Tameside Metropolitan Borough

ASHTON-UNDER-LYNE · AUDENSHAW · DENTON · DROYLSDEN · DUKINFIELD · HYDE · LONGDENDALE · MOSSLEY · STALYBRIDGE

HEALTH AND WELLBEING BOARD

Day: Thursday
Date: 10 November 2016
Time: 10.00 am
Place: Lesser Hall 2 - Dukinfield Town Hall

Item No.	AGENDA	Page No

GENERAL BUSINESS

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

To receive any declarations of interest from Members of the Health and Wellbeing Board.

3. MINUTES 1 - 4

The Minutes of the meeting of the Health and Wellbeing Board held on 22 September 2016 to be signed by the Chair as a correct record.

PRESENTATION

4. OVERVIEW OF DEPARTMENT OF WORK AND PENSIONS ACROSS GREATER MANCHESTER 5 - 10

To receive a presentation from Julie Price, Department of Work and Pensions.

ITEMS FOR DISCUSSION / DECISION

5. DEVELOPING THE FUTURE ROLE AND PRIORITIES OF THE HEALTH AND WELLBEING BOARD / UPDATE ON HEALTH AND WELLBEING STRATEGY 2013/16 11 - 26

To receive the attached report of the Executive Member (Healthy and Working) / Director of Public Health and Performance.

6. CARE TOGETHER PROGRAMME UPDATE 27 - 54

To receive the attached report of the Executive Member (Adult Social Care and Wellbeing) / Programme Director (Tameside and Glossop Care Together).

7. NORTH WEST SECTOR LED IMPROVEMENT: INFANT MORTALITY 55 - 96

To receive the attached report of the Executive Member (Children and

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker on 0161 342 2798 or by emailing linda.walker@tameside.gov.uk, to whom any apologies for absence should be notified.

Families) / Director of Public Health and Performance.

ITEMS FOR NOTING / INFORMATION

8. TAMESIDE SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 97 - 132

To receive the attached report of the Executive Member (Children and Families) / Chair of the Tameside Safeguarding Children Board.

9. HEALTH AND WELLBEING BOARD FORWARD PLAN 2016/17 133 - 134

Report of the Director of Public Health and Performance attached.

10. URGENT ITEMS

To consider any additional items the Chair is of the opinion shall be dealt with as a matter of urgency.

11. DATE OF NEXT MEETING

To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 19 January 2016.

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker on 0161 342 2798 or by emailing linda.walker@tameside.gov.uk, to whom any apologies for absence should be notified.

TAMESIDE HEALTH AND WELLBEING BOARD

22 September 2016

Commenced: 10.00 am **Terminated: 11.50 am**

PRESENT:
Councillor Kieran Quinn (Chair) – Tameside MBC
Councillor Brenda Warrington – Tameside MBC
Councillor Peter Robinson – Tameside MBC
Councillor Gerald P Cooney – Tameside MBC
Graham Curtis – Clinical Commissioning Group
Ben Gilchrist – CVAT
Angela Hardman – Tameside MBC
Karen James – Tameside Hospital NHS Foundation Trust
Steven Pleasant – Tameside MBC
Tony Powell – New Charter Housing Trust
Andy Searle – Chair, Adult Safeguarding Board
Paul Starling – GM Fire and Rescue Service
Clare Watson – Clinical Commissioning Group

IN ATTENDANCE:
Ian Duncan – Tameside MBC
Debbie Watson – Tameside MBC
Gideon Smith – Tameside MBC
David Berry – Tameside MBC
Jessica Williams – Tameside MBC / Clinical Commissioning Group

APOLOGIES:
Alan Dow – Clinical Commissioning Group
Stephanie Butterworth – Tameside MBC

58. DECLARATIONS OF INTEREST

There were no declarations of interest submitted by members of the Board.

59. MINUTES OF PREVIOUS MEETING

The Minutes of the Health and Wellbeing Board held on 10 March 2016 were approved as a correct record.

60. CARE TOGETHER ECONOMY MONITORING STATEMENT

The Director of Finance, Single Commissioning Team, presented a jointly prepared report of the Tameside and Glossop Care Together constituent organisations on the revenue financial positon of the economy. It provided a 2016/17 financial year update on the month 4 financial position at 31 July 2016 and the projected outturn at 31 March 2017.

It was explained that the report included components of the Integrated Commissioning Fund and the progress made in closing the financial gap for the 2016/17 financial year. The total Integrated Commissioning Fund was £447.5m in value, detailed in **Appendix C** to the report, but this value was subject to change throughout the year as new Inter Authority Transfers were actioned and allocations amended.

The 2016/17 financial year was particularly challenging due to the significant financial gap and the risk of CCG QIPP schemes not being sufficiently developed to deliver the required level of

efficiencies in the year. A financial recovery plan was submitted to NHS England on 9 September following consideration by an extraordinary meeting of the Governing Body on 7 September 2016.

Members of the Board noted that section 2 of the report included details of the financial position of the Tameside Hospital NHS Foundation Trust which provided members of the Board with an awareness of the overall financial position of the whole Care Together economy and highlighted the increased risk of achieving financial sustainability in the short term whilst also acknowledging the value required to bridge the financial gap next year and through to 2020/21.

In terms of a financial summary, reference was made to Table 1 detailing the 2016/17 budgets, expenditure and forecast outturn of the Integrated Commissioning Fund and Tameside Hospital NHS Foundation Trust. However, there were a number of key risks that had to be managed within the economy during the financial year:

- Achievement of the original £21.5m projected commissioner financial gap (£13.5m Tameside and Glossop CCG and £8.0m Tameside MBC);
- Delivery of the £17.3m projected financial deficit of Tameside Hospital NHS Foundation Trust;
- Management of any potential overspend within Acute services as any overspend would be an additional pressure over and above the financial gap stated above;
- Ensure Parity of Esteem was achieved in relation to Mental Health Services;
- Financial pressures as a result of national changes to the health contribution of funded nursing care payments (40% increase) generating an estimated increased liability to the CCG of approximately £0.6m but this would be confirmed and reported at month 5;
- Management of Care Home placements due to volatility in this area;
- Unexpected and complex dependency placements within Children's Services;
- Emergency in-year reductions to Central Government resource allocations;
- Proactive management of Continuing Healthcare and Prescribing, both of which were subject to volatility;
- Remaining within the running cost allocation for 2016/17.

RESOLVED

(i) That the 2016/17 financial year update on the month 4 financial position at 31 July 2016 and the projected outturn at 31 March 2017 be noted.

(ii) That the significant level of savings required during the period 2016/17 to 2020/21 to deliver a balanced recurrent economy budget be acknowledged.

(iii) That the significant amount of financial risk in relation to achieving an economy balanced budget across this period be acknowledged.

(iv) That the 2016/17 quarter one Better Care Fund monitoring statement attached at Appendix D be noted.

61. CARE TOGETHER PROGRAMME UPDATE

Consideration was given to a report of the Executive Member (Adult Social Care and Wellbeing) and the Programme Director providing an update on the developments within the Care Together Programme since the last meeting relating to operational progress and next steps.

She also advised that an official announcement was expected on the application to secure transformational funding recently approved by the Greater Manchester Health and Social Care Partnership. The process for determining the milestones and key performance indicators against which the investment would be assessed would now commence.

RESOLVED

(i) That the progress of the Care Together Programme, including the strategic and operational aspects be noted.

(ii) That an update be received at the next meeting.

62. WORK, SKILLS AND HEALTH INTEGRATION

Consideration was given to a report of the Deputy Chief Executive, New Charter Housing, and the Project Lead (Employment and Skills), which explained that Devolution had presented Greater Manchester with the opportunity and ability to deliver improved health outcomes by supporting people to contribute and connect to growth. The Tameside Partnership had endeavoured to create and maximise opportunities to integrate work and health services. This work was captured in the report alongside intentions to shape existing and future service models and commissioning strategies.

Outline details were provided as a guide to the major work and skills initiatives taking place to increase employment, earnings and skill levels. Efforts had focused on integrating these initiatives with health services to maximise the use of resources. Discussions ensued on several innovative pieces of work being developed from this approach including the Healthy Hattersley GP Pilot and a joint Mental Health Employment Post within Working Well.

The Deputy Chief Executive, New Charter Group, was pleased to advise the Board that £9.7m from the Building Better Opportunities project had been awarded to Motiv8 programme, led by New Charter Group, to improve the lives of the most vulnerable people aged 25+ who were homeless, long-term unemployed, living with disabilities and health conditions, or drug and alcohol dependent. Its aim was to tackle the barriers that prevented these groups of people from accessing support with more opportunities for education and training, improved health and wellbeing services, better financial help and new programmes to build confidence. The project would be delivered according to local priorities and therefore provided an opportunity to dovetail with the work, skills and health integration programme priorities.

The Board welcomed the report and the outline of the major employment initiatives in Tameside and the current progress and opportunities to integrate with health services. It was now a key priority for the Board to reflect on this programme of work and focus on what this means moving forward in commissioning services and doing things differently to meet local needs.

RESOLVED

(i) That the employment initiatives taking place in GM and Tameside recognising the work that had taken place to date to integrate work, skills and health services be noted.

(ii) That the development and success of pilots, programmes and approaches detailed in the report be actively promoted and supported to deliver work, skills and health integration in Tameside developed alongside GM models.

(iii) That the progress of work, skills and health integration on a six monthly basis to inform Policy and Commissioning decision-making be reviewed.

63. SAFE AND WELL EVALUATION

The Borough Commander, Greater Manchester Fire and Rescue Authority, presented a report informing the Health and Wellbeing Board of the new economy's initial cost benefit analysis of the Service's primary early intervention and prevention tool – Safe and Well visits – and seeking support to further develop closer working to improve fire and health and social care outcomes.

He explained that the service had a long and successful history of prevention and early intervention and by working in partnership with other organisations, the expertise and experience

of GM Fire and Rescue Service in early intervention and prevention could contribute to GM aspirations for a radical uplift in population health. In discussions with colleagues in health and social care it was clarified that many of the underlying risk factors for fire were also the determinants of health and that any approach to early intervention, prevention and behaviour change relating to them, delivered by the Fire and Rescue Service could also assist in reducing current and future demand for health and social care services. Details of the Safe and Well visits undertaken by community safety teams trained to deliver all aspects of the visit were provided. The service aimed to deliver 30,000 targeted Safe and Well visits annually.

In conclusion, he stated that along with health, social care and voluntary groups, the Fire Service was at the heart of their communities and there was potential to maximise the prevention capability of the service at locality level.

The Board welcomed the opportunities outlined in the report which would assist further in realising the contribution the Fire Service could make and potentially lead of reduced demand on health and social care services. This would therefore contribute towards the delivery of future year efficiency savings alongside reduced resource allocations within the economy.

RESOLVED

(i) That the content of the report be noted.

(ii) That closer joint working with the GM Fire and Rescue Service would improve the opportunity for more collaboration and improved outcomes as detailed in the report.

64. PUBLIC HEALTH ANNUAL REPORT

The Director of Public Health and Performance submitted her Annual Report 2015/16 themed around self-care. The report emphasised that focusing on self-care would help people to increase their confidence to live well, improve their quality of life and improve the patient experience. The report highlighted existing programmes of work and showed where real opportunities existed as a result of the restructure brought about by Care Together and Greater Manchester Devolution.

Members of the Board commented favourably on the Annual Report and accompanying video presentation.

RESOLVED

That the content of the Annual Report 2015/16 be noted.

65. URGENT ITEMS

The Chair advised that there were no urgent items for consideration at this meeting.

66. DATE OF NEXT MEETING

To note that the next meeting of the Health and Wellbeing Board will take place on Thursday 10 November 2016 commencing at 10.00 am.

CHAIR

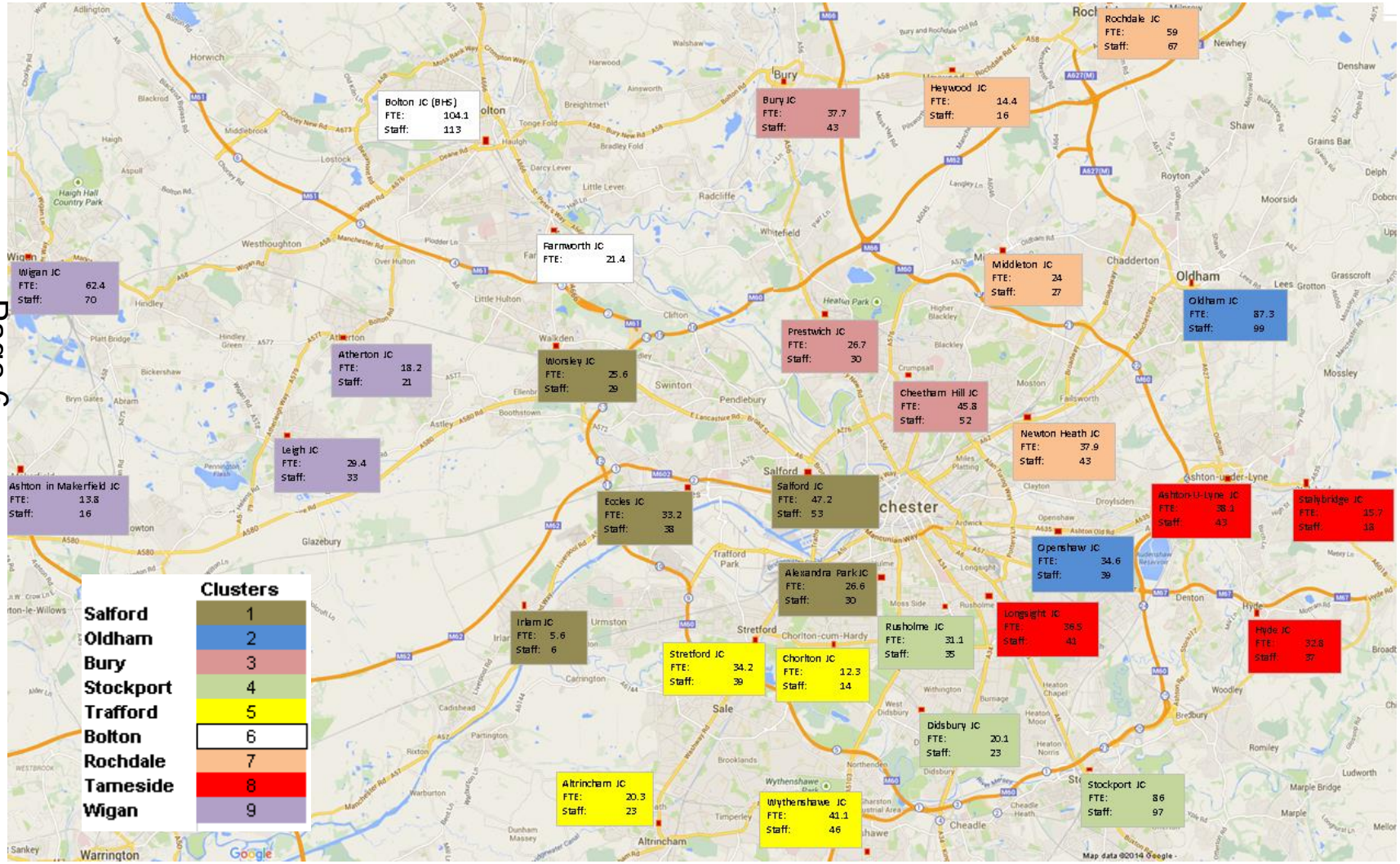
Department for Work & Pensions

Greater Manchester District Jobcentre Plus

Julie Price
Senior External Relations Manager
Greater Manchester District

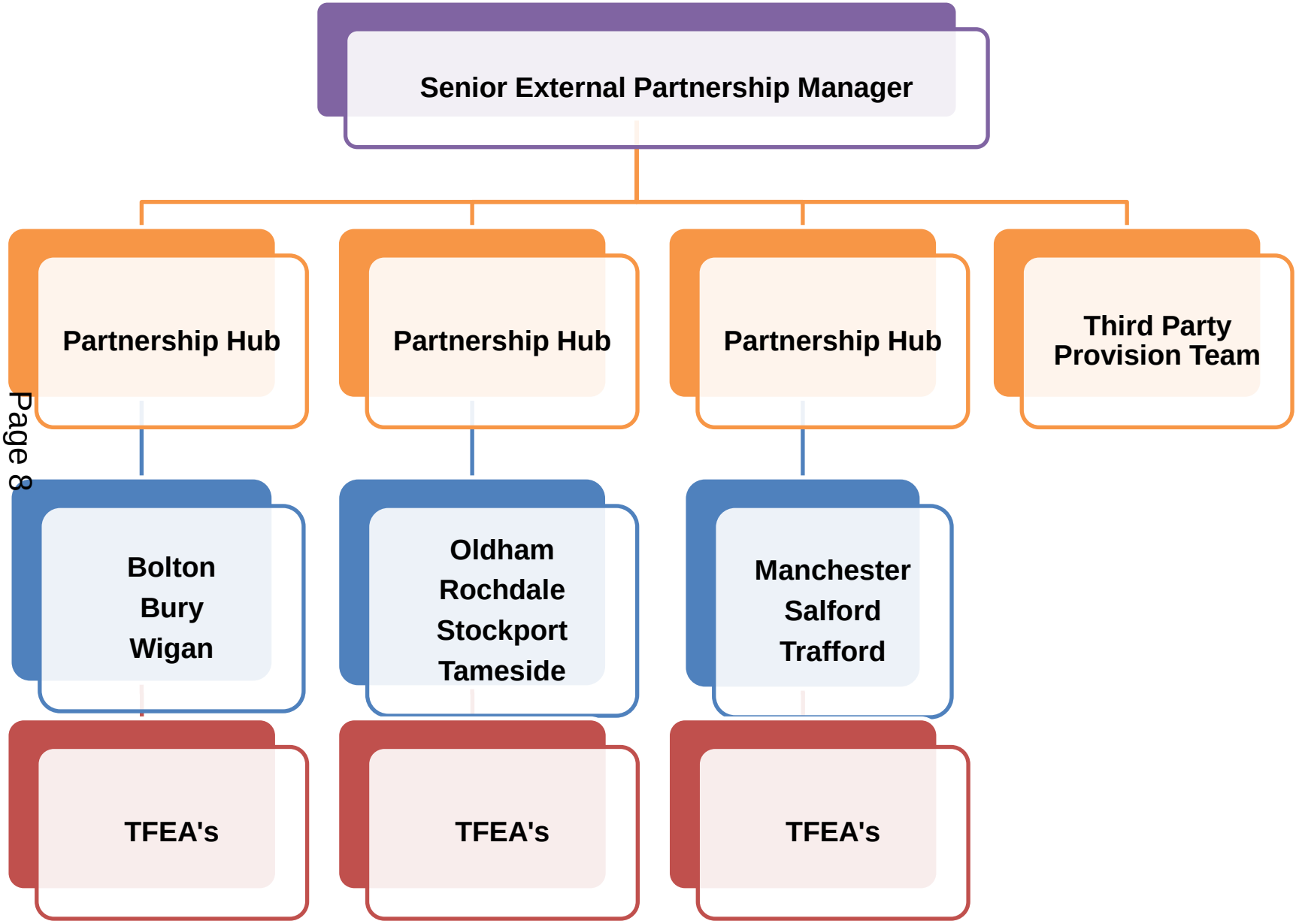
Greater Manchester District

Clusters – The new cluster configuration



Rationale for one GM District

- To be more efficient, reduce duplication, enhance the customer experience to deliver improved outcomes.
- To develop one way of working to better meet the expectations of the Greater Manchester Devolution Agreement
- To drive greater quality and consistency across the Greater Manchester Jobcentre network
- To design and deliver new ways to support people with difficult and complex lives


Senior External Partnership Manager
Partnership Hub
Partnership Hub
Partnership Hub
Third Party Provision Team
Bolton
Bury
Wigan
Oldham
Rochdale
Stockport
Tameside
Manchester
Salford
Trafford
TFEA's
TFEA's
TFEA's

- DWP PRIORITIES / WORK STREAMS

- Disability Employment Gap
- Towards Full Employment
- Support For Schools
- Employer Campaigns

Key Next Steps for DWP

- Build on **UC** rollout
- Develop and resource the **work coach** role for health and disability
- Work more with **employers** – develop Disability Confident
- Develop **partnership working** and joining up with local services
- Engage with stakeholders on possible joint funding opportunities, and the **Work and Health Programme**

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	10 November 2016
Executive Member / Reporting Officer:	Councillor Ged Cooney - Executive Member (Healthy and Working) Angela Hardman – Director of Public Health and Performance
Subject:	**DEVELOPING THE FUTURE ROLE AND PRIORITIES OF HEALTH AND WELLBEING BOARD/ UPDATE ON HEALTH AND WELLBEING STRATEGY 2013-16**
Report Summary:	The Health and Wellbeing Board has recently held a development session to review its purpose as a place-based system-leader. The report brings forward the themes of the workshop with a set of recommendations around the future Forward Plan of the Board. The attached presentation outlines the progress made to date against the Health and Wellbeing Strategy 2013-16.
Recommendations:	The Health and Wellbeing Board are asked: • To discuss and agree the principles outlined in the paper. • To agree wider determinant priority focus areas for collective action moving into next year. • To discuss the arrangements of the refresh of the Health and Wellbeing Strategy beyond 2016, alignment to the locality plan and Commissioning for Reform Strategy.
Links to Health and Wellbeing Strategy:	The work plan of the Health and Wellbeing Board together with partner priorities link to all priorities in the Tameside Joint Health and Wellbeing Strategy.
Policy Implications:	There are a number of core duties defined in the Health and Social Care Act 2012 which underpin the work of Health and Wellbeing Boards these include; undertaking a Joint Strategic Needs Assessment (JSNA) to identify the health and wellbeing priorities of the local population and once these are known, the development of a Joint Health and Wellbeing Strategy (JHWS) outlining how the board intends to achieve improvements to local health outcomes. These processes provide Health and Wellbeing Boards with a strategic framework that health and social care commissioners must have regard to.
Financial Implications: **(Authorised by the Section 151 Officer)**	There are no direct financial implications arising from this report. However Health and Wellbeing Board members are reminded that the strategy and associated priorities need to be delivered within resources available whilst also realising efficiencies.
Legal Implications: **(Authorised by the Borough Solicitor)**	The statutory purpose of the Board is to provide system-wide leadership, offering constructive challenge, in order to: • improve the health and wellbeing of the people in Tameside;

- reduce health inequalities;
- promote the integration of services.

Only the Health and Wellbeing Board has oversight and membership of the entire local health and care system and the factors that impact locally on health and health inequalities such as education, housing, employment, transport, planning and the environment. To improve health outcomes of Tameside residents, it is imperative that locally senior leaders come together to develop this oversight and hold each other collectively for delivery.

Risk Management : As a statutory committee of Tameside Council the Terms and Reference will form part of the Council's Constitution.

Access to Information : The background papers relating to this report can be inspected by contacting Debbie Watson, Head of Health and Wellbeing:

 Telephone:

 e-mail: debbie.watson@tameside.gov.uk

1. INTRODUCTION

1.1 Tameside's Health and Wellbeing Board (HWBB) held a development session in September 2016 to review its role to date regarding local systems and transformation leadership. Members were encouraged to undertake an honest appraisal of the Board's progress to date and reflect upon how the HWBB should proceed to provide effective leadership to both the local and Greater Manchester-wide integration programmes.

1.2 The Tameside Health and Wellbeing Board has been in place since April 2013. Its statutory purpose is to provide system-wide leadership, offering constructive challenge, in order to:

- improve the health and wellbeing of the people in Tameside;
- reduce health inequalities;
- promote the integration of services.

1.3 The Local Government Association (LGA) and NHS Clinical Commissioners (NHSCC)[1] have released a call to action for all HWBBs to review their role and consider how they can strengthen their position to:

- take a place-based preventative approach to health improvement and tackling health inequalities;
- offer system leadership, as the basis for wider devolution of health and social care.

1.4 The Board took time during the year to refresh the governance structures within which it operates, aligning to the Care Together programme and Single Commissioning Board, in order to ensure that it was fully aware of the extent and limitations of its statutory powers and duties.

2. KEY THEMES FROM THE DEVELOPMENT SESSION

2.1 Health and Wellbeing Board members believe that health and wellbeing boards provide a genuine opportunity to develop a place-based, preventative approach to commissioning health and care services, improving health and tackling health inequalities and the wider determinants of health.

2.2 **Systems Leadership, Clarity of Purpose and Function –** this was the fundamental issue that arose from the session. Board Members felt that the primary role should be to provide macro-level system-leadership, across the network of organisations and arrangements that make up the local health economy – i.e. the local 'system'. A manageable number of issues should be explored, discussed and understood, for the purpose of the Board's time adding value to what happens in other parts of the system, rather than to duplicate the efforts of partner organisations.

2.4 Board members distinguished between scrutiny and oversight, considering that it was not the role of the Board to provide scrutiny or performance management, in the way that individual commissioning organisations might for specific service contracts; or as scrutiny panels would across a particular issue.

2.5 Whilst there are a number of decision-making structures across the system, the HWBB is the only forum that brings all of the economy's senior leaders together at one time; and the

[1] LGA/NHSCC. (2015). Making it better together: A call to action on the future of health and wellbeing boards. Local Government Association. See http://www.local.gov.uk/documents/10180/6869714/L15-254+Making+it+better+together+-+A+call+to+action+on+the+future+of+health+and+wellbeing+boards/311885a4-5597-4007-8069-46bc2732d6a2

only space in which there is the opportunity for real discussion and ascertaining an in-depth understanding of issues for the Board's attention.

2.6 As such, the Board should function to protect this space and opportunity for the economy's leaders, in order to enable the Board to provide effective (macro-level) system-leadership. This should be the focus of the Board's function in order for it to make necessary decisions.

2.7 Priority Issues – although the priorities of the Joint Health and Wellbeing Strategy were upheld, there was a consensus in the group that the Board should focus much more on public sector reform and the wider determinants of health. It was considered that the efforts of the Board should be to determine where it can add value to impacting on these priorities via the collective partnership arrangement, and not include items on its agenda that may be duplicated elsewhere within the system.

