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Sefton Council

MEETING: HEALTH AND WELLBEING BOARD

DATE: 7th June 2023

TIME: 2.00 pm

VENUE: Committee Room - Bootle Town Hall, Trinity Road, Bootle, L20 7AE

Member

Cllr. Ian Moncur (Chair)
Cllr. Paul Cummins
Cllr. Mhairi Doyle, M.B.E.
Deborah Butcher
Margaret Jones
Sarah Alldis
Dr. Rob Caudwell
John Turner
Anne-Marie Stretch
Neil Holland
Janine Hyland
Andrew Booth
Superintendant Dawn McNally
Mark Thomas
Adrian Hughes
Angela White
Anita Marsland

COMMITTEE OFFICER: Amy Dyson - Democratic Services Officer

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If you have any special needs that may require arrangements to facilitate your attendance at this meeting, please contact the Committee Officer named above, who will endeavour to assist.

We endeavour to provide a reasonable number of full agendas, including reports at the meeting. If you wish to ensure that you have a copy to refer to at the meeting, please can you print off your own copy of the agenda pack prior to the meeting.

A G E N D A

1. Apologies for Absence

2. Minutes of Previous Meeting (Pages 5 - 10)

3. Declarations of Interest

Members are requested at a meeting where a disclosable pecuniary interest or personal interest arises, which is not already included in their Register of Members' Interests, to declare any interests that relate to an item on the agenda.

Where a Member discloses a Disclosable Pecuniary Interest, he/she must withdraw from the meeting room, including from the public gallery, during the whole consideration of any item of business in which he/she has an interest, except where he/she is permitted to remain as a result of a grant of a dispensation.

Where a Member discloses a personal interest he/she must seek advice from the Monitoring Officer or staff member representing the Monitoring Officer to determine whether the Member should withdraw from the meeting room, including from the public gallery, during the whole consideration of any item of business in which he/she has an interest or whether the Member can remain in the meeting or remain in the meeting and vote on the relevant decision.

4. Sub-Committee Updates (To Follow)

Report of the Director of Public Health

5. Sefton Plan 2023-25 (Pages 11 - 14)

Report of the Associate Director of Transformation and Partnerships (Sefton) – NHS Cheshire and Merseyside

- Sefton Plan 2023-25 (To Follow)

6. Integrated Care Board Joint Forward Plan (Pages 15 - 58)

Report and Presentation of the Associate Director of Transformation and Partnerships (Sefton) – NHS Cheshire and Merseyside and Executive Director of Adult Social Care and Health and Place Director (Sefton)

7. Special Educational Needs and Disabilities Joint Commissioning Plan (Pages 59 - 64)

Report of the Executive Director of Children's Social Care and Education and Executive Director for Adult Social Care and Health/NHS Place Director

8. Child Death Overview Panel Annual Report (Pages 65 - 102)

Report of the Director of Public Health

9. Supporting Sefton's Place Priorities - Sefton CVS (Pages 103 - 122)

Presentation of the Chief Executive of Sefton CVS

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THIS SET OF MINUTES IS NOT SUBJECT TO "CALL IN"

HEALTH AND WELLBEING BOARD

MEETING HELD AT THE COMMITTEE ROOM - BOOTLE TOWN HALL, TRINITY ROAD, BOOTLE, L20 7AE ON WEDNESDAY 8TH MARCH, 2023

PRESENT: Councillor Moncur (in the Chair)
Councillor Cummins (Sefton Council), Councillor Doyle (Sefton Council), Deborah Butcher (Sefton Council), Margaret Jones (Sefton Council), Dr. Rob Caudwell (NHS Cheshire and Merseyside Integrated Care Board), Andrew Booth (Sefton Advocacy), Angela White (Sefton Council for Voluntary Services), John Turner (Healthwatch Sefton), Sarah Alldis (Sefton Council) and Mark Thomas (Merseyside Fire and Rescue Service)

80. APOLOGIES FOR ABSENCE

Apologies for absence were received from Anita Marsland (Sefton Partnership Governance) and Superintendent Dawn McNally (Merseyside Police).

81. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the Minutes of the meeting held on 7 December 2022 be confirmed as a correct record.

82. DECLARATIONS OF INTEREST

No declarations of any disclosable pecuniary interests or personal interests were received.

83. EDUCATION SCORECARD

The Board considered the report of the Executive Director of Children's Social Care and Education which included the first Education Scorecard, bringing together a range of data from across education. The scorecard will be updated and presented every term. Data was taken from Early Years and Phonics, Key Stage 1, Key Stage 2 and Key Stage 4.

RESOLVED:

That the data contained in the scorecard be noted.

84. CHESHIRE AND MERSEYSIDE JOINT FORWARD PLANNING PROCESS

The Board considered a presentation of the Associate Director of Strategy and Collaboration, NHS Cheshire and Merseyside outlining the development of the Cheshire and Merseyside Five Year Joint Forward Plan. Key points included:

- Key plans and how they fit together
- Joint Forward Plans – national guidance
- HCP Interim Strategy – Strategic Objectives
- Next Steps in developing the Joint Forward Plan
- Legislative requirements
- Planning Guidance

The Board also considered a presentation discussing NHS Planning Guidance.

RESOLVED:

That both presentations be noted.

85. SEFTON PLACE ICB PLANNING GUIDANCE

The Board received a presentation by the Associate Director of Finance and Performance, NHS Cheshire and Merseyside, Sefton Place outlining Sefton Place ICB Planning Guidance. The Key Points included:

- Developing a Sefton Place Plan
- Service or content areas
- Timeline
- 2023/24 National NHS Objectives

RESOLVED:

That the presentation be noted.

86. SUB COMMITTEE UPDATES

The Board considered the report of the Director of Public Health that provided an update and summary of activity from the five identified sub-groups, since the 7th December 2022:

(1) Children and Young People Partnership Board (CYPPB) which had met twice since the last report, on 14 December 2022 and 15 February 2023. The Board received updates regarding Communication, Start Well and Early Help.

(2) Special Educational Needs and Disabilities Continuous Improvement Board (SENDCIB) which had not met since the last report.

(3) Sefton Adults Forum which had met on 31 January 2023 and received updates on Dementia developments, national cost of care exercise, Supported Living Consultation, and the Care Home Market.

(4) The Health and Well-being Executive which had not met since the last report.

(5) Sefton Health Protection Forum which had met in January 2023 and discussed childhood immunisation.

The report also included updates regarding pharmacies, the Better Care Fund and the Combating Drugs partnership.

RESOLVED: That

(1) It be noted that in addition to the detail in 2.4 of the report, the Better Care Fund has now been approved and the Department of Health and Social Care has requested that the discharge fund plan be noted, and performance information be published; and

(2) the report be noted.

87. COMMUNICATION AND ENGAGEMENT UPDATE

The Board received the report of the Communications Officer, NHS Cheshire and Merseyside Integrated Care Board – Sefton Place which provided Members a quarterly update on the work of Sefton Health Communications, Engagement and Information Group. The update included achievement since the last report in December 2022 and the Groups' next steps.

The Board discussed upcoming changes to the Sefton Health Communications, Engagement and Information Group and agreed to send a letter expressing concern about upcoming resource reduction from the Board to the relevant body.

RESOLVED: That

(1) The report be noted; and

(2) a letter be sent to the relevant body expressing the Board's concerns regarding upcoming changes within Communications.

88. SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST - NEXT STEPS IN PROPOSED PARTNERSHIP

The Board received a verbal update from the Managing Director of Southport and Ormskirk Hospital NHS Trust outlining the next steps in the proposed partnership between St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust.

The Board were informed that all evidence in support of the partnership will be submitted to the Secretary of State of Health for final approval in the last week of March 2023.

RESOLVED:

That the update be noted.

89. REPORT ON THE PUBLIC HEALTH ANNUAL REPORT 2022/23: AGEING IN SEFTON

The Board considered the report of the Director of Public Health which presented the final draft Public Health Annual Report 2022 (PHAR) on Ageing in Sefton. The report indicated that production of an independent report on one or several aspects of health in the local population or in a specific population group was a statutory requirement upon Directors of Public Health. The report provided an overview of how the PHAR was developed, structure and content, key conclusion and recommendations and plans to publish and disseminate the report.

The Board offered their congratulations to the Director of Public Health and all who had worked on the Public Health Annual Report.

RESOLVED: That

(1) The report and accompanying final draft of the Public Health Annual report be noted;

(2) Plans for publication and dissemination of the report be supported;

(3) The Director of Public Health be requested to bring a review of the report and progress made to the Board in a year's time.

90. CHILDREN'S SERVICES IMPROVEMENT PROGRAMME

The Board considered the report of the Executive Director of Children's Social Care and Education which updated on the progress against the Children Social Care Improvement Plan based around four Themes of Improvement: Quality, Implementation of Learning, Tools and Strategic Partnership.

The Board requested an update report for 6 months' time on progress and impact of the report, as well as opportunities for partner agencies to develop their role and input.

RESOLVED: That

(1) The report, progress made and 3.3 be noted;

(2) The Executive Director of Children's Social Care and Education be requested to provide a follow up report to the Board in 6 months' time.

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Report to:	Health and Wellbeing Board	**Date of Meeting:**	7 June 2023
Subject:	Sefton Plan 2023-25		
Report of:	Executive Director Adult Social Care and Health (DASS) and NHS Place Director (Sefton)	**Wards Affected:**	(All Wards);
Portfolio:	Health and Wellbeing		
Is this a Key Decision:	No	**Included in Forward Plan:**	No
Exempt / Confidential Report:	This report does note contain information which is confidential or exempt.		

Summary:
The Sefton Plan 2023-25 has been developed collaboratively with partners to support the delivery of:

- The Joint Health and Wellbeing Strategy, Living Well in Sefton.
- The Cheshire and Merseyside Health and Care Partnership strategy.
- The NHS Cheshire and Merseyside Joint Forward Plan (JFP).
- The NHS Operational Guidance for 2023/24.

It is a strategic document that sets out key objectives across the life-course, together with their intended impact and timeframe for implementation. It is intended the plan is a "live" document that can respond to the changing needs of Sefton's communities.

Recommendation(s):
The Board is asked to:

1) Note the purpose of, and collaborative approach and engagement undertaken in developing, the Sefton Plan.
2) Provide feedback on the content and offer comments in terms of how best to advance delivery in collaboration with partners and communities.
3) Approve the plan and endorse the approach of it being a "live" document that can respond to the changing needs of Sefton's communities.

Reasons for the Recommendation(s):
Although not a statutory document or requirement, the support of the Board is considered a strong statement of intent in supporting partnership delivery.

Alternative Options Considered and Rejected: (including any Risk Implications)
No alternative options were considered given the plan has been developed following extensive engagement and is an important document for setting out how partners will work together to improve the health and wellbeing of Sefton's residents.

What will it cost and how will it be financed?

(A) Revenue Costs

The plan will be financed through NHS financial allocations and the commitment of all partners to pooling resources (where possible) in support of maximising the impact of the Sefton pound in transforming health and care outcomes for residents.

(B) Capital Costs

N/A

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):
The plan will need to be delivered in line with NHS England funding allocations and partner affordability.

Legal Implications:
There are no direct legal implications.

Equality Implications:
There are no direct implications at this stage given the document is a strategic plan. Individual equality impact assessments will need to be developed to support implementation. An easy-read and accessible version of the plan will also be developed once approved. In support of care experience as a protected characteristic, colleagues within Sefton are leading implementation of the NHS Universal Family (Care Leaver Covenant) Programme. The target date to advertise the offer to care experienced young people is October 2023. This is reflected in the plan.

Impact on Children and Young People: Yes
The Sefton plan includes key objectives across the life-course. Children and Young People, Early Help and Maternity are priority areas under Start Well. The plan specifies the impact each objective will have on Children and Young People together with timeframes for delivery.

Climate Emergency Implications:

The recommendations within this report will

Have a positive impact	Yes
Have a neutral impact	
Have a negative impact	
The Author has undertaken the Climate Emergency training for report authors	N/A

The author has completed NHS Net Zero Training.
Community first is one of three cross-cutting priorities outlined in the Sefton plan. This includes objectives relating to social value and the role of partners as anchor institutions, with reducing environmental impact a key element of this approach. The Sefton plan will also support delivery of the JFP and its objectives in relation the delivery of the NHS Cheshire and Merseyside Green Plan.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: The Sefton plan includes reducing health inequalities as one of three cross-cutting themes. Local implementation of the Core20PLUS5 initiative, which is focused on the 20% most deprived communities and those who are most susceptible to poor access, outcomes and/or experience, will support partners in protecting the most vulnerable across the borough.
Facilitate confident and resilient communities: The Sefton plan includes community first as one of three cross-cutting themes. All partners are committed to co-producing with communities and ensuring their voice informs future plans. This is strongly reflected in objectives relating to enabling functions in particular, including communications and engagement and population health management (PHM).
Commission, broker and provide core services: The Sefton plan is a partnership plan that will help to drive forward the integrated commissioning agenda and result in more jointly commissioned services through use of the Better Care Fund (BCF).
Place – leadership and influencer: The Sefton plan sets out how partners will deliver improved health outcomes for residents working under the umbrella of the Sefton Partnership. It is also acknowledged the Partnership need to work in conjunction with other places to influence the NHS Cheshire and Merseyside agenda, particularly in relation to themes that impact residents across Cheshire and Merseyside e.g., the provision of acute and specialist services.
Drivers of change and reform: The Sefton plan has been developed on the premise that all partners must change how they work as part of an integrated health, care and wellbeing system to drive improved health outcomes for residents. This means working in partnership and breaking-down traditional provider-commissioner barriers.
Facilitate sustainable economic prosperity: The Sefton plan supports delivery of the Cheshire and Merseyside Health and Care Partnership strategy, with one of its key objectives being to support social and economic development. This is also reflected in the community first cross-cutting theme which has an objective to support more Sefton organisations to become anchor institutions – spending more money locally and employing local people.
Greater income for social investment: As above while also noting the Sefton plan includes a number of joint initiatives that will support social investment including, for example, the health-on-the-high-street proposal to support the redevelopment of The Strand in Bootle.
Cleaner Greener As above while noting the Sefton plan supports delivery of the JFP and its objectives in relation the delivery of the NHS Cheshire and Merseyside Green Plan.

What consultations have taken place on the proposals and when?

No formal consultations have been required or undertaken but extensive partner engagement has been completed to develop the plan, including:

- **Monthly updates to the Sefton Partnership Board** in March, April and May setting out the approach, key objectives and inviting opportunities for partner input.

- **A draft copy of the Sefton Plan was shared with partners in April for feedback**, which has been reflected in subsequent versions. The feedback that was collated and the responses were also shared at May's Partnership Board meeting to ensure transparency.

