations, the Disabled Facilities Grant and the Improved Better Care Fund (iBCF). The aim of the BCF is to bring about greater integration between health and social care. The plan includes the Improved Better Care Fund, Better Care Fund and winter pressures, in total there are 21 schemes in operation across the fund.		
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 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 Health and Wellbeing Board (HWB) is asked to agree the Better Care Fund plan for 2019-20.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The following report has separately been distributed to the Better Care Fund Governance Group.		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	No
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	N/A

1 Report Summary

1.1 This report details the Cheshire East Better Care Fund for 2019-20. The aim of the BCF is to bring about greater integration between health and social care. The plan includes the Improved Better Care Fund, Better Care Fund and winter pressures, in total there are 21 schemes in operation across the fund. In total schemes cover some £35m of expenditure.

2 Recommendations

2.1 The Board is asked to agree the Better Care Fund plan for 2019-20.

3 Reasons for Recommendations

3.1 There is a requirement for the Better Care Fund plan to be signed off by the Health and Wellbeing Board. There was a national delay to the release of planning guidance for the Better Care Fund which in turn has delayed the local planning process, following the submission of the BCF plan on 27/09/2019 this report has been produced to provide an overview of the BCF plan.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 This report supports the Health and Wellbeing Priority of Ageing Well.

5 Background and Options

5.1 The following report includes what's in the BCF, the current schemes for 2019/20 an overview of funding and finally expected performance during 2019/20.

5.2 **<u>What is in the BCF</u>**

5.3 The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group allocations, the Disabled Facilities Grant and the iBCF.

5.4 Local BCF plans are subject to national conditions and guidance. Local plans are monitored through NHS England and there are strict timelines regarding submission of plans for both regional and national assurance of plans to take place.

5.5 National Conditions for 2017-19: In 2017-19, NHS England required that BCF demonstrated how the area will meet the following national conditions:

- Plans to be jointly agreed
- NHS contribution to adult social care is maintained in line with inflation
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care.
- Managing Transfers of Care (Delayed Transfers of Care)

5.6 The key objectives for the effective utilisation of the BCF resource include:

- Carers are valued and supported Staff work together, with the person at the centre, to proactively manage long term physical and mental health conditions. The four Cheshire CCGs are committed members of the Cheshire West and Chester and Cheshire East Health and Well Being Boards.
- Those who receive care and the staff providing them have a positive experience of care
- Care is person centred and effectively coordinated
- People spend the appropriate time in hospital with prompt and planned discharge into well organised community care when needed and there are effective alternatives to hospital admission

5.7 The Cheshire East Health and Wellbeing Board (NHS Eastern Cheshire, NHS South Cheshire CCGs with Cheshire East Local Authority) approve plans to manage pooled budgets, the 'Better Care Fund' (BCF), pooled budgets between health and social care to deliver against four key metrics;

- Reduce non-elective admissions
- Effective rehabilitation
- Reduce long term admissions to residential and nursing care homes
- Reduce delayed transfers of care (DTOC)

5.8 **Current schemes**

The following table summarises the schemes which comprise the iBCF, BCF and winter pressures.

Number	Scheme	Description
1	iBCF - Increased weekend capacity for social workers	To maintain Social Work assessments and advice services over 7-days per week. Based within the hospitals at Macclesfield and Leighton.
2	iBCF - Care Sourcing team model	The funding supports and expands the work of the Care sourcing team. The team undertakes all aspects of the

		Brokerage cycle: enquiry, contact assessment, support planning, creation of support plan, brokering, putting the plan into action as well as monitor and review of the support. The service operates 8am until 2pm / 2pm until 8pm, Monday to Sunday.
3	iBCF - Live well	'Live Well Cheshire East' is an online resource. It is designed to give people greater choice and control by providing easily accessible information and advice about care and support services in the region and beyond. This digital channel provides information and advice and a directory of local services in one place covering Adult, Children, Community and Public Health services.
4	iBCF - Funding for additional social care staff to support Discharge to Assess initiatives	Funding for additional Social Care staff (Locality Manager and Practice Manager) for each hospital team to implement and maintain 'Assessment Outside of Hospital' (previously known as 'Discharge to Assess) in a range of locations across Cheshire East. This includes bed-based services and within a person's own home to prevent admissions to hospital and facilitate timely discharge.
5	iBCF - Winter funding	Additional capacity to support the local health and social care system to manage increased demand over the winter period.
6	iBCF - Sustain the capacity, capability and quality within the social care market place	This funding supports and stabilizes the local social care market by offering fee uplifts for both 'Care at Home' (domiciliary care) and Accommodation with Care (Care Homes). The funding relates to the following: • Residential/nursing care – 1360 bed weeks which is 26 placements over the course of the year. • Domiciliary care – 380 new people until the end of the year.
7	iBCF - Electronic Call Monitoring (ECM)	The monitoring providers to ensure that individual level care calls meet planned activity as set out in care plans. The electronic call monitoring system (ECM) will support the delivery of the recommissioned Care at Home service. ECM offers an automated solution to monitor care visits undertaken by the provider's staff, which will help to improve performance monitoring and safeguarding and improve the safety of staff. The ECM solution will also offer the potential to move towards the monitoring of outcomes for service users.

8	BCF Assistive Technology (AT)	Assistive technologies are considered as part of the assessment for all adults who are eligible for social care under the Care Act where it provides greater independence, choice and control and is cost-effective for individuals. The provision of assistive technology is personalized to each individual and is integrated within the overall support plan. This will entail: • Increasing the independence of people living with long term conditions and complex care. • Supporting Carers to maintain their caring role. • Improving access to the right service at the right time. The scheme supports the existing assistive technology service users. But will also involve piloting assistive technology support for adults with a learning disability (both living in supported tenancies and living in their own homes).
9	BCF Early discharge service – ECT is commissioned to provide an Early Discharge Co-ordinator also forming part of this scheme is the commission of the British Red Cross service.	Early discharge service – ECT is commissioned to provide an Early Discharge Co-ordinator, as part of this scheme there is also a commissioned element which supports the British Red Cross service: Cheshire East 'Support At Home' Service is a 2-week intensive support service with up to 6 Interventions delivered within a 2-week period for each individual. The aim is to support people who are assessed as 'vulnerable' or 'isolated' and who are at risk of admission to hospital or becoming a delay in hospital. Service users have been identified as requiring additional support that will enable them to remain independent at home, or to return home more rapidly following a hospital admission. The interventions may include: A 'safe and well' phone call. A 'follow-up visit' within 1 working day. Help with shopping. Signposting and referring to other agencies for specialist support. The main focus of the service is on supporting people to remain at home (preventing unnecessary hospital admissions by increasing intensive support at home).
10	BCF Combined Reablement Service	The current service has three specialist elements delivered across two teams (North and South): 1. Community Support Reablement (CQC-registered) - provides a time-limited intervention supporting adults with physical, mental health, learning disabilities, dementia and frailty, from the age of 18 to end of life, offering personal care and daily living skills to achieve

		maximum independence, or to complete an assessment of ongoing needs. 2. Dementia Reablement - provides up to 12-weeks of personalised, post-diagnostic support for people living with dementia and their Carers. The service is focused on prevention and early intervention following a diagnosis of dementia. 3. Mental Health Reablement - supports adults age 18 and over with a range of mental health issues and associated physical health and social care needs, focusing on coping strategies, self-help, promoting social inclusion and goal-orientated plans.
11	BCF Statutory Social Care activities resulting from the Care Act including Safeguarding	The Care Act 2014 introduced and revised the statutory responsibilities of local authorities. The Partnership will ensure sustainable appropriate embedded solutions are in place to meet these responsibilities. The Partnership encompasses the duties of the Safeguarding Adults Board. This safeguarding scheme also includes the responsibilities which come from the Care Act which includes the following sub-schemes: Provider Quality Reports (BCF Social Care Act Allocation), Maintaining minimum care eligibility thresholds - Contribution towards maintaining care eligibility thresholds at critical and substantial, Continuity of care for people moving into areas - Additional social worker capacity, Assessment of Social Care in prisons - Additional social worker capacity, Disregard for armed forces Guaranteed Minimum Income - Allocated to care packages, Training social care staff in Social Care Act - Delivery of Care Act training to staff, Less reduction for savings from staff time and reduced complaints
12	BCF Disabled Facilities Grant (DFG)	The Disabled Facilities Grant provides financial contributions, either in full or in part, to enable disabled people to make modifications to their home in order to eliminate disabling environments and continue living independently and/or receive care in the home of their choice. Disabled Facilities Grants are mandatory grants under the Housing Grants, Construction and Regeneration Act 1996 (as amended). The scheme will be administered by Cheshire East Council and will be delivered across the whole of Cheshire East.

13	BCF Carers hub	The Cheshire East Carers Hub is an information and support service designed to help Carers of all ages fulfil their caring responsibilities and still enjoy a healthy life outside of their caring role. The Hub will support Carers who live in Cheshire East, along with those who live outside the area but care for a Cheshire East resident.
14	BCF Programme Management and Infrastructure	Overall responsibility for delivery of the principles and targets of the BCF and identifying barriers, risks and mitigation to ensure they are achieved. Staff employed and infrastructure required to support the management and governance arrangements for the BCF.
15	BCF Winter Schemes ECCCG	Evidence-based interventions designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed.
16	BCF Homefirst ECCCG	'Home First' is the 'umbrella' term used to describe a collection of services commissioned by NHS Eastern Cheshire CCG and predominately delivered by East Cheshire NHS Trust
17	BCF Homefirst SCCCG	Home First is an ethos, to support patients to remain in their own homes. This scheme is delivered through a number of community health services predominately delivered by Central Cheshire Integrated Care Partnership.
18	Winter - rapid response	The Rapid Response Service facilitates the safe and effective discharge of service users from hospital who have been declared as medically fit for discharge but who may have still have care needs that can be met in the service users own home. The service will seek to prevent readmission to hospital by ensuring wrap around services are in place in the first 48 hours following hospital discharge. The Service will also provide support to Service Users with complex health needs and end of life support at a level. Through the provision of 7 day working, the service will ensure a timely response to hospital discharge to reduce delayed transfers of care and create capacity and throughput for non-elective admissions.
19	Winter - additional beds	We have 60 short stay beds per week to support step down and step up per bed. Existing Commissioning resource will be used to procure these beds.

20	BCF - Mental health social workers	This scheme supports individuals with mental health who are requiring assessment.
21	Trusted assessor service	The overall aim of this service is to develop and establish a trusted assessor service in Cheshire East; this service will provide a trusted assessment function through Independent Transfer of Care Coordinators. This service will initially work with existing care home residents who have been admitted to hospital and require assessment prior to transferring back to the care home. This service will in part help reduce patient length of stay as well as contributing to a reduction in Delayed Transfers of Care.

5.9 **Overview of funding**

5.10 The following table is a summary of the BCF running balances:

Running Balances	Income	Expenditure	Balance
DFG	£2,064,279	£2,064,279	£0
Minimum CCG Contribution	£24,577,102	£24,901,102	-£324,000
iBCF	£6,999,291	£6,999,291	£0
Winter Pressures Grant	£1,450,638	£1,450,638	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£324,000	£0	£324,000
Total	£35,415,310	£35,415,310	**£0**

5.11 Note: The BCF national template (which has been approved for Cheshire East) categories groups types of income and expenditure together, hence the positon that while the overall income and expenditure fully reconciles there are variances on a couple of individual lines.

5.12 **Expected planned performance**

5.13 Definitions of key metrics are shown in Appendix one, The following tables provide an overview of the expected annual performance of the Better Care Fund in relation to the key metrics, these metrics cover the following areas:

- Delayed transfers of care
- Residential admissions
- Reablement
- Non-elective admissions

8.1 Delayed Transfers of Care

	19/20 Plan
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	24.4

This target uses the average daily DTOC beds. DTOC performance (June) was 37.7, which would require a 35% reduction to hit this target. This target equates to 756 monthly bed days in a 31 day month and 732 in a 30 day month.

Significant progress has been made to reduce DTOC in the two years since the last review (June 2017 to 2019) with monthly DTOC's reducing from approximately 2,000 days per month to approximately 1,000 days per month. However further effort and focus is required to reduce this further. Operational meetings between assessment and care management as well as care sourcing have been held to reduce waiting lists and delays experienced by people awaiting a care package in their own home. In addition a number of winter funding schemes are being deployed which have the aim of reducing Delayed Transfers of Care. We have also held a number of strategic meetings to further reduce delays, these have identified that we need to establish processes for hospitals outside of Cheshire to sign-off on DTOC data which relates to the Cheshire East HWB footprint.

As part of our plan we have 19 schemes which cover a number of funding streams (winter, bcf, ibcf) of these 19 schemes, 14 of them will have an impact on Delayed Transfer of Care. We have a number of schemes which have varying levels of support to ensure service users/patients are supported to return home, this ranges from low level support such as the British Red Cross up to more intensive Reablement and intermediate care solutions. The schemes also recognise that a number of solutions support effective DTOC reduction which includes appropriate levels of assessment and care management as well as weekend working and ensuring that the home has the appropriate level of adaptions.

One of the main winter schemes is rapid response. The Rapid Response Service will facilitate the safe and effective discharge of service users from hospital who have been declared as medically fit for discharge but who may have still have care needs that can be met in the service users own home. The service will seek to prevent readmission to hospital by ensuring wrap around services are in place in the first 48 hours following hospital discharge. The Service will also provide support to Service Users with complex health needs and end of life support at a level. Through the provision of 7 day working, the service will ensure a timely response to hospital discharge to reduce delayed transfers of care and create capacity and throughput for non-elective admissions.

Of all of the DTOC attributable to social care, the largest single source of delays is Awaiting care package in own home – total number of delayed days 2013, % of all delays 53.54, average number of delayed days per month 167.75.

As part of the Cheshire East efforts to reduce DTOC a rapid response service is due to be in place from 1/10/2019, this will provide packages for between 600-969 people, if each of these packages conservatively reduces the delays associated with awaiting a care package in own home by at least one day, then the total number of delays associated with this reason would reduce from 2013 to between 1044-1413.

This would reduce the monthly delay from the average of 167.75 to 87-118. It should be noted that this is the planned performance and the actual performance will be tracked.

In addition to this Cheshire East are implementing a number of other schemes focused on reducing these delays further, these schemes include: Stockport social worker (Stepping Hill), Rapid response, Homecare coverage, Social worker for Station House, Rapid response social worker, Block book beds. These schemes will have the impact of reducing DTOC delays in the following areas: assessment completion, awaiting care package in own home, awaiting community equipment and adaptions and awaiting nursing home placement or availability

8.2 Residential Admissions

		18/19 Plan	19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	711	601
	Numerator	616	530
	Denominator	86,688	88,205

In 2018/19 Cheshire East saw reducing rates of admission to residential and nursing homes for people over the age of 65. More recently the homecare service has been re-commissioned we also have a number of homefirst schemes as well as extracare provision. The target set locally is based on a number of admissions in the year rather than a rate. 18/19 actual performance was considerably lower than the plan figure.

8.3 Reablement

		18/19 Plan	19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into Reablement / rehabilitation services	Annual (%)	89.8%	83.3%
	Numerator	193	320
	Denominator	215	384

This suggested target, whilst quite a bit lower than the previous plan, would still represent a challenge given our 18/19 performance (75.6%) and is reasonable given the 17/18 national performance of 82.9%, regional performance of 84.6% and comparator average of 83.4%, and that we have a higher proportion of 85+. Recent analysis of Reablement performance information (01/04/19-31/07/19 discharge direct to Reablement and Macc IC only) shows the following:

- % of service users who are deceased prior to 91 day marker: 7.0%
- % of service users who go into residential care prior to 91 day marker: 14.0%
- % of service users who are readmitted to hospital prior to 91 day marker: 1.2%

- % of service users who go into residential care or readmitted to hospital prior to 91 day marker: 15.1% (this does not add up to the two figures above due to rounding)

Here is the age group summary for 2019/20 data:

1. Intermediate Care age range vs % of service users: 65-74 - 8.5%, 75-84-36.6%, 85+- 54.9%
2. Reablement age range vs % of service users: 65-74 -16.7%, 75-84 -36.7%, 85+ - 46.7%
3. Reablement / Intermediate Care combined age range vs % of service users: 65-74 -9.9%, 75-84 -36.6%, 85+ - 53.5%

In order to meet the Reablement performance metric two activities are going to be undertaken: 1.The Reablement service will be re-focused to increase the number of referrals accepted from hospital discharge and 2. The eligibility criteria will be reviewed to re-target the service as those best placed to benefit from a spell of Reablement.

8.4 Non-Elective Admissions

	19/20 Plan
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.

The planned Non Elective Admissions information 46,733 as noted in the Non Elective Admission 2019/20 dashboard for CCG mapping.

In reference to Non Elective Admissions information collection the following has been noted: The way these have been calculated involves applying a percentage of each CCG's plan to each HWB area i.e. there will be a number of CCGs for CE HWB not just South Cheshire and Eastern Cheshire CCGs. Just under 5% of the target is made up from CCGs outside of Cheshire East (for residents outside Cheshire East admitted to Cheshire East hospitals. This is different to how we currently monitor this metric as we use the two CCGs totals (whether hospital is in or outside Cheshire East).

As part of our plan we have 19 schemes which cover a number of funding streams (winter, bcf, ibcf) of these 19 schemes 14 of them will have an impact on Non Elective Admission data. A number of the schemes seek to ensure that where possible individuals are helped to remain as independent as possible and in their own homes. In addition to this a number of the schemes can be characterised as assisting with market management and ensuring that demand for services can be dealt with in as efficient manner as possible. We have a number of services such as combined Reablement and British Red Cross which seeks to provide ‘step up’ and ‘step down’ support to individuals in the community and from hospital discharge. We also have a number of projects which we are piloting in care homes these include:

trial of an app in care homes to reduce falls, information and advice for care homes, the use and adoption of a nursing and residential triage tool.

6 Access to Information

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

Name: Alex Jones
Designation: Better Care Fund Programme Manager
Email: Alex.T.Jones@cheshireeast.gov.uk

Appendix one – definitions of key metrics

Delayed transfers of care

- Description: Delayed transfers of care from hospital per 100,000 population
- Data definition: Total number of DToCs (delayed days) per 100,000 population (attributable to either NHS, social care or both)* A DToC occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:
    - a clinical decision has been made that the patient is ready for transfer AND
    - a multi-disciplinary team decision has been made that the patient is ready for transfer AND
    - the patient is safe to discharge/transfer.
- Rationale: This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care (DToCs) and enabling people to live independently at home is one of the desired outcomes of social care. The DToC metric reflects the system wide rate of delayed transfers and activity to address it will involve efforts within and outside of the BCF.
- Outcome sought: Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.

Residential admissions

- Description: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population
- Data definition: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes.
- Rationale: Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.
- Outcome sought: Reducing inappropriate admissions of older people (65+) in to residential care

Reablement

- Description: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into Reablement / rehabilitation services
- Data definition: The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.
- Rationale: Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal.

- Outcome sought: Increase in effectiveness of these services whilst ensuring that those offered service does not decrease.

Non-elective admissions

- Description: Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population.
- Data definition: A Non-Elective Admission is one that has not been arranged in advance. Specific Acute Non-Elective Admissions may be an emergency admission or a transfer from a Hospital Bed in another Health Care Provider other than in an emergency.
- Rationale: Effective prevention and risk management of vulnerable people through effective, integrated Out-of-Hospital services will improve outcomes for people with care needs and reduce costs by avoiding preventable acute interventions and keeping people in non-acute settings.
- Outcome sought: A reduction in the number of unplanned acute admissions to hospital.

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund Quarter 2 Update
Date of meeting:	28/01/2020
Written by:	Alex Jones
Contact details:	Alex.T.Jones@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Cllr. Laura Jeuda (Adults Social Care and Health)

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision x
Why is the report being brought to the board?	The purpose of this paper is to provide the Health & Wellbeing Board (HWB) with a summary of progress made during Quarter 2 2019//20 of 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 ☐ 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 Health and Wellbeing Board (HWB) is asked to note the progress made during quarter 2.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The following report has separately been distributed to the Better Care Fund Governance Group.		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	No
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	N/A

1 Report Summary

1.1 The purpose of this paper is to provide the Health & Wellbeing Board (HWB) with a summary of progress made during Quarter 2. A range of activities have taken place over the course of quarter 2 which includes the production and deployment of a winter plan, the commissioning of two interim trusted assessor services and the establishment of task and finish groups to provide greater focus on reducing delayed transfers of care which are attributable to social care.

2 Recommendations

2.1 The Board is asked to note Better Care Fund performance in Quarter 2 2019/20.

3 Reasons for Recommendations

3.1 The Cheshire East Health and Wellbeing Board is central to the Governance of the BCF, this report and recommendations form part of this ongoing governance.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 This report supports the Health and Wellbeing Priority of Ageing Well.

5 Background and Options

5.1 The following sections aim to describe: the progress made during quarter 2, the performance information used to judge effectiveness, the expected planned performance and explain the actual performance.

5.2 **Programme progress during Quarter 2**

5.2.1 As part of the Cheshire East BCF programme 21 schemes were included for 2019/20. These are a combination of BCF and iBCF funded elements and winter pressures schemes. The council along with partners undertook a number of activities in Quarter 2 and Quarter 3 to ensure effective metric performance, these activities included: producing and implementing winter plan, commissioning interim trusted assessor services and establishing a number of task and finish groups

5.2.2 The council has developed a winter plan; the plan has a particular focus on delayed transfers of care which are attributable to social care. The schemes have been selected to reflect those specific areas and causes of delays (assessment completion, awaiting residential home placement, awaiting nursing home placement and awaiting care package in own home). The schemes which are included within the plan include:

001 Assessment and care management to support winter schemes - a dedicated social worker (x1) and dedicated social care assistants (x2) are being deployed to provide additional assessment and care management capacity to support a range of winter schemes. The workers will work across the following schemes: rapid response (002), homecare coverage (003), and block booked beds (005), spot purchase beds (006) and Reablement (Better Care Fund scheme).

002 Rapid Response - the Rapid Response service will facilitate the safe and effective discharge of service users from hospital who have been declared as medically fit for discharge but who may have still have care needs that can be met in the service users own home. The service will seek to prevent readmission to hospital by ensuring wrap around services are in place in the first 48 hours following hospital discharge. The service will also provide support to service users with complex health needs and end of life support needs.

003 Homecare coverage - due to the geography of Cheshire East is it often difficult to source care at home services for people living in rural areas. This increases their risk of hospital admissions and can result in people being placed in short term residential care or requiring in house Reablement services reducing capacity of these services for people who are medically fit for Hospital Discharge. The Council is offering, at its discretion, an enhanced payment to Prime and Framework care providers of up to £2 on their tendered price for people living in designated rural areas only where it has proven difficult to source care.

004 Social worker (Station House) - this scheme would see an additional social worker (x1) deployed to provide additional assessment and care management capacity to support the discharge to assess beds at Station House in Crewe.

005 Block booked beds - In order to facilitate hospital discharges and prevent unnecessary hospital admissions, 10 beds in the community have been commissioned. Providing residential and residential dementia beds to support winter pressures to facilitate the timely discharge of residents from hospital.

006 Additional Winter Pressure beds - winter pressure funds will be used to purchase additional nursing and residential care home beds as and when needed to facilitate timely hospital discharges and prevent unnecessary hospital admissions. These beds will purchased from care home providers who have successfully applied to the joint Council/CCG Accommodation with Care Dynamic Purchasing System Framework.

5.3 The plan has been developed in conjunction with commissioning and operational colleagues, the Better Care Fund Governance group approved the winter plan.

5.4 **Commissioning interim trusted assessor services**

5.4.1 Two interim trusted assessment services have been commissioned in conjunction with health partners to add additional capacity within the hospital setting to undertake assessments on behalf of nursing and residential care providers to help reduce delays associated with residential/nursing home placements.

5.5 **Establishing a number of task and finish groups with a focus on reducing delayed transfers of care**

5.5.1 We have established a strategic delayed transfer of care group with the aim of reducing

5.5.2 strategic issues which contribute to delayed transfers of care which are attributable to social care. This group is comprised of staff from commissioning as well as operations. It has focused on establishing appropriate processes and sign-off procedures for delayed transfers of care occurring outside of Cheshire East amongst other things. In addition to this we have established a task and finish group to review the waiting list of service users who have been reviewed for a package of care. The aim of this group has been to reduce the wait from referral to package commencement.

5.6 **Performance information**

5.6.1 The performance recorded presents the totality of health and social care performance for the Cheshire East Health and Wellbeing footprint area A breakdown of performance against these four metrics is shown in the main body of the report. In order to further improve performance a continued focus on the metrics has been built into the forward plan for the Better Care Fund Governance Group.

5.6.2 In addition to this each scheme which comprises the BCF/iBCF in Cheshire East has a scheme descriptor which describes what the scheme is, what its due to achieve and in turn how this will impact on the four metrics outlined previously.

5.6.3 New nationally set targets have been introduced for the Delayed Transfers of Care (DTOC). The DTOC target for Cheshire East will be 733 and within this 498 delayed days will be attributable to the NHS and 235 delayed days will be attributable to Social Care. On a daily basis the DTOC expectation is that there will be a total of 24 delayed days, this is made up of 17 delayed days attributable to the NHS and 8 days attributable to Social Care.

5.6.4 There was also a new national ambition to reduce bed occupancy by reducing the number of long stay patients (and long stay bed days) in acute hospitals by 25%. The baseline accompanying the new target sets out that that beds occupied with long stay patients in Cheshire East was 165 , the ambition set which is the maximum number of beds to be occupied with long stay patients would be 122, this represents a local long stay reduction of 26.2%. As yet local information relating to actual performance hasn't been accessible from the Social Care Dashboard.

5.7 **Expected planned performance**

5.7.1 The following tables provide an overview of the expected monthly performance of the Better Care Fund in relation to the key metrics, definitions of key metrics are shown in Appendix one and Appendix two shows local performance in relation to the region and nationally, the Better Care Fund metrics cover the following areas:

- Delayed transfers of care
- Residential admissions
- Reablement
- Non-elective admissions

A summary of performance is as follows:

- Delayed transfers of care - Delayed transfers of care in September 2019 were 11.1% higher than delayed transfers of care in 2018. This is seen against a rise of 16.7% in the North West region. To improve performance partners have implemented winter plans with a number of schemes aimed at improving delayed transfer of care performance.
- Residential admissions - the number of residential admissions in quarter 2 (319.6) were lower than the planned admissions of 325.2. This actual performance was lower than the planned performance for the region.
- Reablement - the % of service users still at home 91 days following Reablement in quarter 2 was 75.6% against a plan of 77.5%. The Reablement service is being re-focused to target a greater proportion of hospital discharges and the eligibility criteria are being reviewed to improve performance.
- Non-elective admissions - The plan for quarter 2 performance was 22,417 admissions the actual performance was 23,151. We have a number of schemes aimed at reducing non elective admissions; we also have a number of projects which we are piloting in care homes these include: trial of an app in care homes to reduce falls, information and advice for care homes, the use and adoption of a nursing and residential triage tool.

BCF Measures	Summary of performance	Actions next steps
Delayed Transfers of Care - Rate per 100,000 popn aged 18+	In Cheshire East, DTOC beds in September 2019 were 11.1% higher than at September 2018 (+59.6% for social care; and -1.0% for NHS delays). At September 2019, in Cheshire East, the top 3 reasons for all delays were: Awaiting care package in own home (30.4%); Awaiting further non-acute NHS care (23.4%); and Awaiting nursing home placement or availability (19.2%)	In Cheshire East partner's implemented winter plans a key focus of which was to reduce Delayed transfers of care. As part of the Cheshire East efforts to reduce DTOC a rapid response service is due to be in place from 1/10/2019, this will provide packages for between 600-969 people, if each of these packages conservatively reduces the delays associated with awaiting a care package in own home by at least one day, then the total number of delays associated with this reason would reduce from 2013 to between 1044-1413. This would reduce the monthly delay from the average of 167.75 to 87-118. It should be noted that this is the planned performance and the actual performance will be tracked.
Residential admissions - Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes (per 100,000)	The plan for quarter 2 was 325.2 admissions the actual performance was 319.6 admissions this represents actual performance which was 1.7% lower than plan. The Cheshire East estimated 2019/20 end year position is 639.2 admissions.	In 2018/19 Cheshire East saw reducing rates of admission to residential and nursing homes for people over the age of 65. More recently the homecare service has been re-commissioned we also have a number of homefirst schemes as well as extracare provision. The target set locally is based on a number of admissions in the year rather than a rate. 18/19 actual performance was considerably lower than the plan figure.
Reablement - Proportion of older people (65 and over) who are still at home 91 days after discharge	The data for this performance measure is submitted at year-end. This performance measure looks at the effectiveness of Reablement services. The measure looks at the % of Reablement service users who remain at home following a package of Reablement. The plan for 2019/20 performance of 83.3% at Q2 the actual performance achieved was 77.5% this compares against actual	In order to meet the Reablement performance metric two activities are going to be undertaken: 1.The Reablement service will be re-focused to increase the number of referrals accepted from hospital discharge and 2. The eligibility criteria will be reviewed to re-target the service as those best placed to benefit from a spell of Reablement. The service will focus on

	performance of 75.6% in 2018/19. Of the service users accessing the service 52.5% were aged 85+ years old.	referrals from hospital discharge as opposed to those in the community; eligibility will include a requirement that the service user has the potential benefit from Reablement, a number of service users have not completed homecare Reablement as a result of unfortunately passing away or being admitted into residential care. In line with research the service will be more focused on accepting 75% of referrals from the hospital, this would see the number of Reablement packages accepted from hospital discharge increasing. Currently the service is made up of approximately 80% of referrals from the community and 20% of referrals from the hospital. Secondly the eligibility criteria for the service will be reviewed, it is hoped that the number of people not completing a Reablement package (approximately 22.2%) will be reduced to national benchmarks of those not completing a Reablement episode 10%. This change will bring about a 12.2% increase in the number of people completing a Reablement package. These two changes will bring about improved numerator and the denominator performance which form part of the metric.
Non-elective admissions - Emergency Admissions (All Age Groups)	The plan for quarter 2 performance was 22,417 admissions the actual performance was 23,151* this represents a 3.3% increase. This 3.3% increase can be seen against national increases of 6%. * Combined figures for Eastern Cheshire CCG and South Cheshire CCG	As part of our plan we have 19 schemes which cover a number of funding streams (winter, bcf, ibcf) of these 19 schemes 14 of them will have an impact on Non Elective Admission data. A number of the schemes seek to ensure that where possible individuals are helped to remain as independent as possible and in their own homes. In addition to this a number of the schemes can be characterised as assisting with market

		management and ensuring that demand for services can be dealt with in as efficient manner as possible. We have a number of services such as combined Reablement and British Red Cross which seeks to provide 'step up' and 'step down' support to individuals in the community and from hospital discharge. We are piloting in care homes these include: trial of an app in care homes to reduce falls, information and advice for care homes, the use and adoption of a nursing and residential triage tool.