2.8 The ability of the Board to manage the structural and financial challenges posed by current financial settlements, public sector reform and the public expectations with regard to the delivery of local services will be tested in the coming years. The presentation attached sets out a comprehensive review of our current Health and Wellbeing Strategy 2013-2016. There was broad agreement amongst Board members at the development session that the Strategy and the life course priorities areas that sit beneath it should be refreshed and updated to align with this evolving context and associated programmes of work.

2.9 Members felt that the Board should choose to work together on 2/3 cross cutting issues that affect the wider health agenda. Ideas proposed included:

- Early Years
- Integrated Neighbourhood working
- Health and Work
- Mental Health and Wellbeing
- Spatial Strategy/Place
- Successful/ Healthy Ageing

2.10 There was general acceptance that the Board needed to adopt the four main strands of the GM Plan Taking Charge of Health and Social Care in Greater Manchester.

2.11 The Board membership was discussed. The Board has recently welcomed membership of both Greater Manchester Police and Greater Manchester Fire and Rescue. It was agreed that a representative from DWP / Job Centre Plus would be asked to join the Board to strengthen links with the Working Well programme.

2.12 The members discussed the Forward Plan of the Board, asking that it was opened up for Board member input, with agenda setting being more streamlined and themed.

3. A PLACE-BASED APPROACH

3.1 Throughout Greater Manchester there are several excellent examples of successful partnerships delivering services effectively and working alongside communities to improve outcomes. Tameside has helped to drive the Public Sector Reform (PSR) programme across Greater Manchester, which has acted as a lever for significant reforms including the health and social care devolution agreement giving greater freedom and flexibilities for local government. There is an acceptance that a further step change is required if truly integrated place based service delivery that works to achieve common objectives, fully engages communities is to become mainstream.

3.2 The proposal is that the Health and Wellbeing Board leads a place-based approach to health and wellbeing based in neighbourhoods, which balances immediate priorities on integration with action on prevention and addressing the wider determinants of health. Only

the Health and Wellbeing Board has oversight and membership of the entire local health and care system and the factors that impact locally on health and health inequalities such as education, housing, employment, transport, planning and the environment. To improve health outcomes of Tameside residents, it is imperative that locally senior leaders come together to develop this oversight. Through the Care Together Programme and GM Devolution the Board will drive the locality plan at the pace and ambition that will allow us to meet our local population's needs. The Board will need to set high standards to achieve a system-wide approach which uses personalisation, prevention and integration to achieve radical change.

3.3 The development sessions show strong support for truly place-based, person centred, preventative approaches as the only way to address complex issues, where many interacting causes require a number of agencies to make a co-ordinated response.

3.4 Place-based approaches will give the board the ability to address unique local conditions drawing on local knowledge and skills. Crucially, they also embody principles of the Greater Manchester devolution agenda with a commitment to subsidiarity – the principle that decisions should be taken at the most local appropriate level. It would also facilitate greater engagement of commissioners with local communities and with health and care providers so that commissioning reflects their needs and services suit the way they live their lives and builds on existing services to ensure that they are fit for the future.

4. PLACE BASED PRINCIPLES

4.1 The feedback from the development sessions has been summarised in the principles below which will inform future Board priorities:

- All of our plans will be focussed on people and places rather than the different organisations that deliver services.
- Our joint commissioning plans will be place based and developed around people's homes, neighbourhoods and towns.
- We will lead a place-based approach to health and wellbeing, which balances immediate priorities on integration with action on prevention and addressing the wider determinants of health.
- We will create an economy of scale culture with a do once and share ethos
- We will promote a preventative approach, which builds on existing community and individual assets to promote health, wellbeing and independence and reduces pressure on acute services.
- We will commissioning services at the most appropriate geographic level and over the required geographic footprint.
- We will deliver place based, joined-up, cross-cutting approaches to local priority issues such as substance misuse, for example with local police, ambulance, community health, businesses and voluntary sector, so that all agencies work together towards mutually agreed outcomes.

5. RECOMMENDATIONS

5.1 As set out at the front of the report.

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Tameside Health and Wellbeing Strategy 2013 - 2016

Angela Hardman

Director of Public Health

Starting Well –Ensuring the best start in life

The evidence base for the life course approach is strong. What happens early in life affects health and wellbeing in later life. There is increasing evidence that, in England, we are not doing as well as we should to achieve good health and wellbeing outcomes for our children and young people – when we compare both historically and within and between countries for mortality, morbidity, wellbeing, social determinants and key indicators of health service provision.

Chief Medical Officer, Dame Sally Davies

Our Children Deserve Better: Prevention Pays, 2012

Starting Well –Ensuring the best start in life

Increased proportion of children ready for school: Improved by 5% up to 63% this year, still below the national average but closing the gap with the NW and England average

Increased rate of breastfeeding (14/15 data): Breastfeeding Initiation England 74.3%, Tameside 59.6%

Still breastfeeding at 6-8 weeks: England 43.8%, Tameside 32%

Drop off % from initiation to 6-8 weeks: England 30.2%,Tameside 27.6%

Reduction in domestic abuse: Rate fell over the most recent 12 month period from 23.5/100 to 22..5/100. Still higher than the England average.

Developing Well - Enabling CYP to maximise their capabilities and have control over their lives

Reduced teenage conceptions: rates almost halved in the past 5 years, now below the NW average. Since 2013 equates to (85) fewer females under 18 years getting pregnant

Sexually transmitted disease: Increase over the most recent 12 months from 875/100,00 in 2014 to 962/100,00 in 2015. significantly above England rates by nearly 20%

Obesity in children and adults: Over the most recent 12 months
Reception – decreased by 1% to 23.6% - 1-2% higher than England average
Year 6 - increased by 1% to 34.6%, slightly higher than the England average
Adults - 7% decrease to 19.7%, nearly in line with the England rate of 19.1%

Other good news since 2013:
GCSE achievement has shown significant improvement equating to an extra (64) 16 year olds leaving school with good GCSE results

Mental Health: Improved offer for CYP, parents and Carers through enhanced work with third section and additional funding, widened access to counselling, delivered wellbeing sessions in schools an supported national mental health campaigns

Other Improvements for CYP

Infant Mortality: significantly lower than the NW or England average. Infant mortality has reduced again from 3.2/1000 live births to 2.8, Child mortality has also significantly reduced from 14.8/100,000 to 9.2.

Child Poverty: Reduced for the 5th year from 22.7% to 22.3% - 100 fewer children under 16 now living in poverty in Tameside.

Low Birth weight: Low birth weight has reduced again from 6.5% to 3.7%.

Immunisations: immunisation rates for MMR (under 5) continue to improve year on year. Now above the England average.

Smoking in Pregnancy: In 2015/16, 16.1% of mums smoked at time of delivery compared to 18.5% in the previous year.

Flu Vaccination in pregnancy: Flu vaccination uptake in pregnant women in Tameside is 49% compared to the England average of 40%.

Government 2-year-old early education entitlement: increased steadily from 53% in Summer 2014 to 89% of eligible children now accessing their free place.

Tameside Metropolitan Borough

NHS Tameside and Glossop Clinical Commissioning Group

Living Well - Creating a safe environment to build strong healthy communities and strengthening ill health prevention

- **Mental Health Champions:** improving understanding of MH issues and support in communities
- **Workplace HWB:** supporting local employers to gain Workplace Wellbeing Charter
- **National MH Campaigns:** Time to Change, National Suicide Prevention Day, World Mental Health Day.
- **Community Grants:** for local groups that contribute to the positive mental health of participants.
- **Community Assets:** trained front line workers to develop and maximise assets
- **Participatory Budgets:** local communities choosing which groups should receive grants. High anxiety scores for adults have fallen from 22% in 2011/12 to 19.8% in 2014/15.
- **Alcohol Admissions;** remained steady since 2012/13 at just over 2,800/100,000 people, still higher than the England average, which was 2,139 in 2014/15.
- **Lifeline Commissioned:** provide a more holistic treatment and support service to tackle alcohol harm
- **Smoking Prevalence**: continues to fall, but remains higher than the England average.
- **Premature Death:** The rate of n Tameside has fallen from 97.4/100,000 people in 2008/10 to 83.5 in 2012/14, due to improved lifestyle choices, such as reduced smoking rates, and better treatment.

Ageing well - Promoting independence and working together to make Tameside a good place to grow older

- **Dementia Friends:** increased across Tameside, which was an action taken up as one of the Leader's pledges during 16/17.

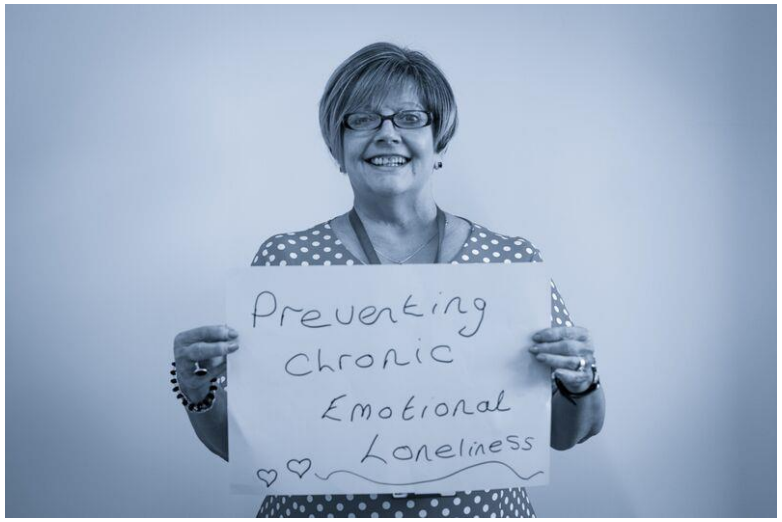
- **Post Dementia Diagnosis** offer for local people and their families and carers, including support for those newly diagnosed.

- **Arts and culture activities for people living with dementia** and for people affected by loneliness, e.g. community operas

- **Investigating community based interventions:** those that reduce dementia behaviours that challenge and potentially reduce prescribing of anti-psychotic drugs.

- **Pilot Bereavement Service**: open to the whole community, but managed by Willow Wood Hospice.

MANCHESTER CAMERATA



Tameside Metropolitan Borough

NHS
Tameside and Glossop Clinical Commissioning Group

Dying Well - Ensuring access to high quality care to all who need it

Priorities: Dignity, choice, quality care

Outcomes: no change in % of deaths at home

Progress:

Dignity - rapid discharges from hospital, including hospice staff in-reach on hospital wards and transfer patients from hospital to hospice

Choice - Tameside and Glossop patients better supported when choosing their place of care by GP, district nurses and community Macmillan team, Marie Curie (night care) and Willow Wood Hospice

- Quality

  - new Consultant in End of Life Care and Macmillan GP in post

  - adoption of Gold Standards Framework in primary care improving dignity, choice and quality

What next?

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	10 November 2016
Executive Member / Reporting Officer:	Councillor Brenda Warrington, Executive Member (Adult Social Care and Wellbeing) Jessica Williams, Programme Director, Tameside & Glossop Care Together
Subject:	**INTEGRATION REPORT - UPDATE**
Report Summary:	This report provides an update to the Tameside Health and Wellbeing Board on the progress and developments within the Care Together Programme since the last presentation in September 2016.
Recommendations:	The Health and Wellbeing Board is asked: 1. To note the progress of the Care Together Programme including the strategic and operational aspects; and 2. To receive a further update at the next meeting.
Links to Health and Wellbeing Strategy:	Integration has been identified as one of the six principles agreed locally which will help to achieve the priorities identified in the Health and Wellbeing Strategy.
Policy Implications:	One of the main functions of the Health and Wellbeing Board is to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate. This meets the requirements of the NHS Constitution.
Financial Implications: **(Authorised by the Section 151 Officer)**	The Care Together Economy has a projected 2016/2017 year end deficit of £23.9m at the period ending 30 September 2016 (£6.6m within the Integrated Commissioning Fund and £17.3m Tameside Hospital Foundation Trust). There is therefore a clear urgency to implement associated strategies to ensure the current year projected funding gap is addressed and closed on a recurrent basis across the whole economy. It should be noted that each constituent organisation will be responsible for the financing of their resulting deficit at 31 March 2017. It is essential that the approved GM Health and Social Care Partnership funding referred to in section 2 of the report is expended in accordance with the investment agreement and recurrent efficiency savings are subsequently realised across the economy.
Legal Implications: **(Authorised by the Borough Solicitor)**	It is important to recognise that the Integration agenda, under the auspices of the 'Care Together' banner, is a set of projects delivered within each organisation's governance model and now to be delivered jointly under the Single Commissioning Board together with the Hospital. However, the programme itself requires clear lines of accountability and decision making due to the joint financial and clinical implications of the proposals. It is important as well as effective decision making processes that there are the means

and resources to deliver the necessary work. This report is to provide confidence and oversight of delivery.

Risk Management :

The Care Together Programme has an agreed governance structure with a shared approach to risk, supported through a project support office.

Access to Information :

The background papers relating to this report can be inspected by contacting Jessica Williams, Programme Director, by:

 Telephone: 0161 304 5342

 e-mail: jessicawilliams1@nhs.net

1. INTRODUCTION

1.1 This report provides an update to the Tameside Health and Wellbeing Board on the developments within the Care Together Programme since the last meeting.

1.2 The report covers:

- Greater Manchester Health and Social Care Partnership;
- Operational Progress;
- Next Steps;
- Recommendation.

2. GREATER MANCHESTER HEALTH AND SOCIAL CARE PARTNERSHIP

2.1 On 30 September, the Partnership Strategic Partnership Board ratified the full transformational funding award of £23.226m to Tameside and Glossop economy over 4 financial years. Confirmation of the terms of this award is attached at **Appendix 1.**

2.2 This is clearly extremely positive and enables the move of the Care Together programme into delivery mode. The next step is to work with the Greater Manchester Health and Social Care Partnership to develop our investment agreement including implementation and delivery milestones to measure progress against the national "must do's" and our transformation priorities as outlined in the Cost Benefit Analysis submission. We aim to have concluded these discussions and be in a position to sign the Investment Agreement on 18 November 2016.

2.3 The transformational funding award unfortunately does not include any capital for IM&T and Estates. The Programme Support Office continues to liaise with Greater Manchester Health and Social Care Partnership and NHS Improvement to understand the potential for funding bids and progress will be continually provided to this Board.

3. OPERATIONAL PROGRESS

Programme Management

3.1 To reflect the move from design to implementation of Care Together, the governance arrangements have been updated. **Appendix 2** shows the new structure, approved by the Care Together Programme Board for implementation from January 2017.

3.2 Significant changes include the Programme Board moving to quarterly which will enable the assurance of economy of progress against the Investment Agreement with the addition of a joint senior leadership team monthly meeting to ensure oversight of implementation and collective problem solving. The new arrangements also importantly bring the "enabling programmes" e.g.; IM&T, Local Workforce Transformation and Estates into sharp focus of the Programme Board.

3.3 An additional Project Board to manage the transaction of adult social care from Tameside MBC to the Integrated Care Organisation Foundation Trust has also been added to the structure following approval of the proposed scope of transfer by the Programme Board. A full business case and due diligence process will now be developed to ensure organisational and regulatory approval for the transfer. It should be stressed however that this is just for the transaction; the transformational work continues apace through the Integrated Neighbourhood organisational developments.

3.4 The scope and responsibilities for the Programme Support Office are currently being reviewed. This may result in the need for increased resource from transformational funds to

ensure dynamic, effective programme management and provide the necessary assurance to the Partnership on spend and delivery of transformational [plans.

Single Commissioning Function

3.5 As previously reported, on 1 April 2016, the two commissioning teams came together under one single leadership, governance and management structure. After a short period as interim chief accountable officer for Tameside and Glossop CCG, Steven Pleasant, Chief Executive Tameside MBC has now been appointed substantively by Simon Stevens, Chief Executive, NHS England.

3.6 As part of the drive to improve efficiency and reduce the costs of commissioning, New Century House will be vacated at the end of the financial year. Plans are in place to move the whole Single Commissioning team to a new Council owned location.

Integrated Care Organisation

3.7 The Model of Care Steering Group continues to work under the leadership of Karen James, Chief Executive, Integrated Care Organisation Foundation Trust, and has largely focussed on the development of Integrated Neighbourhoods and Urgent Care. The schemes arising from these are the basis of the transformational funding bid and following a programme of engagement (summary report attached at **Appendix 3**), implementation planning is now underway.

4. NEXT STEPS

4.1 As well as the continuation of all work above, the notable next steps are as follows;

- Finalising the Investment Agreement with the Partnership;
- Final implementation planning for the transformational schemes;
- Development of a comprehensive programme management plan to ensure delivery of schemes and the resulting improvements in healthy life expectancy and reductions in costs;
- Developing and implementing a measurement framework which accurately ensures our planned transformational schemes are improving the healthy life expectancy of the Tameside and Glossop population;
- Finalising the financial sustainability plan for the economy;
- Developing the business case for the transaction of adult social care into the Integrated Care Organisation;
- Continued discussions to determine options for aligning primary care outcomes alongside those of the Integrated Care Organisation and therefore for the whole population.

4.2 In order to ensure timeliness of information provided to Health and Wellbeing Board, the next steps will be expanded in the presentation provided for discussion.

5. RECOMMENDATIONS

5.1 The Health and Wellbeing Board is asked:

- Note the progress of the Care Together Programme; and
- To receive a further update at the next meeting.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

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Date: 30 September2016

Steven Pleasant
Chief Executive
Tameside Metropolitan Borough Council
Head of Paid Service, Accountable Officer for NHS Tameside and Glossop CCG

Dear Steven

TAMESIDE & GLOSSOP TRANSFORMATION FUNDING AWARD

Thank you for your submission to the Transformation Fund.

In light of the report from the independent evaluator and its review at the Transformation Fund Oversight Group, the Strategic Partnership Board Executive in September 2016 proposed a substantive investment of £23.2m into Tameside & Glossop and requested that I, as Accountable Officer for the Fund, finalise the award on the basis of a number of material conditions and the incorporation of a number of items into the Investment Agreement.

It was agreed that the GMHSC Partnership will request confirmation that NHS Improvement commit to provide continued support to Tameside and Glossop Integrated Care NHS Foundation Trust (THFT), as well as acknowledgement that Tameside & Glossop's financial planning assumes that PDC distress support received by THFT will be converted into a non-repayable loan on delivery of the locality plan.

As a further material condition, agreed by the Strategic Partnership Board Executive, the GMHSC Partnership will seek to combine any proposal by Stockport, Salford and Tameside & Glossop for capital IM&T funding to the Digital Transformation Fund.

In regards to the ICO proposal, we will also need to further explore the implications on the proposal of capital funding not being secured for other programmes outlined in the locality plan. Additionally, in order to improve the ROI and to provide early assurance over the impact of the ICO proposal, Tameside & Glossop will need to provide us with further detail on whether benefits from the ICO can be realised earlier, in particular within 2016/17.

Beyond the above, the Investment Agreement will be drafted to obtain commitment from Tameside & Glossop to undertake the following:

- deliver the national 'must dos', which should be reflected as part of the schedules of the Investment Agreement;
- work with other funded 'Better Care' programmes to share and review their costs/benefits targets and assumptions;
- undergo an implementation capability assessment, as well as agree to continued investment being linked to delivery of the entire locality plan and not just this proposal in isolation;
- develop both quarterly KPIs with baselines and targets, for the proposal and the locality as a whole;
- continue to implement the Healthier Together programme;
- produce an implementation plan beyond 2016/17.

With regard to the construction of the Investment Agreement itself, I have asked my team to work with you to develop the Investment Agreement and schedules, with a view to them being signed by the end of October.

My intention is that we finalise the agreements in a face-to-face meeting, which I believe would be the most efficient way to resolve any issues on the detail.

Yours sincerely,

Jon Rouse
Chief Officer
GM Health & Social Care Partnership

Cc: Karen James
Chief Executive
Tameside and Glossop Integrated Care NHS Foundation Trust

Jess Williams
Tameside Care Together Programme Director

TAMESIDE AND GLOSSOP
Caretogether

Care Together Programme Delivery Structure

Economy Wide
ICO
SCF

CCG Governing Body

TMBC Cabinet

DCC Cabinet

Health & Wellbeing Board
- High level strategy
- Wider PSR

ICO FT Board

Single Commissioning Board
- Implementation of strategy by determining and commissioning population outcomes

Care Together Programme Board (4/12)
- Quarterly assessment of progress against investment agreement
- Recommendations for further investment
- Stakeholder engagement in programme

ICO FT Operational Management Board

Primary Care Commissioning Committee

Care Together Senior Management Team (8/12)
- Oversight of implementation (e.g.; IN, Urgent Care)
- Collective problem solving / challenging ambition of plans
- Development of new commissioning and provider arrangements

Programme Management Office

Performance / Quality / Business Intelligence

Adult Social Care Transfer Board

Local Workforce Transformation

Communication/ Consultation

Strategic Estates Group

Finance Economy Wide

IM&T

Scrutiny Committee

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Appendix 1

Action Together

Care Together

Pre-consultation Engagement Report

September 2016

Contents

1. INTRODUCTION

Over the past 2 years, the Care Together programme has sought to progress proposals to radically rethink the way in which Health and Social Care is provided across Tameside and Glossop.

During 2016, the pace of this has escalated and the programme is about to start implementing some of these reforms.

The ambition is *'to dramatically improve the Healthy Life Expectancy of local people whilst also creating a system that is clinically and financially sustainable through a new approach'*

The approach aims to:

- Support local people to remain well by tackling the causes of ill health, support behaviour and lifestyle change, and maximise the role played by local communities.

- Equip those receiving support with the appropriate knowledge, skills and confidence to enable them take greater control over their own care needs and the services they receive.

- Ensure that when illness or crisis occurs, people receive high quality integrated services that are designed around the needs of the individual and, where appropriate, are provided as close to home as possible.

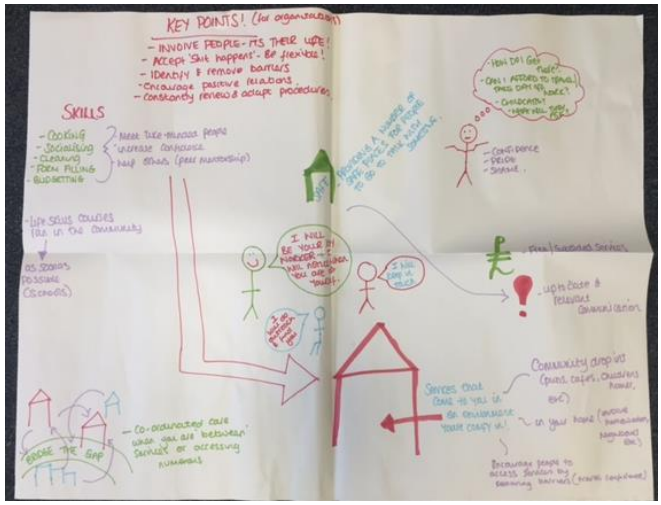
Action Together (and formerly Community and Voluntary Action Tameside), Glossop Volunteer Centre and High Peak CVS have been at the heart of this journey and have played a key role in ensuring that the voices of local people are heard within the programme.

This report captures the latest stage in an engagement journey which commenced in 2014 and will continue during 2016 and 2017.

2. EXECUTIVE SUMMARY

This report highlights the findings of the pre-consultation phase of the Care Together Programme during summer 2016 which was led by Action Together (including input from Healthwatch Tameside), and our counterparts in Glossop – High Peak CVS, and Glossop Volunteer Centre.

In Tameside and Glossop to date we have engaged 602 local people in conversations around the programme ambition, and the development of specific workstreams.



The approach taken was to work with communities of interest, identity and geography using various Asset Based approaches in order to shift the conversation with communities from *'What should services do better?'* to *'What can we do to improve health and wellbeing together?'*.

The focus on self-care, peer support, what we mean by a 'good service' and locally based solutions has come through strongly from the people we have spoken to.

In summary, local people gave us the following key messages:

1. *We experience health and social care that is disjointed and delivered in silos, and would welcome more joined up services;*

2. *Our communities have an abundance of 'assets' (people, groups and facilities) which could be better supported and used by local people;*

3. *We think there is much more to be done to prevent ill health, that much of this sits outside conventional health services, and that we want to shape this;*

4. *The way we make decisions about how, when and where to use services is influenced by a range of factors including awareness, accessibility (transport), relevance, staff attitudes and behaviour and whether we get additional support;*

5. *Families and carers play a vital role but we don't always feel supported, valued or involved. The families and carers of adults with a learning disability, feel particularly marginalised by this;*

6. *We want increased focus upon mental health, loneliness and social isolation.*

3. METHODOLOGY

Working with Care Together colleagues, Action Together employed a variety of Asset Based techniques in order to ensure that data was useful and captured detailed feedback from communities of interest, identity and geography, as well as specific services e.g. Stroke, Discharge to Assess and Home First.

The techniques used were:

Focus groups

By working with voluntary and community groups we were able to reach a large number of service users with particular protected characteristics, particular conditions and experiences of services and from particular geographic communities.

The size of these focus groups was between 6 and 30 people. We were able to give groups a £200 donation for their time and towards the costs of hosting us.

We carried out 32 of these sessions in total, 15 in Tameside and a further 18 undertaken in Glossop by our partners; Glossop Volunteer Centre and High Peak CVS. We reached over 330 local people in this way.

Larger deliberative events

We facilitated several events for specific groups including:

- A Faith Sector Engagement Event (alongside Faiths United)
- A Voluntary and Community Group Engagement Event
- A Community Engagement Event in Droylsden
- A Community Engagement Event in Ashton.

The focus of these events was to develop a shared understanding of the concepts of Care Together, and develop solutions and aspirations for delivery.

The locality based events were for people from a range of backgrounds and were hosted by larger VCFS organisations namely St Peter's Partnerships – LEAP, and Infinity Initiatives. These events were co-delivered with those groups using an Appreciative Inquiry model. We reached over 100 key community connectors via these events.

1:1 interviews

Some of the proposals under Planned and Urgent Care required more detailed service user feedback. We undertook four 1:1 interviews with service users involved in the Home First and Discharge to Access services. The interviews, again, used appreciative inquiry techniques in order to create the conditions for patients to highlight what they would like to see, as well as tell us about limitations of the service. People were encouraged to 'tell us their story' so that we have a real understanding of how it 'feels' for people using services. We also talked to 8 members of staff delivering the service about their experience.