- **Four multi-agency workshops have been held with wide-ranging partners**, including NHS providers, the voluntary, community and faith sector and Sefton Council between February and April to ensure co-design and that the plan reflected partner-wide priorities. The workshops have showcased a range of evidence from different sources, including:

    - Sefton's Joint Strategic Needs Assessment (JSNA)
    - Fingertips
    - RightCare and Model Hospital
    - System P
    - Healthwatch
    - Quality and performance Indicators
    - Global Burden of Disease
    - VCF community insights tool

- **A joint Health & Social Care Forum, Every Child Matters and Healthwatch event was held in May** with approximately fifty attendees from across the VCF sector and service users in attendance. The feedback has already resulted in changes to the plan, with one notable change being re-naming one of the three cross-cutting themes, from community "resourcefulness" to community "first".

- **Members of the Sefton ICB team have supported development of the JFP through planning meetings since February** and engaged with Cheshire & Merseyside programmes of work including, for example, Mental Health, to ensure connectivity (where relevant, based on population need) between Sefton's objectives and those of NHS Cheshire and Merseyside.

Contact Officer:	Stephen Williams
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Appendices:

The following appendices are attached to this report:

- The Sefton Plan 2023-25

Report to:	Health and Wellbeing Board	**Date of Meeting:**	7th June 2023
Subject:	ICB Joint Forward Plan		
Report of:	Deborah Butcher /Stephen Woods	**Wards Affected:**	(All Wards);
Portfolio:	Health and Wellbeing		
Is this a Key Decision:	No Non-Statutory Advice, Guidance or Recommendation to Other Body	**Included in Forward Plan:**	N/A
Exempt / Confidential Report:	This report is not considered to contain information which is confidential or exempt.		

Summary:

The Joint Forward Plan includes a summary describing the priorities for Sefton in delivering the local Joint Health and Wellbeing Strategy, Living Well in Sefton.

The purpose of this report is:

- To share details in relation to the requirement for Integrated Care Boards, and NHS provider partners to produce a Joint Forward Plan which must be published by the end of June 2023
- To provide the draft content of the Cheshire and Merseyside Joint Forward Plan in advance of the final document being presented to the Integrated Care Board for approval on 29th June. This includes:

    - The Joint Forward Plan Content – noting that behind this document there is more detailed content in support of the plans which the reader can access via "links" to the relevant section
    - A one-page summary of the plan content related to Sefton

- To describe, and gain feedback from the Health and Wellbeing Board, on the plan content and alignment with the existing Health and Wellbeing Board Strategies and Plans from across our nine Places.
- To highlight the planned work that is required to finalise the Health and Care Partnership Strategy, and a range of other supporting plans in advance of the Joint Forward Plan being republished in March 2024
- To request that the Health and Wellbeing Board provide a statement for inclusion in the plan to outline whether the document reflects local priorities contained in the Joint Health and Wellbeing Strategy.

Recommendation(s):

1) Note the approach being taken in developing the Cheshire and Merseyside Joint

Forward Plan.

2) Provide feedback as to key areas of content and highlight any additions, or revisions, the Board would like to see in this plan, or which needs to be recognised in the next version of the plan (March 2024).
3) To confirm that the Board will provide a statement outlining whether the plan includes the relevant local priorities contained within the Joint Health and Wellbeing Strategy.

Reasons for the Recommendation(s):

The Joint Forward Plan is a statutory responsibility it pulls together Joint Local Health and Wellbeing Strategies, Health and Care Partnership Strategy and the NHS Operational Plan 2023/4.

- JFP is a new joint statutory responsibility for the ICB and NHS Trusts
- The JFP should describe, as a minimum, how the ICB and its partner trusts intend to arrange and/or provide NHS services… including delivery of the universal NHS commitments and nationally defined NHS priorities for 2023-24.
- Systems are encouraged to use the JFP to develop a shared delivery plan for the Integrated Care Strategy
- JFP must cover the statutory duties of ICBs – e.g., duty to improve quality, duty to promote integration etc.

Health and Wellbeing Boards are required to provide a statement confirming the plan reflects the priorities from their strategy (links to be added in publication)

Alternative Options Considered and Rejected: (including any Risk Implications)

None considered the JFP is statutory responsibility.

What will it cost and how will it be financed?

(A) Revenue Costs

N/A

(B) Capital Costs

N/A
Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets): Will need to be delivered in line with the agreed NHS Financial and Capital Plans.
Legal Implications: JFP is statutory responsibility for the ICB and NHS provider trusts
Equality Implications:

There are no direct equality implications. This is a high-level plan it is anticipated individual EIA's will be considered for the associated delivery and implementation plans.

(Please note that Council have agreed care experience should be treated like a protected characteristic. Please delete as appropriate and remove this text)

Impact on Children and Young People: Yes

If 'Yes' please provide a short narrative here, or within the main body of the report, setting out the impact. **Please delete as appropriate and remove this text.**

The plan includes dedicated work that will positively support the Health and Wellbeing of Children and Young People. Key areas are outlined in the attached summary and the full detail is contained in the main supporting document.

Climate Emergency Implications:

The recommendations within this report will

Have a positive impact	YES
Have a neutral impact	
Have a negative impact	
The Author has undertaken the Climate Emergency training for report authors	Not applicable –

The Joint forward plan includes a dedicated section on how we will work in partnership to deliver the Green Plan. The author has completed NHS Net Zero Training.

Core Priority:
For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

Contribution to the Council's Core Purpose:

Protect the most vulnerable:
The JFP includes a focused EDI section and includes specific actions and outcomes core element around tackling inequalities.

Facilitate confident and resilient communities:
Core aspect of delivery – building on place-based assets it outlines how services should be co-produced with service users and/or carers as well as health and care professionals and system partners including the Voluntary, Community, Faith and Social Enterprise sector.

Commission, broker and provide core services:
JFP focuses on integration of services with the collective aims to improve the health and wellbeing of our population, the quality of services we provide alongside making efficient and sustainable use of NHS resources.

Place – leadership and influencer: The JFP – support Place leadership and the principle of subsidiarity. This means that we want to make decisions as locally as possible. It focuses on enabling local communities in our nine Place based partnerships to develop services which meet the needs of their local population. Complementary to this principle of subsidiarity, our large ICS provides opportunities to work at scale where appropriate.
Drivers of change and reform: The core focus of the JFP supports change and reform.
Facilitate sustainable economic prosperity: Supporting social and economic development is one of our Cheshire and Merseyside Health and Care Partnership Strategic Objectives and this has been reflected in the JFP Included in the core aims of the JFP is to • make efficient and sustainable use of resources. • To grow the number and role of anchor institutions
Greater income for social investment: The JFP contains a dedicated section on Social Value - Supporting social and economic development is one of our Cheshire and Merseyside Health and Care Partnership Strategic Objectives.
Cleaner Greener The Joint forward plan includes a dedicated section on how we will work in partnership to deliver the Green Plan. Core Priority: For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

What consultations have taken place on the proposals and when?

During March and April: Content has been developed with representatives from across the ICS, through a Planning Group who have overseen production of the NHS Operational Plan and JFP (includes NHS Provider/Provider Collaborative representatives, Champs Public Health Collaborative and ICS Programme Leads). Members of the ICB Sefton Team and wider Partnership have participated in these discussions with relevant insights incorporated in the Sefton Plan.

Week of 2nd May: A draft document was shared with partners, including the Sefton Partnership Board, Health and Wellbeing Board members and NHS providers for feedback. This includes the supporting content which will be available by clicking through from the JFP and contains detailed plans and content (180 pages in total).

In January 2023 our Health and Care Partnership (HCP) published a draft Interim HCP Strategy with the intention of undertaking further work with stakeholders, including the

public, to refine the strategy during the summer of 2023. This will include prioritising the content of our HCP strategy, which will in turn impact on the priority focus areas within our Joint Forward Plan. We will use the outcomes of this work to influence the scale of focus and investment into the various transformation programmes described in this document. These priorities will be reflected in future versions of our Joint Forward Plan. A public engagement process has taken place during March and April on the HCP strategy – there were 379 responses from across Cheshire and Merseyside key themes have been identified. A number of the key themes and headline messages have been discussed and shared across Sefton as part of the engagement process undertaken locally.

Contact Officer:	Stephen Woods (ICB Head of Strategy)
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Appendices:

The following appendices are attached to this report:

Copy of the draft JFP Summary Document

Sefton One Page Summary

JFP Background/next steps slides

Background Papers:

(Note there is also the detailed content behind this we can share if requested; we are now working on building the links from the JFP to the detailed plans)

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NHS
Cheshire and Merseyside

Cheshire and Merseyside

Joint Forward Plan

SUMMARY – DRAFT VERSION 1.5

1. About this document

We know that people's lives are better when organisations that provide health and care work together, particularly at the times when people need care most.

This document – our Joint Forward Plan (JFP) – describes how Cheshire and Merseyside Integrated Care Board (ICB), our partner NHS trusts and our wider system partners will work together to arrange and provide services to meet our population's physical and mental health needs.

This Joint Forward Plan contains the actions we will take as an Integrated Care System (ICS) to deliver the priorities identified in:

- The Cheshire and Merseyside draft interim Health and Care Partnership Strategy
- The Joint Local Health and Wellbeing Strategies of our nine Place based Health and Wellbeing Boards
- The priorities outlined by NHS England in The NHS Long Term Plan and the national NHS Planning guidance for 2023-24 (Appendix 1)

Our Joint Forward Plan aims to:

- improve the health and wellbeing of our population.
- improve the quality of services.
- make efficient and sustainable use of our resources.

We are committed to working on all three of these aims simultaneously to best meet our population's needs and to reduce inequalities in access and outcomes.

These aims also align to our statutory duties as an ICB. The details of these statutory duties can be **found here**.

Our Joint Forward Plan aligns with the recently published Hewitt Review (April 2023), which considers the future development of Integrated Care Systems in England. The review supports taking a 'whole system approach' to addressing wider determinants of health, and a shift of focus away from treating problems towards maintaining good health. These two themes align with our statutory duty and also our local commitment to integrate services to benefit our population.

Our approach to developing this Joint Forward Plan

The Cheshire and Merseyside Integrated Care Board was formally established in July 2022. We have already made significant progress, but we are still in a developmental phase and we have considerable work to do to further develop our plans and priorities. This Joint Forward Plan should be read in this context.

Whilst the responsibility to develop this plan sits with NHS Cheshire and Merseyside, and our NHS Providers, we have adopted a collaborative approach to developing this plan. We drew on the wide range of expertise, knowledge, and experience of our health and care professional leaders and partners to help us identify ways to improve integration and innovation. This will help us to deliver better outcomes for our population.

This 2023-2028 Cheshire and Merseyside Joint Forward Plan describes at a summary level the approach we are taking to tackle the current challenges we face in recovering access to services following the Covid 19 pandemic.

It also outlines a programme of radical transformation across our health and care system to address longstanding issues of inequalities in outcomes and financial sustainability.

This JFP builds on our draft interim Health Care Partnership Strategy. The strategy is built around four core strategic objectives:

- Tackling Health Inequalities in outcomes, experiences and access (our eight Marmot principles).
- Improving population health and healthcare.
- Enhancing productivity and value for money
- Helping to support broader social and economic development.

These objectives support us to work towards achieving our vision and mission. The draft interim Health Care Partnership Strategy is broadly focused and contains many priorities. The HCP recognise the need to decide what to prioritise to enable progress to be made. Our residents provided feedback on the draft interim strategy during March and April 2023 which supported this view.

Figure 1: Cheshire and Merseyside Health Care Partnership Vision and Mission

The HCP Strategy is currently in draft form and will be finalised later in 2023, in recognition of this ongoing work we have identified a number of priorities which contribute to making early progress against the ambitions outlined in the draft interim Strategy.

When the priorities in the HCP Strategy are finalised, we will refresh these priorities in our updated Joint Forward Plan, which will be published in March 2024.

Figure 2: Cheshire and Merseyside Priorities

HCP Strategic Objectives	Cross reference to the HCP areas of focus	Priorities	Core plans *	Metric
Tackling Health Inequalities in outcomes, experiences, and access (our eight Marmot principles)	• Give every child the best start in life • Enable all children, young people and adults to maximise their capabilities and have control over their lives • Ensure a healthy standard of living for all • Tackle racism, discrimination and their outcomes • Pursue environmental sustainability and health equity together.	All our Places are actively engaged in the All Together Fairer Programme	**2**	Increase % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage Reduce hospital admissions as a result of self-harm (15-19 years)
		Supporting the safety of vulnerable Women and Children	**2**	Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing Violence Against Women and Girls
Improve population health and healthcare	• Improve early diagnosis, treatment and outcome rates for cancer • Improve satisfaction levels with access to primary care services • Provide high quality, accessible safe services • Provide integrated, accessible, high quality mental health and wellbeing services for all people requiring support.	In relation to preventing ill Health we will focus on: • Increase rates of Early detection of Cancer • Work towards MECC (Making Every Contact Count) • Encourage *'Healthy Behaviours'* with a focus on smoking/alcohol/ physical activity • Ensure access to safe, secure, and affordable housing	**1,2,3**	Core20PLUS5 priorities including cancer, cardiovascular disease and children and young people's mental health services
			2,3	Increased sign up to the NHS prevention Pledge
			2,3	Reduction in Smoking prevalence. Reduction in the % drinking above recommended levels. Increase the % who are physically active.
Enhancing productivity and value for money	• Develop a financial strategy focused on investment on reducing inequality and prioritise making greater resources available for prevention and wellbeing services	Deliver our agreed financial plans for 23/24 whilst working towards a balanced financial position in future years	**1**	Financial strategy and recovery plan in place by Sept 2023
Helping to support broader social and economic development	• Embed, and expand, our commitment to social value in all partner organisations • Develop as key Anchor Institutions in Cheshire and Merseyside, offering fair employment opportunities for local people • Implement programmes in schools to support mental wellbeing of young people and inspire a career in health and social care	Develop as key Anchor Institutions and progress advancing at pace the associated initiatives.	**2**	Grow the number of anchor framework signatories to 25
		Embed and expand our commitment to Social Value	**2**	Support a system-wide approach to embedding the minimum 10% social value weighting across all procurement processes (working towards 20%)
		• Developed focused work in schools around encouraging careers in Health and Social Care • Ensure a Health and Care workforce that is fit for the future.	**2**	To be finalised in advance of the final publication in June 2023 Publish a Strategic Workforce Plan by March 2024
		Achieve Net Zero for the NHS carbon Footprint by 2040	**2**	For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