5.8 **Next steps**

5.8.1 The BCF programme will continue to improve performance of both individual schemes and performance of against the national metrics.

6 Access to Information

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

Name: Alex Jones
Designation: Better Care Fund Programme Manager
Email: Alex.T.Jones@cheshireeast.gov.uk

Appendix one – definitions of key metrics

Delayed transfers of care

- Description: Delayed transfers of care from hospital per 100,000 population
- Data definition: Total number of DToCs (delayed days) per 100,000 population (attributable to either NHS, social care or both)* A DToC occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:
    - a clinical decision has been made that the patient is ready for transfer AND
    - a multi-disciplinary team decision has been made that the patient is ready for transfer AND
    - the patient is safe to discharge/transfer.
- Rationale: This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care (DToCs) and enabling people to live independently at home is one of the desired outcomes of social care. The DToC metric reflects the system wide rate of delayed transfers and activity to address it will involve efforts within and outside of the BCF.
- Outcome sought: Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.

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- Description: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population
- Data definition: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes.
- Rationale: Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.
- Outcome sought: Reducing inappropriate admissions of older people (65+) in to residential care

Reablement

- Description: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into Reablement / rehabilitation services

- Data definition: The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.

- Rationale: Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal.

- Outcome sought: Increase in effectiveness of these services whilst ensuring that those offered service does not decrease.

Non-elective admissions

- Description: Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population.

- Data definition: A Non-Elective Admission is one that has not been arranged in advance. Specific Acute Non-Elective Admissions may be an emergency admission or a transfer from a Hospital Bed in another Health Care Provider other than in an emergency.

- Rationale: Effective prevention and risk management of vulnerable people through effective, integrated Out-of-Hospital services will improve outcomes for people with care needs and reduce costs by avoiding preventable acute interventions and keeping people in non-acute settings.

- Outcome sought: A reduction in the number of unplanned acute admissions to hospital.

Appendix two - BCF Metrics – National, Regional and Local Data Context for Quarter 2 (2019/20) Report

BCF metric	National context	Regional context	Local context
Delayed Transfers of Care - Rate per 100,000 popn aged 18	Nationally, DTOC beds in September 2019 were 3.3% higher than at September 2018 (+5.2% for social care; and –1.1% for NHS). At September 2019, nationally, the top 3 reasons for all delays were: Awaiting care package in own home (21.4%); Awaiting further non-acute NHS care (16.5%); and Awaiting nursing home placement or availability (13.2%) At September 2019, nationally, the top 3 reasons for NHS delays were awaiting further non-acute NHS care (27.6%); Patient/family choice (18.9%); and Awaiting nursing home placement or availability (11.5%) At September 2019, nationally, the top 3 reasons for Social Care delays were awaiting care package in own home (34.0%); Awaiting residential home placement or availability (24.2%); and Awaiting completion of assessment (17.7%)	In the North West region, DTOC beds in September 2019 were 16.7% higher than at September 2018 (+23.3% for social care; and +11.7% for NHS). At September 2019, regionally, the top 3 reasons for all delays were awaiting care package in own home (20.7%); Awaiting completion of assessment (17.8%); and Awaiting further non-acute NHS care (14.5%) At September 2019, regionally, the top 3 reasons for NHS delays were awaiting further non-acute NHS care (27.7%); Patient/family choice (16.7%); and Awaiting nursing home placement or availability (15.5%) At September 2019, regionally, the top 3 reasons for Social Care delays were awaiting care package in own home (37.6%); Awaiting completion of assessment (25.3%); and Awaiting residential home placement or availability (14.2%)	In Cheshire East, DTOC beds in September 2019 were 11.1% higher than at September 2018 (+59.6% for social care; and -1.0% for NHS delays). At September 2019, in Cheshire East, the top 3 reasons for all delays were: Awaiting care package in own home (30.4%); Awaiting further non-acute NHS care (23.4%); and Awaiting nursing home placement or availability (19.2%) At September 2019, in Cheshire East, the top 3 reasons for NHS delays were: Awaiting further non-acute NHS care (37.4%); Awaiting nursing home placement or availability (23.3%); and Awaiting care package in own home (11.0%) At September 2019, in Cheshire East, the top 3 reasons for Social Care delays were: Awaiting care package in own home (62.7%); Awaiting residential home placement or availability (21.7%); and Awaiting nursing home placement or availability (12.4%)
Residential admissions - Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes (per 100,000)	In 2018/19, the year-end rate nationally was 580.0	In 2018/19, the year-end rate for the North West region was 723.5	Qtr 2: 319.6 Qtr 2 Plan: 325.2 -1.7% Cheshire East estimated 2019/20 end year position is 639.2

BCF metric	National context	Regional context	Local context
Reablement - Proportion of older people (65 and over) who are still at home 91 days after discharge	National data is only collected annually and not in-year. Please note that national performance is only measured for those people who were discharged from hospital between 1st October and 31st December. The national percentage achieved in 2018/19 was 82.4%. For the 85+ age group it was 80.0%. 44.6% of the cohort for this measure, nationally, was aged 85+.	National data is only collected annually and not in-year. Please note that national performance is only measured for those people who were discharged from hospital between 1st October and 31st December. The regional percentage achieved in 2018/19 was 84.0%. For the 85+ age group it was 81.5%. 41.5% of the cohort for this measure, regionally, was aged 85+.	Please note that local performance for 2018/19, quoted in brackets, is measured as per the timeframe for the national data. Qtr 2 2019/20 percentage achieved is 77.5% (75.6% in 2018/19). At Qtr 2, for the 85+ age group it was 65.3% (69.6% in 2018/19). 52.5% of the cohort for this measure, in Cheshire East, was aged 85+.
Non-elective admissions - Emergency Admissions (All Age Groups)	Non-elective admissions for year to date at September 2019 increased by 3.8% compared to September 2018	Commissioners in the NHS North West region saw non-elective admissions for year to date at September 2019 increase by 6.9% compared to year to date at September 2018. Within the NHS North West region, the year to date change at September 2019 compared to September 2018 was: Cheshire and Merseyside: +4.1% Greater Manchester: -0.9% Lancashire and South Cumbria: +35.4%	Non-elective admissions for YTD at September 2019 increased by 6.0% compared to year to date at September 2018 Qtr 2: 23,151* Qtr 2 Plan: 22,417* +3.3% * Combined figures for Eastern Cheshire CCG and South Cheshire CCG

Pan-Cheshire Child Death Overview Panel

Annual Report

1st April 2018 – 31st March 2019

Forward

Section 1:

Executive Summary

Section 2:

Overview and Processes:

Section 3:

Data and Analysis

Mike Leaf
Independent Chair
Pan-Cheshire CDOP
September 2019

Forward from the Independent CDOP Chair

This is my third report as Independent Chair for the Pan-Cheshire CDOP, which comes at a time of tremendous change in terms of Safeguarding and the Child Death Review processes. The report aims to not only reflect the cases the panel has considered throughout 2018/19, but also the achievements of the partnership, and the future priorities for action.

Clearly one of the key priorities for this coming year will be the successful implementation of new Child Death Review Guidance and development of new processes and partnerships. Whilst over 80% of child deaths nationally have a medical or public health causation, ALL include an element of vulnerability and as a result, we need to recognise the importance of continuing the development of well-established relationships with the children's safeguarding partners.

At the time of writing, a Memorandum of Understanding between CDOP and the statutory partners for child death review (Local Authorities and Clinical Commissioning Groups) is being considered, which aims to clarify the respective expectations of each partner for an effective child death review system. As Chair, it will be my responsibility to ensure that CDOP provides oversight and assurance of the child deaths review processes, to the statutory partners.

I would like to thank all the Panel members, for their continued commitment and hard work, and in particular, to Anne McKenzie and Rosie Lyden for the hard work that goes on behind the scenes to ensure that the Panel runs smoothly, and keeps pace with the changing landscape.

Mike Leaf

Independent Chair

Pan-Cheshire CDOP

September,2019

Section 1:
Executive Summary

Whilst there will be changes in the future, the Pan-Cheshire CDOP formed a sub-group of the four Local Safeguarding Children Boards (Cheshire East, Cheshire West and Chester, Halton and Warrington LSCBs) and has a statutory responsibility to review the deaths of all children up to the age of 18 years old (excluding infants live-born following planned, legal terminations of pregnancy and stillbirths) resident within the four Local Authority areas. The focus of CDOP should be on identifying any modifiable factors that may help prevent unnecessary future child deaths or harm.

The purpose of this Annual Report is to:

- Clarify and outline the processes adopted by the Pan-Cheshire CDOP
- Assure the four Cheshire LSCBs and future Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Cheshire, which meets national guidance
- Provide an overview of information on trends and patterns in child deaths reviewed across Cheshire during the last reporting year (2018-19)
- Highlight issues arising from the child deaths reviewed between April 2017 and March 2018
- Report on achievements and progress from last year's annual report
- Make recommendations to agencies and professionals involved in the children's safeguarding system across Cheshire

Achievements during 2018-19

- ✓ Managed the transition of Child Death Review process across Cheshire, liaising with statutory partners
- ✓ Pan-Cheshire CDOP continues to play an active role in both regional and national networks, influencing programmes, and gaining insight into proposed changes to the CDOP function in the future
- ✓ Active participation in the organisation of the National CDOP Conference
- ✓ Engagement with other CDOPs across the NW and nationally and sharing good practice
- ✓ Processes have been reviewed in the light of the neo-natal ongoing neonatal enquiry at the Countess of Chester Hospital. All numbers of child death notifications from hospital are monitored
- ✓ Development of top tips to infant safer sleep
- ✓ CDOP Study/ Development day delivered
- ✓ Proposal for eCDOP developed following positive evaluation of using the system

Summary of key points and themes:

Of those deaths reviewed [2017-18 percentage in square brackets]:

- 46.9% of the deaths occurred before the child reached 28 days (23 deaths)[36.2%]
- 67.3% of the deaths occurred before the child reached one year of age (33 deaths)[58.6%]
- 8.2% of the deaths occurred in Children aged 1 year to 4 year (4 deaths) [8.6 %]
- 10.2% of the deaths occurred in Children aged 5 years to 9 years (5 deaths) [8.6%]
- 8.2% of the deaths occurred in Children aged 10 years to 14 years (4 deaths)[8.6%]

- 6.1% of the deaths occurred in Children aged 15 years to 17 years (3 deaths) [15.5%]
- 77.5% of the deaths were male (38 deaths) [53.4%]
- 46.9% were Perinatal/Neonatal events (23 Deaths) [43%]
- 39% of deaths were classed as 'unexpected' (19 deaths) [24%]
- 45% of deaths reviewed had 'modifiable factors' (22 deaths) [40%]

Update on action plan

- ✓ Manage a smooth transition of the Child Death Review process from Local Safeguarding Boards to new governance arrangements- *several briefing papers have been presented to strategic partners over the last 12 months; several workshops organised to explore issues and solutions;*
- ✓ Further develop the relationship with CHAMPS suicide network- *links further developed;*
- ✓ Ensure that the new guidance is implemented including:
    - Ensuring all child death review meetings (e.g. perinatal mortality; hospital mortality; etc) inform the CDOP process in a standardised/ structured manner
    - Implementation of any changes to the reporting processes e.g. Forms A, B, C

  All revised forms have been circulated and are being used; challenges and issues are being monitored, particularly the current duplication of mortality review processes; eCDOP should make the processes easier in the future.
- ✓ Ensure that there is a stronger link with the neonatal network- *meetings have been held between the CDOP Chair and the NW Neonatal Operational Delivery Network (NWNODN) to clarify the protocols for the new arrangements; processes have now been established; The network will provide conclusions and recommendations of their independent reviews for CDOP to consider at panel.*
- ✓ Ensure all agencies understand the new guidance and relevant processes - *CDOP has consulted and engaged with all statutory agencies and other strategic partners to alert them to the new guidance and implications; various briefing documents have been circulated; engagement events have been organised;*
- ✓ Deliver a multi-agency learning event- *a successful interagency/ multi-professional event was organised with a focus on bereavement support;*
- ✓ Ensure that safer sleep messages are being promoted in a consistent way across Cheshire- *Assurance has been provided from health that information and advice is given at planned contacts visits as per NICE guidance (NICE Postnatal Care Guidelines CG37 2014). The Pan Cheshire Multi-Agency Guidance for Infant Safer Sleep 2019 has now been ratified and multi-agencies and awareness will be raised via the Pan Cheshire CDOP newsletter; In conjunction with the launch of the Pan Cheshire Multi-Agency ICON (Infants Cry You Can Cope) programme, an update regarding Infant Safer Sleep is to be provided.*
- ✓ Update the Pan-Cheshire CDOP protocol in accordance with the new guidance- *Processes have been updated, and a self-assessment against standards will be completed in the next year.*
- ✓ Ensure that data is collected for Adverse Childhood Experiences (ACEs), Suicides and Children with learning disabilities- *processes have been implemented partway through the year; a full*

  year's ACE data will be available next year and will feature in next year's report.
- ✓ Explore the observed rise in deaths per u18 population in Cheshire East- *an in-depth analysis on the increased rate was undertaken involving PH England, which provided the CDOP representatives with the necessary assurance that there were no reasons for concern*
- ✓ Ensure that children's deaths are categorised in accordance with the new guidance in terms of either place of local authority residence, or GP registration. Figures will be verified by the

panel at the end of the reporting year- *There have been no anomalies identified since the changes were adopted last year.*

Update on recommendations for Local Safeguarding Partners in the annual report 2017-18 *(in italics)*

Local Safeguarding Partners are asked to:

1. Note to contents of this annual report
2. Ensure that the new Safeguarding arrangements maintain strong links with the child death review processes as they evolve, and in particular, ensure full involvement of the relevant partners- *Local Children's Safeguarding Partnerships will receive periodic reports, and will be alerted of any recommended action from CDOP where safeguarding issues have been identified; this will be defined in the MOU*
3. Work collaboratively to ensure that lessons learned from the COCH neonatal review are effectively cascaded across all appropriate networks, and ensure that robust processes are in place to establish unusual patterns of unexpected child deaths in hospitals – *the Royal College provided a review with recommendations and have been shared through various clinical networks; All numbers of child death notifications from hospital are monitored*

Priorities for 2019-20:

- ✓ Embed the new Child Death Review processes and develop reporting processes for local Children's Safeguarding Arrangements and health and wellbeing Boards
- ✓ Support Trusts in developing robust child death review meetings (e.g.perinatal mortality; hospital mortality; etc) to inform the CDOP process in a standardised/ structured manner
- ✓ Ensure all agencies understand the new guidance and relevant processes
- ✓ Undertake a self-assessment against the standards identified in the new operational guidance, and identify corrective actions to ensure compliance;
- ✓ Develop and agree a MOU between the Statutory Partners (LAs/CCGs) to clarify roles and expectations;
- ✓ Agree future funding formula for CDOP and broader Child Death Review processes.
- ✓ Implement the eCDOP programme across Cheshire, to improve processes and minimise additional administrative burdens;
- ✓ Undertake an audit of LeDeR cases to determine the percentage of cases that did not meet the agreed protocol;
- ✓ Analyse the data on Adverse Childhood Experiences (ACEs) and report on the findings next year.
- ✓ Establish a formal business meeting, separate to the review meetings. (This will not be additional time but will provide opportunities for process development and oversight.)

Recommendations for Local Safeguarding Partners

Local Children's Safeguarding Partners are asked to:

1. Note the contents of this report
2. Endorse the priorities identified
3. Ensure that the CDR processes remain embedded in the new Safeguarding arrangements until at least April 2020.
4. Transfer the responsibility for CDR/CDOP to Health and Wellbeing Boards after 2020.

5. Children's Safeguarding and Health and wellbeing partners should clarify what interagency initiatives are required to reduce the prevalence of modifiable factors identified in the under one population including:
    - Safe sleeping
    - Risk factors for reducing premature births including:
        - High BMI (including healthy diet and physical activity)
        - High blood pressure (linked to high BMI)
        - Smoking
        - Alcohol use
        - Substance misuse
        - Domestic violence
        - Mental health
        - Diabetes (often linked to BMI)
        - Lack of physical activity

Mike Leaf
Independent Chair
Pan-Cheshire CDOP
September, 2019

CDOP Panel Meetings

CDOP Membership

Pan-Cheshire CDOP's core membership comprised of:

- Independent Chair
- CDOP Coordinator
- Designated Nurse for Safeguarding Children (Warrington and Halton)
- CDOP Nurses x 3 (Cheshire East, Cheshire West and Warrington)
- Specialist Midwife
- Public Health
- Coroner's officer
- Designated Doctor for Child deaths x 3 (Cheshire East, Cheshire West, Warrington/Halton)
- Police Representative from PPU Directorate
- Local Authority Service Manager, Safeguarding Unit
- Local Authority Service Manager, Children's Social Care
- Education Representative from Safeguarding in Education Team.
- LSCB Business Manager x1
- Co-opted Advisory Member (Paediatrician/Deputy Coroner)
- North West Ambulance Service (where needed in cases of unexpected deaths)

The Pan-Cheshire CDOP has permanent representatives drawn from the key professional areas represented on participating LSCBs. Members of the CDOP attend the meetings as representatives of their profession/designation rather than representing their employing organisation. Members have a responsibility to disseminate recommendations and learning to agency representatives on the Boards in the other Pan Cheshire LSCB areas. Other members may be co-opted to contribute to the discussion of certain types of death when they occur.

Quoracy

A representative from the police, one Doctor, one Nurse and a minimum of one LSCB Business Manager will ensure that a meeting is quorate. Quoracy is being reviewed in the light of new child death review arrangements.

Frequency of Meetings

The panel currently meet on a quarterly basis and for a whole day. It has been agreed that this frequency will remain unless there was a significant number of cases to review. The business meeting will follow the panel meeting.

Agency Representation at Panel Meetings

The Pan-Cheshire CDOP met on four occasions between April 2018 and March 2019. Attendance is monitored on a regular basis to ensure quoracy and effective representation. On occasions there are times where professional demands have to take priority, and members, in these cases are expected to provide a replacement. Representation has been consistent throughout the year.

Table 1: Agency representation

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

Processes/ Networks/ Reviews and Sub-groups

Notification Process

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

SUDiC Guidance

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

Links to Coroners and Registrars

Within Cheshire there is an excellent working relationship with the Coroners offices, with senior coroner's officer representation, and specific investigatory work being undertaken e.g. a *review of fatal self-harm in children and adolescents*.

Deaths of Children Living Outside Cheshire

Whilst CDOP is responsible for the review of child deaths resident in Cheshire, there is an expectation that it should receive notification of child deaths for children who live out of area, but have died within the boundary. As Cheshire borders Wales, where there is a different process for reviewing child deaths, the numbers of these children may be significant. CDOPs across the country should routinely notify the CDOP where the child died, and visa versa. Any deviations from this process are followed up. In the future, some deaths may be reviewed of non-resident children where there is local learning to be uncovered, but this will be discussed with the CDOP of the child's residency. This will be done on a case by case basis.

Communicating with Parents, Families and Carers

Leaflets and a letter are made available to any parent following the death of a child. A new NHS England leaflet has been produced for use locally. "When a Child Dies" provides a detailed explanation of many of the processes associated with a child's death.

Deaths involving Serious Case Reviews/ Critical Incident Reviews

Child deaths are considered at panel once all relevant investigations and reports have been completed. These include those that have been the subject of Serious Case Reviews, Critical Incident Reviews or any learning review. This approach is consistent with that undertaken across the north-west and much of England, and will continue under the new local and national Safeguarding procedures. This may, on occasions, result in a delay between notification and review completion and CDOP will continue to monitor this process and any delays. This explains why there is usually a difference between the number of death notifications, and the number of reviewed cases.

Regional/ National Links/ Updates:

North-west meetings
Pan-Cheshire CDOP continues to be represented at the north-west CDOP meetings. A common dataset was agreed for all north-west annual reports to allow for the compilation of an overview report covering the area. A north-west CDOP report is produced annually, although falls out of sequence from local CDOP annual reports.

National Network
Some Cheshire CDOP members form part of the national network group which advises on issues of national interest, including the transfer of the CDOP responsibilities to the Department of Health. Panel members attend the national event and feed back to panel.

National Child Mortality Database (NCMD)
Pan-Cheshire CDOP continued to participate, by invitation, on the working group to determine the need for a national CDOP database, and provide data as part of national piloting, prior to the launch of the database in April 2019. Recommendations have been made for Pan-Cheshire CDOP to adopt the eCDOP programme which links directly to the NCMD which will reduce the additional administrative burden resulting from changes to the CDR processes. At the time of writing, decisions to fund the licence have still to be made.

Funding

Contributions

Each LSCB and PH department contributes £1625 (£13000pa total) with additional population-based contributions to cover the CDOP Business Administration costs (Table 2). Funding will continue to be reviewed in light of the expectations placed on partners as a result of the new CDR statutory guidance.

Table 2: Contributions to CDOP process for 2018-19 by LSCB area

	Warrington	Halton	Cheshire West and Chester	Cheshire East	Total
20% for panel admin	£1,179.25	£1,179.25	£1,179.25	£1,179.25	£4,717.00
80% for child deaths	£3,957.80	£2,431.10	£5,592.36	£6,886.74	£18,868.00
Total	**£5,137.05**	**£3,610.35**	**£6,771.61**	**£8,065.99**	£23,585.00

Issues Identified

Missing Data

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

Modifiable Factors

A modifiable factor is one *which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions could be modified to reduce the risk of future child deaths*. Overall the modifiable factors identified for Cheshire during 2018/19 (in order of prevalence) include:

- Smoking by the mother/ parent/ or carer during pregnancy or in the first few years of a child's life (57% of all neonatal deaths)
- Mental health issues (parent or child) (29% of all deaths)
- Alcohol / substance misuse (parent/child) (18% of all deaths)
- High maternal body mass index (BMI) (22% of all neonatal deaths)
- Domestic Violence
- Unsafe sleeping
- Housing overcrowding

The highest annual number of deaths occur neonatally (under 28 days) often as a result of complications through prematurity. Smoking, alcohol consumption and a high maternal BMI all increase the risk of prematurity and low birth weight, resulting in an increased level of vulnerability and risk of early infant death.

It is important that all parts of the health and social care system reinforce messages that reduce risk of prematurity and low birth weight, especially during pregnancy.

National annual statistical data

The LSCBs are required to collect a considerable amount of data following the death of every child. From the 2018 -2019 year onwards the information will be submitted and published by NHS England. The CDOP Co-ordinator is responsible for this function on behalf of each of the four LSCBs. NHS England, in turn, consolidates the returns and publishes a statistical release. At the time of writing, no data has been published by NHS England.

Priorities for 2019-20:

- ✓ Undertake a self-assessment against the standards identified in the new operational guidance, and identify corrective actions to ensure compliance;
- ✓ Develop and agree a MOU between the Statutory Partners (LAs/CCGs) to clarify roles and expectations;
- ✓ Agree future funding formula for CDOP and broader Child Death Review processes.
- ✓ Implement the eCDOP programme across Cheshire, to improve processes and minimise additional administrative burdens;
- ✓ Undertake an audit of LeDeR cases to determine the percentage of cases that did not meet the agreed protocol;
- ✓ Analyse the data on Adverse Childhood Experiences (ACEs) and report on the findings next year.
- ✓ Establish a formal business meeting, separate to the review meetings. (This will not be additional time but will provide opportunities for process development and oversight.)
- ✓ Support the Multi agency ICON & Safe sleep campaign which was developed to support practitioners to deliver the right messages to parents and carers.

Section 3: Data and Analysis

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

Number of Deaths

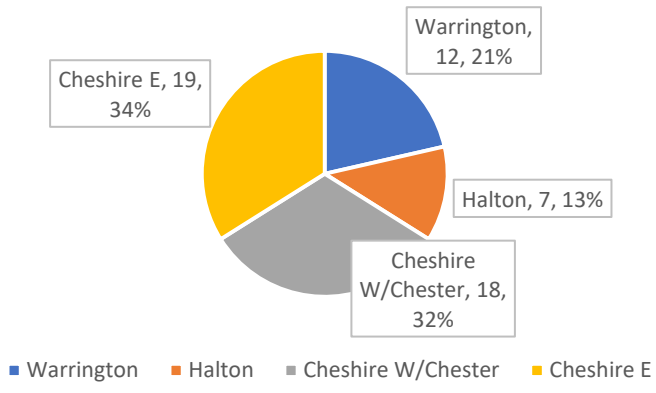
The Pan Cheshire CDOP met on four occasions between April 2018 and March 2019. The total number of child deaths notified across the Pan Cheshire footprint was 56. (Cheshire East (19), Cheshire West and Chester (18), Halton (7) and Warrington (12)).

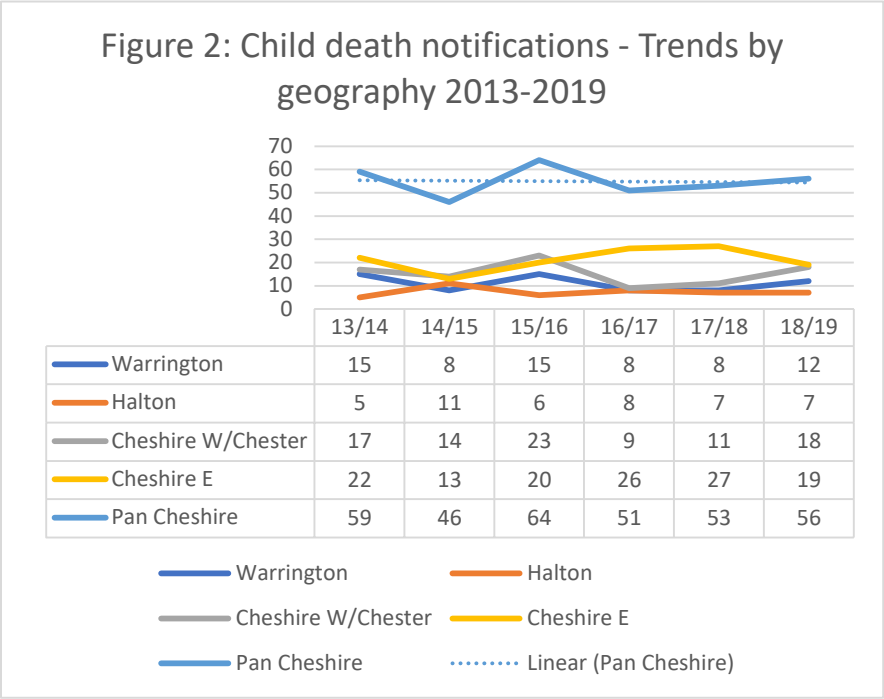
End of Year Case	
2015 - 2016	1
2016 - 2017	2
2017 -2018	4
2018 – 2019 Qtr 1 to Qtr 3	6
2018 – 2019 Qtr 4	15
TOTAL	**28**

At the end of 2018-19 there were 28 child deaths outstanding which have not yet been considered by CDOP. A total of 13 were subject to inquests 15 where reported in the final 3 months of the year.

Figure 1 shows the percentage split of the numbers of notified deaths, by local authority area. A small increase or decrease in notifications can cause significant swings in these proportions each year, and it is sometimes more useful to con
sider trends over a period of time.

Figure 1: Number of notifiable deaths by geography 18/19



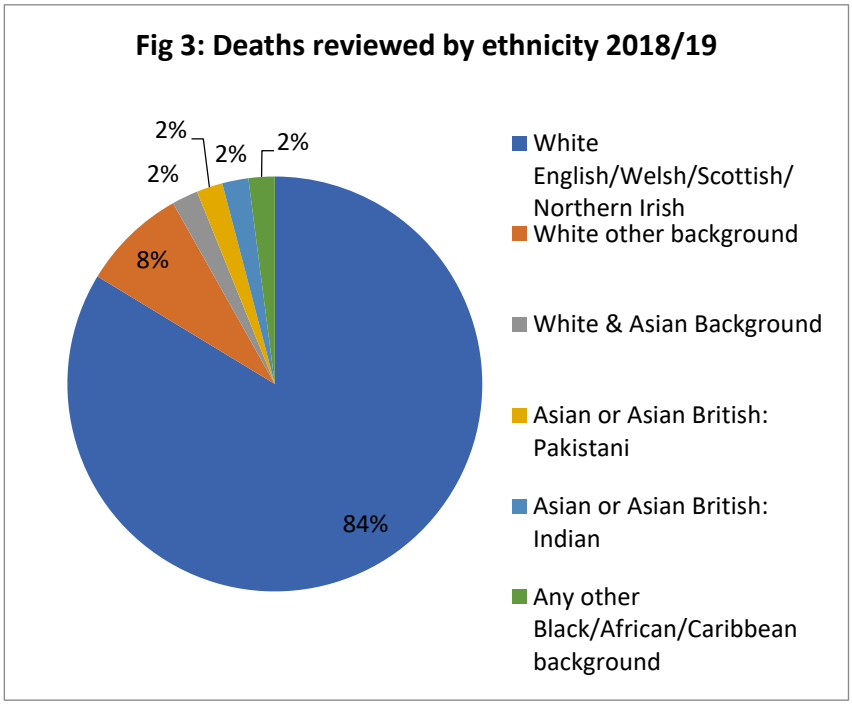


	13/14	14/15	15/16	16/17	17/18	18/19
Warrington	15	8	15	8	8	12
Halton	5	11	6	8	7	7
Cheshire W/Chester	17	14	23	9	11	18
Cheshire E	22	13	20	26	27	19
Pan Cheshire	59	46	64	51	53	56

Figure 2 shows that the very slight downward trend in child death notifications highlighted last year has levelled off. Cheshire East has seen a small decrease in notifications over the same period (see trend line). The mean average number of notifications over the last 5 years is 54.8, which is slightly below the recommended lower limit of 60 deaths per year by NHSE.

Ethnicity of the child

Figure 3 shows that the majority (84%%) of the child deaths reviewed during 2018-19 were of 'British White' ethnicity.