4. KEY FINDINGS – WHAT DID PEOPLE TELL US?

a. We experience health and social care that is disjointed and delivered in silos, and would welcome more 'joined-up' services.

"A 'can do' approach to community support needs to be encouraged as better multi agency working would help the patient's journey and save money."

- People's experiences of access to services, diagnosis, treatment and follow up care were mixed. There is variation between individual practitioners within a service as well as variation in the ways that different services operate.

  Particular examples of conditions where this was felt included:

  - Stroke,
  - Alzheimer's,
  - Multiple Sclerosis,
  - Fibromyalgia,
  - Mental Health,
  - Breast Cancer.

- The interface and referrals between GP's, the Hospital and social care were particular areas of concern for people who cited long waiting times, repeating information at each service, and not receiving information that they were expecting, as examples of where things could be improved.

- People valued being told their treatment date/plan at the time they received a diagnosis.

- Many people felt that services could be better joined up after diagnosis and treatment and that discharge could be quicker, safer and result in fewer disabilities if things were more joined up and if information on local services (including support groups etc.) were given.

- People have very different needs in terms of follow-up care. This is partly to do with the nature of their diagnosis but there is also an element of difference in personalities, cultures and life experiences.

- Professionals we spoke to told us that the quality of referrals were inconsistent because processes, capacity and skills vary between those making referrals and that this needs to be prioritised to be more effective.

  They also told us that the use of language needs consideration e.g. 'referral' means that expectations to see someone are raised whereas 'ask an opinion' does not indicate a visit.

- People want to deal with one person to chase up referrals, appointments etc. This would be especially useful for stroke survivors and people with complex conditions.
- People want care to be better joined up – and some recognise the need for this to include shared data about them.

- People said they valued continuity of care – being able to see the same doctor or nurse every time so they didn't have to keep repeating their history.

- Access was a key concern – including opening hours, out of hours access, transport, waiting times for appointments and making it easier to get home visits.

- In terms of on-line systems people felt that the systems would need to 'talk to each other' first for this to be effective (e.g. GP's having access to hospital notes), that not everyone has a computer, so on-line referrals may not be useful in many cases, texts could be useful for appointments.

- Confidentiality was mentioned as an issue in sharing information between services as the patients themselves often can't remember the details of their treatment.

- Doctors need to ensure that they read notes previous to appointment then they have more time to give to the patient, this is particularly acute when seeing different doctors as patients have to re-tell their story again and again, or receiving a call back asking what the problem is and why they want the appointment. People felt that staying with one doctor would be better.

- Follow up could be improved, and there was a strong feeling that once treatment has happened no-one gets in touch to see how you are 'getting on', some felt that clinical support is withdrawn too quickly.

- People felt that having a specialist unit, where services are all available together would provide a better service. Transport out of a local area is seen by many people as a problem so they welcome the idea that more specialist care could be delivered at a convenient location in their community.

- Support from the physio, OT and socialising with other was seen as a key element of recovery in order to help people 'do more for themselves' stay motivated, and get back to daily living.

"Being told not to eat before an appointment for blood tests etc. then cancelled at last minute, which can be very difficult when managing other conditions such as diabetes."

b. Our communities have an abundance of 'assets' (people, groups and facilities) which could be better supported and used by local people.

"Our GP invited those with COPD to a once a week course for six weeks to explain the condition and how to look after it.

As a result, we were linked with the British Lung Foundation and into a Breatheasy group, which now meets at the Methodist Church. St. Luke's Church."

- People highlighted a raft of 'assets' that could be enhanced and better utilised to support better health and wellbeing and were keen that the conversation move from a deficit to an asset base. These included:

Physical Assets:

- There was a strong feeling from Glossop Groups and residents that George House Primary Care Centre is underused and could provide a great space for multi-disciplinary working. There was a view that each locality should have access to the same range of services. This was particularly strong in Glossop where people felt that it was harder for them to get to Ashton to access some services for example; The challenges of getting from Glossop to Ashton if you need urgent care were raised as the same range of services aren't available in Glossop.

- People highlighted community centres/venues including faith centres as great spaces for services to be delivered and gave examples of where this is already happening to tackle health and the wider social determinants e.g. with the Be Well Service, CAB, Job Clubs, FoodBanks, Exercise classes etc.

The Voluntary, Community and Faith (VCF) Sector:

- The VCF sector has a clear role to play in supporting local people holistically to improve their health and wellbeing, including tackling the wider determinants of health.

- The sector is well placed to support social prescribing, ABCD and interventions at key life stages e.g. pre-birth, early years, old age and family life.

- There was a strong feeling that the sector needs to be better resourced to support this work both financially and in terms of training, and support from health and care professionals to get the best outcomes for people.

- The complexities for Glossop in terms of funding cuts to the Voluntary Sector and the relationship with Social Care for Glossop residents was seen as a significant challenge for Glossop groups and residents in implementing Care Together.

- There was a clear appetite from groups to work with other sectors and professionals (e.g. GPs), and to create closer working relationships among the VCFS sector.

- There were lots of specific ideas for service development e.g. Home Care, Hospital discharge, mentoring, and social prescribing.

People and 'Community':

- 'Neighbourhoods' as defined in Care Together were thought to be too large to resonate with the people we are supporting. Often the VCF sector's offer is on a ward basis, rather than pan-Tameside.

- Local groups (especially self-help and peer support groups) and activities were seen by many people as a way of getting support to be as healthy as they can by accessing information, managing their own condition and supporting others.

- People feel that their experience could be used to help others.

- People felt that transport and the availability of a range of things to get involved in that are widely known about are important as part of this.

c. **We think there is much more to be done to prevent ill health, that much of this sits outside conventional health services, and that we want to shape** this.

"They like coming to groups like Tameside Arts, but it's not about talking about health issues, more about having fun."

- It's more than just health and care interventions that people say keep them healthy.

- Exercise, healthy eating and social contact are given by many people as ways they stay healthy and look after their wellbeing.

- Libraries, music, the arts and volunteering also feature strongly in comments.

- People value being part of something, and having strong connections with people is important to their wellbeing.

- People are aware of the lifestyle factors that support health and wellbeing, but were just as keen to give examples of things that really matter to them outside of the traditional 'health' context.

- People gave examples of how looking after their mental wellbeing was important alongside a diagnosis of a physical illness.

- Managing a long term health condition is seen as important – including taking medications and having regular check-ups.

- Motivation and positive mental wellbeing are seen as important factors in maintaining and improving physical health.

- People highlighted local community groups and family and friends as the key ways that they get information on health and wellbeing outside of their GP or nurse.

- People also valued the contribution of their pharmacy in helping them.

- Finance is seen by some people as a barrier to being healthy – in terms of the cost of participation, the cost of travel to an activity and the cost of healthier food. Other barriers mentioned included physical disability and loneliness.

- Fear of trying something new and being judged by others seems to deter some people from choosing healthier lifestyles.

- Specific examples of the things that people said helped them to stay healthy and well included:

    - Support groups for my medical condition.
    - Volunteering.
    - Having a job.
    - Exercise (including dancing and walking groups).
    - Walking the dog.
    - Diet – eating healthy foods and drinking lots of water.
    - Keeping mentally active – reading, doing puzzles, etc.
    - Mindfulness.
    - Support as a carer and some time away from caring responsibilities.
    - Having regular medical check-ups and taking medication.
    - Going to pharmacy for minor conditions.
    - Holidays and getting outdoors.
    - Art and painting.
    - Good sleep patterns.
    - Listening to music/singing.
    - Good money management.
    - Stopping smoking.
    - Drinking less alcohol.
    - Looking after, each other.
    - Making an effort to talk to other people.
    - Shopping.
    - Pub.
    - Housework/gardening/cleaning.
    - Being outdoors.
    - Grandchildren.
    - Having time off-line.
    - Family and friends.
    - Local groups – including smaller groups and charities
    - Being part of a community.
    - Activities to join in with others.

- Arts and sports activities.
- Libraries.
- Trying new things.
- Help with transport – Ring & Ride, Miles of Smiles and bus passes.
- Exercise.
- Pets.
- Assistive technology – my personal alarm.
- Access to healthcare.
- Local hospital.
- Walk-in centres when you can't get to your GP.
- Doing mental exercises – e.g. crosswords.
- Translation services – language can be a barrier to understanding how to be healthier or explaining a problem.

"self-help groups - get support - it's good to share".

"It helps to speak to someone who knows what you are going through."

"Additional support services such as support groups and the Be Well Service are not shared with patients, but can be really useful support".

d. The way we make decisions about how, when and where to use services is influenced by a range of factors including awareness, accessibility, relevance, staff attitudes and behaviour and whether we get additional support.

"It would be great if GPs had lists of organisations and groups/contacts that you can speak to and brief details of what is available in your local area (not nationally)."

"I know several people from the community who will "borrow" medication from family or friends to cope rather than go to the GP or A&E because it is too difficult - the transport, the processes when you get there. GPs and medical staff don't realise just how difficult some people find it to come to the GP for help. It's got to be more approachable and not judgemental."

- People consistently highlighted that receiving more information on what is available in their local community was a priority and had great ideas for how information can be disseminated.

- People found that a combination of printed information, friends and family, peer support, community based support groups and specialist NHS teams helped them to understand their diagnosis, its implications and the treatment and post-treatment process.

- The way people use their local health services, as well as out of hours' emergency services, depends to some extent on how they feel about their GP. Where people feel that they are being criticised for their lifestyle choices, particularly relating

to smoking, diet, alcohol and exercise there is evidence that they avoid regular contact with their GP and wait until a point of crisis before accessing health services.

- The use of additional services such as 111, and out of hours seems low, as does people's confidence in using them.

- People commented about the difficulty of getting to Ashton – number and frequency of buses, cost of taxis and parking.

- People also described their experience of the Primary Care Centre as 'difficult', saying that when they had been there they had been sent to A&E -they said that they now go straight to A and E instead.

- Some people said that they use A and E because 'gatekeepers' on reception at their GP practice made it difficult to get an appointment.

- Conversely relatives of people with learning disabilities said going to A&E was difficult because staff wouldn't let them support/speak for the person with a learning disability.

- It was suggested that people going to A and E with a mental health problem didn't get appropriate support.

- People felt that having a range of service in one place would help them to get more joined up treatment e.g. GP, Physio and OT.

'The [breast cancer] diagnosis is delivered to you in what is known as the "room of doom", anyone with a cancer diagnosis leaves the room with a large brown envelope, and so everyone waiting knows your situation.'

"Even in hospital my daughter needs to explain what her disabilities are and what she can and cannot do, it is a tiring business."

"Staff are lovely and helpful and friendly", "a lovely way with them, nothing was too much trouble" (People using the Stamford Unit)

e. Families and carers play a vital role but we don't always feel supported, valued or involved. The families and carers of adults with a learning disability, feel particularly marginalised by this.

"In hospital I wanted my husband to come to the handover because I cannot retain information and couldn't speak, but they would not allow it because it wasn't visiting time".

"I potter around the garden as my escape, living with a partner with Alzheimer's is incredibly difficult, until he was prescribed the right medication he didn't really speak

anymore, had no interest in what he had been passionate about before and it was like having a bereavement - I missed the person he was."

- Many of the carers we spoke to felt that they were not always recognised for the role they play in caring for the person receiving treatment. They felt that they are often experts in the person's care and what will work best for them, and that this was too often ignored.

- Examples were given where carers were not involved in conversations, but the person's condition meant that they could not retain the information they were given on their care, appointments being made without speaking to the carer about whether they could practically support the appointment, people not being involved in decision making as a carer when it has been agreed that they should be and assumptions being made that families were able to provide care in the first place when they could not.

- Carers really value additional support including time off from caring, help financially through carer assessments and access to accessible and affordable transport.

- People also told us that at A and E parents/carers have been prevented from supporting adults with a Learning Difficulty or communication disorder during consultations.

- People feel that staff only address physical symptoms and not the additional needs of the patient and that staff in A and E need additional skills in order to support the person as a whole.

- It was also felt that a link person to support the parent and the patient could help this as the role could also look at the wider picture, social, emotional and psychological and that best practice in Children's wards could be shared.

"Being able to see Mum (with Alzheimer's) as 'just someone I care for' sometimes [is important to me]."

"Isolation is the worst thing… I now take anti-depressants"

"Mum goes to day care two days a week, without the Volunteer Drivers this would not happen. I would have no other way of accommodating this care that she needs and work without this service. I have the confidence to know she is safe.""

"People find it very difficult to find out what is available for them both in terms of claims/carers support and also patient support… I only found out in year 4 that mum can have a discount on her Council Tax".

"The Memory Clinic and The De-Caff play a huge part in mental wellbeing, these are services that change the lives of patients and carers and should never be underestimated".

f. We want increased focus upon mental health, loneliness and social isolation.

"I went to A&E with my sister who was experiencing a breakdown and there was no-one there trained to see her. She cut herself because she knew someone would see her. It is ok if you are physically bleeding, but nothing for mental health and it scared the living daylights out of me."

- Mental wellbeing and social connectedness were themes that ran throughout the conversations we have had with people.

- People recognise the link between their mental and physical health, and a large part of this depends on how they connect with others.

- People feel strongly that mental health should be a key element of every service, support for mental illness should be better, and that prevention was key.

- People recognise the importance of their mental wellbeing, and that a large part of how well they feel is linked to their social interactions. Loneliness and social isolation are important features as part of this.

- The availability of crisis support for people with mental illness was felt to be lacking and inconsistent and there was a feeling that Voluntary Sector services are picking up the slack, both in terms of volume and complexity where their resources are already stretched.

"We need more groups like Anthony Seddon Fund [MH support group], for peer support".

"We have successful health checks for people aged 40-70yrs, through the 'Be Well' service to check blood pressure etc. Why don't we have one for mental health, considering the affect this has on people's lives?"

5. CONCLUSIONS

As highlighted throughout the report, 6 key messages permeated this phase of engagement, which are:

a. *We experience health and social care that is disjointed and delivered in silos, and would welcome more joined-up services;*

b. *Our communities have an abundance of 'assets' (people, groups and facilities) which could be better supported and used by local people;*

c. *We think there is much more to be done to prevent ill health, that much of this sits outside conventional health services, and that we want to shape this;*

d. *The way we make decisions about how, when and where to use services is influenced by a range of factors including awareness, accessibility (transport), relevance, staff attitudes and behaviour and whether we get additional support;*

e. *Families and carers play a vital role but we don't always feel supported, valued or involved. The families and carers of adults with a learning disability, feel particularly marginalised by this;*

f. *We want increased focus upon mental health, loneliness and social isolation.*

In addition, there were a number of additional cross-cutting findings that are of relevance to the Care Together Programme. These can be summarized as follows:

- People want to be included in design and implementation and have specific and detailed ideas for shaping and changing services based on their expertise by experience.
- People strongly support the work being done to coordinate and join up services and the importance of multi-agency working (including the voluntary sector) to provide better outcomes and save money. It should also be noted thought that people want to be treated as individuals not in a one size fits all approach or just by their condition and continuity of care also matters.
- Basic things like caring and supportive staff make a big difference and impact on the way people use services. Where people feel that they are being criticised for their lifestyle choices, particularly relating to smoking, diet, alcohol and exercise there is evidence that they avoid regular contact with their GP and wait until a point of crisis before accessing health services.
- The Voluntary, Community and Faith sectors have a clear role to play in supporting local people holistically to improve their health and wellbeing, including tackling the wider determinants of health and interventions at key life stages. This cannot happen without appropriate resourcing including cross-sector relationship building and training. Self-help and peer support groups were seen as particularly important.

- People highlighted the importance of self-care and were keen that the conversation move from a deficit to an asset base – recognising the knowledge base of people living with long term health conditions
- The impact of service changes on those who have protected characteristics needs careful and continued investigation, consideration and response to ensure that they do not inadvertently compound or exacerbate existing discrimination and deprivation.
- Good information sharing and communication matter to people and is often a focus of concern as well as ideas for improvement.
- People understand that keeping healthy and improving wellbeing is about more than just health and care interventions e.g. exercise, healthy eating and social contact and activities (including volunteering).
- Money is seen by some people as a barrier to health and wellbeing – in terms of the cost of participation, the cost of travel to an activity and the cost of healthier food.
- Transport and travel to and from services, including voluntary sector support, is one of the biggest issues, and influences how people experience and use services. Community based support is seen as positive solution to address this.
- There are particular challenges for Glossop residents and groups with a focus on George House Primary Care Centre as a solution.
- People recognised the value of technology in improving access to services and support but want inequalities related to this (e.g. IT literacy and access) to be addressed.

6. RECOMMENDATIONS

As the Care Together Programme Progresses towards implementation we make the following recommendations:

1. Close the feedback loop and move the conversation on:

- This is the third time since 2014 that we have spoken to people about the programme, there is a clear message from people that they want to know what has changed as a result of what they said, and what the next steps are for the programme.

- People are keen to shape the future and we need to harness this in the genuine spirit of co-production as the Care Together Programme progresses towards implementation of a new Model of Care, local people should be actively involved in co-designing new approaches, supporting their implementation and evaluating their success.

- Examples of where this could happen quickly include:

  - Phased implementation of the Patient Activation Measure (PAM)
  - Mapping existing provision that would underpin an asset based health model and approaches such as Social Prescribing, Self-Care and Peer Support.
  - Developing the Integrated Neighbourhood models in partnership with local people and groups
  - Supporting the improved utilisation of community facilities such as the George House Primary Care Centre in Glossop.

2. Hear the Unheard:

- Although engagement to date has been extensive, there are some groups that remain under-represented and unheard.

- During the next phase of Engagement, we will undertake targeted engagement to capture the insight of the groups which include, but are not exclusive to:

  - Children and Young People
  - Black British, African and Caribbean Communities
  - White European Communities (and particularly Polish Communities)
  - People who live in Hattersley, Longdendale, Mossley and Audenshaw.

3. Share the learning:

- We need to ensure that the valuable insight we have from this engagement is shared across the system, and is acted on by all agencies that are involved in the Care Together programme.

- This insight needs to be presented in a way that is useful to people working across systems at each level from strategic to operational.

- The Care Together Programme should identify the most appropriate way to ensure that this happens in a meaningful way including the development of a clear action plan linked to these conclusions and recommendations.

- The specific issues raised in relation to carers, mental health, poverty and equality issues and transport require dedicated attention and championing as current and planned activity in relation to these complex areas is less visible and possibly under-explored at present.

4. Utilise Asset Based Approaches:

- Utilising the power of local groups to get to people that we wouldn't usually hear from works. We need to carry on with this approach, and develop towards co-produced proposals where the resource to get involved is available to the groups that are best able to contribute.

- Using asset based methodology Appreciative Inquiry, motivational interviewing etc. is key to providing the culture shift from 'what should you do for me?' to 'what can we do together?' both in terms of within the communities we serve and in terms of staff and services.

- We need to capture feedback from our organisational assets – our staff and volunteers running services, recognise their contributions and ensure that there is an avenue for them to shape the changes and 'be the change they want to see'.

- We need to further identify the opportunities for the Voluntary, Community and Faith sector both in service delivery, and as a conduit to marginalised communities in order to shape a health, care and wellbeing offer that meets the aspirations of communities of interest, identity and geography. There are opportunities for this particularly through the development of Integrated Neighbourhood Teams and Social Prescribing as well as the engagement program.

7. APPENDICES:

- Appendix 1 – Initial Workstream Findings
- Appendix 2 – Tameside detailed focus group notes
- Appendix 3 – Glossop detailed focus group notes
- Appendix 4 – Healthwatch AGM
- Appendix 5 – Healthwatch Other Insights
- Appendix 6 – VCS Engagement Event
- Appendix 7 – Faith Sector Engagement Event

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	10 November 2016
Executive Member / Reporting Officer:	Councillor Peter Robinson, Executive Member (Children and Families) Angela Hardman, Director of Public Health and Performance
Subject:	**NORTH WEST SECTOR LED IMPROVEMENT: INFANT MORTALITY**
Report Summary:	This Sector Led Improvement review focused on child deaths aged under one year, this age range accounts for around two thirds of all child deaths both locally and nationally. In addition to the benchmark aspect of the review, the objective was to share evidence on actions, and assist each locality to adopt best practice, in order to reduce the number of child deaths under one year old. The aim of the review was to: • Adopt an agreed SLI methodology to review action to reduce infant mortality as part of a peer review approach. The process included identifying activity which is in place to reduce deaths for those children aged under one year old, with a particular focus on modifiable factors. • Taking an appreciative enquiry approach to identify places where actions have resulted in improved outcomes and share the learning. • Identify key themes and recommendations at LA level, sub-regional level and North West level. • Outcomes of the review to provide potential opportunities for collaborative work programmes which may include commissioning. • Enable sharing of good practice and innovation to aid mutual support and drive improvement in outcomes. • Identify any gaps in data and intelligence and provide recommendations for CDOPs. • Produce an action plan for Local area Safeguarding Children and Adult Boards who will be responsible for oversight and implementation.
Recommendations:	The Health and Wellbeing Board are asked to endorse and agree the recommendations from the report contained within the NW Sector Led Improvement Peer Review: Infant Mortality Report 2016 (**Appendix A**).
Links to Health and Wellbeing Strategy:	Starting and Developing Well are strategic priorities in the Health and Wellbeing strategy.

Policy Implications:	In line with Council policy.
Financial Implications: (Authorised by the Section 151 Officer)	Whilst there are no direct financial implications arising from the report, it should be recognised that any investment required to support the report recommendations across the Economy will need to be funded from the Public Health grant received by the Council. The Public Health grant is within the Section 75 funding allocation of the Integrated Commissioning Fund which is monitored by the Care Together Single Commissioning Board.
Legal Implications: (Authorised by the Borough Solicitor)	Reducing Infant Mortality is a good indicator of whether a place based health and wellbeing system is reducing inequality.
Risk Management :	At this stage there are no risks associated with this report.
Access to Information :	The background papers relating to this report can be inspected by contacting Angela Daniel, Programme Manager, Greater Manchester Health and Social Care Partnership  Telephone: 0161 237 4010  e-mail: angela.daniel@tameside.gov.uk

2016

North West Sector Led Improvement: Infant Mortality

Contents

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Foreword

Giving children the best start in life is an ambition that for many is firmly rooted in all that we do, whether we are a parent, or if we work in a role that brings us into contact with children or working with prospective, new and existing parents. We all want to see children in families and the wider community have the opportunity to start life and grow into healthy children, young people and eventually adults. Sadly for some this is not the reality. Whilst we have seen a decline in infant mortality over the past 16 years, a continued effort can help to further reduce unavoidable deaths and the devastation these can cause. Through the Sector-led Improvement (SLI) process and the recommendations that flow from this, I want to ensure that every locality participating across the North West has access to evidence on actions so they are in a position to adopt best practice, in order to reduce the number of avoidable child deaths under the age of 1 year. This means ensuring that action to tackle modifiable risk factors is maximised.

Whilst supporting and enabling individual behaviour is at the heart of this action, a system wide approach is essential to ensure that all efforts are made to raise awareness and mobilise the right support and advice towards reducing risk and enabling all children to have a good start in life.

There is already a considerable amount of targeted work across the North West to tackle those modifiable risk factors that impact on infant mortality. Inter-disciplinary collaboration was key to the SLI process, bringing forward an active, passionate contribution, knowledge, insight and understanding of the range of interventions that are being delivered to effect a reduction in infant mortality. A number of challenges and opportunities to build and strengthen existing approaches and systems to assure and maximise outcomes for infants under 1 year were highlighted. These had an important focus on ensuring the consistency of implementation of what we know works; assuring good quality communication systems; and, critically, firmly positioning the work of Child Death Overview Panels (CDOPs) into local governance and accountability structures, holding the system to account for delivering action and improving outcomes. There are recommendations throughout the report that provide an excellent starting point, together with the richness of local benchmarking work that helped to inform the SLI programme, for system re-design and transformation.

This was the first North West collaborative approach to SLI, involving 22 of the 23 North West localities and bringing together a wealth of knowledge and expertise to shape future improvement work. Thank you to all who took part and supported this important programme of work.

Angela H Hardman
Executive Director of Public Health
Chair, Infant Mortality Sector Led Improvement Group

Background

In February 2015 a Child Death Overview Panel (CDOP) chair from one of the four CDOPs covering Greater Manchester (GM), attended the GM Directors of Public Health meeting and presented the GM CDOP Annual Report. Since then there have been a number of conversations about how the various recommendations within that report should be taken forward, recognising that issues, progress and approaches differ within each CDOP area. Angela Hardman (Director Public Health Tameside and GM Public Health lead for Children and Young People) met with the CDOP chairs and agreed that the first step required is to benchmark the status of each locality in relation to CDOP activity, interventions and implementation of good practice models as defined in the CDOP Annual Report received.

GM Public Health Network (GMPHN) alongside partners in Cheshire and Merseyside and Cumbria and Lancashire secured Association of Directors for Public Health (ADPH) funding as part of the regional Sector Led Improvement (SLI) network plan. This presented an exciting opportunity for Local Authorities and partners to participate and collaborate on an inter-disciplinary review across the North West on infant mortality of which 22 of the 23 North West localities took part. A stakeholder project group was established to oversee the development, implementation and evaluation of the review process.

Scope and Objectives of the Review

The SLI review focused on child deaths aged under one year, this age range accounts for around two thirds of all child deaths both locally and nationally. In addition to the benchmark aspect of the review, the objective was to share evidence on actions, and assist each locality to adopt best practice, in order to reduce the number of child deaths under one year old.

The scope included key modifiable factors such as maternal smoking, co-sleeping, safeguarding consisting of abuse and neglect, drug and alcohol misuse, consanguinity and obesity (plus other factors).

Working Together to Safeguard Children 2015 defines preventable child deaths as those in which modifiable factors may have contributed to the death. ***These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.***

Aims of the Review

The aim of the review was to:

- Adopt an agreed SLI methodology to review action to reduce infant mortality as part of a peer review approach. The process included identifying activity which is in place to reduce deaths for those children aged under one year old, with a particular focus on modifiable factors.
- Taking an appreciative enquiry approach to identify places where actions have resulted in improved outcomes and share the learning.
- Identify key themes and recommendations at LA level, sub-regional level and North West level.
- Outcomes of the review to provide potential opportunities for collaborative work programmes which may include commissioning.
- Enable sharing of good practice and innovation to aid mutual support and drive improvement in outcomes.