***1. Delivery against NHS Operational plan and Long-Term Plan (See appendix 1)**

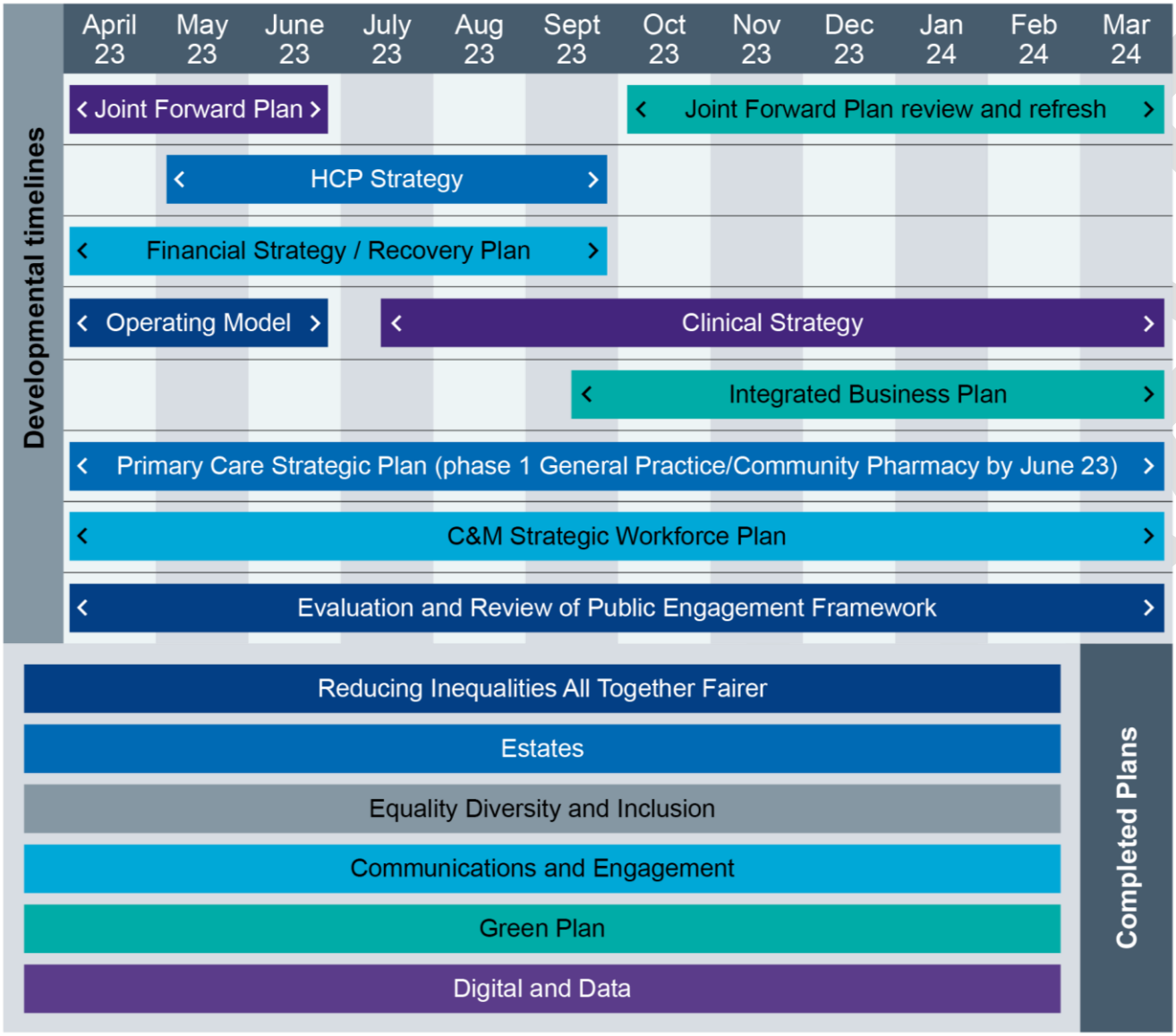
***2. Delivery against the Marmot Beacon Indicators / All Together Fairer (See appendix 2)**

***3. Core20PLUS5 (See appendix 3)**

Whilst this summary document is relatively short, it is underpinned by significant activity across all of the priorities included in the table above. There are various links within this document which provide access to more detail about specific work programmes.

In developing this Joint Forward Plan, we recognise that we are in a developmental phase as an Integrated Care System and that there are some key pieces of planning and strategy work which we will need to align.

We intend to develop a fully integrated business plan during 2023/24 that will incorporate the key strategic plans we have either already developed or intend to develop during this year. These will be reflected in the next iteration of this Joint Forward Plan in March 2024.The table below shows our completed plans and outlines our developmental timeline for 2023/24.



2. How we work as partners for the benefit of our population

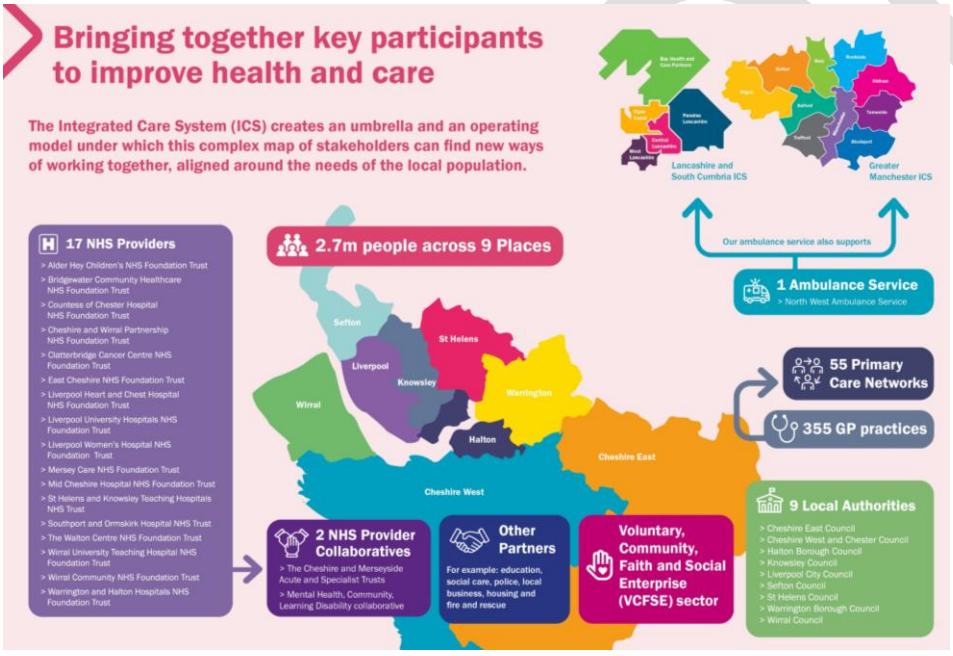
Cheshire and Merseyside is one of the largest Integrated Care Systems in England, with a large number of stakeholders working together to improve the health and care of our population.

The figure below illustrates how we are configured at a Cheshire and Merseyside level.

Some of the ways we come together in the Cheshire and Merseyside system are:

- The Cheshire and Merseyside Health and Care Partnership (HCP). This is a statutory joint committee between NHS Cheshire and Merseyside Integrated Care Board and our nine Local Authorities which also includes a wide range of partners from across the health and care system. This Board works together to support partnership working and is responsible for producing our Health and Care Partnership Strategy
- The NHS Cheshire and Merseyside Integrated Care Board. This is a statutory NHS organisation responsible for managing the NHS budget and arranging for the provision of health services whilst supporting the integration of NHS services with our partners.
- Our nine Place Based Partnerships. These work locally to support the integration of health and care services in support of local Joint Health and Wellbeing Strategies

Figure 3: Cheshire and Merseyside Integrated Care System

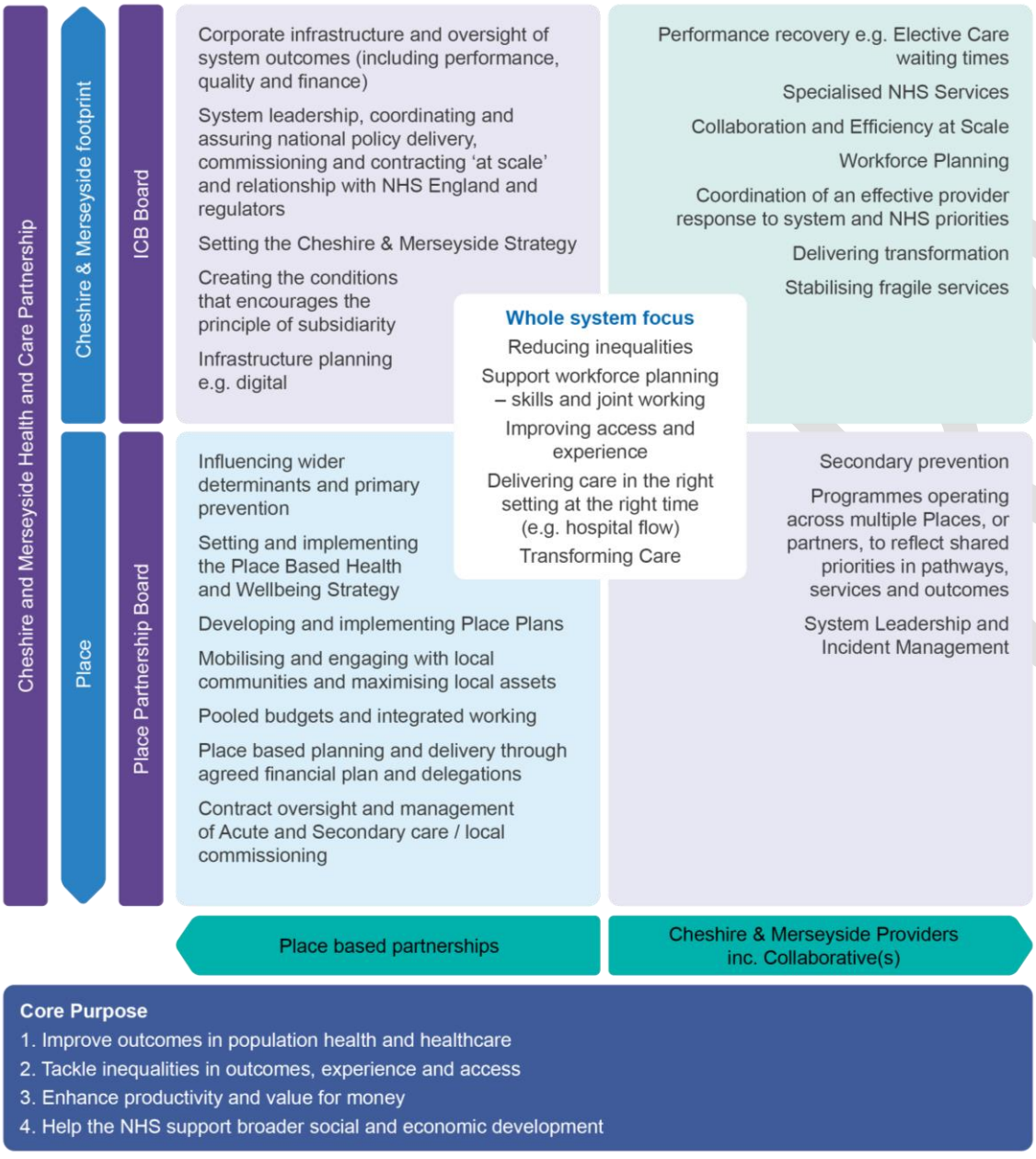


Through our Place based partnerships and the communities within them we are committed to the principle of subsidiarity. This means that we want to make decisions as locally as possible. Our Places and communities are the 'engine room' which drive change by designing and delivering services around the needs of the local population.

Complementary to this principle of subsidiarity, our large ICS provides opportunities to work at scale where appropriate. This enables us to share best practice and to work collectively to deliver efficiencies and manage change. As an example, our two NHS Provider Collaboratives support our NHS providers to work together to deliver service improvement and enhance sustainability.

The picture below shows how we apply the principle of subsidiarity to decision making in our Places and the communities within them, whilst realising the benefits of working at scale in certain areas through our Health and Care Partnership, or ICB-wide programmes or through our two Provider Collaboratives.

Figure 4: Decision making and subsidiarity in Cheshire and Merseyside



Communications and Engagement

As system partners we are committed to engaging with people and communities. We know that harnessing the knowledge and experience of those who use and depend on the local health and care system can help improve outcomes and develop better, more effective services including removing or reducing existing barriers to access.

We are committed to working with those with lived experience to understand the impact of health inequalities and to support us in designing and implementing solutions to address these.

Our Green Plan

Climate change poses a threat to our health as well as our planet. Across Cheshire and Merseyside, we are committed to achieving net zero by 2040 (or earlier). The ICB and NHS Trusts and many Local authority partners have well established plans to achieve this.

Complementary to these local plans, NHS Cheshire and Merseyside has a strong system level Green Plan, and we work collaboratively as system partners to maximise the impact of our initiatives.

Our planet will continue to warm until circa 2060 we will continue climate adaptation / mitigation work to ensure we can continue to provide access to quality health and care for our population even as the climate changes. Including work to tackle air pollution, increased access to mental health services, coastal and other flooding, vector-borne diseases / prep for changing patterns of disease / sustained heat and high temperatures / impact on patients and on workforce, etc.

We will:

Reduce the emissions we control directly (the NHS Carbon Footprint), achieving net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

Supporting wider social and economic development

Supporting social and economic development is one of our strategic objectives. We are working together on a plan for improving health including addressing wider determinants. Wider determinants, also known as social determinants, are a diverse range of social, economic, and environmental factors which impact on people's health.

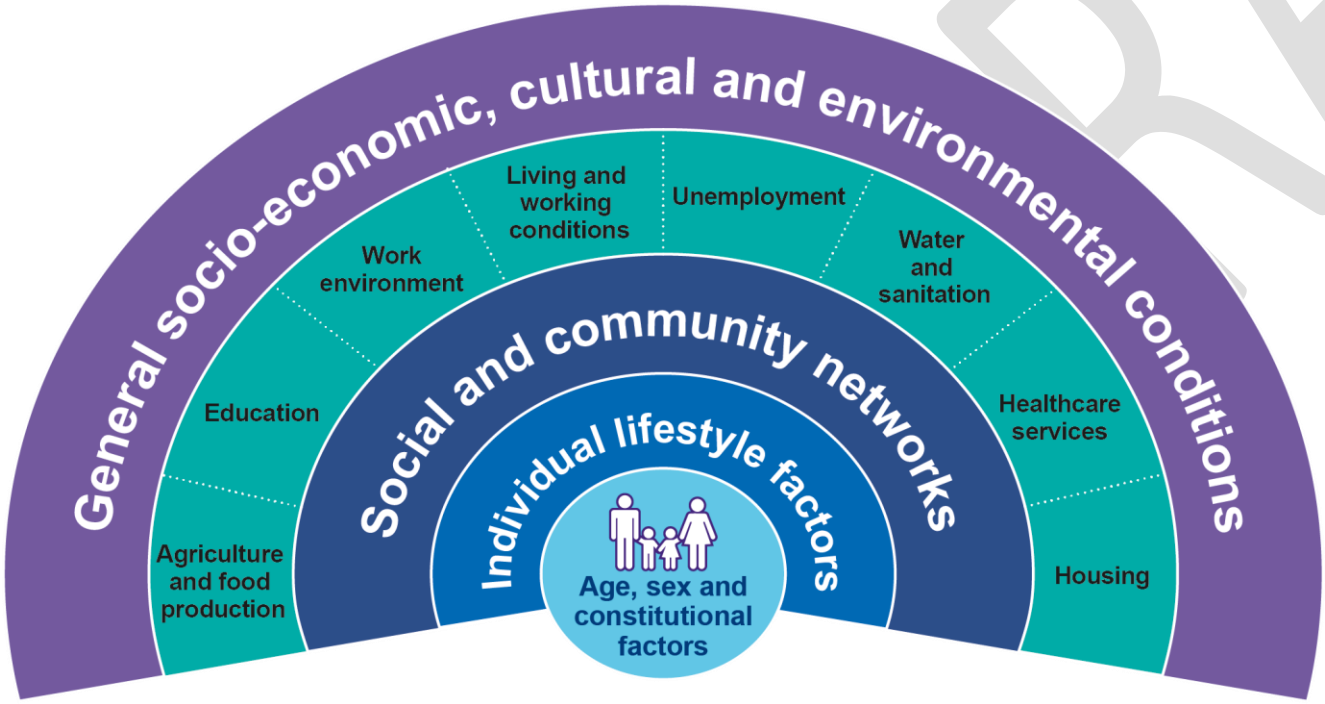
We will:

Increase the number of Anchor Framework signatories to 25 by the end of March 2024

And:

- Embed, and expand, our commitment to social value
- Develop as key Anchor Institutions within Cheshire and Merseyside
- Use an asset and strengths-based approach to planning
- Share data and insights, so resource can be targeted
- Ensure service, pathway and care model redesign is undertaken in collaboration
- Develop outcomes-focused funding models and contracts
- Support health and care professionals to think about care and support holistically
- Support a system-wide approach to embedding the minimum 10% social value weighting across all procurement processes (working towards 20%).