Child Population

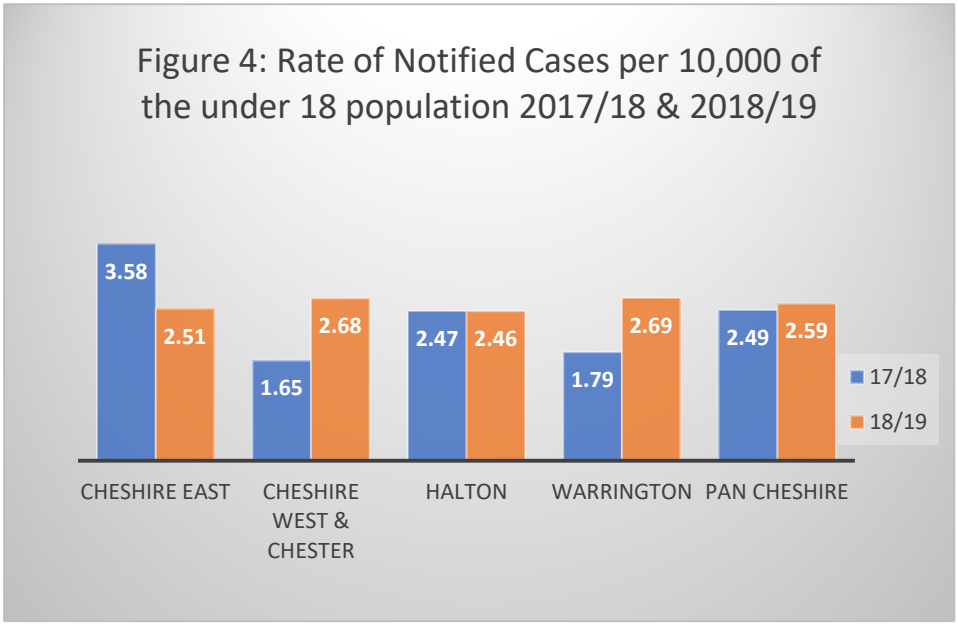
The child population estimates in each of the four LSCB areas is detailed in the following table 4.

Table 4: Child Populations by local authority

LSCB area	Child population size* (0-17 years)
Cheshire East	75,834
Cheshire West & Chester	67,284

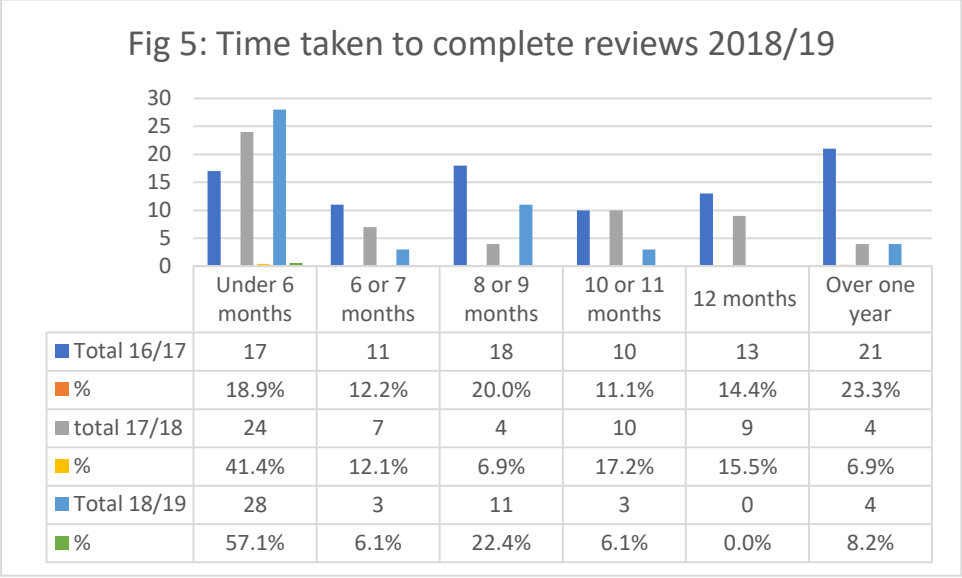
Halton	28,408
Warrington	44,646
Pan Cheshire	216,172

* Source: ONS mid-Year Population Estimates, 2017



Local child populations are useful when comparing local areas. Normally, one would expect to see the numbers of deaths in each geography, to be proportionate to the number of under 18-year olds living in each, but there may be differences according to deprivation levels. Figure 4 shows the rate of deaths per 10,000 0-18 years population over the last 2 years, and highlights that the number of child death notifications relative to the under 18 population of an area is similar to Cheshire as a whole.

Review Completion



	Under 6 months	6 or 7 months	8 or 9 months	10 or 11 months	12 months	Over one year
Total 16/17	17	11	18	10	13	21
%	18.9%	12.2%	20.0%	11.1%	14.4%	23.3%
total 17/18	24	7	4	10	9	4
%	41.4%	12.1%	6.9%	17.2%	15.5%	6.9%
Total 18/19	28	3	11	3	0	4
%	57.1%	6.1%	22.4%	6.1%	0.0%	8.2%

Figure 5 provides a breakdown of the time taken to complete the reviews over the last 3 years. It shows that during 2018/19, 57.1%% of reviews were completed within 6 months compared to 41.4% in the previous year. This has been a steady improvement over the last 2 years. CDOP is confident that unnecessary delays in the process are being kept to a minimum and will keep the matter closely under review.

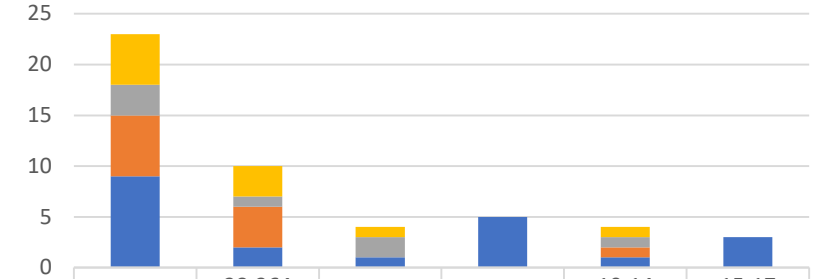
Deaths by gender

From April 2018 – March 2019 of the 49 child deaths reviewed by the CDOP, 38 were male (77.5%) and 11 were female (22.5%).

Child Deaths Reviewed by Age (DfE categorisation)

Figure 6 shows that the largest number of child deaths occurred within the first twelve months of life (67.3%). Nationally, 60% of deaths in childhood occur during the first year of a child's life, and are strongly influenced by pre-term delivery and low birth weight; with risk factors including maternal age, smoking and disadvantaged circumstances (Wolfe and Macfarlan, 2015).

Fig 6: Deaths reviewed by age 2018/19



	0-27 days	28-364 days	1-4 years	5-9 years	10-14 years	15-17 years
WA	5	3	1	0	1	0
HA	3	1	2	0	1	0
CW	6	4	0	0	1	0
CE	9	2	1	5	1	3

In Summary (last years' figures in [brackets]:

- 46.9% of the deaths occurred before the child reached 28 days (23 deaths)[36.2%]
- 67.3% of the deaths occurred before the child reached one year of age (33 deaths)[58.6%]
- 8.2% of the deaths occurred in Children aged 1 year to 4 year (4 deaths) [8.6 %]
- 10.2% of the deaths occurred in Children aged 5 years to 9 years (5 deaths) [8.6%]
- 8.2% of the deaths occurred in Children aged 10 years to 14 years (4 deaths)[8.6%]
- 6.1% of the deaths occurred in Children aged 15 years to 17 years (3 deaths) [15.5%]

Deaths reviewed by CDOP with modifiable factors

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

Fig 7: Modifiable factors by age groups 2018/19

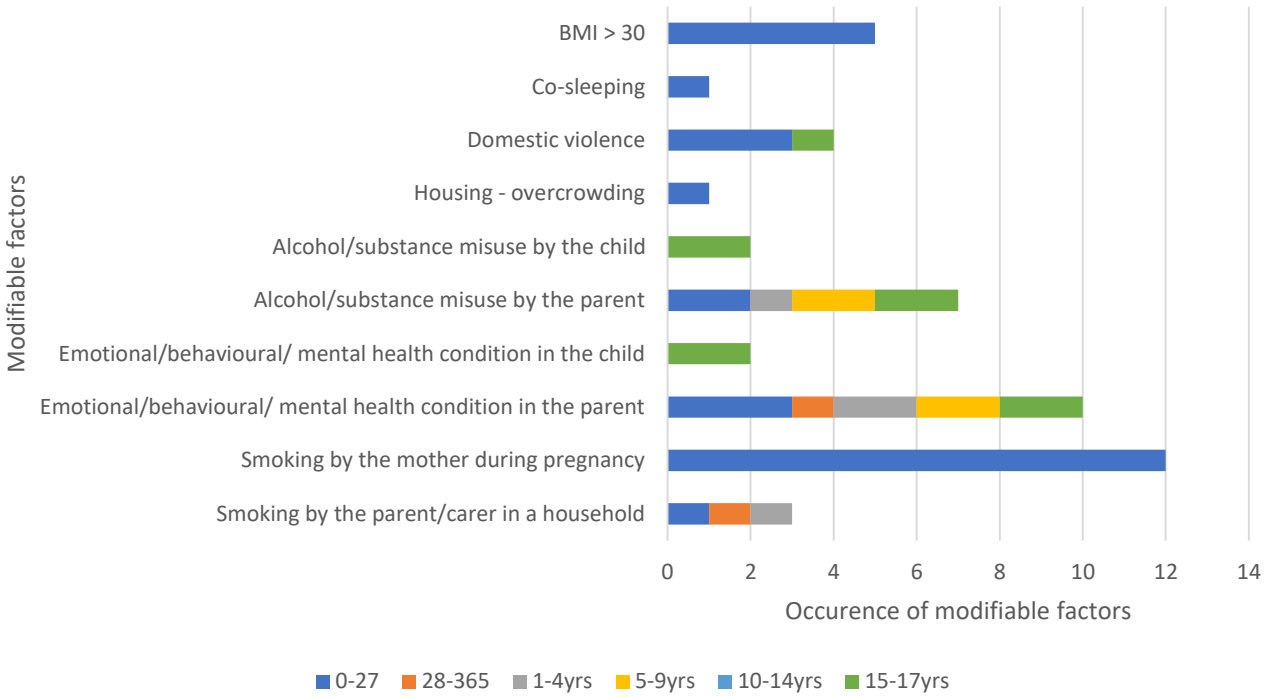


Fig 7 shows the modifiable factors identified for Cheshire including:

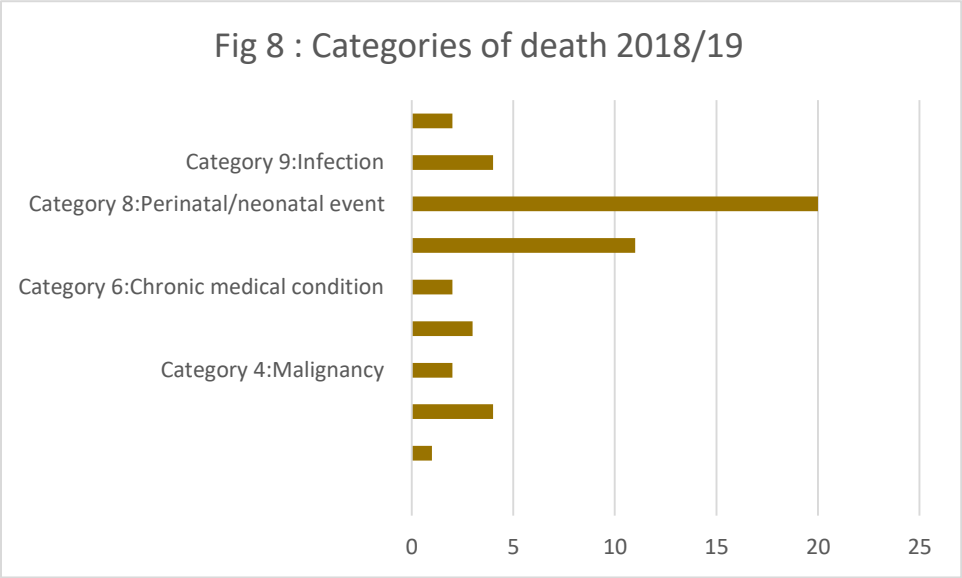
- Smoking by the mother/ parent/ or carer during pregnancy or in the first few years of a child's life (57% of all neonatal deaths)
- Mental health issues (parent or child) (29% of all deaths)
- Alcohol / substance misuse (parent/child) (18% of all deaths)
- High maternal body mass index (BMI) (22% of all neonatal deaths)
- Domestic Violence
- Unsafe sleeping
- Housing overcrowding

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

Category of Child Death

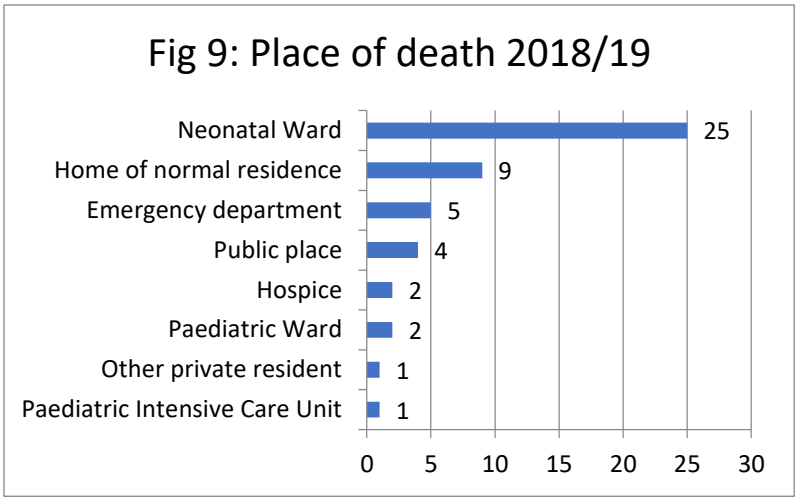
The CDOP panel is required to record each death against 1 of 10 nationally-set categories as follows:

Category 1: Deliberately inflicted injury, abuse or neglect (0)
Category 2: Suicide or deliberate self-inflicted harm (1)
Category 3: Trauma and other external factors (4)
Category 4: Malignancy (2)
Category 5: Acute medical or surgical condition (3)
Category 6: Chronic medical condition (2)
Category 7: Chromosomal, genetic and congenital anomalies (11)
Category 8: Perinatal/neonatal event (20)
Category 9: Infection (4)
Category 10: Sudden unexpected, unexplained death (2)

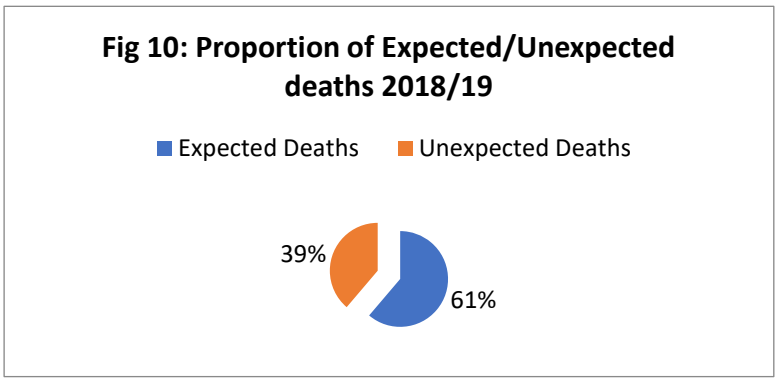


Further explanations can be found in Appendix 1. It can be seen in Figure 8 that the greatest proportion of deaths relate to perinatal/ neonatal event (category 8) which compares with the patterns seen in the NW and nationally. Chromosomal, genetic and congenital anomalies (category 7) is the second highest category, as it has been for the last three years.

Location of Child Death

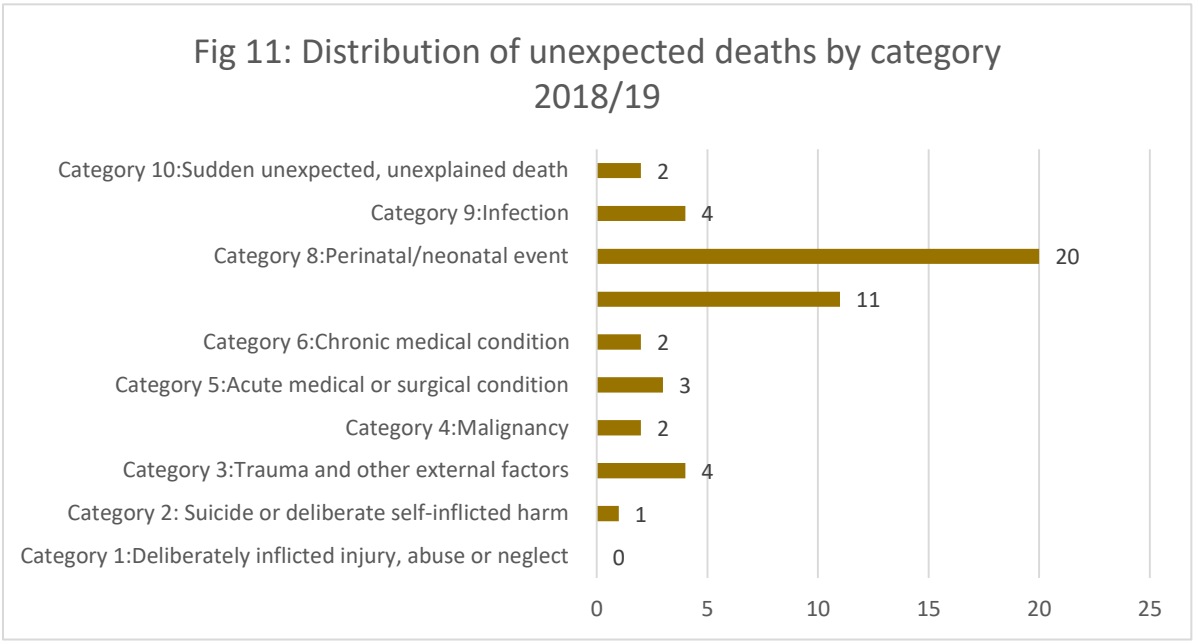


The majority of deaths (69.4%) occur within a hospital setting, the majority (51%) of these occurring in the neonatal units (Figure 9).
This is unsurprising because, by their very nature, these units provide care for premature babies and the most vulnerable/ at risk.



Expected / Unexpected deaths

An expected death refers to a death that could reasonably been foreseen by clinicians for a period of at least 24 hours before it occurred. An unexpected death is then defined as the death of an infant or child which was not anticipated as a significant possiblity 24 hours before the death or, where there was was an unexpected collapse or incident precipitating the events that led to that death. Between April 2017 and March 2018, there were 19 deaths (39%) that were classified as 'unexpected'.



The proportion of unexpected deaths has increased from 11% (2016-17) to 24% (2017-18) to 39% 2018-19. Similar to the previous two years, categories 7 and 8 contain the the most unexpected deaths, but also contain the highest proportion of deaths.

Acknowledgements

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

Mike Leaf
Independent CDOP Chair
September 2019

Glossary of Terms

Term	Meaning
Child	A person aged 0-18th birthday
Expected death	A death that could have been reasonably predicted 24 hours before the death occurred or 24 hours before the immediate events leading to the death occurred
Infant	Aged less than 1 year of age
Modifiable factors	Factors associated with a death which by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths
Neonatal period	From birth until 28 days of life
Perinatal period	From viable gestation (around 23 weeks of pregnancy) until 7 days following birth
Unexpected death	A death that could not have been reasonably foreseen 24 hours before it occurs – or where there was an unexpected collapse or precipitating events leading to the death

Abbreviations

CDOP – Child Death Overview Panel

SUDI – Sudden Unexplained Death in Infants

LSCB – Local Safeguarding Children Board

Appendix 1: Classification of Death

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

Category	Name & description of category	Tick box below
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	☐
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	☐
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect. (category 1).	☐
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	☐
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	☐
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.	☐
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.	☐

8	**Perinatal/neonatal event** Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	☐
9	**Infection** Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	☐
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	☐

The panel should categorise the 'preventability' of the death – tick one box.

Preventable child deaths are defined in Chapter 5, paragraph 11 (p85) of Working Together to Safeguard Children (2015).

LSCB Annual Report 2018-19 & Business Plan Priorities 2018-19

Cheshire East Local Safeguarding Children Board

Foreword from the Independent Chair

I am pleased to present the 2018 - 19 Annual Report on behalf of all the agencies represented on the Cheshire East Local Safeguarding Children Board (CELSCB). The reports shows that in Cheshire East we have continued to build on the strong partnership foundation to meet the many challenges facing agencies in ensuring that we are not only keeping children and young people safe but also improving the outcomes for our most vulnerable children.

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

I hope that you will find that the report helps you to better understand how organisations and people work together and the contribution the Safeguarding Board has made to this. It sets out how these arrangements can continue to improve on the basis of the Safeguarding Board and partners being able to objectively and critically learn from what works well and act to improve what may not work as well as was intended.

This report covers 1 April 2018 to 31 March 2019 and highlights the activity, progress and challenges faced by CELSCB with a particular focus on the journey of the child; implementation of both the Neglect and Early Help Strategies. We have set out the achievements made in 2018-19 and the areas where we need to continue to make improvements.

As you read through the pages of this report you will gain an insight into the work of CELSCB, how we audit, review, learn and invest in partnerships with the ultimate aim of improving the lives of our children. There is no doubt that there is much to celebrate in our work, but much more that we can do. We are committed to continuous improvement and strive to improve the lives of children who are neglected or in need of early help, those who live with the toxic trio of parental domestic abuse, substance misuse or poor mental health and those who are at risk of child sexual exploitation. We are determined to tackle these issues from every possible angle, to improve practice, to better engage with children and communities and to build stronger partnerships.

In January 2019 we had our annual development/planning day where we reviewed the progress against the 2017-19 Business Plan; and agreed the priority areas for 2019-22:

- ✓ Our approach to Contextual Safeguarding
- ✓ Continuing the work on improving the quality and

effectiveness of child in need planning for children

- ✓ Emotional Health and Wellbeing of our most vulnerable children,
- ✓ Embedding and testing the effectiveness of our new arrangements.

We also took the opportunity at this session to consider all the feedback we had received as a partnership regarding our proposal for the future arrangement

As Independent Chair I am committed to ensuring our children, young people and their families have a voice and are heard. Capturing and responding to 'Voice of the Child' is a strength in Cheshire East working alongside the excellent work that is done by the Safeguarding Children in Education Team. In 2018-19 following the Act Now Conference presented by the children and young people a number of board members linked with the schools to champion their work and provide a direct link to the Board. We had a presentation from young people and the work they had done within their school environment in relation to on line safety.

The continuing challenge will be maintaining the progress of the last few years, through a time of policy change and new national priorities that include changes to Safeguarding Boards; without losing sight of what matters – the safeguarding of children in Cheshire East.

Looking forward, legislation came into effect in July 2018 and Local Safeguarding Boards are to be replaced with new multi-agency safeguarding arrangements which have to be established by September 2019 at the latest. Until these new arrangements are in place the statutory requirements for the CELSCB will remain and it will be vital to ensure that the transition arrangements are robust to ensure that the safeguarding of children and young people remain at the heart of what is developed in the future.

Following an inclusive approach across the partnership Cheshire East have published the new arrangements – with a stronger emphasis on partnerships and working together. You can read more about the new arrangement at here. An area for focus in 2019-20 will be embedding the new arrangements and testing their effectiveness.

To conclude, I would like to thank members of the Board, across the partnership of our voluntary, community and statutory services and all the frontline practitioners and managers for their commitment, hard work and effort in keeping children and young people safe in Cheshire East. We will continue to seek out what we can do better, to support the community we serve and ensure that children and young people are safer as a result.

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

Gill Frame, Independent Chair, Cheshire East Safeguarding Children Board.

Cheshire East Local Safeguarding Children Board

Background

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

In the year 2018-2019, the partnership has been working towards meeting and publishing the new arrangements as set out in Working Together to Safeguard Children 2018. The new multi-agency safeguarding children arrangements were published in June 2019 and will be implemented by September 2019.

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

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

The Board

Cheshire East Local Safeguarding Children's Board consisted of senior representatives from agencies working with children and young people from the local authority, schools, health, the police and others. The Board members work together to keep children and young people safe from harm.

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

In order to provide effective scrutiny, CELSCB was independent from other local structures and had an independent chair that holds all agencies to account. The main role of the CELSCB is set out in its constitution. It is to co-ordinate and to ensure the effectiveness of work undertaken by each agency on the Board for the purposes of safeguarding and promoting the welfare of children in Cheshire East.

Our Collective Vision for the Children and Young People of Cheshire East

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

We aim to do this through our collective commitment to:

- **Strategic Leadership across the partnership** – to make the safety of children and young people a priority

- **Challenge** – through focused inquiries or investigations into particular practice or issues on the basis of evidence, practitioner experience and the views of children and young people, in order for us to improve together
- **Learning** – to achieve the highest standards of development and to ensure all practitioners have the skills and knowledge to be effective

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

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

We will:

- Actively involve children and young people and their families, as what they say will shape the way that we work;
- Listen to front line practitioners and their managers and take their views into account;
- Act in an open and transparent way and foster a culture of challenge, scrutiny and support across the partnership;
- Ensure that our staff have the skills, support and supervision to keep children and young people safe;
- Share information and intelligence that will enable us to keep our children and young people safe;
- Celebrate strengths and positive achievement. We are committed to continuously improve;
- Embed the principles of 'Signs of Safety' across our partnership;
- Work with other strategic partnerships in Cheshire East to ensure that our plans are aligned in order to maximise the opportunities for children and young people.

Governance

CELSCB had three tiers of activity (see Appendix 1):

The Board which consisted of representatives from the partner agencies as set out in Working Together 2015. Board members were sufficiently senior to ensure they are able to speak confidently and had the authority to sign up to agreements on behalf of their agency.

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

Sub-groups and Task and Finish Groups (Cheshire East) – these groups work on the board's priority areas on a targeted and thematic basis. They report to the Executive and are ultimately accountable to the Main Board.

Operating at March 2019 were:

Sub-groups

- Quality and Outcomes
- Audit and Case Review
- Learning and Improvement
- Safeguarding Children Operational Group
- Policy & Procedures

Task and Finish Groups

- Child Exploitation
- Early Help

Sub groups (Pan-Cheshire) – CELCSB worked closely with the other Cheshire LSCBs on certain areas to maximise the opportunity for streamlined processes across our boundaries. The following Pan-Cheshire sub-groups were in operation:

- Child Death Overview Panel
- Policies and Procedures
- Youth Detention
- Child Exploitation
- Harmful Practices

Key Roles

Independent Chair – The Independent Chair for Cheshire East was Gill Frame and was accountable to the Chief Executive of the local authority.

During 2018/19 the Acting Chief Executive of Cheshire East was **Kath O'Dwyer**. It is her role to appoint or remove the LSCB chair. The Chief Executive meets quarterly with the Independent Chair through the Safeguarding Review Meetings to maintain an overview of the effectiveness of the board, to hear any safeguarding concerns and to challenge the performance of the Board.

The Acting Executive Director of People was **Mark Palethorpe**, who holds the role of Director of Children's Services and is a member of the main Board. He had responsibility to ensure that the CELSCB functions effectively, liaised closely with the Independent Chair and also attended the Safeguarding Review Meetings.

Lead Member – the Lead member for Children's Services has responsibility for making sure that the local authority fulfils its legal duties to safeguard children and young people. **Councillor Jos Saunders** represented the Council. The Lead Member contributes to the CELSCB as a 'participating observer', i.e. they take part in the discussion, but are not part of the decision making process.

Lay Member – **Lukhvinder Kaur** who represented the local community operating as a full member of the CELSCB.

Participation – A strength of the Board is its commitment to ensure that the voice of children and young people is a key focus of the Board. The Board commenced each meeting with a spotlight on participation activity by partners.

Health and Wellbeing Board (HWBB) – CELSCB links with the Health and Wellbeing Board and is held to account for key safeguarding issues for children in Cheshire East. This annual report and business plan will be presented to the Health and Wellbeing Board.

Cheshire East Local Safeguarding Adults Board (CELSAB) - CELSAB carries out the safeguarding functions in relation to adults 18 years and over. A number of members of the CELCSB also sit on CELSAB.

Safer Cheshire East Partnership (SCEP) – SCEP is responsible for the commissioning of Domestic Homicide Reviews (DHR's), which are undertaken on its behalf by the CELSAB. It receives reports on domestic abuse and sexual violence. SCEP is the lead partnership for 'Prevent' (the approach to tackling extremism and radicalisation) in Cheshire East and works with the other partnership boards to ensure that the Prevent strategy is being implemented across all agencies and in the community.

Partnership Key Lead Areas

Key partnerships agreed the following leads for shared priority areas:

Shared priority area	Strategic governance lead
Domestic Abuse	Cheshire East Domestic & Sexual Abuse Partnership Board
Prevent	Safe Cheshire East Partnership
Reducing Offending	SCEP & Youth Justice Board
Anti-social Behavior	SCEP
Organised crime	SCEP
Hate Crime	SCEP
Child Sexual exploitation	CELSCB
Trafficking and Modern Slavery	CELSAB
Hate crime	CELSAB
Substance misuse	HWBB
Mental Health	HWBB
Improving outcomes for children and young people	Children and Young People's Trust

Member Agency Management Boards – CELSCB members are senior officers within their own agencies providing a direct link between the CELSCB and their own single agency management boards to ensure that high quality multi-agency practice is embedded.

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

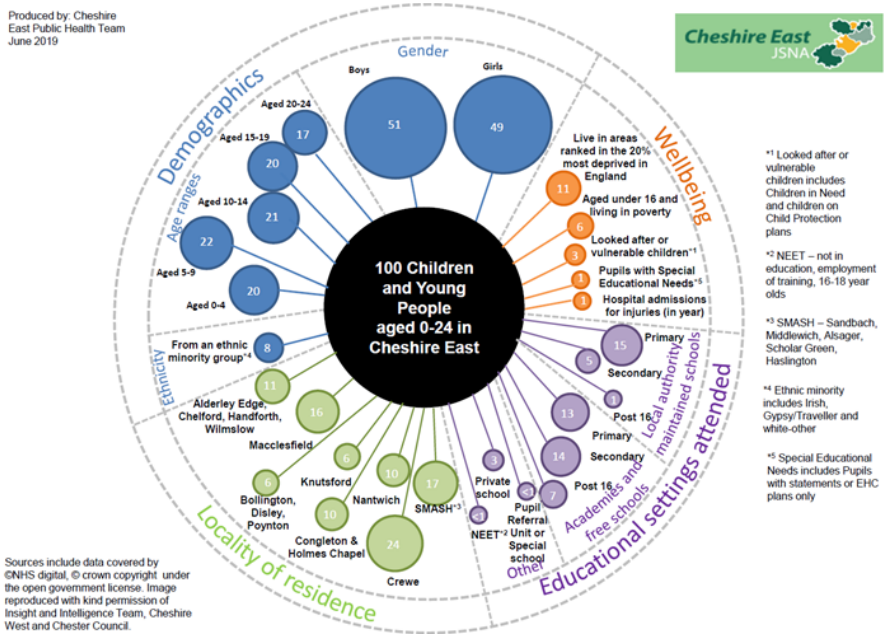
Board Membership and Attendance

The Board is well attended by key partners. A summary of Board membership and attendance for 2018-19 is in Appendix 2.