- Identify any gaps in data and intelligence and provide recommendations for CDOPs.
- Produce an action plan for Local area Safeguarding Children and Adult Boards who will be responsible for oversight and implementation.

Principles

Peer Review Sector-led improvement is based on a culture of collaborative working, sharing good practice, constructive challenge and learning.

It is based on the principles of mutual support and assistance, involving a discrete process of self-assessment and peer review. It is sustainable through collective action, peer support and strategic leadership.

Underpinning Values

- Working with peers to find sustainable solutions
- Being open to constructive challenge from peers on progress and commitment
- Undertake a self-assessment that will be reviewed by peers
- Participants are accountable to their peers where there are performance issues relating to the review remit
- There is a clear series of stages in the process and areas will need to take part in all stages

Ground Rules

- Buy-in needs to be throughout the system being reviewed from front-line practitioners through to corporate leads, especially lead members and service leaders.
- Participants should adhere to the agreed timetable - since the approach requires rapid implementation and the co-operation of all areas, local areas need to respond in an open and timely manner to all requests for data, intelligence or information.
- Information shared as part of the programme should be respected and should not be shared outside of the review without permission.
- Localities need to recognise that the programme can make recommendations on the activities to be commissioned/de-commissioned but that districts are not obliged to implement recommendations. Implementation is a matter of local choice.
- Mutual help underpins this approach. Staff at all levels should be discouraged from making judgements of the services/performances in other districts.

Methodology

A stakeholder meeting was held in December 2015 with representation from various organisations and disciplines across the North West including: Director of Public Health, Local Safeguarding Children's Board (LSCB), Child Death Overview Panel, Clinical Commissioning Group (CCG), Public Health England, North West Employers and NHS England to review and agree the methodology and scope. Those that were not able to attend were provided with the proposals to enable comment.

The staged approach methodology of benchmarking data, completion of self-assessment, followed by peer review, (the methodology used by GM Public Health Network for Sector Led Improvement Peer Reviews), was agreed by all stakeholders.

Due to the number of localities involved in the review it was agreed that a single full day workshop would be the most appropriate approach to facilitate the review process. The benchmarking data for each Local Authority was collected between September and December 2015. Data from Child Death Overview Panels was collated and made available at the time the self-assessment template was distributed to participants. All documents were made available on a secure page of the GMPHN website, links were provided to participants.

The self-assessment template was developed and tested by stakeholders; the expectation was that the lead for each locality had the responsibility for coordinating the completion of the self-assessment. They ensured colleagues from different agencies including Public Health, CCG Maternity Commissioners, Maternity Service, Health Visiting Service, Local Authority Children's Service, CDOP, LSCB, Police etc. contributed to the self-assessment (where appropriate).

Once completed the self-assessments were included on the webpage so that they could be viewed by all participating localities prior to the workshop day. A summary document was produced for each locality and included on the webpage.

What the data shows

The primary purpose of CDOPs is to review individual deaths, to identify modifiable causes to inform strategic planning on how "best to safeguard and promote the welfare of the children in their area" (Working Together to Safeguard Children, 2015) that is, to learn lessons and put the lessons into practice to prevent future deaths. To meet these ends and to support the operational functions of the CDOP each CDOP collects information about each child death in their area including the conclusions of the panel review.

In addition to the local reports produced by each CDOP there is also a GM Annual Report and a NWCDOP Annual Report. These reports include the following data, with overall numbers increasing as the area expands.

- Number of notified deaths in year - Number of closed cases in year
- Deaths by age
- Cause of death by category
- Child deaths by ethnicity
- Modifiable factors identified
- Child deaths by deprivation quintile
- Expected versus unexpected deaths

In 2014/15 across the North West (23 local authorities) there were a total of 328 infant deaths (<1 year), that had been reviewed and closed. 37% of North West infant deaths were of infants from a BME background (a known risk factor) and 63% of deaths were of infants with a birth weight of less than 2500 grams. 43% of deaths were of infants whose mothers were from the most deprived quintile (quintile 1).

Of the 328, infant deaths 27% had at least one modifiable issue implicated in the death. The most common modifiable issue identified across the North West was safeguarding consisting of abuse and neglect (62% of deaths with a modifiable issue identified). The next largest modifiable issue identified was smoking (59%). 33% of infant deaths where a modifiable issue had been identified were due to drugs or alcohol misuse and 23% through co-sleeping.

Although infant mortality both nationally and regionally has declined somewhat since 2002 (table 1), it is important, if not essential, that we work to reduce the number of modifiable factors in order to continue the downward trend in child mortality rates.

Trends in rates of infant mortality for England and the Northwest 2002 - 14

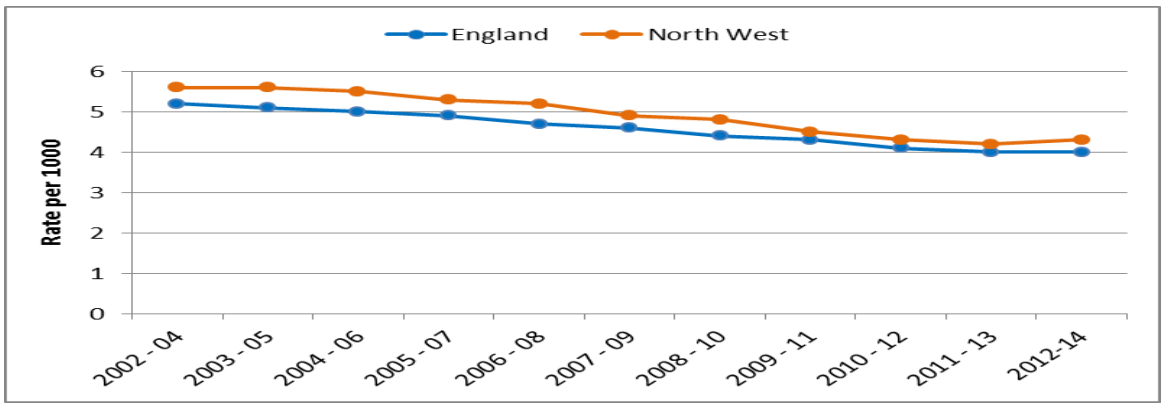

Table 1

Outcomes of the Workshop

A total of 69 professionals attended the workshop from across the 22 NW localities. They represented a multitude of professional groups such as Public Health Commissioners, Local Authority, Health Visitors, Family Nurse Partnership, CCG, Midwifery, LSCB, CDOP, Public Health England, North West Employers and NHS England to name a few.

There were 7 thematic sessions covered on the day:

- Child Death Overview Panels
- Capacity to Improve
- Safeguarding
- Congenital Abnormalities
- Co-sleeping
- Smoking in Pregnancy
- Deprivation

Each of the following sections provides a summary, context, questions posed for discussion, an overview of the discussions, followed by recommendations for across the regions and recommendations for localities.

Market Place

Attendees took part in a 'Market Place' where good practice and further work under 'themes' were presented at 'stalls' around the room. Attendees were tasked to either request further information (for good practice) or offer support (for further work) on the different themes. The intention was to enable sharing of good practice and innovation to aid mutual support and drive improvement in outcomes.

There were 168 requests for further information and 32 offers of support across the themes.

The following recommendations from the Market Place are made based on the information gathered from the different localities with interests in a particular area of work. Some of the Market Place recommendations have been placed in the topic section contained later in this report (such as safeguarding).

	Recommendations	Proposed lead
1	Task and finish group to look at campaigns which could be developed on a NW footprint such as: • Foetal Alcohol Syndrome (see Halton's social marketing campaign) • Safe sleeping campaigns (good examples in Bolton, Blackpool, St Helens, Sefton and Wirral)	Public Health England North West North West Localities
2	Establish a method of sharing good practice (including evidence of impact, improvement in outcomes and Cost Benefit Analysis) across the North West on an on-going basis.	Public Health England North West

Child Death Overview Panel (CDOP)

Responsibilities of CDOPs (Working together to safeguarding children: March 2015)

The functions of CDOP include reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law. They collect and collate information on each child and seek relevant information from professionals and, where appropriate, family members.

They provide relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn can convey this information in a sensitive manner to the family. They determine whether the death was deemed preventable (those deaths which include modifiable factors which may have contributed to the death) and decide what, if any actions could be taken to prevent future such deaths.

The CDOPs make recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible. Identify patterns or trends in local data and report these to LSCB.

In reviewing the death of each child, CDOPs should consider modifiable factors and consider what action could be taken locally, regionally and nationally.

Questions discussed at the CDOP workshop:

1. *How are the local, regional and NW CDOP reports embedded across organisations? Is it used for CDOP/safeguarding or does it also filter through to Health and Wellbeing board and wider work?*
2. *Have there been any emerging issues coming through CDOP reports that we need to keep an eye on? For example more babies being born above the 95th percentile due to the increase in obesity and its impact on mortality in infants, another example is post-natal depression and self-harm.*
3. *What can be done to CDOP reports to make them more useable: for example the development of a minimum dataset to allow bench marking to occur more frequently; or standardisation of what a modifiable factor is; or more information on the characteristics of mother and baby?*

KEY ISSUES RAISED IN DISCUSSION

- Data recording, data sets and the importance of data. There was a general frustration regarding missing routine data particularly in regards to the mother's partner and that this needs to be stressed to frontline staff (this is commonly found in Serious Case Reviews). Many partners felt that there was a barrier to data sharing due to the incompatibility of I.T. systems across services. The regional and GM reports now use a minimum data set which allows benchmarking across the different geographical areas as well as year on year comparison.

- Modifiable factors. It would be useful for a piece of work to be undertaken to clarify what each CDOP classifies as 'modifiable'. There was also concern about the subjectivity of some of the data collected; the panel may find it difficult to be able to make a decision based on the material they receive; if the panel has a change of membership those decisions can be skewed by new membership or by a dominant member. Clear criteria about what constitutes a particular modifiable factor would be helpful. As data collection improves it has

become more apparent that there are a disproportionate number of BME deaths and this needs to be investigated further.

- **Governance and identified leadership**. Across the Region accountability for the CDOP report varies in its distribution and governance i.e. in some areas it goes to only the LSCB in other areas it goes to both LSCB and Health and Wellbeing Board. The annual CDOP report can be presented at LSCB, responses can be varied with accountability for recommendation implementation not identified. CDOP prioritisation is often not evident to chairs based on the lack of change in outcomes. A lack of change in outcomes suggests that some areas may not sufficiently prioritise the dissemination and follow up of CDOP recommendations or identify accountability for actions.

- **Learning from CDOPs** should be shared widely and routinely to ensure a 'wide' audience is captured. Recommendations within CDOP reports need to be SMART and ensure that all relevant agencies take responsibility. A rolling three year action plan was suggested with accountability for change and improvement to reside with the Quality Assurance group within LSCBs. It was suggested that CDOP reports should include recommendations regarding dissemination; however this may be useful to agree at a NW level to ensure wide coverage.

As with Serious Case Reviews it was felt that it would be helpful for the learning from CDOPs to feed directly into the Safeguarding Training.

	Recommendations	Proposed lead
1	Bi-annual workshop for all NW CDOP members to review the criteria for modifiable factors to agree a common data set and improve consistency	North West Child Death Overview Panel Group
2	Detailed annual reports in response to the NW and local CDOP report to go to LSCB and Health and Wellbeing Boards to ensure a local response and assurance with a clear plan to respond to actions and recommendations	Child Death Overview Panels
3	CDOPs to: • Establish a mechanism of feeding directly back to individual frontline staff regarding modifiable factors identified in infant mortality cases they have worked with. • Establish a process to share learning from CDOPs to all frontline staff (explore doing this jointly with shared learning from Serious Case Reviews) • Work with LSCB training group to ensure learning is embedded into safeguarding training	Child Death Overview Panels
4	Communication and engagement strategy to cascade key learning across NW CDOPs and back to front line practitioners.	Child Death Overview Panels

	Recommendations for individual localities	Proposed lead
1	Clearly define governance of CDOP report within individual localities	Chair of LSCB Director Public Health
2	Clarify how findings from CDOP cases within the locality are shared for action.	

Capacity to Improve

The Capacity to improve workshop focussed on two particular aspects:

- Ownership
- Visibility

Ownership – what high performing Public Health systems do:

- Have clear overall leadership for infant mortality, including clear leadership at organisational level (named individuals)
- Have good multi-agency understanding of the activities already in place and partnerships to tackle infant mortality in local areas (across public health, NHS, LA safeguarding, CCG etc.).
- Effective communication which enables partners to understand their individual efforts in the wider context of a multi-agency partnership improvement programme

Visibility – what high performing Public Health systems do:

- Ensure the relationship between the measure (especially measures for modifiable factors) and outcomes for local people/public sector services are well understood.
- Measures are included in locality level strategic discussions
- CDOP findings (annual reports) are shared appropriately with groups (commissioners and providers) which can positively impact on infant mortality (including CCG, public health, maternity services, health visiting services, local authority services, police etc.).

Questions discussed at the capacity to improve workshop:

1. *How do we ensure that reducing infant mortality is on everyone's agenda?*
2. *How do we secure ongoing and sustainable commitment to continuing to improve outcomes across all parts of the system?*
3. *Who will provide the leadership and how do we secure their commitment?*
4. *How do we make the work that is going on more visible?*
5. *How do we raise* awareness of the local facts and figures and evidence base?

KEY ISSUES RAISED IN DISCUSSION:

- Having people who are passionate and committed to reducing infant mortality was identified as a key priority. Good, strong, passionate leadership could give assurance and management as well as accountability. It can also ensure that ownership on reducing infant mortality is embedded within the local system. Leadership amongst elected members is equally as important to ensure commitment to reduce infant mortality.

- The leadership needs to be able to work across agencies/services and ensure there is an integrated response to reducing infant mortality across the locality.

- The importance of public engagement including how localities are communicating and engaging with the local population to influence behaviour change and social norms (social movement) was emphasised. It was felt that to influence the reduction in infant mortality we do need to look at organisation development to support the wider workforce and population who can influence behaviour change.

- Commissioning and contract management was discussed with the conclusion that areas need to have good contract management in place to ensure what they are commissioning is bringing the change needed to reduce infant mortality.

	Recommendations for individual localities	Proposed lead
1	Identify a named lead for reducing infant mortality within the locality	Chair of LSCB Director Public Health
2	Identify a lead elected member for reducing infant mortality	
3	Modifiable factors associated with infant mortality are firmly embedded in integration programmes	
4	Consider opportunities to influence behaviour change and social norms for modifiable factors associated with infant mortality (such as social movement).	
5	All services commissioned are evaluated to ensure they make positive changes to modifiable factors	

Safeguarding

Safeguarding is a term which is broader than 'child protection' and relates to the action taken to promote the welfare of children and protect them from harm. Safeguarding is everyone's responsibility.

Safeguarding is defined in Working together to safeguard children 2015 as:

- protecting children from maltreatment;
- preventing impairment of children's health and development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes;
- Neglect often plays a role in child deaths.

Types of Neglect

Physical neglect:-	Poor Diet, unhygienic or dangerous home conditions, poor clothing, unsupervised.
Educational neglect:-	Poor school attendance, poor school presentation, unprepared for school, condoning problem behaviour at school, refusing to allow specialist intervention.
Emotional neglect:-	Domestic violence, lack of affection, belittling, scapegoating and blame.
Medical neglect:-	Not accessing medical, dental etc. on regular basis. Withholding medical attention in emergency, not allocating prescribed medication as directed, fabricated illness.

All Forms of Child Neglect Can Lead To A Lifetime Of Low Self Esteem and Poor Social and Emotional Development and sometimes Death

Questions included in the safeguarding workshop:

1. *What early intervention and prevention strategies are in place locally to reduce the impact of safeguarding on infant mortality?*
2. *How does your area ensure safeguarding approaches are joined up across all partners?*
3. *How responsive are we to incremental information about families?*

KEY ISSUES RAISED IN DISCUSSION

- The family dynamic and genogram was deemed important, professionals do not routinely undertake a genogram for families and an assumption is made about family connections as the nuclear family. Identification of risk factors surrounding the family is an important part of the assessment process and is crucial to preventing harm. Assessment and discussion of family norms and values was recommended as an easy way to explore family dynamics and cultures. This needs to include the wider social elements such as housing, police information and wider services which can contribute to the 'family picture'

- Use of demographic data could allow for profiling of communities where infant mortality is a risk, resulting in a differentiated delivery model in those areas, raising awareness in different ways, using community leaders to share knowledge and develop the messaging around approaches to reducing risk. Working locally provides the opportunity to build relationships (especially in those communities who are more at risk of infant mortality). There are opportunities to integrate services based in localities closer to the communities they serve.

- Information sharing: One of the most common barriers discussed was information sharing. Information sharing is a key enabler in safeguarding children and has long been identified as a key issue in Serious Case Reviews. The duty to share information at the right time is vital to safeguarding. Information should be shared as soon as risk is identified, ensuring a common assessment framework is commenced if any predisposing risk factors for infant mortality are identified. The groups questioned whether the toxic trio of mental health, drugs and domestic abuse information was available to midwives and health visitors in the antenatal period to allow a full assessment to be undertaken. The group recommended the link to the GM IM&T enabler group and GM connect work stream.

- Early help was identified as a key theme for families where previous child protection proceedings had been put in place. The group acknowledged that families are often left to continue on a path without support once a child has been removed. A review of existing successful models, noted below, would be beneficial:
    - Model of excellence in Salford Strengthening Families, proving successful supporting families in this situation to support those families who have a child removed to help plan or prevent for the next pregnancy.
    - The Blackburn model using the Adverse Childhood Experiences (ACE) criteria scoring was hailed as a model of excellence and scoring criteria applied to families to ensure an early help assessment and referral where required

A number of disparate areas where gaps or aspects of need were acknowledged:

- Thresholds of need: For professionals working in areas of high deprivation the professional's views of 'normal' had the potential to be skewed especially when frontline practice is being stretched and social norms can become distorted. There was a suggested solution that staff should rotate so they can experience 'normal' and ensure there is good supervision in place.

- Safeguarding adults: Many adults are vulnerable and require safeguarding themselves, learning disabilities was a key theme, many parents do not have the capacity to parent and need enhanced support.

- Father's role in the prevention of infant mortality: Most information, advice and guidance is targeted at mothers in the antenatal period.

- Public perception around domestic abuse and neglect: Discussion focused on whether the public fully understand (perceive) what domestic abuse is and what is neglect (public thresholds). There was a recommendation that we need to change the way we think about safeguarding; we need to change the concept of safeguarding as a social care intervention to one that is seen to offer support. This recognises that parents sometimes need help and this can be offered within and alongside local communities rather than as corporate entities working in isolation.

- Relationship between services: Was seen as both a blockage and an enabler (especially between maternity and health visiting). Having integrated services should go some way to address this with the right workforce development and integrated leadership.

- The role of CDOPs: In terms of looking forward as well as backwards to ensure there is a long term response to a family, and other children within that family, who have been impacted upon by the death of a child/infant.

Recommendations		Proposed lead
1	Support and training is required for professionals to understand respective roles in reducing infant mortality	Regional Local Safeguarding Boards in Greater Manchester, Cheshire & Merseyside, Lancashire & Cumbria)
2	Develop an approach to record all family members in the antenatal period using a structured approach such as genogram, Blackburn ACE model	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
3	Parenting support and prevention to include fathers/partners/carers and grandparents	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
4	Develop a NW campaign to raise awareness of neglect and domestic abuse and its impact on infant mortality for staff and the public	Regional Local Safeguarding Boards in Greater Manchester, Cheshire & Merseyside, Lancashire & Cumbria)

5	Risk and information sharing to be picked up in GM with IM&T enabler and GM Connect	Greater Manchester – Health and Social Care Partnership – GM Connect
6	Task and finish group to examine the multi-agency drug/alcohol/mental health/domestic abuse screening tool developed by Cheshire East to see if this would be useful to implement across the regions. (*This recommendation was taken from the Market Place*)	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria

	Recommendations for individual localities	Proposed lead
1	Data sharing and information governance within localities facilitates safeguarding for all agencies	Chair of LSCB Director Public Health
2	Effective partnership working including information sharing to support safeguarding.	
3	All staff working with children and families have the capacity and capability to work effectively to ensure safeguarding and understand the implications in relation to infant mortality	
4	Review working practices for professional staff working in deprived areas and ensure rotation to more affluent areas to prevent social norms becoming distorted	

Congenital Abnormalities

Background

The Born in Bradford (BiB) study, funded by the National Institute for Health Research under the Collaboration for Leadership in Applied Health Research and Care programme, and the largest of its type ever conducted, examined detailed information collected about more than 11,300 babies involved in the Born in Bradford (BiB) project, a unique long term study which is following the health of babies who were born in the city at the Bradford Royal Infirmary between 2007 and 2011. The research team found that the overall rate of birth defects in the BiB babies was approximately 3% - nearly double the national rate.

Each year, approximately 1.7% of babies in England and Wales are born with a birth defect (for example heart or lung problems or recognised syndromes such as Down's), which may be life-limiting. These disorders occur as a result of complex interactions between genetic and environmental factors, or because of damage done by infections such as rubella and cytomegalovirus.

It is important to note that the vast majority of babies born to couples who are blood relatives are absolutely fine, consanguineous marriage increases the risk of birth defect from 3% to 6%; however the overall absolute risk is small. We should also remember that consanguinity accounts for a third of birth defects.

In the Pakistani subgroup, 77% of babies born with birth defects were to parents who were in consanguineous marriages. In the White British subgroup 19% of babies with an anomaly were born to mothers over the age of 34. Links between the age of mothers and the prevalence of birth defects are already well-established.

Questions included in the congenital abnormality workshop:

1. *Based on the evidence and data above what are the optimal strategies for tackling congenital abnormality and infant mortality. How do we deal with this issue sensitively with communities? Discuss the barriers and opportunities for local action.*
2. *What range of services or programmes are/should be in place for those identified at risk of congenital abnormality based on the experience of Bradford and other areas?*

KEY ISSUES RAISED IN DISCUSSION

- Building relationships and engaging families and communities to help deal with the issue of tackling congenital abnormality and infant mortality was deemed important and included engaging various audiences such as community leaders, places of workshop, schools and political leaders. This has been done previously with constructive action being shown to have the support of the community (http://www.tandfonline.com/doi/abs/10.1080/02646838908403571?journalCode=cjri20)

- The importance of planning for pregnancy with the suggestion that information needs to be appropriate for cohorts should be considered. Preconception care needs to be reviewed to ensure it has the right service in place i.e. screening programmes.

	Recommendations	Proposed lead
1	Bi-annual North West event to share good practice such as engaging leaders within communities and places of worship	Public Health England North West
2	Task and finish group (include public representation) to identify workforce development needs for integrated services to improve cultural awareness and understanding of the issues of consanguinity and its impact on congenital abnormalities	Public Health England North West
3	Use the intelligence gained from new born screening data (held by GPs) to develop a model to engage adolescents and reinforce the risk associated with congenital abnormalities.	Public Health England North West
4	Explore whether screening programmes are cost effective and share findings across the NW	Public Health England North West

	Recommendations for individual localities	Proposed lead
1	Reliable information system to enable access to high quality intelligence to identify 'at risk' population groups	Chair of LSCB Director Public Health
2	Preconception care in place which targets 'at risk' groups of congenital abnormality	
3	Outreach worker in each locality where there is a high rate of congenital abnormality	
6	Engage with community leaders and families in high risk groups to communicate messages about consanguinity and the advantages of genetic screening	

Co-sleeping

Significant progress has been made in reducing Sudden Infant Death Syndrome (SIDS) in the past 20 years in the UK. In 2013 249 (0.36 per 1000 live births) unexplained deaths occurred in England and Wales. More than half of these deaths occurred in unsafe sleeping circumstances.

National risk factors are baby's sex, birthweight, maternal age, marital status, sleeping position, sleep environments, not breastfeeding, temperature and smoking.

During 10 years: 2004 – 2013 Wales and the NW had highest rates at 0.54 and 0.53 deaths per 1000 live births. In 2013 the rate in NW was 0.45.

NICE guidance says:
Parents or carers with a child under the age of 1 should be advised / informed about the factors associated with co-sleeping (falling asleep with your baby in a bed, or on a sofa or chair) and Sudden Infant Death Syndrome (SIDS) to allow them to weigh up the possible risks and decide on sleeping arrangements that best fit their family.

The following is to inform localities to help reduce SIDS:

Parents/carers should be advised never to fall sleep with their baby especially:

- If they or their partner smoke or smoked in the ante natal period, even if they never smoke in bed or at home.
- If they or their partner have been drinking alcohol.
- If they or their partner take medication or drugs (prescribed or otherwise) which cause drowsiness.
- If they or their partner feel very tired.
- If their baby was low birth weight (less than 2.5kg)
- If their baby was premature (born before 37 weeks)

Factors which increase risk

There is an association between sudden infant death syndrome if certain risk factors are present, these include:

- If the mother has smoked at all during the ante-natal period or either parent is a smoker (Carpenter 2004).
- Co-sleeping (Carpenter et al, 2013, Carpenter et al 2006, Hauck et al 2004, Carpenter et al, 2004).
- Sleeping prone (face down) has a higher risk of SUDI (Beal 1999, Mitchell 1991).
- Low birth weight babies / prematurity -under 2.5kg/under 37 weeks gestation (Blair et al 2006, Carpenter 2006, Mitchell 2007).
- Overheating as a result of overwrapping, inappropriate bedding, swaddling or illness (Carpenter et al 2004, Fleming et al 1996, Gilbert et al 1992, Williams et al 1996).
- Changes in sleeping circumstances e.g. holidays or staying with friends or relatives.

- Previous SUDI, possibly because some risk factors are still present. Referral to the Care of Next Infant (CONI) programme should be offered.
- Depression
- Drugs and alcohol abuse (Blair et al 1999, Blair et al 2009).
- Use of prescribed medication which may impair parental consciousness.
- Conditions affecting spatial awareness e.g. diabetes, epilepsy and blindness.

