Health & Wellbeing Board

Start well | Live well | Age well

Blackburn with Darwen
Health and Wellbeing Board

Tuesday 7 March 2017 at 5.30pm
Conference Room 1, Blackburn Town Hall

Agenda

1. Welcome and Apologies
2. Minutes of the meeting held on 13th December 2016
3. Declarations of interest
4. Public Questions

ITEMS FOR INFORMATION ONLY OR FOR THE BOARD TO NOTE

5. Live Well thematic update – Sayyed Osman – verbal update
6. Joint Commissioning and Better Care Fund update – Claire Jackson
7. Health and Wellbeing Board Arrangements for Lancashire – verbal update – for information Dominic Harrison
8. Child and Adolescent Mental Health Services review update presentation – Kelly Taylor
9. North West Sector Led Improvement Infant Mortality Report – Helen Lowey
10. International Women's Week – verbal update – Cllr Maureen Bateson
11. Winter pressures – Kevin McGee – verbal update
12. New Pharmacy Legislation Requirements – Sheena Wood, NHS England

ITEMS REQUIRING DECISION

13. Eat Well Move More Shape Up strategy – Shirley Goodhew / Beth Wolfenden

Blackburn with Darwen Health and Wellbeing Board
Minutes of a Meeting held on Tuesday, 13th December 2016

PRESENT:

Councillors	Mohammed Khan (Chair)
	Maureen Bateson
	Mustafa Desai
Clinical Commissioning Group (CCG)	
	Dr Chris Clayton
	Graham Burgess
East Lancashire Hospital Trust (ELHT)	Kevin McGee
Lancashire Care NHS Foundation Trust (LCFT)	
Lay Members	Joe Slater
NHS England	--
Voluntary Sector	Vicky Shepherd
	Angela Allen
Healthwatch	--
Council	Linda Clegg
	Dominic Harrison
	Sally McIvor
	Steve Tingle
Council Officers	Charlotte Bradshaw
	Laura Wharton
	Christine Wood
CCG Officers	Claire Jackson
Other	

1 WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and apologies were received from Max Marshall, Penny Morris, Abdul Mulla, Damian Riley and Graham Urwin. The Chair advised the Board that Abdul Mulla (Vice-Chair of

Healthwatch) would replace Sir Bill Taylor on the Health and Wellbeing Board.

2 MINUTES OF THE MEETING HELD ON 27th SEPTEMBER 2016

RESOLVED - That the minutes of the last meeting held on 27th September 2016 be confirmed as a correct record subject to the amendment (item 2) that that minutes of the meeting on 21st June 2016 had been agreed as a correct record and not 27th September 2016 as previously stated.

3 DECLARATIONS OF INTEREST

Joe Slater declared an interest in agenda items 6 and 7 (Annual Safeguarding reports - Chair of Board of Trustees of CANW) and remained in the meeting during submission of each item to the Board.

4 PUBLIC FORUM

No questions had been received.

5 AGE WELL – THEMATIC UPDATE – PRESENTATION

A presentation was delivered to update the Board on the Priorites, Achievements, Plans and challenges in relation to 'Age Well' theme. Priorities were outlined as follows:

1. To develop Blackburn with Darwen as a Dementia Friendly community
2. To increase support to reduce social isolation and loneliness
3. To take action on agreed key determinants of the health of older people
4. To develop the local integrated service offer to promote independence

Progress in relation to each of the priority areas was outlined within the presentation which included detailed case studies and presentations, providing examples, a summary of achievements and positive outcomes in relation to each of the priorities.

The Board was advised of the Each Step Dementia Care Home that had opened in Blackburn in May 2016 (run by Community Integrated Care) and had recently been awarded 'Best Dementia Care Home 2016' at the National Dementia Care Awards. Phil Benson, Manager at Each Step had also been awarded the Best Dementia Care Manager 2016 at the event. Plans for the Albion Mill Extra Care Scheme were also outlined to the Board.

Future challenges were also outlined to the Board as follows:

- Combination of increasing numbers and complex needs was creating a non-linear increase in demand across health and care, areas like BwD suffer disproportionately given health inequalities, housing and poverty.
- Health life expectancy appeared to be decreasing
- Full integration of health and care mandated by 2020
- Prevention spend was under threat within health and social care although part of the solution
- Reducing resources and large scale budget pressure in social care impacting on the wider system

- Demographic pressures increase markedly after 2020 – we would need more of everything
- Dementia pathway needs improving
- Still too many “single points of access” and difficulty in navigating the health and care system

A discussion took place and some of they key points that arose were:

- Possible increase in local Council Tax to fund Social Care (not considered to be the answer for this area)
- Suggestion that increase in income tax would fairer process
- Lack of public transport issue leading to loneliness
- Unmet need for BME residential care

RESOLVED – That the presentation be noted.

6 LOCAL SAFEGUARDING ADULTS BOARD (LSAB) ANNUAL REPORT, 2015-2016 AND LOCAL SAFEGUARDING CHILDREN'S BOARD (LSCB) ANNUAL REPORT 2015-2016

A report was submitted presenting the Local Safeguarding Adults Board Annual Report and Local Safeguarding Children's Board Annual Report 2015-2016 to to the Board. Business Plans 2016-2017 for each Board were also presented to the Health and Wellbeing Board.

The Annual Reports set out how the various statutory functions of the Safeguarding Boards had been fulfilled in 2015-2016 and how local safeguarding arrangements would be improved and prioritised in 2016-2017.

It was reported that all priorities set out in the business plans aimed to ensure that children, young people and adults at risk of abuse and neglect in the borough were 'safe from harm' and 'felt safe from harm'.

The reports were key evidence to promote local accountability about the safety of local residents. For individual partners, their commitment and involvement in meeting the priorities set out in the business plans would be a key area of judgement in their partnership work.

It was reported that one of the statutory objectives of the Safeguarding Boards was to ensure the effectiveness of what all partners do to safeguard children, young people and adults at risk of abuse and neglect. All partner agencies of the Safeguarding Boards and of the Health and Wellbeing Board would be required to have regard to the priority areas set out in both reports.

It was also reported that Safeguarding Boards were funded through contributions by partner agencies. The reports also set out the budget and spending in 2015-2016; resource implications of the 2016-2017 priority areas would be met from the budget already agreed with Council Finance Officers (agreed for the 2016-2017 period in August 2016).

The Board was advised that all partners of the LSCB AND LSAB, including the voluntary sector had been consulted throughout the process of producing the document.

RESOLVED – That the reports be noted.

7 LGA PEER REVIEW – CHILDREN IN CARE, 2016 VERBAL UPDATE

The Board was advised of the The Local Government Association (LGA) recently completed peer review of Children's Services (5th – 8th December 2016). The peer review had been in the form of a Care Practice Diagnostic (CPD), designed to assist councils in further strengthening their work with and support to children and young people in care and to provide an independent view about the quality of care practice.

It was reported that the review team had noted strengths in Blackburn with Darwen in the commitment to children at all levels and across partners, the can-do culture, visible leadership and good engagement with children and young people.

It was further reported that a number of suggestions of areas had been made to consider for improvement, most of which had focused around the increased demand and the ability to meet that demand with current resources available. There were also some issues to consider, such as more joint commissioning around health, and a reconsideration of the work taken by the Multi-Agency Safeguarding Hub (MASH) to ensure that single agency work was not inadvertently being handed over to the MASH

RESOLVED – That the above be noted.

8 PENNINE LANCASHIRE TRANSFORMATION PROGRAMME/LANCASHIRE AND SOUTH CUMBRIA STP

A report was submitted to update the Board on the development of the Pennine Lancashire Transformation Programme's Local Delivery Plan and the Lancashire and South Cumbria Sustainability and Transformation Plan.

It was reported that Lancashire and South Cumbria, along with all other STP footprints, had submitted outline plans and financial information to NHS England and NHS Improvement in line with national requirements in June, September and October 2016.

Members were advised that the Lancashire and South Cumbria Sustainability and Transformation Plan (October 2016) had been published on 11th November 2016. Areas that had been focussed on were outlined in the report.

The Pennine Lancashire Transformation Programme was currently developing a Business Case, which would be published for consultation in January/February 2017. Proposals for a new model of care in line with the Programme's commitments were outlined in the report.

It was reported that the Programme was utilising the Solution Design Process to develop the new model of care. Solution Design provided a framework for designing, refining and approving the key elements of the new health and care system. This would ensure a wide range of health and care professionals and patient representatives were involved in the design of the new health and care system and included public engagement as an integral part of the process.

It was further reported that alongside the development of the new model of care, the Pennine Lancashire System Leaders' Forum was working through an agreed process to develop proposals for how an Accountable Care System could be designed for Pennine Lancashire. This would include consideration of the proposals for the new models of care and discussions about which services were appropriate for inclusion in the design of an Accountable Care System.

The Board was advised that a programme of consultation and engagement was underway as part of the Pennine Lancashire Transformation Programme. This had included three public engagement events to date and a strong social media presence alongside the regular publication of briefings and newsletters. Further engagement events were planned for early 2017.

An engagement report would be submitted to a future meeting of the Health and Wellbeing Board.

A copy of the Pennine Lancashire Local Delivery Plan on a Page was attached to the report for information.

RESOLVED – That the Health and Wellbeing Board:

1. Note the progress towards developing a Local Delivery Plan for Pennine Lancashire; and
2. Note the progress on development of the Sustainability and Transformation Plan for Lancashire and South Cumbria.

9 LANCASHIRE COMBINED AUTHORITY (LCA)

The Board was advised that the LCA had been in operation in shadow form since July 2016, continued to meet on a monthly basis and had five core policy themes as follows:

- Skilled Lancashire
- Better Homes for Lancashire
- Connected Lancashire
- Prosperous Lancashire
- Public Services Working for Lancashire

It was reported that the shadow LCA was already having a positive impact for Lancashire and was developing a Lancashire Plan which would set out a vision for Lancashire based on the five core themes.

The Board was advised that over recent months Leaders had been developing a proposal for devolution to the Lancashire Combined Authority, which could enable greater control, power and influence over a range of programmes and funding delivered in Lancashire.

Members were advised that in order to establish the Combined Authority, an Order must be laid before Parliament. It was anticipated that this would be agreed shortly and Leaders would be requested to write to the Secretary of State to consent to the Order being laid. It was also anticipated that the Lancashire Combined Authority would be formally established from April 2017,

although there was some frustration from Lancashire Leaders on the slow progress from Government, and this was also being reflected nationally.

RESOLVED – That the update be noted.

10 BETTER CARE FUND QUARTER 2 REPORT

A report was submitted to provide the Board with an overview of Better Care Fund performance reporting for quarter 2 (July-September 2016).

It was reported that the quarter 2 submission had been made on 25th November following sign off by the Chair of the Board. The submission had included an update on performance against national metrics between July and September 2016. Details of the performance against national metrics between July and September 2016 were outlined in the report.

A review of performance in relation to key successes, challenges and actions that had been included in the submission were also outlined in the report.

Members were advised that further submissions would be required on a quarterly basis and would be reported to the Health and Wellbeing Board at subsequent meetings.

The Board was reminded that the 2016/17 budget was £12,433,000. Details of how the budget had been allocated were highlighted as follows:

Spend on Social Care	£5,544,332.00
Spend on Health Care	£4,119,224.00
Spend on Integration	£2,165,536.00
Contingency	£603,908.00

It was also reported that it had been agreed that the contingency budget would be held until later in the financial year to enable a wider understanding of system requirements. This would be monitored by the Executive Joint Commissioning Group during quarters 3 and 4.

The Board was advised that the BCF policy framework and planning guidance for 2017-18 had not yet been released. It was expected that HWB's would be required to sign off plans prior to final submission. Guidance would be shared with Members of the Board once, published, along with required timescales for submission.

RESOLVED – That the report be noted.

Lancashire Children & Young People's Emotional Wellbeing & Mental Health Transformation Programme

Reflecting on Year 1 & Looking Ahead to Year 2: 'Our Business for the Future'

Tuesday 13th December 2016

Shirley Waters
Service Redesign Officer
Midlands and Lancashire CSU

Kelly Taylor
Commissioning Lead – Maternity, Children & Families
East Lancashire and Blackburn with Darwen CCGs

Overview

1. Recap on the Plan and year 1
2. THRIVE model of care
3. Funding allocations
4. What have we achieved across Pan Lancashire and in Blackburn with Darwen?
5. Preparing for year 2
6. Your views…

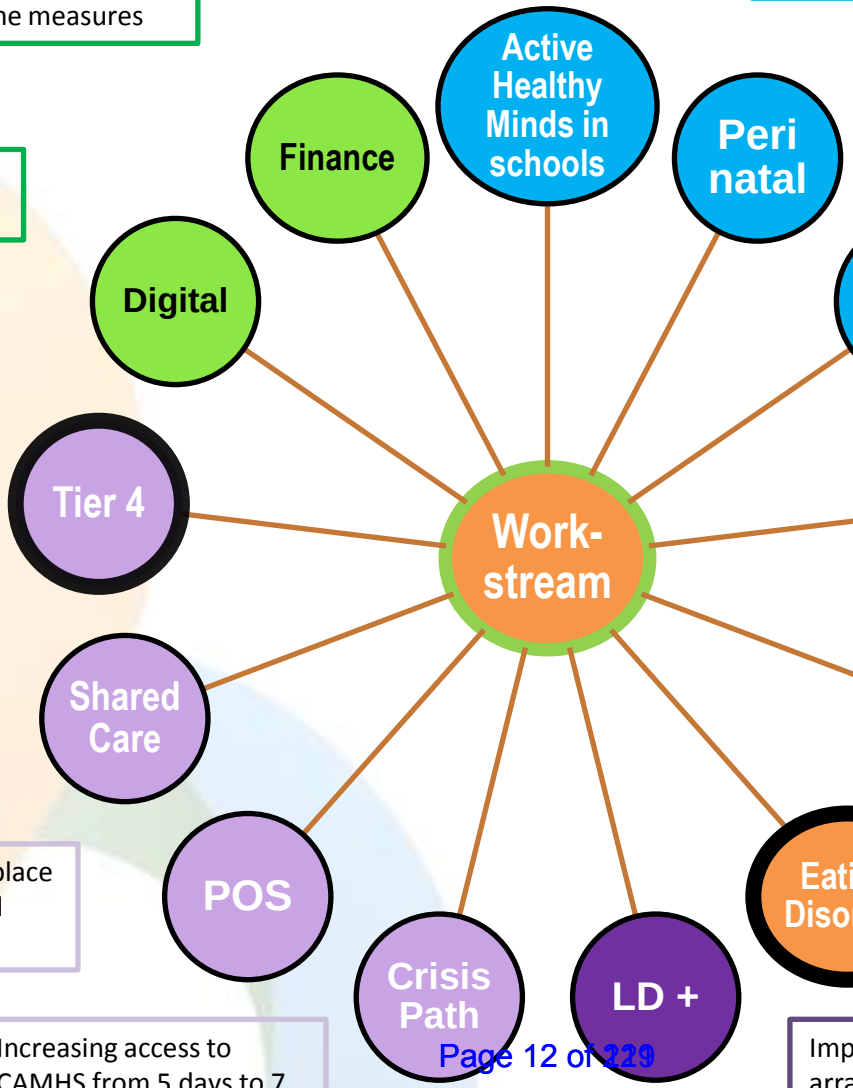
Recap on the Plan

- **0-25** years of age
- An additional **£3m+ a year** for 5 years
- Promoting **Resilience, prevention and Early Intervention**
- Increasing Access to Specialist **Perinatal and Infant Mental Health** Support
- Improving **Access** to Effective Support
- Ensuring appropriate support and intervention for CYP in **Crisis**
- Improving **Care for the Most Vulnerable**
- Improving Service **Quality**

THRIVE

Description of the THRIVE-Groups

Input offered



Lancashire Active Healthy Minds Programme targeting 40 schools a year

Pan Lancashire specialist peri natal community mental health team, delivering improved support for up to 500 women by 2019*

Monitoring of investment, consistent performance and outcome measures

Primary Mental Health Worker roles across Lancashire in 2017, to enable easier access to support and provision of a single point of contact for schools and primary care

Developing Digital Thrive by 2019

Improving access to psychological therapies by increasing the number of trained staff by up to 42 in 2017

Influencing NHS England for the provision of Tier 4 services

Extending the upper age range for community CAMHS up to the 19th birthday in 2017

Implementing a protocol and pathway across all acute providers and CAMHS services in 2017

Implementing a new Community Eating Disorder Service in 2017

Developing a dedicated place of safety for children and young people by 2019

Increasing access to CAMHS from 5 days to 7 days in 2017

Improving service arrangements for children with Learning Disabilities in 2017

Eating Disorder Allocation

	East Lancashire	Blackburn with Darwen	Pennine Lancashire Total
Eating Disorders	£214,000	£95,000	£309,000

Lancashire Care Foundation Trust to provide an all-age Eating Disorder Service commencing in April 2017

CCG Name	Shares of weighted pop'n (National)	2016/17	2017/18	2018/19	2019/20	2020/21
Blackburn with Darwen CCG	0.32%	£376,040	£442,400	£537,200	£600,400	£676,240
Blackpool CCG	0.37%	£437,920	£515,200	£625,600	£699,200	£787,520
Chorley and South Ribble CCG	0.32%	£376,040	£442,400	£537,200	£600,400	£676,240
East Lancashire CCG	0.71%	£847,280	£996,800	£1,210,400	£1,352,800	£1,523,680
Fylde and Wyre CCG	0.29%	£342,720	£403,200	£489,600	£547,200	£616,320
Greater Preston CCG	0.38%	£447,440	£526,400	£639,200	£714,400	£804,640
Lancashire North CCG	0.28%	£333,200	£392,000	£476,000	£532,000	£599,200
West Lancashire CCG	0.20%	£238,000	£280,000	£340,000	£380,000	£428,000
Total Lancashire		£3,398,640	£3,998,400	£4,855,200	£5,426,400	£6,111,840

Acceleration Funding

CCG Name	National Allocation Additional Monies	Shares of weighted population s (National)	Est. Share of add 21m	Est. share of add 4 m
NHS Blackburn with Darwen CCG	79,000	0.32%	£66,360	£12,640
NHS Blackpool CCG	92,000	0.37%	£77,280	£14,720
NHS Chorley and South Ribble CCG	79,000	0.32%	£66,360	£12,640
NHS East Lancashire CCG	178,000	0.71%	£149,520	£28,480
NHS Fylde and Wyre CCG	72,000	0.29%	£60,480	£11,520
NHS Greater Preston CCG	94,000	0.38%	£78,960	£15,040
NHS Lancashire North CCG	70,000	0.28%	£58,800	£11,200
NHS West Lancashire CCG	50,000	0.20%	£42,000	£8,000
National Resource	25,000,000		21,000,000	4,000,000
Total Lancs	£714,000		£599,760	£114,240

Blackburn with Darwen highlights

- Improving Access To Psychological Therapies
  11 staff (Pennine Lancs) CANW, CAMHS, Add-Action
- 6 Primary Care Mental Health Workers
- Winter Pressures – 44 Out of Hours assessments on Ward via A&E with 48 bed night saved
- Eating Disorders services extended up to 17th birthday, care offered 5 days a week 8AM – 8 PM. Meal support offered on Paediatric Ward

Measures of Success

National

- Eating Disorders for delivery of a dedicated community services with access times of 4 weeks (2 weeks for urgent cases)
- Transformation – At least 70,000 CYP each year will receive evidence based treatment. Local services will be able to meet the needs of 35% of those with diagnosable mental health conditions
- Perinatal Mental Health – An additional 30,000 women each year will receive evidence based treatment closer to home

Local Position 2016/17 (Q1 + 2)

- Number of WTE Staff = 14.5
- Number of local stakeholders received training = 180
- Number of CYP seen = 377

Health and Wellbeing Passport

Re-freshed Plan:

http://eastlancsccg.nhs.uk/patient-information/your-health/children-and-young-people-s-health/camhs-child-and-adolescent-mental-health-services

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Kelly Taylor Commissioning Lead – Maternity Children and Families East Lancashire & Blackburn with Darwen CCGs
DATE:	March 2017

SUBJECT:
Children & Young People Emotional Wellbeing and Mental Health Transformation Plan

1. PURPOSE
The purpose of this paper is to update the Health &Wellbeing Board of progress of implementation of the Emotional Wellbeing and Mental Health Transformation Plan since publication in December 2015.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD
Following receipt of this report and the presentation, it is recommended the Health & Wellbeing Board note;

- Governance systems and priorities of the Pan-Lancashire Transformation Board
- Local spend and outcomes delivered in 2016/17 (Appendix A)
- Proposals for Commissioning Priorities, Targets, Metrics and Outcomes and Intended Investment Plans in 2017/18 and beyond (Appendix B)

3. BACKGROUND
Following the publication of Future in Mind (Department of Health, NHS England and Department of Education) 2015; Clinical Commissioning Groups were tasked with leading on a 5 year Transformation Plan that would take a whole system approach to improving emotional health and wellbeing of children with a focus on improved access to services.

The presentation sets out progress to date including;

- Programme and local outcomes delivered
- Refresh of the Transformation Plan including priorities going forward
- NHS England expectations/assurance
- Governance of the TransformationBoard
- Challenges/risks

4. RATIONALE
The rationale is part of a driver to improve the parity of esteem and to ensure that within our health, social care systems and throughout our everyday lives we value mental health equally with physical health. NHS England has mandated growth in spend on health care to try and achieve investment levels that are on par with physical health.

The case for change is set out in the national document Future in Mind (2015), stating that 75% of mental health problems in adult life (excluding dementia) start by the age of 18. Failure to support children and young people with mental health needs costs lives and money. Early intervention

avoids young people falling into crisis and avoids expensive and longer term interventions in adulthood. There is a compelling moral, social and economic case for change

The last UK epidemiological study suggested that, at that time, less than 25% – 35% of those with a diagnosable mental health condition accessed support. NHS England has issued a target for health and social care economies to increase the number of children accessing services with a diagnosable mental health condition by 10%.

5. KEY ISSUES

Some of the key issues are fragmentation of services across health and social care systems. This includes NHS England who commission Tier 4 beds and it has been recognised through a national review that there is a shortage across the country. The impact of fragmentation at all levels impacts on children, families and staff who often struggle to get the right care at the right time.

6. POLICY IMPLICATIONS

The Emotional Wellbeing and Mental Health Transformation Board and the refresh of the Transformation Plan is in line with National Policy including;
Future in Mind, *NHS England, Department for Education and Department for Health* (2015)
Implementing the Five Year Forward View for Mental Health *NHS England* (2016)

7. FINANCIAL IMPLICATIONS

The Transformation Plan set out a financial baseline across Pan-Lancashire. There is an expected allocation to be used by CCGs from existing baselines in order to achieve a 'parity of esteem'. This means that funding for mental health should be on a par with physical health.

The baseline funding levels noted in the Pan-Lancashire plan reflect a collaborative way of working across health and social care systems. Health and Social care have in the past jointly funded CAMHS services as part of a collaborative commissioning response aimed at reducing fragmentation across the system.

NHS England are monitoring CCGs to ensure funding spent ensures a 10% increase in Children and Young People who are accessing services.

8. LEGAL IMPLICATIONS

Pieces of transformation work will check legal implications as required. For example where procurement advice is required.

9. RESOURCE IMPLICATIONS

The presentation will set out the financial commitment from CCGs going forward. This includes funding for a Community Eating Disorders Service and Transformation monies. Funding is expected to be drawn down for a Community Perinatal Mental Health Services through a bidding process.

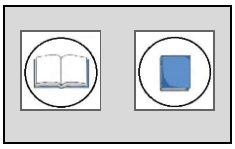
Resources cannot be considered in isolation and there is recognition of collaborative commissioning arrangements and partnership work across health and social care systems in order to achieve joint outcomes for children and young people. This is of particular relevance to our most vulnerable children and young people such as Looked After Children, those known to Young Offending Teams and involved in Child Sexual Exploitation who are over-represented within emotional wellbeing and mental health services.

10. EQUALITY AND HEALTH IMPLICATIONS
Equality Impact Assessments are undertaken for new services or changes in service. One example of this is for new Community Eating Disorder Service commencing in April 2017.

11. CONSULTATIONS
Consultation is undertaken with Children and Young People. Examples include; Consultation with young people prior to commissioning the new Eating Disorder Service. Local service consultation has been undertaken with prior to drawing up the Learning Disability Passports.