Financial Arrangements 2018-19

The finances of the Board for 2018-19, including member contributions are at Appendices 3 and 4.

Children and Young People in Cheshire East



Our Child Population

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

Cheshire East has 18 areas which are within the top 20% of the most deprived areas in England, affecting 31,600 people or 8.5% of Cheshire East's population. 13 of these areas are in Crewe, with two in Macclesfield, one in Wilmslow, one in Alsager, and one in Congleton. Overall, relative deprivation has increased since 2010, as only 16 areas were previously within the top 20% of most deprived areas.

There are approximately 75400 children and young people under the age of 18 in Cheshire East, 51% are male and 49% are female. Children and young people make up approximately 20% of the total population.

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

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

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

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

The number on a child protection plan has reduced from 286 on 31st March 2018 to 268 on the 31st March 2019.

At any one time during 2018-19 there were between 11-14 disabled children on a child protection plan.

As at 31st March 2019, 485 children and young people were cared for by Cheshire East which is a 2% increase from last year; 22% of these live outside Cheshire East and more than 20 miles from home.

The Child's Journey in Cheshire East

Cheshire East Consultation Service

Cheshire East Consultation Service (ChECS) is the 'front door' to access services, support and advice for children, young people and their families; from early help and support through to safeguarding and child protection. All referrers are required to have a telephone discussion with a qualified social worker and are advised on the level of need for the child and family and the appropriate next steps. Co-located within the front door arrangements at ChECS 'front door' team are the police, multi- agency missing from home service, Child Sexual Exploitation (CSE) service and domestic abuse hub.

	Consultation activity	No. converted to referral
2015-16	9843	3687 (37%)
2016/17	10,432	3438 (33%)
2017/18	9536	2976 (31%)
2018/19	9418	2558 (27%)

Number of consultations over the past four years that resulted in a referral to children's social care

There has been a 1% reduction in consultation activity since last year. Conversion to referral has reduced by 4% to 27%

Early Help

Prevention and Early Help Service

Recent years has seen an increasing demand for family support services, often with the issues that families are facing becoming increasingly complex. The Early Help Brokerage Service is a service with a dedicated team whose aim is the swift allocation of early help cases. This will provide timely referrals to early help, and identification of the best service to meet the needs of the child or young person and their family.

During 2018-19 ChECS received 9418 contacts of which 3234 were passed to Early Help Brokerage Service. Overall this was 34% of ChECS contacts.

CELSCB will continue to scrutinise the effectiveness of the front door and responses to early help in 2019-20.

The Local Authority aims to ensure that family support services are offered across a Continuum of Need with the right level of support meeting the right level of need.

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

- High quality advice and information through the Family Information Service support to our partners to engage with and deliver Signs of Wellbeing early help services, and supported access to more targeted services through CHECs and the Early Help brokerage.
- The Early Start service will deliver services in the Early Years Foundation Stage, and support families to achieve social mobility and early childhood health and ensuring localised intervention strategies between Children Centers and Maintained, Private, Voluntary and Independent childcare settings.
- Children Centers embed the Parent Journey consistently across all centers as the service universal offer.
- Family Support is offered across the continuum of need, and resources are aligned to need across level 2 Targeted and Level 3 Complex caseloads.

- Family Support services lead the council provision for parenting interventions.
- Supporting young people who are Not in Education, Employment or Training (NEET) to access provision post 16.

Children in Need and Child Protection

Local authority	Completed in 45 days		
	2015-16	2016-17	2018-19
England	83%	83%	83%
North West	83%	81%	84%
Cheshire East	89%	88%	81%
Statistical neighbour average	83%	82%	86%

Assessment timescales

2989 social care assessments were completed in 2018-19, compared to (3098) last year (4102 in 16/17). 81% of these were completed within 45 day.

Children in Need

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

As at the 31st March 2019 there were 2108 children with open episodes – this equates to 278.0 per 10,000 compared to 289.4 last year (the statistical neighbour average was 293.1 in 2017/18). This is in line with what we would expect to see given our demographic profile and reduction in referrals.

Child Protection

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

The number of S47's initiated within the year was 776 a decrease of 8% from the previous year (844) however similar to the 2016/17 figure of 786.

The number of Initial Child Protection Conferences (ICPCs) undertaken in the year was 400 a decrease of 19% from the previous year (492) but again in line with the 2016/17 figure of 397. The % of S47's with an outcome of ICPC is 52% which although slightly lower than the previous again in line with that seen in the previous 2 years.

The number of Child protection plans started in the year was 361 which is almost identical to 16/17 (362) but 20% lower than last year at 452.

This would possibly suggest that last year was an anomaly.

Child protection numbers 2015-19

Key Indicators	15-16	16-17	17-18	18-19
CPPs lasting 2 years or more	0%	0.5%	1.1%	0.3%
CPP for a 2nd or subsequent time	23%	17%	18%	26%
CP cases reviewed within required timescales	100%	99%	95%	98%
ICPC within 15 days	70%	80%	84%	81%

We have identified that there has been a rise in the number of children who return on a child protection plan for a second or subsequent time, an audit to identify the themes that relate to this has been completed and the following actions taken:

- Findings have been reported to the Child in Need task and finish group as more robust activity at child in need is required after a child steps down from child protection
- Work will be done to consider how we better evidence change where there is domestic abuse in the family (other than a cessation of reported incidents)
- Greater focus on evidence sustainability of change will be included in child protection conferences
- The circumstances for each child will continue to be considered at Joint performance meetings by social care

Cared for Children

Cared for children are those that are looked after by the local authority either voluntarily or through a statutory order. As at 31 March 2019, 485 children and young people were being cared for by the local authority, an increase of 2% from the previous year.

- 22% live outside the local authority area and over 20 miles from home;
- 36 live in residential children's homes;
- 1 lived in residential specialist school;
- 319 children and young people in foster placements;
- A number of individuals were supported who presented as unaccompanied asylum seeker children with support and advice including accommodation, where appropriate.

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

In the last 12 months a total of 147 children have ceased to be cared for by the Local Authority. Of these, 18 children have been adopted; 43 children became subject of special guardianship orders; 50 individuals have left care due to turning 18.

Care Leavers

As at 31 March 2019 there were 234 care leavers in Cheshire East. This has increased over the last 12 months.

Review of Priorities for 2018-19

The following three partnership objectives underpin the key plans for children and young people; the children and young people's plan, the children and young people's improvement plan and the CELCSB business plan:

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

CELSCB agreed the following priorities to deliver these objectives in 2017/19:

We will improve frontline multi-agency practice through:

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

We will continue to improve the participation of young people in CELCSB business through:

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

We will strengthen the partnerships through:

- Engaging the community through links with voluntary and faith sector
- Improving the board's role and traction in relation to developing early help

Improvements against the Priorities

Improving CELSCB's engagement with frontline staff

CELSCB e-bulletins

CELSCB has continued to publish its e-bulletin, Newsflash and Frontline Bulletins. These have covered a variety of topics including

• Modern Slavery • Suicide & Self Harm • LSCB Child Sexual Abuse Partnership Audit • ILACS Inspection • Safeguarding British minors returning from Syria	• Children who cannot communicate themselves due to learning difficulties • SEND/LD written statement of action • Audit into practice • CAHMS out of office advice line • Domestic abuse hub

• Signs of Safety • Neglect • Safeguarding Children in Sport • National Childrens Day • SEND Inspection • Children & Families Audit • Emotionally Healthy Schools • Bruising in children who aren't independently mobile • CSE Peer Champions • DfE Child protection campaign • Promoting road safety ahead of school holidays • CEDAS screening & referral tool • Dangers for young people travelling abroad to Spain • CDOP • Pan Cheshire safer sleep • Safeguarding Awards • Cheshire anti-slavery network • Reach Project • SEND/LD training consultation	• Abuse of older children • Disrespect nobody • #knifefree campaign • My Voice – Cared for children's event • Child exploitation – new screening tool • Child Criminal Exploitation • Open the door – Pan Cheshire domestic abuse campaign • National adoption week • Childrens rights month • NHS ages & stages assessment tool • Liberty protection safeguards • Parking around schools • Duty of care campaign • Children of prisoners • Child sexual abuse and exploitation social media library • Private fostering 7 minute guide • Neglect 7 minute guide • FGM table top review

Feedback from Board members has been that this method of communication is effective in supporting them in promoting CELCSB and in disseminating safeguarding information within their services.

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

- **Spotlight – The Voice of the Child**

  Board meetings continued to have a partner agency sharing an example of their practice in developing participation by children and young people in their safeguarding work.
  - Engagement Work at the CCGs and across Cheshire East
  - Youth Justice Services
  - Family Nurse Partnership
  - Early Help

- **November Children's Rights Month**

  November Children's Right's Month is an annual celebration of children's rights across the borough. CELSCB members took part in a range of activities including the 'Reverse Take Over Menu' developed by young people for adults to experience life in their shoes based on the 6 outcomes of the Children and Young People's Plan. Within Cheshire East we worked with Cheshire East Youth Council to make it a celebration of the positive participation of Children and Young People for services within Cheshire East.

  Key events included –
  - Reverse Take Over Month - professionals choose from a menu of the challenges set by young people and then complete an evaluation form at the end. The aim is to experience life as a child or young person;
  - 'Step up Day" - teams were asked to use pedometer to compete and find out who was willing to go the extra mile for

children's rights. This challenge represented young people who often have to walk quite far to school or college and outcome 4 of the Children and Young People's Plan 'Being Healthy and Making Positive Choices'

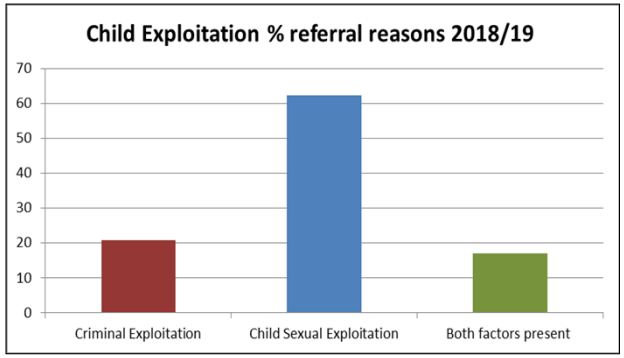
- The Take Over Challenge is where children and young people have the opportunity to become a professional for the day and run a specific area of business. This year twelve young people took over being a manager and director for the day.

The partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East.

- **Continuing to drive developments around Child Exploitation**

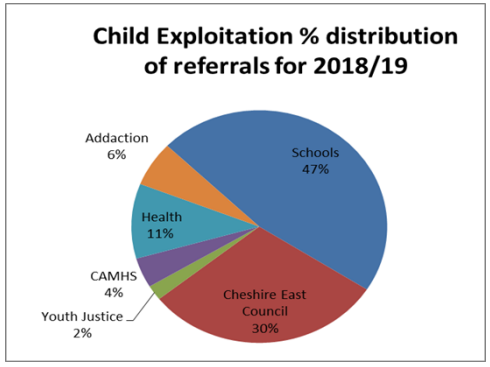
  This is managed through the multi-agency Missing From home/Child Sexual Exploitation team. The practice model has developed from the previous year and now operates as one group meeting that covers both North and South cases. This was in response to the difference number of referrals being discussed in each group. This operational group now also covers Criminal Exploitation.

  During 2018-2019 there were 53 young people referred as at risk of Child Exploitation that were considered at the operational group. This is an increase of 51% from 2017/2018. The majority of the increase can be attributed to referrals for Criminal Exploitation.



There has also been an increase in referrals for Child Sexual Exploitation, in 2017/18 the group review 26 referrals and in 2018/19 there was increase of 7. This suggests the specialist service is having an impact in supporting professionals to increase awareness and identify children and young people at risk of Child Sexual Exploitation and more recently in Criminal Exploitation.

Referrals were received from a range of agencies



The ratio of referrals from agencies has remained comparable to the previous year. There have been noted overall improvements

in the quality of the screening tools with good evidence of multi-agency collaboration in completion.

Females made up 68% of those identified as being at risk. This higher percentage in comparison to males is an ongoing trend from previous years reporting and in line with the national picture. The percentage of Males has increased however from the previous year by 24%. The majority of this due to referrals for Criminal Exploitation predominantly regarding males.

Young people identified as being at risk were aged between 11-18 years. Last year saw the youngest referral being 13. This suggests that either children or young people are being groomed younger or that professionals are identifying it earlier.

Similar trends were reported recently in the Children Society's Counting Lives, July 2019 where the research identified that '14-17 year olds are most likely to be exploited criminally…., but with evidence that primary school aged children as young as seven and eight are being targeted'.

The study went on to identify that 'Where children are being criminally exploited, safeguarding responses are largely reactive. Professionals reported that many children come to attention of statutory agencies when exploitation is *already* present in their lives'.

The referrals we have received for Criminal Exploitation indicate that the areas multi agencies are pro-active with identifying children and young people at risk, rather than reactive. Of the 11 Criminal Exploitation screening tools received, only two were completed following an arrest for criminal activity. The remaining were completed by schools, Addaction and Youth services based on intelligence of risk such as known associates (others at risk of Criminal Exploitation and/or Gang members), substance misuse, and changes in behaviour at home and or school and information of risk (coercion) disclosed by children and young people themselves. In addition, 6 of the 11 had no social care involvement at the time the tool was completed.

- **Trafficking**

  A number of victims and perpetrators of modern slavery have been identified across our boroughs, reinforcing the reality that modern slavery exists here, today, just as it does in others parts of the UK.

  Modern slavery involves the abuse and coercion of vulnerable people and it constitutes a safeguarding issue and, learning from our work around Child Sexual Exploitation, Forced Marriage, Female Genital Mutilation and Radicalisation, agencies across Cheshire are well placed to tackle it effectively. However, it presents a great number of overlapping issues and crimes which require a strong, coherent partnership response. It is essential that all of us across the public sector recognise that protecting people from slavery and exploitation is everybody's business, and part of our day job as professionals who work continuously to safeguard and support those at risk.

  The Pan-Cheshire vision will be delivered through four priorities:

  1. Embed the Modern Slavery Act into mainstream activity
  2. Improve awareness, understanding and identification

3. Develop a positive protection and support system for victims
4. Hold perpetrators to account and promote appropriate prosecutions

- **Continuing to drive developments around children in a home with domestic abuse**

  Cheshire East Domestic and Sexual Abuse Partnership (CEDSAP) undertook the following directly addressing Children and Young People's work.

  1. High Risk Cases - 17% reduction in high risk/ Multi Agency Risk Assessment Conference (MARAC) cases over the last three years and a parallel rise in early help seeking through the Domestic Abuse Hub sited alongside ChECS. 576 children have been heard at MARAC which is a decrease from the 663 last year and 782 in 2015-16.

  2. Initial Child Protection Conferences (ICPCs) - Specialist Services (Independent Domestic Violence Advisor (IDVA), Barnardo's and Cheshire Without Abuse) are present at all initial conferences where domestic abuse is a factor, regardless of whether the case is open to services in order to broker support and advise on appropriate interventions. Domestic abuse was identified as a factor in 36% of 273 notifications sent. In addition to these a further 9% of referrals were open to domestic services but were at conference for other reasons, therefore 45% ICPCs had domestic abuse as a factor.

  3. Joint Working with Child in Need/Child Protection Teams - Specialist services staff now sit alongside these teams three days a week facilitating information exchange and shared planning as well as undertaking joint visits where appropriate. This has improved working relationships significantly resulting in better input and outcomes for families.

  4. Training - Specialist Services deliver a wide range of training supporting workforce development to safeguard children and families:
     - 4 x Level 1, Level 2 Domestic Abuse
     - 6 x Parenting Challenges (Toxic Trio)
     - 4 x Sexual Violence awareness
     - 3 x Adult Safeguarding and Domestic Abuse
     - Hospital based delivery through Hospital IDVAs
     - Responding to those who harm

  5. Priorities for 2018-19
     These include:
     - Recommissioning outreach, accommodation and specialist children's services and ensuring that these work in an increasingly integrated way with partners and whole families
     - Embedding Signs of Safety tools and approach across the specialist sector
     - Introducing eMARAC to fast track information and action to protect families at the highest risk

- **Continuing to drive developments around Female Genital Mutilation (FGM)**

  The Local Safeguarding Children and Adults Boards across Cheshire agreed and implemented Pan-Cheshire practice guidance for FGM. This covers female children under the age

of 18 and adult females including those who come under the Care Act 2014 definition of an Adult at risk.

To prevent FGM in the future, agencies need to work closer with practicing communities and foster stronger links so together we are able to break the taboo and silence surrounding the harmful practice of FGM.

- **Continuing to drive developments around Radicalisation and extremism**

The primary legislation which governs PREVENT activity is the Counter Terrorism and Security Act 2015, supported by Channel Panel Guidance 2015. During 2017 Pilot DOVETAIL ran in 9 Local Authorities, in March 2019 it went LIVE in Cheshire East and Cheshire West, with the HUB being located in Liverpool and a Local Channel Coordinator serving both Local Authorities. A North West Working Group continues to monitor feedback and progress.

Channel is a voluntary, confidential programme which provides support to children or adults who are vulnerable to being drawn into terrorism. A multi-agency panel is held regularly, with the aim of providing safeguards to the harm which radicalisation can cause, before they come to harm or become involved in criminal behaviour. Between January and December 2018 the Cheshire East Channel PANEL was chaired by the Head of Communities. Six cases were heard at 3 Panel meetings during the year. Due to the low numbers the number of young people considered has been suppressed.

In January 2019 the Head of Adult Safeguarding took over as Chair of the Local Channel PANEL and is supported by the Locality Manager for Safer Communities as Vice Chair. During the next 12 months, the Local Panel will continue to develop in line with the new requirements of DOVETAIL, and new Channel Guidance due to be published in 2020. Changes will include improvements in referral pathways and systems to support swift information exchange and promoting Independent Intervention Providers, who are specifically recruited to address ideologies in a positive way.

- **Child Protection Case Strategy meetings**

Strategy Meetings have continued to be a focus of partner agencies in particular Health and Police. There is a bi-monthly interface between Social Care, Health and Police which focuses on a number of different area's to improve partnership working and a standard item on this agenda is a Strategy Meeting Audit which considers a dip sample of meetings requested from the previous 8 weeks.

This dip sample considers attendance of Police and Health, the quality of the information recorded and who was the source of the information and an SOS approach from the partnership in preparing and agreeing Danger Statements and Safety goals. This is a significantly improved picture with Health being invited to almost all meetings and face to face meetings taking place more often than not with increasing representation from Education. Sustaining this progress will be our focus and ensuring that the rational for decision making is clear and where investigations are to follow a Strategy Meeting, the actions are clear, timely and specific.

- **Implementing our neglect strategy**

The LSCB set up a group to review and launch a new neglect strategy and action plan, it has achieved this and has had the following impact;

- ✓ The awareness of neglect has risen to a level similar to that of CSE/Domestic Abuse
- ✓ The neglect campaign and branding is strong
- ✓ Over 600 staff have been trained in the use of the Graded Care Profile2 (GCP2)
- ✓ The use of the GCP2 tool has significantly increased, for Q1 80% of reviews used it
- ✓ The use of the neglect screening tool to support contacts is increasing with 20% in Q1
- ✓ Improving the use of GCP2 and neglect screening tool in early help assessments
- ✓ The quality of Police Vulnerability Person Assessment has improved and use the Signs of Safety and voice of the child
- ✓ We have revised and maintained the neglect scorecard to measure performance
- ✓ We continue to have a focus on adolescent neglect and the Children and Young People Trust stay safe priority lead is working with young people to develop more accessible information.
- ✓ 50% of CP plans are for neglect.

What are we worried about/what needs to happen?

- ➢ Length of time on Child Protection plan for neglect had reduced is now creeping back up.
- ➢ The use of the neglect screening tool has to consistantly used
- ➢ The impact of early help planning on preventing neglect escalating is questionable
- ➢ Continue need to focus on adolescent neglect and relationship to wider child exploitation.
- ➢ The effectiveness of multi-agency planning

- **Developing our Early Help Strategy**

The majority of level 3 Early Help interventions in Cheshire East take place within three broad workforces: the Council's Early Help Services, Health providers and educational establishments. Alongside these workforces there are a range of voluntary, community and faith organisations that play an extensive role in providing early help to families in Cheshire East.

Central to our approach to early help is our Early Help Brokerage service. This is a team within the Cheshire East Consultation Service (CHECS) which acts as the front door to Children and Families' services. Referrals to CHECS are initially triaged to ensure any safeguarding issues are identified quickly and referred to support from Children's Social Care. Families that do not require safeguarding-level services are then referred to Early Help Brokerage, which is a dedicated service for matching the needs of families with the right Early Help support.

Early Help Brokerage also offers support to agencies using the Early Help Assessment framework which is based on our Signs of Safety practice model, in order to ensure that assessments are robust and result in clear and focused multi-agency action plans that support children and families to achieve their best outcomes.

Early Help Brokerage also supports cases that are stepping down from support within Children's Social Care, identifying the right early help support for them to ensure that families remain supported to maintain the improvements they have achieved. Effective delivery of early help relies on robust multi-agency arrangements.

- **Learning and Development**

The Learning and Development sub-group have supported and improved Safeguarding practice across agencies –

- ✓ The 7 minute briefings and One Minute Guides have been located and placed in one page on the Learning & Development (L&D) page on the CELSCB website.
- ✓ A page on the L & D "multi-agency assessment " has been created where all assessment tools can be located

A blended learning approach is being adopted to inform agencies regarding the learning from the two Serious Case Review's.

- ✓ A multi-agency "Professional Challenge & Critical thinking "course has been developed in response to the findings in both SCR's. It has been developed to support practitioners to challenge when necessary and respond to complex safeguarding cases.
- ✓ A 7 minute guide "Professional Challenge" has been produced.

The group are looking at the ICON Abusive Head Trauma resources and training material to ensure all agencies support families in a consistent manner applying the same guidance. It is planned to roll out multi-agency training for practitioners alongside a refresher session on safe sleep.

Strengthening Partnerships

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

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

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

Performance, Scrutiny and Challenge

CELSCB has a comprehensive quality assurance framework, which can be found on our website. In 2018-19 this has provided CELSCB with a range of quantitative and qualitative information in relation to the effectiveness of safeguarding in Cheshire East. CELSCB has strategic oversight and scrutiny of the quality of children's services and the key issues for children and young people in Cheshire East.

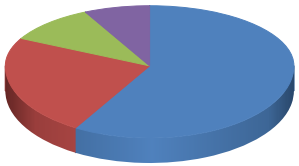
Performance A quarterly picture, showing a clear trajectory of progress. Allowing us to set targets and evaluate our performance against our statistical neighbours	**Feedback from Children and Young People, Parents and Carers** What children, young people and their families want and is important to them,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

Performance Monitoring

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

The CELSCB Quality and Outcomes Sub Group is effectively scrutinising and challenging partnership performance and are driving improvements to partnership working.

A range of quality assurance activity supports performance monitoring. Arrangements for this are robust and support and supplement partnership performance monitoring. This includes the CELCSB multi-agency audit programme.



The Audit and Case Review subgroup has:

- ✓ Overseen a Reflective review
- ✓ Undertaken audits on Neglect, Step Up/Step Down and the Child Protection Process
- ✓ Further developed the audit methodology which is much more comprehensive and inclusive with better practice based findings and effective multi-agency debate and agreement on findings.
- ✓ Scrutinised and monitored the progress of agreed actions from audits and reflective reviews
- ✓ Merged with the Quality and Outcomes group to form a Quality Assurance Group as part of the new partnership arrangements.
- ✓ Scrutinised S11 submissions

Multi- Agency Audits

These audits consider three different themes covering a range of ages and levels of need each time. The agencies audit their own involvement using a common tool. They all make judgements on the quality of partnership working. Agencies then came together to analysis the audits and make recommendations for improvements. The agreed improvements are then tracked to completion by the Audit and Case Review Sub-Group.

Neglect

What are we worried about?	What's going well?
• There was no evidence of GCP2 being used routinely to assess change. • Referrals to Adults Learning Difficulties Team were not required in any of the sample so it was not possible to consider if this area of work has improved. • There were examples of not all relevant agencies being invited to relevant meetings, informed of the concerns and of referrals being made that the receiving agency were not aware of i.e. Housing, early Help, North West Ambulance Service and a GP. • Voice of the child was not evident in all the cases, including a child with communication difficulties. • Parental engagement was not assessed. • There were opportunities to consider neglect but agencies "treated" the symptoms rather than using screening tools to look at the source of the concern. • An example of an agency considering that Step Down was too early but no evidence of this having been challenged. • When a mother declines the Family Nurse Partnership service there is not a notification process to alert other services.	• Neglect audit 59% of case neglect was recognised at the earliest opportunity. • Agencies considered that they were effectively working together. • The use of GCP2 and the Neglect Screening tool was more evident than in the previous audit with 38% of cases having one. • 67% of audits found that the assessment identified what was working well in the family. • 84% of audits the child's lived experience being reflected in the assessment. • 87% of the cases the work undertaken resulted in improved outcomes for the child i.e. school attendance, health and future secured. • Evidence of wide multiagency attendance at Strategy meetings. • Example of a referral of Neglect concerns from a member of the public. • Examples of agencies reflecting on their practice and acting to improve it i.e. Barnardo's and accessing relevant information. • SCIES have developed a pack to support communication with children with communication difficulties.
What do we need to do?	
• Ensure that parental capacity and ability to sustain change are assessed at the outset. • Review the process of promoting the Family Nurse Partnership and actions to take where it is declined. • Seek assurance that the work that Cheshire Local Authorities and Clinical Commissioning Groups have initiated with North West Ambulance Service to improve the referral process is completed.	

- Information sharing between child and adult services needs to be improved.
- Continue to increase the use of the GCP2 as both an assessment and reviewing tool.
- Seek assurance that the work to improve the referral of Adults to the Learning difficulties Team has had a positive impact.
- Publicise the SCIES pack for communication with children with communication difficulties.

Step Up Step Down

What are we worried about?	What's going well?
• Step down is not consistently informed by re-assessment. • Sustained change is not routinely examined and evidenced at the point where step down is applied. • Evidence of a delay in escalating a housing issue has meant that Housing was unable to intervene to prevent an eviction. • The Guidance for managing Child Protection/Child in Need multi-agency meetings is not consistently applied resulting in delays in receipt of plans and meeting notes. The Audit panel did question if it is cost effective to have practitioners process this paperwork. The equivalent Child Protection Conferences process works, should a similar business support resource be available for CiN meetings? • The current step down guidance section 2 starts from a Children's Social Care process and should focus on a multi-agency approach to decision making that is informed by re-assessment and evidence of sustained change. • 2 cases evidence step back up happening more than once.	• A range of agencies are using screening tools. • The Voice of the child is well represented in several agencies' practice via the Childs words, presentation and the evidencing of the lived experience. • At Step Up there is consistent use of screening and assessment tools and strategy meetings. • In a couple of cases there was evidence of sustained change. • Evidence of improved outcomes in half of the cases. • Working together strengths. • The Ages and Stages Questionnaires are being routinely used by Wirral Community Trust.
What do we need to do?	
• CiN Safety plans must evidence the criteria for Step Up or Step Down. • Wider partnership to be informed about the Ages and Stages Questionnaire and how it can inform their work. • Inform practitioners about the Housing referral requirements. • Partners to assure the board that they are monitoring the application of the Guidance for managing Child Protection/Child in Need multi-agency meetings by their practitioners. • Update the step up step down guidance to include a multiagency approach to decision making that is informed by re-assessment and evidence of sustained change. • Repeat plans assure the board that wider work on this includes Common Assessment Framework/Child in Need.	

Child Protection Process

What are we worried about?	What's going well?
• Identified need for agencies to be closer with mental health, alcohol and drug services and adult services. • Lack of engagement of fathers, particularly in cases of Domestic Abuse • Children & Families assessment not being routinely updated to reflect changes in circumstances or every 12 months. • Crewe CiN/CP has had some significant changes of staff which has contributed to drift and delay (this situation has now improved) – some cases had multiple changes of Social Worker. • Some examples of challenge not being followed up as robustly as it could be. • There was not consistent challenge, still room for improvement. • Lack of consistency in using tools to evidence level of need/category – this has improved greatly but more work is needed by agencies • Absent parents it was not clear in all cases that this was addressed. • Parents not routinely investigated for neglect – CPS goals have changed and evidence needed – transfer case on this audit didn't meet the crime threshold. • Further work on making the lived experience apparent in the work is required. • Strategy meetings improvement in participation but further work required to ensure the correct attendance.	• There is evidence that the use of tools has improved greatly, this means that agencies ensure evidence is available. • Lived experience of child evidence is improving through use of tools. For example health use the 'Ages and Stages' Questionnaire (ASQ). • Continued evidence that the Signs of Safety model promotes the voice of the child and their lived experience with the use of 'words and pictures' supporting. • The Signs of Safety model is being embraced by all agencies and agencies report that this model is working well to support Children and Families in Cheshire East. • Examples of absent parents being considered. • Contingency planning – improvement and evidence of some plans. • Positive impact for children. • Strong evidence that Multi-agency working is strength in Cheshire East and information sharing is common practice. • Timely working is evident. • In one of the cases, it was identified that the category of need was changed to reflect the child's lived experience.

What do we need to do?
• An LSCB eBulletin highlighted the need for agencies to use tools and where/how to use these tools. • Fully implement the strategy meetings developments. • Seek assurance that partners have a process for tracking escalations via the Single Agency Section 11 Audit. • Assess the impact of the training that's been delivered for engaging with perpetrators of domestic abuse. • Seek assurance from Childrens Social Care regarding staff turnover in CiN/CP. • A new training developed by the LSCB to address 'Challenge' has been developed and is due to be rolled out in the New Year. This training to be advertised across multi agencies, via the LSCB and agencies to be encouraged to attend.