Known protective factors

- Reducing or quitting smoking in pregnancy reduces the risk of SUDI
- Placing a baby to sleep on his or her back in their own cot carries the lowest risk of SUDI. It does not increase the risk of choking in a healthy baby.
- Room sharing (sleeping in parents' bedroom) for the first six months of life lowers the risk.
- Several studies have found that breast feeding has health benefits for both mother and baby. Breastfeeding has been shown to significantly reduce the risks of SIDS. It is recognised that mothers who bring their babies into bed to feed tend to continue to breastfeed longer than those who do not. However, no studies have found co-sleeping under any circumstances to be safe, and some studies have shown a significant risk, even if the parents are non-smokers (Carpenter et al 2013).
- In circumstances where parents indicate that they intend to bed share, then advice from the UNICEF leaflet "Sharing a bed with your Baby" can be downloaded from www.babyfriendly.org.uk/pdfs/sharingbedleaflet.pdf. or "Caring for your baby at night: A guide for parents" www.unicef.org.uk/caring at night.
- Having an infant sleep plan and routine particularly if change in sleep environment e.g. staying with friends/relatives overnight.
- Ensure the room temperature is between 16-18°c and avoid over wrapping or swaddling an infant.
- The correct use of lightweight cellular blankets or British standard baby sleeping

Questions included in the co-sleeping workshop:

1. *What are the barriers to ensuring all workers, who come into contact with families or carers of babies, know and can communicate the risks and safety measures related to co-sleeping?*
2. *Given your knowledge of your local co-sleeping related deaths, what recommendations would you make to improve messages and understanding? Do you think that a multi-agency approach to reducing infant mortality would be useful and how would that look?*

KEY ISSUES RAISED IN DISCUSSION

- Barriers which impact on the decision making process for parents around co-sleeping with their baby, included belief in the message, conflicting messages (such as attachment), variety of available information, inappropriate products sold/marketed, covert behaviour and stigma associated with inappropriate behaviours (such as smoking) leads to denial to professionals and inconsistent advice from professionals

- It was felt that there should be more social marketing on safe sleeping and clearer/simpler messages throughout the professional world and beyond (communities, 3rd sector etc.). There were suggestions of making this modifiable factor part of a soap storyline and linking in with the wider media and social networking to widen the audience it engages.

	Recommendations	Proposed lead
1	Midwives and Health Visitors to undertake assessment of the sleeping environment	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
2	Using Starting Well national guidance provide simple, clear and consistent messages regarding safe sleeping to all staff.	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
3	Insight work to be undertaken to understand how messages are received but why they are not followed	Regional Local Safeguarding Boards in Greater Manchester, Cheshire & Merseyside, Lancashire & Cumbria)
4	Highlight powerful case studies which show the devastating impact of Sudden Infant Death Syndrome	Regional Local Safeguarding Boards in Greater Manchester, Cheshire & Merseyside, Lancashire & Cumbria)

	Recommendations for individual localities	Proposed lead
1	Ensure clear and consistent messaging for safe sleeping across all agencies within the locality and include wider services such as 3rd sector, social media, forums (e.g. mumsnet), housing, guest houses etc. using Starting Well National Guidance	Chair of LSCB Director Public Health

Smoking in pregnancy

Overall, smoking during pregnancy increases the risk of infant mortality by around 40%. It has been estimated that a 10% reduction in infant and foetal deaths could be achieved if all pregnant women stopped smoking. The case for targeting pregnant smokers is clear; smoking is the single most modifiable risk factor for adverse outcomes in pregnancy. The cost of smoking in pregnancy is borne not only by the woman herself but by her unborn child, her family and the broader health and social care systems which support her; with impacts in the short, medium and long term.

Tobacco smoke brings over 4,000 chemicals into the body, including 200 known poisons and 69 carcinogens. Every cigarette smoked during pregnancy introduces carbon monoxide into the maternal bloodstream and disrupts the foetal oxygen supply for around 15 seconds and in turn reduces the oxygen flow to the foetus for a period of around 15 minutes.

Smoking, and maternal exposure to tobacco smoke, during pregnancy increases the risk of:
ectopic pregnancy; miscarriage; placental abnormalities and premature rupture of the foetal membranes; still-birth; preterm delivery; low birth weight (under 2,500 grams); perinatal mortality; sudden infant death syndrome

More than a quarter of cases of sudden infant death syndrome (SIDS) are attributable to maternal smoking during pregnancy. The risk is tripled for the babies of mothers who smoke both during and after pregnancy and the greater the number of cigarettes smoked the greater the risk.

Research studies have confirmed the correlation between maternal smoking and lower birth weight. Babies born to women who smoke during their pregnancy are an average 175-200g lighter than those born to non-smoking mothers. This is significant given that low birth weight is the single most important risk factor in perinatal and infant mortality.

Antenatal exposure to maternal smoking risks not only to the viability of the pregnancy but to the immediate and future health and the physical and intellectual development of the child increasing risk of: congenital abnormalities i.e. cranial, eye and facial defects including cleft lip and palate; impaired lung function and cardio-vascular damage; acute respiratory conditions such as asthma; problems of the ear, nose and throat; attention deficit and hyperactivity disorder (ADHD); learning difficulties.

Babies born to mothers who smoke are further disadvantaged as those mothers are less likely to breastfeed than non-smoking mothers and those who do, produce a smaller amount of milk and breastfeed for a shorter time. There is a strong link between cigarette smoking and socio-economic group. In 2014, 30% of adults in routine and manual occupations smoked compared to 13% in managerial and professional occupations.

In the UK around 207,000 children start smoking every year. Very few children are smokers when they start secondary school: among 11 year olds less than 0.5% are regular smokers. The likelihood of smoking increases with age so that by 15 years of age 8% of pupils are regular smokers. Among children who try smoking it is estimated that between one third and one half are likely to become regular smokers within two to three years.

Smoking initiation is associated with a wide range of risk factors including: parental and sibling smoking, the ease of obtaining cigarettes, smoking by friends and peer group members, socioeconomic status, exposure to tobacco marketing, and depictions of smoking in films, television and other media.

Children who live with parents or siblings who smoke are up to 3 times more likely to become smokers themselves than children of non-smoking households. It is estimated that, each year, at least 23,000 young people in England and Wales start smoking by the age of 15 as a result of exposure to smoking in the home.

Questions included in the smoking in pregnancy workshop:

1. *Based on the evidence and data above how can we ensure every pregnant woman who smokes is identified as early as possible in pregnancy and offered effective support to quit and stay quit? Discuss current barriers and opportunities for local implementation of NICE Guidance PH26?*
2. *Are there opportunities to integrate interventions and programmes on smokefree pregnancy into other pregnancy focused interventions?*

KEY ISSUES RAISED IN DISCUSSION

- There are opportunities to decrease the prevalence of smoking amongst pregnant women using a number of programmes in localities across the North West that target pregnant women who smoke and their families, communicating the risks and providing cessation support. It was acknowledged that reducing smoking prevalence within the general population would impact on rates of pregnant smokers and the number of children exposed to secondhand smoke. Continued efforts to stem the flow of new smokers and to support smokers to quit will reduce smoking prevalence and make non-smoking a societal 'norm'.

- All health and social care professionals have a role to play in communicating the risks of smoking in pregnancy and secondhand smoke. Midwives and Health Visitors were identified best placed to engage and intervene at the right time (both with pregnant women and their partners). A number of Maternity Department's operate a mandatory CO monitor test at booking and at 20 week scan with robust referral pathways in place to offer immediate cessation support (with an 'opt out' system is in place). Evidence shows that cessation rates are higher when CO monitors are used consistently.

- Further work is required to engage with proportion of women that do not attend midwifery department appointments as it is this cohort who are most at risk. Data gathered by Salford's Family Nurse Partnership identified that the majority of women on the caseload were smoking. Schemes such as Smokefree Incentive Schemes and BabyClear were identified as effective models to reduce smoking in pregnancy in these groups.

- A consistent language/narrative is required to effectively communicate the risks associated with smoking during pregnancy / secondhand smoke. Strong lines of communication between Community Midwives and Health Visitors in St Helens has seen positive cessation results and high levels of both staff and patients satisfaction.

The following was referenced as 'good practice' examples:

- Evidence based Smokefree Pregnancy Incentive schemes – 4 week quit / 12 week quit (70% quit rate at delivery)
- Healthy Community Pharmacies provide cessation intervention upon purchase of pregnancy test kit.
- Smoking cessation intervention delivered at by sonographers at scan appointment (Blackpool)
- BabyClear programme

There are opportunities to target specific groups such as girls aged 13-15 years old; couples who are planning to start a family and partners of pregnant women/new fathers. Exposure to secondhand smoke is a risk factor, particularly in younger children, and so smokefree homes schemes were seen as an essential offer within localities. Further work is required to determine effective approaches to engage with those women who do not attend midwifery appointments

Recommendations		
1	Mandatory CO Monitor testing at booking and at 20 week midwifery appointments for all pregnant women/ partners and immediate referral	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
2	Consistent practice across the NW – All hospitals to adopt 'opt-out' referral system after identifying pregnant smokers using carbon monoxide monitors. There is evidence that this increases the numbers of pregnant smokers setting quit dates and reporting smoking cessation.	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
3	Share good practice across NW of engaging with women who do not attend midwifery appointments	Public Health England North West
4	All NW LAs to adopt BabyClear system-wide approach to identifying, referring and supporting pregnant women to stop smoking support, including awareness raising & engagement, training, performance management, monitoring and evaluation	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
5	Develop a template for a North West policy on smoking and secondhand smoke to reduce infant mortality that could be used locally	Public Health England North West
6	To explore opportunities to embed smoking into Ofsted framework to add traction within schools/academies (Blackburn currently exploring opportunities for public health within Ofsted)	Greater Manchester – Health and Social Care Partnership – Theme 1 Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
7	Task and finish group to review the various good practice around smoking in pregnancy and at time of delivery learning from the following • Commissioning and delivery of effective stop smoking service to pregnant women from the maternity service (Rochdale) • Smoking in pregnancy – range of initiatives – midwife	Public Health England North West

	delivered, baby clear pathway, incentive scheme etc. (St Helens) • BabyClear and development of a stop Smoking Incentive scheme aimed at pregnant women (Stockport) • Tommy's research project re. interventions for young pregnant women (Blackpool) • Specialist advisor re. smoking cessation for pregnant women – outreach for vulnerable groups and home visits (Blackpool) • Midwives trained to provide CO monitoring, brief intervention and referral (Bury) And make recommendations across the NW. (*This recommendation was taken from the Market Place*)	

	Recommendations for individual localities	Proposed lead
1	Smoking cessation targets for midwives and health visitors.	Chair of LSCB Director Public Health
2	Smoking cessation interventions at 20 week scan delivered by trained sonographers (Blackpool model)	
3	Healthy Community Pharmacies provide cessation intervention upon purchase of pregnancy test kit. Opportunities for Public Health interventions.	
4	Improve referral pathways to enable immediate cessation support	
5	Implement evidence based smoking and pregnancy incentive scheme – other 'softer' rewards such as certificates of achievement are extremely valuable / motivational tools.	

Deprivation

Importance of the first years of life

What a child experiences during the early years lays down a foundation for the whole of their life. Development begins before birth when the health of a baby is crucially affected by the health and well-being of their mother. Low birth weight in particular is associated with poorer long-term health and educational outcomes.

Socially graded inequalities are present prenatally and increase through early childhood. Maternal health and wellbeing and early years services are key to support vulnerable families with young children.

Based on this analysis, one quarter of all deaths under the age of one would potentially be avoided if all births had the same level of risk as those to women with the lowest level of deprivation.

Progress to date

In the last 10 years public health approaches to reducing infant mortality has improved outcomes but inequality remain stubborn in some of our most socially disadvantaged communities.

Tackling inequalities in health and outcomes needs a whole system approach and a concerted focus on the early years.

In the environment of reducing resources a range of services aimed at the most vulnerable mothers and children have been negatively impacted by cuts to children's centres, outreach work, community support programmes and peer support. As the public sector reduces there is a risk that outcomes worsen.

Questions included in the deprivation workshop:

How does your service 'offer' differ for those mothers (and families) who are pregnant and come from a more deprived area?
How do we identify good practice or emerging innovation in early years?
How can we roll it out at pace and evaluate it in real time?

KEY ISSUES RAISED IN DISCUSSION

- Patients who develop a therapeutic relationship with their GP will often share a wealth of information (both clinical and non-clinical) that can be harnessed to support those who are in the greatest need. Further work is needed to identify deprived individuals / families and the GP Practices that serve them. Work is ongoing within GM to develop a scaled approach to finding and treating the most deprived people across the conurbation. This 'find and treat' work includes the development of a visualisation tool that identifies GP practices located in the most deprived areas/or GP Practices with the most deprived populations.

- Marmot (2010) highlighted the importance of patient empowerment through expert patient programmes for example, strengthening pathways to work; and co-designing services with communities. There are many examples of co-production across the North West, however it was acknowledged during the discussions that a cultural shift was needed in order to nurture 'social movements' within our communities to enable people to make their own informed life-style choices and create new platforms for full engagement.

- Breastfeeding support programmes and smokefree pregnancy incentive schemes were referenced during discussions as effective programmes that support behaviour change. The benefits of integrated, multi-disciplinary teams were discussed, and how a shared intelligence between health and social care professionals (including soft intelligence) would enable services to provide an intense and focused support package for those with the greatest need.

- In Greater Manchester, the devolution of health and social care provides an opportunity to develop a new approach to addressing the needs of differing communities, be that through longer appointment times, different care support, a scaled up offer around social prescribing and/or pathways into work. A balance of evidence based practice and innovation should be encouraged in order to drive change.

- Enabling the accessibility of current data and intelligence for vulnerable individuals and their families was deemed important. However, there is the risk that services will be unable to cope with increased referrals (particularly vulnerable families).

- Services should be continuously evaluated and assessed to determine if outcomes are being achieved and to inform re-commissioning though it was acknowledged that this presented a financial challenge to localities.

- There is opportunity to utilise Ofsted scrutiny to identify need and / or solutions to drive pupil premium investment. Collaboration across local authorities, housing, health and social care is essential in order to deliver better health and wellbeing outcomes and to reduce health inequalities in the North West. There are examples of successful collaborations between the housing sector and the health and social care sector that improve health and wellbeing across the housing tenure.

	Recommendations	Proposed lead
1	Share models of supporting families from deprived communities (learning from enhanced midwifery service in Tameside and integrated health service team in Wigan which support top 2% most deprived)	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
2	Engage with a range of partners, third sector and statutory, to explore opportunities such as the development of the Fire and Rescue Service home check model to support families, housing and health programmes and economic initiatives	Greater Manchester – Health and Social Care Partnership – Theme 1 Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
3	Share the learning from the 'Find and treat' work in GM	Greater Manchester – Health and Social Care Partnership – Theme 1 Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria

	Recommendations for individual localities	Proposed lead
1	Services provide an additional 'offer' to families who are most deprived e.g. free vitamins for pregnant mothers, smoking incentive schemes, pathways to employment/education	Chair of LSCB Director Public Health

Next steps

This report represents a significant amount of work undertaken over the past 12 months enabled with the support and contribution of a wide range of individuals with a passion for improving outcomes for children. The report brings together an important set of recommendations for improvement action across the North West and in individual localities. Delivery of this improvement will be reliant on the content of the report being firmly embedded within local improvement plans and delivery models.

To this end, the report will be:

- Circulated and presented to all Local Safeguarding Children and Adult Boards and Health and Wellbeing Boards across the North West with a recommendation that local plans are developed to enable implementation of the report recommendations.
- Presented to the Greater Manchester Health and Social Care Partnership and GM Children's Safeguarding Board to align regional recommendations with strategic initiatives and priorities
- Presented to CHAMPS and Lancashire & Cumbria to align recommendations with network and local strategic plans.
- Circulate the SLI evaluation report to the Association of Directors of Public Health with the proposal that a 12 month follow up evaluation takes place.

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Thank you to the Infant Mortality Sector Led Improvement Group:

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Liz McQue Chief Executive, NW Employers

Localities who took part in the Review

Greater Manchester

- Bolton
- Bury
- Manchester
- Oldham
- Rochdale
- Salford
- Stockport
- Tameside
- Trafford
- Wigan

Cheshire and Merseyside

- Sefton
- Liverpool
- Knowsley
- Cheshire East
- St Helens
- Cheshire West and Chester
- Halton
- Warrington
- Wirral

Lancashire and Cumbria

- Lancashire
- Blackburn with Darwen
- Blackpool

Appendix A – List of Recommendations

Regional

	Recommendations	Proposed lead
1	Task and finish group to look at campaigns which could be developed on a NW footprint such as: • Foetal Alcohol Syndrome (see Halton's social marketing campaign) • Safe sleeping campaigns (good examples in Bolton, Blackpool, St Helens, Sefton and Wirral)	Public Health England North West North West Localities
2	Establish a method of sharing good practice (including evidence of impact, improvement in outcomes and Cost Benefit Analysis) across the North West on an on-going basis.	Public Health England North West
3	Bi-annual workshop for all NW CDOP members to review the criteria for modifiable factors to agree a common data set and improve consistency	North West Child Death Overview Panel Group
4	Detailed annual reports in response to the NW and local CDOP report to go to LSCB and Health and Wellbeing Boards to ensure a local response and assurance with a clear plan to respond to actions and recommendations	Child Death Overview Panels
5	CDOPs to: • Establish a mechanism of feeding directly back to individual frontline staff regarding modifiable factors identified in infant mortality cases they have worked with. • Establish a process to share learning from CDOPs to all frontline staff (explore doing this jointly with shared learning from Serious Case Reviews) • Work with LSCB training group to ensure learning is embedded into safeguarding training	Child Death Overview Panels
6	Communication and engagement strategy to cascade key learning across NW CDOPs and back to front line practitioners.	Child Death Overview Panels
7	Support and training is required for professionals to understand respective roles in reducing infant mortality	Regional Local Safeguarding Boards in Greater Manchester, Cheshire & Merseyside, Lancashire & Cumbria)
8	Develop an approach to record all family members in the antenatal period using a structured approach such as genogram, Blackburn ACE model	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
9	Parenting support and prevention to include fathers/partners/carers and grandparents	Greater Manchester – Health and Social Care Partnership – Early Years

	Recommendations	Proposed lead
		Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
10	Develop a NW campaign to raise awareness of neglect and domestic abuse and its impact on infant mortality for staff and the public	Regional Local Safeguarding Boards in Greater Manchester, Cheshire & Merseyside, Lancashire & Cumbria)
11	Risk and information sharing to be picked up in GM with IM&T enabler and GM Connect	Greater Manchester – Health and Social Care Partnership – GM Connect
12	Task and finish group to examine the multi-agency drug/alcohol/mental health/domestic abuse screening tool developed by Cheshire East to see if this would be useful to implement across the regions. (*This recommendation was taken from the Market Place*)	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
13	Bi-annual North West event to share good practice such as engaging leaders within communities and places of worship	Public Health England North West
14	Task and finish group (include public representation) to identify workforce development needs for integrated services to improve cultural awareness and understanding of the issues of consanguinity and its impact on congenital abnormalities	Public Health England North West
15	Use the intelligence gained from new born screening data (held by GPs) to develop a model to engage adolescents and reinforce the risk associated with congenital abnormalities.	Public Health England North West
16	Explore whether screening programmes are cost effective and share findings across the NW	Public Health England North West
17	Midwives and Health Visitors to undertake assessment of the sleeping environment	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
18	Using Starting Well national guidance provide simple, clear and consistent messages regarding safe sleeping to all staff.	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
19	Insight work to be undertaken to understand how messages are received but why they are not followed	Regional Local Safeguarding Boards in Greater Manchester, Cheshire & Merseyside, Lancashire & Cumbria)

	Recommendations	Proposed lead
20	Highlight powerful case studies which show the devastating impact of Sudden Infant Death Syndrome	Regional Local Safeguarding Boards in Greater Manchester, Cheshire & Merseyside, Lancashire & Cumbria)
21	Mandatory CO Monitor testing at booking and at 20 week midwifery appointments for all pregnant women/ partners and immediate referral	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
22	Consistent practice across the NW – All hospitals to adopt 'opt-out' referral system after identifying pregnant smokers using carbon monoxide monitors. There is evidence that this increases the numbers of pregnant smokers setting quit dates and reporting smoking cessation.	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
23	Share good practice across NW of engaging with women who do not attend midwifery appointments	Public Health England North West
24	All NW LAs to adopt BabyClear system-wide approach to identifying, referring and supporting pregnant women to stop smoking support, including awareness raising & engagement, training, performance management, monitoring and evaluation	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
25	Develop a template for a North West policy on smoking and secondhand smoke to reduce infant mortality that could be used locally	Public Health England North West
26	To explore opportunities to embed smoking into Ofsted framework to add traction within schools/academies (Blackburn currently exploring opportunities for public health within Ofsted)	Greater Manchester – Health and Social Care Partnership – Theme 1 Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
27	Task and finish group to review the various good practice around smoking in pregnancy and at time of delivery learning from the following • Commissioning and delivery of effective stop smoking service to pregnant women from the maternity service (Rochdale) • Smoking in pregnancy – range of initiatives – midwife delivered, baby clear pathway, incentive scheme etc. (St Helens) • BabyClear and development of a stop Smoking Incentive scheme aimed at pregnant women	Public Health England North West

	Recommendations	Proposed lead
	(Stockport) • Tommy's research project re. interventions for young pregnant women (Blackpool) • Specialist advisor re. smoking cessation for pregnant women – outreach for vulnerable groups and home visits (Blackpool) • Midwives trained to provide CO monitoring, brief intervention and referral (Bury) And make recommendations across the NW. (*This recommendation was taken from the Market Place*)	
28	Share models of supporting families from deprived communities (learning from enhanced midwifery service in Tameside and integrated health service team in Wigan which support top 2% most deprived)	Greater Manchester – Health and Social Care Partnership – Early Years Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
29	Engage with a range of partners, third sector and statutory, to explore opportunities such as the development of the Fire and Rescue Service home check model to support families, housing and health programmes and economic initiatives	Greater Manchester – Health and Social Care Partnership – Theme 1 Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria
30	Share the learning from the 'Find and treat' work in GM	Greater Manchester – Health and Social Care Partnership – Theme 1 Regional Local Safeguarding Boards in Cheshire & Merseyside, Lancashire & Cumbria

Local

	Recommendations for individual localities	Proposed lead
1	Clearly define governance of CDOP report within individual localities	Chair of LSCB Director Public Health
2	Clarify how findings from CDOP cases within the locality are shared for action.	
3	Identify a named lead for reducing infant mortality within the locality	Chair of LSCB Director Public Health
4	Identify a lead elected member for reducing infant mortality	
5	Modifiable factors associated with infant mortality are firmly embedded in integration programmes	
6	Consider opportunities to influence behaviour change and social norms for modifiable factors associated with infant mortality (such as social movement).	
7	All services commissioned are evaluated to ensure they make positive changes to modifiable factors	
8	Data sharing and information governance within localities facilitates safeguarding for all agencies	Chair of LSCB Director Public Health
9	Effective partnership working including information sharing to support safeguarding.	
10	All staff working with children and families have the capacity and capability to work effectively to ensure safeguarding and understand the implications in relation to infant mortality	
11	Review working practices for professional staff working in deprived areas and ensure rotation to more affluent areas to prevent social norms becoming distorted	
12	Reliable information system to enable access to high quality intelligence to identify 'at risk' population groups	Chair of LSCB Director Public Health
13	Preconception care in place which targets 'at risk' groups of congenital abnormality	
14	Outreach worker in each locality where there is a high rate of congenital abnormality	
15	Engage with community leaders and families in high risk groups to communicate messages about consanguinity and the advantages of genetic screening	
16	Ensure clear and consistent messaging for safe sleeping across all agencies within the locality and include wider services such as 3rd sector, social media, forums (e.g. mumsnet), housing, guest houses etc. using Starting Well National Guidance	Chair of LSCB Director Public Health
17	Smoking cessation targets for midwives and health visitors.	Chair of LSCB Director Public Health
18	Smoking cessation interventions at 20 week scan delivered by trained sonographers (Blackpool model)	
19	Healthy Community Pharmacies provide cessation intervention upon purchase of pregnancy test kit. Opportunities for Public Health interventions.	

	Recommendations for individual localities	Proposed lead
20	Improve referral pathways to enable immediate cessation support	
21	Implement evidence based smoking and pregnancy incentive scheme – other 'softer' rewards such as certificates of achievement are extremely valuable / motivational tools.	
22	Services provide an additional 'offer' to families who are most deprived e.g. free vitamins for pregnant mothers, smoking incentive schemes, pathways to employment/education	Chair of LSCB Director Public Health

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Report to:	**HEALTH AND WELLBEING BOARD**
Date:	10 November 2016
Executive Member / Reporting Officer:	Councillor Peter Robinson, Executive Member (Children and Families) David Niven, Chair, Tameside Safeguarding Children Board
Subject:	**TAMESIDE SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2015/6**
Report Summary:	The Tameside Safeguarding Children Board (TSCB) Annual Report provides an overview of the Board's safeguarding activity against its 2015/6 priorities. It identifies particular vulnerable groups and outlines any emerging themes. The report provides details of the strategic priorities and actions for 2016/17.
Recommendations:	To ensure the priorities and agendas of the Tameside Safeguarding Children Board, Health and Wellbeing Board and Adult Safeguarding Partnership Board are joined up via a shared safeguarding strategy.
Links to Health and Wellbeing Strategy:	The Tameside Safeguarding Children Board Strategic Priorities for 2015-18 are Domestic Abuse, Child Sexual Exploitation, Early Help, Neglect and Self-Harm. There is lots of scope for joint work between the Tameside Safeguarding Children Board and that of the Health and Well Being Board for example in relation to work on the Sexual Health Strategy, Mental Health Services provision and in relation to addressing child poverty. It has been agreed at the Joint Board Development Session in April that an overarching safeguarding strategy should be developed.
Policy Implications:	In line with Council policy.
Financial Implications: **(Authorised by the Section 151 Officer)**	The current annual Council contribution to the TSCB is £0.124 million. In addition partner agencies also provide financial contributions, the details of which are provided in Annex B of the report. It should be noted that any residual unspent balance at the end of each financial year is retained within the Council's accounts and carried forward to subsequent financial years via a reserve. Any expenditure in excess of budget at the end of the financial year is financed from the reserve balance.
Legal Implications: **(Authorised by the Borough Solicitor)**	Safeguarding Children requires strong leadership, shared intelligence and appropriate joint commissioning arrangements to be effective. Safeguarding means: "Protecting children from maltreatment, preventing impairment of children's health or development, ensuring that children are growing up in circumstances consistent with the provision of safe and effective care, and undertaking that role so as to enable those children to have

optimum life chances and to enter adulthood successfully." (Working Together to Safeguard Children, 2010).