VERSION:	

CONTACT OFFICER:	
DATE:	
BACKGROUND PAPER:	



Pennine Lancs Transformation Funding 2016/17 Quarter 3	
15% Topslice - Pan Lancs Schemes	IAPT Backfill 2 year education programme Crisis
Primary Mental Health workers	**Primary Care Mental Health Workers** Funding provides a multidisciplinary Primary Care Mental Health on a 2 year pilot basis. Provision of Primary Mental Health Workers is a clear part of the CAMHS Transformation Plan and all CCGs are commissioning the service but the models may differ. Evaluation of the different models and outcomes will feed into the Resilience Work stream. This local team provides an outreach service from ELCAS and establishes close liaison, training and development with the Integrated Neighbourhood Teams in East Lancashire CCG and Integrated Locality Teams in Blackburn with Darwen CCG. The team are based in Primary Care and will support young people throughout different settings including education to facilitate a multi-agency response to mental health recovery. The teams will liaise with locality based prevention services through the Troubled Families Council based schemes. The teams are currently based at; Stonebridge Surgery, Oswaldtwistle, Roman Road Surgery, Blackburn and Yarnspinners, Nelson. This service was fully recruited to in Q2 of this financial year. **Number of staff: 6** **Number of additional YP supported: 28 new referrals**
Crisis Care – Out of Hours Assessments	An additional 1.5 WTE Band 6 hours provided from 1 August 2016 until 31 March 2017. This will cover the self-harm/ward assessment element of the service over 7 days rather than the 5 days currently commissioned. This will support increased daily capacity from current 2 daily self-harm assessments. Provision will include 8 hours a day on Saturdays and Sundays with 2 band 6 mental health practitioners and consultant psychiatrist cover, to run the self-harm assessments over 7 days. ELCAS will also provide training to the Emergency Department staff and where possible will undertake some shadowing and working alongside the Emergency Department staff. Financial commitment for recurrent funding is available from 1 April 2017 subject to agreement on the model through the Pan-Lancashire Crisis group. **Number of staff: 1.5 WTE** **Number of additional YP supported: 16 weekend referrals and/or YP assessed saving around 25-30 bed days**
Perinatal Mental Health	Scoping of mental health support required in Neonatal Intensive Care service. The Womens Centre will undertake a scoping exercise of how families can be supported with emotional health and wellbeing whilst babies are under the care of in the Unit and through engagement with Core services if required. 30 MP3 Players with self-hypnosis and relaxation from the EMPOWER programme. This will be a library of resources available to vulnerable groups. It is available at a cost of £5 for other service users. 25 Health Visitors to undertake Neonatal Behavioural Observation Training

	delivered by Brazelton. This is recommended within the National Health Visitor Service Specification (NHS England) and the 1001 Critical Days Coalition as best practice example of promoting infant and parent mental health an secure attachments. Training is 2 days theoretical and practical. Practitioners will incorporate practice which takes 15-20 minutes into core contacts including New Birth Visit and 1st Mental Mood Assessment **Number of staff Trained: 25** **Number of Posts: 1 WTE**
ASD /ADHD Pathways	Leaflets and resources for patients around ADHD pathways
ADHD Northwest	Funding for 12 months for this voluntary sector provision in Blackburn with Darwen. This supports a Pennine Lancashire services as is already funded in East Lancashire. This is to respond to gaps identified in provision of family support for families of children with ADHD **Number of staff: 1** **Number of additional YP supported: service only commenced on the 1 October 2016 awaiting report.**
Action for ASD	Funding for 12 months for this voluntary sector provision in Blackburn with Darwen and East Lancashire. This is to respond to gaps identified in provision of family support for families of children with ASD and offers 1:1 support and Cygnet Parenting Courses. **Number of staff: 3WTE** **Number of additional YP supported: East Lancs new referrals 94, with 285 contacts. BwD service only commenced on the 1 November 2016, awaiting report.**
Project Manager	CAMHS Commissioning Manager for East Lancashire and Blackburn with Darwen CCGs
Voluntary Sector Innovation	Health and Wellbeing Grants to be available for third sector organisations to bid for small pots of funding to support children and young people with early intervention emotional health and wellbeing services available in local areas. **Number of innovations: First phase of applications for BPR, nine applications successful. Second phase roll out in January.** **Number of young people supported: Up to 630 for the first phase for Burnley, Pendle and Rossendale**
Self-Harm Training (Harm-Ed)	Harm-ed has provided self-harm training to adults who come into contact with children and young people, in particular health, education and social care. During the original commission during 2015/16 26 courses were delivered across Pennine with a total of 452 participants attending, including a session at the BwD GP protected learning time. Due to demand the commission has been extended till the end of March 2017 with 143 out of the 198 places already booked.

	Number of staff Trained: During the first commission 452, with 152 booked on the remaining sessions
CYP IAPT Training **IAPT Readiness**	**Number of staff on training including representatives from the voluntary sector: 18** Funding for hand held devices to enable staff working in the community to undertake assessment and record outcomes in 'real time'. **Number of devices:**
Self-harm	N-Compass commissioned from April 2016 for 12months to provide self-harm workshops and one to one counselling to pupils identified as using self-harming behaviours who attend high schools across Pennine Lancashire. NCompass will provide six week programmes to high schools signed up to the project. Pilot of safe self-harm 'distraction items' to be provided on the Paediatric Wards and within ELCAS. This is based on similar provision at Blackpool Teaching Hospital. Evaluation by young people on effectiveness in respect to self-care with a view to further roll out to pharmacies. **Number of staff: 2 WTE** **Number of young people supported: 61**
Training Courses/Community Development	National training courses including Perinatal MH for Front line staff.

Appendix B

2017/18 Commissioning Priorities, Targets, Metrics and Outcomes and Intended Investment Plans (Summary)

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
Promoting resilience, prevention and early intervention				
1. By the 30th September 2017 we will have designed and commissioned a **"Mental Health Anti-Stigma Campaign"** building on the existing approach through "Life's ups and downs". By the 31st March 2018 we will have mobilised the campaign across Lancashire.	30.9.17 31.03.18	**Health & Wellbeing:** The campaign will give children, young people and their families, practical advice and support to help them look after their own emotional health and wellbeing, creating resilience. **Care & Quality:** The programme will raise awareness and understanding of emotional wellbeing and mental health, enabling CYP and their families to be identified earlier, better supported and accessing the right support, in the right place, at the right time. **Finance & Efficiency:** Greater resilience will enable us to more effectively respond to predicted increasing demand.	**Local measures:** Number of people visiting the 'Coping with life's ups and downs' website. Life in Lancashire survey – 2-3 questions.	**Nil**
2. By the 31st March 2018 we will have developed, published and launched a Lancashire wide **"Resilience Framework"** which will includes the following components: • Set a common	31.3.18	**Health & Wellbeing:** The framework will help to ensure that any resilience programmes and work that are commissioned and delivered are in line with best practice thus maximising children and young people's resilience, including their ability to manage and recover from mental	**Local measures:** Stakeholder feedback. Life in Lancashire survey – 2-3 questions. Take up of toolkit.	**Nil**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
understanding of what is meant by 'Resilience' in the context of the pan-Lancashire area, in line with the CYP EWMH Transformation Programme. • Provide a step by step guide considering, what, where, with whom and how resilience activities should be best delivered according to the evidence base. • Provide information about sources of local good practice and opportunities for local networking and support. • Provide a quality assurance checklist to ensure that activities are high quality, safe, and based upon best practice.		health issues. **Finance & Efficiency:** Greater resilience will enable us to more effectively respond to predicted increasing demand.		
3. By the 31st March 2019 we will have designed and commissioned a **"Resilience training programme"** in line with the resilience framework for: a. Schools b. CYP c. Families d. Parent carers and young carers	31.3.19	**Health & Wellbeing:** The programme will give children, young people and their families access to practical advice, support, tools and techniques to help them look after their own emotional health and wellbeing. Maximising children and young people's resilience, including their ability to manage and recover from mental health issues. **Care & Quality:**	**Local measures:** Uptake of training programmes Participant feedback Life in Lancashire Survey – 2-3 questions	**Nil**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
e. Other staff working with CYP and families in universal and community service 2017/18 Continue Year 2 of the Active Schools Programme		The programme will raise awareness and understanding of emotional wellbeing and mental health, enabling CYP and their families to be identified earlier, better supported and accessing the right support, in the right place, at the right time. **Finance & Efficiency:** Greater resilience will enable us to more effectively respond to predicted increasing demand.		**£72,000**
4. By 31st March 2018 we will have defined a **"complementary offer"** of support to wrap around clinical services to help children; young people and families avoid escalation, recover earlier and maintain wellbeing. We will have mobilised by 2020/21.	31.3.18 31.3.21	**Health & Wellbeing:** By nurturing the development of a range of asset based supports such as peer support, buddying, online communities, community events and mutual aid we will enable and empower children, young people and families to support themselves and each other. **Finance & Efficiency:** Nurturing resilience and the development of community assets will enable us to more effectively respond to predicted increasing demand.	**Local measures:** Life in Lancashire Survey – 2-3 questions	**£73,934**
5. By the 30th September 2017 we will have expanded the number of **"Primary Mental Health Workers"** (PMHW) or their equivalent and introduced **"Psychological Wellbeing Practitioners"**	30.9.17	**Health & Wellbeing:** By providing the link between specialist CAMHS and primary and community services the workers will help to: • Build capacity and capability within community services in relation to prevention, early identification and	**Local measures:** Service user views Number of assessments Number of evidence based therapeutic interventions Outcome measures to be agreed PMHW and PWPs in post	**£683,513**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
(PWPs) to work within universal and targeted services to support and improve mental health and psychological wellbeing of children and young people.		intervention. • Help promote awareness and importance of emotional health and wellbeing, improving perceptions and attitudes. **Care & Quality:** Support access to appropriate services. Offer effective assessments and evidence based therapeutic interventions. **Finance & Efficiency:** Greater resilience will enable us to more effectively respond to predicted increasing demand.		
6. By the 30th September 2017 we will have defined and designed a Lancashire wide approach to delivering a **"single point of contact"** which will include the following components: • A definition of what we mean by single point of contact • A description of the component parts of the single point of contact • Guidance for commissioners on how to implement the approach locally • Resources and tool for providers to use to develop local protocols	30.9.17	**Care & Quality:** By establishing a consistent approach to single point of contact across Lancashire we will ensure that speed and ease of access to a seamless service is improved, reducing delays and ensuring that children and young people receive the support they need. **Finance & Efficiency:** By improving timely access to support and treatment, escalation will be reduced and as such the number of contacts and the need for more intensive services will decrease. We will also reduce the number of inappropriate referrals by providing support earlier in the pathway.	**National measures:** Referral to treatment times for IAPT and ED. **Local measures:** Referrals to CAMHS Inappropriate referrals to CAMHS Admissions to tier 4 Patient experience measures	**Nil**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
By 31st March 2018 we will have implemented the **"single point of contact"** approach in each health economy.	31.3.18			
Increasing Access to Specialist Perinatal and Infant Mental Health Support				
7. By March 31st 2021 we will have delivered "**improvements in Universal Services"** including: • Consistent Clinical Pathways • specialist post and leadership roles on universal services	31.3.21	**Health & Wellbeing:** • The development of resilient children supported by positive parent and child attachment achieved via multidisciplinary family centred approaches. • Early recovery and maintenance of mental well-being that enables women with serious or complex mental illness and their families to function effectively in day to day life i.e. childcare activities, employment, social activities etc. **Care & Quality:** • The ability for women to make informed choices through the provision of pre conception counselling. • A reduction in the risk of avoidable harm to women and infants due to mental health needs in the perinatal period. • A reduction in the severity, duration, and the negative impact of mental illness in the perinatal period. **Finance & Efficiency:** • Access to specialist care close to home reducing the need for inpatient	**National Measure:** NICE Quality Standards QS133 National Data set **Local Measure:** Evidence of local arrangements to undertake comprehensive assessment before intervention programme for attachment difficulties	**Nil**
8. By March 31st 2021 we will have delivered **"improvements in services for infant mental health"** including: • Infant Mental Health posts to be commissioned and emerging new pathways developed. • Training of Adult Psychiatry and IAPT services.	31.3.21		**National Measure:** NICE Quality Standards QS133 National Data set IAPT Data set **Local Measure:** Evidence of local arrangements to undertake comprehensive assessment before intervention programme for attachment difficulties	**Nil**
9. By the 31st March 2021 we will have commissioned a **"specialist"** community perinatal mental health team allowing at least an additional 495 women each year to receive evidence based	31.3.21		**National measure:** Number of women receiving specialist peri-natal care in a community team. **Local measures:**	***Subject to release of national resource**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
treatment closer to home when they need it. *subject to release of national resource		admission and eliminating the need for travel to access specialist care out of area.	21 women per year accessing specialist inpatient mother and baby units.	
10. By the 31st March 2021 we will have a **"specialist"** inpatient mother and baby unit allowing at least an additional 21 women each year to receive evidence based treatment closer to home when they need it. 2017/18 Continue year 2 funding of peri natal community service pilots	31.3.21		Patient reported outcome measures.	***Subject to release of national resource** **£103,971**
Improving Access to Effective Support				
11. By 31st March 2017 we will have developed a specification and commissioned a provider for an online one stop portal known locally as **"Digital THRIVE"** offering information, advice, self-help, care pathways and self-referral. By 31st March 2018 our online one stop portal known locally as **"Digital THRIVE"** will be operational across Lancashire	31.3.17	**Health & Wellbeing:** The portal is expected to improve the health and wellbeing of CYP and families by improving access to information, self-help materials and support: • Enabling people to access support earlier • Reducing reliance on T3 and T4 CAMHS • Supporting appropriate use of CAMHS	**Local measures:** Reduction in % inappropriate referrals to CAMHS. Increase in the number of CYP with a diagnosed mental health condition enabled to access help. Number of hits on the Digital Thrive portal.	**Nil**
12. By the 31st March 2017 we will have established a dedicated all age **"eating disorder"** service which fulfils the requirements of the Eating Disorders Commissioning Guide: Access and Waiting	31.3.17	**Health & Wellbeing:** The service is expected to improve outcomes for CYP with ED by: • Offering a dedicated specialist service offering NICE guideline compliant treatments. • Improving access to information, advice	**National measures:** By 2020/21, 95% of CYP (up to age 19) referred for assessment or treatment for an ED should receive NICE-approved treatment within 1 week for urgent cases and 4 weeks for every other case.	**£865,000**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
Time Standards (NHSE).		and self-help through the development of an upstream offer. **Care & Quality:** The service is expected to improve access to ED support that is compliant with national commissioning guidance. **Finance & Efficiency:** The service is expected to lead to reduced admissions to tier 4 CAMHS ED beds.	**Local measures:** Admissions of CYP with ED to Tier 4 CAMHS ED beds. Patient reported outcome measures.	
13. By 30th September 2017 we will have a **"0-19"** years (up to 19th birthday) CAMHS service model operational across Lancashire which will include arrangements for 7 day working and out of hours provision.	30.9.17	**Care & Quality:** The new 0-19 arrangements will offer a consistent level of service across Lancashire, supporting greater numbers of children and young people to access the support they need. The new arrangements will also improve outcomes by delaying transitions until after adolescence, enabling continuity of care throughout this challenging period for CYP and families. The 0-25 offer will ensure a comprehensive and consistent set of services and supports across Lancashire. **Finance & Efficiency:** Increased access and continuity of care will lead to better outcomes for CYP and will enable us to more effectively respond to predicted increasing demand. In the longer term it will lead to reduced demand for adult mental health services.	**National measures:** By 2020/21, at least 35% of CYP with a diagnosable mental health condition will receive treatment from an NHS funded community mental health service. By 2021, increased numbers of therapists and supervisors will have been employed to meet the additional demand. **Local measures:** Admissions to CAMHS tier 4 inpatient beds. Patient reported outcome measures.	**£652,168 (equal to the LCC disinvestment in LCF and ELHT 7 months pro rata)**
14. By 31st March 2018 we will have defined a local offer of service provision for CYP with EWMH needs aged **"0-25"** years. By the 31st March 2020 we will have developed and implemented our **"0-25"** years offer.	31.3.18 31.3.20			**Nil**
Ensuring appropriate support and intervention for C&YP in Crisis				
15. By 31st March 2017 we will have developed and implemented a **"pathway"** for	31.3.17	**Care & Quality:** The pathway and protocol will lead to a consistent multi-agency response to CYP	**Local measures:** Time from triage to admission and assessment (if appropriate).	**Nil**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
CYP admitted to acute hospitals in crisis and a set of shared principles to be incorporated into local operational protocols. By 30th September 2017 all acute hospitals will have worked with local CAMHS providers and agreed local operational protocols.	30.09.17	who are admitted to paediatric wards, ensuring their needs are assessed in a timely and holistic way, reducing lengths of stay and reducing delayed discharges. **Finance & Efficiency:** The pathway and protocol will lead to reduced lengths of hospital stay and reduced incidences of delayed discharge.	Length of stay. Delayed discharges.	
16. By 31st March 2018 we will have developed and implemented as part of the all-age crisis care concordat • a **"consistent crisis response service** "for C&YP within acute hospitals e.g. mental health triage/liaison services in A&E • Provision of mental health support helplines for CYP, parents, carers, schools, the voluntary sector and other professionals.	31.3.18	**Care & Quality:** Children and young people across Lancashire will receive a consistent response when they are in crisis.	**Local measures:** Number of staff trained to treat young people with empathy and supportive methods. Admissions to acute and specialist services.	**Nil**
17. By 31st March 2017 we will have "**7 day CAMHS crisis response service to CYP in acute hospitals"** in place across Lancashire.	31.3.17	**Care & Quality:** Children and young people across Lancashire will receive a timely response from local CAMHS services 7 days per week. **Health & Wellbeing:** By providing a 7 day service children and	**Local measures:** Time to triage and assessment. Length of stay. Number of acute admissions.	**£760,895**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
		young people will be supported to avoid escalation and maintain their wellbeing.		
18. By 31st March 2019 we will have **"Place of Safety (Section 135/6) and improved Crisis Assessment facilities"** in place across Lancashire CYP.	31.3.19	**Care & Quality:** Dedicated and tailored facilities will offer children and young people a more appropriate environment for assessment at times of crisis. **Health & Wellbeing:** Children and young people will be supported to avoid escalation and maintain their wellbeing.	**Local measures:** Number of acute admissions.	**Funding from separate Crisis Concordat pilot monies**
19. By 31st March 2017 we will have developed a **"Tier 4 collaborative commissioning plan"** for inpatient services for children and young people in Lancashire which supports our aspiration to work towards a balance between inpatient beds and intensive outreach support.	31.3.17	**Care & Quality:** The work will improve access to Tier 4 CAMHS services for CYP by ensuring that the level of provision locally reflects demand. It will also improve the quality of patient experience by developing a seamless pathway. **Finance & Efficiency:** Reducing admission to Tier 4 will free up investment that can be re-invested in community based services.	**National measures:** Total bed days in CAMHS tier 4 per CYP population. **Local measures:** Tier 4 out of area placements. Tier 4 admissions. Tier 4 delayed admissions. Tier 4 delayed discharges.	**Nil**
20. By 31st March 2021 we will have developed, agreed and implemented clear **"Tier 4 pathways"** for CYP entering and leaving Tier 4 services.	31.3.21			**Nil**
Improving Care for the Most Vulnerable				
21. By 31st March 2021 we will have implemented a minimum service offer **"pathway for vulnerable groups" which seeks to improve access to assessment ,services and**	31.3.21	**Care & Quality:** • Thresholds for CAMHS and the CAMHS offer for vulnerable groups will take cognisance of complexity and the specific needs of the vulnerable groups.	**Local measures:** Gold Standard pathway in place for Autism based on NICE guidance and ratified by Strategic Clinical Network (SCN). Waiting times	**£520,636**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
outcomes as follows: a. Children with ADHD b. Children with ASD c. Children looked after d. Children with Learning disabilities e. Children vulnerable to exploitation f. Children in contact with the youth justice system g. Children with adverse childhood experiences		• There will be a standardised approach to diagnosis through tools and MDT • Support for families on waiting list for diagnosis or where children have a diagnosis of Autism or ADHD. • Improved pathway for vulnerable children and within THRIVE model 'getting support'. Families are able to accept diagnosis and are supported to make a management plan. • Alignment of outcomes with Transforming Care Programme for CYP with LD who are over-represented in CAMHS Services. • Implementation of Routine Enquiry for Adverse Childhood Experiences. • Training programme for staffing and building Routine Enquiry as a commissioning requirement within Service Specifications • CAMHS, Paediatrics, LD and school nursing (including Sp school nursing) have up to date training to support children with Autism, ADHD, Learning Disabilities, children known to CSE and YOT	Families feel supported/ prevention family breakdown/improved emotional wellbeing of CYP. Pathways and reduced admissions through proactive Care and Treatment Reviews Vulnerable young people feel able to understand reasons for behaviour earlier and be supported Following ACE Training, Staff in universal services understand the impact of adversity on behaviours	
Improving Service Quality				
22. By 30th September 2017 we will have established and mobilised a CYP Lancashire wide **"provider network"** to facilitate joint working and	30.9.17	**Care & Quality:** Improved joint working and collaboration, partners sharing learning and working jointly on relevant standards, targets and pathways. This will lead to improved	**Local measures:** Work programme delivers agreements on shared approaches.	**Nil**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
collaboration, improve pathways and share good practice.		coordination of services between providers and seamless pathways for children young people and families. Documentation and procedures will be consistent.		
23. By 31st December 2017 the network will have a defined **"provider network work programme"** focussing on the following key priorities: a. Early intervention in psychosis b. Self-harm c. Workforce retention, recruitment, training, CPD and supervision d. Carers and working carers assessments and feedback e. Policies, procedures and guidance f. Approach to risk support in line with Thrive g. Information sharing h. Using outcomes to inform practice and service planning i. Prescribing protocols j. Suicide strategy k. Transitions policy l. Out of hours psychiatry model m. CYP IAPT programme n. Parity of esteem with physical health	31.12.17			**Nil**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
2017/18 Continue to fund the IAPT Programme				**£330,000**
24. By 31st March 2017 we will have developed a **"performance dashboard"**.	31.3.17	**Care & Quality:** Gaps and issues will be more readily identified and addressed.	**Local measures:** Time from issue or breach to actions to address them.	**Nil**
25. By 31st March 2017 CAMHS service providers will routinely collect **"outcome measures"** which will be aggregated and reported through to the System Performance Group.	31.3.17	**Care & Quality:** Consistent comparisons between providers will enable gaps in provision to be addressed as a whole system. **Finance and Efficiency:** Members of the system will hold each other to account.	**Local measures:** Dataset available and reported routinely.	**Nil**
26. By 31st March 2018 NHS commissioned services will produce and publish produce and publish **"annual quality improvement plans".**	31.3.18	**Care & Quality:** Drawing on the work of the provider network, performance dashboard and outcome measures service providers will be able to readily identify areas for improvement, develop plans to address these and work collaboratively to implement.	**Local measures:** Plans published annually and actions implemented.	**Nil**
Total 17/18 Investment on schemes (exclusive of the ring fenced allocation for Eating Disorders): £3,197,117 **Noted: Remaining balance is available to support non STP funded programme costs. There is also a variance to BWD CCG resulting from BWD Local Authority continuing to fund their contribution to CAMHS. This has resulted in more transformation monies being available for local spend in BWD CCG and these will be spent collaboratively with the HWWB against their priorities.**				

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Linda Clegg, Director of Children's Services Dominic Harrison, Director of Public Health
DATE:	February 2017

SUBJECT: Update on the Sector Led Improvement Review for Infant Mortality and its recommendations

PURPOSE

1. To provide an update on the recent North West Sector Led Improvement Review on Infant Mortality.

2. To provide assurance that the recommendations from the Review are being actioned via the Director of Public Health and/or the Chair of the Local Safeguarding Children's Board (LSCB), as appropriate.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

1. Note the local arrangements that are in place to reduce infant mortality.
2. Note the local arrangements put in place to respond to the recent North West Sector Led Improvement Review on Infant Mortality
3. Receive an update in 12 months' time on the progress from the North West Sector Led Improvement Review on Infant Mortality recommendations.

3. BACKGROUND

Historically, rates of deaths in the first year of life (infant mortality) have consistently been significantly higher than the regional and national average in Blackburn with Darwen. In 2013, a local review of how best to deliver this priority for children's health and wellbeing took place across Blackburn with Darwen and, East Lancashire (where there are similar outcomes in Pendle and Burnley). From the local intelligence on infant mortality and to align with both commissioner and service provider geographical areas, a Pennine Lancashire approach was agreed to reduce infant mortality. This proposal was supported by the Public Health Directors for Blackburn with Darwen and the East Lancashire Locality, by both East Lancashire and Blackburn with Darwen Clinical Commissioning Groups (CCGs), East Lancashire Hospitals Trust (ELHT), who provide Maternity and Paediatric services and Lancashire Care Foundation Trust (LCFT), who provide Health Visitor Services, both across Pennine Lancashire.

The Pennine Lancashire Infant Mortality Group continues to meet to work together to reduce infant mortality via an agreed Framework for Action, which is underpinned by:

- On-going analysis of infant mortality data and intelligence to inform developments.
- An assets based approach, building on strengths and co-production (where service users, carers, service providers come together to find a solution and co-design the services).
- Consideration and application of evidence based practice and benchmarking e.g. Born in Bradford study.
- Impact of the wider determinants of health on infant mortality and how this can be addressed e.g. education, housing, employment.

The Priorities within the Framework are as follows: Smoking in Pregnancy; Infant Feeding; Safer Sleeping; Social Needs Assessment; Maternal Healthy Weight; Family Genetics; Maternal Mental Health; Awareness raising for wider partners, which were prioritised based on the above principles.

4. RATIONALE

In 2016, 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.

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.

The Review focussed on child deaths aged under one year; this age range accounts for around two thirds of all child deaths both locally and nationally. 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).

The aim of the review was to:

i. 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.
ii. Taking an appreciative enquiry approach to identify places where actions have resulted in improved outcomes and share the learning.
iii. Identify key themes and recommendations at LA, sub-regional and North West levels.
iv. Outcomes of the review to provide potential opportunities for collaborative work programmes which may include commissioning.
v. Enable sharing of good practice and innovation to aid mutual support and drive improvement in outcomes.
vi. Identify any gaps in data and intelligence and provide recommendations for Child Death Overview Panels (CDOPs).
vii. Produce an action plan for Local Area Safeguarding Children and Adult Boards who will be responsible for oversight and implementation.