Serious Case Reviews (SCR):

This year there were 2 Serious Case Reviews underway. These reviews were completed within this year. A learning summary was published in February 2019 on one. The other awaits the conclusion of other processes.

Reflective Reviews:

This year the CELCSB accepted the recommendations of a Reflective Review reported to it. These are being progressed. A learning summary was also published on the website.

Section 11 Audits

Section 11 (4) of the Children Act 2004 requires each person or body to which the duties apply to ensure they have arrangements in place to safeguard and promote the welfare of children. The Board partners completed audits and the findings were reported to the Quality and Outcomes Subgroup. This indicated that services areas are broadly compliant in relation to safeguarding arrangements.

Overall very positive responses to the S11 Audit with most submissions rating themselves as, at least, effective in most areas of the self-assessment.

Working well

- Most partners senior management commitment to the importance of safeguarding and promoting children's welfare.
- Induction process for staff which clearly addresses safeguarding and use safeguarding recruitment, vetting procedures and allegations against staff processes
- A number of health teams are co-located with Preventative Services teams
- Evidence in recent safeguarding audit and JTAI that National Probation Service staff are aware of escalation policies and are comfortable to challenge decisions.

Worried about

- A partner self assessed as having less effective senior management commitment to the importance of safeguarding and their safer recruitment process.
- The County Lines strategy encompasses other forms of organised abuse but there needs to be a more defined process for Trafficking and Slavery.

A further report was presented providing an update on progress which provided assurance that partners were addressing the recommended actions.

Section 175/157 Audits

The Education Department, Schools, LSCB support team and CEC IT developed an online S175 submission tool. This was successfully piloted in the spring term with a volunteer cohort of schools. This proved successful and will be rolled out to all schools in the summer term of 18/19.

Local Authority Designated Officer (LADO)

The LADO oversees individual cases, provides advice and guidance to employers, voluntary organisations and liaises with the Police and other agencies as required. The LADO has a responsibility to monitor the progress of individual cases to

ensure they are dealt with quickly, fairly and consistently, as well as identifying significant patterns and trends across the workforce.
In Cheshire East there are currently two part time LADOs and one dedicated Business Support Officer; they sit within the Children's Safeguarding and Quality Assurance Unit.

During 2018/19 there were 209 referrals to the Cheshire East LADO, which is a reduction of 22 from 2017/18.

- Of the 209 referrals: 77 (37%) were categorised as Consultations; 78 (37%) as No Further Action after Initial Consideration; and 54 (26%) met the threshold for a LADO strategy meeting. Most referrals were from professionals working in the Education Sector (36%) which is a consistent trend and linked to the majority of referrals relating to education staff
- There have been fewer referrals (9.5%) to the LADO this year and it is noted that there have been less referrals from fostering agencies, early year's settings and the voluntary sector.
- As a proportion, 26% of referrals met the threshold for a strategy meeting, which is largely consistent with previous years with a 4% variance. The LADO role involves providing advice to employers
  and it is therefore expected that the threshold for a strategy meeting will not be met following every consultation/referral.
- Referrals not meeting the threshold for a strategy meeting came
  from all organisations: there are no discernible themes in relation
  to particular sectors or organisations.
- The details of referrals that don't meet threshold are recorded for future reference. This ensures repeated referrals regarding an employee's/volunteer's concerning behavior can be considered as potentially more serious and an indicator that they pose a risk of harm to children. This also helps to identify if a specific agency needs more support in understanding thresholds and the role of the LADO.

The LADO continues to ensure allegations are managed consistently and in a timely manner; 87% of strategy meetings were held within 5 working days and 82% were concluded within 6 months. Of the cases taking longer than 12 months 80% involved police investigations and the remaining 20% involved complicated employer disciplinary practices. These elements are beyond the control of the LADO and where it has been considered that unreasonable delay has occurred, this has been escalated with the appropriate agency.

Child Death Overview Panel

The death of any child is a tragedy. It is important that all child deaths are carefully reviewed. These reviews are conducted by a Child Death Overview Panel on behalf of the Local Safeguarding Children Board. This is a Pan-Cheshire Panel and is made up of a group of professionals who met on four occasions between April 2018 and March 2019. The total number of child deaths notified across this footprint was 56, of those reported 19 were Cheshire East children.

The total number of child deaths the panel reviewed during this period was 49 of which 21 were from Cheshire East.

The Panel has a role to identify any trends or themes and to make recommendations to the CELSCB on learning from the reviews and how to prevent and reduce child deaths The panel has an independent chair who provides regular updates to the CELSCB and produces an annual report that summarises the key themes arising from child deaths, progress against actions and priorities for the coming year.

CELSCB Training and Development

CELSCB Learning and Development continues to develop, deliver and evaluate a robust needs led multi-agency training package.

Working Well	Next Steps
Signs of Safety 2 day training delivered to over 440 participants across the workforce. Evaluations were outstanding and excellent examples of partners using the tool across a range of services are already evident. The local approach to implementing the GCP2 Neglect assessment tool won a NSPCC award for the successful implementation. Completed tools are being frequently seen in case conferences and planning meetings. In response to the serious case reviews recommendations • New critical thinking course developed learning. • Workshops and briefings also delivered to partners to share the learning from both Serious Case Review's • All existing courses have been redeveloped to include Serious Case Review learning. • Working Together lunchtime seminars relaunched with sessions on learning from Serious Case Reviews. Training bulletin and 7 minute briefings have supported learning opportunities. New course developed on Harmful Practices and delivered on a Pan-Cheshire basis. Partners offered venues free of charge to reduce venue costs particular thanks to Oakenclough Children's centre, Kings School Macclesfield, South Cheshire College and Cheshire Without Abuse. Free E-Learning modules now available on the LSCB website, use has doubled in the past year. Several requests made to LSCB training manager to support the development of single agency training; this includes Crewe Alexander Football Club, Tatton Park and a private fostering organisation.	Continue work with the LSAB to support a partnership approach to learning and improvement across adult and children's services. Development of learning and improvement opportunities for managers: mental capacity and Deprivation of Liberty (DoLs) and Risk management. Further development of pan-Cheshire learning opportunities. Review of charging policy. Review of Sexual Assault Referral Centre referrals to inform future course numbers. Work with schools safeguarding forum to obtain the views of a range of children and young people across Cheshire East. Single agency training standards to be further developed for C.S.E and Neglect. Continue to deliver 2 day signs of safety training to partners and consider refresher training for 2020. Review of impact on practice data collection methods. Establish means to follow up e-learning course users. GCP2 refresher training.
Worries	
Signs of Safety, Implementation and associated training delivery to partners are underway which as predicted has meant lower attendance on existing courses. More courses need to be considered for managers across the partnership. The voice of the child within the training environment could be stronger. Evaluation returns are low post course; therefore evidencing impact on practice is challenging. GCP2 and Rape and Sexual Abuse Support Centre numbers have significantly dropped over year.	

The post course survey responses demonstrate that overall

- More than 92% participants value the courses and engage with change when delivering services to children.
- 93% of respondents self-report that the training has positively changed or influenced practice.
- 71% of respondents identify discussion with managers following attendance on LSCB courses
- 87% have said they have shared information with colleagues, both of these figures show an increase of 25% and more in comparison to previous years.

GCP2 evaluation shows 94% of attendants would use the tool even if they haven't had the opportunity to date. All participants have stated that the tool will be helpful in their work with families where Neglect is a feature. Of those who have used the tool 100% said families liked and understood the assessment. Data from the safeguarding unit shows a considerable increase in the numbers of completed tools at case conference and reviews.

2018-19 Annual Reports

Summary of reports

Each partner agency is expected to meet their safeguarding responsibilities as described in the member compact and under Section 11. All agencies are expected to ensure their staff and volunteers undertake appropriate single and multi-agency training.

Partner agencies are expected to provide an annual update for scrutiny to the board, setting out any key achievements in the previous year.

Impact of Partners safeguarding activity against the Board's Key Business Plan Objectives	
1. Strategic Partnership Objective Improving frontline practice	
Partners	**Outcome to be achieved -** Competent practitioners and consistent practice. Children and Families provided with the right level of support and intervention.
Cheshire Police	• Continual professional development training continues within the Public Protection Directorate (PPD) ensuring that officers skills and knowledge are at a high standard. All officers receive training on a structured rotation to ensure operational competence is maintained. • The police services nationally are professionalising the approach to public protection policing and investigations, specifically for senior leaders. The aim ultimately is to ensure that all senior officers in command of public protection assets in England and Wales are appropriately trained, experienced and skilled to carry out their roles. • Two of the PPD senior leadership team have already undergone the first element of this training to have their operational competence formally recognised.
Eastern and South Cheshire CCGs	The Clinical Commissioning Groups have: • Successfully worked to develop their safeguarding team, policies and safeguarding assurance processes across 4 CCGs and 2 LA areas. • Worked with their providers to develop dashboards which reflect safeguarding standards. • Developed quality visits to providers with focus on safeguarding children • Focussed on GP practice including development of contribution by GPs to e-Marac process • Worked in partnership with public health to further develop the role of specialist nurse working within Cheshire East Contact and Referral Service. • Worked in partnership with public health and health providers to develop the health contribution to strategy meetings. • Supported and developed Child Exploitation nurse role. • Worked with NHS England to fully implement the Child Protection - Information Sharing system across the Local Authority and all

	NHS acute providers in our footprint. • Worked with NHS England to implement Female Genital Mutilation programme (e-FGM) system. • Contributed to multi-agency work between health and the Local Authority to establish timely and good quality health assessments for Cared for Children. There has been further improvement and the work will continue. • Through their Child Death Overview Panel professionals, been closely involved in developing a Pan-Cheshire approach to coping with and understanding infant crying through the use of ICON Programme (a national tool for prevention of Abusive Head Trauma).
Education	• Education settings engage in regular safeguarding staff training, involving staff such as midday assistants, office staff, caretakers, governors etc. They are involved in 3 yearly Basic Safeguarding Awareness and annual Safeguarding Refresher training which is reinforced in staff meetings. Designated Safeguarding Leads (DSLs) undertake enhanced training appropriate to their roles and responsibilities. • Every year staff sign to say that they have read and understood "Keeping Children Safe in Education" which informs their practice. • The Safeguarding Children in Education Settings Team (SCiES) hold termly meetings DSLs and Headteachers where key information sharing takes place; these are always well attended and learning/information is cascaded by those DSLs/ Headteachers within schools. Discussions take place within these meetings where questions can be asked, inconsistencies can be challenged and a clearer understanding gained of processes • Education settings which have engaged with SCiES Safeguarding Scenarios have found these have generated valuable discussions between staff, have reinforced key messages from training, have helped to embed knowledge and have reinforced expectations around practice and procedures. • Engagement with Signs of Safety has supported education practitioners to identify risks, plan together to minimise risk and make a positive difference to the lives of children enhancing the quality of conversations, reducing problem admiration and supporting the effectiveness of outcomes. • Regular newsletters are provided to DSLs / Headteachers by SCIES and CESCP to ensure they are kept up-to-date with new guidance, emerging themes, and other relevant information regarding Safeguarding in schools. DSLs ensure that these are shared with staff to enhance their knowledge; they are often seen displayed in staff rooms. • Many education settings engage with the SCiES team, the Attendance and Children out of school team, the Virtual school, the Medical Needs team and Early Help for support with cases where they are unsure of the appropriate level of support for the child and / or family. These teams provide information and may liaise with other partner agencies on behalf of the school to ensure the right actions are taken and things move forward positively for the child and family • Education and social care liaison meetings have helped to develop positive relationships and mutual understanding which is impacting on practice.

	• Supervision provided to DSLs has supported them in identifying and reinforcing the positives, share their frustrations and concerns and identify next steps. • Education settings engage with Safeguarding Policy in Practice Reviews; where these have been undertaken they have celebrated and reinforced achievements and identified areas for development leading to actions resulting in improved practice.
Children's Social Care (CSC)	CELSCB has continued to support the embedding of our single operating model, Signs of Safety. There have been over 500 front line practitioners trained across the partnership since the model was implemented. The impact of Signs of Safety can be seen through improved safety planning with families and their wider network of support. Recruitment of permanent social workers has been a positive story over the last 12 months with a strategic approach that has focussed on "grow your own" social workers and opportunities for internal development within the service from students to the new Director of Children's Social Care. The Independent Reviewing Officers now all carry out peer observations to both share ideas and promote consistency of best practice. They have group supervision every month and team development days every quarter to review practice and improvements. A number of Local Authorities have asked to observe how we do Child Protection Conferences. The Quality Assurance information in the form of weekly reports goes out to all partners to support their improvement in the front line practice. A focus this year has been on use of the Graded Care profile, representation of children's views at conference and developing danger statements and safety goals that parents understand and are clear about what needs to happen. The new Conference model is improving parental participation and understanding of the plan and we have visual representation of children's views at conference.
National Probation Service (NPS)	NPS provides, essentially, three levels of service to individuals convicted in adult courts of a sentence that is managed by one of the Probation Service Providers. This includes: - • Court based services supporting Sentencers in making their sentencing decisions in relation only to adults; • Management of individuals sentenced to offences of a serious violent and/or sexual nature largely covered by MAPPA (Multi-Agency Public Protection Arrangements) processes and other high risk of harm offenders. The Management of individuals can be within the community, serving prison sentences or subject to hospital orders. • A victim liaison Service offered to victims of serious violent and/or sexual offences for which the perpetrator has been sentenced to more than 12 months custody. As such it is unlikely that NPS staff either working in courts or offender management will come in to direct contact with a child or children as part of their work but within these limitations the NPS has a responsibility to ensure that the voice of the child is heard. NPS's Victim Liaison Service have contact with victims through their Victim Liaison Officer (VLOs) network. Within this context VLOs will have a broader level of contact with victims, their families, children, and carers etc., including the families of offenders. Training, both internal to NPS and externally sourced through local safeguarding arrangements, is made available to staff. Staff are enabled to attend relevant training. A record of training is kept locally and this is repeated periodically. Staff induction includes

	mandatory familiarisation of child safeguarding responsibilities, processes and procedures. Job Descriptions and staff appraisals include objective/s supporting the effective discharge of their child safeguarding duties. There is national mandatory NPS Safeguarding training for all staff (e-learning followed by classroom based – for face to face staff and their managers who work with offenders. All staff, including trainees, are expected to undertake it. Safeguarding training remains under regular review. NPS within Cheshire have identified practitioner level safeguarding champions within each local team to promote and drive improvements.
2. Strategic Partnership Objective - Listening to children and young people	
Partners	**Outcome to be achieved - Children's views are strongly represented.**
Cheshire Police	• The 'voice of the child' is a priority for Cheshire Constabulary. The Vulnerability Person Assessment has been revised and digitalised requiring investment. The final product to go live in Autumn 2019 has a "Voice of the Child" mandatory field for completion. Officers will not be able to progress and complete the form without completing this vital element of the form. This will improve the quality of vulnerability assessments and the identification of the lived experience of the child. • Officers across the area have received additional training for the Voice of the Child. Investment has been made in corporate communications and training materials to ensure that the importance of this is recognised by all.
Eastern and South Cheshire CCGs	The CCGs have strengthened their approach to listening to children and representing their views on services and redesign of services. They have approached children participation groups and worked with other agencies to establish a network of young people who can provide a voice. The CCGs have through their Self Care Awards in local schools, enabled children to become Self Care Champions – sharing information and messages throughout their schools as well as starring in Self Care videos which are shared throughout our Social Media Channels. Feedback from the children has shown that this work has supported local children and young people to feel empowered to take more responsibility for their own and their families' self-care.
Education	• Many primary schools have engaged with locality based children's safeguarding conferences throughout the year which are designed to empower children to talk about safeguarding issues which affect them. The children have then taken responsibility for taking the key learning points and themes back into their own schools to share. • Children from secondary schools and alternative provisions have engaged in the Act Now Conference 2019 where their views were clearly stated to adults from CELSCB; resulting in clear expectations of the adults from those services. • Children in secondary schools co-produced a Cheshire East Bullying Prevention Strategy for schools which made priorities and expectations clear from their point of view. • Education settings are able to evidence the involvement of children and young people in developing safeguarding provision and

	procedures. Many have safeguarding groups, others have safeguarding as an agenda item on every school council meeting. Their voice has been effective in identifying key themes to be taught, developing security around the internal and external environment, writing policy. • DSLs have ensured that staff are familiar with screening tools and other resources such as 3 Houses, 3 Islands and other voice of the child activities used as well as engaging children and families with Helping Hands' etc. so as to support them in identifying the individual child's lived experience. Some of these materials have been extremely impactful on helping agencies and parents understand things from the child's point of view, and have sometimes taken them in a different direction than they first thought. • Draft safeguarding exemplar policies, developed on behalf of education settings by the SCiES team, are Quality Assured by Pride Youth Network Poynton High School. • Education settings identify the use of questionnaires to capture children's views e.g. how safe they feel in school; who they would talk to with a worry or problem; how they would keep themselves safe etc. which then impact on practice. • SCiES facilitated a number of face to face meetings with secondary school aged children from a range of settings including to gather information about what the children understood about the key priorities for the CESCP, e.g. Neglect, Online safety in order to inform CELSCB objectives.
Children's Social Care	CSC continues to have a strong focus on ensuring that children's lived experience is clearly understood. There continue to be outstanding examples of direct work with children, their view influencing planning and reviews. Front line practitioners have used direct work tools developed as part of the Signs of Safety model to build on their skills. The involvement of children and young people in developing and contributing to the design of services has strengthened over the last 12 months, evidenced through our Investing in Children Award. Children, young people and care leavers have worked with CSC on the development of our new Bespoke model, the recommissioning of the children's home contract and the Children and Young People's Plan. The work of the CP IROs in the multi-agency conference process have a strong focus on establishing what the child's view about the plan and how this impacts on their sense of safety. This has improved the next phase is for front-line staff to move from 'wishes and feelings' to how children understand the plan to keep them safe and if they think this is effective and what else they may want.
National Probation Service	• If applicable Pre Sentence Reports and risk assessment processes recognise and incorporate 'The Voice of the Child'. • MAPPA and MARAC meetings incorporate victims and child safeguarding considerations. Voice of the child is a standing item on the MAPPA Agenda; chairs are required to consider the voice of the child in individual case decision making. • NPS offender assessments capture details of children at risk; NPS are also required to identify children at the point of sentence. Work has been completed to raise the profile of recording children's information and the impact of their parent receiving a custodial sentence and this is audited frequently.

	• NPS have rolled out toolkits to support an adult facing service in recognising child related concerns and there is a home visiting protocol and guidance about how to record any direct contact with Children.
3. Strategic Partnership Objective Strengthening partnerships	
Partners	**Outcome to be achieved - Strong safeguarding culture across the system, effective scrutiny, and challenge and evidence of improved outcomes**
Cheshire Police	• A clear escalation policy is in place within Cheshire East. Bi-monthly meeting attended by PPD Detective Inspector and managers of core agencies where process and procedures are scrutinised/challenged. • Cheshire Constabulary has recently undergone the PEEL Vulnerability HMICFRS Inspection. The inspection includes all aspects of vulnerability and there is a strong focus on the protection of children and partnership working. The inspectors were very positive and whilst the result of the inspection has not formally been released, the Constabulary is currently graded as good and we aim to maintain this grading.
Eastern and South Cheshire CCGs	The CCGs have: • Contributed to partnership working through the Health and Well-Being Board, the LSCB and its sub groups and the Pan Cheshire CDOP. • Worked with Local Authority commissioners to develop joint safeguarding standards and quality assurance processes for providers; • Strengthened links to the Corporate Parenting Board and worked jointly with the Local Authority to improve the timeliness and quality of initial and review health assessments for Cared for Children. • Worked with the Police and Local Authority to develop and fully implement the new local safeguarding arrangements in Cheshire East. • Developed understanding of the increased CCG Safeguarding responsibilities across CCG Governing bodies. • Worked with Partners to develop new CDOP arrangements across the Pan Cheshire footprint. • Worked with partners to agree a partnership score card for safeguarding assurance.
Education	• Schools continue to demonstrate good safeguarding practice as evidenced in Ofsted reports (89.7% Good or Outstanding); practice includes: ensuring children know who they need to talk to if they have concerns; assemblies and tutor time spent on a full range of issues (often led by the students themselves and/ or significant partners, for example, police, health); information around the school; emphasis within the curriculum (all subjects and PHSCEE); all members of staff understanding that they have safeguarding responsibilities and knowing to whom they need to report concerns (DSL and/ or Headteacher); regular training and updates for staff and positive engagement with the SCiES team. • CELSCB scrutinise the 175 audit and a report is written identifying common activities, positive activities and areas for members of CELSCB to support the education settings with.

	• Where concerns are raised around safeguarding practice non-judgmental support is offered. CELSCB have developed an escalation policy to resolve professional concerns; this has been shared with all education settings to ensure they understand it and feel confident to use it when necessary.
Children's Social Care	There have been many examples over the year for how CSC has work collaboratively to strengthen the partnerships. For example: • Supported Police to improve the quality of their vulnerable people assessments, through contributing to the new template and training for police officers. • Development of multi-agency audits in the front door to test and further strengthen the quality of information provided threshold application and decision making. • Development of a strategic operational meeting attended by police, health and children's social care. This has led to improvements in the quality of information shared and representation of agencies at strategy meetings. • Collaboratively working with partner agencies to improve the quality of child in need planning and the use of escalation and challenge to ensure improved outcomes for children. • Establishing a culture of high support and high challenge with education, working together to support children to attend school full time. This has resulted in a reducing risk of exploitation for some vulnerable children. • Strengthened relationships between health providers in the Front Door: The impact has been a shared understanding of Signs of Safety and how it is used when making a referral. This ensures the right information is provided by professionals improving timeliness and decision making for children who may be in need of help or protection. • Safeguarding children who are at risk of exploitation through the introduction of weekly multi-agency meetings in the front door. There is a shared assessment of risk and early decision making to ensure children are safeguarded at the earliest opportunity. • Introduction of a joint working protocol with housing to ensure a timely assessment and support to 16/17 year old young people presenting as homeless. • A set of tools for assessing the impact of DA across all the family have been produced and disseminated all agency staff through the LSCB, and workshops have been provided on how to assess the typology of those who harm in their relationships • The Safeguarding and quality assurance Unit produce a weekly report of agency provision of reports and if these have been shared with parents prior to the meeting. Agency leads are held to account in case conference if reports have not been produced or shared.
National Probation Service	• There is a National Director who has a lead for Safeguarding and within each Division; there is a senior manager who has the divisional lead for safeguarding. Cheshire Cluster of the NPS has a designated lead and have taken the additional step of identifying champions in each team. • The Safeguarding lead for NPS Cheshire plays an active role in attending the LSCB and now participates in new safeguarding arrangements as well as identifying a Manager lead for a relevant subgroup. NPS identifies relevant staff to contribute to SCR,

	DHR and multi-agency audits where relevant. • Efforts to improve multi-agency working between the NPS and CSC have been championed by the NPS with recent work to visit and build relationships with the front door of children's services. The NPS along with the CRC are also exploring improved engagement with structures to assess and manage risks presented by Child Exploitation. • The NPS is subject to an annual inspection has achieved a 'Good' rating in its most recent inspection - the standards incorporate safeguarding children considerations. • NPS participated in the Neglect JTAI in Cheshire West and more recently in Halton and improvements in practice were seen between the two inspections.

Key Priorities for 2019-20

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

Improve frontline multi-agency practice through working on:

- Our approach to Contextual Safeguarding
- Improving the quality and effectiveness of child in need planning for children
- Emotional Health and Wellbeing of our vulnerable children
- Embedding the New Arrangements

Aim to do this through our collective commitment to

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

Budget for 2018-19

An outline budget for CELSCB's work in 2018-19 is set out at Appendix 4.

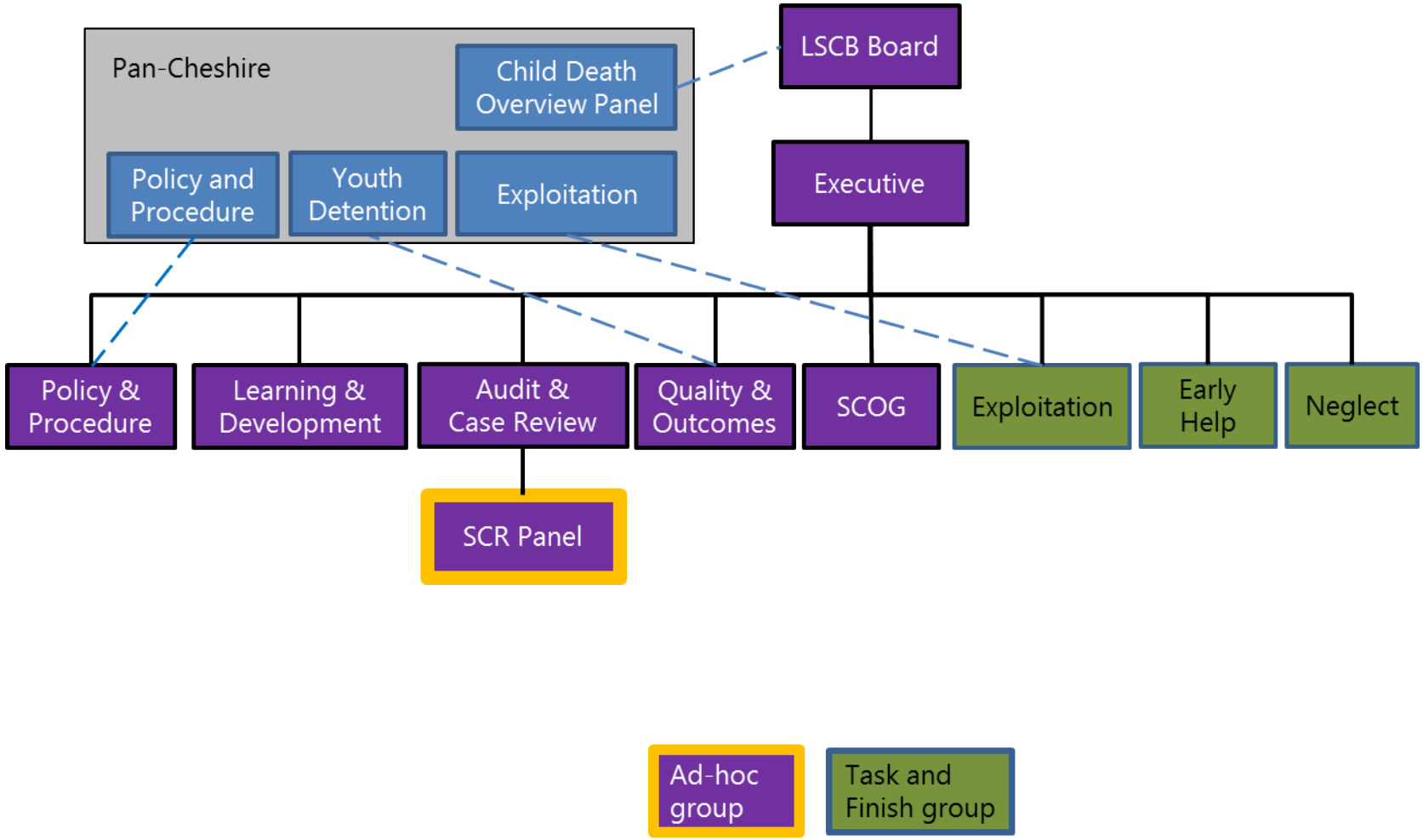
Risks and Issues

It is essential to identify, analyse and priorities risks to ensure that these are managed effectively and do not impact adversely on the Board's plans. The Board maintains a risk register which is reviewed and updated bi-monthly with action updates at the Executive Group. During the year the following risks were on the LSCB Risk register.

Registered	Risk	Actions	Status year end
May 17	Changes in membership of the Board through: • restructures within partner organisations impact on the continuity of the business and pace of change needed to improve, • uncertainty in relation to the future model of safeguarding partnership arrangements (Wood Review); • emerging Pan Cheshire Structures that could impact on partner's capacity. will impact upon the Boards ability to fulfil its functions	Continue to strengthen the Pan Cheshire approach. Agreement in principle from Cheshire Senior Leadership group to look at opportunities for alignment of LSCB's.	Open
Feb 18	The need to improve the Effectiveness of Multi-agency Child Protection Plans/Children in Need has been identified in LSCB audits.	The effective use of a suite of evidence based practice tools for assessments, direct work and planning to be agreed. Signs of Safety model implementation.	Open
May 18	The effective implementation of the two SCR multi-agency/single agency actions plans, for E & A	Multi-agency audits of the themes from the SCRs will be conducted in 2019 Frontline staff briefings are being held to ensure the learning and actions from the SCRs are understood. Changes to practice as required by the action plans are being addressed.	Open
Sept 18	Strengthen the engagement of the LSCB and support provided to Schools with key safeguarding activity	Actively engage with schools forums on the development of the Future Arrangements as these are a key relevant	Open

		agency. Review the schools contribution in line with the work on the development of the Future Arrangements LSCB Chair to meet with Independent Schools Heads teachers/Designated leads.	
Sept 18	The effective provision of services for children who are held in police detention overnight.	Pan-Cheshire protocol to be update to include the escalation procedure.	Open
Sept 18	The LSCB reduced School contributions and has not increased other partner's contributions for the last two years. During this time it has been using its reserves. A number of schools are indicating that they will not contribute financially to the current level in 19/20.	CE Safeguarding Partnership Task and Finish group to review budgets for 18/19 and 19/20	Open

Appendix 1: Cheshire East Local Safeguarding Board Structure



Appendix 2: Board Membership and Attendance

Attendance Log	Meetings 2018 - 2019						
	27/04/18 Extraordinary	29/05/18	07/06/18 Extraordinary	30/07/18	26/09/18	30/11/18	21/01/19 Dev Day
Independent Chair LSCB	✓	✓	✓	✓	✓	✓	✓
Executive Director of People	✓	A	A	A	R	R	✓
Director of Children's Social Care	✓	✓	✓	✓	✓	✓	
Head of Service – Children in Need and Child Protection	✓	✓	✓	D	✓	✓	✓
Head of Service - Children's Safeguarding	A	A	✓	✓	✓	✓	✓
Director of Children's Prevention & Support	✓	✓	A	A	D	R	D
Principal Manager for Early Help	✓	✓	D	A	✓	R	
Senior Lawyer	A	D	D	A	D	D	A
Head of Adult Safeguarding	✓	✓	A	✓	A	✓	✓
Portfolio Holder for Children and Families Services	A	A	✓	A	✓	A	A
Public Health	A	R	A	A			
Cheshire East Housing Strategy Manager	✓	✓	A	✓	✓	A	A
Southern and Eastern CCG	✓	✓	✓	R	✓	✓	A
South Cheshire CCG	R	✓	D	R	A	A	✓
Designated Doctor	✓	✓	A	✓	✓	✓	A
East Cheshire Trust NHS	✓	R	R	✓	A	✓	✓
Cheshire and Wirral Partnership	✓	✓	✓	✓	✓	✓	✓
Mid Cheshire Hospitals NHS Foundation Trust	✓	R	R	✓	✓	✓	✓
NHS England	A	A	A	D	D	D	D
Deputy Director of Nursing - Wirral Community NHS Trust	R	R	R	R	R	A	R
Head of Service – Youth Justice	✓	✓	✓	R	D	✓	D
Cheshire and Manchester - CRC	D	R	R	R	R	D	D
Senior Operational Support Manager - NPS	R	✓	✓	A	✓	✓	✓
Cheshire Police	✓	✓	✓	R	R	R	✓
Cheshire Fire Service			A	A	D	D	A
HMPYOI Styal	D	R	D	A	D	✓	D
Primary Heads Representative	A	D	D	D			
Acting Primary Heads Representative - eCAPH					✓	✓	✓
Secondary Heads Representative - CEASH	✓	A	✓	✓	✓	A	✓
Representing Independent Schools – The Kings	D	A	D	D	✓	A	✓
Vice Principal - Reaseheath College	D	✓	A	✓	✓	A	✓
Representing children and young people in Cheshire East	D	✓	D	D	A	A	D
Programme Manager The Children's Society	✓	A	D	A	R	A	R
Cheshire CAFCASS	A	A	A	A	✓	✓	A
Representing the Voluntary, Faith and Community Sector	✓	✓	✓	A	A	✓	✓
Representing the Voluntary Sector	✓	D	D	A	D	✓	A
LSCB Lay Member	D	D	D	A	✓	A	D

 = Attended, A = Apologies, R = Designated Rep, D = Did Not Send Apologies

Appendix 2: Financial Arrangements – 2018-19

The tables below sets out the CELSCB's outline budget and outturn expenditure for 2017-18, along with the financial contributions from partners.