Figure 5: Wider social determinants of health and health inequalities, Dahlgren and Whitehead 1991



Safeguarding our population

Safeguarding is a shared responsibility across the health and care economy. Our teams work with colleagues from across the NHS, Local Authorities, the Police, and other partner agencies to drive improvements through local and regional partnership working to embed responsive safeguarding practice. This enables us to address national and local priorities and influence safe and effective care and commissioning.

Effective safeguarding at both system and organisational levels relies on systems that ensure safeguarding is integral to daily business.

We are committed to:

- Strengthening Collaboration and Communication
- Improving Training and Awareness
- Early Identification and Intervention
- Strengthening Partnership Working
- Enhancing Monitoring and Evaluation
- Empowering Service Users
- Promoting a Culture of Safeguarding

We will:

Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing Violence Against Women and Girls.

3. Our approach to improving Population Health

Our established Population Health Board oversees our Population Health programme of work. The aims of this are to improve health outcomes and reduce health inequalities by embedding a sustainable system-wide shift towards focusing on prevention and reducing health inequality. Our newly appointed Director of Population Health plays a key leadership role in this work.

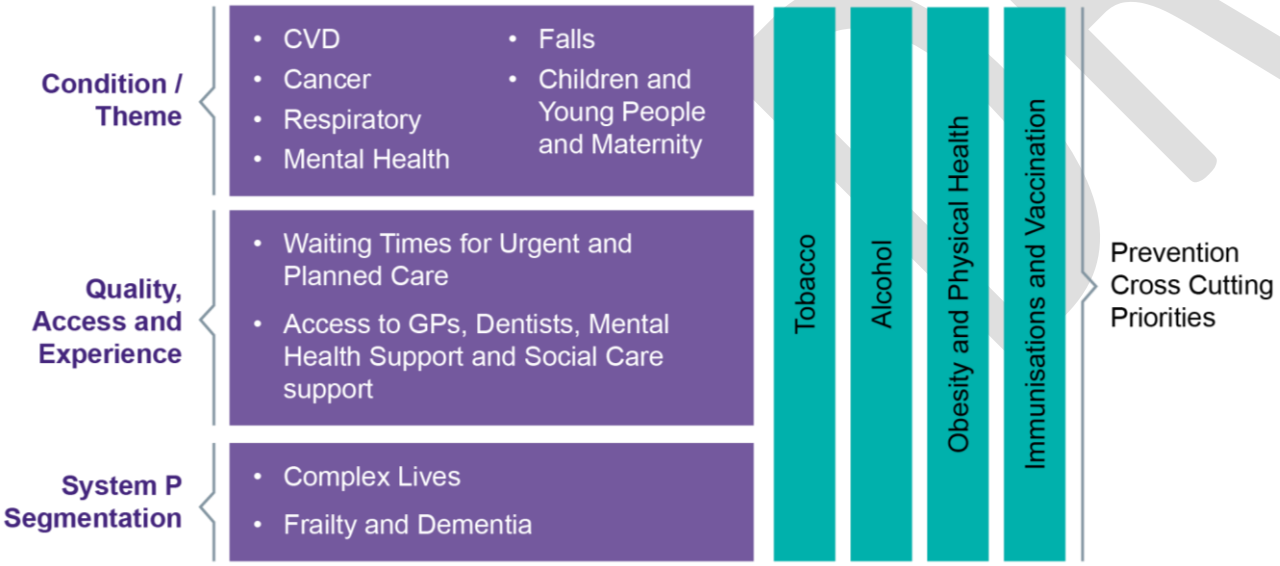
Figure 6 provides a summary of the areas which our analysis tells us that our population experience worse outcomes when compared to the "England average", and where our people have told us their experience of accessing care does not meet their expectations.

We know that it is often the wider social determinants of health which are the cause of these poorer outcomes and this is why we are committed to addressing these wider determinants and to promote good health.

In line with the Hewitt Review recommendations, as an ICB we intend to increase year on year the proportion of our budget being spent on prevention. Over time we expect that this will improve the health of our population, whilst helping to address the variation and inequality in access and outcomes we see across Cheshire and Merseyside.

The following programmes describe how we are approaching this.

Figure 6: Population Health needs and cross cutting prevention themes in Cheshire and Merseyside



Strategic Intelligence

Strategic business intelligence is vital to underpin, inform and drive a coordinated and sustainable population health management approach across ICS programmes.

As outlined in our Digital and Data Strategy, we will build on our CIPHA and System P Programmes to enhance our strategic intelligence functionality. This will enable us to better identify areas for targeted interventions and monitor progress.

All Together Fairer

The primary objective of the draft interim Health Care Partnership Strategy is to reduce health inequalities, this commitment is at the heart of all of our programmes of work. This includes through our established All Together Fairer programme where we aim to improve population health and reduce population level inequalities in health, by focussing on the social determinants of health across Cheshire and Merseyside and supporting action at Place level. The All Together Fairer programme supports the eight Marmot principles, which are to:

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

An example is how we will work together to support our population to access safe, secure, and affordable housing.

We know that access to safe, secure, and affordable housing has a huge impact on the health of our population, and also that providing the right accommodation in the community supports people with a mental health condition or learning disability to access services in a more appropriate environment. A number of partners across our Health and Care Partnership provide excellent services which support our population to meet their housing needs.

Within the NHS many of our services such as community nursing services often involve visiting people at home. We can 'Make Every Contact Count' by using these interactions as opportunities to sign-post people to other local services which can help improve the environment they live in, impacting positively on their overall health and wellbeing.

We will measure the success of the All Together Fairer programme in the 2023-28 period against the 22 beacon indicators in the Marmot indicator set *(Appendix 2)*.

We will:

- **Increase the % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage**
- **Reduce hospital admissions as a result of self-harm (15-19 years)**

Core20PLUS5: System-wide action on healthcare inequalities

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities. It identifies focus clinical areas requiring accelerated improvement. Making progress against these areas is a cross-cutting, system-wide responsibility, and delivery against priority clinical area objectives sits with respective ICS programmes and workstreams.

Our Population Health Programme strategic intelligence and system leadership will strengthen the oversight and monitoring of progress against the Core20PLUS5 clinical priorities *(Appendix 3)*.

We will: Focus on delivery of the CORE20PLUS5 clinical priorities with an emphasis on:

- **Increasing the proportion of cancers diagnosed at an early stage (stage 1 or 2)**
- **Increasing the percentage of patients with hypertension treated to NICE guidance to 77% by March 2024**
- **Improving access, and equity of access, to Children and Young Peoples Mental Health services (0-17).**

System-wide action on Prevention and Making Every Contact Count

We are committed to working collaboratively as a system. As part of this commitment, we are embedding the philosophy of Making Every Contact Count. This is an approach to behaviour change that maximises the opportunity within routine health and care interactions for a brief discussion on health or wellbeing factors. This can support people in making positive changes to their physical and mental health and wellbeing.

We are also focusing on evidence-based and high impact interventions which include:

- Reducing smoking prevalence
- Reducing harm from Alcohol
- All Together Active Physical Activity Strategy
- Promoting Healthy Weight
- Increasing Health Checks
- Mental Wellbeing.

We will monitor our progress against key system objectives using an integrated framework that is currently being co-produced by system partners, and will incorporate key metrics in ICS, ICB and Marmot (All Together Fairer) dashboards.

We will:

- **Reduce smoking prevalence**
- **Reduce the % drinking above recommended levels**
- **Increase in the % who are physically active.**

NHS Prevention Pledge

Our providers are delivering against the 14 core commitments in the NHS Prevention Pledge. We are strengthening our focus on prevention, social value, and inequalities, embedding Making Every Contact Count (MECC) at scale, and supporting participating Trusts to achieve Anchor Institution charter status.

We are also exploring how we interpret the Pledge in a primary care setting, which involves considering how it may apply to colleagues such as GPs, dentists, optometrists, and pharmacists. This may provide further opportunities for partners to take early action to support health and wellbeing across a broader range of health and care settings.

We will:

Increase sign up to the NHS Prevention Pledge.

Vaccination and Immunisation

We plan to work with NHS England, UK Health Security Agency (UKHSA) and Place based commissioning teams to strengthen screening and immunisation uptake, and to reduce inequalities.

We will:

Work with partners to strengthen screening and Immunisation uptake and reduce inequalities.

4. How we will improve our services and outcomes

We have adopted a life course approach to improving services and outcomes.

Starting Well – Living Well – Ageing Well

We are already working hard to improve services and outcomes for our residents through a wide range of programmes. The table below summarises our core areas of focus. Further details of our work can be accessed by clicking against the appropriate link.

Theme	Heading	Focus	Drivers	Link	Cross Cutting
Starting Well	**Maternity & Women's Health**	Reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury. Deliver the actions from the Ockenden report Workforce development All women have personalised and safe care Reduce inequalities in access and outcomes Women's Health and Maternity (WHaM) programme Gynaecology Network Estate - Women's Health Hubs	Core20PLUS5 All Together Fairer Long Term Plan	Click to Access	Personalised Care and supporting Self Care Supporting Our Carers and Vulnerable Groups
	Children and Young People Beyond Programme	Emotional wellbeing and mental health Learning difficulties, disabilities and autism Diabetes Epilepsy Respiratory / asthma Healthy weight and obesity Oral health Estate - Women's Health Hubs	Core20PLUS5 All Together Fairer Long Term Plan	Click to Access	
Living Well Ageing Well	**Physical Health**	Cancer Cardiovascular Disease (CVD) Community health services Diabetes Elective Recovery Neurosciences Respiratory Stroke Urgent & Emergency Care Accessing Adult Social Care	Core20PLUS5 NHS Operational Plan Long Term Plan	Click to Access	
	Mental Health	Improving Mental health access and outcomes Continued investment in Mental Health Improved choice A new community-based Mental Health offer PCNs to have Mental Health Practitioners More comprehensive crisis pathways Improved access for children and young people Suicide Prevention Dementia	Core20PLUS5 NHS Operational Plan Long Term Plan	Click to Access	
	Neurodiversity	Learning Difficulties, Disability & Autism (LDDA) Attention Deficit Hyperactivity Disorder (ADHD)			
	End of Life Care (EOLC)	Access to information to support EOLC Access and sustainability palliative /EOLC services Specialist Workforce development Engaging with people	Long Term Plan	Click to Access	
Cross Cutting	Primary Care - General Practice / Dental / Optometry /Community Pharmacy				
	Diagnostics - Priority supporting Recovery and Restoration				

5. Our Workforce

Our plans recognise the importance of investing in our workforce.

To achieve Cheshire and Merseyside Health and Care Partnership's strategic priorities we need to change the way we work. We will have new teams, new roles, and we will need to work across multiple organisations and Places.

In 2022/23 the Cheshire and Merseyside People Board, which has a broad membership across Cheshire and Merseyside stakeholders, agreed a set of ambitious Workforce Priorities for 2022-25 (see below).

Our system Workforce Strategy and the programme to support delivery of these priorities will be further developed during 2023/24.

Systemwide Strategic Workforce Planning to:	Creating New Opportunities across C&M to:	Promoting Health and Wellbeing to:	Maximising and valuing the skills of our staff to:	Creating a positive and inclusive culture to:
• Ensure a health and care workforce that is fit for the future • Smarter workforce planning linked to population health need • Creation of a 5-, 10- and 15-year integrated workforce plan • Developing a greater triangulation and monitoring between workforce / productivity / activity / finance.	• Grow our own future workforce • Increased focus on apprenticeships • Embed New Roles • Review barriers to recruitment • Work with the further and higher education sector • PCN Development • Greater links with social care and primary care • Ensuring an effective student experience.	• Ensure appropriate health and wellbeing support for all staff • Ensure good working environment • Focus on retention. • Preventing burnout • Ensuring appropriate supervision and preceptorship is available.	• Understand the impact of 5 generations working together/ changing expectation of the workforce • Developing career options at different stages of our lives and across health and social care • Responding to reviews / staff surveys and recommendations in a positive manner.	• Ensure proactive support of inclusion and diversity as a priority • Collaborative and inclusive system leadership • Understanding the barriers for staff / future employees • Development of learning and restorative practice.

Developing our culture and leadership

We plan to adopt, apply, and invest in the following areas to develop our culture, workforce, and ways of working as a system.

We will:

- **Ensure a Health and Care workforce that is fit for the future.**

  And:

- **Publish a Strategic Workforce Plan by March 2024**
- **Create new opportunities across health and care providers**
- **Promote health and wellbeing of all workforce**
- **Maximise and value the skills of our workforce**
- **Create a positive and inclusive culture**
- **Ensure digital upskilling for the whole workforce**
- **Further develop our partnerships with Health Education Institutes (HEI's), further education providers and school**

Cultural transformation

- Organisational and system redesign necessary for integration
- Competence and capability development to deliver integrated ways of working.
- Team cohesion to drive resource optimisation through sustainable collaboration.
- Growth mindset to stimulate systems leadership thinking and practice.
- A shared cultural identity values and behaviours premised on the principles of public service founded by the NHS Constitution, Equality Act and Nolan Principles

Talent management

- Talent management for effective capacity, demand and supply planning mapped to population health / market trends.
- Robust succession planning strategies for business-critical roles and hard to fill roles specifically.
- Reward and recognition strategies to ensure that success is rewarded and celebrated and improve staff engagement and retention.

Leadership development

- Resilient collective (systems) leadership evidenced in the continual enablement of integration for improved health and care integration.
- Compassionate and inclusive leadership cultures towards improving health inequalities.
- Culturally competent leadership to drive cultural competence in decision making for integration.
- Clinical leadership for integration towards health creation models of care

6. System development

Our Integrated Care System is geographically large and comprises a wide range of partners. This is reflected in how we apply our intention to distribute leadership to the most appropriate point in the system, which in many cases is as locally as possible.

In line with the concept of a "self-improving system" described in the Hewitt Review we intend to develop our capabilities and be ambitious in developing our leadership, workforce and improvement approaches alongside the plans already outlined in this document.