From the Review, there were 30 recommendations for the Regional level, and 22 recommendations for the Individual Localities. The overall ask was to:

- Consider and agree how the locality recommendations should be translated into local action plans.
- Agree the governance and accountability arrangements to assure implementation of locality recommendations.
- Provide an annual update on implementation progress to the LSCB, Health and Wellbeing Board (HWBB) and local CDOP.

For Blackburn with Darwen, the recommendations for the Individual Localities are to be incorporated into the Pennine Lancashire Framework. The majority of the recommendations are already within the local framework and progress is presented in Appendix 1.

For Blackburn with Darwen, the governance and accountability for Infant Mortality is the Health and Wellbeing Board via the Children's Partnership Board and, the Borough's LSCB.

An update on progress of the Individual Localities will be reported in 12 months to the Pan Lancashire CDOP.

5. KEY ISSUES

A number of actions via recommendations were identified from the Review; of which 22 were identified for Individual Localities. Appendix 1 outlines all of the Individual Locality Recommendations and provides a brief summary of status, and the recommendation for the next steps.

Please refer to Appendix 1 for the summary of actions / recommendations.

6. POLICY IMPLICATIONS

This Review aligns to our local policy and priorities and strengthens the work that is already progressing across the Borough to reduce Infant Mortality.

7. FINANCIAL IMPLICATIONS

There are no financial implications with the outcomes of the Review and its recommendations.

8. LEGAL IMPLICATIONS

There are no legal implications with the outcomes of the Review and its recommendations.

9. RESOURCE IMPLICATIONS

There are no resource implications with the outcomes of the Review and its recommendations.

10. EQUALITY AND HEALTH IMPLICATIONS

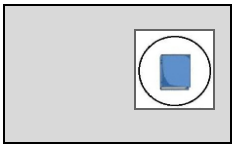
There are no equality and health implications with the outcomes of the Review and its recommendations.

11. CONSULTATIONS

There are no further consultations required as the Review took an appreciate enquiry approach and was gathering good practice / consultations within the Review.

VERSION:	Ver 0.4

CONTACT OFFICER:	Helen Lowey, Consultant in Public Health, Blackburn with Darwen Borough Council
DATE:	06 / 02 / 2017
BACKGROUND PAPER:	Appendix 1 Sector Led Improvement (SLI) Infant Mortality: Recommendations for individual localities Sector Led Improvement Review: Infant Mortality



Appendix 1

Blackburn with Darwen Borough Council /Blackburn with Darwen Local Safeguarding Children's Board

Sector Led Improvement (SLI) Infant Mortality: Recommendations for individual localities

Recommendation for individual localities Proposed lead: Chair of LSCB/ Director Public Health (Directly taken from the Review)	Blackburn with Darwen Borough Council Comments	Recommendation for Local Action
Child Death Overview Panel (CDOP)		
1. Clearly define governance of CDOP report within individual localities.	Pan Lancashire CDOP Annual Report is presented to Blackburn with Darwen's (BwDs) Children's Partnership Board and, BwD's Local Safeguarding Children Board (LSCB). It will also be discussed at the Pennine Lancashire Infant Mortality meeting in addition	To maintain the governance that is in place
2. Clarify how findings from CDOP cases within the locality are shared for action.	Actions arising from individual cases are tracked by the Pan Lancashire CDOP. Within the BwD locality these are also presented to the Pennine Lancashire Infant Mortality Group.	To maintain the governance that is in place
Capacity to improve		
3. Identify a named lead for reducing infant mortality within the locality	Currently public health chair the Infant Mortality Group, but no formally named lead	The Director of Public Health (DPH) should be nominated as the lead officer
4. Identify a lead elected member for reducing infant mortality	Currently public health chair the Infant Mortality Group, and reported to Health SPT but no formally named lead	The portfolio holder for Health should be nominated as lead elected member

Appendix 1

5. Modifiable factors associated with infant mortality are firmly embedded in integration programmes. (Modifiable factors include safeguarding in relation to abuse and neglect, smoking, drugs and alcohol misuse, and co-sleeping)	This is part of the Pennine Lancashire Infant Mortality Framework as the enabler	To strengthen this recommendation within the local Framework
6. Consider opportunities to influence behaviour change and social norms for modifiable factors associated with infant mortality (such as social movement).	**Smoking in pregnancy** Tobacco Free Lancashire Strategy See comments within recommendations 17 to 21 below for further details. **Diet and nutrition** Eat Well, Shape Up Move More Strategy, including promotion of breastfeeding **Stress** The Parenting Strategy supports this component as does the work across the Mental Health First Aid Training programmes etc. Emotional Wellbeing for children and young people (including parents) is a priority for the Children's Partnership Board and part of the Early Help offer. Pan Lancashire Emotional Health & Wellbeing (CAMHS) Systems Board provides leadership and development of programmes and services for children, young people and families' mental health and wellbeing, which includes BwD representation. **Healthy pregnancy** Local programmes include work to reduce alcohol exposed pregnancies, and promote healthy	To review the actions within the Pennine Lancashire Infant Mortality Framework and cross-check with the thematic strategies

Appendix 1

	pregnancy and breastfeeding. Children's Centre's deliver Healthy Start voucher and vitamins schemes (see 22. below for further details). Also part of the Early Help Offer Other relevant strategies and action plans include: • Domestic Abuse Strategy • Alcohol Strategy • Accident Prevention Strategy • Substance Misuse Strategy • Health and Wellbeing Strategy • Children & Young People's EHWB Transformation Plan • Lancashire Infant feeding plan • Healthy Child Programme – local delivery model	
7. All services commissioned are evaluated to ensure they make positive changes to modifiable factors	This is undertaken in an ad hoc manner	To have an explicit recommendation within the Pennine Lancashire Framework to ask this directly and capture the responses.
Safeguarding		
8. Data sharing and information governance within localities facilitates safeguarding for all agencies	Currently covered via LSCB's Information Protocol: defines legal gateways for sharing information between agencies for safeguarding purposes. Within midwifery and health visiting there is the consent to share process that is completed at initial visits/appointments and both services complete	For the LSCB and Infant Mortality Groups to continue the learning and progress with data sharing.

Appendix 1

	initial 'social needs assessments'. Recent serious case reviews (SCRs) have identified the process in both organisations requires improvement to include family history (adverse childhood experiences possible option) and checking self-reported history with other agencies as currently reliant on self-reporting alone. The process in midwifery of managing pregnancies between community and hospital midwifes requires improvement as all information on risks is not always in records, especially hospital records. Information on unmet need is usually in patient hand-held midwifery records.	
9. Effective partnership working including information sharing to support safeguarding.	Existing process between midwifery, health visiting and children's centres to share information and refer to services at early help level. Both health providers also have processes to refer to their safeguarding teams for any risk cases that require referral to Multi Agency Safeguarding Hub (MASH) for Children in Need /Child Protection /Looked After Children concerns. The LSCB's Continuum of Need Framework identifies the thresholds for Early Help to Looked After Children concerns and audit identifies that most agencies do understand the thresholds.	To continue with the good partnership working and to continue to be strengthened.
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	Whilst LSCB training does not cover explicitly the risks associated with infant mortality, CDOP & SCR briefings do. Training sessions on safer sleep have been delivered in the past. BwD's risk model is covered in LSCB training and this	There is an opportunity to consider current training needs and how these could best be addressed to look at ways in which all front line staff could ensure consistent messaging and brief interventions

Appendix 1

	focuses on practitioners becoming knowledgeable on assessing unmet need and risks using accepted child development milestones within the assessment framework (the framework has three domains: child's needs; parenting capacity; and family/environmental factors). Within the domains are further sub-domains that cover implicitly infant mortality.	on factors associated with infant mortality e.g. safer sleeping, smoke free pregnancy, smoke free homes, breastfeeding, managing stress, and healthy weight.
11. Review working practices for professional staff working in deprived areas and ensure rotation to more affluent areas to prevent social norms becoming distorted	In the 'Child W' case review that was completed in 2012, it found: The repeated exposure of professionals to intractable and long term problems 'normalise' their response and understanding of deviant and risky parental behaviour The finding led to the development of the BwD risk model (now also being rolled out across Lancashire) that clearly identifies what are 'underlying risk factors' and 'high risk indicators'.	To review the BwD Risk Model over time.
Congenital abnormalities		
12. Reliable information system to enable access to high quality intelligence to identify 'at risk' population groups	Public Health England (PHE) recently taken over responsibility for congenital anomaly registers nationally. Impact on ability to identify 'at risk' population groups is not yet apparent	To review the data once established
13. Preconception care in place which targets 'at risk' groups of congenital abnormality	Pennine Lancashire has a service which engages with communities and extended families who practice customary cousin marriage, and the health care staff who serve them, to raise awareness, promote conversations and provide genetic counselling for those with a family history of possible recessive disorder. This includes pre-marital and pre-conception advice and carrier testing (if feasible).	To continue with the service within the community

Appendix 1

14. Outreach worker in each locality where there is a high rate of congenital abnormality	Pennine Lancashire has an outreach service which engages with communities and extended families who practice customary cousin marriage, and the health care staff who serve them, to raise awareness, promote conversations and provide genetic counselling for those with a family history of possible recessive disorder. There are currently no other causes of congenital abnormality which takes this approach.	To continue with the service within the community
15. Engage with community leaders and families in high risk groups to communicate messages about consanguinity and the advantages of genetic screening	Pennine Lancashire has an outreach service which engages with communities and extended families who practice customary cousin marriage, and the health care staff who serve them, to raise awareness, promote conversations and provide genetic counselling for those with a family history of possible recessive disorder	To continue with the service within the community
Co-sleeping		
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	Pan Lancashire Safer Sleeping Guidelines well established across statutory agencies. Safer sleep assessment tool that has been developed by CDOP Pan-Lancashire safer sleep training later this year	Need to understand whether the Safer Sleep guidance has reached the 'wider services' mentioned here, therefore we recommend a simple survey to assess 'reach'.
Smoking in pregnancy		
17. Smoking cessation targets for midwives and health visitors.	There are no targets set within maternity or health visiting service contracts in Pennine Lancashire for smoking cessation in pregnancy.	To review smoking cessation provision and pathways in line with available local resources

Appendix 1

18. Smoking cessation interventions at 20 week scan delivered by trained sonographers (Blackpool model)	Training of midwives was conducted on the risk perception intervention (RPI) and CO monitoring at the first scan appointment in 2015. However, due to a shortage of resources and a change in staff, RPI is not being undertaken at the present time. Carbon Monoxide (CO) monitoring and the opt-out pathway remains in place and is conducted by the East Lancashire Hospital Trust (ELHT) maternity services.	To review maternal health care and support provided in relation to smoking in pregnancy in line with available local resources and capacity
19. Healthy Community Pharmacies provide cessation intervention upon purchase of pregnancy test kit. Opportunities for Public Health interventions.	This is not in operation at the present time in BwD. Pharmacies provide smoking cessation services and clinics, along with GP practices locally.	Review smoking cessation provision provided by pharmacies in line with available local resources.
20. Improve referral pathways to enable immediate cessation support	The opt-out pathway is in place at ELHT maternity services for but BwD referrals to the stop smoking service may not be guaranteed within 24 hours (weekly collection of paper based referrals forms).	Review smoking cessation referral pathways in line with available local resources.
21. Implement evidence based smoking and pregnancy incentive scheme – other 'softer' rewards such as certificates of achievement are extremely valuable / motivational tools	There is no incentive scheme or rewards available for BwD for smoking in pregnancy.	Review maternity care and smoking cessation support in pregnancy and explore funding opportunities to support incentive scheme
Deprivation		
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	**Healthy Start vitamin scheme** In BwD, the Healthy Start scheme is available for pregnant mothers, delivered through children's centres and distributed by health visitors at routine postnatal home visits. This includes vouchers for families on low income. These can be exchanged for fresh or frozen fruit or vegetable and milk. The	Review of holistic local 'offer' for families who are most deprived, with a focus on pathways to employment and education

	scheme also provides vitamins to support intake during pregnancy and early years. The government has recently re-committed to this scheme in the recent National Child Obesity Strategy and the Healthy Start is embedded within the Eat Well, Shape Up and Move More Strategy. **Reducing smoking rates** Tobacco Free Lancashire Strategy is in place which was refreshed in 2015, with BwD representation on the strategic group). BwD also sit on Pan Lancashire Smoking In Pregnancy group. **Pathways to employment/education** Tackling youth unemployment is a key priority of the Blackburn with Darwen's Early Help Strategy. The New Directions service supports and monitors all school leavers around further education, job seeking and careers advice. Children's Centres provide a wide range of information, advice and guidance for parents and families, including childcare, benefits, parenting support groups, and outreach home visits for families with additional needs. **Early Help Strategy** One of the five priorities of the Blackburn with Darwen's Early Help Strategy is to 'keep children and young people safe', which explicitly contributes to safeguarding children and promoting children's welfare, monitored by Children's Partnership Board.	

End of Report

HEALTH & WELLBEING BOARD CHECKLIST

Report title: Update on the Sector Led Improvement Review for Infant Mortality and its recommendations

EIA and HIA Completed	Completed by	Date (dd/mm/yyyy)	Comments
Yes ☐ **No** ✓ ☐	Helen Lowey	16/02/2017	Not required as update of an external review

Officer consulted	Version Number	Date (dd/mm/yyyy)	Comments
Legal Sian Roxborough	0.4	24/2/17	No comments.
Finance Gill Minshall	0.4	23/02/17	No financial implications.

2016

North West Sector Led Improvement: Infant Mortality

Contents

Contact:

Angela Daniel – angela.daniel@tameside.gov.uk

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

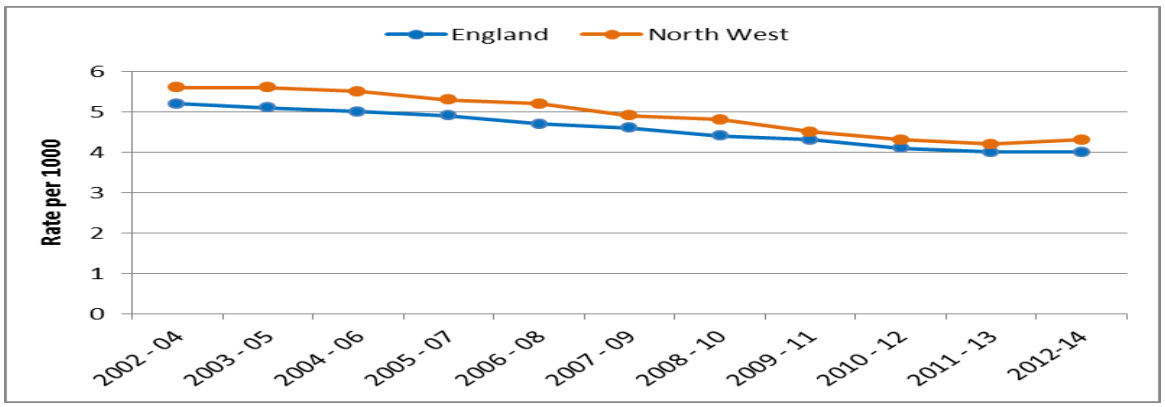


Table 1

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 benefits 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.

Acknowledgements

To everyone who participated in the SLI process and specifically to Angela Daniel from the GM Public Health Network Team for her commitment and support in bringing this important piece of work to fruition.

Thank you to the Infant Mortality Sector Led Improvement Group:

Angela Hardman Executive Director of Public Health, Chair - Infant Mortality Sector Led Improvement Group
Angela Daniel Programme Manager, Greater Manchester Public Health Network
Helen Marsh Policy Analyst, Greater Manchester Public Health Network
Mick Lay Greater Manchester CDOP chair
Irene Wright Merseyside Child Death Overview Panel Manager, Liverpool Safeguarding Children Board
Jacqui Dorman Public Health, Intelligence Manager, Tameside
Debbie Blackburn Assistant Director Public Health Nursing, Salford City Council
Pippa Tavriger Public Health Practitioner, Liverpool City Council
Peter Elton Clinical Director, Greater Manchester Strategic Clinical Network
Paula Hawley-Evans Health and Well Being Programme Lead, Public Health England North West
Claire Haigh Director of Improvement, NW Employers
Gifford Kerr Consultant in Public Health, Blackburn with Darwen Borough Council
Abdul Razzaq Director of Public Health Trafford Council and NW Public Health Chair
Debbie Fagan South Sefton CCG
Janice Bleasdale Specialist Nurse for the Child Death Overview Panel, Cheshire East
Chris McLoughlin Director Safeguarding & Prevention Stockport MBC
Mark Brown Programme Manager Greater Manchester Public Health Network
Hakeel Qureshi Programme Manager Greater Manchester Public Health Network
Emily Parry-Harries Speciality Registrar Public Health, Tameside MBC
Jane Rossini Deputy Centre Director, Public Health England North West
Rebecca Wagstaff Deputy Director, Health and Wellbeing Board, Public Health England North West
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

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	NHS England
DATE:	06/02/2017

SUBJECT: Notification of change in legislation in relation to HWBs requirement to provide supplementary statements to the PNA

1. PURPOSE

The purpose of the executive is to highlight the key issues as a result of the changes to legislation which requires the HWBs to comment upon Pharmaceutical Applications and thereafter the requirement to produce a supplementary statement to the PNA.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

The Health and Wellbeing Board is recommended to:

Note the process for reviewing Pharmaceutical Applications

1. Note the requirement for the Health and Wellbeing Board to provide comment in relation to any Pharmaceutical Applications and to issue a supplementary statement to the PNA when required as per the legislation.
2. Note the request for NHS England to receive a copy of any such additional statements, ensuring that they are emailed to england.lancsat-pharmacy@nhs.net for reference purposes.

3. BACKGROUND

SI 1077 of 2016 introduced amendments to the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Primarily, the new legislation allows applications for consolidation of 2 or more pharmacy sites to be considered. The opinion of the HWB on this issue must be given when the application is notified locally and representations are sought. If the application is granted and pharmacy premises are removed from the relevant pharmaceutical list, if the HWB does not consider that a gap in service provision is created as a consequence, it must publish a supplementary statement to be published alongside its pharmaceutical needs assessment recording its view.

4. RATIONALE

To keep the PNA up to date in line with legislation changes.

5. **KEY ISSUES**

As above.

6. POLICY IMPLICATIONS

7. FINANCIAL IMPLICATIONS

8. LEGAL IMPLICATIONS

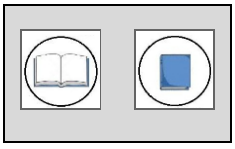
9. RESOURCE IMPLICATIONS

10. EQUALITY AND HEALTH IMPLICATIONS

11. CONSULTATIONS

VERSION:	

CONTACT OFFICER:	*Sheena Wood, NHS England, 0113825 5385, sheena.wood2@nhs.net*
DATE:	06/02/2017
BACKGROUND PAPER:	• *National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013* • *SI 1077 of 2016 – The National Health Service (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016*



HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Director of Public Health
DATE:	23 January 2017

SUBJECT: Eat Well Move More Shape Up Strategy 2017-2020

1. PURPOSE

To raise awareness of physical inactivity and unhealthy weight as a local public health issue.

To request approval from the Board to implement the partnership Blackburn with Darwen Eat Well Move More Shape Up Strategy

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

That the Health and Wellbeing Board:

- Notes that obesity and physical inactivity is a significant public health issue requiring senior level leadership and commitment to increasing physical activity levels, improving access to healthy and sustainable food and encouraging self-care from council, partners and stakeholders.

- Approves the three year food, physical activity and healthy weight strategy and action plan.

3. BACKGROUND

Food and Nutrition

Food is essential for life and impacts can be both positive and/or negative, depending on the type of food we eat. Food helps meet our physical needs by providing energy and nutrients but for many people it can also meet social, cultural and emotional needs. Food selection is not only a behavioural choice but can also be influenced by factors such as cost, access, knowledge and social norms. Significant differences in nutritional knowledge have been linked to different socioeconomic groups, with knowledge declining with lower socioeconomic status.

Physical Activity

Physical inactivity is the fourth leading cause of global mortality, and the cause of many leading preventable diseases in society such as coronary heart disease, some cancers and type 2 diabetes. Evidence tells us that being physically active has benefits for mental health and wellbeing, quality of life and maintaining independent living in older age and also plays a key role in brain development in early childhood and is good for longer-term educational attainment. Physical activity can help to play a role in reducing health and social inequalities and as a result of its wide reaching impact has been described as the 'best buy' in public health. The cost of physical inactivity to BwD amounts to £3,206,550 compared to an average of £1,817,285 nationally.

Healthy Weight

Obesity is a major public health problem due to its association with serious chronic diseases and the costs to both the individuals and society as a whole. Obesity is a complex, but largely

preventable condition which has serious, far reaching physical, psychological and social consequences that affects virtually all age and socioeconomic groups although some more than others. Obesity affects a person's wellbeing, quality of life and ability to earn.

Key Drivers

There are numerous national and local drivers which support a comprehensive strategic policy approach to addressing these cross cutting agendas, including the national strategies: *Everybody active, everyday – An evidence based approach to physical activity* (Oct 2014); *Sporting Futures: A new strategy for an active nation* (Dec 2015*)*; *Towards an Active Nation* (May 2016*)*; *NHS 5 Year Forward View* (2014); *Get Well Soon – Place Based Health* (2016) the recently released *Childhood Obesity: A Plan for Action (*Aug 2016) and the refreshed BwD Health and Wellbeing Strategy. The strategy will also be driven by the Together A Healthier Future Programme and will be a key document in the prevention agenda of the transformation programme across the Pennine footprint. The strategy will be aligned with the '*Cumbria and Lancashire Sport and Physical Activity Strategy'* and the '*Lancashire Walking and Cycling Strategy'*.

4. RATIONALE

The purpose of the Blackburn with Darwen Eat Well Move More Strategy is to provide a framework for action across the life-course to increase healthy life expectancy. It provides an approach to health improvement which recognises the contributions that can be made across all sectors of our society. It draws on local experience and research evidence, aiming to increase both physical activity levels and the number of residents who are a healthy weight.

The national obesity and physical activity strategies are clear that it is not the sole responsibility of any one sector alone. It is important that stakeholders and partners work together to help reduce the prevalence of non-communicable diseases such as Type 2 Diabetes, coronary heart disease and stroke through a healthy lifestyle and co-ordinate and deliver interventions with local communities to ensure that they are effective in helping to improve healthy life expectancy in Blackburn with Darwen.

5. KEY ISSUES

Demographics:

- The Borough has the second highest all-age mortality rate for cardiovascular disease (CVD) out of 152 upper-tier authorities in England.
- Childhood poverty continues to be a key issue
- BwD was ranked the worst local authority with the lowest proportion of children aged 5 with no obvious dental decay in 2015.

Physical Inactivity

- Physical inactivity directly contributes to 1 in 6 deaths, and around a quarter of the population is inactive and 45% of women and 33% of men are not active enough to benefit their health.
- Only 21% of boys and 16% of girls aged 5-15 are achieving their recommended physical activity targets (1 hour moderate activity daily).
- In BwD only 40,000 people (16+) are active enough to benefit their health which is 12% lower than the national average.

Healthy Weight

- BwD has a rate of 48.9 per 100,000 killed or seriously injured in BwD compared to 39.3 nationally
- More than 1 in 5 Reception children in BwD are overweight or obese and more than 1 in 3 Year 6 children are overweight or obese.
- The rate of obesity more than doubles between Reception and Year 6 from 9.4% to 22.6%.
- The prevalence of underweight children remains a local issue however this has reduced from last year's figures but still remains higher than the regional and national prevalence.
- 25% of adults aged 35-70 who had a Health Check in 2015-16 were identified as having pre diabetes. This figure is more than double the rate seen in Lancashire (10%). This poses a significant challenge to both the local authority and Clinical Commissioning Group in the

management of those who have been identified.

The current Pennine Lancashire health and social care transformation programme seeks to redesign the future of health care in our area and presents a challenge in saving over 20% of its total budget over the next five years. This also presents an opportunity in providing a case for change from a primary prevention perspective within which food and physical activity initiatives and policy changes within this strategy could support the case for change.

6. POLICY IMPLICATIONS

This strategy has been aligned to both local and national recommendations and guidelines for improving access to healthy and sustainable food, increasing physical activity levels and achieving a healthy weight and BwD's Health and Wellbeing strategy. The action plan has been developed in line with national policies and guidelines and local priorities as derived from the extensive consultation work undertaken.

The strategy and action plan take into account the policies and strategies listed earlier in this paper and those listed below:

- Public Health Outcomes Framework 2014-15 (Department of Health, 2014)
- Fair Society, Healthy Lives. A strategic review of health inequalities in England post 2010 (The Marmot Review, 2010)
- Blackburn with Darwen Health and Wellbeing Strategy 2015-18
- BwD Planning for Health Supplementary Planning Document
- BwD Integrated Strategic Needs Assessment
- Local Authority Declaration on Healthy Weight https://www.blackpool.gov.uk/News/2016/March/Blackpool-Council-signs-up-to-healthy-charter.aspx

7. FINANCIAL IMPLICATIONS

There are no financial implications. The strategy and action plan will be delivered within existing partner agency budgets and the Department of Health Public Health Prevention grant.