The 'Working Together to Safeguard Children' guidance from 2010 sets out how organisations and individuals should work together to safeguard and promote the welfare of children. The 2011 Munro review of child protection made 15 recommendations for reforming the child protection system, focusing on a system that values professional expertise, clarifying accountabilities and improving learning, sharing responsibility for the provision of early help, developing social work expertise, and supporting effective social work practice. The need for interagency cooperation to improve safeguarding arrangements, early intervention, and improved support is well documented. The ambition is for children in Tameside to be safer through protection from maltreatment, prevention of impairment to health and/or development, ensuring safe and effective care, and ensuring a safe environment.

The Tameside Safeguarding Children's Board needs to demonstrate that it is holding the whole system to account to deliver collectively.

Risk Management : The Tameside Safeguarding Children's Board is required to produce an Annual Report and would be in breach of the legislative requirement if it failed to do so.

Access to Information : The background papers relating to this report can be inspected by contacting Stewart Tod, Business Manager by;

Telephone:0161 342 4344

e-mail: stewart.tod@tameside.gov.uk

Tameside Safeguarding Children Board

Report To: TSCB Strategic Board
Date presented: 26th September 2016
Reporting Officer: TSCB Business Manager, Stewart Tod
Subject: TSCB Annual Report 2015/1
Report Summary:

In accordance with Working Together (2015):

The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area.

The Annual Report provides information covering the activities and effectiveness of the Board for the financial year 2015/16. It details the Board's resources both staffing and financial, structure, membership, and activities in line with its core responsibilities and strategic priorities. The headlines are as follows;

1. TSCB Team has been fully staffed since October 2015
2. The Board has a healthy financial reserve of £127,987 but needs to identify further cost efficiencies
3. The Threshold Guidance, Child in Need Policy and Children's Needs Framework have been revised
4. The Board Training and Development and Communication sub-groups have been re-structured to make them more effective
5. S.11 Audits have been returned by all statutory partners and action plans continue to be monitored
6. The Barnardo's CSE 'Real Love Rocks' and 'Love or Lies' resource is available to all schools and other youth settings
7. A Safeguarding Youth Forum was established and contributed toward changes to the TSCB website, publicity materials and safer social media messages
8. Training on FGM and Prevent has been provided to increase awareness of statutory responsibilities
9. The Board made challenges in respect of the Public Service Hub Safeguarding arrangements, CAF data and resources and continues to monitor these
10. Serious Case Review Action Plans for Child M & N were signed off and two further reviews for Child Q and R were completed

N.B. Sub-Group Annual Reports detailing their specific activities are available upon request and are reported to TSCB Business Group

Please state how the wishes and feelings of children and young people been listened and responded to:

The implementation of learning from case reviews and quality assurance and performance management activity will strengthen multi-agency child protection arrangements and activity for children in Tameside.

TSCB Training raises awareness of child protection responsibilities, promotes multi-agency working and helps to share good practice.

Please state how the wishes and feelings of children and young people been listened and responded to:

The Safeguarding Youth Forum have directly influenced some of the Board's work especially in regards to raising awareness of social media.

The Annual Report highlights the need for additional training in relation to 'Self-Harm and Suicide' and 'Respectful Challenge' as a direct response to the learning from Serious Case Reviews.

Recommendations & Requirements

Recommendation	Policy/Financial & Legal Implications	Requirements from the TSCB	Implications if accepted/rejected or deferred by TSCB
1. To agree and sign off the TSCB Annual Report 2015/16 as an accurate reflection of the Board's activities, achievements and challenges for the year	No additional implications	To continue to deliver against the Board's core responsibilities and strategic priorities	LSCBs are required to publish an Annual Report each financial year detailing its safeguarding activities and effectiveness

TSCB Decisions and Actions

For TSCB Business Group and Strategic Board Use Only: Decision to accept/reject or defer

	Decision A/R/D	Conditions/Alterations	Actions agreed by TSCB	SMART check Y/N
Report & all recommendations				
Or Recommendations				
1.				
2.				
3.				

Tameside Safeguarding Children Board

TAMESIDE SAFEGUARDING CHILDREN BOARD (TSCB) ANNUAL REPORT 2015/16

TAMESIDE SAFEGUARDING CHILDREN BOARD (TSCB) ANNUAL REPORT 2015/16

FOREWORD

David Niven- Chair of Tameside Safeguarding Children Board

Over the last twelve months Tameside has experienced challenges at national, regional and local levels. To the great credit of the many people in the agencies, organisations and individuals that make up the Local Safeguarding Children Board, the work to keep our children safe has been constant and effective. The national challenge includes having to maintain quality services while implementing the requirements of the Government's austerity measures and exploring the implications of the Wood Review of Local Safeguarding Children Boards. Both these continue to be addressed. The austerity agenda looks to be maintained and the Wood recommendations are under discussion as to what would be best for the children of Tameside as there have been no legislative changes as yet. Regionally there has been considerable work to prepare for the devolution of Greater Manchester and the ten local authorities and their partners in all services have done a great deal in what has been a complex and difficult exercise. How Safeguarding will look in 2017 is still being worked on but Tameside is determined to maintain a local voice and make the best arrangements to ensure that the protection of our children remains a high priority. Working with colleagues in all disciplines remains as important as ever and a recent joint development day with the Adult Safeguarding Board illustrated how crucial cooperation on the overlap areas, such as mental health, domestic abuse and substance abuse, was. If the work of the Health and Wellbeing Board and its responsibilities are also effectively linked then we can work on efficiencies of scale and avoidance of duplication. The continuing contribution of colleagues in Social Care, Health, Education and Law Enforcement, Probation, the Voluntary sector and lay members is vital and the way all can work together has been a hugely encouraging part of the work of the Safeguarding Board. The sub-groups of the Board provide a significant contribution to the overall protection of Tameside's children. Their work covers everything from assessment of new cases where children have been injured or died in circumstances that may have learning implications for any of the agencies, monitoring and supporting work to combat child sexual abuse, overseeing the comprehensive training role of the Board, collection and analysis of data to provide vital information on the safeguarding work of all agencies, maintaining the drive to reduce the high instance of domestic abuse that impact children's lives. So many agencies and individuals contribute to the protection of Tameside's children on or through the Safeguarding Board, often with little or no recognition or thanks, so I would like to pay tribute to them and their effort. All of this is supported by a small, dedicated staff team whose hard work and dedication is crucial to the effective and efficient running of all our activities.

At this stage we are not entirely sure how the work of the Board will be delivered following devolution in 2017 but I am reassured by the commitment of those in Tameside and beyond that the safety of our children is of the highest priority and that any new or wider arrangements will not reduce that in any way. What I can say is that the year ahead will present, as always, considerable challenges but we will always look to improve performance, communication, training and oversight while fulfilling the statutory requirement to hold agencies to account.

The Board is always to improve the support from the public and I believe that making better effort to communicate our work through media outlets and community initiatives will help clarify what we do and reassure the people of Tameside that the safety of children is an essential and necessary duty.

Should you require any further information regarding the work of the Board please do not hesitate to contact us.

CONTENTS

EXECUTIVE SUMMARY

During 2015/16 Tameside Safeguarding Children Board made a strong commitment to the ongoing improvement of its safeguarding practice by investing in a Quality Assurance Officer, Training Assistant and additional part time Board Administrator. Recruitment to those posts meant that the Board benefitted from a fully resourced team from October 2015 that enabled all functions of the Board to be fully supported and developed further. A number of changes were made to the TSCB Structure to ensure that it could deliver its statutory roles and responsibilities in the most effective way possible. The Board established a Safeguarding Youth Forum to ensure that the views of children in relation to safeguarding are listened and responded to. It combined the existing Training and Development Sub-Group and Communications Sub-Group into a new Learning and Improvement Activity Group so that practitioners could be directly involved in the development and dissemination of learning from case review and audit activity. These structural changes are captured in the Learning and Improvement Framework 2015/16.

2 Serious Case Reviews and one Multi-Agency Critical Review were initiated in 2015/16. One of the Serious Case Reviews will continue into 2016/17. In addition the recommendations and actions from 2 Serious Case Reviews published in the previous year still had to be completed and signed off and as a result the Serious and Significant Case Panel has successfully managed an extremely busy workload during the last 12 months and overseen the implementation of new or improved safeguarding practices, policies, procedures and systems. The Quality Assurance and Performance (QAPM) sub group will continue to monitor the key themes/learning of each review as part of its QA activity in line with the Board's Learning Improvement Framework.

The Board has responded quickly and effectively to new statutory guidance in relation to Female Genital Mutilation and Preventing Radicalisation by delivering a comprehensive package of training. The delivery of the TSCB Training Programme is now supported by an online booking system and the introduction of a charging policy is helping to improve attendance. Further work is required in 2016/17 to recruit additional members to the training pool so that the successful delivery of the training programme continues in the future.

The Board has listened and responded to the views of children and young people by securing joint funding for the Barnardo's 'Real Love Rocks' and 'Love or Lies' resource and rolling it out to all schools across Tameside. The TSCB website has been improved based on feedback from its Safeguarding Youth Forum and TSCB publicity materials and other communication methods have also been developed, most notably the 7 minute briefings which have enabled learning from case reviews to be widely disseminated and discussed.

A robust verification process of partner agencies S.11 Audits has been completed to ensure compliance with safeguarding standards. The development of the quality assurance functions and framework has enabled the Board to scrutinise and challenge safeguarding practice based on a strong evidence base. The Board plans to oversee or monitor the implementation of the required improvements in 2016/17 and will demonstrate how this has led to improved outcomes for children and young people in Tameside.

WHAT IS TAMESIDE SAFEGUARDING CHILDREN BOARD?

Tameside Safeguarding Children Board is made up of statutory partner agencies including the Local Authority, Health, Police, Education, Probation and the Voluntary and Community Sector. They all have a legal responsibility to safeguard children through their day to day work. We want to make sure that children and young people that are in Tameside are protected from abuse, neglect and feel safe and cared for.

LEGAL FRAMEWORK

Tameside Safeguarding Children Board and all other Local Safeguarding Children Boards are established in accordance with The Children Act 2004 (Section 13).

Tameside Safeguarding Children Board reflects the core functions of The Local Safeguarding Children Boards Regulations 2006 and is governed by Working Together to Safeguard Children 2015 which sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people.

ROLES AND RESPONSIBLITIES

The role of LSCBs are to coordinate, monitor and support what is done by each person or body represented on the LSCB for the purposes of safeguarding and promoting the welfare of children in the area of the authority. TSCB should ensure the effectiveness of what is done by each such person or body for that purpose.

LSCB responsibilities as set out in chapter three of Working Together to Safeguard Children (2015) include:

1. developing policies and procedures for safeguarding and promoting the welfare of children
2. communicating the need to safeguard and promote the welfare of children, raising awareness of good practice and encouraging staff and services to carry out their safeguarding responsibilities to the best of their ability
3. monitoring and evaluating the effectiveness of what is done by Board partners individually and collectively to safeguard children
4. participating in the planning of services for children in the area
5. conducting reviews of serious cases and advising Board partners on the lessons to be learned

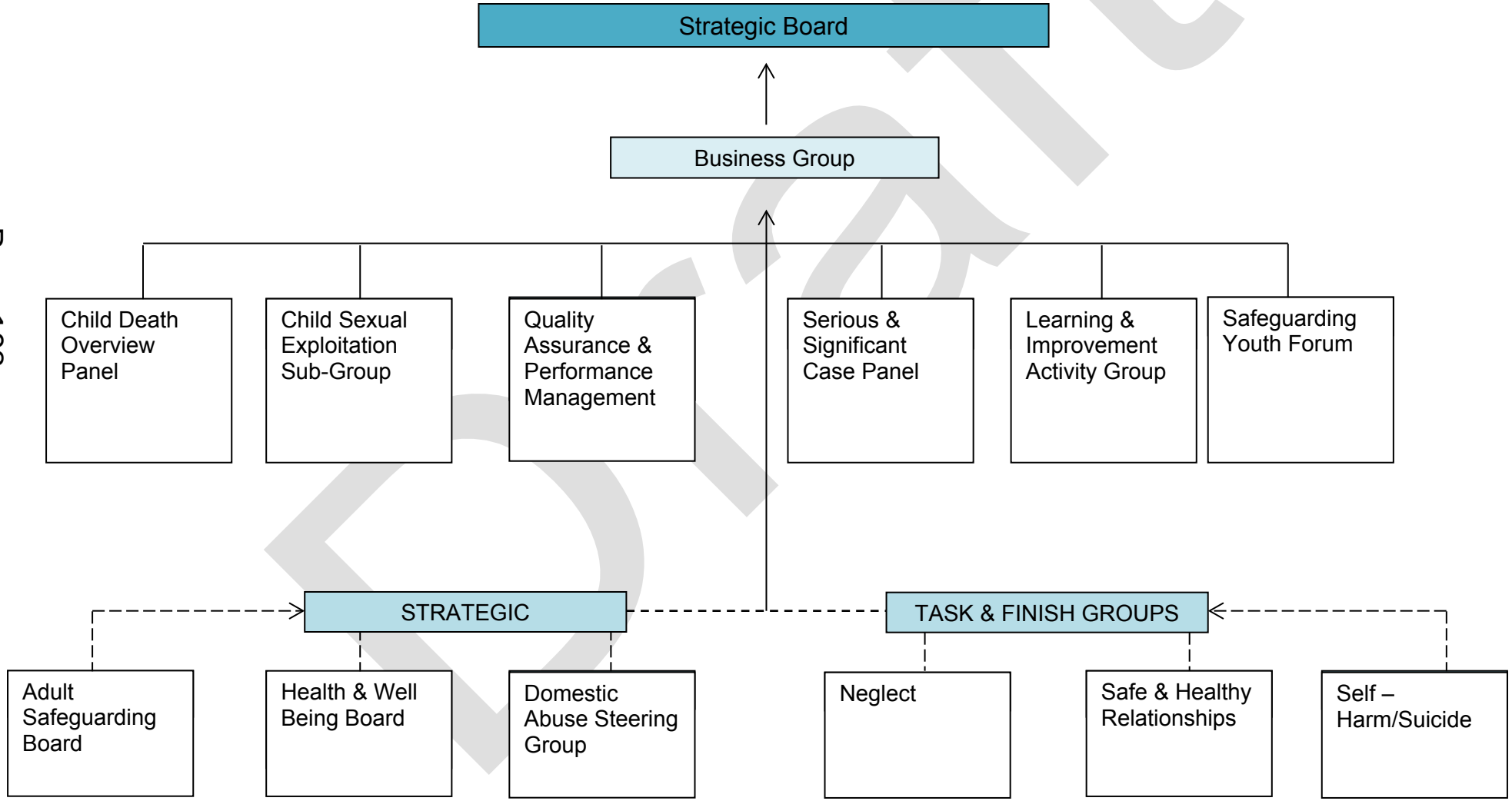
The guidance also sets out the requirements for this Annual Report stating that it should;

1. Assess the effectiveness of child safeguarding and the promotion of the welfare of children in Tameside
2. Provide a rigorous and transparent assessment of the performance and effectiveness of local safeguarding arrangements.
3. Identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action.
4. Include lessons from reviews undertaken within the reporting period.
5. List the financial contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training.

The report is a public document published on the TSCB website for members of the public to find out what the LSCB has achieved during 2015-2016. It is submitted to the Chief Executive of the Local Authority, Leader of the Council, the Local Police and Crime Commissioner and the Chair of the Children's Trust, Health and Wellbeing Board, Community Safety Partnership and Adult Safeguarding Board.

STRUCTURE OF THE TAMESIDE SAFEGUARDING CHILDREN BOARD

Tameside Safeguarding Children Board will be organised around the following infra-structure:



TSCB Structure and Support

In order to achieve its roles and responsibilities the Board has a four tiered structure.

1. The Strategic Board – meets every quarter and sets the strategic direction for the Board, agrees priorities and monitors effectiveness of both single agency and the collective arrangements.

2. The Business Group – meets every six weeks and is the operational arm of the Board. It discusses emerging safeguarding themes in Tameside and agrees how work in these areas will be progressed. The group monitors and reviews the implementation of the Business Plan via progress/annual reports from TSCB Sub Groups, TSCB Task and Finish Group and Strategic Partnerships. Annual Reports are subsequently reported to the Strategic Board.

3. Sub Groups – carry out the ongoing core functions of the Board as well as time limited actions or projects linked to the agreed strategic priorities or emerging safeguarding themes. Sub-Groups cover the areas of, Quality Assurance and Performance Management, Serious and Significant Case Reviews, Child Sexual Exploitation, Youth Participation (Safeguarding Youth Forum), Communications (Learning and Improvement Activity Group) and Child Deaths (Child Death Overview Panel). Sub groups Chairs brief the Business Group every 6 weeks and report formally via a progress report twice a year. One of these progress reports is a full annual report that is submitted to the Business Group prior to it being presented to the Strategic Board.

4. TSCB Staff – Individual staff members carry out additional responsibilities in relation to training and development, policies and procedures, quality assurance and communication. They are informed of any new learning and improvement requirements through the existing sub-groups, with any recommendations agreed in advance by the Business Group. (Refer to Learning and Improvement Framework for further details). They also consult and report back into those same structures in order to agree any new areas of work that they will lead on or support.

Improved involvement and structural support

During 2015/16 a number of changes were made to the TSCB Structure to ensure that it could deliver its statutory roles and responsibilities in the most effective way possible. 3 significant alterations were made including to;

1. Establish a Safeguarding Youth Forum to ensure that the views of children in relation to safeguarding are listened and responded to.
2. Combine the existing Training and Development Sub-Group and Communications Sub-Group into a new Learning and Improvement Activity Group so that practitioners are involved in the development and dissemination of learning from case review and audit activity.
3. Allow the flexibility to establish time bound task and finish groups to undertake specific tasks linked to emerging safeguarding concerns and priorities.

These structural changes are captured in the Learning and Improvement Framework 2015/16. That Framework outlines how the various components of the Board work together under clear governance arrangements to continually scrutinise, challenge and improve the safeguarding practice of partner agencies.

TSCB Team

The Board has a staff team comprising of a Business Manager, Quality Assurance Officer, Training Organiser, Training Assistant and Board Administrator. In the first half of 2015/16 a full time Quality Assurance Officer, Training Assistant and a part time Administrator, were recruited so that the Board had a fully staffed team. In addition the Board has an Independent Chair for 3 days a month.

Key Roles

The Board is comprised of statutory partner agencies, identified in Working Together (2015), and by key appointments and professionals. They include;

- **Independent Chair –** The Board is led by an Independent Chair who can hold all agencies to account. It is the responsibility of the Chief Executive (Head of Paid Service) of Tameside Metropolitan Borough Council to appoint or remove the Chair with the agreement of a panel including Board partners and lay members. The Chief Executive, drawing on other Local Safeguarding Children Board partners and, where appropriate, the Lead Member will hold the Chair to account for the effective working of the Board.

- **Partner Agencies –** All partner agencies in Tameside are committed to ensuring the effective operation of Tameside Safeguarding Children Board. Members of the Board, where they hold a strategic role within an organisation are able to speak for their organisation with authority, commit their organisation on policy and practice matters and hold their organisation to account.

- **Local Authority –** Tameside Council is responsible for establishing a Local Safeguarding Children Board in their area and ensuring that it is run effectively. The Director of Children's Service is held to account for the effective working of the Board by the Chief Executive of Tameside Council and challenged where appropriate by the Lead Member. The Lead Member is a 'participating observer' of the Local Safeguarding Children Board and regularly attends Board meetings.

- **Designated Professionals –** The Local Safeguarding Children Board includes on its Board, appropriate expertise and advice from, frontline professionals from all the relevant sectors. This includes a designated doctor and nurse, the Director of Public Health, Principal Child and Family Social Worker, Legal Advisor and the voluntary and community sector.

- **Local Authority Designated Officer –** The role of the Local Authority Designated Officer is to oversee investigations into allegations of child abuse by professionals who work with children and young people and to investigate behaviour which may place children at risk. The aim of the role is to promote an effective, consistent and proportionate response by employers, police and child protection agencies. The role is financed by Tameside Safeguarding Children Board.

- **Lay Member –** The role of the lay member is to help to make links between the Local Safeguarding Children Board and community groups, support stronger public engagement in local child safety issues and an improved public understanding of the LSCB's child protection work. A Lay Member was recruited to the Board in May 2015 and attends the TSCB Business Group.

All Board members are required to sign a membership agreement which sets out their roles and responsibilities in accordance with Working Together to Safeguard Children, 2015. A full list of Board members and advisors is available at Appendix A for information. The Board's Induction Programme is regularly updated to reflect the latest national legislation and guidance and local priorities and progress. Induction sessions for new Board Members have been offered approximately once every quarter. One to one inductions will be offered from early 2016 so that new members can be offered an induction at the earliest opportunity.

FINANCIAL MANAGEMENT

Tameside Safeguarding Children Board has always been well supported by monetary contributions from both statutory and non-statutory partners and for the last 5 years the Board has been in a position to carry a reserve into the new financial year. This reserve has been maintained in order to finance unexpected commitments including the costs of Serious Case Reviews. At the end of 2015/16, Tameside Safeguarding Children Board carried forward £127,987. A reduction in income from Education in 2015/16, which will continue into this coming year, means that TSCB will have to review its expenditure and make some savings in order to break even in 2016/17.

DELIVERY AGAINST THE TSCB BUSINESS PLAN 2015/16

The TSCB Business Plan 2015/16 details how the Board and its team would deliver against its statutory responsibilities and the agreed strategic responsibilities.

STATUTORY RESPONSIBILITIES

The 4 tiered structure of the TSCB ensures that the statutory responsibilities are delivered and that clear and robust reporting and governance arrangements are in place. This section identifies how the TSCB Sub-Groups and TSCB staff deliver against each of the statutory responsibilities.

Policies and Procedures

Tameside's 'Threshold for Assessment and Continuum of Need' was updated in October 2015 to reflect changes to the Public Service Hub. To help ensure the levels of intervention are understood and applied by all partner agencies a new Threshold's Guidance page was created on the TSCB website and promoted via a range of communication channels including in TSCB training and the TSCB e-bulletin.

The Children's Needs Framework has been updated to reinforce the requirement placed upon all partner agencies to provide an early assessment of need and coordinated holistic response. The Children's Needs Framework will be launched in June 2016 together with a revised 'Common Assessment Framework' (CAF) training offer that will promote the Family CAF as the primary assessment and planning process for all early help services. In response to learning from local case reviews, including Serious Case Reviews, the Framework also provides guidance on multi-agency consultation and links to a range of other risk assessments for practitioners to use and to the Service Information Directory. It highlights the principles and good practice that practitioners should work towards including for example, respectful challenge, professionals meetings, and escalation.

The local Child in Need Procedure has been updated in response to learning from 2 Serious Case Reviews. The procedure reinforces the expectation that in all cases Health (School Nurse or Health Visitor) and Education (School or Nursery) will attend Child in Need meetings and will therefore automatically receive a copy of the Child in Need plan. A Health representative will liaise with the G.P. to share and gather relevant information.

Tameside continues to contribute towards the Greater Manchester Safeguarding Procedures. The TSCB Business Manager regularly attends the Tri-X meetings to review and update those procedures and liaises locally with partner agencies on any proposed changes. The GM Safeguarding Procedures are promoted in all training and learning events and in the TSCB e-bulletin where practitioners are also encouraged to sign up for email alerts to inform them of any changes to procedures.

Communication and Raising Awareness of Safeguarding Issues

The TSCB Training Organiser and Training Assistant coordinate the delivery of a comprehensive TSCB Training Programme. An online booking system established in September 2015 has enabled bookings and attendance to be more accurately recorded. It is estimated that approximately 1400 participants from 20 agencies attended training during 2015/16. A charging policy introduced in November 2015 is expected to reduce non-attendance at training in 2016/17.

Efforts to recruit new members to the Training Pool will be a priority in 2016/17 as the Training Organiser, who has actively delivered many training courses, retires in June 2016. A new Training Organiser will be recruited to continue the delivery of the programme.

During 2015/16 a new multi-agency Prevent Awareness course was delivered to 29 participants. The course was delivered as a Train the Trainer session so that those participants could deliver the key messages within their respective service areas. Identifying and tackling Female Genital Mutilation has been added to the existing Forced Marriage training course and delivered in December 2015. This will continue to be delivered twice a year.

Six Safeguarding Practice Updates were delivered in 2015/16 and have proved popular with staff with an average attendance of 40. Topics have included Feedback from Tameside Case Reviews; Domestic Abuse; Child Sexual Exploitation; Respectful Challenge; Assessment in Safeguarding; What Works Best in Safeguarding Practice; and Working with Children in Need.

A range of new communication methods have been developed during 2015/16 to help raise the awareness of key learning from case reviews. A series of 7 minute briefings have proven especially popular as they provide bite size information in a format that facilitates discussion in team meetings. A series of Top 10 Tips provide a quick and easy reference on key practice issues for practitioners. An independent report presented to the TSCB in April 2015 rated the TSCB website as good and in the top quartile of all safeguarding sites visited. Recommendations for improvement have been taken forward with the TSCB website now being mobile friendly and many of the TSCB web pages having been re-written or re-structured to make information and resources more accessible for practitioners and for children and young people. This work has been done in consultation with the Safeguarding Youth Forum that was established in June 2015. The Parents section of the TSCB website needs to be revised in 2016/17 in consultation with parents.

Improvements to communication methods have been possible through the creation of a new Learning and Improvement Activity Group. The group combined the previous Training and Development Sub-Group and the Communications Sub-Group into one. Practitioners are actively involved in developing training and resources so that they are relevant and practical. The group has also led to increased awareness and sharing of good practice, tools and resources between a range of service providers.