In early 2023/24 we will be delivering work to develop and embed an agreed operating model for our system, working alongside system partners. Part of this will involve considering how we can work more efficiently as a system to enable the integration of services across health, care and our wider partners and communities, within our Places and our communities to prosper whilst working collectively at a Cheshire and Merseyside level when it makes most sense to do so.

Clinical and Care Professional leadership

We have developed a Clinical and Care Leadership Framework which outlines how clinical and care leaders across Cheshire and Merseyside will be involved in key aspects of ICS decision making.

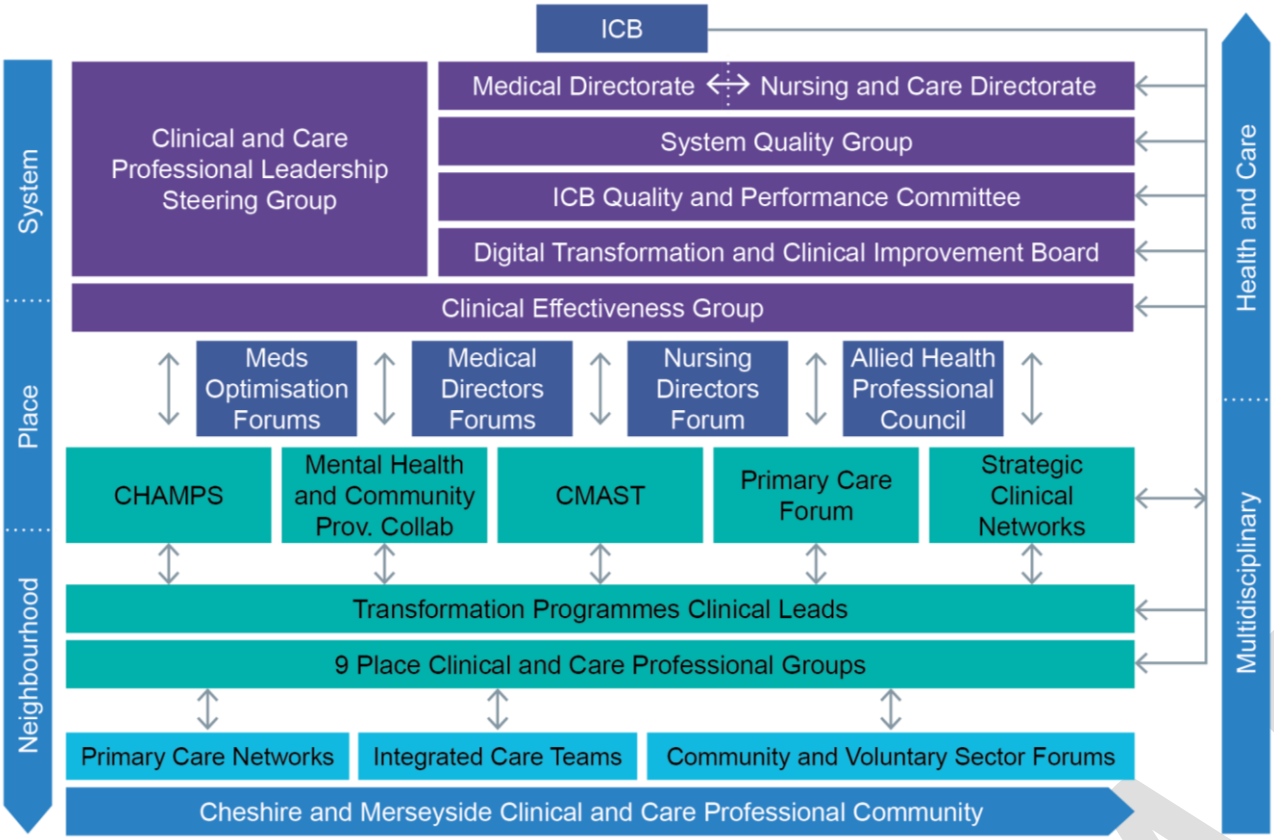
The framework was developed collaboratively with a wide range of clinical and care professionals and in partnership with the Innovation Agency. It will:

- Empower our leaders to work across traditional organisational boundaries
- Support specific groups of clinicians and care professionals to connect their particular areas of work to the ambitions of the ICS
- Create an environment where distributed leadership can thrive
- Maintain and develop the depth and breadth of clinical leadership we currently have, including development of our future leadership to be more reflective the diverse Cheshire and Merseyside population we serve
- Build on the expertise of existing clinical and care professional networks
- Enable clinical and care professionals to collaborate for improved health and care outcomes for people in Cheshire and Merseyside.

We will:

Develop a Cheshire and Merseyside Clinical Strategy by March 2024.

Figure 7: Clinical and Care Leadership in Cheshire and Merseyside



Quality Improvement

The government and public rightly expect Integrated Care Boards and their respective systems to ensure that the services we commission provide the highest standards of care. The development of our system quality strategy is being informed by the National Quality Board (NQB) guidance. The NQB publication 'Shared Commitment to Quality' provides a nationally agreed definition of quality and a vision for how quality can be effectively delivered through ICSs.

Quality Principles

We will work together as a system to improve quality and use the key principles for Quality Management, as set out by the NQB, in developing our approach to deliver care that is:

- Safe
- Effective
- A Positive Experience
- Responsive and Personalised
- Caring
- Well-led
- Sustainably Resourced
- Equitable

Our Provider Collaboratives

Effective collaboration and system working requires us to continually evolve, develop, improve and partner to further embed progress and capacity within the ICS and ultimately to provide more and better care to our residents and patients.

In Cheshire and Merseyside, we have two provider collaboratives:

- Cheshire and Merseyside Acute and Specialist Trusts Collaborative (CMAST)
- Mental Health, Community and Learning Disability and Community Provider Collaborative (MHLDC)

Our collaboratives are leading a range of work programmes which support delivery of the Cheshire and Merseyside HCP strategic priorities.

Our Cheshire and Merseyside Acute and Specialist Trusts Collaborative (CMAST) programmes and key areas of focus are listed below:

- Elective Recovery and Transformation
- Clinical Pathways
- Diagnostics
- Finance, Efficiency and Value
- Workforce

Our Mental Health Learning Disabilities and Community Provider Collaborative (MHLDC) is a joint working arrangement between the nine providers of community, mental health and learning disabilities services. The work programme priorities for 2023/24 are:

- Community urgent care:
  - Urgent community response teams
  - Intermediate care
  - Roll out of Urgent Treatment Centre specification
  - Virtual Wards
- Community services for children and young people
- Access to care, fragile services and community waiting times
- Population health and prevention
- Mental health transformation
- Workforce transformation

We will:

Work with our collaboratives on a range of work programmes which support delivery of the HCP strategic priorities.

Our VCFSE Transformation Programme

In Cheshire and Merseyside we are fortunate to have a strong and engaged Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector across our nine Places. This is supported by established local infrastructure organisations providing skills, knowledge, and capacity to enable two-way communications and engagement between local neighbourhoods and the health and care system.

The new health and care structures which have recently been established provide an opportunity to transform services and make a lasting difference to patients and communities. VCFSE partners will play a vital role in transformation programmes with a focus on:

- Embedding VCFSE as key delivery partners
- Supporting investment in the VCFSE both financially and organisationally
- Building on VCFSE infrastructure and assets

We will:

Focus on embedding the VCFSE as a key delivery partner.

Our Places

Our nine Cheshire and Merseyside Places have been working collectively since before the formation of ICS in 2022, working through local partnership arrangements to deliver against the priorities in their local joint health and wellbeing strategies.

We have used a 'Place Development Assessment Framework' to support our Place Partnerships in their development, applying learning from other geographies. There are 4 key domains:

- Ambition and Vision
- Leadership and Culture
- Design and Delivery
- Governance

Place Partnerships have developed detailed plans to improve local services and outcomes.

We will:

As part of our Operating Model we will enable our nine Places to most effectively deliver functions and decision making at a local level.

Evolving our Commissioning and Corporate Services

We are developing a single suite of commissioning policies across Cheshire and Merseyside by March 2024, and we will publish new policies as soon as these are completed and have been through the relevant engagement and governance processes required.

The Health and Care (2022) Act has created provisions for NHS England to delegate functions relating to the planning/commissioning of certain services to Integrated Care Boards. In April 2023 the ICB took on responsibility for dental, ophthalmic and pharmacy services, and we are planning for future delegation of Specialised Services from April 2024.

We have a number of programmes of work designed to support our system to improve consistency and value for money as its functions evolve. These include:

- Corporate infrastructure: we are reviewing the licenses and applications in use across our nine places, to improve consistency and realise operational and financial efficiencies.
- Commissioning support functions: we are reviewing all services currently provided to the ICB by Midlands and Lancashire Commissioning Support unit for consistency and value for money.

Research and Innovation

As described in our draft interim Health Care Partnership Strategy we have an ambitious vision for research in Cheshire and Merseyside. Our ICS is investing in the clinical leadership to realise this ambition with Director and Deputy Director of Research to work closely with our stakeholders to develop the best performing research network in the country.

We are working closely as a system involving the CHAMPS public health collaborative, our academic institutions, HCP partners (including population health), research partners (including National Institute for Health and Care Research, National Cancer Research Institute and Academic Health Science Network) and industry.

We will:

- **Establish a Cheshire and Merseyside Research Development Hub**
- **Create a network of research champions across our system**
- **Deliver annual learning events to showcase latest research and to enable the sharing of skills, toolkits and research to support in-house evaluation of projects**
- **Contribute to the development of a North West Secure Data Environment for research.**

Digital and Data

Cheshire and Merseyside ICS published its three year Digital and Data Strategy in November 2022 following endorsement from the NHS Cheshire and Merseyside Board. We are committed to using digital and data to improve outcomes and services for our residents.

The strategy describes an ambition to improve the health and well-being of our region now and into the future by incorporating digital and data infrastructure, systems, and services throughout the pathways of care we provide.

This requires 'levelling up' our digital and data infrastructure to help address the significant inequalities so clearly faced by parts of our population and to ensure we successfully support all we serve.

We are committed to turning 'intelligence into action' by using increasingly sophisticated ways of understanding the health and care needs of our population, and then finding and intervening for those in greatest need to improve their health and care outcomes in an equitable way.

We will:

Work in partnerships to deliver the goals outlined in the Digital and Data Strategy, including making the Share2Care (shared care record) platform available in all NHS and Local Authority Adult Social Care providers, by March 2024.

Effective use of resources

In line with many other systems Cheshire and Merseyside faces significant financial challenges. As a system, we are spending more money on health and care services then we receive in income. We must take action to improve the long-term sustainability of the Cheshire and Merseyside health and care system by managing demand and transforming the way we use services, staff, and buildings.

As part of the Cheshire and Merseyside draft interim Health Care Partnership Strategy there is a commitment to developing a system-wide financial strategy during the first half of 2023-24 to:

- Determine how we will best use our resources to support reduction in inequalities, prevention of ill health and improve population health outcomes
- Support health and care integration
- Identify key productivity and efficiency opportunities at both a Place and ICS footprint
- Outline system-wide estates and capital requirements and plans

As recommended in the Hewitt Review, we are focussed on ensuring we are getting best value from our investments and increasing the proportion of our ICB budgets allocated to prevention of ill health.

We will:

Agree a financial strategy and recovery plan by September 2023 which details how we will move to a sustainable system-wide financial position in Cheshire and Merseyside

Finance Efficiency and Value Plans

As part of our wider development of a system financial strategy, we have established an Efficiency at Scale programme. One of our provider collaboratives, CMAST, is hosting the programme on behalf of the ICB. The programme works across the NHS and links with partners from the wider system as appropriate.

The key areas of focus for the Efficiency at Scale programme are:

- Consolidating financial systems, approaches and capacity across organisations where appropriate, including financial ledgers.
- Delivering a structured procurement workplan to reduce influenceable spend across all providers.
- Building on existing medicines optimisation projects to deliver a more sustainable approach to pharmacy capacity and resourcing across Cheshire and Merseyside.
- Specific discrete workforce projects, for example a collaborative staff bank for Health Care Assistants.

This complements wider work on our financial strategy and recovery plan where system partners work to reduce costs, through ICB, Place, provider and partner led plans.

Capital plans

We have developed a Capital Plan which describes how we will use available capital funding to invest in our buildings and infrastructure. This is publicly available to view at: INSERT LINK TO CAPITAL PLAN

Our capital plans will be routinely shared with members of the Cheshire and Merseyside Health and Care Partnership and the nine Health and Wellbeing Boards in Cheshire and Merseyside.

We will continue working in partnership to deliver against our Capital plans.

Estates

Cheshire and Merseyside Health and Care Partnership's Estates Strategy sets out our system commitment for the next five years. We are committed to the NHS, local government and other agencies working together to deliver our Estates Plan and take steps to create stronger, greener, smarter, better, fairer health and care infrastructure together with efficient use of resources and capital to deliver them.

Our focus for delivery will primarily be in eight key areas:

- Fit for Purpose
- Maximising Utilisation
- Environmentally Sustainable
- Value for Money and Social Value
- Services and Buildings in the right place
- Flexibility
- Technology
- Working in Partnership

During the year we will be supporting our nine Place Partnerships and Primary Care Networks to ensure our focus areas translate into deliverable local plans.

All Age Continuing Health Care

The ICB is accountable for the fair and equitable commissioning of All Age Continuing Health Care (AACC) to support the assessed needs of our residents. We are accountable for the quality, safety and financial assurance of the continuing care provided.

We have recently reviewed the services we provide to people who receive Statutory funded continuing care. This review will have a range of benefits. It will improve the appropriateness of the care provided, meaning care is of higher quality. By providing more appropriate solutions, we also expect to improve the value for money of the services we provide meaning our funding can go further.

We will:

Complete the review and work with partners to establish an equitable model for delivery of services across Cheshire and Merseyside.

7. Our Place Plans

Click her to see our Place plans. (link to be added).

8. Glossary

An online glossary of terms has been developed by NHS Cheshire and Merseyside and can be accessed through this link:

cheshireandmerseyside.nhs.uk/get-involved/glossary/

9. Summary of Outcomes

In addition to the priorities outlined in Section 1 there are a range of additional outcomes the plans outlined in this document will deliver and can be accessed by clicking here (link to be added).

10. Links to our partners plans

Click here to find links to the strategic plans of our NHS Provider and Local Authority Partners. (link to be added).

Appendix 1 NHS Operational Plan and Long-Term Plan

Nation NHS Objectives

	Area	Objective
Recovering our core services and improving productivity	Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
LTP and transformation	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

*ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published.

Appendix 2 Marmot 8 principles and 22 Beacon indicators

The tables below highlight the principles describing how we intend reducing inequalities and the indicators we will use to measure progress.