Area of Expenditure	2018-19 (£)
Direct Employee Exps	
Safeguarding Project Manager (0.70 fte)	£205,689
Performance Officer (0.50 fte)	
Training Manager (0.81 fte)	
Training Officer (0.91 fte)	
CELSCB Admin (2 fte)	
Transport	
Mileage and car parking	£2,060
Premises	
Hire of rooms for training, CELSCB meetings	£1,520
Supplies and Services	
Independent Chair	£25,466
Training costs – printing and course costs	
CDOP Pan-Cheshire Chair (CE contribution)	
Phone and mobile phone charges	
Refreshments for meetings	
TOTAL EXPENDITURE	£234,735
Carry forward reserves from 2017-18	-£39,918
Income in 2018-19	-£220,463
Total available spend 2018-19	-£260,381
Expenditure 2018-19	£234,735
Reserve carry forward to 2018-19	**-£25,646**

Appendix 3: Partner Contributions.

	CELSCB Partners	2018-19 contributions (proposed)
Health	Eastern Cheshire NHS	£5,000
	Mid Cheshire Hospitals	£6,772
	South Cheshire CCG	£18,778
	Eastern Cheshire CCG	£18,778
	Cheshire and Wirral Partnership	£4,093
	Wirral Community NHS Trust	£5,500
Criminal Justice	Probation Service (NRC)	£1,700
	Probation Service (NPS)	£992
	Police	£25,000
	HMP STYAL	£2,000
	CAFCASS	£550
LA	Local Authority	£44,300
Education	Schools	To be agreed
	Independent Schools	
	Cheshire FE Consortium	To be agreed

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Agenda Item 9

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:	Public Sector Transformation Programme: Mental Wellbeing Strategy- Heading in the right direction (HIRD)
Date of meeting:	28 January 2020
Written by:	Guy Kilminster
Contact details:	01270 686560 guy.kilminster@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Mark Palethorpe

Executive Summary

Is this report for:	Information ☐	Discussion X	Decision ☐
Why is the report being brought to the board?	To encourage discussion and to create opportunities for partner commissioning intentions to further impact on mental wellbeing		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Creating a place that supports health and wellbeing for everyone living in Cheshire East ☐ Improving the mental health and wellbeing of people living and working in Cheshire East ☐ Enable more people to live well for longer ☐ All of the above X		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness X Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above ☐		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	1. How do we ensure that the evidence base for the strategy is refreshed and that we have resident engagement in our priority setting? 2. How can and will the Health and Wellbeing Board influence other strategic partnerships such as the LEP (beyond engagement over the Local Industrial Strategy) 3. Would the Cheshire East Health and Wellbeing Board wish to consider working with the Public Sector Transformation Programme (PSTP) to develop meaningful measures of wellbeing, and to turn these metrics into targets which can be integrated into local commissioning activity? 4. The strategy contains a delivery plan with KPIs. The PSTP Board should be invited to return to the H&W Board on an annual basis with a review of progress against KPIs		

Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	Yes, report considered by Peoples DMT on 28/11 and recommended for consideration by Health and Wellbeing Board.
Has public, service user, patient feedback/consultation informed the recommendations of this report?	The strategy has not been submitted for public consultation. It has been developed using the 'promising approaches' methodology promoted by Public Health England: **Review of desk research using published and grey literature and stakeholder engagement** **Review of action 'in the field'** **Use of complex thinking theory to propose solutions**
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	The PSTP identified poor mental health as a barrier to residents thriving across Cheshire and Warrington from the Case for Change evidence review in 2016 and partners have been looking at mental health and prevention since then. However, there is so much more to preventing mental ill-health and promoting wellbeing than recommending help from specialist services. Emotional distress, anxiety and depression can stop people accessing jobs, cultural and leisure opportunities and more pervasive and enduring mental health conditions can impact on people's housing situation and their ability to interact positively with friends and family. The evidence review highlighted the impact of poverty, worklessness, unstable housing and unhealthy environments on mental wellbeing and this strategy reviews what is currently being done to address these 'wider determinant' issues across the partnership and proposes further actions across the sub-region.

1 Report Summary

1.1 The purpose of this report is to set out the background, context and recommendations from the Public Sector Transformation Programme (PSTP) Mental Wellbeing Strategy for Cheshire and Warrington- 'Heading in the right direction' for Portfolio holders prior to the strategy being submitted to the Cheshire East Health and Wellbeing Board in the new year. The strategy is following a similar process of approval in each borough and associated partnerships. The purpose of this further engagement is to provide partners with an opportunity to consider how best to connect activities which seek to improve the mental wellbeing of residents of Cheshire and Warrington.

2 Recommendations

2.1 Members are asked to consider 4 questions:

2.2 How do we ensure that the evidence base for the strategy is refreshed and that we have resident engagement in our priority setting?

2.3 How can and will the Health and Wellbeing Board influence other strategic partnerships such as the LEP (beyond engagement over the Local Industrial Strategy)

2.4 Would the Cheshire East Health and Wellbeing Board wish to consider working with the Public Sector Transformation Programme to develop meaningful measures of wellbeing, and to turn these metrics into targets which can be integrated into local commissioning activity?

2.5 The strategy contains a delivery plan with KPIs. The PSTP Board should be invited to return to the H&W Board on an annual basis with a review of progress against KPIs.

3 Reasons for Recommendations

3.1 These recommendations are designed to engage Health and Wellbeing boards in the development and implementation of sub regional and local approaches to promoting the potential impact of partner activity on **mental wellbeing.** The NHS and its partners have a mandate to address **mental health service** provision within the NHS Long Term Plan. Locally these responsibilities are being discharged through the Cheshire and Mersey Health Care Partnership- Mental Health Programme Board (MHPB) and the Prevention Worksteam (PW). The PSTP are collaborating with the MHPB/PW to ensure that this strategy complements their work. This strategy is firmly focussed on the **wider determinants of mental wellbeing.**

4 Impact on Health and Wellbeing Strategy Priorities

4.1 This strategy seeks to demonstrate the potential impact of place on mental wellbeing. The evidence base for the impact of housing, employment and/or meaningful activity and access to green spaces is strong. If residents also have access to 'people' focussed support to develop for example positive social networks, the evidence would suggest partners will be able to demonstrate they have done what they can to recognise protective factors identified in safe, stable and sustainable communities.

5 Background and Options

5.1 The strategy takes a population approach to improving mental wellbeing informed by a model proposed by the Kings Fund. This model suggests system building to affect change whilst recognizing the challenges to drive this change are at the intersections of each part of the system, essentially focussing actions where 'responsibility falls between the cracks and/or actions become nobody's responsibility'

The draft 'Heading In The Right Direction' strategy proposes 11 recommendations (5 actions and 6 enablers) which have been worked up into a delivery plan:

i. The national Time to Change (TtC) and Every Mind Matters (EMM) programmes are promoted widely across the sub region in a coordinated campaign and sustainable long term support for self care is developed based on Making Every Contact Count (MECC) and greater access to digital tools. Partners should continue to identify and deliver opportunities for mental well-being training for all frontline staff.

ii. The Journey First European Social Fund (JFESF) bid/programme should include a focus on providing mental wellbeing interventions to enable the programme outcomes to be met

iii. Local programmes aimed addressing economic wellbeing and poverty, employment and workplace, housing and homelessness, social capital and isolation, access to green spaces and natural environment and community safety should be subjected to an audit to assess impact on mental wellbeing This should enable commissioners to drive up the mental wellbeing dividends from the wider determinate programmes.

iv. The Connected Communities Programme in Cheshire East explores measures to demonstrate impact on people accessing primary mental health services. This information should be used to guide commissioning of similar services across the sub region.

v. The Emotionally Healthy Child (EHC) programme in Cheshire East and Trauma Informed Practice (TIP) work being undertaken in Cheshire West and Halton are being evaluated for impact on referrals to services with a view to guiding commissioning of similar approaches across the sub region

vi. The collaboration between the PSTP and Cheshire and Mersey Public Health Collaborative (ChaMPHs) should continue and be strengthened through a joint delivery plan to ensure the workforce impact is maximized

vii. The evidence base for action should be revisited focussing on recent challenges such as impact of welfare reform

viii. All PSTP partners should commit to sign the Public Health England Prevention Concordat for Better Mental Health

ix. A more detailed Equalities Impact Analysis is undertaken on this strategy

x. There should be consistent use of the WEMWBS tool for measuring population mental wellbeing. Outcome measures must be used when evaluating specific services and interventions to promote mental wellbeing.

xi. ONS4 questions within the annual population survey, quality of life questions should be used to monitor impact on borough wide population group.

5.2 This delivery plan is accountable to the PSTP board and driven by the PSTP project management team.

5.3 We propose that PSTP Board members take responsibility for ensuring the strategy uses appropriate governance process to enable it to reach Health and Wellbeing Boards in each of the partner LA areas. The PSTP team will be happy to assist with this process.

5.4 Following this engagement we propose the strategy is put into the public domain for comment.

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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Tel No: 01270 686560
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Draft 19.12.19

Heading in the right direction - An all-age mental wellbeing strategy for Cheshire, Warrington and Halton 2019-21

Cheshire & Warrington
Public Sector Transformation Programme

Acknowledgements

The Cheshire and Warrington Public Sector Transformation Board wish to acknowledge the London Borough of Waltham Forest Public Health team and the Public Health Intelligence team at Cheshire East Council for their contributions to this strategy.

The board also wish to acknowledge colleagues across the sub region who are working on mental health and mental wellbeing agenda and who have contributed knowingly or otherwise to this strategy

Note throughout this document we refer to Cheshire and Warrington, by this we mean the Local Authority areas known as Cheshire East, Cheshire West and Chester and Warrington and Halton sub region or C/W&H.

Foreword

The Cheshire and Warrington Sub-regional Leaders Board (C&W SRLB) is a collaborative partnership which brings together key public and private sector partner organisations from across the Sub-region. The Board and its partners work to deliver our two overarching priorities – economic growth and public service reform – set out in our Prospectus for Inclusive Growth and the Cheshire and Warrington Public Sector Transformation Programme. Following the successes of the Complex Dependency Programme, Sub-regional partners decided to build on the momentum by collaboratively co-designing a three-year transformation plan for Public Sector Transformation across Cheshire and Warrington, spanning 2018-2021. The PSTP strategic plan reflects the opportunities and needs of the Sub-region and will continue to deliver improved outcomes for the collective population and consists of six priority themes:

- Complex Dependency Legacy
- Health Related Worklessness and Low Pay
- Preventing Poor Mental Health
- Reducing Offending
- Reducing Domestic Abuse
- Enablers to Achieve Change

We identified poor mental health as a barrier to residents thriving across our boroughs in our *Case for Change* evidence review in 2016 and partners have been looking at the mental health and prevention since then. However, there is so much more to preventing mental ill-health and promoting wellbeing than finding help from specialist services. Emotional distress, anxiety and depression can stop people accessing jobs, cultural and leisure opportunities and more pervasive and enduring mental health conditions can impact on people's housing situation and their ability to interact positively with friends and family.

Our evidence review highlighted the impact of poverty, worklessness, unstable housing and unhealthy environments on mental wellbeing. So since November 18, we have been looking at what is currently being done to address these individual behaviours **and** 'wider determinant' issues across the partnership and to propose solutions to what could be done through collaboration across the sub-region. We want to take a population approach to improving mental wellbeing across the sub region.

The NHS and its partners have a mandate to address mental health service provision within the NHS Long Term Plan. Locally these responsibilities are being discharged through the Cheshire and Mersey Health Care Partnership- Mental Health Programme Board (MHPB). We are collaborating with the MHPB to ensure that this strategy complements their work.

The strategy takes a population approach to improving mental wellbeing informed by a model proposed by the Kings Fund see Fig 1 below. This model suggests action in each part of the model are required to affect change whilst recognizing the challenges to drive this change are at the boundaries of each section, essentially *'responsibility for mental wellbeing falls between the cracks and/or actions becoming nobody's responsibility'*

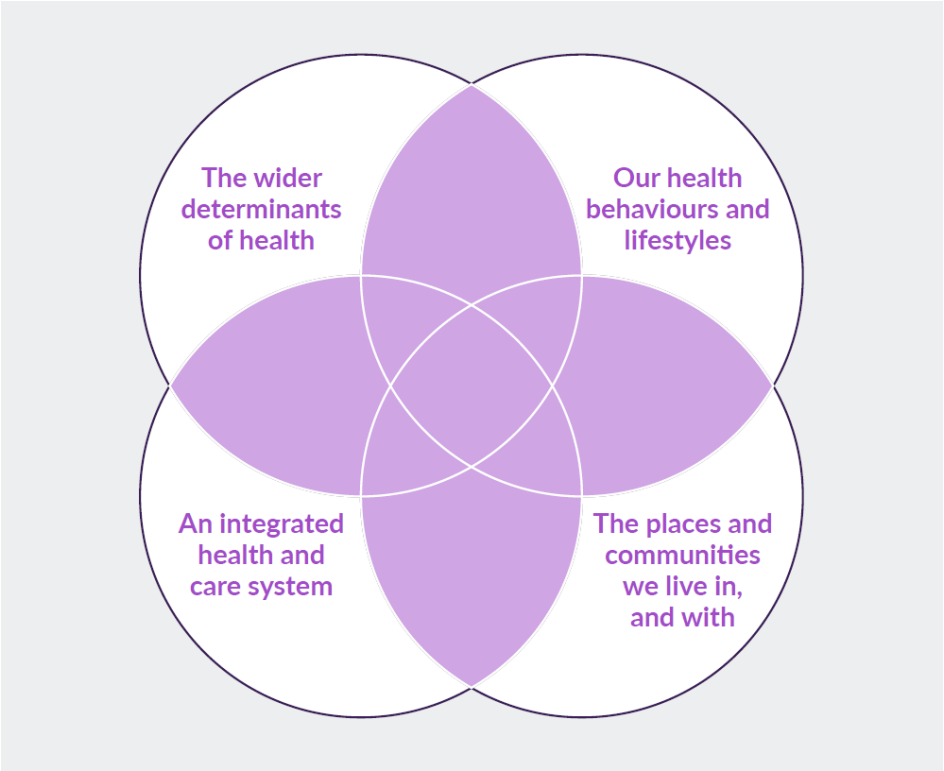


Fig1: Kings Fund (2018): Population Health System: Vision for population health

The report contains recommendations for action by partners within the Cheshire and Warrington sub region predominantly within the wider determinants section of the model, and 'between the cracks'.

To be signed by Chair of PSTP Board

Executive summary

The Cheshire Warrington& Halton Mental Wellbeing Strategy calls for an increased focus on the promotion of population mental wellbeing and the prevention of mental health conditions through early intervention wherever people are struggling with their mental wellbeing.

Although the relationship between mental health conditions and mental wellbeing is complex, mental wellbeing can be simply viewed as the positive end of the mental health spectrum. It comprises:

'a positive state of mind and body that includes both feeling good and functioning well.

In Cheshire/Warrington and Halton(C&W&H) there is a positive picture in terms of the mental wellbeing of our population. We are better than the national average for all four of the wellbeing measures reported annually by the Government; life satisfaction, feeling life is worthwhile, happiness and anxiety (see fig 2 below). The darker the colour in this interactive tool illustrates the higher the

life satisfaction score. In line with the country as a whole these indicators have all improved in recent years although they tend not to change significantly over time. These indicators should be considered alongside objective indicators of wellbeing for example GP presentations for low mood and referrals to specialist mental health services. They, of course, also mask variation within boroughs and are based on population sampling. We recommend further work is undertaken to understand these contradictions and variations in this strategy

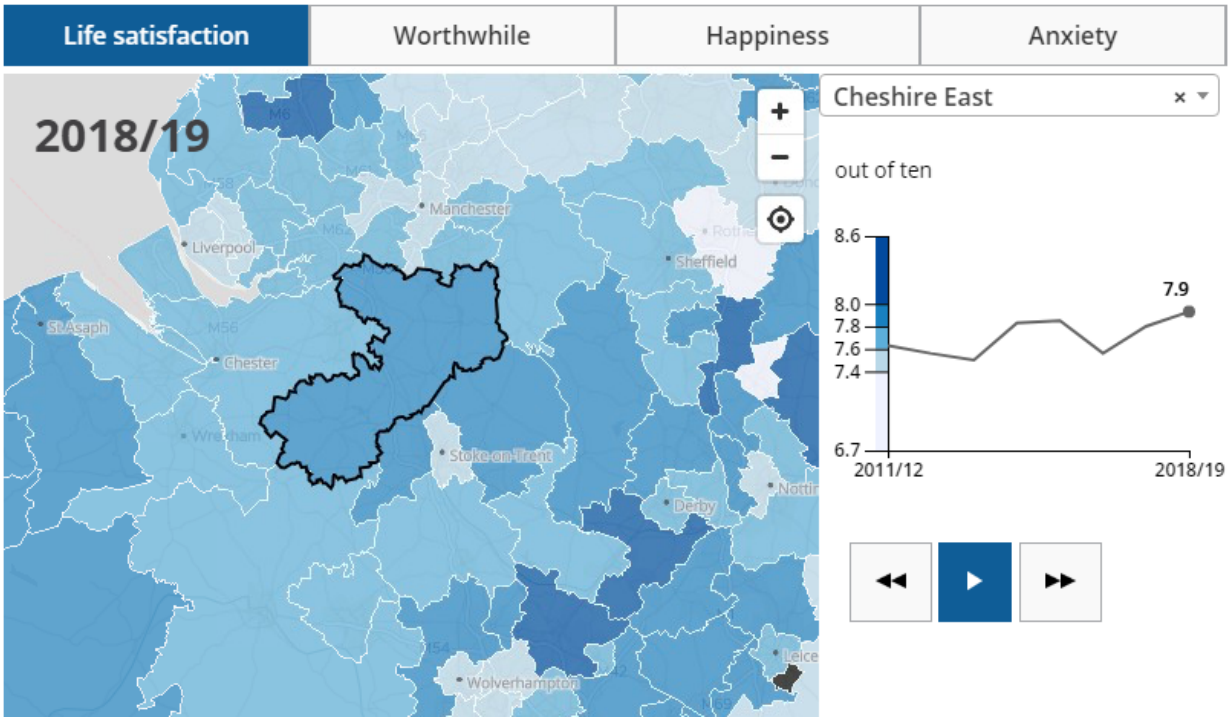


Fig 2: ONS.gov.uk/peoplepopulationandcommunity/wellbeing

In order to develop a mental wellbeing strategy we have engaged with stakeholders including mental health professionals and other front-line staff, commissioners, service users and residents from across C/W&H. The views and information we have collected have informed the objectives and actions we have identified, and the recommendations. We have also sought to incorporate relevant local, regional and national policy into the strategy wherever possible.

Through our development work five key objectives were identified which are:

1. **Speak up for mental wellbeing, challenging stigma and discrimination and promote early/self care**
2. **Support more people who identify mental wellbeing as a barrier whilst in work and for those seeking to enter or re-enter the workplace**
3. **Promote places to live that are safe, stable and add to quality of life**
4. **Contribute to an integrated approach to mental heath support from the promotion of wellbeing to the recovery from mental ill-health**
5. **Improve the mental health and wellbeing in the early years and young people**

We have looked for 'promising approaches' from across each of the participating boroughs and their Partners for each of the objectives. These approaches have been developed through evidenced based thinking and/or on a pilot basis in order to generate data proving impact and outcome. This approach has been informed by the work of Public Health England in their Evidence Review within the Transforming Children and Young people's Mental Health Green Paper in 2016.

These are summarised below:

1. ***Speaking up for mental wellbeing, challenging stigma and discrimination and promoting early/self care***

Warrington LA have consistently invested in promoting positive mental wellbeing and are operating as a Time to Change hub:https://www.warringtonspeakup.org.uk/time-to-change/
This will enable them to access support, training and resources from the national Time to Change campaign. This includes a network to develop and support 'Time to Change' champions who can communicate their experiences of living with mental health conditions back to their communities and the general public in order to challenge the negative stereotypes that so many people still hold.

Providing support at an early stage for those who are struggling with their mental health is key to preventing more serious mental health problems developing further down the line. The https://www.nhs.uk/oneyou/every-mind-matters/campaign has recently been launched by Public Health England (PHE) to promote access to digital self help for people with low level mental health problems such as stress, anxiety and sleeping problems. This is a time limited national campaign and whilst providing a short term solution, we are working with colleagues in London to investigate options for a region specific Digital Mental Wellbeing Service, based on their https://www.good-thinking.uk/ platform.

Another important aspect of early intervention work is the training front-line staff and communities across the sub region including those working with children and young people to identify when people are struggling with their mental health and provide basic advice and signposting to services. 1:100 adults have been provided mental health awareness training across the sub region such as Mental Health First Aid over the last two years and we should continue to identify and deliver opportunities for training.

The https://www.makingeverycontactcount.co.uk/ programme now includes mental wellbeing as one of its components and offers an evidence based approach to **Asking** about mental wellbeing, **and Assisting and Advising** people to find solutions or signposting to someone who can help them further

1. We recommend that the Time to Change (TtC) and Every Mind Matters (EMM) programmes are promoted widely across the sub region in a coordinated campaign and sustainable long term support for self care is developed based on MECC and greater access to digital tools. Partners should continue to identify and deliver opportunities for mental well-being training for all frontline staff.

2. Supporting more people who identify mental wellbeing as a barrier whilst in work and for those seeking to enter or re-enter the workplace

There are two distinct aspects of employment that relate to mental wellbeing:

- Being in work, and particularly good work, as opposed to under or unemployed, is known to have significant benefits for positive mental wellbeing.
- The conditions experienced in the workplace for those that are employed are also an important determinant. For example, workplace stress caused by unrealistic workloads and expectations or insecure employment status can lead to depression and anxiety.

In terms of workplace mental health, a national survey conducted by mental health charity MIND suggested that more than 1 in 6 employees have experienced common mental health problems, including anxiety and depression. The survey also showed that work is often the biggest cause of stress in people's lives, more so than housing issues or financial problems. Mental health problems are the leading cause of sickness absence from work.

Worklessness and its associated mental health barriers such as resilience and confidence of individuals in the world of work and matching the right people to the right jobs to ensure sustained employment and consistency for employers continue to present challenges across the Cheshire and Warrington sub-region. We believe collaboration is the key. The Into Work Board - A strong partnership of 16 key stakeholders are driving forward collaboration and resulting in the submission of a successful sub-regional European Social Investment Fund bid for £5.4m for a co-designed, intensive supported employment model that will be embedded in services that support our most vulnerable families, children and individuals. The Journey First Programme will provide over 30 employment support workers in existing multi-agency teams and that will focus on prevention, early intervention and de-escalation of a range of complex problems that prevent individuals from being able to focus on progression into training and employment.

2.We recommend the Journey First programme includes a focus on providing mental wellbeing interventions to enable the programme outcomes to be met

3. *Promoting places to live that are safe, sustainable and add to quality of life*

The strategy identifies five key determinants of mental wellbeing that impact of on our population. These are:

- economic wellbeing including poverty
- employment & workplace
- housing and homelessness
- social capital and social isolation
- access to green space and the natural environment

C&W SRLB Partners are taking steps to alleviate the impact of the social, physical and economic environment on residents' health including through investment and strategy development. Examples include:

Cheshire East Council are commissioning a Health Impact Assessment on the housing stock within the private rented sector across the borough to improve the evidence base to support investment decisions in relation to housing provision.

Social prescribing in Cheshire/Warrington is usually a joint initiative between the Council, CCG and voluntary sector. Social prescribing enables health professionals, mainly in primary care, to refer people to a range of local, non-clinical services. Social prescribing seeks to address people's needs in a holistic way and aims to support individuals to take greater control of their own mental health. One of the most common concerns of people referred is mental health needs.

Halton are a demonstrator site for the NHS Healthy New Town Programme through the Halton Lea project. The development at Halton Lea, Runcorn, has the potential to regenerate the area into a thriving community hub, with new opportunities for social and community prescribing, healthy retail provision and integrated housing, health and social care provision. The 'One Halton' model of care and support is focused on enhancing services in the community and ensuring easy access to those services, focusing on developing a health and wellbeing ecosystem, with people at the heart of it, and an infrastructure that supports wellbeing and health .

Community Safety

Local Community safety partnerships are changed with strategic planning to respond to locally defined needs. There is scope to influence these plans as they reach review date to ensure the impact of crime and disorder on offender mental health and community wellbeing is recognized and prioritized. This is particularly relevant to issues such as domestic abuse and substance use, often referred to as the 'toxic trio' which surround offending behaviour. Police and PPC colleagues also report very high and increasing activity in order to respond to mental health needs of residents in distress. Action to address this demand is being considered by the Cheshire and Mersey Health and Care Partnership, Crisis Care workstream.

3.We recommend housing, employment, community safety and regeneration schemes should be subjected to an audit to assess impact on mental wellbeing This should enable commissioners to drive up the mental wellbeing dividends from the wider determinate programmes. (see appendix 3)

4. ***Contributing to an integrated approach to mental health support from the promotion of wellbeing to the recovery from mental ill-health***

Providing support for people who are struggling with their mental health at an early stage is key to preventing the development of more serious mental health conditions further down the line. This includes people who have not reached the stage of having a diagnosable condition but may be experiencing high levels of stress or low mood and could benefit from advice, support and non-medical interventions.

We know that many people will not consult a health professional at the early stages of poor mental health and often the first person to offer, or be asked for help will be a family member, friend or colleague. A key principle of our approach is therefore to provide training and information for

relevant front-line professionals, people working in the community and members of the public so that they are able to identify when people around them are struggling and provide timely advice and signposting to services when relevant. Nationally 1:100 adults have received mental health first aid training including front line staff: health professionals, teachers, community groups and Local Authority staff. But there are still many opportunities to engage more people in mental health training.

The Cheshire East Council Together, Connected Communities mental wellbeing programme is aimed at people recovering from mental ill-health. There is a need to ensure pathways are developed into early help such as social prescribing and IAPT as well as crisis support services to ensure this programme is safe and sustainable.

4.We recommend the Connected Communities Programme in Cheshire East is evaluated for impact on people accessing primary mental health services with a view to guiding commissioning of similar services across the sub region.

5. Improving the mental health and wellbeing in the early years and young people-

The early years and childhood are crucial times for setting people up to enjoy good mental wellbeing for life. Secure attachment to caregivers can promote a child's self-esteem and resilience, influence the way in which the child relates to and behaves with others and insulate itself from the impact of Adverse Childhood Experiences (ACEs). Services can also respond through use of for example trauma informed practice as evidenced in CWaC and Halton

Schools and other educational settings have been shown to provide a good opportunity for mental health promotion and Cheshire East has a strong local Emotionally Healthy Child programme with most schools in the borough participating. Emotional health and wellbeing is one of the core strands of this programme. They are also developing an equivalent programme for Early Years Settings including childminders and nurseries.

Cheshire West and Chester LA and Halton LA are using trauma informed practice training for all frontline delivery staff (for both children and adults) to assess impact on service use.

5.We recommend the emotionally healthy child programme in Cheshire East and trauma informed practice work being undertaken in Cheshire West and Halton are evaluated for impact on referrals to services with a view to guiding commissioning of similar approaches across the sub region

Summary

Mental health and wellbeing can be maintained, improved and diminished just like physical health. This strategy focusses on improving mental wellbeing and preventing mental health conditions from developing before they become serious problems. In order to do so we are proposing action within partnerships across the sub region leading on health and care, housing provision, employment and 'place-making' to enable residents to contribute to their community, and reach their full potential.

Introduction

Mental ill-health represents the largest single cause of disability in the UK (Mental Health 5 Year Forward View with NHS Long Term Plan). People can be affected by mental health problems at any point in their lives; including new mothers, children, teenagers, adults and older people. It is estimated that one in four adults will suffer from a mental health problem in any given year, equivalent to almost 180, 000 people in Cheshire/Warrington.