8. LEGAL IMPLICATIONS

Transfer of public health from the NHS to local government and Public Health England (PHE) has introduced a significant extension of local government powers and duties and represents an opportunity to change focus from treating sickness to actively promoting health and wellbeing. Section 12 of the Health and Social Care Act inserts a new section 2B into the NHS Act 2006 to give each relevant local authority a new duty to take such steps as it considers appropriate to improve the health of the people in its area. This section also gives the Secretary of State a power to take steps to improve the health of the people of England and it gives examples of health improvement steps that either local authorities or the Secretary of State could take, including giving information, providing services or facilities to promote healthy living and providing incentives to live more healthily.

Local authorities have considerable discretion in how they choose to invest their grant to improve their population's health, although they have to have regard to the Public Health Outcomes Framework and should consider the extant evidence regarding public health measures.

It will be necessary to ensure compliance with planning and licensing laws with regard to activities in the strategy and plan such as applications relating to the operation of food take aways. Legal advice will also be sought in relation to highways legislation and pilot programmes planned including temporary street closures for street play.

9. RESOURCE IMPLICATIONS
The strategy and action plan will be delivered by strategic health and wellbeing board partners, with the council's Public Health team providing a leadership and co-ordination role.

10. EQUALITY AND HEALTH IMPLICATIONS
In determining this matter the Board need to consider the HIA associated with this item in advance of making the decision, which accompanies this report

11. CONSULTATIONS
Extensive consultation around the strategy has taken place over the last 18 months. An initial period of consultation and insight work took place during 2015 and involved a Start Well and Age Well consultation along with a commissioned consultation around the issue of food poverty in the borough. There was also an initial online public consultation in 2015 which had 201 responses.

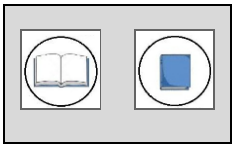
From this work the draft action plan was produced and further targeted consultation has taken place during 2016, particularly concentrated between May and September. The consultation has included the following:

- Public Online Consultation – 110 responses
- Health Professional Online Consultation – 27 responses
- Stakeholder Engagement event in June 2016 and face to face/email engagement with individual stakeholders
- Senior Policy Team briefings across all portfolios
- Quarterly Eat Well Move More Shape Up Steering Group meetings
- Primary School Catering Managers
- Clinical Commissioning Group Protected Learning Time event and Clinical Commissioning Group Operations Group
- Bangor Street Ladies group & Inter Madrassah Organisation Women 4 Women group
- Families Health & Wellbeing Consortium
- Older People's Forum and Age UK consultation
- Learning Disabilities Partnership Board
- Blackburn with Darwen Health and Wellbeing Board, Live Well Board and Children's Partnership Board

Intelligence gathered through the BwD Integrated Strategic Needs Assessment (ISNA) and subject specific ISNAs has also informed the action plan.

VERSION:	**1.0**

CONTACT OFFICER:	Beth Wolfenden
DATE:	23 January 2017
BACKGROUND PAPER:	Eat Well Move More Shape Up Strategy and Action Plan, Plan on a Page http://www.blackburn.gov.uk/Pages/Public-health.aspx Health Impact Assessment



Blackburn with Darwen Eat Well Move More Shape Up Strategy 2017 – 2020:

Our Vision:
Success for us is when everyone in Blackburn with Darwen is able to move more, eat well and maintain a healthy weight

We will do this by:

- Supporting an environment that empowers people to make physical activity and healthy eating the easy choice for everyone throughout the course of their lives
- Encouraging positive lifestyle changes that enables everyone to improve their health and wellbeing and to be a healthy weight
- Empowering the most vulnerable and at risk of poor health in our community to make positive behaviour changes
- Building community capacity and mobilising the workforce in our Borough to make every contact count

Challenges	Opportunities	Cross cutting themes			Priorities	
High levels of physical inactivity and obesity in children, young people and adults Poor healthy life expectancy and disability from largely preventable long term conditions High levels of diabetes and cardiovascular disease High levels of dental decay in children Continuing poverty, deprivation and disadvantage Increasing levels of food poverty Varied food knowledge and cooking skills Reducing budgets for service provision	• Wide range of key partners engaged • Parks & Open Spaces • Network of volunteers • Strong community spirit • Healthy settings approach • Workforce development	Local Authority Declaration on Healthy Weight	Positive mental health & wellbeing	Communications & marketing	**Eat Well:** **1.** Promote healthy and sustainable food choices for all **2.** Tackle food poverty and diet related ill health **3.** Build community food knowledge, skills and resources **4.** Promote a vibrant, diverse local food economy **5.** Transform catering and food procurement **6.** Reduce waste and the ecological footprint of the food system **Move More:** **1.** Active Society: creating a social movement where physical activity is a priority for everyone **2.** Moving Professionals: activating networks of expertise to create healthy workplaces and make every contact count to promote physical activity **3.** Active Environments: creating the right spaces for safe and enjoyable physical activity **4.** Moving at scale: maximising the potential of the existing assets and partnerships **Shape Up:** **1.** Transforming the environment we live in **2.** Making healthier choices easier by educating and empowering individuals and communities **3.** Giving all children the best start and tackling the generational issue of healthy weight in families **4.** Ensuring holistic and integrated evidence based support for individuals with weight related conditions – either under or overweight	KEY OUTCOMES
OPPORTUNITIES/DRIVERS /ENABLERS		Every Body Active Every Day, Childhood Obesity: A Plan for Action, UK Active Blueprint for an Active Nation, Sport England's Towards an Active Nation, Lancashire Walking & Cycling Strategy, NHS 5 Year Forward View, Locality Working, Healthy Child Programme, Digitalisation				

EXECUTIVE BOARD CHECKLIST

Report title:	Eat Well Move More Shape Up Strategy 2017-20

EIA and HIA Completed	**Completed by**	**Date (dd/mm/yyyy)**	**Comments**
Corporate Equality – Legal will require a copy of the completed EIA with the report prior to sign-off.			
EIA Yes ☐ **No** ☒			As advised by Equalities EIA not required as it is covered in the HIA
HIA Yes ☒ **No** ☐	Beth Wolfenden	14/07/2016	

Officer consulted	**Version Number**	**Date (dd/mm/yyyy)**	**Comments**
Equality Tom Keighley	0.03	07/10/2016	Due to the overwhelming association with health, all equality impacts have been included and considered within a HIA toolkit.
Legal Sian Roxborough	0.03	14/10/16	Delete current legal implication and replace with: *'Transfer of public health from the NHS to local government and Public Health England (PHE) has introduced a significant extension of local government powers and duties and represents an opportunity to change focus from treating sickness to actively promoting health and wellbeing.* *Section 12 of the Health and Social Care Act inserts a new section 2B into the NHS Act 2006 to give each relevant local authority a new duty to take such steps as it considers appropriate to improve the health of the people in its area. This section also gives the Secretary of State a power to take steps to improve the health of the people of England and it gives examples of health improvement steps that either local authorities or the Secretary of State could take, including giving information, providing services or facilities to promote healthy living and providing incentives to live more healthily.* *Local authorities have considerable discretion in how they choose to invest their grant to improve their population's health, although they have to have regard to the*

			Public Health Outcomes Framework and should consider the extant evidence regarding public health measures. *It will be necessary to ensure compliance with planning and licensing laws with regard to activities in the strategy and plan such as applications relating to the operation of food take ways. Legal advice will also be sought in relation to highways legislation and pilot programmes planned including temporary street closures for street play.* Please also put link to attach the strategy in body of the report not background paper.
Finance	0.03		
Equality Tom keighley	0.08	16/01/2017	No further comments
Legal Sian Roxborough	0.08	19/1/2017	My original legal advice above still applies- this has not been included in this latest version and needs to be.
Finance Gill Minshall	0.08	24/1/2017	Financial section checked and agreed.
SPT Co-ordinator Gary Rich	0.08	24/1/17	Legal comments addressed. E-mail from legal saved in document history.

Is the item a key decision? **Yes** ☒ **No** ☐

Is the item a Part II? **Yes** ☐ **No** ☒

Indicate the date of the Executive Board the report is to be submitted to: 9th February 2017

JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If the item is a key decision to be considered at Executive Board, at least 28 days clear notice before the decision is made will need to be provided in the forward plan

Signed: **Director HR, Legal & Corporate Services:**	**Signed:** **Director of Finance & IT:**
Date:	**Date:**
First Portfolio	
In making this decision I confirm that I have considered and understood the Equalities Impact Assessment (EIA) associated with this item. (if applicable)	
Signed: **Executive Member:**	**Signed:** **Chief Officer:**
Date:	**Date:**

Health Impact Assessment

Eat Well Move More Shape Up 2017-20

Toolkit produced by:	Public Health
Toolkit version:	1.1
HIA version:	V0.5
Date HIA completed:	21 September 2016

Health is not merely the absence of disease or infirmity but a state of complete physical, mental, social and spiritual well-being.
(modified by M. Birley (2013) from World Health Organisation's definition – 1948)

Title of policy, programme or project ("activity") to be assessed:
Eat Well Move More Shape Up Strategy 2016-19

What is the activity about? What is the context outlined for the activity? (e.g. policy context, history, background)

Out of a population of almost 113,000 adults aged over 16[i] in Blackburn with Darwen just over 75,000 are overweight or obese (66.5%) and only just over 40,000 are active enough to benefit their health (35.7%) with physical inactivity costing the borough over £3million.

The borough has a higher than average young population, ONS mid-year estimates record a 23.2% 0-15 population in Blackburn with Darwen compared with 18.9% regionally and 19% nationally. In addition to this, 52% of school aged children are from a minority ethnic background. The most recent National Child Measurement Programme data in Blackburn with Darwen shows that almost 9% of 4-5 year olds are obese and this more than doubles to 20% of 10-11 year olds and 20.6% of 3 year olds in the borough have decayed, missing or filled teeth.

The 2015 Indices of Multiple Deprivation found that 28 out of 91 LSOA's (Lower Super Output Areas) in Blackburn with Darwen were in the 1st national decile (most deprived). In addition, healthy life expectancy is considerably lower than the national average particularly amongst males in the borough with the second highest death rate from cardiovascular disease (CVD) out of 152 upper tier authorities. Along with major risk factors for CVD of obesity, physical inactivity, deprivation and ethnicity Blackburn with Darwen also has a steadily increasing over 65 population further impacting on levels of CVD in the borough.

The local authority is developing an action plan to help increase physical activity levels and increase the number of people in Blackburn with Darwen who are a healthy weight to help reduce ill health and increase healthy life expectancy and therefore quality of life.

Our vision is for everyone in Blackburn with Darwen to move more, eat well and maintain a healthy weight, we aim to do this by:

- Supporting an environment that empowers people to make physical activity and healthy eating the easy choice for everyone throughout the course of their lives
- Encouraging positive lifestyle changes that enable the people of Blackburn with Darwen to improve their health and wellbeing and to be a healthy weight
- Empowering the most vulnerable and at risk of poor health in our community to make positive behaviour changes
- Building community capacity and mobilising the workforce of Blackburn with Darwen to make every contact count

Does this activity have the potential to impact on health? Explain *(please consult appropriate Public Health colleague if you are unsure or require further information)*
The strategy has the potential to improve the health of all residents of Blackburn with Darwen by increasing opportunities to be more physically active, by improving access to locally sourced, good quality, affordable and healthy food, making healthy choices the easiest option and providing an environment which supports everyone to be a healthy weight. An extensive three year action plan covering the three strands of the strategy has been developed to detail how this will take place and by which stakeholders (http://www.blackburn.gov.uk/Lists/DownloadableDocuments/Eat-Well-Shape-Up-Move-More-Strategy-Action-Plan.pdf). Health impacts include reduced incidence of heart disease, certain cancers, stroke and dementia. The ultimate aim of the strategy is to increase healthy life expectancy and quality of life through making the healthy choice the easy choice. In doing so the burden on the public purse will be significantly reduced through reduced health care costs, increased productivity and increased educational attainment.

If no health impacts are identified then the screening does not need to continue, but please ensure that this has been discussed with the appropriate Public Health colleague prior to discontinuation

Does this activity relate to / impact on any of the Health & Wellbeing Strategy objectives?

- ☒ **Best start for children and young people**
- ☒ **Health & Work**
- ☒ **Safe & healthy homes & neighbourhoods**
- ☒ **Promoting health and supporting people when they are unwell**
- ☒ **Older people's independence and social inclusion**

Does the activity concern any of the following determinants?		
Lifestyle	Yes ☒	No ☐
Physical environment	Yes ☒	No ☐
Social / economic environment	Yes ☒	No ☐
Other, please specify		

What are the potential positive impacts?
• Improved overall health and wellbeing of residents through encouraging a healthy, affordable diet and improved access to locally produced, affordable food and by promoting the benefits of and opportunities to be physically active across the whole life course. • Improved healthy life expectancy • Reduced health inequalities • Reduced levels of overweight and obesity across the life course • Focus on children and young people to prevent the cycle of generational obesity to improve quality of life and reduced risk of diabetes and heart disease • Improved dental health by focussing on education on sugar and sugar reduction initiatives and campaigns • Improved maternal and infant health by promoting breastfeeding, healthy weaning and physical activity, significantly reducing the risk of obesity and disease in later life and therefore reducing the burden on the local economy along with reduced personal burden • Reduced food poverty by improving access to affordable food and encouraging community food schemes to support those most in need within specific communities • Reducing food waste and the environmental footprint of food by encouraging communities to

shop locally wherever possible and exploring community growing options
- Boosting the local food economy by promoting the use of local markets and local food suppliers where possible in improved procurement or direct purchases from the public.
- Improved community resilience by supporting community growing, shopping skills and cooking skills
- Increased physical activity levels which will reduce the burden of disease and contribute to a healthy weight and reduce the cost to the local economy which is currently in excess of £3million
- Increased active travel which have positive effects on the environment, health and the economy
- Reduced social isolation and improved mental health and wellbeing through the effective promotion and communication of food and activity initiatives such as luncheon clubs, health walks etc.
- Improving access to sport and physical activity in underrepresented groups – disability, BME, women and girls, deprived communities – the detailed strategy action plan provides further information on how the strategy aims to achieve this (http://www.blackburn.gov.uk/Lists/DownloadableDocuments/Eat-Well-Shape-Up-Move-More-Strategy-Action-Plan.pdf)
- Better partnership working and use of resources for the benefit of the residents of Blackburn with Darwen

What are the potential negative impacts?

There may be a proportion of the population who do not understand the need for the strategy and the health implications if there is no change in behaviour. They may not want to embrace health improvement initiatives and may be resistive to environmental policy changes e.g. opposition to temporary street closures for street play initiatives, healthy vending in public buildings and healthy catering policies at events. Overall there are very few potential negative impacts.

What are the assumptions/risks embedded in or underpinning the activity?

There is an assumption is that everyone will embrace the action plan in strategy and that the strategy will enable everyone to make healthier choices. There is also an assumption that parents/carers will pass the messages to their children/those in their care and make choices that will benefit their health.
The risks of not embracing the rationale and action plan of the strategy is that those individuals health will not improve and they will continue to require preventable support from the state e.g. welfare, health and social care. However if the strategy was not developed this cohort of residents would be at risk regardless.

Are there any external factors which identify the nature and extent of the impacts on health for this type of proposal (e.g. research; policy changes etc.)

- Funding – there are cuts across a number of public sector services. Funding available to third sector organisations is becoming increasingly difficult to obtain, all of which places pressure on the services and organisations committed to delivering the outcomes of the strategy
- Encouraging the council to adopt the Local Authority Declaration on Healthy Weight will require a strong direction from executive members and will allow public health to embed it in all council policies
- Council workforce review – may affect the ability to implement the strategy due to fewer staff having greater remits and changes in priorities

List the groups most likely to be affected by this proposal

All residents of Blackburn with Darwen across the life course will be affected by this proposal

What are some of the potential equity issues?
The strategy is designed to address all residents of the borough by taking both a population and targeted approach. The Integrated Strategic Needs Assessments for the borough and extensive consultation with the public and stakeholders will inform the areas of greatest need. The strategy aims to be fully inclusive and will encourage those most at risk of ill health to make better health choices. As outlined throughout this assessment there are a number of positive impacts on many of the 9 protected characteristics set out in the 2010 Equality Act.

CHECKLIST

Answers favouring doing an HIA	To your knowledge	Answers favouring not doing a HIA
	Health impacts	
☒ Yes ☐ Not sure	Does the initiative affect health directly?	☐ No
☒ Yes ☐ Not sure	Does the initiative affect health indirectly?	☐ No
☐ Yes ☐ Not sure	Are there any potential serious negative health impacts that you currently know of?	☒ No
☐ Yes ☐ Not sure	Is further investigation necessary because more information is required on the potential health impacts?	☒ No
☐ No	Are the potential health impacts well known and is it straightforward to identify effective ways in which beneficial effects can be maximised and harmful effects minimised?	☒ Yes
☐ No	Does evidence, data or experience already exist out there, regarding this policy, programme or project so that an HIA might be a waste of resources?	☒ Yes
	Community	
☒ Yes ☐ Not sure	Is a large proportion of the population likely to be affected by the initiative *(over 25% of the resident population*)?	☐ No
☒ Yes ☐ Not sure	Are there any socially excluded, vulnerable, disadvantaged groups likely to be affected?	☐ No
☐ Yes ☐ Not sure	Are there any community concerns about any potential health impacts?	☒ No
	Initiative	
☐ Yes ☐ Maybe	Is there some reason to suspect that health issues not considered in the planning process of this initiative might become more visible by doing an HIA?	☒ No
☐ Yes ☐ Maybe	Is the cost of the initiative high (*over £100,000*)?	☒ No
☐ Yes ☐ Maybe	Is the nature and extent of the disruption to the affected population likely to be major?	☒ No
	Organisation	
☒ Yes	Is the initiative a high priority/important for the organisation/partnership?	☐ No
☒ Yes ☐ Maybe	Are the individuals and organisations with a stake in this initiative likely to buy into the HIA process?	☐ No
☒ Yes ☐ Maybe	Is there potential to change the proposal? Will there be any other similar proposals in the future?	☐ No
FOR = 7	**TOTAL**	**AGAINST** =8

Choosing which HIA to do

Health Impact Statement	Type of HIA	Comprehensive
☐ Yes	Is there only limited time in which to conduct the HIA?	☒ No
☒ Yes	Is there only limited opportunity to influence the decision?	☐ No
☒ Yes	Is the timeframe for the decision-making process set by external factors beyond your control?	☐ No
☒ Yes	Are there only very limited resources available to conduct the HIA?	☐ No

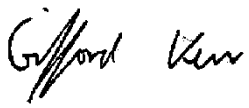
Deciding who should do the HIA

External	Assessors	Internal
☐ No	Do personnel in the organisation or partnership have the necessary skills and expertise to conduct the HIA?	☒ Yes
☒ No	Do personnel in the organisation or partnership have the time to conduct the HIA?	☐ Yes

Is an HIA appropriate?	☐ Yes ☒ No
Why or why not?	
It is anticipated that due to the overwhelming positive impact that this strategy hopes to have on health in the borough a full Health impact Assessment is not required. This strategy targets all of the boroughs residents and aims to support and encourage them to make life choices and changes that will improve health and wellbeing.	
If yes, what type and how?	
N/A	
Recommendations / comments	
It is recommended that this activity continues without change. As previously mentioned, the aim of this strategy is to target health inequalities and improve health and wellbeing of everyone across the borough.	

Completed by: _Beth Wolfenden_____ **Date: 21/09/2016**

Approved by
(Head of Service/Director): **Date: 21/09/2016**



This signature signifies the acceptance of the responsibility and ownership of the HIA and the resulting action plan (if applicable).

Approved by
(Public Health):_____ **Date: _____**
This signature signifies the acceptance of the responsibility to publish the completed HIA.

Once this form has been completed and approved, this document should be saved as the Health Impact Statement for the specified activity, any actions should be monitored appropriately

[i] ONS (2015). *Mid-year population estimates*

Start well | Live well | Age well

Blackburn with Darwen
Health and Wellbeing Board

Tuesday 7 March 2017 at 5.30pm
Conference Room 1, Blackburn Town Hall

Agenda

1. Welcome and Apologies
2. Minutes of the meeting held on 13th December 2016
3. Declarations of interest
4. Public Questions

ITEMS FOR INFORMATION ONLY OR FOR THE BOARD TO NOTE

5. Live Well thematic update – Sayyed Osman – verbal update
6. Joint Commissioning and Better Care Fund update – Claire Jackson
7. Health and Wellbeing Board Arrangements for Lancashire – verbal update – for information Dominic Harrison
8. Child and Adolescent Mental Health Services review update presentation – Kelly Taylor
9. North West Sector Led Improvement Infant Mortality Report – Helen Lowey
10. International Women's Week – verbal update – Cllr Maureen Bateson
11. Winter pressures – Kevin McGee – verbal update
12. New Pharmacy Legislation Requirements – Sheena Wood, NHS England

ITEMS REQUIRING DECISION

13. Eat Well Move More Shape Up strategy – Shirley Goodhew / Beth Wolfenden

Blackburn with Darwen Health and Wellbeing Board
Minutes of a Meeting held on Tuesday, 13th December 2016

PRESENT:

Councillors	Mohammed Khan (Chair)
	Maureen Bateson
	Mustafa Desai
Clinical Commissioning Group (CCG)	
	Dr Chris Clayton
	Graham Burgess
East Lancashire Hospital Trust (ELHT)	Kevin McGee
Lancashire Care NHS Foundation Trust (LCFT)	
Lay Members	Joe Slater
NHS England	--
Voluntary Sector	Vicky Shepherd
	Angela Allen
Healthwatch	--
Council	Linda Clegg
	Dominic Harrison
	Sally McIvor
	Steve Tingle
Council Officers	Charlotte Bradshaw
	Laura Wharton
	Christine Wood
CCG Officers	Claire Jackson
Other	

1 WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and apologies were received from Max Marshall, Penny Morris, Abdul Mulla, Damian Riley and Graham Urwin. The Chair advised the Board that Abdul Mulla (Vice-Chair of

Healthwatch) would replace Sir Bill Taylor on the Health and Wellbeing Board.

2 MINUTES OF THE MEETING HELD ON 27th SEPTEMBER 2016

RESOLVED - That the minutes of the last meeting held on 27th September 2016 be confirmed as a correct record subject to the amendment (item 2) that that minutes of the meeting on 21st June 2016 had been agreed as a correct record and not 27th September 2016 as previously stated.

3 DECLARATIONS OF INTEREST

Joe Slater declared an interest in agenda items 6 and 7 (Annual Safeguarding reports - Chair of Board of Trustees of CANW) and remained in the meeting during submission of each item to the Board.

4 PUBLIC FORUM

No questions had been received.

5 AGE WELL – THEMATIC UPDATE – PRESENTATION

A presentation was delivered to update the Board on the Priorites, Achievements, Plans and challenges in relation to 'Age Well' theme. Priorities were outlined as follows:

1. To develop Blackburn with Darwen as a Dementia Friendly community
2. To increase support to reduce social isolation and loneliness
3. To take action on agreed key determinants of the health of older people
4. To develop the local integrated service offer to promote independence

Progress in relation to each of the priority areas was outlined within the presentation which included detailed case studies and presentations, providing examples, a summary of achievements and positive outcomes in relation to each of the priorities.

The Board was advised of the Each Step Dementia Care Home that had opened in Blackburn in May 2016 (run by Community Integrated Care) and had recently been awarded 'Best Dementia Care Home 2016' at the National Dementia Care Awards. Phil Benson, Manager at Each Step had also been awarded the Best Dementia Care Manager 2016 at the event. Plans for the Albion Mill Extra Care Scheme were also outlined to the Board.

Future challenges were also outlined to the Board as follows:

- Combination of increasing numbers and complex needs was creating a non-linear increase in demand across health and care, areas like BwD suffer disproportionately given health inequalities, housing and poverty.
- Health life expectancy appeared to be decreasing
- Full integration of health and care mandated by 2020
- Prevention spend was under threat within health and social care although part of the solution
- Reducing resources and large scale budget pressure in social care impacting on the wider system

- Demographic pressures increase markedly after 2020 – we would need more of everything
- Dementia pathway needs improving
- Still too many “single points of access” and difficulty in navigating the health and care system

A discussion took place and some of they key points that arose were:

- Possible increase in local Council Tax to fund Social Care (not considered to be the answer for this area)
- Suggestion that increase in income tax would fairer process
- Lack of public transport issue leading to loneliness
- Unmet need for BME residential care

RESOLVED – That the presentation be noted.

6 LOCAL SAFEGUARDING ADULTS BOARD (LSAB) ANNUAL REPORT, 2015-2016 AND LOCAL SAFEGUARDING CHILDREN'S BOARD (LSCB) ANNUAL REPORT 2015-2016

A report was submitted presenting the Local Safeguarding Adults Board Annual Report and Local Safeguarding Children's Board Annual Report 2015-2016 to to the Board. Business Plans 2016-2017 for each Board were also presented to the Health and Wellbeing Board.

The Annual Reports set out how the various statutory functions of the Safeguarding Boards had been fulfilled in 2015-2016 and how local safeguarding arrangements would be improved and prioritised in 2016-2017.

It was reported that all priorities set out in the business plans aimed to ensure that children, young people and adults at risk of abuse and neglect in the borough were 'safe from harm' and 'felt safe from harm'.

The reports were key evidence to promote local accountability about the safety of local residents. For individual partners, their commitment and involvement in meeting the priorities set out in the business plans would be a key area of judgement in their partnership work.