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

22 Beacon Indicators

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

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

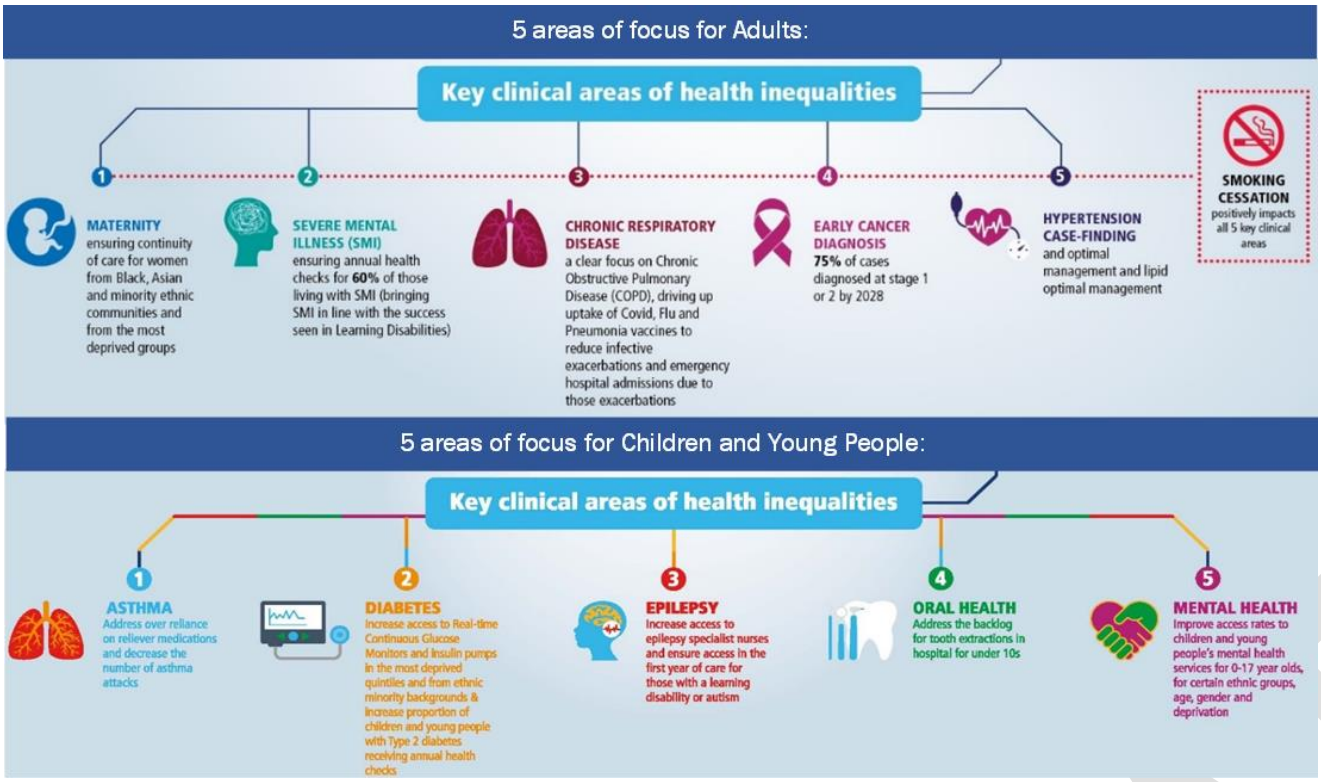
*** Both the Progress 8 and Attainment 8 scores are proposed for inclusion. Progress 8 scores at local authority level demonstrate that schools with a neg ative average score require systematic intervention. Attainment 8 shows the percentage achievement of school-leavers and is a more sensitive measure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

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

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

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

Appendix 3 Core20PLUS5



NHS
Cheshire and Merseyside

Background to Cheshire and Merseyside Five Year Joint Forward Plan 2023-28

Health and Wellbeing Boards & NHS Boards – May 2023

Neil Evans
Associate Director of Strategy and Collaboration
NHS Cheshire and Merseyside ICB

Agenda Item 6

What a Five Year Joint Forward Plan (JFP) is

NHS Cheshire and Merseyside

- Led by the Place Health and Wellbeing Board Partners
- Duration: 5 years
- Informed by: Place priorities driven from evidence in JSNA
- Purpose: Strategy outlining the priorities for improving the health and wellbeing of local population, including addressing inequalities
- Review date varies by Place/HWB

Joint Local Health and Wellbeing Strategies

Health and Care Partnership Strategy

- Led by the HCP (ICP) partners
- Duration: 5 years
- Informed by: C&M wider partnership priorities; National Guidance; Health and Wellbeing Plans; Place plans
- Purpose: strategy for broad health, social care needs of the population including wider determinants of health
- Interim strategy published Jan 2023 with work to prioritise content happening through to summer 2023

- *FP is a new joint statutory responsibility for ICB and HS Trusts*
- *he JFP should describe, as a minimum, how the ICB and its partner trusts intend to arrange and/or provide NHS services… including delivery of the universal NHS commitments*
- *Systems are encouraged to use the JFP to develop a shared delivery plan for the Integrated Care Strategy*
- *JFP must cover the statutory duties of ICBs – e.g. duty to improve quality, duty to promote integration etc.*
- *Health and Wellbeing Boards are required to provide a statement confirming the plan reflects the priorities from their strategy (links to be added in publication)*

Five Year Joint Forward Plan

- **Statutory responsibility to produce plan sits with ICB and NHS Providers to develop document with input from HCP partners and local stakeholders**
- **Duration: 5 Years (greatest focus initial part of this period)**
- **Informed by: HCP (ICP) Strategy; National NHS Plans and Health and Wellbeing Strategies**
- **Purpose: Delivery Plan for HCP Strategy priorities, Health and Wellbeing Board (Place) plans, and NHS Universal priorities (Long Term Plan and Operational Planning)**
- **Ready by: Must be published by June 2023 (final)**
- **Has to be republished annually (next publication Mar 2024)**

NHS Operational Plan 2023/4

- Led by the ICB and NHS Providers
- Duration: 2023/24
- Informed by: NHS Priorities issued in national guidance
- Purpose: Detailed Delivery Plan for 2023/24 (finance and capital, workforce, activity and performance…..).
- Content in the form of national templates.
- Ready by: 23rd February (draft); 30th March (final).

Other content required in the NHS England Guidance

NHS Cheshire and Merseyside

In addition to the statutory duties of an ICB the JFP also includes content on:

- *Workforce (plans align with operational and financial plans)*
- *Performance (trajectories/milestones aligned to NHS operational planning requirements and NHS Long Term Plan)*
- *Digital/data (steps to increase digital maturity and reduce digital inequality in an integrated health and care system)*
- *Estates (plans for improved health and care infrastructure aligned with financial and capital plan)*
- *Procurement/supply chain (plans to deliver more efficient procurement and best value; can describe governance and supporting technology & infrastructure)*
- *Population health management (prevention and personalised care models through data, address inequalities and model future demand and service/financial impacts to support redesign and integrated models*
- *System development (How the system will operate e.g. governance, emphasising the importance of Place partnerships, provider collaboratives, clinical and care professional leadership, system OD)*
- *Supporting wider social and economic development (approach to social, environmental and economic factors impacting health and well being e.g. Anchor Institute plans within communities)*

We have also included:

- *A summary and link to a copy of each "Place Plan" reflecting the priorities agreed within each Place and aligned to the Place Health and Wellbeing Strategy*
- *Delivery plans in relation to a wider range of local programmes that are described in the interim draft Cheshire and Merseyside Health and Care Partnership Strategy e.g. existing C&M transformational programmes such as elective recovery, disease/condition specific programmes or priorities e.g. cardiovascular disease, mental health or carers*
- *Key ICB organisational programmes for example: NHS England delegation of Specialised Services to the ICB*
- *Links to partner strategic documents/sections on NHS provider and local authority websites*

The approach to developing the plan

NHS Cheshire and Merseyside

Context

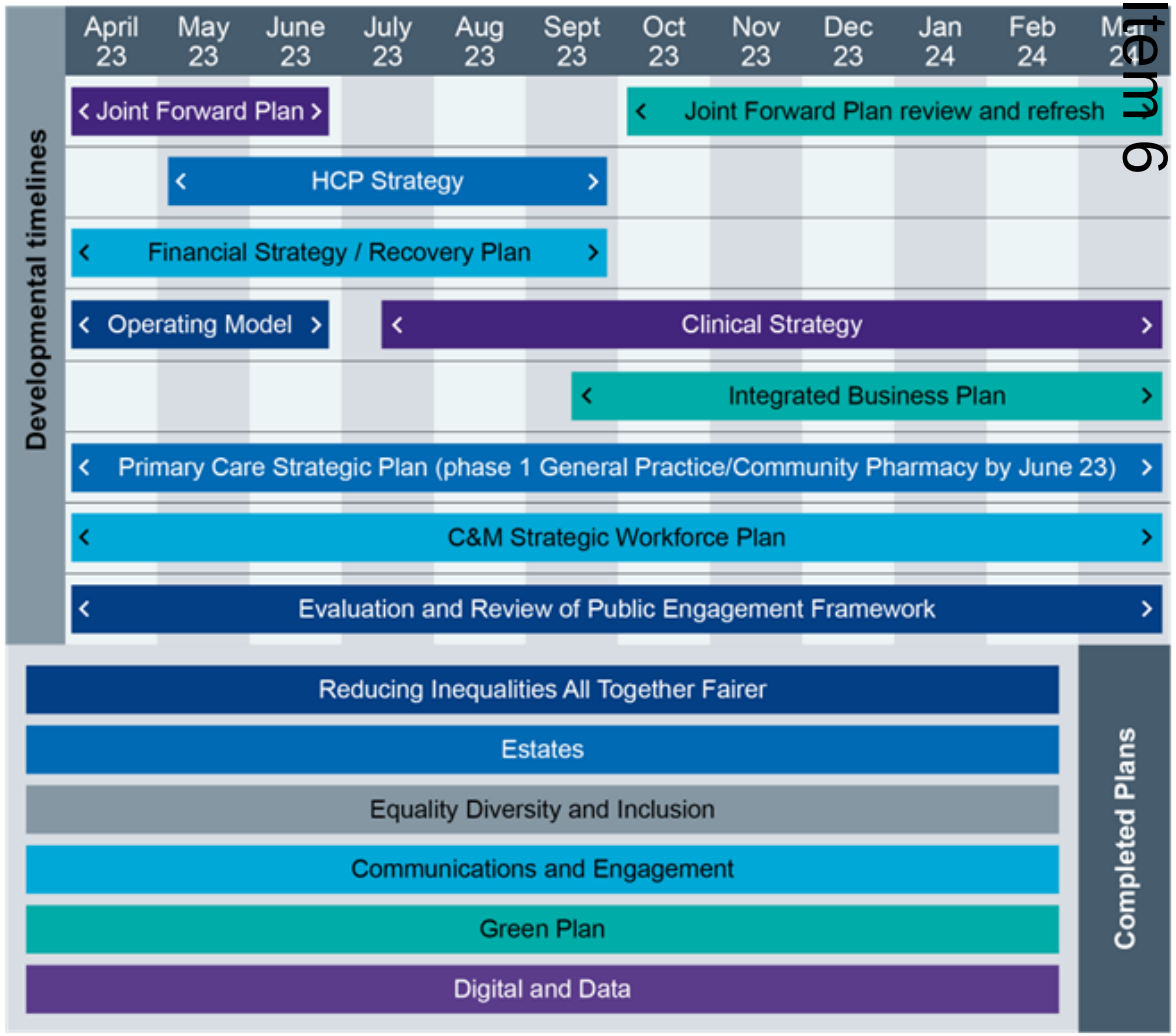
- Whilst the plan, and priorities contained within the JFP, are built from the draft interim HCP Strategy* it is recognised that the final HCP strategy won't be finalised until later in 2023:
  - As a system there are a number of key strategies and plans in development e.g. workforce, finance
  - Our final Cheshire and Merseyside HCP priorities will be agreed in the final HCP Strategy
- Over the course of this year the priorities and plans will mature and can be reflected in the updated JFP (March 2024) and will then reflect a more refined and mature system plan

Document Style

- A relatively short document is to be published (<30 pages) but developed to be interactive with links through to much more detailed content describing specific plans in areas that the reader may be interested in finding out more about
- This includes specific links to the local Place plans/priorities and drawn from the relevant Joint Health and Wellbeing Strategy

**alongside local Place Health and Wellbeing Board and NHS Operational Planning priorities*

Summary timeline for developing key strategic planning documents



Timeline for finalising the plan

NHS
Cheshire and Merseyside

- During March and April: Content has been developed with representatives from across the ICS, through a Planning Group who have overseen production of the NHS Operational Plan and JFP (includes NHS Provider/Provider Collaborative representatives, Champs Public Health Collaborative and ICS Programme Leads).

- Week of 2nd May: A draft document was shared with partners, including Place Partnerships, Health and Wellbeing Board members and NHS providers for feedback. This includes the supporting content which will be available by clicking through from the JFP and contains detailed plans and content (180 pages in total).

- etween 22nd May - 30th June - Final draft JFP shared reflecting feedback and in a "designed format"
  - Health and Wellbeing Boards asked to review and provide a statement confirming their opinion as to whether the JFP includes the priorities from their Joint Health and Wellbeing Strategy
  - NHS providers to share with Board members, and with relevant colleagues internally, to provide sight of the document content and to ensure providers have a further opportunity to provide feedback
  - ICB Board asked to approve publication of JFP (29th June)

- 30th June - Publish Final 2023-28 JFP on ICB website (and link from Provider websites).
  This will include the JFP (circa 30 pages) and "click through" links to the detailed content on plans relating to the specific content areas.

- 31st March 2024 – Updated JFP published for 2024-2029

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Sefton

The Sefton Partnership plan sets out our objectives and how we will work together to deliver improved health outcomes for local people over the next two years.
We have adopted a collaborative approach to developing our plan, working with all our partners to gain their unique knowledge, learning and experience from working with local people. We have embraced the Partnership's collaboration agreement principles, which centre on working together so that we can:

- Achieve financial sustainability
- Deliver person-centred care
- Act ethically at all times - being open
- Act as one - focusing on outcomes
- Invest in innovation and creativity
- Act based on evidence and a structured framework

Our plan supports delivery of the health and wellbeing strategy, Living Well in Sefton. We share a single vision, namely that Sefton will be:

"*A confident and connected borough that offers the things we all need to start, live and age well, where everyone has a fair chance of a positive and healthier future*"

Our plan sets out our objectives across the life-course, starting from pregnancy and continuing right through to supporting those who are nearing the end of their life. The service areas included under each life-course stage have been identified based on their being (i) included within the national planning guidance, (ii) part of the JFP requirements or (iii) a local Sefton priority.

Start Well:	Live Well:	Age Well:	All Age:
1. Children & Young People 2. Early Years 3. Maternity	4. Cancer 5. Complex Lives 6. Diagnostics 7. Learning Disabilities & Autism 8. Long Term Conditions 9. Mental Health 10. Planned Care	12. Community Services 13. Dementia 14. Urgent & Emergency Care	15. Carers 16. Obesity 17. Palliative & End of Life Care 18. Primary Care

	11. Women's Health		

In order to realise our vision and deliver our objectives, we have identified three cross-cutting themes:

1 Reducing health inequalities: We recognise there are stark differences in the quality and length of life across Sefton and that we need to work together to prioritise those who stand to gain the most.