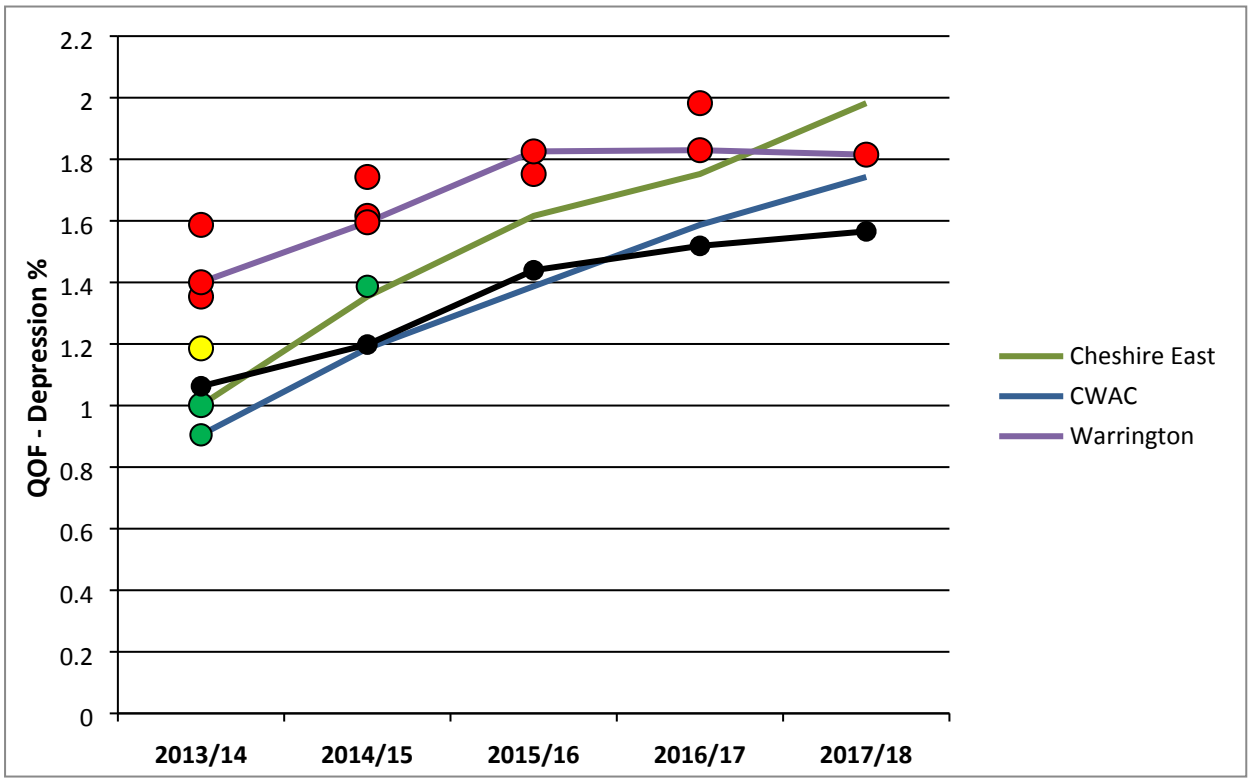


Fig 3 New cases of depression in adults aged 18 and over Cheshire and Warrington 2013-2018

Cheshire and Warrington sub-region is a predominantly affluent area which masks areas of poor health experience:

Adults in C&W spend around **fifth** of their life in **poor health** High levels of adults classified as **overweight or obese – two thirds** in Cheshire East and Cheshire West and Chester, **nearly 70%** in Warrington Similar rates of **physical inactivity** to the national average of **28.7%** Proportion **claiming out of work benefits** is **lower than NW average** of 11% - Cheshire East (6.0%), Cheshire West and Chester (7.5%) and Warrington (7.4%) Most common reason for claiming either incapacity benefit or Employment and Support Allowance was **mental and behavioural disorders,** followed by **musculoskeletal issues** **Over 70%** of those reporting worklessness in C&W also report some degree of **limiting long term illness of disability**

Fig 4: Public health indicators across the sub region (Local Enterprise Partnership analysis)

This strategy sets out our approach to improving population mental wellbeing, which evidence shows will help prevent mental health problems from developing further down the line. We want to support residents to look after their own mental health, just as many do for their physical health, by engaging in mentally healthy behaviours such as social activities and physical activity. There is now a strong evidence base to guide us in terms of how mental wellbeing can be improved and it is known that initiatives to improve wellbeing can be both cost-effective and popular. Tackling the stigma and discrimination around mental health is also a vitally important part of this work as we know this prevents people from talking about, or seeking help for, their mental health and wellbeing. The strategy also highlights how we aim to support residents early on, when they need support, in order to prevent low level mental health problems developing into more serious conditions.

The delivery of effective mental health services and the prevention of suicide is beyond the scope of this strategy, as are services to support the recovery of people from serious mental illness. Both of these mental health priorities are being addressed by Health and Care Partnership Mental health Programme However, good mental wellbeing is something everyone can achieve regardless of age, gender, socio economic status or mental health diagnosis given the right social conditions in which to do so

Successful approaches to promoting population mental wellbeing involve enabling people and communities to support themselves and to be able to make meaningful decisions about their lives and local neighborhoods. This resonates strongly with a number of sub regional programmes, particularly the Health and Care Partnership, the Strategic Housing Partnership and the Local Enterprise Partnership

In summary, mental health can be maintained, improved and diminished just like physical health. To improve population mental health we will focus on improving mental wellbeing. In doing so, we can enable our residents to enjoy a good quality of life, making contributions to their communities,

developing meaningful social networks and relationships, and reaching their full potential.

Strategy development

Our approach has been to collaborate as far as possible in both the strategy development and in exploring the promising approaches in actions which seek to address the issues highlighted. Our main collaborator has been Cheshire and Mersey Public Health Network (CHAMPS).

6.Recommendation: We feel this collaboration should continue and be strengthened through a formal agreement to ensure the PSTP and Champs workforce impact is maximized

Collaboration has also taken place with the **Health and Care Partnership** and **Mental Health Programme Board** to ensure to ensure their focus on mental health service transformation and suicide prevention are referenced in our thinking.

We have also discussed joint working with the Liverpool City Region on population mental health improvement and on the concept of a Mental Health Commission spanning both Cheshire and Merseyside. (See below for further details on the Commission)

In order to develop the strategy, we have undertaken a desk top review of evidence, national and local policy drivers and a mapping exercise of actions underway in each of the boroughs areas across the sub region.

Evidence review

Much of the work to understand what affects mental wellbeing and what works to address this had been commissioned by CHAMPS and undertaken by John Moores University in 2016.

This review has informed our work, however, it is felt that there are now gaps in this evidence review for **example it did not include a review of the impact of austerity and the changes to welfare provision.**

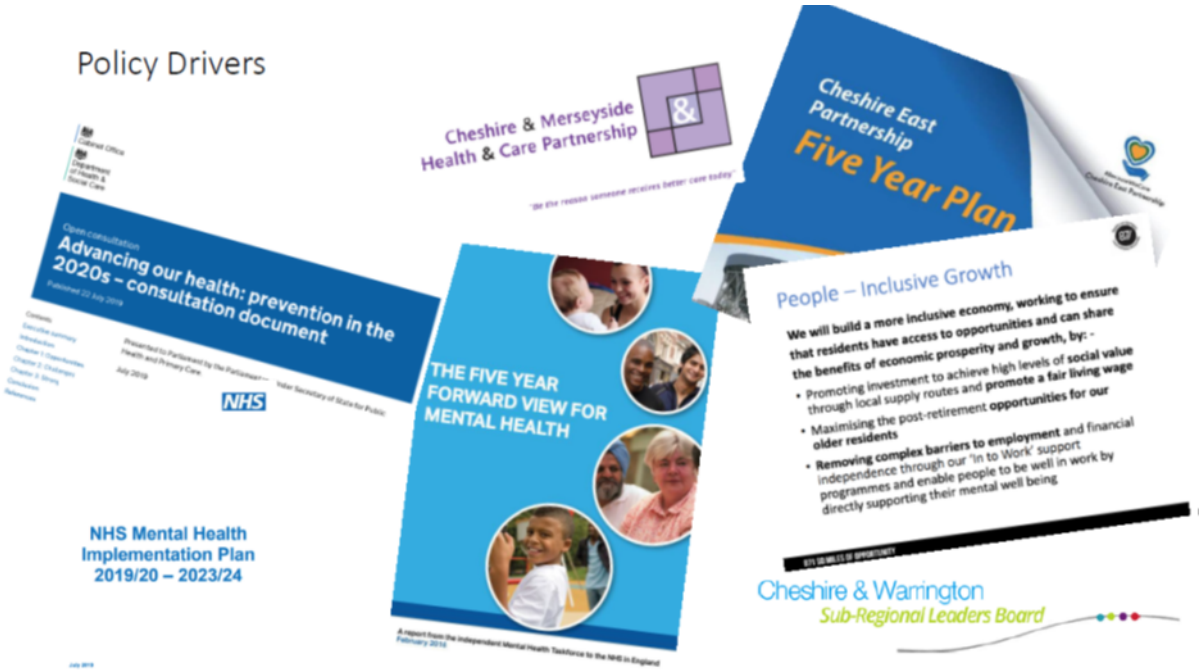
7.Recommendation: This evidence base should be revisited

An evidence review should identify the contribution that the sub region could make to addressing poor mental health and wellbeing for adults of working age and include:

- ***An audit of current or planned initiatives relating to mental health, whether public, private or voluntary sector to include crisis care; housing and housing related support; employment; recovery colleges; service user engagement, place-making and prevention and promotion activity.***
- ***Championing of the Prevention Concordat for Better Mental Health- the development of action plans by signatory organisations to improve mental wellbeing through their actions policies and procedures***

8.We recommend all C&WSRLB partners should commit to sign the Public Health England http://www.preventionconcordat.co.uk/ for Better Mental Health

Policy Drivers



We reviewed national and local policies to ensure our strategy was well informed

Mapping exercise

Our mapping work involved a review of partners mental health strategies and JSNAs and work programmes for the HCP Mental health and Prevention work-streams and interviews with commissioners, service managers and VCFS provides across the sub region.

Key messages to emerge from mapping:

*"Move from a individual focus to a population health system approach (as advocated by the Kings Fund)"**

"Focus on opportunities presented from joining up commissioning activity rather than looking back at what has ben commissioned in the past"

"And add value to any work to improve mental wellbeing by focusing on prevention"

Finally we held a workshop in September 2019 for stakeholders where we tested some of our ideas and listened to thoughts and ideas about refining these into a draft strategy for consultation. The box below summarises some of the discussions at the workshop.

Cheshire/Warrington Strategy development workshop Sep 19
Cheshire/Warrington supported the campaign by hosting a workshop for mental health and wellbeing stakeholders across the borough in September 2019. The discussions at the event centered around the key principles to inform a strategy, a prevention model and an approach to encourage collective actions. We agreed the following principles:

- A focus on wider determinants
- Add value to existing work
- Raise the bar
- Systemize and/or strengthen local provision
- Focus across the life course
- Tackle structural issues and join things up
- Tackle common tasks
- Challenge the orthodoxy
- Use evidence to drive practice
- Be informed by lived experience

A number of key messages came from the workshop discussions. Firstly, with regard to a position statement on prevention, the group felt this should be; positive, aspirational 'edgy', non-medicalised, and acknowledge inequalities and the impact of poverty.

We came up with this position statement for the strategy:

We will work together to improve mental wellbeing across Cheshire and Warrington, challenging inequalities and encouraging healthy communities

We discussed adopting a **population health system** model as advocated by the Kings Fund*

Our behaviours and lifestyles: we agreed there is a need to promote both 'the message' and the ways in which people can be helped and help themselves, however, we agreed there is danger this becomes the entire focus of the strategy and further medicalises responses to mental wellbeing.

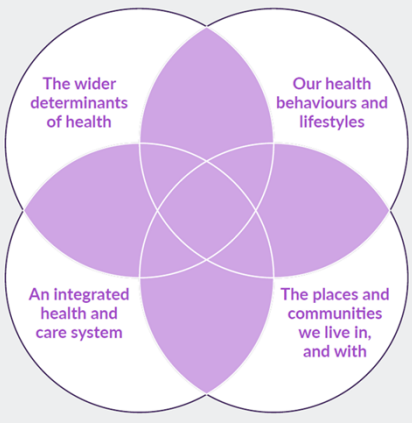
An integrated health and care system: We felt our focus should be on early intervention and preventing escalations. It should enable this strategy to connect to the work to improve mental health services.

The wider determinants of health: This definition would enable this work to connect to work with housing provision, employment support and place making

The places and communities we live in and with: The important role of the community and voluntary sector was also made clear, with community groups of all types and sizes important. It was felt that despite challenges faced by the community and voluntary sector, Cheshire/Warrington benefits from strong communities and these can be utilised better to explain King Fund model to support population mental wellbeing.(see below)

We recognized the importance of *consulting and engaging with communities* at every opportunity and that this has to be real and meaningful engagement where everybody has an opportunity to influence actions in their communities.

Finally, it was thought that there still needs to be better support and education for children and young people on understanding and dealing with their emotions and wellbeing and work to build their self- esteem and resilience to cope with everyday stresses such as exams, relationships and



family life.

Equalities Analysis

Mental ill-health and mental wellbeing can be disproportionately present across society. The strategy has been subjected to an Equality Impact Assessment and this suggests further work should be undertaken to ensure the strategy is informed by a full understanding of inequality and how this affects mental wellbeing.

9.We recommend a more detailed Equalities Impact Analysis is undertaken on this strategy

Financial landscape

This strategy has been developed at a time of financial constraint. Organisations across the region in every sector have had to make difficult decisions about where best to direct resources and how to use funding as effectively as possible. While there is no new funding attached to this strategy to improve mental wellbeing, we wish to ensure that existing resources are used as effectively and efficiently as possible. This will include ensuring that mental health and wider wellbeing services are as joined up as possible with no duplication of activities. We will also explore opportunities for bidding for new funding to support the strategy objectives wherever possible.

Measuring wellbeing

There is a need to ensure there is a consistency of approach to measuring mental wellbeing across the sub region. This is in terms of evaluation of projects and interventions and in terms of any surveys to measure population mental wellbeing levels. . Wellbeing measurement frameworks such as https://www.socialprogress.org/, https://worldhappiness.report/ed/2019/ and others reviewed by https://whatworkswellbeing.org/should be evaluated as potential measures of impact across the sub region.

In terms of evaluating local initiatives to improve population mental wellbeing, the **Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)** is a validated scale of items used for the measurement of mental wellbeing of the population aged 13 to 74. There is a longer version of 14 questions and a shorter version of seven items. It is the seven item scale that we recommend for use locally, as it is validated, widely used throughout the UK, free to use and quick and easy to administer. It is also now available in a number of different languages including Urdu, Arabic, French, Lithuanian and others. The scale comprises seven positively worded statements and participants are asked to answer each mental wellbeing statement for the previous two weeks. See appendix 1 for the full set of questions. Many local projects are already utilising this scale for evaluation purposes.

Personal wellbeing, which is about how positively people evaluate their own lives, and highly relevant to mental wellbeing is also measured by ONS as part of the Annual Population Survey and this provides estimates at borough level See appendix 2 This includes four questions, each scored on a 10 point scale, as shown in appendix 2. The questions relate to satisfaction with life, feeling the things you do are worthwhile, happiness and feeling anxious. While the WEMWEBS scale is the recommended choice for measuring mental wellbeing, local surveys which require a more general

measure of wellbeing should consider use of the ONS survey questions.

10.We recommend the consistent use of the WEMWBS tool for measuring population mental wellbeing, particularly in terms of evaluating specific services and interventions to promote mental wellbeing.

11.We recommend use of the ONS annual population survey, quality of life questions to monitor impact on borough wide population group.

Influencing Others

Through collaboration and joint working in the development of this strategy we have been able to influence a number of partner programmes such as the Local Enterprise Partnership- Local Industrial Strategy, the Public Sector Transformation programme Employment Support Programme and Reducing Parental Conflict programme. We hope this Collaboration continues.

Aim of the strategy

The aim of this strategy is to promote population mental wellbeing in Cheshire/Warrington and Halton. It will do this by supporting residents to improve and protect their own wellbeing and by reducing risk factors for poor mental wellbeing and mental health problems.

Our objectives are to:

- Speak up for mental wellbeing, challenging stigma and discrimination and promoting early/self care
- Support more people who identify mental wellbeing as a barrier whilst in work and for those seeking to enter or re-enter the workplace
- Promote places to live that are safe, stable and add to quality of life
- Contribute to an integrated approach to mental heath support from the promotion of wellbeing to the recovery from mental ill-health
- Improve the mental health and wellbeing in the early years and young people

Background

What is mental wellbeing and why is it important?

Mental wellbeing comprises a positive state of mind and body that describes both feeling good and functioning well. It represents a positive state of holistic health, including a person's sense of happiness, connection with other people, communities, and the wider environment. It involves a

subjective component, a self-evaluation of living a meaningful and satisfactory life, and an objective component of whether basic living needs are met . The UK Faculty of Public Health has stated that good mental wellbeing includes the capacity to:

- Realise one's abilities, live a life with purpose and meaning, and make a positive contribution to the community.
- Form positive relationships with others, and feel connected and supported.
- Experience peace of mind, contentment, happiness and joy.
- Cope with life's ups and downs and be confident and resilient.
- Take responsibility for oneself and for others around you.

Positive mental wellbeing is an important aspiration in its own right, contributing to educational attainment, economic success, fostering community cohesion and quality of life, but it is also important as a means of preventing mental ill-health. While the relationship between mental wellbeing and mental health problems is complex, it is accepted that promoting mental wellbeing at a population level will prevent the development of mental health conditions further down the line. With the burden of mental ill-health a significant problem across the country, prevention is a crucial element of efforts to tackle this issue and there have been repeated calls for an increased focus on prevention. Alongside efforts to promote positive mental wellbeing in the population, this will also require targeted actions for those groups at high risk of poor mental health and effective early intervention for those who are struggling.

Mental wellbeing is a positive state of mind and body that describes both feeling good and functioning well.

Some of the key wider determinants of mental health and wellbeing are described in detail in sections 2&3 However, the factors highlighted below are known to affect people's mental wellbeing at individual, social and environment levels.

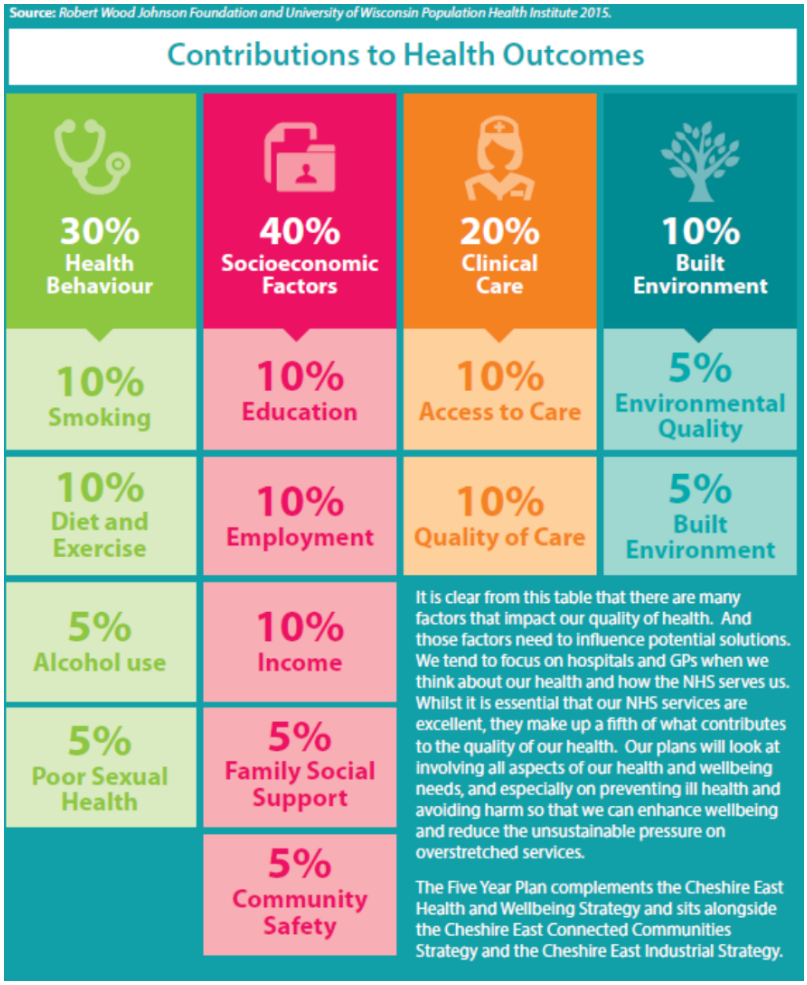


Fig 5: Contribution to health outcomes: Cheshire east Partnership Five Year Plan

What is the local picture across the region?

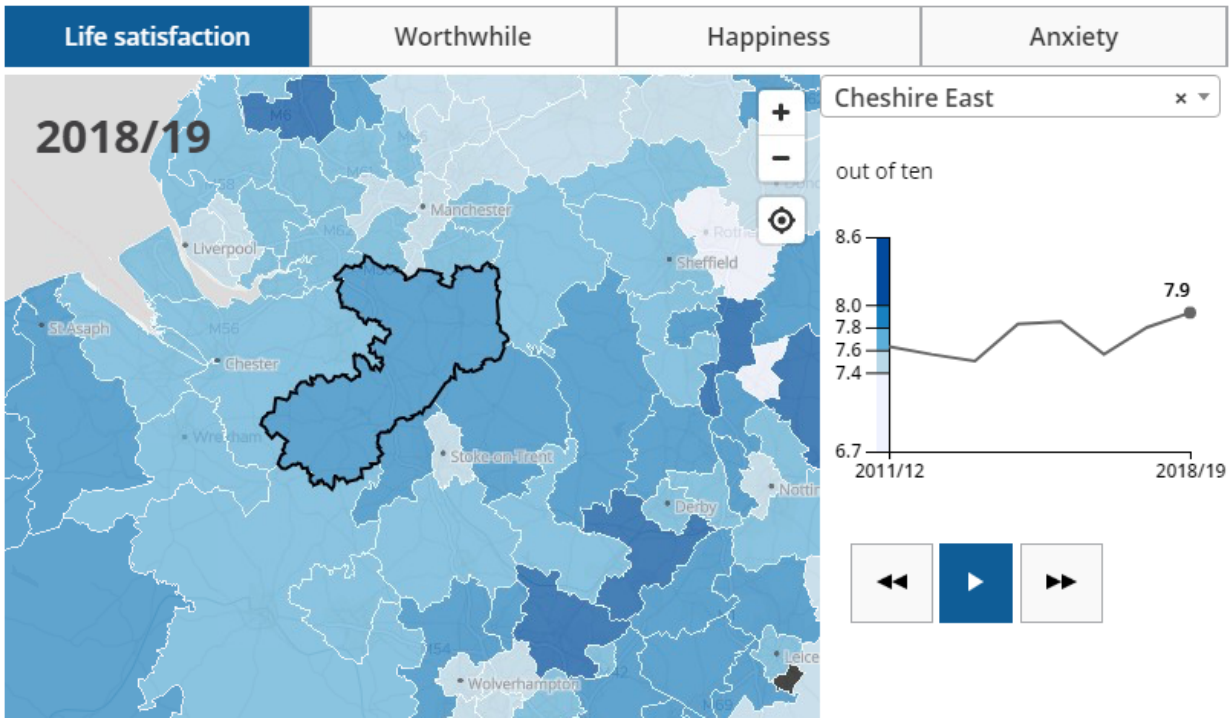


Fig 2

Data from the national Wellbeing Programme at LA level (where this exists) suggest we are average or above average for our scores in relation to happiness, satisfaction with life, and feeling worthwhile although there has been little change over time. They also, of course, mask variation within boroughs and are based on population sampling and we recommend further work is undertaken to understand this variation in this strategy. This would include running local surveys of the population using the same questions to compare against borough and regional scores. The findings from these surveys could be used to drive investigations into things which influence these factors such as access to work, green space, good quality housing and a positive network of friends and family contacts.

1. Tackling stigma and discrimination and promoting self care

What is stigma and discrimination?

Mental health stigma refers to negative attitudes and beliefs held toward people who have a mental health problem. It often results in discrimination which may be obvious and direct, such as someone making a negative remark about someone's mental illness, or indirect like exclusion from social circles or employment. The importance of tackling stigma and discrimination around mental health is a key issue for people with lived experience of mental illness.

Impact of stigma and discrimination on mental wellbeing and other aspects of life

Mental ill health is common and one in four people experience a mental health problem in any year. Most people who experience mental health problems recover fully, or are able to live with and manage them, especially if they get help early on. But despite the fact that so many people are affected, there is a strong social stigma attached to mental ill-health, and people with mental health problems can experience discrimination in all aspects of their lives.

Nationally, almost 90% of service users report that stigma and discrimination has had a negative impact on their lives, including discrimination by other people, employers, and self-stigma which significantly impacts on self-esteem and confidence. There are many misconceptions and myths about mental health that are all too readily reinforced by the media, and there are also a number of important cultural factors that influence attitudes to mental health. Stigma and discrimination have a significant impact because they can:

- Prevent people seeking help
- Delay treatment
- Impair recovery
- Isolate people
- Exclude people from day-to-day activities and stop people getting jobs[39]

We know that people with mental health problems are amongst the least likely of any group with a long-term health condition or disability to:

- Find work
- Be in a steady, long-term relationship
- Live in decent housing
- Be socially included in mainstream society

This is because society may have extreme views about mental illness and how it affects people. Many people believe that people with mental ill-health are violent and dangerous, when in fact they are more at risk of being attacked or harming themselves than harming other people. The situation is exacerbated by the media with reports often linking mental illness with violence, or portraying people with mental health problems as dangerous, criminal and unable to live normal, fulfilling lives.

Research shows that the best way to challenge and break down these stereotypes is through firsthand contact with people with experience of mental health problems. Communicating positive, evidence based information through social and other media channels can also have a positive

impact.[40]

Local and National attempts to tackle mental health stigma and discrimination and promote self care

Whereas all boroughs have Time to Change action plans, Warrington LA has become a Time to Change Hub . This will enable them to access support, training and resources from the national Time to Change campaign. We propose a partnership is brought together to develop and support 'Time to Change' champions who can communicate their experiences of living with mental health conditions back to their communities and the general public in order to challenge the negative stereotypes that people may still hold.

Providing support at an early stage for those who are struggling with their mental health is key to preventing more serious mental health problems developing further down the line. The Every Mind Matters (EMM) campaign has recently been launched by Public Health England (PHE) to promote access to digital self help for people with low level mental health problems such as stress, anxiety, sleeping problems and others.

We recommend that the Time to Change (TtC) and Every Mind Matters (EMM) programmes are promoted widely across the sub region in a coordinated campaign and a sustainable long term support for self care is developed based on MECC and greater access to digital tools

EMM is a time limited national campaign and we are also working with colleagues in London to investigate options for a region specific Digital Mental Wellbeing Service, based on their Good Thinking platform providing links to IAPT services across the sub region

Another important aspect of early intervention work is the training front-line staff and communities across the sub region including those working with children and young people to identify when people are struggling with their mental health and provide basic advice and signposting to services. 1:100 adults across C/W&H have been provided mental health awareness training across the sub region such as Mental Health First Aid over the last two years.

The Making Every Contact Count (MECC) programme now includes mental wellbeing as one of its components and offers an evidence based approach to **Asking** about mental wellbeing, **and Assisting and Advising** people to find solutions or signposting to someone who can help them further

We recommend partners should continue to identify and deliver opportunities for mental well-being training for all frontline staff.

2. Tackling mental health as a barrier to employment

Economic wellbeing including poverty

Poverty produces an environment that is extremely harmful to individuals', families' and communities'

mental health. The impacts of poverty are present throughout the life course (from before birth and into older age) and have cumulative impacts. There are particular groups of people at risk of developing mental health problems specifically children and adults living at a socio-economic disadvantage as those at some of the highest risk levels.

Many of the impacts of poverty on mental wellbeing occur via some of the other wider determinants described below including poor housing, poor educational attainment, unemployment etc. However, financial hardship and insecurity is also known to be a specific risk factor for poor mental wellbeing in its' own right. Across the UK, both men and women in the poorest fifth of the population are twice as likely to develop mental health problems as those on average incomes. Socio-emotional and behavioural difficulties have been found to be inversely distributed by household wealth as a measure of socio-economic position in children as young as 3 years old.

The recent global financial and economic crisis has accentuated and reinforced long-term trends in inequality, low pay and related poverty in Europe. While the initial impact was high rates of male redundancy, women have experienced higher wage cuts. The primary health impacts of economic downturns are on mental health (including the risk of suicide).[41] People with no previous history of mental health problems may develop them as a consequence of having to cope with the ongoing stress of job insecurity, sudden and unexpected redundancy, and the impacts of loss of employment (financial, social and psychological).

An additional challenge relevant to this area is the introduction of changes to the benefits system including roll-out of universal credit. Additional stress and anxiety can result from uncertainty around future income and actual losses of income worsens the effect of poverty and impacts on many of the wider determinants of mental health and wellbeing. The economic impacts of Brexit and ongoing local economic changes in Cheshire/Warrington will bring fresh challenges to population mental wellbeing that we will need to be aware of in the coming years.

The box below outlines an approach to addressing poverty being taken in Cheshire West

West Cheshire Poverty Truth: It all started with a question

Could people living in poverty help shape the way our borough's leaders make decisions about the support services in place? Would it make a difference to the decisions that are being made? Would it also strengthen relationships, change attitudes and create solutions to some of the difficult questions poverty creates? The answer to that is yes. Following on from the success of the very first Poverty Truth Commission (PTC) in Glasgow, Scotland, we set up our own commission. More than 200 community, voluntary, faith and public sector organisations came together to support the launch of the first commission in West Cheshire back in 2017. With the aim of tackling the root causes of poverty, the commission is different to what you might normally expect. That is because it makes sure people with lived experience are at the heart of how the borough thinks and acts in tackling poverty and inequality.

So what is the West Cheshire Poverty Truth Commission (WCPTC)?

It aims to give a face to the facts. This is done by creating safe spaces for community inspirers, those with lived experience of poverty, to tell their stories. It also provides opportunities for those making and influencing decisions to listen. The project deepens understanding of the emotive and difficult sides of poverty, improves perceptions, challenges stereotyping, and leads to better decision-making by the borough's leaders across business, public and voluntary sectors.

What have we done for individuals?

- Community inspirers feel empowered – they now have a voice.
- Inspirers have a sense of belonging and purpose, reducing isolation and building confidence.

- Two community inspirers from the first commission have found permanent work, others are actively seeking work and some have taken up voluntary opportunities, such as Public Speaking.

How have we changed cultures, behaviours and attitudes?