It was reported that one of the statutory objectives of the Safeguarding Boards was to ensure the effectiveness of what all partners do to safeguard children, young people and adults at risk of abuse and neglect. All partner agencies of the Safeguarding Boards and of the Health and Wellbeing Board would be required to have regard to the priority areas set out in both reports.

It was also reported that Safeguarding Boards were funded through contributions by partner agencies. The reports also set out the budget and spending in 2015-2016; resource implications of the 2016-2017 priority areas would be met from the budget already agreed with Council Finance Officers (agreed for the 2016-2017 period in August 2016).

The Board was advised that all partners of the LSCB AND LSAB, including the voluntary sector had been consulted throughout the process of producing the document.

RESOLVED – That the reports be noted.

7 LGA PEER REVIEW – CHILDREN IN CARE, 2016 VERBAL UPDATE

The Board was advised of the The Local Government Association (LGA) recently completed peer review of Children's Services (5th – 8th December 2016). The peer review had been in the form of a Care Practice Diagnostic (CPD), designed to assist councils in further strengthening their work with and support to children and young people in care and to provide an independent view about the quality of care practice.

It was reported that the review team had noted strengths in Blackburn with Darwen in the commitment to children at all levels and across partners, the can-do culture, visible leadership and good engagement with children and young people.

It was further reported that a number of suggestions of areas had been made to consider for improvement, most of which had focused around the increased demand and the ability to meet that demand with current resources available. There were also some issues to consider, such as more joint commissioning around health, and a reconsideration of the work taken by the Multi-Agency Safeguarding Hub (MASH) to ensure that single agency work was not inadvertently being handed over to the MASH

RESOLVED – That the above be noted.

8 PENNINE LANCASHIRE TRANSFORMATION PROGRAMME/LANCASHIRE AND SOUTH CUMBRIA STP

A report was submitted to update the Board on the development of the Pennine Lancashire Transformation Programme's Local Delivery Plan and the Lancashire and South Cumbria Sustainability and Transformation Plan.

It was reported that Lancashire and South Cumbria, along with all other STP footprints, had submitted outline plans and financial information to NHS England and NHS Improvement in line with national requirements in June, September and October 2016.

Members were advised that the Lancashire and South Cumbria Sustainability and Transformation Plan (October 2016) had been published on 11th November 2016. Areas that had been focussed on were outlined in the report.

The Pennine Lancashire Transformation Programme was currently developing a Business Case, which would be published for consultation in January/February 2017. Proposals for a new model of care in line with the Programme's commitments were outlined in the report.

It was reported that the Programme was utilising the Solution Design Process to develop the new model of care. Solution Design provided a framework for designing, refining and approving the key elements of the new health and care system. This would ensure a wide range of health and care professionals and patient representatives were involved in the design of the new health and care system and included public engagement as an integral part of the process.

It was further reported that alongside the development of the new model of care, the Pennine Lancashire System Leaders' Forum was working through an agreed process to develop proposals for how an Accountable Care System could be designed for Pennine Lancashire. This would include consideration of the proposals for the new models of care and discussions about which services were appropriate for inclusion in the design of an Accountable Care System.

The Board was advised that a programme of consultation and engagement was underway as part of the Pennine Lancashire Transformation Programme. This had included three public engagement events to date and a strong social media presence alongside the regular publication of briefings and newsletters. Further engagement events were planned for early 2017.

An engagement report would be submitted to a future meeting of the Health and Wellbeing Board.

A copy of the Pennine Lancashire Local Delivery Plan on a Page was attached to the report for information.

RESOLVED – That the Health and Wellbeing Board:

1. Note the progress towards developing a Local Delivery Plan for Pennine Lancashire; and
2. Note the progress on development of the Sustainability and Transformation Plan for Lancashire and South Cumbria.

9 LANCASHIRE COMBINED AUTHORITY (LCA)

The Board was advised that the LCA had been in operation in shadow form since July 2016, continued to meet on a monthly basis and had five core policy themes as follows:

- Skilled Lancashire
- Better Homes for Lancashire
- Connected Lancashire
- Prosperous Lancashire
- Public Services Working for Lancashire

It was reported that the shadow LCA was already having a positive impact for Lancashire and was developing a Lancashire Plan which would set out a vision for Lancashire based on the five core themes.

The Board was advised that over recent months Leaders had been developing a proposal for devolution to the Lancashire Combined Authority, which could enable greater control, power and influence over a range of programmes and funding delivered in Lancashire.

Members were advised that in order to establish the Combined Authority, an Order must be laid before Parliament. It was anticipated that this would be agreed shortly and Leaders would be requested to write to the Secretary of State to consent to the Order being laid. It was also anticipated that the Lancashire Combined Authority would be formally established from April 2017,

although there was some frustration from Lancashire Leaders on the slow progress from Government, and this was also being reflected nationally.

RESOLVED – That the update be noted.

10 BETTER CARE FUND QUARTER 2 REPORT

A report was submitted to provide the Board with an overview of Better Care Fund performance reporting for quarter 2 (July-September 2016).

It was reported that the quarter 2 submission had been made on 25th November following sign off by the Chair of the Board. The submission had included an update on performance against national metrics between July and September 2016. Details of the performance against national metrics between July and September 2016 were outlined in the report.

A review of performance in relation to key successes, challenges and actions that had been included in the submission were also outlined in the report.

Members were advised that further submissions would be required on a quarterly basis and would be reported to the Health and Wellbeing Board at subsequent meetings.

The Board was reminded that the 2016/17 budget was £12,433,000. Details of how the budget had been allocated were highlighted as follows:

Spend on Social Care	£5,544,332.00
Spend on Health Care	£4,119,224.00
Spend on Integration	£2,165,536.00
Contingency	£603,908.00

It was also reported that it had been agreed that the contingency budget would be held until later in the financial year to enable a wider understanding of system requirements. This would be monitored by the Executive Joint Commissioning Group during quarters 3 and 4.

The Board was advised that the BCF policy framework and planning guidance for 2017-18 had not yet been released. It was expected that HWB's would be required to sign off plans prior to final submission. Guidance would be shared with Members of the Board once, published, along with required timescales for submission.

RESOLVED – That the report be noted.

TO:	Health and Wellbeing Board
FROM:	Claire Jackson Interim Director of Commissioning Operations BwD CCG
DATE:	7th March 2017

SUBJECT: Better Care Fund Quarter 3 report

1. PURPOSE

The purpose of this report is to provide Health and Wellbeing Board (HWBB) members with an overview of Better Care Fund (BCF) performance reporting for quarter 3 (October – December 2016).

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

Health and Wellbeing Board members are recommended to:

- note the BCF quarter 3 submission and progress made against delivering the BCF plan, including performance metrics

3. BACKGROUND

As outlined in previous reports, the Health and Wellbeing Board is accountable for the delivery of the Better Care Fund plan. The management of the plan is undertaken by Executive Joint Commissioning Group.

The Blackburn with Darwen BCF plan for 2016/17 was submitted on 3rd May 2016, following an update on planning requirements to HWBB members in March.

Health and Wellbeing Board members have received quarterly updates on 2016-17 BCF plan performance.

4. RATIONALE

Better Care Fund

As outlined within previous reports to the HWBB, the case for integrated care as an approach is well evidenced. Rising demand for services, coupled with the need to reduce public expenditure, provides a compelling argument for greater collaboration across health, care and the voluntary sector.

The Spending Review set out an ambitious plan so that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020. This is reflected in the NHS Planning Guidance 2016/17-2020/21 Delivering the Forward View. The Better Care Fund remains a key policy driver to support integration of health and care services at a local level.

5. KEY ISSUES

Quarter 3 2016/17 submission

The BCF quarter 3 submission was made on 3rd March following sign off by the Chair of the Health and Wellbeing Board. The submission requirements remain unchanged from quarter 2.

The submission includes an update on performance against national metrics between October and December 2016, as outlined below.

- Non-elective admissions have reduced by 723 during quarters 1 and 3 of 2016 compared to same reporting period in 2015/16, however acuity of patients being admitted to hospital is increasing which is reflected in increased costs.

- Performance is slightly above plan for residential care admissions. The total for the year to date (3 quarters) is 122 admissions, i.e. 586.5 per 100,000 pop over 65. If extrapolated for a full year this would equate to 782.1 per 100,000 pop over 65, against the target of 758.2.

- The target of 90% of older people (aged over 65) that are still at home 91 days after discharge from hospital was met for quarter 1 and quarter 2 targets. In quarter 3 the figure was slightly lower at 87%, but remains well above the North West and England averages (82.1% and 82.7% respectively in 2015/16). Use of reablement continues to be a key factor in preventing unnecessary admissions into residential and nursing care and supporting timely discharge from hospital.

- Performance is currently below target by 246 bed days for reducing Delayed Transfers of Care (DToC). A recovery plan is being implemented across Pennine Lancashire, led by the A&E Delivery Board.

- Performance is ahead of plan for the local dementia diagnosis target.

The Q3 submission requires local areas to identify areas of success and challenges which have been outlined below.

Highlights and successes

- Learning from experience of joint working to deliver the local BCF plan continues to influence the development of the Sustainability and Transformation Plan and Pennine Lancashire Local Delivery Plan.
- This includes the development of the Out of Hospital model of care

- Our local model of care has been further developed, with plans to extend neighbourhood teams to include wellbeing services, mental health, services to meet the needs of vulnerable adults and children and young people.

- Positive relationships continue to be developed and strengthened across health and care

- Implementation of Discharge to Assess model across Pennine Lancashire

- Developed an integrated specification for the procurement of community rehabilitation beds aligned to a new capital build project

- Commenced joint procurement of Community Equipment Service

Challenges and concerns

- System and financial pressures, including increased acuity, remains a significant pressure across health and care

- Delayed Transfers of Care position at quarter 3 remains above plan. A number of initiatives, aligned to the local A&E Delivery Board, have been identified including a focus on development of Discharge to Assess and review of Integrated Discharge pathways to ensure optimum utilisation of intermediate care beds and community resources

- Maintaining momentum and engagement across partnerships during a time of significant system transformation

- Delay in the release of national BCF framework and planning guidance is delaying agreement of budgets for 2017-18. This is impacting on contracts for some services, particularly Voluntary sector which could result in loss of skills and capacity.

Two national conditions have still not been achieved locally. They include;

- Is the NHS Number being used as the consistent identifier for health and social care services?
- Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?

Plans continue to be developed to support the achievement of these conditions, including learning from other areas that are reporting as achieved. It is unlikely that these indicators will be required within 2017-18 BCF plans.

2016/17 BCF Finance

The 2016/17 BCF budget is £12,433,000 with a forecast spend at the end of Month 9 of £12,215,674.

The 2016/17 budget has been broken down into:

- Spend on Social Care - £5,544,332 (45%)
- Spend on Health Care - £4,119,224 (33%)
- Spend on Integration - £2,165,536 (17%)
- Contingency - £603,908

In line with the use of the BCF contingency in 2015/16, Exec JCG members have approved allocation of the total contingency budget to the CCG and Local Authority with a 50:50 share, in accordance with the Section 75 agreement for pooled resources.

This resource can then be utilised to support increased demand and acuity pressures across health and care for the remainder of the financial year. This will be supporting non-elective case mix changes for the CCG and support the Local Authority to meet the continuing demand for services in particular home care, crisis support and reablement.

2017-18 planning

The BCF policy framework and planning guidance for 2017-18 has not yet been released. It is expected that Health and Wellbeing Boards will be required to sign off plans prior to final submission. Guidance will be shared with HWBB members once published, along with required timescales for submission. It is likely that local BCF plans will be expected to align to Sustainability and Transformation Plans (STP) and the Pennine Lancashire 'Together a Healthier Future' Local Delivery Plan.

BCF pooled budget 2017-18

The CCG minimum pooled budget contribution for 2017/18 will be £11,169,000. This is an increase of £197,000 from 2016/17 requirement. It is anticipated that the BCF planning guidance will outline expectations for allocation of budget against national conditions.

Government have consulted on the distribution of the Improved Better Care Fund as part of the Local Government Finance Settlement 2017/18. The spending review set out the expected available revenue for Local Government spending through to 2019/20 and Core Spending Power information for Local Authorities has now been issued including proposed allocations of the Improved Better Care Fund.

The Improved Better Care Fund represents nationally an additional £105 million in 2017/18, £825 million in 2018/19 and £1.5billion in 2019/20. The proposed approach to distributing the Improved Better Care Fund recognises that authorities have varying capacity to raise council tax (including that through the adult social care precept).

The Core Spending Power included proposed allocations of the Improved Better Care Fund for BwD as follows:

- 2017/18 £717,301
- 2018/19 £3,714,497
- 2019/20 £6,257,725

The improved Better care Fund is to be allocated directly to Local Authorities and as such has been included within the Local Authority Medium Term Financial Strategy. Further guidance in respect of the improved Better Care Fund and its inclusion in pooling arrangements is still awaited.

6. POLICY IMPLICATIONS

The key policy drivers are outlined within the main body of this report and within previous BCF papers presented to HWBB members. Local areas are expected to fulfil these requirements. Any further impact due to changes in National Policy or planning guidance will be reported as they arise.

7. FINANCIAL IMPLICATIONS

No further financial implications have been identified for quarter 3.

8. LEGAL IMPLICATIONS

Legal implications associated with the Better Care Fund governance and delivery has been presented to Health and Wellbeing Board members in previous reports. A Section 75 agreement is in place between the Local Authority and CCG which outlines risk sharing arrangements associated with the Better Care Fund and other funding streams aligned to integrated delivery locally. The agreement has been reviewed to reflect joint arrangements in 2016/17.

9. RESOURCE IMPLICATIONS

Resource implications relating to the Better Care Fund plan have been considered and reported to Health and Wellbeing Board members as part of the initial plan submission. Any further resource implications will be reported as they arise.

10. EQUALITY AND HEALTH IMPLICATIONS

Equality and health implications relating to the Better Care Fund plan were considered and reported to Health and Wellbeing Board members prior to submission of the plan.

Equality Impact Assessments are ongoing as part of the development of all BCF and integrated care

schemes, including new business cases, and are integral to service transformation plans.

11. CONSULTATIONS

The details of engagement and consultation with service providers, patients, service users and the public have been reported to Health and Wellbeing Board members throughout development of the local BCF plan. Learning from the Pennine Lancashire 'Together a Healthier Future' engagement will inform the development of the 2017-18 BCF plan. Consultation and engagement will form part of business case development for any new or redesigned BCF schemes.

VERSION:	**V1**

CONTACT OFFICER:	Claire Jackson
DATE:	21st February 2017
BACKGROUND PAPER:	Previous BCF reports to HWBB members

HEALTH & WELLBEING BOARD CHECKLIST

Report title: Better Care Fund- quarter 3 update

EIA and HIA Completed	Completed by	Date (dd/mm/yyyy)	Comments
Yes ☒ **No** ☐	Paul Hegarty Lauren Martin Lisa Kiernan (CCG)	Various	Due to the scale and complex nature of BCF, EIA team advised that individual project specific EIAs are completed and updated where necessary. All projects have been subject to Level 1 EIA and, where necessary, Level 2.

Officer consulted	Version Number	Date (dd/mm/yyyy)	Comments
Legal			
Finance Zoe Evans	1.00	28/02/2017	Additional commentary regarding the allocation of 2017/18 Improved Better care Fund added to the report. No further comments.
Corporate Equality			

Lancashire Children & Young People's Emotional Wellbeing & Mental Health Transformation Programme

Reflecting on Year 1 & Looking Ahead to Year 2: 'Our Business for the Future'

Tuesday 13th December 2016

Shirley Waters
Service Redesign Officer
Midlands and Lancashire CSU

Kelly Taylor
Commissioning Lead – Maternity, Children & Families
East Lancashire and Blackburn with Darwen CCGs

Overview

1. Recap on the Plan and year 1
2. THRIVE model of care
3. Funding allocations
4. What have we achieved across Pan Lancashire and in Blackburn with Darwen?
5. Preparing for year 2
6. Your views…

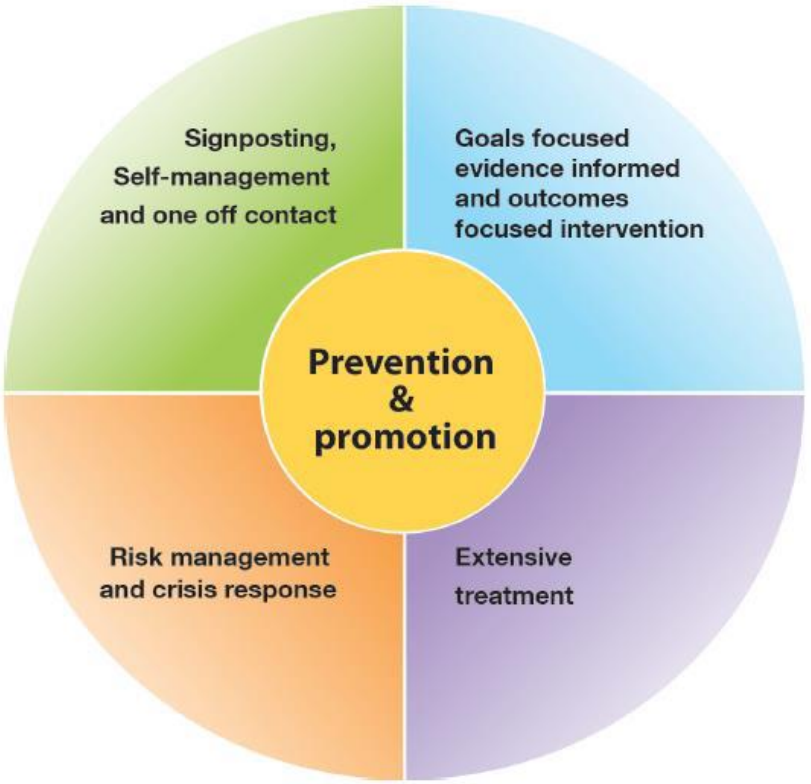
Recap on the Plan

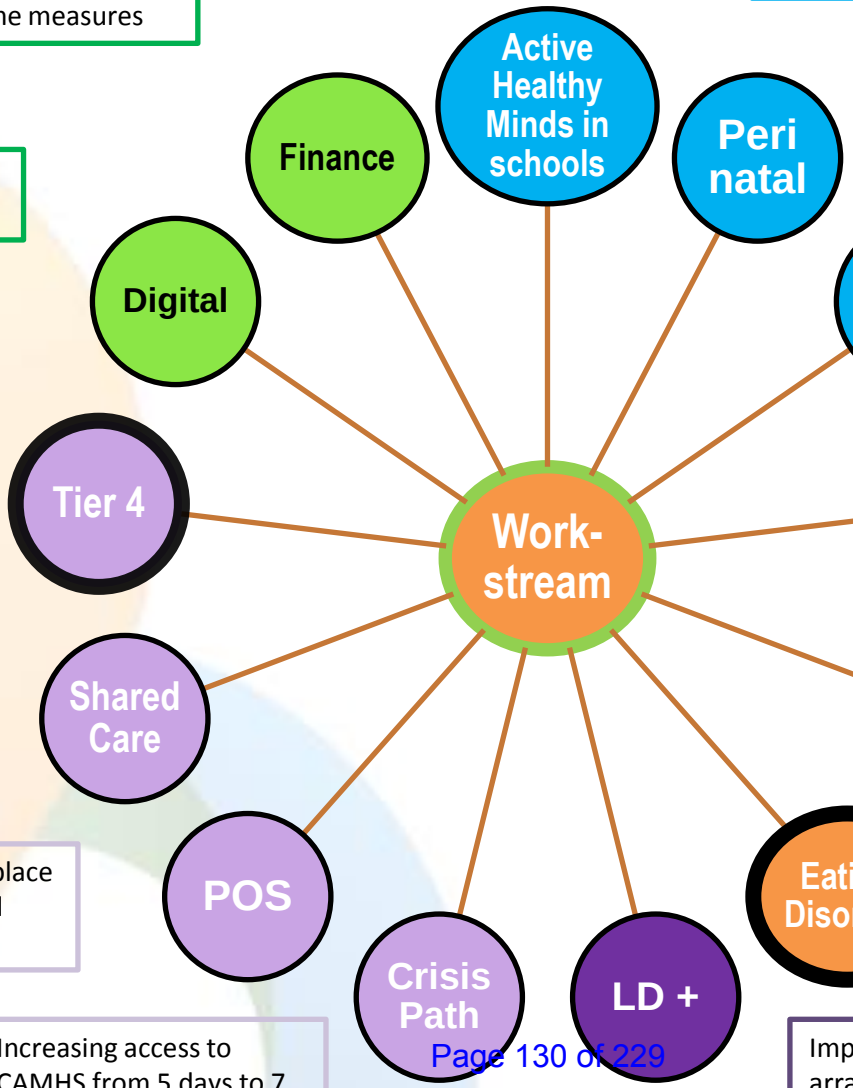
- **0-25** years of age
- An additional **£3m+ a year** for 5 years
- Promoting **Resilience, prevention and Early Intervention**
- Increasing Access to Specialist **Perinatal and Infant Mental Health** Support
- Improving **Access** to Effective Support
- Ensuring appropriate support and intervention for CYP in **Crisis**
- Improving **Care for the Most Vulnerable**
- Improving Service **Quality**

THRIVE

Description of the THRIVE-Groups

Input offered





Lancashire Active Healthy Minds Programme targeting 40 schools a year

Pan Lancashire specialist peri natal community mental health team, delivering improved support for up to 500 women by 2019*

Monitoring of investment, consistent performance and outcome measures

Primary Mental Health Worker roles across Lancashire in 2017, to enable easier access to support and provision of a single point of contact for schools and primary care

Developing Digital Thrive by 2019

Improving access to psychological therapies by increasing the number of trained staff by up to 42 in 2017

Influencing NHS England for the provision of Tier 4 services

Extending the upper age range for community CAMHS up to the 19th birthday in 2017

Implementing a protocol and pathway across all acute providers and CAMHS services in 2017

Implementing a new Community Eating Disorder Service in 2017

Developing a dedicated place of safety for children and young people by 2019

Increasing access to CAMHS from 5 days to 7 days in 2017

Improving service arrangements for children with Learning Disabilities in 2017

Eating Disorder Allocation

	East Lancashire	Blackburn with Darwen	Pennine Lancashire Total
Eating Disorders	£214,000	£95,000	£309,000

Lancashire Care Foundation Trust to provide an all-age Eating Disorder Service commencing in April 2017

CCG Name	Shares of weighted pop'n (National)	2016/17	2017/18	2018/19	2019/20	2020/21
Blackburn with Darwen CCG	0.32%	£376,040	£442,400	£537,200	£600,400	£676,240
Blackpool CCG	0.37%	£437,920	£515,200	£625,600	£699,200	£787,520
Chorley and South Ribble CCG	0.32%	£376,040	£442,400	£537,200	£600,400	£676,240
East Lancashire CCG	0.71%	£847,280	£996,800	£1,210,400	£1,352,800	£1,523,680
Fylde and Wyre CCG	0.29%	£342,720	£403,200	£489,600	£547,200	£616,320
Greater Preston CCG	0.38%	£447,440	£526,400	£639,200	£714,400	£804,640
Lancashire North CCG	0.28%	£333,200	£392,000	£476,000	£532,000	£599,200
West Lancashire CCG	0.20%	£238,000	£280,000	£340,000	£380,000	£428,000
Total Lancashire		£3,398,640	£3,998,400	£4,855,200	£5,426,400	£6,111,840

Acceleration Funding

CCG Name	National Allocation Additional Monies	Shares of weighted population s (National)	Est. Share of add 21m	Est. share of add 4 m
NHS Blackburn with Darwen CCG	79,000	0.32%	£66,360	£12,640
NHS Blackpool CCG	92,000	0.37%	£77,280	£14,720
NHS Chorley and South Ribble CCG	79,000	0.32%	£66,360	£12,640
NHS East Lancashire CCG	178,000	0.71%	£149,520	£28,480
NHS Fylde and Wyre CCG	72,000	0.29%	£60,480	£11,520
NHS Greater Preston CCG	94,000	0.38%	£78,960	£15,040
NHS Lancashire North CCG	70,000	0.28%	£58,800	£11,200
NHS West Lancashire CCG	50,000	0.20%	£42,000	£8,000
National Resource	25,000,000		21,000,000	4,000,000
Total Lancs	£714,000		£599,760	£114,240

Blackburn with Darwen highlights

- Improving Access To Psychological Therapies
  11 staff (Pennine Lancs) CANW, CAMHS, Add-Action
- 6 Primary Care Mental Health Workers
- Winter Pressures – 44 Out of Hours assessments on Ward via A&E with 48 bed night saved
- Eating Disorders services extended up to 17th birthday, care offered 5 days a week 8AM – 8 PM. Meal support offered on Paediatric Ward

Measures of Success

National

- Eating Disorders for delivery of a dedicated community services with access times of 4 weeks (2 weeks for urgent cases)
- Transformation – At least 70,000 CYP each year will receive evidence based treatment. Local services will be able to meet the needs of 35% of those with diagnosable mental health conditions
- Perinatal Mental Health – An additional 30,000 women each year will receive evidence based treatment closer to home

Local Position 2016/17 (Q1 + 2)

- Number of WTE Staff = 14.5
- Number of local stakeholders received training = 180
- Number of CYP seen = 377

Health and Wellbeing Passport

Re-freshed Plan:

http://eastlancsccg.nhs.uk/patient-information/your-health/children-and-young-people-s-health/camhs-child-and-adolescent-mental-health-services

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Kelly Taylor Commissioning Lead – Maternity Children and Families East Lancashire & Blackburn with Darwen CCGs
DATE:	March 2017

SUBJECT:
Children & Young People Emotional Wellbeing and Mental Health Transformation Plan

1. PURPOSE
The purpose of this paper is to update the Health &Wellbeing Board of progress of implementation of the Emotional Wellbeing and Mental Health Transformation Plan since publication in December 2015.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD
Following receipt of this report and the presentation, it is recommended the Health & Wellbeing Board note;

- Governance systems and priorities of the Pan-Lancashire Transformation Board
- Local spend and outcomes delivered in 2016/17 (Appendix A)
- Proposals for Commissioning Priorities, Targets, Metrics and Outcomes and Intended Investment Plans in 2017/18 and beyond (Appendix B)

3. BACKGROUND
Following the publication of Future in Mind (Department of Health, NHS England and Department of Education) 2015; Clinical Commissioning Groups were tasked with leading on a 5 year Transformation Plan that would take a whole system approach to improving emotional health and wellbeing of children with a focus on improved access to services.