2 Service transformation: We know our provider partners are under increasing pressure and that we have to radically transform how we deliver services to local people.

3 Community first: We recognise our communities have a vital role in improving their health and wellbeing and we are committed to working with them and co-producing solutions together.

Delivery will, in turn, be supported by a series of enabler functions that include:

- Clinical and Care Leadership
- Communications and Engagement
- Digital
- Estates
- Medicines Optimisation
- Organisational Development
- Population Health Management

We have a shared commitment to adopting a "whole population, whole partnership" approach given that we know health and life chances are impacted by a wide range of factors. We therefore recognise that we will only achieve our objectives by strengthening how we work together as a Partnership over the next two years.

Link to Local Plan (Note: Links to local plans to be added as they are published.)

Report to:	Health and Wellbeing Board	**Date of Meeting:**	7th June 2023
Subject:	Special Educational Needs and Disabilities Joint Commissioning Plan 2023 – 2026		
Report of:	Executive Director of Children's Social Care and Education and Executive Director for Adult Social Care and Health/NHS Place Director	**Wards Affected:**	(All Wards);
Portfolio:	Cabinet Member for Children's Social Care Cabinet Member for Education		
Is this a Key Decision:	No	**Included in Forward Plan:**	No
Exempt / Confidential Report:	No		

Summary:

A report to present the Special Educational Needs and Disabilities (SEND) Joint Commissioning Plan for 2023 – 2026. Detailing the process of development and highlight the key points.

Recommendation(s):

(1) Members are asked to review and endorse the adoption of the Strategy

Reasons for the Recommendation(s):

It is a statutory requirement under the Children- and Families Act 2014 to have a defined Joint Commissioning Strategy.

Alternative Options Considered and Rejected: (including any Risk Implications)

N/A

What will it cost and how will it be financed?

(A) Revenue Costs

The contents of the report do not constitute additional revenue costs

(B) Capital Costs

The contents of the report do not constitute additional revenue costs

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):

Legal Implications:

Children and Families Act 2014

Equality Implications:

There are no equality implications.

Impact on Children and Young People: Yes

The report details the strategic approach to the Joint Commissioning of services for Children and Young People with Special Educational Needs and Disabilities.

Climate Emergency Implications:

The recommendations within this report will

Have a positive impact	No
Have a neutral impact	Yes
Have a negative impact	No
The Author has undertaken the Climate Emergency training for report authors	Yes

The contents of the report represent a neutral impact on the climate emergency

Contribution to the Council's Core Purpose:

Protect the most vulnerable: The Strategy will deliver improved services for Children and Young People with Special Educational Needs and Disabilities
Facilitate confident and resilient communities: The Strategy seeks to deliver comprehensive offer of support which is accessible in our local community.
Commission, broker and provide core services: The Strategy directly details how we will commission services in this area
Place – leadership and influencer: Sets out ambition to drive improvement in this area
Drivers of change and reform: The Strategy is a key piece of work for the SEND Continuous Improvement Board.

Facilitate sustainable economic prosperity: N/A
Greater income for social investment: N/A
Cleaner Greener N/A

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD.7251/23) and the Chief Legal and Democratic Officer (LD.5451/23) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

The Strategy has been developed with input from the SEND Continuous Improvement Board and Health and Wellbeing Board, and Sefton Parent Carer Forum.

Implementation Date for the Decision

Immediately following the Cabinet meeting.

Contact Officer:	Eleanor Moulton
Telephone Number:	Tel: 0151 934 2068
Email Address:	Eleanor.moulton@sefton.gov.uk

Appendices:

The following appendices are attached to this report:

The SEND Joint Commissioning Strategy 2023 – 2026
Plan on the Page

Background Papers:

There are no background papers available for inspection.

1. Introduction

1.1 The Children and Families Act places a legal duty on Local Authorities and NHS Place teams to secure services to meet the provision set out in individual EHC Plans.

1.2 This means that NHS Place Team and the Local Authority will work together to ensure the full integration of special educational needs and disabilities (SEND) provision across education, health and care and strengthen the principles of joint

planning and commissioning of services as set out in the Children and Families Act 2014, including those that will:

- improve the identification of needs
- support and develop further joint commissioning arrangements between the Cheshire and Merseyside Integrated Care Board, Sefton Pace, the Local Authority and Public Health
- build on work already undertaken in the joint health and wellbeing strategy
- support the creation of a draft joint commissioning strategy

1.3 The Children and Families Act requires the Local Authority and its partner NHS Place Team to act consistently with the joint commissioning arrangements, to keep arrangements under review and to update them.

1.4 Joint commissioning strategies will consider the whole system challenges of personalisation, personal budgets and resource allocation. In addition to this, strategic, costed and evidence-based decisions about early intervention will be identified to ensure shared outcomes. To this end the Local Authority and NHs Place Teams are working together to review current provision within children's services. Current provision will be compared to the needs identified in the Joint Strategic Needs Assessment (JSNA) and we will then explore opportunities to commission services jointly.

1.5 Ultimately, the joint commissioning arrangements and strategy will ensure that the Local Authority and the NHS Place Team are able to secure education, health and care provision for all children and young people who have special educational needs and disabilities, including those who have an Education, Health and Care Plan

2. Process of development

The report presents to Cabinet/health and Wellbeing Board a SEND Joint Commissioning Strategy for 2023 – 2026 the following steps have been taken in creating this document.

- Consideration of other key strategies including Education Excellence, the Children and Young Peoples plan and the Emotional Health and Wellbeing Strategy.
- A detailed review of the last 4 years of Parent Carer Surveys
- A comprehensive audit of the previous Startegy which ran from 2020 -2023. This identified the completed actions and brought forward anything that needed further work
- Consideration of national best practice and local need recorded through the Joint Strategic Needs Assessment

3. Key points

The Startegy ultimately seeks to ensure that Sefton's Special Educational Needs and Disabilities (SEND) offer enhances the experience and outcomes for children and young people, our focus is on co-production and collaboration to provide good

quality services, to achieve good outcomes for the children, young people, and families we serve.

It highlights 4 priorities.

1. High aspirations for all our children and young people
2. A comprehensive offer of support which is accessible in our local community.
3. The opportunity to provide support at the earliest opportunity.
4. To work with families and young people to maximise choice and control

These will be delivered through a delivery plan summarized as follows:

Outcomes & Actions	Priority 1	Priority 2	Priority 3	Priority 4
Delivery of the Delivering Better Value (DBV) Programme including Diagnostic Case Reviews and development of a DBV Action Plan for June 2023	X		X	X
Consider the social care needs of families when developing SEND services and pathways by recruiting a Designated Social Care Officer (DSCO)	X		X	X
Increase choice and control for those with complex health needs via Personalisation or Personal Health Budgets, utilising a partnership approach in the delivery of services. Actions will include developing a 18-25 diagnostic pathway and a graduated neurodevelopmental approach, reviewing OT sensory services and the development and implementation of shared care pathways.	X	X	X	X
Improved access to Early language and communication support tools including Speech and Language Therapy support, advice and assessment if specialist support required.	X	X	X	
Improved awareness of SEND amongst workforce including the continued promotion of the Local Offer and enhanced staff training.	X		X	
Increase accessibility of information for SEND through the creation of an information helpline hosted on Integrated Front Doors.	X		X	X
Improved access to timely and efficient mental health support through investing to support access and improve waiting times.	X	X	X	X
Embedding Technology Enabled Care (TEC) to secure the best outcomes for those with SEND through rollout of training to all staff; evaluation of the Brain in Hand pilot, workshop planning for the Sefton Youth Conference and raising awareness internally of TEC.	X	X	X	X
Partnership approach to service delivery including implementing the NW Framework SEND Purchasing systems.	X		X	
Enhancing provision of SEND services and groups first by mapping existing resources and	X		X	

Outcomes & Actions	Priority 1	Priority 2	Priority 3	Priority 4
reviewing best practice and producing a snap shot tool				
Committing to continually improving the SENDIASS offer by improving our delivery models to ensure sufficient capacity and impartiality by supporting continuous improvement through monitoring.	X		X	
Working across Health and Adult Social Care to review and ensure contract compliance and quality assurance across SEND contracts.	X		X	
Develop a joint outcomes framework and shared approach to needs assessment in the interest of continuous improvement and transparency.	X		X	
Adapting our strategic approach to understand educational sufficiency and its current pressures per the Delivering Better Value Programme, going on to deliver Sefton's Education Strategy via a delivery plan.	X	X	X	

4. Next Steps

4.1 The Strategy reinforces our committee to co-production and we will go on to develop a joint outcomes framework and shared approach to needs assessment in the interest of continuous improvement and transparency. Working with the Sefton Parent Carer forum to ensure we prioritise what matters most to them and those Children and Young People with special educational needs and disabilities in Sefton.

4.2 We commit to producing an easy read version to support accessibility to the Strategy.

4.3 We will re convene a Joint Commissioning group as a subgroup of the SEND Continuous Improvement board to action the delivery. This group will be made up of key stakeholders across Education, Social Care and Health and ensure representation for the Parent Carer forum and children and young people themselves. This will include ensuring an appropriate and sustainable resource is allocated.

5. Conclusion

This comprehensive Strategy has been developed with the intention to make a real and lasting difference to our Children and Young People. We ask members to consider its content, provider any comment and consider their endorsement to adopt the Strategy.

Sefton Council

Report to:	Health and Wellbeing	**Date of Meeting**	7 June 2023
Subject:	Merseyside Child Death Overview Panel and Isle of Man Annual Report		
Report of:	Child Death Overview Panel – Merseyside	**Wards Affected:**	All Wards
This Report Contains Exempt / Confidential Information	No		
Contact Officer:	Margaret Jones – Director of Public Health, Sefton Council		
Email:	margaret.jones@sefton.gov.uk		

Purpose / Summary of Report:

There is a legal requirement for the statutory partners to make arrangements to carry out child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), or equivalent, to review the deaths (excluding infants live-born following planned, legal terminations of pregnancy, and stillbirths) of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children. The focus of CDOP should be on identifying any modifiable factors that may help prevent unnecessary future child deaths or harm. Sefton Council is responsible for reviewing child deaths within Sefton.

Recommendation(s): That

(1) the Board notes the contents of the report; and
(2) the Board discusses/suggests joint actions that can be taken to prevent child death.

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Merseyside Child Death Overview Panel and Isle of Man Annual Report

1st April 2021 – 31st March 2022

Foreword

This is my sixth report as Independent Chair for the Merseyside CDOP and reflects another historical year in which we have had to deal with the pressures of the Covid pandemic, with a series of restrictions which left an impact on all partners involved in child death reviews. Inevitable there have been some impacts on the processes leading to some delays, particularly those involving coroners' inquests and neonatal deaths.

At the time of writing, the NHS is in the midst of a major reorganization which will see the disappearance of CCGs and the emergence of Integrated Care Boards/systems; local government facing severe financial challenges; and local communities facing inflationary pressures due to rising energy costs. We need to ensure that despite these challenges, the child death review processes remain robust, with the appropriate oversight, to ensure that we maximise the opportunity to learn from every child death and reduce future risks.

I would like to thank all the Panel members, for their continued commitment and hard work, and in particular to how they switched swiftly to virtual working, without compromising the quality of the panel meetings. I would also like to thank Irene Wright, Helen Fleming-Scott and Vicki Kinsley for the hard work that goes on behind the scenes to ensure that the Panel runs smoothly and keeps pace with the changing landscape.

Mike Leaf
Independent Chair
Merseyside CDOP
Autumn 2022

Section 1: Executive Summary

There is a legal requirement for the statutory partners to *make arrangements to carry out child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), or equivalent, to review the deaths (excluding infants live-born following planned, legal terminations of pregnancy, and stillbirths) of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children*. The focus of CDOP should be on identifying any modifiable factors that may help prevent unnecessary future child deaths or harm.

Across Merseyside, during 2021/22, responsibility for reviewing child deaths sat with the following:

- NHS Liverpool Clinical Commissioning Group (CCG)
- NHS Knowsley CCG
- NHS South Sefton CCG
- NHS Southport and Formby CCG
- NHS St Helens CCG
- NHS Wirral CCG
- Knowsley Borough Council
- Liverpool City Council
- Sefton Borough Council
- St Helens Borough Council
- Wirral Borough Council
- Isle of Man

It has been agreed as part of a MOU that Merseyside CDOP will:

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

The purpose of this Annual Report is to:

- Clarify and outline the processes adopted by the Merseyside CDOP
- Assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Merseyside, which meets national guidance
- Provide an overview of information on trends and patterns in child deaths reviewed across Merseyside during the last reporting year (2021/22)
- Highlight issues arising from the child deaths reviewed
- Report on achievements and progress from last year's annual report
- Make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across Merseyside

Achievements during 2021/22 (*Update from last year's priorities in italics)*

- ✓ Improve the quality and frequency of analysis forms from CDRM meetings
  Both the quality and content of feedback from CDRM meetings has improved since covid pressures began to ease, and in particular the numbers of analysis forms being received. There is still, however, much room for improvement. Merseyside is not an outlier as other CDOPs have found it challenging to ensure all relevant parties are involved and contribute.
- ✓ Re-evaluate the role of virtually held panels and meetings following the covid pandemic
  Whilst there were a mixture of views from various professionals, panel and business meetings have reverted to face to face meetings. The group will continue to keep this under review.
- ✓ Provide assurance that multi-agency partner strategies are in place to address modifiable factors
  A communication has been sent to all Chairs of the Health and Wellbeing Boards and Children's Safeguarding Partnerships requesting a clarification of what assurance they will be seeking to ensure that there is a coordinated strategic approach to addressing:
    - *Smoking in pregnancy and at the time of delivery (SATOD)*
    - *Substance misuse*
    - *Issues relating to high or low Body Mass Index (BMI) before pregnancy*
    - *Alcohol misuse*
    - Unsafe sleeping
- ✓ Improve information provision from GPs
  There has been an improvement in information being provided by GPs, although it recognised there is still a long way to go. Merseyside CDOP is not an outlier as many CDOPs up and down the country recognise this as an ongoing issue.
- ✓ Develop use of the Sentinel system for Isle of Man participants
  There have been personnel changes in IoM, and still needs to be developed.