TSCB has produced draft publicity material to promote the purpose and the work of the Board to partner agencies and to members of the public. Board Members will be asked to distribute leaflets in public spaces including G.P. surgeries, children and community centres and reception areas in early 2016.

Monitoring and Evaluating Effectiveness

The work of the Quality Assurance and Performance Management (QAPM) Sub-Group is coordinated by the Quality Assurance Officer who was appointed in May 2015. The QA Officers first task was to establish a robust verification process for the S.11 Audits that had been returned in the previous year 2014/15. This has meant that S.11 Audits have only been signed off where evidence has been provided to show that agencies meet the requirements of the audit standards. There were a number of examples where audits had been completed thoroughly and clearly identified actions for development to enhance practice. Most notably, the audit returns from Tameside Hospital and Greater Manchester Police provided clear evidence and accountability in relation to managing child safeguarding concerns. A robust review of the supporting evidence showed some excellent examples of child protection policies and procedural guidance including the submission from Positive Steps which contained several examples of good practice, and clearly displayed where internal procedures had been closely scrutinised and reviewed to ensure compliance with the audit.

A new Quality Assurance Framework detailing the annual audit activity has been devised and forms the basis of the QAPM work plan. Improvements have been made to the dataset and quarterly reports of child protection activity allowing challenges to be made on the basis of strong evidence. This has led to improved practice in areas such as the Housing Protocol, further training on the Common Assessment Framework, and scrutiny of the Public Service Hub processes.

Thematic Multi-Agency Audits are determined by the current strategic priorities and learning from case reviews. In 2015/16 audits were completed on Child Sexual Exploitation and Domestic Abuse. Findings and recommendations are produced from the multi-agency audits and developed into action plans that are taken forward by the relevant sub-groups or individual service areas. Subsequent improvements to practice have been made for example in relation to improved recording of case details and risk levels, support for victims, and increased co-working.

It will be important to establish a programme of multi-agency audits in 2016/17 that check the implementation of, and adherence to, a number of recommendations from case reviews that impact on multi-agency practice. The QAPM group will also need to ensure that similar checks of single agency practice are completed by having oversight of a single agency audit framework.

Participating in the Planning of Services

TSCB has been represented on the Emotional Health and Well Being Board since identifying self-harm as one of its strategic priorities in the TSCB Strategy and Business Plan. The Emotional Health and Well Being Board, now the Transformation Board, developed its Transformation Plan in October 2015 which outlines a new CAMHS Offer. The Transformation Board have endorsed a local self-harm referral pathway which links to the new Healthy Young Minds Service and the TSCB have created a new self-harm page on its website which promotes 2 E-Learning modules linked to self-harm.

Self-Harm training is to be developed in 2016/17 and will combine the accredited Mental Health First Aid Training with learning from local Serious Case Reviews and incorporate the GM Guidance and Resources.

A new Safeguarding Youth Forum was established in July 2015 so that young people could provide their views about the work of the TSCB. Members agreed with the existing strategic priorities set by the Board but advised that social networking was an underlying causal factor linked to a number of those strategic priorities. Through further discussion with the Forum a plan for pupils to deliver Safer Social Networking sessions to younger pupils was developed and is due to be piloted by pupils at New Charter Academy in May and June 2016. If successful the pilot will be rolled out to other secondary schools. The Safeguarding Youth Forum has also been consulted on the TSCB website and on the best methods of communication. Based on their feedback changes have been made to the website and publicity materials have been produced. Due to the age of Forum members many have moved on to University or into work and TSCB will seek to recruit new members as part of the roll out of the Safer Social Networking sessions in 2016/17.

The TSCB Business Manager and the Manager of the Adult Safeguarding Partnership Board meet regularly and in 2015/16 worked with their respective Independent Chairs to organise a Joint Development Session which will take place in April 2016. The purpose of the session will be to identify and explore the crossover between the 2 Boards and how this work informs a Joint Safeguarding Strategy to support the delivery Health and Well Being Board Strategy.

Conducting Reviews of Serious Cases

TSCB has a Serious and Significant Case Panel that receive referrals of Serious and Significant Incidents from professionals and partner agencies, gather relevant information and decide whether they meet the criteria for a case review. The screening and notification process was amended in early 2015 to reflect the revised 'Working Together to Safeguarding Children' guidance that was published in April 2015 and is included in an updated Learning and Improvement Framework.

There have been 3 Notifiable Incidents from March 2015 to March 2016. One case did not meet the criteria for a Serious Case Review and two cases did meet the criteria (Child R and Child S). The National Serious Case Review Panel endorsed all decisions made by the Serious and Significant Case Review Panel. One other case (Child Q) was not a Notifiable Incident but the Panel felt it did meet the criteria for a Multi-Agency Critical Review. The Overview Reports for Child Q and R were completed within 6 months and endorsed by the Strategic Board in March 2016 and the Child S Overview Report will be presented to the Strategic Board in June 2016. In addition to considering any new referrals the Serious and Significant Case Panel will continue to be responsible for ensuring that the learning and recommendations from all case review activity is implemented and widely communicated.

During the last 12 months the final multi-agency action plans for Child M and Child N, that were both Serious Case Reviews undertaken in the previous year, have been signed off. The Quality Assurance and Performance Management (QAPM) sub-group will now monitor the key themes/learning of each review as part of its quality assurance activity in line with the Board's Learning Improvement Framework.

Findings and recommendations from case reviews are shared in a variety of ways including practitioner events, safeguarding practice updates, 7 minute briefings, e-bulletins and will also include the promotion of new policies, tools and resources and training. Training courses are regularly updated as required.

Female Genital Mutilation

In April 2015 new Statutory Guidance for Female Genital Mutilation resulted in the development of a referral pathway into the Public Service Hub so that any identified risk factors could be appropriately managed. During 2015/16 there were 4 referrals into the Public Service Hub. In all cases strategy discussions have been held and no further action has been required.

FGM Guidance has been added to the Forced Marriage Training course. This was delivered for the 1st time in December 2015 and will continue to be delivered as part of the TSCB Training Programme.

Preventing Radicalisation

All cases of potential radicalisation are referred to and considered by a multi-agency Channel Panel and follow the Channel process. Since its inception in April 2014 to the end of March 2016 there have been a total of 28 referrals, including 11 referrals for children.

In order for schools and childcare providers to fulfil the June 2015 Prevent duty Tameside Safeguarding Children Board ran 2 multi-agency sessions on Prevent Awareness which was attended by 29 participants. Education delivered 2 sessions to schools and the Local Authority Workforce Development Team delivered a further 4 sessions to Local Authority staff.

TSCB STRATEGIC PRIORITIES 2015 - 2018

The five strategic priorities set by Tameside Local Safeguarding Children Board for 2015-2018 were as follows:

1. **Domestic Abuse**

    - To develop and deliver an educational awareness programme to universal services
    - To continue to deliver multi-agency training on the 'whole family approach to Domestic Abuse' and to evaluate its impact
    - To explore and develop ways to tackle domestic abuse at an earlier stage

2. **Child Sexual Exploitation**

    - To improve intelligence gathering from multi-agency partners
    - To ensure that a tiered package of support is available for victims of CSE
    - To increase awareness of CSE amongst children and young people, parents and community
    - Develop a local Missing from Home Protocol that reflects the response to missing children who are known to be at risk of CSE

3. **Self-Harm**

    - Develop and promote a self-harm and preventing suicide policy
    - Develop and deliver a package of self-harm and suicide training and support
    - Improve practitioners understanding that patterns of risk taking behaviour e.g. substance use & eating disorders may also be a form of self-harm
    - Work with the Emotional Health and Well Being Board to develop the referral pathways and service offer for CAMHS

4. **Early Help**

    - Review the Public Service Hub

- Revise Children's Needs Framework including an updated Thresholds of Need, Escalation and Step Up/Step Down procedure
- Strengthen joint working through effective and timely information sharing across the thresholds of need
- Improve recognition and understanding of children's disabilities and specifically the impact that they can have upon safeguarding
- Improve offer of early help at the early years stage where threshold for statutory intervention is not met i.e. refer to Children's Centres and to free Child Care Placements

5. Neglect

- Develop a multi-agency neglect strategy that enables partners to identify and respond to neglect at the earliest opportunity and escalate when necessary
- Encourage the consistent use of the Graded Care Profile in all cases of known or suspected neglect and develop a system to track progress and improvement against the Graded Care Profile

It was agreed that action plans would be updated annually and that progress against the 5 strategic priorities would be reported to the TSCB Business Group and Strategic Board as part of the Board governance arrangements. The following section provides an overview of the work that has been completed or is underway in relation to each of the strategic priorities.

Domestic Abuse

During 2015/16 TSCB has delivered the 'Whole Family Approach to Domestic Abuse' training course to 42 practitioners. Feedback has been overwhelmingly positive with practitioners reporting an increased confidence in their ability to identify problems early and engage with different members of the family to address them. However, the DARIM assessment tool, designed to assess the impact of domestic abuse on children, is proving difficult to implement in practice and alternative assessment tools do need to be considered. In addition there remain some practical difficulties in engaging with the perpetrators of domestic abuse and ways to overcome these require further exploration in 2016/17.

In November 2015, Better Futures Tameside, was approved as the commissioned service for the provision of a universal education and prevention service in Tameside Schools. Age-appropriate resources for Key Stage 1-5 will be co-designed with a group of children and the Local Authority Youth Council will be consulted on those resources before being piloted. The programme will be tested in 14 schools during 2016 including 8 Primary Schools, 4 Secondary Schools, a Pupil Referral Unit and a Special School. In addition a 'train the trainer' element will be provided so that specific 'champions' can provide future sessions and secure the sustainability of the subject in order for it to remain on the PHSE agenda of each school beyond this sessional delivery in 2016/17. These 'champions' will also provide a source of information for the development of peer advisors in selected schools.

2015/16 saw 355 cases heard at MARAC, a decrease of 150 compared to the previous year; however, the average percentage of cases featuring children increased, from 65% in 2014/15 to more than 70% during 2015/16. Additionally, there was an average increase in the number of cases defined as 'repeats', reflecting more than one referral into MARAC during a 12 month period.

Child Sexual Exploitation (CSE)

Tameside has had a multi-agency Phoenix Team since August 2013. It is part of a Greater Manchester Model know as Project Phoenix which a joint approach by Greater Manchester Police (GMP) and Association of Greater Manchester Authorities (AGMA). It is governed by an Executive Committee which, in turn, informs the Strategic Group who set the agenda for the practice managers responsible for running the local CSE teams. The manager of the Phoenix Tameside team is represented at this group and also attends the TSCB CSE Sub-Group that delivers a CSE work plan.

Project Phoenix and the CSE Sub-Group aims to tackle child sexual exploitation through the following three strands:

1. Prevention - Educating those at risk, the community and other professionals on how to identify, reduce or avoid the dangers of CSE.
2. Protection - Safeguarding those identified as at risk of vulnerable to CSE through multi-agency assessment, support and intervention.
3. Prosecution - Investigating and prosecuting those identified as committing CSE offences or disrupting where the opportunity is present through multiagency, proactive enforcement.

Tameside's School Advisor set up a Safe and Healthy Relationship Group in 2015 to explore the best way to raise awareness of a number of different safeguarding issues including CSE and Domestic Abuse. The group secured joint funding from Public Health and New Charter Housing to provide every school in Tameside with the Barnardo's 'Real Love Rocks' resource. There are 2 packs available, one for Primary schools aimed at year 6 and one for secondary schools for years 7 to 9.

54 out of 76 primary schools attended the training, 12 out of 15 secondary schools, 4 out of 5 special schools and both Pupil Referral Units. The training covered basic awareness of CSE, how to use the packs and the licence to allow the school to use the product. In addition the training was opened up to other agencies working with children such as the multi-agency Phoenix and Youth Offending Team , Early help and Social Work Team, school nurses, and children's homes, both private and local authority. There have been 6 training sessions between 24th June 2015 and 25th January 2016. The training has been attended by 122 people from schools and other agencies.

To complete the school roll out in Tameside Barnardo's have issued a pack for each school who have not attended the training and lifted the need to attend any training. This is a really good result and will enable key messages about CSE to be given to all children in our LA. Spare packs have been retained at Tameside Safeguarding Children Board's office and these are available on a library loan basis and can be borrowed by any partner agency. TSCB continues to deliver multi-agency CSE training twice a year as well as one Train the Trainer course so that participants can deliver the key messages to their teams and service areas.

A member of the Local Authority Policy and Communications Team attends the Greater Manchester Phoenix Communications Group that runs a CSE 'Week of Action' campaign twice a year. During the 'It's Not Okay' Week of Action from the 14th to 20th March 3 of the 5 key media events were held in Tameside and there was extensive operational and communications activity in Tameside to raise awareness and help tackle CSE. The week received great media coverage and social media engagement and helped to raise the profile of key messages to our local audience and beyond. The work carried out by Policy and Communications Team and Phoenix Tameside, closely aligning front line operations and publicity and communications, was praised by GM Project Phoenix Manager who described it "amongst the best practice of its kind".

Future proposals to promote safer social media messages to both pupils and parents will be developed and delivered during 2016/17. This will build on the initiatives already piloted this year by the TSCB Quality Assurance Officer and the Communications Officer.

Phoenix Tameside has been the operational arm of CSE for the past 3 years providing protection and support to the victims, and those at risk, of CSE and disruption, investigation and prosecution of businesses and individuals. Phoenix Tameside reports to the TSCB via its CSE Sub-Group that meets every 2 months and to the Business Group.

During 2015/16 there were 63 new referrals to Phoenix Tameside and after screening a total of 47 cases (75%) were risk assessed as high, medium or low risk. At the end of the year a cumulative figure of 140 children were flagged at risk of CSE. A large proportion of those at risk of CSE are also reported missing and have bespoke trigger plans which are managed and overseen by a multi-agency missings panel that meets every 2 weeks.

Operation Labyrinth is coordinated by Tameside Police and initially seeks to identify and develop intelligence opportunities by plain-clothes officers visiting premises on Friday and Saturday evenings. Information is

developed which can then lead to either further criminal investigation or disruption tactics including Joint Enforcement Team (JET) visits by Licensing/ Trading Standards/Environmental Health / Fire Service. As a result of Operation Labyrinth there have been 104 enforcement visits which have led to a range of civil orders and Abduction Warning Notices. In total 56 Abduction Warning Notices have been issued to individuals to prevent them from associating with individuals. Young people have reported to the Phoenix Team that the Notices have given them the excuse they need to say no to potential perpetrators whereas previously they would feel pressured into meeting with them. There were 19 CSE related prosecutions in 2015/16 and 8 CSE related convictions. As of March 2016 there were 57 open CSE criminal investigations, almost twice the figure from 2014/15. Phoenix Tameside were shortlisted as finalists in the NWG Network 'National Policing Leads Award' and a PCSO from the team won the 'Neighbourhood Champion Award'.

Self-Harm

The Overview Reports published in 2015 for Child M and Child N Serious Case Reviews highlighted the need for improved self-harm policies and referral pathways and for these to be widely promoted. Further research identified that existing self-harm procedures, together with a range of other practical resources, were available on the Greater Manchester Safeguarding Partnership website. Other Local Authority areas had local referral pathways attached to those procedures and it was agreed that Tameside would adopt the same approach. A local Transformation Board, coordinated by the Clinical Commissioning Group and with representation from members of the TSCB, has supported the development of the pathway. Final sign off of the pathway will be sought from the TSCB Business Group in June 2016 before being added to the Greater Manchester Safeguarding Partnership website in August 2016.

The Workforce Development element of the Transformation Board has developed a training ladder which identifies 4 levels of training from basic e-learning to advanced and specialist training. Staff will be able to complete the training most suited to their needs. 2 E-Learning modules provided by MindED were added to a newly created self-harm section of the TSCB website in early 2016. Level 2 training will combine elements of an accredited Mental Health First Aid Training course with learning from local Serious Case Reviews and with the Greater Manchester Self-Harm Procedure and local referral pathway. In 2016/17 staff will be identified to attend a Train the Trainer course and those staff will then be responsible for the ongoing delivery of a 'Self-Harm' training course as part of the TSCB Training Programme.

The Transformation Board published a Transformation Plan 2015-2020 in October 2015. Its aim is to ensure that, when it is required, children young people and their families have swift and easy access into evidence based specialist support. It resonates with the learning and recommendations from the Board's Serious Case Reviews and recognises that CAMHS should be integrated within a wider network of services providing a range of support for emotional and mental health needs, which includes General Practitioners, Schools, Health Visiting, Youth Offending, Social Care and Third Sector provision (to name a few). TSCB will continue to support the work of Transformation Board and to deliver the Transformation Plan in 2016/17.

Early Help

The Public Service Hub was established in October 2014 and TSCB requested a 12 month review of the safeguarding arrangements which was presented to the Board in December 2015. The review examined the front door arrangements and how cases were received at the point of contact and progressed to referral and assessment. Several areas of improvement were identified within the report thereby requiring continued scrutiny from the Board and the progression of these has been a standing agenda item on the Group from the beginning of 2016.

Demand on the Public Service Hub is very high with more than 1000 contacts per month of which nearly 2/3 are for information and advice. Figures from the Public Service Hub report showed that of the 5684 contacts received from April to August 2015 1341 (23.5%) required an intervention. Of those;

- 33% (445) progressed to a referral to children's social care.
- 67% (896) progressed to a referral to another agency including Early Help Service and INSPIRE

The volume of referrals to the Early Help Service has led to a delay in allocation of some cases. This had been identified in the learning from case reviews and therefore led to scrutiny of the common assessment (CAF) process and the Board later requested the findings of an Early Help review that Children's Services had completed. Improving the common assessment process could potentially reduce the number of calls to the Public Service Hub which result in information and advice only.

CAF Support has diminished since the Public Service Hub was established. This has impacted on services willingness and ability to complete an early assessment of need and on the ability to monitor CAF activity. This lead to a formal challenge from the Board and CAF data was subsequently provided where the Early Help Service had completed the CAF themselves from quarter 3 of 2015/16 and in the final quarter CAF data was provided where Early Help were involved in the case.

Continued challenge has resulted in the Board discussing how the CAF resource will be renewed and a resolution will be reached in 2016. TSCB has worked alongside the Early Help Service to update the Children's Needs Framework which will reinforce the requirement placed upon all partner agencies to provide an early assessment of need and coordinated holistic response. The Children's Needs Framework will be launched in June 2016 together with a revised 'Common Assessment Framework' (CAF) training offer that will promote the Family CAF as the primary assessment and planning process for all early help services.

In response to learning from local case reviews, including Serious Case Reviews, the Children's Needs Framework also provides guidance on multi-agency consultation and links to a range of other risk assessments for practitioners to use and to the Service Information Directory. It highlights the principles and good practice that practitioners should work towards including for example, respectful challenge, professionals meetings, and escalation. CAF Training delivered by the Early Help Service has been added to the TSCB Training Programme for 2016/17 and will also be delivered to schools.

Other key processes were updated in 2015 including the 'Threshold of Need' guidance, 'Child in Need' protocol and 'Step Up/Step Down' policy. TSCB web pages have been re-structured to make all documents as clear and accessible as possible and have been promoted via the TSCB Board Members, E-Bulletin and regular training courses and learning events.

Tameside's Escalation Policy has been superseded by the Greater Manchester Escalation Policy but learning from a number of case reviews has highlighted the need for greater 'respectful challenge' amongst professionals. Although a specific learning event was delivered in 2015 further work needs to be done to ensure that the culture of 'respectful challenge' is the expected norm and that professionals response to challenge is one of continuous reflection and improvement.

In March this year the Early Years Team and Policy & Communications worked on a campaign to promote free child care for two year olds.

This government funding is targeted to low income families and children in care or with special needs to help give children from more vulnerable backgrounds the best possible educational start. 69% of eligible families were accessing free child care in 2014/15 and the Early Help Service aimed to increase this to 80% by the end of 2015. Feedback from the service following the campaign was extremely positive, with applications for two year places rising to over 90%. During 2015/16 the Early Years' Service has also established a new Early Years Delivery Model and it was rolled out to Health Visiting Teams across Tameside. Health Visitors now use the Ages and Stages Questionnaire (ASQ3) to identify developmental need at 2 months, 9 months and 2 years with a targeted assessment at 18 months and refer to services as required.

Neglect

The Ofsted thematic inspection report on neglect, "In the Child's Time: professional responses to neglect" (March 2014) details a picture of continuing high levels of neglect across the country. The Ofsted report highlights the role of the LSCB to:

- Monitor the quality of practice in relation to neglect across all partner agencies offering support to families on an early help, child in need or child protection basis.

- Raise the profile of neglect to ensure agencies are working together effectively.

Neglect was made a strategic priority in the TSCB Business Plan 2015/16 and a Neglect Strategy was developed jointly with partner agencies. The aim of the multi-agency strategy was to clarify a definition of Neglect and its impact on children, to encourage a consistent approach in recognition and response, as well as promoting early intervention and establish a vision to tackle neglect cross-borough.

The strategy outlined a set of practice principles for practitioners working with families where neglect was a concern, as well as strategic objectives for the implementation of the strategy.

The practice principles enable the achievement of the Strategic Objectives:

- Improve awareness and understanding of neglect
- Improve recognition and assessment of children and young people living in neglectful situations
- Develop and sustain an agreed multi-agency approach to neglect

LOCAL DEMOGRAPHICS

Tameside has an overall population of 220,597 with a youth population aged 0-19 of 53,847 which is 24% of the total.

Table 1: Tameside's Youth Population 0-19

	Mid-2013 Tameside Population		
	Males	**Females**	**Persons**
0-4	7,514	7,319	14,833
5-9	6,765	6,561	13,326
10-14	6,254	6,065	12,319
15-19	6,922	6,447	13,369

The breakdown of Tameside's population by ethnic group is shown in 2. National studies show that different ethnic groups are at greater risk of specific safeguarding issues such as Female Genital Mutilation and Forced Marriage for example.

The largest ethnic groups within Tameside are the South-Asian ethnicities Indian, Pakistani, and Bangladeshi accounting for 1.7, 2.2 and 2% of the Tameside population respectively. The overall white British population is considerably higher in Tameside at 88.5% compared to the English average of 79.8%.

Table 2: Population Breakdown by Ethnicity in England, the North-West and Tameside

	England (%)	North-West (%)	Tameside (%)
White: English/Welsh/Scottish/Northern Irish/British	79.8	87.1	88.5
White: Irish	1	0.9	0.7
White: Gypsy or Irish Traveller	0.1	0.1	0
White: Other White	4.6	2.1	1.7
Mixed/multiple ethnic group: White and Black Caribbean	0.8	0.6	0.6
Mixed/multiple ethnic group: White and Black African	0.3	0.3	0.2
Mixed/multiple ethnic group: White and Asian	0.6	0.4	0.4
Mixed/multiple ethnic group: Other Mixed	0.5	0.3	0.2
Asian/Asian British: Indian	2.6	1.5	1.7
Asian/Asian British: Pakistani	2.1	2.7	2.2
Asian/Asian British: Bangladeshi	0.8	0.7	2
Asian/Asian British: Chinese	0.7	0.7	0.4
Asian/Asian British: Other Asian	1.5	0.7	0.3
Black/African/Caribbean/Black British: African	1.8	0.8	0.5
Black/African/Caribbean/Black British: Caribbean	1.1	0.3	0.2
Black/African/Caribbean/Black British: Other Black	0.5	0.2	0.1
Other ethnic group: Arab	0.4	0.3	0.1
Other ethnic group: Any other ethnic group	0.6	0.3	0.1

Source: NOMIS, 2015

The ethnic breakdown of the populations of Tameside's wards is detailed in table 3. It shows that higher proportions of Indian and Pakistani populations exist in Ashton Wards, whereas higher proportions of Bangladeshi population exist in Hyde.

TSCB has agreed with the Voluntary and Community Sector and Faith Sector to refresh the safeguarding training in Madrassahs and this is due to be delivered in 2016/17. It will cover key legislation and processes to protect against FGM, Forced Marriage and Radicalisation.