The presentation sets out progress to date including;

- Programme and local outcomes delivered
- Refresh of the Transformation Plan including priorities going forward
- NHS England expectations/assurance
- Governance of the TransformationBoard
- Challenges/risks

4. RATIONALE
The rationale is part of a driver to improve the parity of esteem and to ensure that within our health, social care systems and throughout our everyday lives we value mental health equally with physical health. NHS England has mandated growth in spend on health care to try and achieve investment levels that are on par with physical health.

The case for change is set out in the national document Future in Mind (2015), stating that 75% of mental health problems in adult life (excluding dementia) start by the age of 18. Failure to support children and young people with mental health needs costs lives and money. Early intervention

avoids young people falling into crisis and avoids expensive and longer term interventions in adulthood. There is a compelling moral, social and economic case for change

The last UK epidemiological study suggested that, at that time, less than 25% – 35% of those with a diagnosable mental health condition accessed support. NHS England has issued a target for health and social care economies to increase the number of children accessing services with a diagnosable mental health condition by 10%.

5. KEY ISSUES

Some of the key issues are fragmentation of services across health and social care systems. This includes NHS England who commission Tier 4 beds and it has been recognised through a national review that there is a shortage across the country. The impact of fragmentation at all levels impacts on children, families and staff who often struggle to get the right care at the right time.

6. POLICY IMPLICATIONS

The Emotional Wellbeing and Mental Health Transformation Board and the refresh of the Transformation Plan is in line with National Policy including;
Future in Mind, *NHS England, Department for Education and Department for Health* (2015)
Implementing the Five Year Forward View for Mental Health *NHS England* (2016)

7. FINANCIAL IMPLICATIONS

The Transformation Plan set out a financial baseline across Pan-Lancashire. There is an expected allocation to be used by CCGs from existing baselines in order to achieve a 'parity of esteem'. This means that funding for mental health should be on a par with physical health.

The baseline funding levels noted in the Pan-Lancashire plan reflect a collaborative way of working across health and social care systems. Health and Social care have in the past jointly funded CAMHS services as part of a collaborative commissioning response aimed at reducing fragmentation across the system.

NHS England are monitoring CCGs to ensure funding spent ensures a 10% increase in Children and Young People who are accessing services.

8. LEGAL IMPLICATIONS

Pieces of transformation work will check legal implications as required. For example where procurement advice is required.

9. RESOURCE IMPLICATIONS

The presentation will set out the financial commitment from CCGs going forward. This includes funding for a Community Eating Disorders Service and Transformation monies. Funding is expected to be drawn down for a Community Perinatal Mental Health Services through a bidding process.

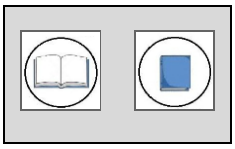
Resources cannot be considered in isolation and there is recognition of collaborative commissioning arrangements and partnership work across health and social care systems in order to achieve joint outcomes for children and young people. This is of particular relevance to our most vulnerable children and young people such as Looked After Children, those known to Young Offending Teams and involved in Child Sexual Exploitation who are over-represented within emotional wellbeing and mental health services.

10. EQUALITY AND HEALTH IMPLICATIONS
Equality Impact Assessments are undertaken for new services or changes in service. One example of this is for new Community Eating Disorder Service commencing in April 2017.

11. CONSULTATIONS
Consultation is undertaken with Children and Young People. Examples include; Consultation with young people prior to commissioning the new Eating Disorder Service. Local service consultation has been undertaken with prior to drawing up the Learning Disability Passports.

VERSION:	

CONTACT OFFICER:	
DATE:	
BACKGROUND PAPER:	



Pennine Lancs Transformation Funding 2016/17 Quarter 3	
15% Topslice - Pan Lancs Schemes	IAPT Backfill 2 year education programme Crisis
Primary Mental Health workers	**Primary Care Mental Health Workers** Funding provides a multidisciplinary Primary Care Mental Health on a 2 year pilot basis. Provision of Primary Mental Health Workers is a clear part of the CAMHS Transformation Plan and all CCGs are commissioning the service but the models may differ. Evaluation of the different models and outcomes will feed into the Resilience Work stream. This local team provides an outreach service from ELCAS and establishes close liaison, training and development with the Integrated Neighbourhood Teams in East Lancashire CCG and Integrated Locality Teams in Blackburn with Darwen CCG. The team are based in Primary Care and will support young people throughout different settings including education to facilitate a multi-agency response to mental health recovery. The teams will liaise with locality based prevention services through the Troubled Families Council based schemes. The teams are currently based at; Stonebridge Surgery, Oswaldtwistle, Roman Road Surgery, Blackburn and Yarnspinners, Nelson. This service was fully recruited to in Q2 of this financial year. **Number of staff: 6** **Number of additional YP supported: 28 new referrals**
Crisis Care – Out of Hours Assessments	An additional 1.5 WTE Band 6 hours provided from 1 August 2016 until 31 March 2017. This will cover the self-harm/ward assessment element of the service over 7 days rather than the 5 days currently commissioned. This will support increased daily capacity from current 2 daily self-harm assessments. Provision will include 8 hours a day on Saturdays and Sundays with 2 band 6 mental health practitioners and consultant psychiatrist cover, to run the self-harm assessments over 7 days. ELCAS will also provide training to the Emergency Department staff and where possible will undertake some shadowing and working alongside the Emergency Department staff. Financial commitment for recurrent funding is available from 1 April 2017 subject to agreement on the model through the Pan-Lancashire Crisis group. **Number of staff: 1.5 WTE** **Number of additional YP supported: 16 weekend referrals and/or YP assessed saving around 25-30 bed days**
Perinatal Mental Health	Scoping of mental health support required in Neonatal Intensive Care service. The Womens Centre will undertake a scoping exercise of how families can be supported with emotional health and wellbeing whilst babies are under the care of in the Unit and through engagement with Core services if required. 30 MP3 Players with self-hypnosis and relaxation from the EMPOWER programme. This will be a library of resources available to vulnerable groups. It is available at a cost of £5 for other service users. 25 Health Visitors to undertake Neonatal Behavioural Observation Training

	delivered by Brazelton. This is recommended within the National Health Visitor Service Specification (NHS England) and the 1001 Critical Days Coalition as best practice example of promoting infant and parent mental health an secure attachments. Training is 2 days theoretical and practical. Practitioners will incorporate practice which takes 15-20 minutes into core contacts including New Birth Visit and 1st Mental Mood Assessment **Number of staff Trained: 25** **Number of Posts: 1 WTE**
ASD /ADHD Pathways	Leaflets and resources for patients around ADHD pathways
ADHD Northwest	Funding for 12 months for this voluntary sector provision in Blackburn with Darwen. This supports a Pennine Lancashire services as is already funded in East Lancashire. This is to respond to gaps identified in provision of family support for families of children with ADHD **Number of staff: 1** **Number of additional YP supported: service only commenced on the 1 October 2016 awaiting report.**
Action for ASD	Funding for 12 months for this voluntary sector provision in Blackburn with Darwen and East Lancashire. This is to respond to gaps identified in provision of family support for families of children with ASD and offers 1:1 support and Cygnet Parenting Courses. **Number of staff: 3WTE** **Number of additional YP supported: East Lancs new referrals 94, with 285 contacts. BwD service only commenced on the 1 November 2016, awaiting report.**
Project Manager	CAMHS Commissioning Manager for East Lancashire and Blackburn with Darwen CCGs
Voluntary Sector Innovation	Health and Wellbeing Grants to be available for third sector organisations to bid for small pots of funding to support children and young people with early intervention emotional health and wellbeing services available in local areas. **Number of innovations: First phase of applications for BPR, nine applications successful. Second phase roll out in January.** **Number of young people supported: Up to 630 for the first phase for Burnley, Pendle and Rossendale**
Self-Harm Training (Harm-Ed)	Harm-ed has provided self-harm training to adults who come into contact with children and young people, in particular health, education and social care. During the original commission during 2015/16 26 courses were delivered across Pennine with a total of 452 participants attending, including a session at the BwD GP protected learning time. Due to demand the commission has been extended till the end of March 2017 with 143 out of the 198 places already booked.

	Number of staff Trained: During the first commission 452, with 152 booked on the remaining sessions
CYP IAPT Training **IAPT Readiness**	**Number of staff on training including representatives from the voluntary sector: 18** Funding for hand held devices to enable staff working in the community to undertake assessment and record outcomes in 'real time'. **Number of devices:**
Self-harm	N-Compass commissioned from April 2016 for 12months to provide self-harm workshops and one to one counselling to pupils identified as using self-harming behaviours who attend high schools across Pennine Lancashire. NCompass will provide six week programmes to high schools signed up to the project. Pilot of safe self-harm 'distraction items' to be provided on the Paediatric Wards and within ELCAS. This is based on similar provision at Blackpool Teaching Hospital. Evaluation by young people on effectiveness in respect to self-care with a view to further roll out to pharmacies. **Number of staff: 2 WTE** **Number of young people supported: 61**
Training Courses/Community Development	National training courses including Perinatal MH for Front line staff.

Appendix B

2017/18 Commissioning Priorities, Targets, Metrics and Outcomes and Intended Investment Plans (Summary)

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
Promoting resilience, prevention and early intervention				
1. By the 30th September 2017 we will have designed and commissioned a **"Mental Health Anti-Stigma Campaign"** building on the existing approach through "Life's ups and downs". By the 31st March 2018 we will have mobilised the campaign across Lancashire.	30.9.17 31.03.18	**Health & Wellbeing:** The campaign will give children, young people and their families, practical advice and support to help them look after their own emotional health and wellbeing, creating resilience. **Care & Quality:** The programme will raise awareness and understanding of emotional wellbeing and mental health, enabling CYP and their families to be identified earlier, better supported and accessing the right support, in the right place, at the right time. **Finance & Efficiency:** Greater resilience will enable us to more effectively respond to predicted increasing demand.	**Local measures:** Number of people visiting the 'Coping with life's ups and downs' website. Life in Lancashire survey – 2-3 questions.	**Nil**
2. By the 31st March 2018 we will have developed, published and launched a Lancashire wide **"Resilience Framework"** which will includes the following components: • Set a common	31.3.18	**Health & Wellbeing:** The framework will help to ensure that any resilience programmes and work that are commissioned and delivered are in line with best practice thus maximising children and young people's resilience, including their ability to manage and recover from mental	**Local measures:** Stakeholder feedback. Life in Lancashire survey – 2-3 questions. Take up of toolkit.	**Nil**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
understanding of what is meant by 'Resilience' in the context of the pan-Lancashire area, in line with the CYP EWMH Transformation Programme. • Provide a step by step guide considering, what, where, with whom and how resilience activities should be best delivered according to the evidence base. • Provide information about sources of local good practice and opportunities for local networking and support. • Provide a quality assurance checklist to ensure that activities are high quality, safe, and based upon best practice.		health issues. **Finance & Efficiency:** Greater resilience will enable us to more effectively respond to predicted increasing demand.		
3. By the 31st March 2019 we will have designed and commissioned a **"Resilience training programme"** in line with the resilience framework for: a. Schools b. CYP c. Families d. Parent carers and young carers	31.3.19	**Health & Wellbeing:** The programme will give children, young people and their families access to practical advice, support, tools and techniques to help them look after their own emotional health and wellbeing. Maximising children and young people's resilience, including their ability to manage and recover from mental health issues. **Care & Quality:**	**Local measures:** Uptake of training programmes Participant feedback Life in Lancashire Survey – 2-3 questions	**Nil**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
e. Other staff working with CYP and families in universal and community service 2017/18 Continue Year 2 of the Active Schools Programme		The programme will raise awareness and understanding of emotional wellbeing and mental health, enabling CYP and their families to be identified earlier, better supported and accessing the right support, in the right place, at the right time. **Finance & Efficiency:** Greater resilience will enable us to more effectively respond to predicted increasing demand.		**£72,000**
4. By 31st March 2018 we will have defined a **"complementary offer"** of support to wrap around clinical services to help children; young people and families avoid escalation, recover earlier and maintain wellbeing. We will have mobilised by 2020/21.	31.3.18 31.3.21	**Health & Wellbeing:** By nurturing the development of a range of asset based supports such as peer support, buddying, online communities, community events and mutual aid we will enable and empower children, young people and families to support themselves and each other. **Finance & Efficiency:** Nurturing resilience and the development of community assets will enable us to more effectively respond to predicted increasing demand.	**Local measures:** Life in Lancashire Survey – 2-3 questions	**£73,934**
5. By the 30th September 2017 we will have expanded the number of **"Primary Mental Health Workers"** (PMHW) or their equivalent and introduced **"Psychological Wellbeing Practitioners"**	30.9.17	**Health & Wellbeing:** By providing the link between specialist CAMHS and primary and community services the workers will help to: • Build capacity and capability within community services in relation to prevention, early identification and	**Local measures:** Service user views Number of assessments Number of evidence based therapeutic interventions Outcome measures to be agreed PMHW and PWPs in post	**£683,513**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
(PWPs) to work within universal and targeted services to support and improve mental health and psychological wellbeing of children and young people.		intervention. • Help promote awareness and importance of emotional health and wellbeing, improving perceptions and attitudes. **Care & Quality:** Support access to appropriate services. Offer effective assessments and evidence based therapeutic interventions. **Finance & Efficiency:** Greater resilience will enable us to more effectively respond to predicted increasing demand.		
6. By the 30th September 2017 we will have defined and designed a Lancashire wide approach to delivering a **"single point of contact"** which will include the following components: • A definition of what we mean by single point of contact • A description of the component parts of the single point of contact • Guidance for commissioners on how to implement the approach locally • Resources and tool for providers to use to develop local protocols	30.9.17	**Care & Quality:** By establishing a consistent approach to single point of contact across Lancashire we will ensure that speed and ease of access to a seamless service is improved, reducing delays and ensuring that children and young people receive the support they need. **Finance & Efficiency:** By improving timely access to support and treatment, escalation will be reduced and as such the number of contacts and the need for more intensive services will decrease. We will also reduce the number of inappropriate referrals by providing support earlier in the pathway.	**National measures:** Referral to treatment times for IAPT and ED. **Local measures:** Referrals to CAMHS Inappropriate referrals to CAMHS Admissions to tier 4 Patient experience measures	**Nil**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
By 31st March 2018 we will have implemented the **"single point of contact"** approach in each health economy.	31.3.18			
Increasing Access to Specialist Perinatal and Infant Mental Health Support				
7. By March 31st 2021 we will have delivered "**improvements in Universal Services"** including: • Consistent Clinical Pathways • specialist post and leadership roles on universal services	31.3.21	**Health & Wellbeing:** • The development of resilient children supported by positive parent and child attachment achieved via multidisciplinary family centred approaches. • Early recovery and maintenance of mental well-being that enables women with serious or complex mental illness and their families to function effectively in day to day life i.e. childcare activities, employment, social activities etc. **Care & Quality:** • The ability for women to make informed choices through the provision of pre conception counselling. • A reduction in the risk of avoidable harm to women and infants due to mental health needs in the perinatal period. • A reduction in the severity, duration, and the negative impact of mental illness in the perinatal period. **Finance & Efficiency:** • Access to specialist care close to home reducing the need for inpatient	**National Measure:** NICE Quality Standards QS133 National Data set **Local Measure:** Evidence of local arrangements to undertake comprehensive assessment before intervention programme for attachment difficulties	**Nil**
8. By March 31st 2021 we will have delivered **"improvements in services for infant mental health"** including: • Infant Mental Health posts to be commissioned and emerging new pathways developed. • Training of Adult Psychiatry and IAPT services.	31.3.21		**National Measure:** NICE Quality Standards QS133 National Data set IAPT Data set **Local Measure:** Evidence of local arrangements to undertake comprehensive assessment before intervention programme for attachment difficulties	**Nil**
9. By the 31st March 2021 we will have commissioned a **"specialist"** community perinatal mental health team allowing at least an additional 495 women each year to receive evidence based	31.3.21		**National measure:** Number of women receiving specialist peri-natal care in a community team. **Local measures:**	***Subject to release of national resource**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
treatment closer to home when they need it. *subject to release of national resource		admission and eliminating the need for travel to access specialist care out of area.	21 women per year accessing specialist inpatient mother and baby units.	
10. By the 31st March 2021 we will have a **"specialist"** inpatient mother and baby unit allowing at least an additional 21 women each year to receive evidence based treatment closer to home when they need it. 2017/18 Continue year 2 funding of peri natal community service pilots	31.3.21		Patient reported outcome measures.	***Subject to release of national resource** **£103,971**
Improving Access to Effective Support				
11. By 31st March 2017 we will have developed a specification and commissioned a provider for an online one stop portal known locally as **"Digital THRIVE"** offering information, advice, self-help, care pathways and self-referral. By 31st March 2018 our online one stop portal known locally as **"Digital THRIVE"** will be operational across Lancashire	31.3.17	**Health & Wellbeing:** The portal is expected to improve the health and wellbeing of CYP and families by improving access to information, self-help materials and support: • Enabling people to access support earlier • Reducing reliance on T3 and T4 CAMHS • Supporting appropriate use of CAMHS	**Local measures:** Reduction in % inappropriate referrals to CAMHS. Increase in the number of CYP with a diagnosed mental health condition enabled to access help. Number of hits on the Digital Thrive portal.	**Nil**
12. By the 31st March 2017 we will have established a dedicated all age **"eating disorder"** service which fulfils the requirements of the Eating Disorders Commissioning Guide: Access and Waiting	31.3.17	**Health & Wellbeing:** The service is expected to improve outcomes for CYP with ED by: • Offering a dedicated specialist service offering NICE guideline compliant treatments. • Improving access to information, advice	**National measures:** By 2020/21, 95% of CYP (up to age 19) referred for assessment or treatment for an ED should receive NICE-approved treatment within 1 week for urgent cases and 4 weeks for every other case.	**£865,000**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
Time Standards (NHSE).		and self-help through the development of an upstream offer. **Care & Quality:** The service is expected to improve access to ED support that is compliant with national commissioning guidance. **Finance & Efficiency:** The service is expected to lead to reduced admissions to tier 4 CAMHS ED beds.	**Local measures:** Admissions of CYP with ED to Tier 4 CAMHS ED beds. Patient reported outcome measures.	
13. By 30th September 2017 we will have a **"0-19"** years (up to 19th birthday) CAMHS service model operational across Lancashire which will include arrangements for 7 day working and out of hours provision.	30.9.17	**Care & Quality:** The new 0-19 arrangements will offer a consistent level of service across Lancashire, supporting greater numbers of children and young people to access the support they need. The new arrangements will also improve outcomes by delaying transitions until after adolescence, enabling continuity of care throughout this challenging period for CYP and families. The 0-25 offer will ensure a comprehensive and consistent set of services and supports across Lancashire. **Finance & Efficiency:** Increased access and continuity of care will lead to better outcomes for CYP and will enable us to more effectively respond to predicted increasing demand. In the longer term it will lead to reduced demand for adult mental health services.	**National measures:** By 2020/21, at least 35% of CYP with a diagnosable mental health condition will receive treatment from an NHS funded community mental health service. By 2021, increased numbers of therapists and supervisors will have been employed to meet the additional demand. **Local measures:** Admissions to CAMHS tier 4 inpatient beds. Patient reported outcome measures.	**£652,168 (equal to the LCC disinvestment in LCF and ELHT 7 months pro rata)**
14. By 31st March 2018 we will have defined a local offer of service provision for CYP with EWMH needs aged **"0-25"** years. By the 31st March 2020 we will have developed and implemented our **"0-25"** years offer.	31.3.18 31.3.20			**Nil**
Ensuring appropriate support and intervention for C&YP in Crisis				
15. By 31st March 2017 we will have developed and implemented a **"pathway"** for	31.3.17	**Care & Quality:** The pathway and protocol will lead to a consistent multi-agency response to CYP	**Local measures:** Time from triage to admission and assessment (if appropriate).	**Nil**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
CYP admitted to acute hospitals in crisis and a set of shared principles to be incorporated into local operational protocols. By 30th September 2017 all acute hospitals will have worked with local CAMHS providers and agreed local operational protocols.	30.09.17	who are admitted to paediatric wards, ensuring their needs are assessed in a timely and holistic way, reducing lengths of stay and reducing delayed discharges. **Finance & Efficiency:** The pathway and protocol will lead to reduced lengths of hospital stay and reduced incidences of delayed discharge.	Length of stay. Delayed discharges.	
16. By 31st March 2018 we will have developed and implemented as part of the all-age crisis care concordat • a **"consistent crisis response service** "for C&YP within acute hospitals e.g. mental health triage/liaison services in A&E • Provision of mental health support helplines for CYP, parents, carers, schools, the voluntary sector and other professionals.	31.3.18	**Care & Quality:** Children and young people across Lancashire will receive a consistent response when they are in crisis.	**Local measures:** Number of staff trained to treat young people with empathy and supportive methods. Admissions to acute and specialist services.	**Nil**
17. By 31st March 2017 we will have "**7 day CAMHS crisis response service to CYP in acute hospitals"** in place across Lancashire.	31.3.17	**Care & Quality:** Children and young people across Lancashire will receive a timely response from local CAMHS services 7 days per week. **Health & Wellbeing:** By providing a 7 day service children and	**Local measures:** Time to triage and assessment. Length of stay. Number of acute admissions.	**£760,895**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
		young people will be supported to avoid escalation and maintain their wellbeing.		
18. By 31st March 2019 we will have **"Place of Safety (Section 135/6) and improved Crisis Assessment facilities"** in place across Lancashire CYP.	31.3.19	**Care & Quality:** Dedicated and tailored facilities will offer children and young people a more appropriate environment for assessment at times of crisis. **Health & Wellbeing:** Children and young people will be supported to avoid escalation and maintain their wellbeing.	**Local measures:** Number of acute admissions.	**Funding from separate Crisis Concordat pilot monies**
19. By 31st March 2017 we will have developed a **"Tier 4 collaborative commissioning plan"** for inpatient services for children and young people in Lancashire which supports our aspiration to work towards a balance between inpatient beds and intensive outreach support.	31.3.17	**Care & Quality:** The work will improve access to Tier 4 CAMHS services for CYP by ensuring that the level of provision locally reflects demand. It will also improve the quality of patient experience by developing a seamless pathway. **Finance & Efficiency:** Reducing admission to Tier 4 will free up investment that can be re-invested in community based services.	**National measures:** Total bed days in CAMHS tier 4 per CYP population. **Local measures:** Tier 4 out of area placements. Tier 4 admissions. Tier 4 delayed admissions. Tier 4 delayed discharges.	**Nil**
20. By 31st March 2021 we will have developed, agreed and implemented clear **"Tier 4 pathways"** for CYP entering and leaving Tier 4 services.	31.3.21			**Nil**
Improving Care for the Most Vulnerable				
21. By 31st March 2021 we will have implemented a minimum service offer **"pathway for vulnerable groups" which seeks to improve access to assessment ,services and**	31.3.21	**Care & Quality:** • Thresholds for CAMHS and the CAMHS offer for vulnerable groups will take cognisance of complexity and the specific needs of the vulnerable groups.	**Local measures:** Gold Standard pathway in place for Autism based on NICE guidance and ratified by Strategic Clinical Network (SCN). Waiting times	**£520,636**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
outcomes as follows: a. Children with ADHD b. Children with ASD c. Children looked after d. Children with Learning disabilities e. Children vulnerable to exploitation f. Children in contact with the youth justice system g. Children with adverse childhood experiences		• There will be a standardised approach to diagnosis through tools and MDT • Support for families on waiting list for diagnosis or where children have a diagnosis of Autism or ADHD. • Improved pathway for vulnerable children and within THRIVE model 'getting support'. Families are able to accept diagnosis and are supported to make a management plan. • Alignment of outcomes with Transforming Care Programme for CYP with LD who are over-represented in CAMHS Services. • Implementation of Routine Enquiry for Adverse Childhood Experiences. • Training programme for staffing and building Routine Enquiry as a commissioning requirement within Service Specifications • CAMHS, Paediatrics, LD and school nursing (including Sp school nursing) have up to date training to support children with Autism, ADHD, Learning Disabilities, children known to CSE and YOT	Families feel supported/ prevention family breakdown/improved emotional wellbeing of CYP. Pathways and reduced admissions through proactive Care and Treatment Reviews Vulnerable young people feel able to understand reasons for behaviour earlier and be supported Following ACE Training, Staff in universal services understand the impact of adversity on behaviours	
Improving Service Quality				
22. By 30th September 2017 we will have established and mobilised a CYP Lancashire wide **"provider network"** to facilitate joint working and	30.9.17	**Care & Quality:** Improved joint working and collaboration, partners sharing learning and working jointly on relevant standards, targets and pathways. This will lead to improved	**Local measures:** Work programme delivers agreements on shared approaches.	**Nil**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
collaboration, improve pathways and share good practice.		coordination of services between providers and seamless pathways for children young people and families. Documentation and procedures will be consistent.		
23. By 31st December 2017 the network will have a defined **"provider network work programme"** focussing on the following key priorities: a. Early intervention in psychosis b. Self-harm c. Workforce retention, recruitment, training, CPD and supervision d. Carers and working carers assessments and feedback e. Policies, procedures and guidance f. Approach to risk support in line with Thrive g. Information sharing h. Using outcomes to inform practice and service planning i. Prescribing protocols j. Suicide strategy k. Transitions policy l. Out of hours psychiatry model m. CYP IAPT programme n. Parity of esteem with physical health	31.12.17			**Nil**

OBJECTIVE	DELIVERY DATE	WHAT DIFFERENCE WILL IT MAKE?	HOW WILL WE EVIDENCE IMPACT?	2017/18 TP INVESTMENT
2017/18 Continue to fund the IAPT Programme				**£330,000**
24. By 31st March 2017 we will have developed a **"performance dashboard"**.	31.3.17	**Care & Quality:** Gaps and issues will be more readily identified and addressed.	**Local measures:** Time from issue or breach to actions to address them.	**Nil**
25. By 31st March 2017 CAMHS service providers will routinely collect **"outcome measures"** which will be aggregated and reported through to the System Performance Group.	31.3.17	**Care & Quality:** Consistent comparisons between providers will enable gaps in provision to be addressed as a whole system. **Finance and Efficiency:** Members of the system will hold each other to account.	**Local measures:** Dataset available and reported routinely.	**Nil**
26. By 31st March 2018 NHS commissioned services will produce and publish produce and publish **"annual quality improvement plans".**	31.3.18	**Care & Quality:** Drawing on the work of the provider network, performance dashboard and outcome measures service providers will be able to readily identify areas for improvement, develop plans to address these and work collaboratively to implement.	**Local measures:** Plans published annually and actions implemented.	**Nil**
Total 17/18 Investment on schemes (exclusive of the ring fenced allocation for Eating Disorders): £3,197,117 **Noted: Remaining balance is available to support non STP funded programme costs. There is also a variance to BWD CCG resulting from BWD Local Authority continuing to fund their contribution to CAMHS. This has resulted in more transformation monies being available for local spend in BWD CCG and these will be spent collaboratively with the HWWB against their priorities.**				

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Linda Clegg, Director of Children's Services Dominic Harrison, Director of Public Health
DATE:	February 2017

SUBJECT: Update on the Sector Led Improvement Review for Infant Mortality and its recommendations

PURPOSE

1. To provide an update on the recent North West Sector Led Improvement Review on Infant Mortality.

2. To provide assurance that the recommendations from the Review are being actioned via the Director of Public Health and/or the Chair of the Local Safeguarding Children's Board (LSCB), as appropriate.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

1. Note the local arrangements that are in place to reduce infant mortality.
2. Note the local arrangements put in place to respond to the recent North West Sector Led Improvement Review on Infant Mortality
3. Receive an update in 12 months' time on the progress from the North West Sector Led Improvement Review on Infant Mortality recommendations.