- Housing benefit letters are now more customer-friendly.
- We have been working closely with the Department for Work and Pensions (DWP) to develop a GP engagement strategy.
- The PTC pledge has been introduced, promoting respectful treatment of all people. If you would like to sign up to the pledge, you can get in touch with the team.

How have we influenced national policy?

- Community inspirers presented the key issues and proposed solutions to MPs at the House of Commons.
- We have submitted written evidence to the Work and Pension Select Committee.

How have we made a difference locally?

- We have worked with the Building Futures project to help secure funding for mental health awareness training for up to 300 frontline staff at Cheshire West and Chester Council and partner organisations.
- We have contributed to a new and refreshed Local Offer website.

How have we been noticed?

- We have had plenty of media coverage, such as appearances on the Sunday Politics Show, BBC News, Dee 106 and BBC Radio Merseyside.
- We have now been put forward as a case study for the Local Government Network's Good practice in engaging with the public.

Building on the positive work

The second WCPTC launched at Storyhouse on 31 January 2019, bringing together a new group of community inspirers with civic and business leaders. More than 150 people from many different sectors attended the launch as community inspirers took centre stage to share their stories and experiences. The second WCPTC will now be aiming to build on the positive work of the first commission. It is working with the Youth Senate and a group of young people from Winsford Academy and Wharton Primary School, helping to strengthen the voice of young people and allowing them to influence change.

Employment & workplace

The Cheshire LEP is currently working on a Local Industrial Strategy which seeks to address productivity challenges across the sub-region. This work has identified that mental illness and mental wellbeing are major factors in improving quality of life for working age population thereby impacting on productivity.

There are two distinct aspects of employment that relate to mental wellbeing:

- Being in work, and particularly good work, as opposed to under or unemployed, is known to have significant benefits for positive mental wellbeing.
- The conditions experienced in the workplace for those that are employed are also an important determinant. For example, workplace stress caused by unrealistic workloads and expectations or insecure employment status can lead to depression and anxiety.

In terms of workplace mental health, a national survey conducted by mental health charity MIND suggested that more than 1 in 6 employees have experienced common mental health problems,

including anxiety and depression. The survey also showed that work is often the biggest cause of stress in people's lives, more so than housing issues or financial problems. Mental health problems are the leading cause of sickness absence from work.

Worklessness and its associated mental health barriers such as resilience and confidence of individuals in the world of work and matching the right people to the right jobs to ensure sustained employment and consistency for employers continue to present challenges across the Cheshire and Warrington sub-region. We believe collaboration is the key. The Into Work Board - A strong partnership of 16 key stakeholders are driving forward collaboration and resulting in the submission of a sub-regional European Social Investment Fund bid for £5.4m for a co-designed, intensive supported employment model that, if successful, will be embedded in services that support our most vulnerable families, children and individuals. The **Journey First Programme** will provide over 30 employment support workers in existing multi-agency teams and that will focus on prevention, early intervention and de-escalation of a range of complex problems that prevent individuals from being able to focus on progression into training and employment.

Other workplace wellbeing programmes such as the https://www.activecheshire.org/services/active-minds/ should also be supported. We have been working with Active Cheshire on a mental health package which they can promote to SME's who approach them for workplace wellbeing support.

The HCP are actively promoting a https://www.cheshireandmerseysidepartnership.co.uk/our-work/social-valueto commissioning health and care services in the form of draft policies and some commissioning guidelines. These present an ideal opportunity to generate mental wellbeing dividends for service providers and those who receive services should commissioners wish to stipulate mental wellbeing outputs as part of their social value criteria in any tenders.

We recommend the Journey First programme is focused on providing mental wellbeing interventions to enable the programme outcomes to be met

3. Promote places that are safe sustainable and contribute to quality of life

Housing and homelessness

There is a clear link between people's housing and their mental health and wellbeing and the absence of suitable, stable accommodation is a serious risk factor for poor mental health. Recent research by housing charity Shelter found that 1 in 5 adults in England had experienced a housing related issue that had negatively impacted on their mental health in the last five years. Stress was the most common mental health issue reported (60%), followed by anxiety (54%) and Sleeping problems (50%).

Housing issues can impact on mental health in various ways including:

- Rising prices for both renters and owners leading to stress around financial insecurity and poor economic wellbeing.
- Poor quality housing stock with dampness, poor safety and security leading to poor physical health and mental wellbeing. Cold homes caused by fuel poverty and poor insulation also have a negative impact.
- Overcrowded accommodation, leading to poor sleep, reduced educational attainment and high stress levels.
- Homelessness is one of the biggest threats to mental health with research by the Homeless

Link charity finding that 80% of homeless people reported some form of mental health issue and 45% had been diagnosed with a mental health condition.

Housing issues are a particularly pressing concern in Cheshire/Warrington .

The Councils have recognised these issues and Housing – ensuring that everyone has a decent roof over their head. This involves commitments to:

- prioritise affordable housing for local people;
- take action against overcrowding and prosecute bad landlords; and
- improve the regions housing estates

The Homelessness Reduction Act come into force from April 2018, is a key piece of legislation affecting housing. It sets out new responsibilities for local authorities and public sector partners to tackle homelessness through a focus on earlier intervention and prevention.

Cheshire east Council are commissioning a Health Impact Assessment on the housing stock within the private rented sector across the borough to improve the evidence base to support investment decisions in relation to housing provision. **This work should be reviewed for potential replication across the sub region**

Halton are a demonstrator site for the NHS Healthy New Town Programme through the Halton Lea project. The development at Halton Lea, Runcorn, has the potential to regenerate the area into a thriving community hub, with new opportunities for social and community activities, healthy retail provision and integrated housing, health and social care provision. The 'One Halton' model of care and support is focused on enhancing services in the community and ensuring easy access to those services, focusing on developing a health and wellbeing ecosystem, with people at the heart of it, and an infrastructure that supports wellbeing and health. **This programme should be reviewed for its potential impact across the sub region.**

Further joint work with the Local Enterprize Partnership (LEP) on housing provision may be mutually helpful

Social capital and social isolation

Social capital has been defined as the resources people develop and draw on to increase their confidence and self-esteem, their sense of connectedness, belonging, and ability to bring about change in their lives and communities.

Increasing social capital involves the creation of strong networks, good levels of support and positive relationships which help to integrate individuals and communities. The health benefits include: increased confidence and self-esteem, particularly in one's ability to handle a crisis, a sense of connectedness and belonging, the ability to bring about change in one's own life or in their community. Evidence shows that all of these support the development of good mental wellbeing and are protective factors in relation to poor mental health.

Conversely, the opposite of having high levels of social capital is social isolation, which causes

loneliness and is known to be a strong risk factor for mental ill-health. Research shows that lacking social connections is as damaging to our health as smoking 15 cigarettes a day and loneliness increases the likelihood of mortality by 26% (Holt-Lunstad, 2015). Much of this impact on health is seen through poor mental health and wellbeing. UK survey data from Age UK shows that 3 in 10 of those aged over 80 report being lonely.

In Cheshire/Warrington, 30% of adults aged 65 and over live alone. This comprises around 13% of all households in the sub-region, higher than England (5.2%). While living alone doesn't necessarily mean social isolation or loneliness, it is seen as a good indicator of the likely burden, particularly in older adults.

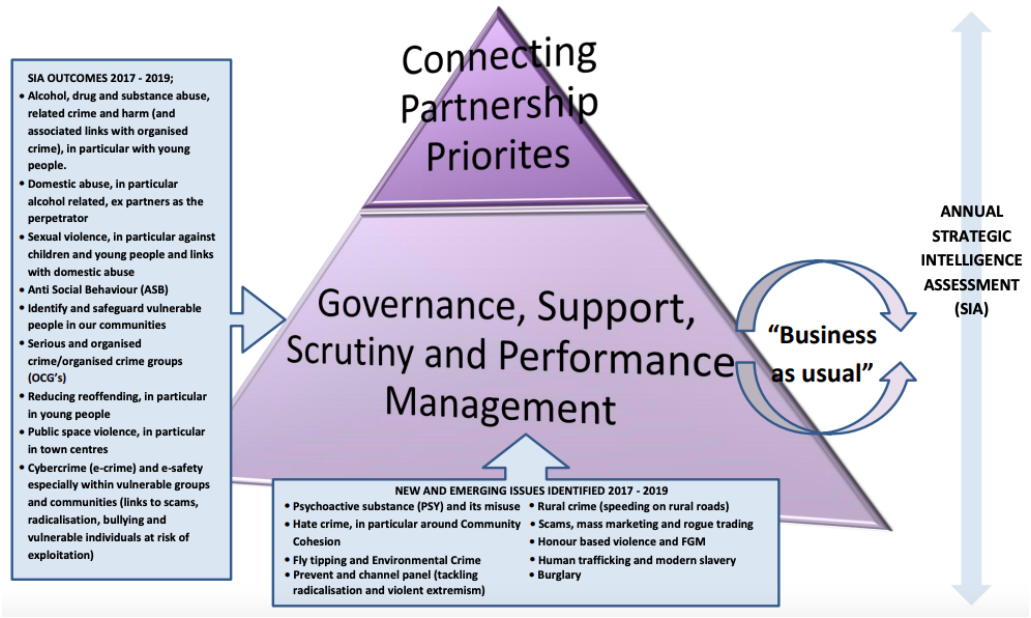
In Cheshire/Warrington, 40% of adult carers (aged 18 and over) say that they have as much social contact as they would like, which is higher than the England average(36%), suggesting a lower degree of social isolation/greater potential for social capital.

Age UK have produced 'loneliness maps' that show the relative risk of loneliness across neighbourhoods in England. The relative risk of loneliness is based on the Census figures for a number of the factors identified above including living alone and marital status, low income and poor physical health. These maps can be used to support the targeting of social and befriending opportunities within the boroughs.

Over the next decade, as more services become digital by default, digital exclusion among older populations is likely to increase and may compound loneliness and other forms of social exclusion. Conversely, social media platforms offer opportunities to engage older adults provided they are IT literate and have access to the necessary facilities to engage.

Community Safety

Local Community safety partnerships are changed with strategic planning to respond to locally defined needs *(see Fig 6 below: Community Safety Plan on a page, Cheshire East).* There is scope to influence these plans as they reach review date to ensure the impact of crime and disorder on offender mental health and community wellbeing is recognized and prioritized. This is particularly relevant to issues such as domestic abuse and substance use, often referred to as the 'toxic trio' which surround offending behaviour. Police and PPC colleagues also report very high and increasing activity in order to respond to mental health needs of residents in distress. Action to address this demand is being considered by the Cheshire and Mersey Health and Care Partnership, Crisis Care workstream.



Social prescribing

The social prescribing services in Cheshire/Warrington and Halton are usually joint initiatives between the Council and CCG. Social prescribing enables health professionals, mainly in primary care, to refer people to a range of local, non-clinical services. Social prescribing seeks to address people's needs in a holistic way and aims to support individuals to take greater control of their own mental health. One of the most common concerns of people referred is mental health needs.

Social prescribing works with people to access local sources of support such as volunteering, arts activities, group learning, gardening, befriending, healthy eating advice and a range of sports etc.

Access to green space and the natural environment

It is well known that contact with the natural environment and green space promotes good health and the evidence is particularly strong for positive associations between experience of natural environments and mental health. Contact with natural environments evokes positive emotions, promoting psychological restoration, improving mood and attention, and reduces stress and anxiety. Research has also shown the benefits of green space include reduced aggression and crime by improving companionship, sense of identity, belonging and happiness. In addition to providing a direct benefit to mental wellbeing, green space can act to indirectly improve wellbeing via increasing physical activity opportunities and community participation, while reducing noise and light pollution. As a sub region Cheshire and Warrington includes substantial areas of green space providing good opportunity to access this. A green space audit has been undertaken in Cheshire looking into current and future use of green space assets across the sub region.

As with all opportunities for accessing facilities and services that can provide a positive impact on mental wellbeing, it is important that work is undertaken to improve access to green spaces for all groups in the population, particularly those with risk factors for poor mental health and wellbeing.

We recommend the above programmes should be subjected to an audit to assess impact on mental wellbeing. This should enable commissioners to drive up the mental wellbeing dividends from the wider determinate programmes. (see appendix 3)

4. Contributing to an integrated approach to mental heath support from the promotion of wellbeing to the recovery from mental ill-health

Providing support for people who are struggling with their mental health at an early stage is key to preventing the development of more serious mental health conditions further down the line. This includes people who have not reached the stage of having a diagnosable condition but may be experiencing high levels of stress or low mood and could benefit from advice, support and non-medical interventions.

We know that many people will not consult a health professional at the early stages of poor mental health and often the first person to offer, or be asked for help will be a family member, friend or colleague. A key principle of our approach is therefore to provide training and information for relevant front-line professionals, people working in the community and members of the public so that they are able to identify when people around them are struggling and provide timely advice and signposting to services when relevant. In Cheshire/Warrington Mental Health First Aid Training is already being delivered to front line staff including health professionals, teachers, community groups and Local Authority staff. But there are still many opportunities to engage more people in mental health training and we will explore options for delivery beyond the PSTP partners

In Cheshire/Warrington and Halton there are many services spanning the statutory, private and voluntary sectors that support residents who are struggling with their mental health and wellbeing in order to prevent future mental ill-health. Examples include:

> *The Cheshire East Council Together, Connected Communities mental wellbeing programme is aimed at people recovering from emotional distress, mental health concerns and mental ill-health. There is a need to ensure pathways are developed into early help such as IAPT as well as crisis support* services to ensure this programme is safe and sustainable.

We recommend the Connected Communities Programme in Cheshire East is included in primary mental health service planning in Cheshire East and evaluated for impact on people accessing primary mental health services.

Talking therapies

Talking Therapies is a service which is part of the national Improving Access to Psychological Therapies (IAPT) programme. The service provides talking therapies for people with mild to moderate mental health problems and is accessed via referral from GPs and other health professionals or self-referral. The service offers individual or group sessions which run for 6-20 weeks depending on level of need. The services offered include; mindfulness, anxiety management, winter

wellbeing groups, post-traumatic stress disorder and others.

NHS England has set a national ambition to increase access to talking therapies so that by 2021 at least 25% of those with anxiety or depression have access to a clinically proven talking therapy service. There is also a commitment to improving access to services for people with long-term conditions, people from Black and Minority Ethnic communities, and to embed psychological support in pathways across health care so mental and physical healthcare is as joined-up as possible.

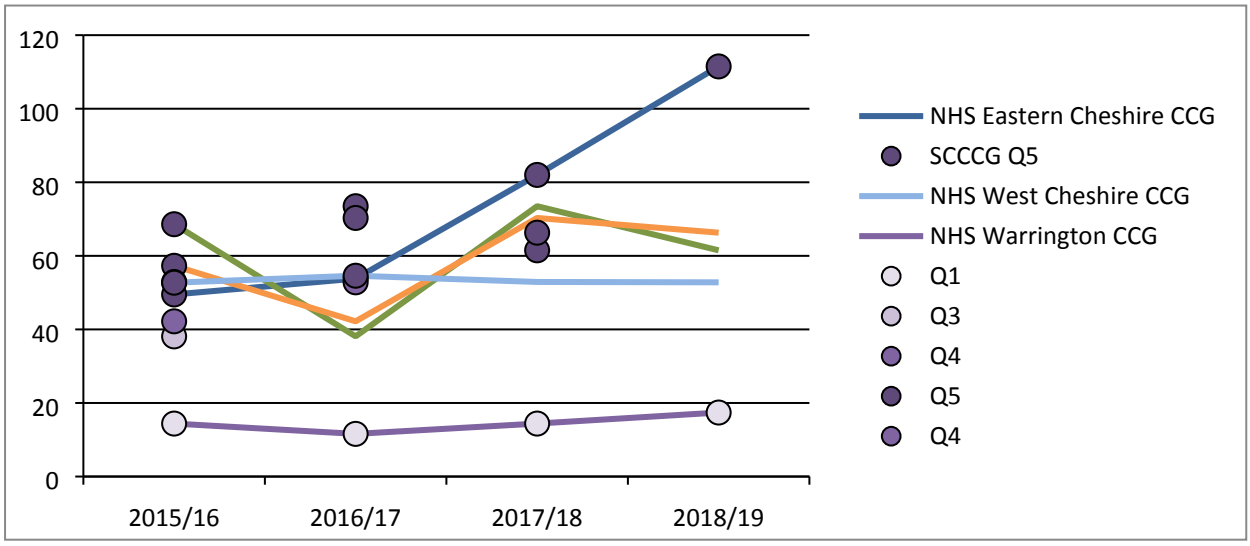


Fig 6: Average waiting times between1st and 2nd treatment (annual) 2015-2019

Social prescribing

Social prescribing (SP) services across in Cheshire/Warrington are quite well established and the recent additional investment in Link Workers based with Primary care networks (PCNs) should build on existing services. There has however also been a reduction in grant funding to support the vol/comm sector to provide community based activity. Social prescribing enables health professionals, mainly in primary care, to refer people to a range of local, non-clinical services. Social prescribing seeks to address people's needs in a holistic way and aims to support individuals to take greater control of their own mental health. Nationally wherever SP schemes exist, one of the most common concerns of people referred is mental health needs.

SP should be expanded with some caution to ensure vol/comm provided services are not overwhelmed with referrals from the Link Work programme.

5. Maternal health, early years and young people

Pregnancy and the early years is a critical time for both parent and children's mental health. Good physical and mental health in pregnancy is associated with better outcomes for children. Anxiety,

depression and maternal stress – especially the experience of domestic abuse – have been linked to impaired emotional, cognitive and language development in infants. During infancy, a child's secure attachment to their main caregiver creates expectations in the child and provides a mental model for future relationships. Secure attachment insulates from trauma and promotes a child's self-esteem and resilience, and influences the way in which the child relates to and behaves with others. It gives the child an internal working model of the world as a safe and secure one in which the main caregiver will respond to its needs. This supports the development of neural pathways.

Maternal depression (both in the antenatal and postnatal period) is one of the strongest predictors of poor attachment and emotional and mental health difficulties in childhood and later in life. Over 50% of lifetime mental illness (excluding dementia) manifests by age 14 with 75% of all adult mental illness manifesting by age 24.

The early years and childhood are crucial times for setting people up to enjoy good mental wellbeing for life. Secure attachment to caregivers can promote a child's self-esteem and resilience, influence the way in which the child relates to and behaves with others and insulate itself from the impact of Adverse Childhood Experiences (ACEs). Services can also respond through use of for example trauma informed practice

Schools and other educational settings have been shown to provide a good opportunity for mental health promotion and Cheshire East has a strong local Emotionally Healthy Child programme with most schools in the borough participating. Emotional health and wellbeing is one of the core strands of this programme. They are also developing an equivalent programme for Early Years Settings including childminders and nurseries.

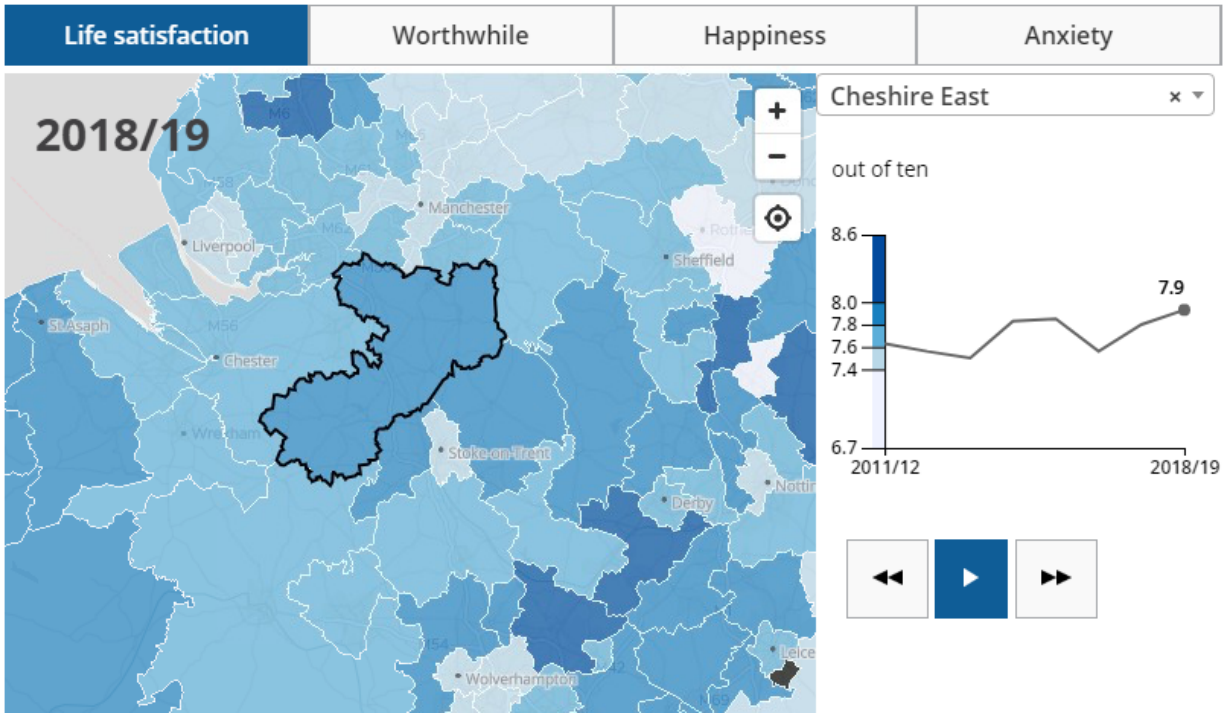
Cheshire West and Chester LA and Halton LA are using trauma informed practice training for all frontline delivery staff (for both children and adults) to assess impact on service use. This comprises of sessions on neurodevelopment and the impact of trauma, identification of trauma affected behaviour and interventions to support people affected by trauma.

We recommend the emotionally healthy child programme in Cheshire East and Trauma Informed Practice work being undertaken in Cheshire West and Halton are evaluated for impact on referrals to services in order to influence commissioning of similar approaches across the sub-region

6.Measuring the impact of the Strategy

The following key performance indicators are proposed:

The overall programme should be monitored against the indicators contained within the national Wellbeing dataset



The strategic objectives should be monitored as follows:

	Objective	How will we know things have changed	What's the current position	What's our target
1	Stigma and self care	• Increase in number of people reached by social media campaign • No of people registered on digital self help platform	• Investigate data captured locally on Time to Change campaign visibility to establish local/sub region baselines • Investigate current data captured on use of existing self help tools approved by NHS app library	• Develop targets based on increasing reach for sub-regional Time to change campaign • Develop targets based on increasing number of people using self help tools
2	Barrier to work	• NHS digital publish dat of no. of fit notes issued by CCG by ICD code • DWP data can be used to show number of people	• Trend is upward • Trend is upward	• Develop a trajectory to show slowing rate of increase over lifetime of the strategy • Develop a trajectory to show slowing rate of increase

		claiming out of work benefits by ward by ICD code • Mental Health dataset contains measures relating to number of people in contact with CJS	• No local analysis	over lifetime of the strategy • We should consider requesting bespoke analysis to develop targets
3	Safe and stable	• National Housing Survey has satisfaction measures but key issue is lack of provision • Social capital metrics, access to green/open spaces, and/or community safety metrics which impact on mental wellbeing	• Largely unchanged from 2010-2016	• Should consider use of bespoke neighbourhood audits and/or processes such as health Impact Analysis to develop targets No analysis by sub region undertaken to date
4	Integrated systems	• No of commissioning and provider organisations adopting PHE prevention concordat	• Little if any take up so far	• All commissioning authorities adopt the concordat and produce action plans by March 20
5	CYP	• Referrals to CAMHS	• Trend is upward	• Consider use of Cheshire East Emotionally Healthy Child outcome indicators across sub region systems

7.Measuring Mental Wellbeing

There is a need to ensure there is a consistency of approach to measuring mental wellbeing across the sub region. This is in terms of evaluation of projects and interventions and in terms of any surveys to

measure population mental wellbeing levels. Wellbeing measurement frameworks such as https://www.socialprogress.org/, https://worldhappiness.report/ed/2019/ and others reviewed by https://whatworkswellbeing.org/should be evaluated as potential measures of impact across the sub region.

In terms of evaluating local initiatives to improve population mental wellbeing, the **Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)** is a validated scale of items used for the measurement of mental wellbeing of the population aged 13 to 74. There is a longer version of 14 questions and a shorter version of seven items. It is the seven item scale that we recommend for use locally, as it is validated, widely used throughout the UK, free to use and quick and easy to administer. It is also now available in a number of different languages including Urdu, Arabic, French, Lithuanian and others. The scale comprises seven positively worded statements and participants are asked to answer each mental wellbeing statement for the previous two weeks. See appendix 1 for the full set of questions. Many local projects are already utilising this scale for evaluation purposes.

Personal wellbeing, which is about how positively people evaluate their own lives, and highly relevant to mental wellbeing is also measured by ONS as part of the Annual Population Survey and this provides estimates at borough level See appendix 2 This includes four questions, each scored on a 10 point scale, as shown in appendix 2. The questions relate to satisfaction with life, feeling the things you do are worthwhile, happiness and feeling anxious. While the WEMWEBS scale is the recommended choice for measuring mental wellbeing, local surveys which require a more general measure of wellbeing should consider use of the ONS survey questions.

10.We recommend the consistent use of the WEMWBS tool for measuring population mental wellbeing, particularly in terms of evaluating specific services and interventions to promote mental wellbeing.

11.We recommend use of the ONS annual population survey, quality of life questions to monitor impact on borough wide population group.

Appendix 1

The Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)

Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

Appendix 2

Measuring Wellbeing

Measuring National Well-being (MNW) is about looking at "GDP and beyond" to measure what really matters to people. The MNW programme began in November 2010 with the aim to "develop and publish an accepted and trusted set of National Statistics which help people understand and monitor well-being". We describe well-being as "how we are doing" as individuals, as communities and as a nation, and how sustainable this is for the future.

Personal well-being (sometimes referred to as "subjective well-being") is one of many ways in which the MNW programme aims to assess the progress of the nation.

Office for National Statistics uses four survey questions to measure personal well-being as illustrated in below. People are asked to respond to the questions on a scale from 0 to 10 where 0 is "not at all" and 10 is "completely".

Four measures of personal well-being

Next I would like to ask you four questions about your feelings on aspects of your life. There are no right or wrong answers. For each of these questions I'd like you to give an answer on a scale of 0 to 10, where 0 is "not at all" and 10 is "completely".

Measure	**Question**
Life Satisfaction	Overall, how satisfied are you with your life nowadays?
Worthwhile	Overall, to what extent do you feel that the things you do in your life are worthwhile?
Happiness	Overall, how happy did you feel yesterday?
Anxiety	On a scale where 0 is "not at all anxious" and 10 is "completely anxious", overall, how anxious did you feel yesterday?

Source: Office for National Statistics

Appendix 3

Mental well-being checklist

Are specific protective factors being addressed appropriately – at the individual and community level?

ENHANCING CONTROL	✓
Individual level	
A sense of control e.g. setting and pursuit of goals, ability to shape own circumstances	
Belief in own capabilities and self determination e.g. sense of purpose and meaning	
Knowledge skills and resources to make healthy choices e.g. understanding what makes us healthy and being able to make choices	
Maintaining independence e.g. support to live at home, care for self and family	
Community / organisation level	
Self-help provision e.g. information advocacy, groups, advice, support	
Opportunities to influence decisions e.g. at home, at work or in the community	
Opportunities for expressing views and being heard e.g. tenants groups, public meetings	
Workplace job control e.g. participation in decision making, work-life balance	
Collective organisation and action e.g. social enterprise, community-led action, local involvement, trades unions	
Resources for financial control and capability e.g. adequate income, access to credit unions, welfare rights, debt management	
Other?	

INCREASING RESILIENCE AND COMMUNITY ASSETS	✓
Individual level	
Emotional well-being e.g. self esteem, self-worth, confidence, hopefulness, optimism, life satisfaction, enjoyment and having fun	
Ability to understand, think clearly and function socially e.g. problem solving, decision making, relationships with others, communication skills	
Have beliefs and values e.g. spirituality, religious beliefs, cultural identity	
Learning and development e.g. formal and informal education and hobbies	
Healthy lifestyle e.g. taking steps towards this by healthy eating, regular physical activity and sensible drinking	
Community / organisation level	
Trust and safety e.g. belief in reliability of others and services, feeling safe where you live or work	
Social networks and relationships e.g. contact with others through family, groups, friendships, neighbours, shared interests, work	
Emotional support e.g. confiding relationships, provision of counselling support	
Shared public spaces e.g. community centre, library, faith settings, café, parks, playgrounds, places to stop and chat	
Sustainable local economy e.g. local skills and businesses being used to benefit local people, buying locally, using Time Banks	
Arts and creativity e.g. expression, fun, laughter and play	
Other?	

FACILITATING PARTICIPATION AND INCLUSION	✓
Individual level	
Having a valued role e.g. volunteer, governor, carer	
Sense of belonging e.g. connectedness to community, neighbourhood, family group, work team	
Feeling involved e.g. in the family, community, at work	
Community / organisation level	
Activities that bring people together e.g. connecting with others through groups, clubs, events, shared interests	
Practical support e.g. childcare, employment, on discharge from services	
Ways to get involved e.g. volunteering, Time Banks, advocacy	
Accessible and acceptable services or goods e.g. easily understood, affordable, user friendly, non-stigmatising, non-humiliating	
Cost of participating e.g. affordable, accessible	
Conflict resolution e.g. mediation, restorative justice	
Cohesive communities e.g. mutual respect, bringing communities together	
Other?	

Are the wider structural determinants being considered?

WIDER DETERMINANTS (often at a socio-economic / environmental/ structural level)	✓
Access to quality housing e.g. security, tenure, neighbourhood, social housing, shared ownership, affordable and appropriate	
Physical environment e.g. access to green space, trees, natural woodland, open space, safe play space, quality of built environment	
Economic security e.g. access to secure employment (paid and unpaid), access to an adequate income, good working conditions, meaningful work and volunteering opportunities	
Good quality food e.g. affordable, accessible	
Leisure opportunities e.g. participate in arts, creativity, sport, culture	
Tackling inequalities e.g. addressing relative deprivation and poverty	
Transport access and options e.g. providing choice, affordability and accessibility	
Local democracy e.g. devolved power, voting, community panels and increasing community participation	
Ease of access to high quality public services e.g. housing support, health and social care	
Access to education e.g. schooling, training, adult literacy, hobbies	
Challenging discrimination e.g. racism, sexism, ageism, homophobia and discrimination related to disability, mental illness or faith	
Other?	