Table 3: Ethnic Breakdown of Tameside Ward Populations (%)

	Ashton Hurst	Ashton St Michael's	Ashton Waterloo	Audenshaw	Denton North East	Denton South	Denton West	Droylsden East	Droylsden West	Dukinfield	Dukinfield Stalybridge	Hyde Godley	Hyde Newton	Hyde Werneth	Longdendale	Mossley	St Peter's	Stalybridge North	Stalybridge South
White: Total	85.4	81.0	85.1	93.7	95.5	95.7	95.5	93.3	95.8	94.3	95.8	89.9	93.4	80.5	97.1	96.8	70.3	95.4	95.5
White: English/Welsh/ Scottish/Northern Irish/British	82.8	76.4	82.9	91.6	93.3	93.6	93.2	91.4	94.0	91.9	94.0	87.7	91.4	78.9	95.3	94.6	64.3	93.2	93.4
White: Irish	0.5	0.6	0.5	0.9	0.9	0.9	1.5	1.0	1.0	0.6	0.6	0.6	0.7	0.5	0.9	0.8	0.6	0.4	0.5
White: Gypsy or Irish Traveller	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0
White: Other White	2.0	4.0	1.6	1.1	1.2	1.2	0.8	0.8	0.8	1.8	1.1	1.5	1.4	1.0	0.9	1.4	5.4	1.7	1.6
Mixed/multiple ethnic group: White and Black Caribb	0.4	0.5	0.5	0.7	0.6	0.8	0.8	0.9	0.9	0.4	0.5	0.5	0.7	0.6	0.6	0.5	0.7	0.4	0.5
Mixed/multiple ethnic group: White and Black Africar	0.2	0.4	0.4	0.2	0.3	0.3	0.3	0.2	0.3	0.2	0.1	0.2	0.2	0.1	0.1	0.2	0.3	0.3	0.1
Mixed/multiple ethnic group: White and Asian	0.5	0.7	0.7	0.3	0.3	0.3	0.3	0.3	0.2	0.4	0.3	0.3	0.4	0.3	0.2	0.4	0.7	0.3	0.3
Mixed/multiple ethnic group: Other Mixed	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.4	0.2	0.2	0.1	0.3	0.2	0.1	0.2	0.3	0.3	0.3	0.1
Asian/Asian British: Indian	5.4	6.4	5.9	0.6	0.6	0.3	0.5	0.9	0.4	1.2	1.1	0.2	0.4	0.6	0.3	0.4	3.7	1.4	1.3
Asian/Asian British: Pakistani	5.2	6.7	4.1	2.0	0.5	0.2	0.8	0.8	0.3	1.1	0.8	0.5	0.6	0.7	0.2	0.0	15.2	0.4	1.2
Asian/Asian British: Bangladeshi	0.5	0.9	1.5	0.3	0.2	0.3	0.2	0.2	0.2	0.4	0.1	6.8	3.0	15.7	0.2	0.6	5.1	0.3	0.1
Asian/Asian British: Chinese	0.3	0.5	0.2	0.7	0.6	0.4	0.5	0.9	0.6	0.5	0.3	0.3	0.3	0.4	0.1	0.2	0.7	0.4	0.4
Asian/Asian British: Other Asian	0.5	1.1	0.4	0.2	0.3	0.3	0.2	0.4	0.1	0.3	0.3	0.1	0.1	0.4	0.1	0.2	0.9	0.2	0.2
Black/African/Caribbean/Black British: African	0.7	0.9	0.4	0.7	0.4	0.7	0.2	1.2	0.7	0.4	0.2	0.4	0.3	0.2	0.5	0.2	1.5	0.5	0.1
Black/African/Caribbean/Black British: Caribbean	0.1	0.2	0.2	0.2	0.1	0.2	0.3	0.3	0.2	0.1	0.1	0.1	0.2	0.1	0.2	0.1	0.3	0.1	0.1
Black/African/Caribbean/Black British: Other Black	0.1	0.2	0.2	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0
Other ethnic group: Arab	0.3	0.1	0.1	0.1	0.1	0.0	0.0	0.1	0.0	0.1	0.1	0.1	0.0	0.1	0.0	0.0	0.1	0.0	0.1
Other ethnic group: Any other ethnic group	0.1	0.2	0.3	0.1	0.1	0.0	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.0

Source: NOMIS, 2015

EARLY HELP & STATUTORY INTERVENTION FOR VULNERABLE GROUPS

1. Public Service Hub

The Public Service Hub was launched on the 1st October 2014 to bring Tameside's early help, complex dependency and safeguarding services together into one multi-agency partnership. Its Operating Functions are as follows:

- Prioritise tackling issues of demand due to complex dependency
- Draw together intelligence and information and carry out research to identify critical and high risk cases
- Define and identify families who would benefit from early intervention and reduce future dependency
- Create and deliver bespoke interventions and packages of support using a whole family approach
- Coordinate interventions across public services, agencies and agendas
- Progress and develop the integration of public services
- Encourage and promote the sharing of information

Representative from the agencies below sit on the Strategic Public Service Hub Group and continue to develop and improve policies and procedures to ensure information sharing, risk assessment and management etc. are robust.

Agency/Service
Greater Manchester Police
TMBC Strategy and Early Intervention
TMBC Children's Social Care
Job Centre Plus
NHS Pennine Care Mental Health and Substance Misuse
National Probation Service
Community Rehabilitation Company
Greater Manchester Fire and Rescue Service
TMBC Neighbourhood Services
TMBC Education
New Charter Housing
TMBC Public Health
NHS Clinical Commissioning Group
Community and Voluntary Action Tameside
NHS Stockport Foundation Trust
TMBC Performance and Development
Tameside Hospital NHS Foundation Trust

The table below illustrates the total number and percentage of contacts received by the Public Service Hub and those that progressed to a referral into Children's Social Care.

Table 4: Contacts & Referrals to Public Service Hub 2015/16

Quarterly Figures	Number of contacts received 2014/15	Number of contacts received 2015/16	No. of Contacts Progressed to Referral 2015/16	% progressed to a referral 2015/16
Apr/May/June		3811	265	7.6
July/Aug/Sept		3221	259	7.4
Oct/Nov/Dec	3055	3360	365	8.9
Jan/Feb/March	3476	3200	365	8.9

2. Early Years & Early Help

Early Help locality teams have been operating in Tameside for a number of years focused on developing an early intervention model for Tameside families, developing the Troubled Families offer and meeting Children's Centres agenda for early years. Tameside's Early Help offer includes Early Help family intervention teams, Young Carers, Early Years Children's Centre locality teams, Provider Development team for Private Voluntary and Independent settings in early years, Family Information Service and Portage, YOU Think sexual health team, and Special Educational Needs and Disabilities Information and Advice Support Service. Teams are supported by coordinated commissioned services including Homestart, Breastfeeding Peer Support, Positive Steps careers advise service and Branching Out support for young people with substance misuse and alcohol issues.

In 2015/16 1697 families were referred to the Early Help service an increase of 155% from 665 in 2014/15. Despite the increase in referrals the Early Help Service has continued to work with a similar number of families at any one time, 325 families in 2015/16 compared to 350 in 2014/15 which equated to between 700-750 and 800-900 children respectively. This demonstrates why there is a delay in the allocation of some cases. Of all the cases 160 were stepped down to universal service provision indicating their additional needs had been provided for. In the previous year 483 cases were stepped down. Cases are therefore having to remain open to Early Help longer suggesting that they are managing more complex cases.

3. Children in Need

A child in need is seen as one for whom the threshold for statutory services has been met, where assessment and intervention is necessary but which stops short of formal child protection planning or becoming a child in care. Throughout the year, Children's Social Care have worked with 730 children on this basis compared to 840 in the previous year. This remains a high number leading to workers having caseloads above the national average. However with good quality supervision and oversight these numbers have been managed.

4. Child Protection

The total number of children subject to an initial Child Protection Conference in 2015/16 was 244 compared to 265 in 2014/15 a decrease of 8.6%. At the end of March 2016, 220 children and young people were the subject of a child protection plan, an increase of 8 cases (17.6%) from the previous year. Children Social Care is working with more complex families and an internal Children's Services audit has demonstrated closure of cases where appropriate

Repeat Child Protection Plans & those open for more than 2 years

Over the course of 2015/16 the proportion of young people subject to a child protection plan for a second or subsequent time increased each quarter from 22.5% in quarter 1 to 24.6% in quarter 4. This is a slight increase to that of 2014/15 (20.8%). Children's Social Care are again exploring the reasons why the number

of repeat plans has increased and working to ensure that effective support is provided when cases are stepped down.

The number of Child Protection cases open for 2 years or more had reduced from 11 (5.4%) to 7 (3.2%) over the course of the year. An audit will be conducted by Children's Services on the 7 cases open at the end of 2015/16 to check the reasons why the cases have been open for 2 years or more.

5. Child Protection by Category of Abuse

Chart 1 and 2 below show that the share of child protection cases under the category of physical abuse has remained static and the proportion of sexual abuse cases has reduced by more than 60% from 2014/15 to 2015/16 although the actual number of cases equate to 8 cases in March 2015 to 3 cases in March 2016. During that period there has been a 2% increase in neglect cases and 1% increase in emotional abuse cases.

Chart 1: Category of Abuse 2015/16 Year End

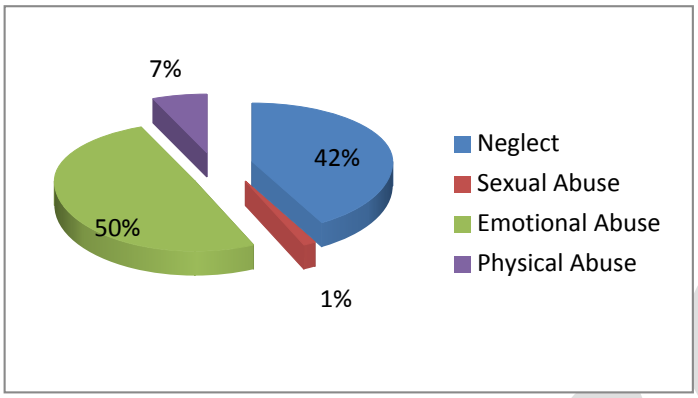
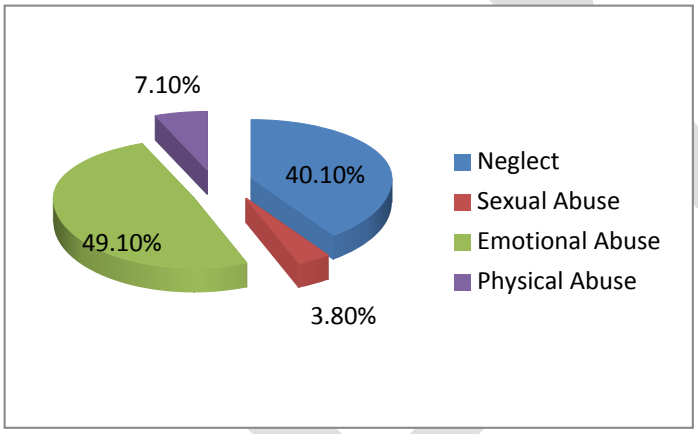


Chart 2: Category of Abuse 2014/15 Year End



It is important to note that despite the national high profile abuse cases and subsequent activity to tackle child sexual exploitation, neglect and emotional abuse remain a much more common form of abuse, and both have increased further in the year 2015/16.

6. Children with Disabilities

The Integrated Service for Children with Additional Needs (ISCAN) offer treatment and support to Children with a Disability and/or Complex Health Needs. The team is an Integrated Service comprising of Health and Social Care staff who work from a range of sites across Tameside, including community clinics, special and mainstream schools and nurseries and home visits providing a range of Nursing, Therapeutic, Behavioural and Social Care Interventions. There is a Children with Disabilities Pathway between the Public Service Hub and ISCAN and in 2015/16 there were approximately 24 contacts resulting in 6 referrals a month to the ISCAN Team. Joint working and protocols are in place to ensure that ISCAN are appropriately involved in S47

enquiries, specialist assessments for court purposes and legal planning meetings. ISCAN managed an average of 78 Child in Need, 1 Child Protection case and 23 LAC cases a month during 2015/16. ISCAN are also represented on a variety of panels including the Placement Panel and Education Panel.

7. Children in Care

Children in care are those looked after by the local authority. Only after exploring every possibility of protecting a child at home will the local authority seek a parent's consent or a court decision to remove a child away from his or her family. Such decisions, whilst incredibly difficult, are made when it is in the best interest of the child.

As of 31 March 2016, 423 children were being looked after by the local authority compared to 483 at 31 March 2015 and 423 at 31 March 2014. Of the total number, 378 (78%) were placed in the Tameside area and 105 (22%) placed out of the borough.

Table 5: Placement Breakdown as at 31/03/2016

Type of placement	**No. of children**
Placement with foster carer in borough	215
Placement with foster carer out of borough	81
Residential placement in borough	22
Residential placement out of borough	27
Placement in hostels or supported lodgings	7
Placed with parents	37
Same placement for 2+ years or placed for adoption	123
Other Local Authority LAC placed in Tameside	
Placement with foster carer	299
Residential placement	54

As of 31 March 2016 the Local Authority had a record of 353 children placed in care from out of borough. The majority (86%) were placed in foster care and the remainder in residential placements.

8. Children in the Youth Justice System

The 2015/16 data shows that there has been a drop in the number of children entering the criminal justice system for the first time when compared to the previous year. This is in line with the national trend and is due to a number of factors, including effective diversionary work and changes to policing approaches. The Youth Offending Team (YOT) is currently working at a Greater Manchester level with colleagues from Greater Manchester Police (GMP) to try and further develop this work by increasing engagement with young people and adopting a whole family approach at the first available opportunity. At a local level there are plans in place to ensure that the prevention offers provided by both the YOT and early help services are better aligned.

Data relating to re-offending rates amongst children and young people has historically been problematic to capture but in October of last year the Youth Justice Board (YJB) launched a new toolkit to address this. The YOT has been tracking re-offending rates since this time and the first six months of data shows a marked reduction in the number of children in the cohort, which in turn means a reduction in the number of further offences being committed; however, the rate of re-offending amongst this cohort does not appear to be falling and the young people involved are presenting with a range of complex issues and tend to be known to multiple services. These children are tracked through the Deter Young Offender (DYO) group and are closely monitored through partnership working with GMP.

In respect of the use of custody for Tameside children and young people, the total number of custodial sentences imposed has decreased from 12 in 2014/15 to 8 in 2015/16. The use of custody is closely

monitored by the YOT and alternative community based disposals are routinely presented to the court when matters of public protection deem it safe to do so. Safeguarding concerns in relation to the secure estate for children have been reported on widely in the media over the past twelve months and recent inspection reports on a range of establishments have been less than favourable, highlighting in particular a trend in rising levels of violence across the juvenile estate. Nationally there has been a significant reduction in the use of custody for youths, meaning that a number of beds have been de-commissioned across the sector, resulting in the closure of HMYOI Hindley that had been the local provision for GM. Whilst the reduction in numbers is positive, the knock on effect is that children tend to be placed further away from home and as such have less contact with their families, something that is counterproductive to effective resettlement. The YOT continues to closely monitor children in custody and there are plans for a GM Officer to be permanently based in HMYOI Wetherby to provide a direct link to GM YOT's.

Both YJB grant funding and partner contributions to the YOT have reduced significantly over recent years and the budget for remands has been devolved from the YJB to the Local Authority. This carries with it significant risk as the cost of beds in the secure estate is high and this is an area of work that is difficult to control or predict; last year the entire remand budget went on one child who spent over eight months on remand for a serious offence that subsequently resulted in a life sentence being imposed.

SPECIFIC RESPONSIBILITIES UNDER WORKING TOGETHER TO SAFEGUARD CHILDREN (2015)

CHILD DEATH OVERVIEW PANEL

The Child Death Overview Panel (CDOP) is a multi-disciplinary sub-group of Local Safeguarding Children Boards that reviews the deaths of all children aged from birth to under the age of 18years old (excluding still births and planned terminations carried out under the law) who normally reside within the relevant boroughs. There are 4 CDOP's across Greater Manchester, including one for Stockport, Tameside and Trafford with an independent chair, Mick Lay.

The CDOP Annual Report for Stockport, Tameside and Trafford 2014/15 was presented to TSCB with the following recommendation:

It is the recommendation from this report that each LSCB ensure that Public Health take the lead in providing evidence of the work being carried out both locally and across GM that will have an impact on reducing the number of child deaths.

Based on the evidence in this report the areas which require specific focus are:

- Actions to prevent premature births which have a disproportionate effect on the child mortality rate.
- Actions to identify and then focus on groups where risk appears to be highest based on ethnicity and deprivation.

This will involve Public Health providing each LSCB with evidence of its action plans already in place to address the areas above and how these actions will be measured for outcomes.

Tameside is taking part in the current NW Sector-Led Improvement Infant Mortality Peer Review Programme which involves a detailed self-assessment by local stakeholders, a workshop for all participating areas, and development of action plans addressing local and shared priorities. The Tameside Action Plan developed through this process will form the principal local response to the CDOP Annual Report recommendations, and is expected to be agreed during summer 2016.

LOCAL AUTHORITY DESIGNATED OFFICER

The Local Authority Designated Officer (LADO) task is to oversee investigations into allegations of child abuse by professionals working with children and young people or behaviour which may place children at risk. It includes the chairing of inter-agency Professional Abuse Strategy Meetings (PASMs) on behalf of the Tameside Safeguarding Children Board and being available for advice and consultation.

Allegations against professionals working with children are varied. Many arise within the context of behaviour management, there are a small number of very serious allegations and there are others involving professional boundaries. They come to light through a variety of sources, most frequently children and parents who may complain to the agency concerned or contact the police.

Professional Abuse Strategy Meetings

Professional Abuse Strategy Meetings (PASMs) are convened in agreement with referring and employing agencies and investigators. PASMs are necessary when a clear and documented allegation against an individual arises and there is possibly significant harm caused to a child or children. Strategy Meetings are also held when there is a need for a formally agreed inter-agency strategy for dealing with the case. Complaints to the police have generally required PASMs.

Consultations

Consultations concern matters that do not require co-ordinated inter-agency action. These have increased year on year since the LADO has been in post which indicates that the awareness raising of this role and of partners responsibilities has been effective.

Strategy Meetings are not convened following a consultation when all appropriate action has been taken, only one agency was involved, or where the evidence of risk to children was very weak.

Many of the consultations have involved inappropriate behaviour of staff working with children. Incidents such as saying inappropriate comments, use of social media and giving children lifts. To address this issue the LADO has issued and promoted the 'Guidance for Safer Working Practice for Adults who work with children and young people'.

Table 6: Breakdown of All LADO Referrals

Year	PASMs	Consultations	Total
2008/09	41	21	62
2009/10	24	20	44
2010/11	36	35	71
2011/12	13	48	61
2012/13	25	49	74
2013/14	31	67	98
2014/15	22	106	128
2015/16	26	120	146

Employing Agencies referred to LADO

As with previous years the majority of referrals have concerned professionals with the greatest and most regular direct exposure to children i.e. school staff, foster carers, residential workers and early year's services.

Agencies Contacting LADO for advice or to refer cases

Agency	Number of contacts
Health	4
Education	35
Early Years	4
Other LADO	0
Residential	21
Children's social care	32
Police	13
OFSTED	5
Other	4

(Other includes agencies such as parents, MPs, HR, NSPCC)

Breakdown of Employing Agencies discussed

Agency	2013/14	2014/15	2015/16
Health	10	7	7
Education	26	46	55
Early Years	11	24	16
Residential	14	17	22
Children's Social Care			3
Police	4		1
Foster carers	16	14	18
Other	17	20	4

Breakdown of Categories of the cases which progressed to an initial consideration/strategy meeting. These are the cases where there it is agreed with the employed that their employee may have:

- Behaved *in a way that has harmed, or may have harmed a child;*
- *Possibly committed a criminal offence against, or related to a child; or*
- *Behaved towards a child or children in a way that indicates they may pose a risk of harm to children*

5 foster carers
5 residential care workers
1 social worker
3 Health
10 Education
2 Early Years

7 of these cases were substantiated, 14 unsubstantiated and 5 were ongoing at 31st March 2016. Training needs were identified in 5 of the cases, 3 cases resulted in the member of staff being dismissed and 10 cases needed no further action after initial consideration.

STRATEGIC PRIORITIES FOR 2015-18 AND BUSINESS OBJECTIVES 2016-17

Based on the Board's current and ongoing safeguarding activity and the emerging safeguarding trends locally the following Strategic Priorities have been agreed for 2015-18. The actions which underpin the strategic priorities are reviewed annually in response to ongoing quality assurance activities, case reviews and annual reports.

Domestic Abuse

- To develop and deliver an educational awareness programme to universal services
- To continue to deliver multi-agency training on the 'whole family approach to Domestic Abuse' and to evaluate its impact

- To explore and develop ways to tackle domestic abuse at an earlier stage

Child Sexual Exploitation

- To ensure that a tiered package of support is available for victims of CSE
- To increase awareness of CSE amongst children and young people, parents and community
- To revise the local Missing from Home Protocol that reflects the response to missing children who are known to be at risk of CSE

Self-Harm

- Develop and deliver a package of self-harm and suicide training and support
- Improve practitioners understanding that patterns of risk taking behaviour e.g. substance use & eating disorders may also be a form of self-harm

Early Help

- Review the Public Service Hub in relation to safeguarding & early help activity and response
- Roll out revised CAF Training & improve CAF Support
- Strengthen joint working through effective and timely information sharing across the thresholds of need

Neglect

- Implement the multi-agency neglect strategy that enables partners to identify and respond to neglect at the earliest opportunity and escalate when necessary

APPENDIX A

Tameside Safeguarding Children Board Membership 2015/16

Working Together (2015) LSCB Membership requirements	**TSCB Membership**	**Representative**
Metropolitan Borough Council;	TMBC, Chief Executive	Steven Pleasant
	TMBC, Executive Director for Communities, Adults, Children's and Health	Stephanie Butterworth
The NHS Commissioning Board and clinical commissioning groups;	Director of Nursing & Quality, Tameside & Glossop CCG	Gill Gibson
	Acting Director of Operations and Delivery NHS England	Margaret O'Dwyer
NHS Trusts and NHS Foundation Trusts all or most of whose hospitals, establishments and facilities are situated in the local authority area;	Associate Director, Stockport Foundation Trust Community Healthcare Business Group	Michelle Lee
	Service Director, Pennine Care NHS Foundation Trust (Mental Health Services)	Stan Boaler
	Deputy Director of Nursing, Tameside Foundation Trust (Emergency and Specialist Services)	Peter Weller
Director of Public Health		Angela Hardman
Chief Officer of Police;	Chief Superintendent, Tameside Police	Donna Allen (Vice Chair)
Local Probation Trust;	Cheshire and Greater Manchester CRC	Nigel Elliott
	Head of Tameside and Stockport Probation Service	Richard Moses
Cafcass;	Service Manager, CAFCASS	Glen Hagan
Voluntary & Community Sector	Community and Voluntary Action Tameside (CVAT).	Ben Gilchrist

2 Lay Members	2 Lay Members	Cathy Wilde Vacant post
Education	Assistant Executive Director	Bob Berry
The governing body of a maintained school	Head Teacher, Primary School	Carolyn Divers
	Head Teacher, Secondary School	Maureen Brettell
Further education institution situated in the authority's area.	Assistant Principal, Tameside College	John McCall
Housing	Strategy Housing Officer	John Hughes
Children's Services	Assistant Executive Director	Dominic Tumelty
Voluntary Sector	CVAT	Ben Gilchrist
Advisers to the Board	TSCB Business Manager	Stewart Tod
	Head of Children's Safeguarding	Lorna Schlechte
Designated Doctor Designated Nurse	Designated Doctor Designated Nurse	Munera Khan Hazel Chamberlain
Legal Adviser	Legal Adviser	Alison Robertson
Observer	Councillor	Peter Robinson

APPENDIX B

Tameside Safeguarding Children Board Financial Statement 2015/16

TAMESIDE SAFEGUARDING CHILDREN BOARD INCOME	
In 2015/16 total annual income equalled £390,792 and was made up as follows:	
Tameside Council contribution	£123,330
School/Academies	£91,449
Clinical Commissioning Group	£134,700
Police	£13,200
New Charter Housing	£3,569
Probation	£3,333
CAFCASS	£550
Training Charges	£4,200
Total Contributions 2015/16	**£374, 421**

TAMESIDE SAFEGUARIDNG CHILDREN BOARD EXPENDITURE 2015/16	
Account Code Description	**Spend 2015/16**
Staffing costs	£ 174,203
TSCB General	£143,039
Training Strategy	£30,986
Serious Case Review	£40,755
TOTAL EXPENDITURE	**£388,983**

RESERVE	
Headings	**2015/16**
Funds from 1 April 2015	£142,549
Total Expenditure in excess of income	-£14,562
Balance in Reserve 31/03/16	**£127,987**

GLOSSARY

CAFCASS	**Children and Family Court Advisory and Support Service**
CAMHS	**Child and Adolescent Mental Health Service**
CCG	**Clinical Commissioning Group**
CDOP	**Child Death Overview Panel**
CSE	**Child Sexual Exploitation**
GMP	**Greater Manchester Police**
ICS	**Integrated Care System**
IDVA	**Independent Domestic Violence Advisor**
LADO	**Local Authority Designated Officer**
LGBT	**Lesbian, Gay, Bi-Sexual, Trans-Gender**
LSCB	**Local Safeguarding Children Board**
MARAC	**Multi-Agency Risk Assessment Conference**
TMBC	**Tameside Metropolitan Borough Council**
TSCB	**Tameside Safeguarding Children Board**
PASM	**Professional Abuse Strategy Meeting**
YP	**Young Person**

Report to:	**HEALTH AND WELLBEING BOARD**
Date:	10 November 2016
Executive Member / Reporting Officer:	Councillor Gerald P Cooney – Executive Member (Healthy and Working) Angela Hardman – Director of Public Health Debbie Watson – Head of Health and Wellbeing
Subject:	**HEALTH AND WELLBEING FORWARD PLAN 2016/17**
Report Summary:	This paper provides an outline forward plan for consideration by the Board
Recommendations:	The Board is asked to agree the draft forward plan for 2016/17.
Links to Health and Wellbeing Strategy:	The Health and Wellbeing Strategy to address needs, which commissioners will need to have regard of in developing commissioning plans for health care, social care and public health. The Forward Plan ensures coverage of key issues associated with the Board's duties to deliver improved outcomes through the strategy
Policy Implications:	The Forward Plan has been designed to cover both the statutory responsibilities of the Health and Wellbeing Board and the key projects that have been identified as priorities by the Board.
Financial Implications: **(Authorised by the Section 151 Officer)**	There are no direct financial implications for the Council relating to this report
Legal Implications: **(Authorised by the Borough Solicitor)**	Local Authorities are obliged to publish a forward plan setting out the key decisions and matters they will consider over a rolling 4 months.
Risk Management :	There are no risks associated with this report**.**
Access to Information :	The background papers relating to this report can be inspected by contacting Debbie Watson, Head of Health and Wellbeing by: Telephone:0161 342 3358 e-mail: debbie.watson@tameside.gov.uk

TAMESIDE HEALTH AND WELLBEING BOARD FORWARD PLAN 2016/17

	Strategy / policy and Board process	Priorities and performance	Integration	Other
19 January 2017	• Greater Manchester Population Health Plan – Theme 1 • Update on SEND Reform	• Refresh of Health and Wellbeing Strategy • System wide Outcomes Framework	• Care Together Update	• Minutes of Health Protection Group • Forward plan
9 March 2017			• Care Together Update	• Forward Plan
NOTE: AGENDA ITEMS ARE SUBJECT TO CHANGE				
	Items to include: • JHWS – approval, alignment with other strategies • JSNA – updates and approval of arrangements • GM HWB and other strategy updates • National policy updates • Updates from linked governance processes – eg Health Protection Forum, Healthwatch.	Items to include: • JHWS Performance monitoring (outcomes) • JSNA updates • PH annual report • HWB performance	Items to include: • Regular public service reform updates • Integrated Commissioning Programme – Care Together • Partner member business planning updates (including CCG operating plan)	Items to include: • Forward Plan • Consultation on key issues and developments