3. BACKGROUND

Historically, rates of deaths in the first year of life (infant mortality) have consistently been significantly higher than the regional and national average in Blackburn with Darwen. In 2013, a local review of how best to deliver this priority for children's health and wellbeing took place across Blackburn with Darwen and, East Lancashire (where there are similar outcomes in Pendle and Burnley). From the local intelligence on infant mortality and to align with both commissioner and service provider geographical areas, a Pennine Lancashire approach was agreed to reduce infant mortality. This proposal was supported by the Public Health Directors for Blackburn with Darwen and the East Lancashire Locality, by both East Lancashire and Blackburn with Darwen Clinical Commissioning Groups (CCGs), East Lancashire Hospitals Trust (ELHT), who provide Maternity and Paediatric services and Lancashire Care Foundation Trust (LCFT), who provide Health Visitor Services, both across Pennine Lancashire.

The Pennine Lancashire Infant Mortality Group continues to meet to work together to reduce infant mortality via an agreed Framework for Action, which is underpinned by:

- On-going analysis of infant mortality data and intelligence to inform developments.
- An assets based approach, building on strengths and co-production (where service users, carers, service providers come together to find a solution and co-design the services).
- Consideration and application of evidence based practice and benchmarking e.g. Born in Bradford study.
- Impact of the wider determinants of health on infant mortality and how this can be addressed e.g. education, housing, employment.

The Priorities within the Framework are as follows: Smoking in Pregnancy; Infant Feeding; Safer Sleeping; Social Needs Assessment; Maternal Healthy Weight; Family Genetics; Maternal Mental Health; Awareness raising for wider partners, which were prioritised based on the above principles.

4. RATIONALE

In 2016, 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.

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.

The Review focussed on child deaths aged under one year; this age range accounts for around two thirds of all child deaths both locally and nationally. 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).

The aim of the review was to:

i. 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.
ii. Taking an appreciative enquiry approach to identify places where actions have resulted in improved outcomes and share the learning.
iii. Identify key themes and recommendations at LA, sub-regional and North West levels.
iv. Outcomes of the review to provide potential opportunities for collaborative work programmes which may include commissioning.
v. Enable sharing of good practice and innovation to aid mutual support and drive improvement in outcomes.
vi. Identify any gaps in data and intelligence and provide recommendations for Child Death Overview Panels (CDOPs).
vii. Produce an action plan for Local Area Safeguarding Children and Adult Boards who will be responsible for oversight and implementation.

From the Review, there were 30 recommendations for the Regional level, and 22 recommendations for the Individual Localities. The overall ask was to:

- Consider and agree how the locality recommendations should be translated into local action plans.
- Agree the governance and accountability arrangements to assure implementation of locality recommendations.
- Provide an annual update on implementation progress to the LSCB, Health and Wellbeing Board (HWBB) and local CDOP.

For Blackburn with Darwen, the recommendations for the Individual Localities are to be incorporated into the Pennine Lancashire Framework. The majority of the recommendations are already within the local framework and progress is presented in Appendix 1.

For Blackburn with Darwen, the governance and accountability for Infant Mortality is the Health and Wellbeing Board via the Children's Partnership Board and, the Borough's LSCB.

An update on progress of the Individual Localities will be reported in 12 months to the Pan Lancashire CDOP.

5. KEY ISSUES

A number of actions via recommendations were identified from the Review; of which 22 were identified for Individual Localities. Appendix 1 outlines all of the Individual Locality Recommendations and provides a brief summary of status, and the recommendation for the next steps.

Please refer to Appendix 1 for the summary of actions / recommendations.

6. POLICY IMPLICATIONS

This Review aligns to our local policy and priorities and strengthens the work that is already progressing across the Borough to reduce Infant Mortality.

7. FINANCIAL IMPLICATIONS

There are no financial implications with the outcomes of the Review and its recommendations.

8. LEGAL IMPLICATIONS

There are no legal implications with the outcomes of the Review and its recommendations.

9. RESOURCE IMPLICATIONS

There are no resource implications with the outcomes of the Review and its recommendations.

10. EQUALITY AND HEALTH IMPLICATIONS

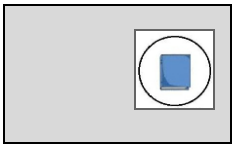
There are no equality and health implications with the outcomes of the Review and its recommendations.

11. CONSULTATIONS

There are no further consultations required as the Review took an appreciate enquiry approach and was gathering good practice / consultations within the Review.

VERSION:	Ver 0.4

CONTACT OFFICER:	Helen Lowey, Consultant in Public Health, Blackburn with Darwen Borough Council
DATE:	06 / 02 / 2017
BACKGROUND PAPER:	Appendix 1 Sector Led Improvement (SLI) Infant Mortality: Recommendations for individual localities Sector Led Improvement Review: Infant Mortality



Appendix 1

Blackburn with Darwen Borough Council /Blackburn with Darwen Local Safeguarding Children's Board

Sector Led Improvement (SLI) Infant Mortality: Recommendations for individual localities

Recommendation for individual localities **Proposed lead:** **Chair of LSCB/ Director Public Health** **(Directly taken from the Review)**	**Blackburn with Darwen Borough Council Comments**	**Recommendation for Local Action**
Child Death Overview Panel (CDOP)		
1. Clearly define governance of CDOP report within individual localities.	Pan Lancashire CDOP Annual Report is presented to Blackburn with Darwen's (BwDs) Children's Partnership Board and, BwD's Local Safeguarding Children Board (LSCB). It will also be discussed at the Pennine Lancashire Infant Mortality meeting in addition	To maintain the governance that is in place
2. Clarify how findings from CDOP cases within the locality are shared for action.	Actions arising from individual cases are tracked by the Pan Lancashire CDOP. Within the BwD locality these are also presented to the Pennine Lancashire Infant Mortality Group.	To maintain the governance that is in place
Capacity to improve		
3. Identify a named lead for reducing infant mortality within the locality	Currently public health chair the Infant Mortality Group, but no formally named lead	The Director of Public Health (DPH) should be nominated as the lead officer
4. Identify a lead elected member for reducing infant mortality	Currently public health chair the Infant Mortality Group, and reported to Health SPT but no formally named lead	The portfolio holder for Health should be nominated as lead elected member

Appendix 1

5. Modifiable factors associated with infant mortality are firmly embedded in integration programmes. (Modifiable factors include safeguarding in relation to abuse and neglect, smoking, drugs and alcohol misuse, and co-sleeping)	This is part of the Pennine Lancashire Infant Mortality Framework as the enabler	To strengthen this recommendation within the local Framework
6. Consider opportunities to influence behaviour change and social norms for modifiable factors associated with infant mortality (such as social movement).	**Smoking in pregnancy** Tobacco Free Lancashire Strategy See comments within recommendations 17 to 21 below for further details. **Diet and nutrition** Eat Well, Shape Up Move More Strategy, including promotion of breastfeeding **Stress** The Parenting Strategy supports this component as does the work across the Mental Health First Aid Training programmes etc. Emotional Wellbeing for children and young people (including parents) is a priority for the Children's Partnership Board and part of the Early Help offer. Pan Lancashire Emotional Health & Wellbeing (CAMHS) Systems Board provides leadership and development of programmes and services for children, young people and families' mental health and wellbeing, which includes BwD representation. **Healthy pregnancy** Local programmes include work to reduce alcohol exposed pregnancies, and promote healthy	To review the actions within the Pennine Lancashire Infant Mortality Framework and cross-check with the thematic strategies

Appendix 1

	pregnancy and breastfeeding. Children's Centre's deliver Healthy Start voucher and vitamins schemes (see 22. below for further details). Also part of the Early Help Offer Other relevant strategies and action plans include: • Domestic Abuse Strategy • Alcohol Strategy • Accident Prevention Strategy • Substance Misuse Strategy • Health and Wellbeing Strategy • Children & Young People's EHWB Transformation Plan • Lancashire Infant feeding plan • Healthy Child Programme – local delivery model	
7. All services commissioned are evaluated to ensure they make positive changes to modifiable factors	This is undertaken in an ad hoc manner	To have an explicit recommendation within the Pennine Lancashire Framework to ask this directly and capture the responses.
Safeguarding		
8. Data sharing and information governance within localities facilitates safeguarding for all agencies	Currently covered via LSCB's Information Protocol: defines legal gateways for sharing information between agencies for safeguarding purposes. Within midwifery and health visiting there is the consent to share process that is completed at initial visits/appointments and both services complete	For the LSCB and Infant Mortality Groups to continue the learning and progress with data sharing.

Appendix 1

	initial 'social needs assessments'. Recent serious case reviews (SCRs) have identified the process in both organisations requires improvement to include family history (adverse childhood experiences possible option) and checking self-reported history with other agencies as currently reliant on self-reporting alone. The process in midwifery of managing pregnancies between community and hospital midwifes requires improvement as all information on risks is not always in records, especially hospital records. Information on unmet need is usually in patient hand-held midwifery records.	
9. Effective partnership working including information sharing to support safeguarding.	Existing process between midwifery, health visiting and children's centres to share information and refer to services at early help level. Both health providers also have processes to refer to their safeguarding teams for any risk cases that require referral to Multi Agency Safeguarding Hub (MASH) for Children in Need /Child Protection /Looked After Children concerns. The LSCB's Continuum of Need Framework identifies the thresholds for Early Help to Looked After Children concerns and audit identifies that most agencies do understand the thresholds.	To continue with the good partnership working and to continue to be strengthened.
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	Whilst LSCB training does not cover explicitly the risks associated with infant mortality, CDOP & SCR briefings do. Training sessions on safer sleep have been delivered in the past. BwD's risk model is covered in LSCB training and this	There is an opportunity to consider current training needs and how these could best be addressed to look at ways in which all front line staff could ensure consistent messaging and brief interventions

Appendix 1

	focuses on practitioners becoming knowledgeable on assessing unmet need and risks using accepted child development milestones within the assessment framework (the framework has three domains: child's needs; parenting capacity; and family/environmental factors). Within the domains are further sub-domains that cover implicitly infant mortality.	on factors associated with infant mortality e.g. safer sleeping, smoke free pregnancy, smoke free homes, breastfeeding, managing stress, and healthy weight.
11. Review working practices for professional staff working in deprived areas and ensure rotation to more affluent areas to prevent social norms becoming distorted	In the 'Child W' case review that was completed in 2012, it found: The repeated exposure of professionals to intractable and long term problems 'normalise' their response and understanding of deviant and risky parental behaviour The finding led to the development of the BwD risk model (now also being rolled out across Lancashire) that clearly identifies what are 'underlying risk factors' and 'high risk indicators'.	To review the BwD Risk Model over time.
Congenital abnormalities		
12. Reliable information system to enable access to high quality intelligence to identify 'at risk' population groups	Public Health England (PHE) recently taken over responsibility for congenital anomaly registers nationally. Impact on ability to identify 'at risk' population groups is not yet apparent	To review the data once established
13. Preconception care in place which targets 'at risk' groups of congenital abnormality	Pennine Lancashire has a service which engages with communities and extended families who practice customary cousin marriage, and the health care staff who serve them, to raise awareness, promote conversations and provide genetic counselling for those with a family history of possible recessive disorder. This includes pre-marital and pre-conception advice and carrier testing (if feasible).	To continue with the service within the community

Appendix 1

14. Outreach worker in each locality where there is a high rate of congenital abnormality	Pennine Lancashire has an outreach service which engages with communities and extended families who practice customary cousin marriage, and the health care staff who serve them, to raise awareness, promote conversations and provide genetic counselling for those with a family history of possible recessive disorder. There are currently no other causes of congenital abnormality which takes this approach.	To continue with the service within the community
15. Engage with community leaders and families in high risk groups to communicate messages about consanguinity and the advantages of genetic screening	Pennine Lancashire has an outreach service which engages with communities and extended families who practice customary cousin marriage, and the health care staff who serve them, to raise awareness, promote conversations and provide genetic counselling for those with a family history of possible recessive disorder	To continue with the service within the community
Co-sleeping		
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	Pan Lancashire Safer Sleeping Guidelines well established across statutory agencies. Safer sleep assessment tool that has been developed by CDOP Pan-Lancashire safer sleep training later this year	Need to understand whether the Safer Sleep guidance has reached the 'wider services' mentioned here, therefore we recommend a simple survey to assess 'reach'.
Smoking in pregnancy		
17. Smoking cessation targets for midwives and health visitors.	There are no targets set within maternity or health visiting service contracts in Pennine Lancashire for smoking cessation in pregnancy.	To review smoking cessation provision and pathways in line with available local resources

Appendix 1

18. Smoking cessation interventions at 20 week scan delivered by trained sonographers (Blackpool model)	Training of midwives was conducted on the risk perception intervention (RPI) and CO monitoring at the first scan appointment in 2015. However, due to a shortage of resources and a change in staff, RPI is not being undertaken at the present time. Carbon Monoxide (CO) monitoring and the opt-out pathway remains in place and is conducted by the East Lancashire Hospital Trust (ELHT) maternity services.	To review maternal health care and support provided in relation to smoking in pregnancy in line with available local resources and capacity
19. Healthy Community Pharmacies provide cessation intervention upon purchase of pregnancy test kit. Opportunities for Public Health interventions.	This is not in operation at the present time in BwD. Pharmacies provide smoking cessation services and clinics, along with GP practices locally.	Review smoking cessation provision provided by pharmacies in line with available local resources.
20. Improve referral pathways to enable immediate cessation support	The opt-out pathway is in place at ELHT maternity services for but BwD referrals to the stop smoking service may not be guaranteed within 24 hours (weekly collection of paper based referrals forms).	Review smoking cessation referral pathways in line with available local resources.
21. Implement evidence based smoking and pregnancy incentive scheme – other 'softer' rewards such as certificates of achievement are extremely valuable / motivational tools	There is no incentive scheme or rewards available for BwD for smoking in pregnancy.	Review maternity care and smoking cessation support in pregnancy and explore funding opportunities to support incentive scheme
Deprivation		
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	**Healthy Start vitamin scheme** In BwD, the Healthy Start scheme is available for pregnant mothers, delivered through children's centres and distributed by health visitors at routine postnatal home visits. This includes vouchers for families on low income. These can be exchanged for fresh or frozen fruit or vegetable and milk. The	Review of holistic local 'offer' for families who are most deprived, with a focus on pathways to employment and education

	scheme also provides vitamins to support intake during pregnancy and early years. The government has recently re-committed to this scheme in the recent National Child Obesity Strategy and the Healthy Start is embedded within the Eat Well, Shape Up and Move More Strategy. **Reducing smoking rates** Tobacco Free Lancashire Strategy is in place which was refreshed in 2015, with BwD representation on the strategic group). BwD also sit on Pan Lancashire Smoking In Pregnancy group. **Pathways to employment/education** Tackling youth unemployment is a key priority of the Blackburn with Darwen's Early Help Strategy. The New Directions service supports and monitors all school leavers around further education, job seeking and careers advice. Children's Centres provide a wide range of information, advice and guidance for parents and families, including childcare, benefits, parenting support groups, and outreach home visits for families with additional needs. **Early Help Strategy** One of the five priorities of the Blackburn with Darwen's Early Help Strategy is to 'keep children and young people safe', which explicitly contributes to safeguarding children and promoting children's welfare, monitored by Children's Partnership Board.	

End of Report

HEALTH & WELLBEING BOARD CHECKLIST

Report title: Update on the Sector Led Improvement Review for Infant Mortality and its recommendations

EIA and HIA Completed	Completed by	Date (dd/mm/yyyy)	Comments
Yes ☐ **No** ✓ ☐	Helen Lowey	16/02/2017	Not required as update of an external review

Officer consulted	Version Number	Date (dd/mm/yyyy)	Comments
Legal Sian Roxborough	0.4	24/2/17	No comments.
Finance Gill Minshall	0.4	23/02/17	No financial implications.

2016

North West Sector Led Improvement: Infant Mortality

Contents

Contact:

Angela Daniel – angela.daniel@tameside.gov.uk

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

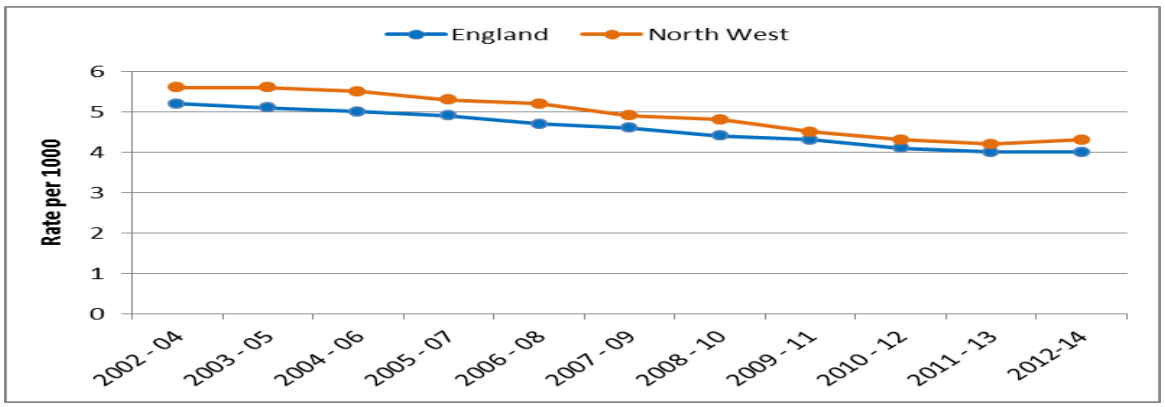


Table 1

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 benefits 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.

Acknowledgements

To everyone who participated in the SLI process and specifically to Angela Daniel from the GM Public Health Network Team for her commitment and support in bringing this important piece of work to fruition.

Thank you to the Infant Mortality Sector Led Improvement Group:

Angela Hardman Executive Director of Public Health, Chair - Infant Mortality Sector Led Improvement Group
Angela Daniel Programme Manager, Greater Manchester Public Health Network
Helen Marsh Policy Analyst, Greater Manchester Public Health Network
Mick Lay Greater Manchester CDOP chair
Irene Wright Merseyside Child Death Overview Panel Manager, Liverpool Safeguarding Children Board
Jacqui Dorman Public Health, Intelligence Manager, Tameside
Debbie Blackburn Assistant Director Public Health Nursing, Salford City Council
Pippa Tavriger Public Health Practitioner, Liverpool City Council
Peter Elton Clinical Director, Greater Manchester Strategic Clinical Network
Paula Hawley-Evans Health and Well Being Programme Lead, Public Health England North West
Claire Haigh Director of Improvement, NW Employers
Gifford Kerr Consultant in Public Health, Blackburn with Darwen Borough Council
Abdul Razzaq Director of Public Health Trafford Council and NW Public Health Chair
Debbie Fagan South Sefton CCG
Janice Bleasdale Specialist Nurse for the Child Death Overview Panel, Cheshire East
Chris McLoughlin Director Safeguarding & Prevention Stockport MBC
Mark Brown Programme Manager Greater Manchester Public Health Network
Hakeel Qureshi Programme Manager Greater Manchester Public Health Network
Emily Parry-Harries Speciality Registrar Public Health, Tameside MBC
Jane Rossini Deputy Centre Director, Public Health England North West
Rebecca Wagstaff Deputy Director, Health and Wellbeing Board, Public Health England North West
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

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	NHS England
DATE:	06/02/2017

SUBJECT: Notification of change in legislation in relation to HWBs requirement to provide supplementary statements to the PNA

1. PURPOSE

The purpose of the executive is to highlight the key issues as a result of the changes to legislation which requires the HWBs to comment upon Pharmaceutical Applications and thereafter the requirement to produce a supplementary statement to the PNA.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

The Health and Wellbeing Board is recommended to:

Note the process for reviewing Pharmaceutical Applications

1. Note the requirement for the Health and Wellbeing Board to provide comment in relation to any Pharmaceutical Applications and to issue a supplementary statement to the PNA when required as per the legislation.
2. Note the request for NHS England to receive a copy of any such additional statements, ensuring that they are emailed to england.lancsat-pharmacy@nhs.net for reference purposes.

3. BACKGROUND

SI 1077 of 2016 introduced amendments to the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Primarily, the new legislation allows applications for consolidation of 2 or more pharmacy sites to be considered. The opinion of the HWB on this issue must be given when the application is notified locally and representations are sought. If the application is granted and pharmacy premises are removed from the relevant pharmaceutical list, if the HWB does not consider that a gap in service provision is created as a consequence, it must publish a supplementary statement to be published alongside its pharmaceutical needs assessment recording its view.

4. RATIONALE

To keep the PNA up to date in line with legislation changes.

5. **KEY ISSUES**

As above.

6. POLICY IMPLICATIONS

7. FINANCIAL IMPLICATIONS

8. LEGAL IMPLICATIONS

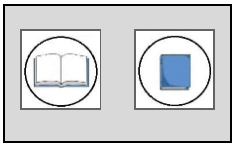
9. RESOURCE IMPLICATIONS

10. EQUALITY AND HEALTH IMPLICATIONS

11. CONSULTATIONS

VERSION:	

CONTACT OFFICER:	*Sheena Wood, NHS England, 0113825 5385, sheena.wood2@nhs.net*
DATE:	06/02/2017
BACKGROUND PAPER:	• *National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013* • *SI 1077 of 2016 – The National Health Service (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016*



HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Director of Public Health
DATE:	23 January 2017

SUBJECT: Eat Well Move More Shape Up Strategy 2017-2020

1. PURPOSE

To raise awareness of physical inactivity and unhealthy weight as a local public health issue.

To request approval from the Board to implement the partnership Blackburn with Darwen Eat Well Move More Shape Up Strategy

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

That the Health and Wellbeing Board:

- Notes that obesity and physical inactivity is a significant public health issue requiring senior level leadership and commitment to increasing physical activity levels, improving access to healthy and sustainable food and encouraging self-care from council, partners and stakeholders.

- Approves the three year food, physical activity and healthy weight strategy and action plan.

3. BACKGROUND

Food and Nutrition

Food is essential for life and impacts can be both positive and/or negative, depending on the type of food we eat. Food helps meet our physical needs by providing energy and nutrients but for many people it can also meet social, cultural and emotional needs. Food selection is not only a behavioural choice but can also be influenced by factors such as cost, access, knowledge and social norms. Significant differences in nutritional knowledge have been linked to different socioeconomic groups, with knowledge declining with lower socioeconomic status.

Physical Activity

Physical inactivity is the fourth leading cause of global mortality, and the cause of many leading preventable diseases in society such as coronary heart disease, some cancers and type 2 diabetes. Evidence tells us that being physically active has benefits for mental health and wellbeing, quality of life and maintaining independent living in older age and also plays a key role in brain development in early childhood and is good for longer-term educational attainment. Physical activity can help to play a role in reducing health and social inequalities and as a result of its wide reaching impact has been described as the 'best buy' in public health. The cost of physical inactivity to BwD amounts to £3,206,550 compared to an average of £1,817,285 nationally.

Healthy Weight

Obesity is a major public health problem due to its association with serious chronic diseases and the costs to both the individuals and society as a whole. Obesity is a complex, but largely

preventable condition which has serious, far reaching physical, psychological and social consequences that affects virtually all age and socioeconomic groups although some more than others. Obesity affects a person's wellbeing, quality of life and ability to earn.

Key Drivers

There are numerous national and local drivers which support a comprehensive strategic policy approach to addressing these cross cutting agendas, including the national strategies: *Everybody active, everyday – An evidence based approach to physical activity* (Oct 2014); *Sporting Futures: A new strategy for an active nation* (Dec 2015*)*; *Towards an Active Nation* (May 2016*)*; *NHS 5 Year Forward View* (2014); *Get Well Soon – Place Based Health* (2016) the recently released *Childhood Obesity: A Plan for Action (*Aug 2016) and the refreshed BwD Health and Wellbeing Strategy. The strategy will also be driven by the Together A Healthier Future Programme and will be a key document in the prevention agenda of the transformation programme across the Pennine footprint. The strategy will be aligned with the '*Cumbria and Lancashire Sport and Physical Activity Strategy'* and the '*Lancashire Walking and Cycling Strategy'*.

4. RATIONALE

The purpose of the Blackburn with Darwen Eat Well Move More Strategy is to provide a framework for action across the life-course to increase healthy life expectancy. It provides an approach to health improvement which recognises the contributions that can be made across all sectors of our society. It draws on local experience and research evidence, aiming to increase both physical activity levels and the number of residents who are a healthy weight.

The national obesity and physical activity strategies are clear that it is not the sole responsibility of any one sector alone. It is important that stakeholders and partners work together to help reduce the prevalence of non-communicable diseases such as Type 2 Diabetes, coronary heart disease and stroke through a healthy lifestyle and co-ordinate and deliver interventions with local communities to ensure that they are effective in helping to improve healthy life expectancy in Blackburn with Darwen.

5. KEY ISSUES

Demographics:

- The Borough has the second highest all-age mortality rate for cardiovascular disease (CVD) out of 152 upper-tier authorities in England.
- Childhood poverty continues to be a key issue
- BwD was ranked the worst local authority with the lowest proportion of children aged 5 with no obvious dental decay in 2015.

Physical Inactivity

- Physical inactivity directly contributes to 1 in 6 deaths, and around a quarter of the population is inactive and 45% of women and 33% of men are not active enough to benefit their health.
- Only 21% of boys and 16% of girls aged 5-15 are achieving their recommended physical activity targets (1 hour moderate activity daily).
- In BwD only 40,000 people (16+) are active enough to benefit their health which is 12% lower than the national average.

Healthy Weight

- BwD has a rate of 48.9 per 100,000 killed or seriously injured in BwD compared to 39.3 nationally
- More than 1 in 5 Reception children in BwD are overweight or obese and more than 1 in 3 Year 6 children are overweight or obese.
- The rate of obesity more than doubles between Reception and Year 6 from 9.4% to 22.6%.
- The prevalence of underweight children remains a local issue however this has reduced from last year's figures but still remains higher than the regional and national prevalence.
- 25% of adults aged 35-70 who had a Health Check in 2015-16 were identified as having pre diabetes. This figure is more than double the rate seen in Lancashire (10%). This poses a significant challenge to both the local authority and Clinical Commissioning Group in the

management of those who have been identified.

The current Pennine Lancashire health and social care transformation programme seeks to redesign the future of health care in our area and presents a challenge in saving over 20% of its total budget over the next five years. This also presents an opportunity in providing a case for change from a primary prevention perspective within which food and physical activity initiatives and policy changes within this strategy could support the case for change.

6. POLICY IMPLICATIONS

This strategy has been aligned to both local and national recommendations and guidelines for improving access to healthy and sustainable food, increasing physical activity levels and achieving a healthy weight and BwD's Health and Wellbeing strategy. The action plan has been developed in line with national policies and guidelines and local priorities as derived from the extensive consultation work undertaken.

The strategy and action plan take into account the policies and strategies listed earlier in this paper and those listed below:

- Public Health Outcomes Framework 2014-15 (Department of Health, 2014)
- Fair Society, Healthy Lives. A strategic review of health inequalities in England post 2010 (The Marmot Review, 2010)
- Blackburn with Darwen Health and Wellbeing Strategy 2015-18
- BwD Planning for Health Supplementary Planning Document
- BwD Integrated Strategic Needs Assessment
- Local Authority Declaration on Healthy Weight https://www.blackpool.gov.uk/News/2016/March/Blackpool-Council-signs-up-to-healthy-charter.aspx

7. FINANCIAL IMPLICATIONS

There are no financial implications. The strategy and action plan will be delivered within existing partner agency budgets and the Department of Health Public Health Prevention grant.

8. LEGAL IMPLICATIONS

Transfer of public health from the NHS to local government and Public Health England (PHE) has introduced a significant extension of local government powers and duties and represents an opportunity to change focus from treating sickness to actively promoting health and wellbeing. Section 12 of the Health and Social Care Act inserts a new section 2B into the NHS Act 2006 to give each relevant local authority a new duty to take such steps as it considers appropriate to improve the health of the people in its area. This section also gives the Secretary of State a power to take steps to improve the health of the people of England and it gives examples of health improvement steps that either local authorities or the Secretary of State could take, including giving information, providing services or facilities to promote healthy living and providing incentives to live more healthily.

Local authorities have considerable discretion in how they choose to invest their grant to improve their population's health, although they have to have regard to the Public Health Outcomes Framework and should consider the extant evidence regarding public health measures.

It will be necessary to ensure compliance with planning and licensing laws with regard to activities in the strategy and plan such as applications relating to the operation of food take aways. Legal advice will also be sought in relation to highways legislation and pilot programmes planned including temporary street closures for street play.

9. RESOURCE IMPLICATIONS
The strategy and action plan will be delivered by strategic health and wellbeing board partners, with the council's Public Health team providing a leadership and co-ordination role.

10. EQUALITY AND HEALTH IMPLICATIONS
In determining this matter the Board need to consider the HIA associated with this item in advance of making the decision, which accompanies this report

11. CONSULTATIONS
Extensive consultation around the strategy has taken place over the last 18 months. An initial period of consultation and insight work took place during 2015 and involved a Start Well and Age Well consultation along with a commissioned consultation around the issue of food poverty in the borough. There was also an initial online public consultation in 2015 which had 201 responses.

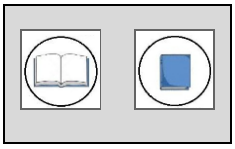
From this work the draft action plan was produced and further targeted consultation has taken place during 2016, particularly concentrated between May and September. The consultation has included the following:

- Public Online Consultation – 110 responses
- Health Professional Online Consultation – 27 responses
- Stakeholder Engagement event in June 2016 and face to face/email engagement with individual stakeholders
- Senior Policy Team briefings across all portfolios
- Quarterly Eat Well Move More Shape Up Steering Group meetings
- Primary School Catering Managers
- Clinical Commissioning Group Protected Learning Time event and Clinical Commissioning Group Operations Group
- Bangor Street Ladies group & Inter Madrassah Organisation Women 4 Women group
- Families Health & Wellbeing Consortium
- Older People's Forum and Age UK consultation
- Learning Disabilities Partnership Board
- Blackburn with Darwen Health and Wellbeing Board, Live Well Board and Children's Partnership Board

Intelligence gathered through the BwD Integrated Strategic Needs Assessment (ISNA) and subject specific ISNAs has also informed the action plan.

VERSION:	**1.0**

CONTACT OFFICER:	Beth Wolfenden
DATE:	23 January 2017
BACKGROUND PAPER:	Eat Well Move More Shape Up Strategy and Action Plan, Plan on a Page http://www.blackburn.gov.uk/Pages/Public-health.aspx Health Impact Assessment



Blackburn with Darwen Eat Well Move More Shape Up Strategy 2017 – 2020:

Our Vision:
Success for us is when everyone in Blackburn with Darwen is able to move more, eat well and maintain a healthy weight

We will do this by:

- Supporting an environment that empowers people to make physical activity and healthy eating the easy choice for everyone throughout the course of their lives
- Encouraging positive lifestyle changes that enables everyone to improve their health and wellbeing and to be a healthy weight
- Empowering the most vulnerable and at risk of poor health in our community to make positive behaviour changes
- Building community capacity and mobilising the workforce in our Borough to make every contact count

Challenges	Opportunities	Cross cutting themes			Priorities	
High levels of physical inactivity and obesity in children, young people and adults Poor healthy life expectancy and disability from largely preventable long term conditions High levels of diabetes and cardiovascular disease High levels of dental decay in children Continuing poverty, deprivation and disadvantage Increasing levels of food poverty Varied food knowledge and cooking skills Reducing budgets for service provision	• Wide range of key partners engaged • Parks & Open Spaces • Network of volunteers • Strong community spirit • Healthy settings approach • Workforce development	Local Authority Declaration on Healthy Weight	Positive mental health & wellbeing	Communications & marketing	**Eat Well:** **1.** Promote healthy and sustainable food choices for all **2.** Tackle food poverty and diet related ill health **3.** Build community food knowledge, skills and resources **4.** Promote a vibrant, diverse local food economy **5.** Transform catering and food procurement **6.** Reduce waste and the ecological footprint of the food system **Move More:** **1.** Active Society: creating a social movement where physical activity is a priority for everyone **2.** Moving Professionals: activating networks of expertise to create healthy workplaces and make every contact count to promote physical activity **3.** Active Environments: creating the right spaces for safe and enjoyable physical activity **4.** Moving at scale: maximising the potential of the existing assets and partnerships **Shape Up:** **1.** Transforming the environment we live in **2.** Making healthier choices easier by educating and empowering individuals and communities **3.** Giving all children the best start and tackling the generational issue of healthy weight in families **4.** Ensuring holistic and integrated evidence based support for individuals with weight related conditions – either under or overweight	**KEY OUTCOMES**
OPPORTUNITIES/DRIVERS /ENABLERS		Every Body Active Every Day, Childhood Obesity: A Plan for Action, UK Active Blueprint for an Active Nation, Sport England's Towards an Active Nation, Lancashire Walking & Cycling Strategy, NHS 5 Year Forward View, Locality Working, Healthy Child Programme, Digitalisation				

EXECUTIVE BOARD CHECKLIST

Report title:	Eat Well Move More Shape Up Strategy 2017-20

EIA and HIA Completed	**Completed by**	**Date (dd/mm/yyyy)**	**Comments**
Corporate Equality – Legal will require a copy of the completed EIA with the report prior to sign-off.			
EIA Yes ☐ **No** ☒			As advised by Equalities EIA not required as it is covered in the HIA
HIA Yes ☒ **No** ☐	Beth Wolfenden	14/07/2016	

Officer consulted	**Version Number**	**Date (dd/mm/yyyy)**	**Comments**
Equality Tom Keighley	0.03	07/10/2016	Due to the overwhelming association with health, all equality impacts have been included and considered within a HIA toolkit.
Legal Sian Roxborough	0.03	14/10/16	Delete current legal implication and replace with: *'Transfer of public health from the NHS to local government and Public Health England (PHE) has introduced a significant extension of local government powers and duties and represents an opportunity to change focus from treating sickness to actively promoting health and wellbeing.* *Section 12 of the Health and Social Care Act inserts a new section 2B into the NHS Act 2006 to give each relevant local authority a new duty to take such steps as it considers appropriate to improve the health of the people in its area. This section also gives the Secretary of State a power to take steps to improve the health of the people of England and it gives examples of health improvement steps that either local authorities or the Secretary of State could take, including giving information, providing services or facilities to promote healthy living and providing incentives to live more healthily.* *Local authorities have considerable discretion in how they choose to invest their grant to improve their population's health, although they have to have regard to the*

			Public Health Outcomes Framework and should consider the extant evidence regarding public health measures. *It will be necessary to ensure compliance with planning and licensing laws with regard to activities in the strategy and plan such as applications relating to the operation of food take ways. Legal advice will also be sought in relation to highways legislation and pilot programmes planned including temporary street closures for street play.* Please also put link to attach the strategy in body of the report not background paper.
Finance	0.03		
Equality Tom keighley	0.08	16/01/2017	No further comments
Legal Sian Roxborough	0.08	19/1/2017	My original legal advice above still applies- this has not been included in this latest version and needs to be.
Finance Gill Minshall	0.08	24/1/2017	Financial section checked and agreed.
SPT Co-ordinator Gary Rich	0.08	24/1/17	Legal comments addressed. E-mail from legal saved in document history.

Is the item a key decision? **Yes** ☒ **No** ☐

Is the item a Part II? **Yes** ☐ **No** ☒

Indicate the date of the Executive Board the report is to be submitted to: 9th February 2017

JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If the item is a key decision to be considered at Executive Board, at least 28 days clear notice before the decision is made will need to be provided in the forward plan

Signed: **Director HR, Legal & Corporate Services:**	**Signed:** **Director of Finance & IT:**
Date:	**Date:**
First Portfolio	
In making this decision I confirm that I have considered and understood the Equalities Impact Assessment (EIA) associated with this item. (if applicable)	
Signed: **Executive Member:**	**Signed:** **Chief Officer:**
Date:	**Date:**

Health Impact Assessment

Eat Well
Move More
Shape Up
2017-20

Toolkit produced by:	Public Health
Toolkit version:	1.1
HIA version:	V0.5
Date HIA completed:	21 September 2016

Health is not merely the absence of disease or infirmity but a state of complete physical, mental, social and spiritual well-being.
(modified by M. Birley (2013) from World Health Organisation's definition – 1948)

Title of policy, programme or project ("activity") to be assessed:
Eat Well Move More Shape Up Strategy 2016-19

What is the activity about? What is the context outlined for the activity? (e.g. policy context, history, background)

Out of a population of almost 113,000 adults aged over 16[i] in Blackburn with Darwen just over 75,000 are overweight or obese (66.5%) and only just over 40,000 are active enough to benefit their health (35.7%) with physical inactivity costing the borough over £3million.

The borough has a higher than average young population, ONS mid-year estimates record a 23.2% 0-15 population in Blackburn with Darwen compared with 18.9% regionally and 19% nationally. In addition to this, 52% of school aged children are from a minority ethnic background. The most recent National Child Measurement Programme data in Blackburn with Darwen shows that almost 9% of 4-5 year olds are obese and this more than doubles to 20% of 10-11 year olds and 20.6% of 3 year olds in the borough have decayed, missing or filled teeth.

The 2015 Indices of Multiple Deprivation found that 28 out of 91 LSOA's (Lower Super Output Areas) in Blackburn with Darwen were in the 1st national decile (most deprived). In addition, healthy life expectancy is considerably lower than the national average particularly amongst males in the borough with the second highest death rate from cardiovascular disease (CVD) out of 152 upper tier authorities. Along with major risk factors for CVD of obesity, physical inactivity, deprivation and ethnicity Blackburn with Darwen also has a steadily increasing over 65 population further impacting on levels of CVD in the borough.

The local authority is developing an action plan to help increase physical activity levels and increase the number of people in Blackburn with Darwen who are a healthy weight to help reduce ill health and increase healthy life expectancy and therefore quality of life.

Our vision is for everyone in Blackburn with Darwen to move more, eat well and maintain a healthy weight, we aim to do this by:

- Supporting an environment that empowers people to make physical activity and healthy eating the easy choice for everyone throughout the course of their lives
- Encouraging positive lifestyle changes that enable the people of Blackburn with Darwen to improve their health and wellbeing and to be a healthy weight
- Empowering the most vulnerable and at risk of poor health in our community to make positive behaviour changes
- Building community capacity and mobilising the workforce of Blackburn with Darwen to make every contact count

Does this activity have the potential to impact on health? Explain *(please consult appropriate Public Health colleague if you are unsure or require further information)*
The strategy has the potential to improve the health of all residents of Blackburn with Darwen by increasing opportunities to be more physically active, by improving access to locally sourced, good quality, affordable and healthy food, making healthy choices the easiest option and providing an environment which supports everyone to be a healthy weight. An extensive three year action plan covering the three strands of the strategy has been developed to detail how this will take place and by which stakeholders (http://www.blackburn.gov.uk/Lists/DownloadableDocuments/Eat-Well-Shape-Up-Move-More-Strategy-Action-Plan.pdf). Health impacts include reduced incidence of heart disease, certain cancers, stroke and dementia. The ultimate aim of the strategy is to increase healthy life expectancy and quality of life through making the healthy choice the easy choice. In doing so the burden on the public purse will be significantly reduced through reduced health care costs, increased productivity and increased educational attainment.

If no health impacts are identified then the screening does not need to continue, but please ensure that this has been discussed with the appropriate Public Health colleague prior to discontinuation

Does this activity relate to / impact on any of the Health & Wellbeing Strategy objectives?

- ☒ **Best start for children and young people**
- ☒ **Health & Work**
- ☒ **Safe & healthy homes & neighbourhoods**
- ☒ **Promoting health and supporting people when they are unwell**
- ☒ **Older people's independence and social inclusion**

Does the activity concern any of the following determinants?		
Lifestyle	Yes ☒	No ☐
Physical environment	Yes ☒	No ☐
Social / economic environment	Yes ☒	No ☐
Other, please specify		

What are the potential positive impacts?
• Improved overall health and wellbeing of residents through encouraging a healthy, affordable diet and improved access to locally produced, affordable food and by promoting the benefits of and opportunities to be physically active across the whole life course. • Improved healthy life expectancy • Reduced health inequalities • Reduced levels of overweight and obesity across the life course • Focus on children and young people to prevent the cycle of generational obesity to improve quality of life and reduced risk of diabetes and heart disease • Improved dental health by focussing on education on sugar and sugar reduction initiatives and campaigns • Improved maternal and infant health by promoting breastfeeding, healthy weaning and physical activity, significantly reducing the risk of obesity and disease in later life and therefore reducing the burden on the local economy along with reduced personal burden • Reduced food poverty by improving access to affordable food and encouraging community food schemes to support those most in need within specific communities • Reducing food waste and the environmental footprint of food by encouraging communities to

shop locally wherever possible and exploring community growing options
- Boosting the local food economy by promoting the use of local markets and local food suppliers where possible in improved procurement or direct purchases from the public.
- Improved community resilience by supporting community growing, shopping skills and cooking skills
- Increased physical activity levels which will reduce the burden of disease and contribute to a healthy weight and reduce the cost to the local economy which is currently in excess of £3million
- Increased active travel which have positive effects on the environment, health and the economy
- Reduced social isolation and improved mental health and wellbeing through the effective promotion and communication of food and activity initiatives such as luncheon clubs, health walks etc.
- Improving access to sport and physical activity in underrepresented groups – disability, BME, women and girls, deprived communities – the detailed strategy action plan provides further information on how the strategy aims to achieve this (http://www.blackburn.gov.uk/Lists/DownloadableDocuments/Eat-Well-Shape-Up-Move-More-Strategy-Action-Plan.pdf)
- Better partnership working and use of resources for the benefit of the residents of Blackburn with Darwen

What are the potential negative impacts?

There may be a proportion of the population who do not understand the need for the strategy and the health implications if there is no change in behaviour. They may not want to embrace health improvement initiatives and may be resistive to environmental policy changes e.g. opposition to temporary street closures for street play initiatives, healthy vending in public buildings and healthy catering policies at events. Overall there are very few potential negative impacts.

What are the assumptions/risks embedded in or underpinning the activity?

There is an assumption is that everyone will embrace the action plan in strategy and that the strategy will enable everyone to make healthier choices. There is also an assumption that parents/carers will pass the messages to their children/those in their care and make choices that will benefit their health.
The risks of not embracing the rationale and action plan of the strategy is that those individuals health will not improve and they will continue to require preventable support from the state e.g. welfare, health and social care. However if the strategy was not developed this cohort of residents would be at risk regardless.

Are there any external factors which identify the nature and extent of the impacts on health for this type of proposal (e.g. research; policy changes etc.)

- Funding – there are cuts across a number of public sector services. Funding available to third sector organisations is becoming increasingly difficult to obtain, all of which places pressure on the services and organisations committed to delivering the outcomes of the strategy
- Encouraging the council to adopt the Local Authority Declaration on Healthy Weight will require a strong direction from executive members and will allow public health to embed it in all council policies
- Council workforce review – may affect the ability to implement the strategy due to fewer staff having greater remits and changes in priorities

List the groups most likely to be affected by this proposal

All residents of Blackburn with Darwen across the life course will be affected by this proposal

What are some of the potential equity issues?
The strategy is designed to address all residents of the borough by taking both a population and targeted approach. The Integrated Strategic Needs Assessments for the borough and extensive consultation with the public and stakeholders will inform the areas of greatest need. The strategy aims to be fully inclusive and will encourage those most at risk of ill health to make better health choices. As outlined throughout this assessment there are a number of positive impacts on many of the 9 protected characteristics set out in the 2010 Equality Act.

CHECKLIST

Answers favouring doing an HIA	To your knowledge	Answers favouring not doing a HIA
	Health impacts	
☒ Yes ☐ Not sure	Does the initiative affect health directly?	☐ No
☒ Yes ☐ Not sure	Does the initiative affect health indirectly?	☐ No
☐ Yes ☐ Not sure	Are there any potential serious negative health impacts that you currently know of?	☒ No
☐ Yes ☐ Not sure	Is further investigation necessary because more information is required on the potential health impacts?	☒ No
☐ No	Are the potential health impacts well known and is it straightforward to identify effective ways in which beneficial effects can be maximised and harmful effects minimised?	☒ Yes
☐ No	Does evidence, data or experience already exist out there, regarding this policy, programme or project so that an HIA might be a waste of resources?	☒ Yes
	Community	
☒ Yes ☐ Not sure	Is a large proportion of the population likely to be affected by the initiative *(over 25% of the resident population*)?	☐ No
☒ Yes ☐ Not sure	Are there any socially excluded, vulnerable, disadvantaged groups likely to be affected?	☐ No
☐ Yes ☐ Not sure	Are there any community concerns about any potential health impacts?	☒ No
	Initiative	
☐ Yes ☐ Maybe	Is there some reason to suspect that health issues not considered in the planning process of this initiative might become more visible by doing an HIA?	☒ No
☐ Yes ☐ Maybe	Is the cost of the initiative high (*over £100,000*)?	☒ No
☐ Yes ☐ Maybe	Is the nature and extent of the disruption to the affected population likely to be major?	☒ No
	Organisation	
☒ Yes	Is the initiative a high priority/important for the organisation/partnership?	☐ No
☒ Yes ☐ Maybe	Are the individuals and organisations with a stake in this initiative likely to buy into the HIA process?	☐ No
☒ Yes ☐ Maybe	Is there potential to change the proposal? Will there be any other similar proposals in the future?	☐ No
FOR = 7	**TOTAL**	**AGAINST** =8

Choosing which HIA to do

Health Impact Statement	Type of HIA	Comprehensive
☐ Yes	Is there only limited time in which to conduct the HIA?	☒ No
☒ Yes	Is there only limited opportunity to influence the decision?	☐ No
☒ Yes	Is the timeframe for the decision-making process set by external factors beyond your control?	☐ No
☒ Yes	Are there only very limited resources available to conduct the HIA?	☐ No

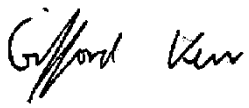
Deciding who should do the HIA

External	Assessors	Internal
☐ No	Do personnel in the organisation or partnership have the necessary skills and expertise to conduct the HIA?	☒ Yes
☒ No	Do personnel in the organisation or partnership have the time to conduct the HIA?	☐ Yes

Is an HIA appropriate?	☐ Yes ☒ No
Why or why not?	
It is anticipated that due to the overwhelming positive impact that this strategy hopes to have on health in the borough a full Health impact Assessment is not required. This strategy targets all of the boroughs residents and aims to support and encourage them to make life choices and changes that will improve health and wellbeing.	
If yes, what type and how?	
N/A	
Recommendations / comments	
It is recommended that this activity continues without change. As previously mentioned, the aim of this strategy is to target health inequalities and improve health and wellbeing of everyone across the borough.	

Completed by: _Beth Wolfenden_____ **Date: 21/09/2016**

Approved by
(Head of Service/Director): **Date: 21/09/2016**



This signature signifies the acceptance of the responsibility and ownership of the HIA and the resulting action plan (if applicable).

Approved by
(Public Health):_____ **Date: _____**
This signature signifies the acceptance of the responsibility to publish the completed HIA.

Once this form has been completed and approved, this document should be saved as the Health Impact Statement for the specified activity, any actions should be monitored appropriately

[i] ONS (2015). *Mid-year population estimates*