In addition, CDOP has:

- ✓ Managed and maintained oversight of the Child Death Review processes during major disruption to services due to the global Covid 19 pandemic
- ✓ Engaged with other CDOPs across the NW and nationally, and sharing good practice e.g. Safe sleep messaging, preventing shaking baby (ICON)
- ✓ Circulated good practice, learning and tools across Merseyside e.g. seven minute briefings including new partners
- ✓ Ensured that exceptional care is recognised by writing to providers where care has gone beyond that which might be expected.
- ✓ Supported Trusts in developing robust child death review meetings (e.g. Perinatal mortality; hospital mortality; etc) to inform the CDOP process in a standardised/ structured manner
- ✓ Continued to collect data for Adverse Childhood Experiences (ACEs), and analyze patterns and links between ACEs and child deaths

Priorities for 2022/23 (some rolled over from previous year):

- ✓ Review the current processes with a purpose of identifying areas of improving effectiveness and efficiency
- ✓ Improve the quality and frequency of analysis forms from CDRM meetings
- ✓ Re-evaluate the role of virtually held panels and meetings following the covid pandemic
- ✓ Provide assurance that multi-agency partner strategies are in place to address modifiable factors
- ✓ Improve information provision from GPs
- ✓ Develop use of the Sentinel system for Isle of Man participants
- ✓ Re-establish a lay representative to panel meetings.
- ✓ Undertake a review of the CDOP and CDR arrangements, including appointment and development of a new CDOP Manager following retirement of existing staff

Summary of key points and themes (2020/21 figures in [brackets]):

<u>Knowsley (14 deaths reviewed)</u>

- 78.6% of deaths reviewed during 2021-22 were completed within 12 months [45.5%]
- 75% of deaths were expected [84.6%]
- 85.7% of deaths were children under 1 year of age [72.7%]
- 50% of deaths had modifiable factors identified [36.4%]

Most prevalent modifiable factors (greater than one) included: Maternal BMI; Smoking/smoking in pregnancy; Alcohol/substance abuse; Domestic abuse/violence

<u>Liverpool (43 deaths reviewed)</u>

- 65.1% of deaths reviewed during 2021/22 were completed within 12 months [68.2%]
- 52% of deaths were expected [82.1%]
- 72.1% of deaths were children under 1 year of age [77.3%]
- 44.2% of deaths had modifiable factors identified [68.2%]

Most prevalent modifiable factors included: Service issues; Maternal BMI; Smoking/smoking in pregnancy; Alcohol/substance abuse; Engagement with health services; Domestic abuse/violence; Unsafe Sleeping; Housing/home conditions; Maternal health

Sefton (13 deaths reviewed)

- 61.5% of deaths reviewed during 2021-22 were completed within 12 months [70%]
- 68% of deaths were expected [100%]
- 53.8% of deaths were children under 1 year of age [65%]
- 38.5% of deaths had modifiable factors identified [35%]

Most prevalent modifiable factors included: Maternal BMI; Smoking/smoking in pregnancy; Unsafe Sleeping

St Helens (5 deaths reviewed)

- 20% of deaths reviewed during 2021/22 were completed within 12 months [80%]
- 71% of deaths were expected [100%]
- 80% of deaths were of children under 1 year of age [30%]
- 60% of deaths had modifiable factors identified [20%]

Most prevalent modifiable factors included: Service issues; Maternal BMI

Wirral (12 deaths reviewed)

- 58.3% of deaths reviewed during 2021/22 were completed within 12 months [69.2%]
- 71% of deaths were expected [42.9%]
- 83.3% of deaths were children under 1 year of age [53.8%]
- 33.3% of deaths had modifiable factors identified [23.1%]

Most prevalent modifiable factors included: Neglect; Unsafe Sleeping; Housing/home conditions

Merseyside (91 deaths reviewed including IoM)

- 61.5% of deaths reviewed during 2021/22 were completed within 12 months [66.7%]
- 68.3% of deaths were expected [80%]
- 72.5% of deaths were of children under 1 year of age [63.2%]
- 42.9% of deaths had modifiable factors identified [39.7%]

The most frequently occurring modifiable factors in ranked order include:

  - *Service issues (19%) [22%]*
  - *Maternal Body Mass Index BMI (15%) [4%]*
  - *Smoking/smoking in pregnancy (15%) [6%]*
  - *Alcohol/substance abuse (11%) [22%]*
  - *Engagement with health services (11%) [0%]*
  - *Domestic abuse/violence (8%) [4%]*
  - *Neglect (5%) [3%]*
  - *Unsafe Sleeping (5%) [4%]*
  - *Housing/home conditions (4%) [0%]*
  - *Physical environment (4%) [0%]*
  - *Maternal health (3%) [0%]*
  - *Mental health (1%) [5%]*

There has been a marked increase in the proportion of reviewed cases that have modifiable factors that were identified at panel with the information provided.

There were 4 deaths reviewed in the Isle of Man.

Recommendations for Strategic Partners

Local Safeguarding and Health and Wellbeing partners are asked to:

1. Note the contents of this annual report, and note that Merseyside has robust processes for oversight and undertaking child death reviews;
2. Continue to assure themselves that through the various strategic partnerships that there is an adequate coordinated approach to reducing:

    - Smoking in pregnancy and at the time of delivery (SATOD)
    - Substance misuse
    - Issues relating to high or low Body Mass Index (BMI) before pregnancy
    - Alcohol misuse
    - Unsafe sleeping

Section 2: Overview and Processes

CDOP Membership
Merseyside CDOP has a core membership of:

- Independent CDOP Chair
- CDOP Manager & Administrator
- Children's Social Care/Safeguarding Manager
- Merseyside Police
- Education
- Public Health
- Consultant Paediatricians
- Lay Members
- Legal Services
- Named GPs
- Mental Health Trust
- Local Children's Safeguarding Partnership representative
- Safeguarding Nurse/Named Nurse
- Designated Nurses
- Consultant Neonatologists
- Consultant Obstetrician

Other members can be co-opted as and when necessary.

Dedicated agency representatives were identified to ensure consistency between panel meetings. A Memorandum of Understanding has been compiled and incorporates the terms of reference and membership.

Lay Membership

Previously CDOP had Lay member participation in non-neonatal meetings from Liverpool and Sefton LSCPs and an ex CDOP member. Since the start of the Covid pandemic, CDOP has not had any Lay membership. During 2022-23, we will endeavour to re-establish this arrangement.

Frequency of Meetings

CDOP operates 3 types of meeting: neonatal panel (0-27 days); non-neonatal panel (28 days up to 18 years); and a business meeting. It is planned that there will be four meetings of each type per year.

Agency Representation at Meetings

There is a consistent membership for both neonatal and non-neonatal processes to promote greater collective memory and the advantages of a dedicated membership. Membership will be continually reviewed to ensure that there continues to be representation from all professional perspectives and geographies. The Business meeting continues to develop a more strategic focus and will ensure that it receives the input from relevant organisations. The transition group established to oversee the transition to the new Child Death Review processes continues to meet and provides senior level involvement.

Notification Process

The notification process via paediatric liaison and hospital/hospice staff continues to function well. The contact for this within the Isle of Man at present is a public health officer. The ability to cross-reference with information received through the Registrars and Coroner's Officers, has led to identification of some child deaths not reported through the expected route.

When Merseyside child deaths occur out of area, CDOP has sometimes been notified by hospitals and CDOP contacts out of the area, as well as Merseyside agencies. This continues to demonstrate good communication between local organisations and CDOP within Merseyside.

SUDiC Implementation Group

The CDOP Manager and Administrator remain involved with the SUDiC Implementation Group meetings as chair and administrator respectively. Feedback from the SUDiC Implementation Group is now a standing item on the CDOP business meeting agenda.

Links to Coroners and Registrars

There continues to be an excellent working relationship with the Coroners for Liverpool and Wirral and the Coroner for Knowsley, Sefton and St Helens within Merseyside, as well as good engagement with Merseyside Registrars. This enables issues and queries from both perspectives to clarified and resolved in a timely manner.

Deaths of Children Living Outside Merseyside

104 child deaths were reported to Merseyside CDOP regarding children who had died in this area with some having lived in areas external to Merseyside. Notification of the death of a child who

lives outside of Merseyside is securely e-mailed to the respective CDOP contact for the Local Authority area within 24 hours, or as soon as practically possible.

Communicating with Parents, Families and Carers

The Merseyside CDOP leaflet, 'What we have to do when a child dies' is distributed by the registrars to families, along with a list of support resources to enable them to exercise some choice if they want to pursue bereavement support. Many will already have had contact with bereavement support resources through the hospitals, but the opportunity to access alternative/additional support is enabled through the provision of this information.

When a Child Dies – A Guide for Parents and Carers is a newly compiled leaflet and should be provided to all bereaved families or carers: https://www.lullabytrust.org.uk/wp-content/uploads/parent-leaflet-child-death-review.pdf The leaflet provides a detailed explanation of many of the processes associated with a child's death and remains available on LOCAL AUTHORITY and NHS Trust websites.

Deaths involving Child Safeguarding Practice Reviews/Critical Incident Reviews/North-West Neonatal Network.

Child deaths are considered at panel once all relevant investigations and reports have been completed. These include deaths that have been the subject of a child safeguarding practice review (previously a serious case review (SCR)), critical incident reviews or any learning review. This approach is consistent with that undertaken across the north-west and much of England. This may, on occasions, result in a delay between notification and completion that exceeds the specified six month timescale, CDOP will continue to monitor this process. During the Covid 19 pandemic, there have been delays to this process, and whilst there have been some improvements, delays continue to be a feature. Referral pathways have been developed.

Transition Group

Meetings with senior representatives from Childrens Safeguarding (DCS), public health (DPH), NHS (Director of Nursing) and the CDOP team was established in 2018 to initially oversee transition of CDOP from Local Childrens Safeguarding Boards in light of new guidance. Issues discussed include the development of a job description for a Merseyside Designated Doctor for Child Deaths.

Regional/National Links/ Updates:

North-West meetings

Merseyside CDOP continues to be represented at the North-West CDOP meetings. During the Covid 19 pandemic, it has not been possible to secure the required public health analytical support to produce the usual annual report for the NW, which Merseyside CDOP contributes to. It is envisaged that the annual report will be re-constituted once the covid pressures are resolved. At the time of writing Covid rates were significantly high.

National Network

Merseyside CDOP forms part of the National Network group that advised on issues of national interest, and the Manager remains a member of the Executive Committee. Issues such as themed reviews and reviewing out of area child deaths will be explored at the national network. This has not met through the pandemic.

National Database Development Project

Data collected by the National Database is now being collated and is released on a quarterly basis, with the second annual set of data released for 2021/22 included in this Merseyside CDOP annual report for the third time.

Funding

Contributions

The proportion of funding that each area contributes from Public Health funds, calculated using a formula linked to the population numbers of under 18 year olds and is based upon the amount needed to cover the two key support posts and running costs. The Local Authority contributions (including the Isle of Man) provide a budget for campaigns and contribute to the running costs. The amounts for contributions for 2021-22 were agreed at the rate from previous years:

FINANCE

Income

	Knowsley	**Liverpool**	**Sefton**	**St Helens**	**Wirral**	**IoM - total**
PH contribution - £	7,076	20,069	11,468	7,869	14,518	10,246
CCG contribution		*£61k – split between all Merseyside CCGs				

*Liverpool CCG pays the total amount then invoices the respective areas

Expenditure

- Salaries: inclusive of on-costs
  - Independent Chair: £11,364.84
  - CDOP Manager: £63,673.43
  - Admin 1: £19,676.72
  - Admin 2: £8,601.17
- £9.62 – IT equipment
- £31.80 – stationery
- £161.00 – Life Bank room booking and refreshments

Table 3: CDOP expenditure in 2021/22

Issues Identified

Missing Data
There is a statutory responsibility for agencies and professionals to provide information to CDOP, and this will form part of the oversight programme. There has been an improvement on the details provided on the forms, but the failure to record details of father/male household figures continue to be an issue in some cases. CDOP continues to flag these issues as they arise, and will be working through regional and national networks, to identify good practice from other areas.

GP Engagement
Like many other areas, CDOP is still experiencing a lack of information from GPs upon request, although there is evidence that this is improving. Through safeguarding leads CDOP aims to improve these processes.

Covid Issues
Inevitably, the Covid 19 pandemic has had an impact on deaths. These include:

- Delays in accessing services
- Missed opportunities to view the home by professionals e.g. where baby sleeps, bonding
- Children learning remotely therefore not being seen by agencies

The National Child Mortality Database is informed of all deaths where covid may have been an issue and will produce a report in due course.

Service Issues
Invariably, as the majority of cases die in hospital, service issues continue to be picked up during reviews carried out prior to and at CDOP panel. These issues will be fed back to individual organizations where organizational learning is needed, or through established clinical networks e.g. maternity, paediatric, obstetric etc.

Modifiable Factors

A modifiable factor is one *which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths*. Overall, the modifiable factors identified for Merseyside, and ranked in terms of frequency are:

- Service issues (19%) [22%]
- Maternal Body Mass Index BMI (15%) [4%]
- Smoking/smoking in pregnancy (15%) [6%]
- Alcohol/substance abuse (11%) [22%]
- Engagement with health services (11%) [0%]
- Domestic abuse/violence (8%) [4%]
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- Housing/home conditions (4%) [0%]
- Physical environment (4%) [0%]
- Maternal health (3%) [0%]
- Mental health (1%) [5%]

In addition to the modifiable factors identified, Merseyside CDOP is made aware of any outcomes from Child Safeguarding Practice Reviews, single and multi-agency reviews and internal review processes that occur within agencies. In these circumstances implementation of any action to address the modifiable factors, and the monitoring of the progress rests with the agency or agencies identified within the reports and the specific sub-group identified. On occasions, CDOP will flag issues up through regional and national networks where universal learning can be highlighted.

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Section 3: Data and Analysis

It should be noted that it is often difficult to make clear conclusions from analysing data from a relatively small number of cases reviewed each year. The learning from each individual case is noted at each CDOP meeting, with the appropriate action taken at that time. Merseyside's figures are amalgamated to other CDOP data across the NW to provide opportunities for identifying more reliable trends.

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

(a) Trends

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

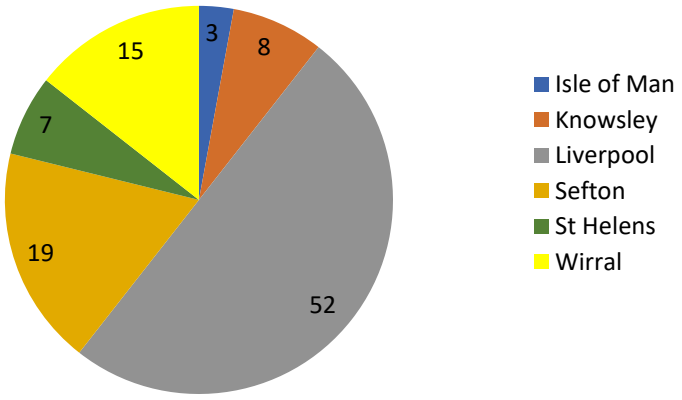
Child death notifications over time

Number of Deaths

Figure 1 shows the numbers and percentage split of the numbers of notified deaths.

During the reporting period 1st April 2021 to 31st March 2022, 104 child deaths were notified to CDOP across the five Local Authority areas (See Figure 1) and 3 for the Isle of Man (IoM). This is an 18% increase on the previous year. At the end of 2021/22 there were 109 child deaths outstanding which had not yet been considered by CDOP. Many of these were subject to additional processes including inquests, criminal processes, post-mortem, and internal review processes such as Serious Incident Reviews. Seven CDOP meetings were held during the year.

Figure 1: Total number of child deaths occuring in 2021-22



The “Heat map” in Figure 2 shows the relative locations of all notified deaths throughout Merseyside 2021-22, and the areas of greatest concentrations. (The Isle of Man figures are not included in the heat map in view of the small numbers which might be identifiable.)

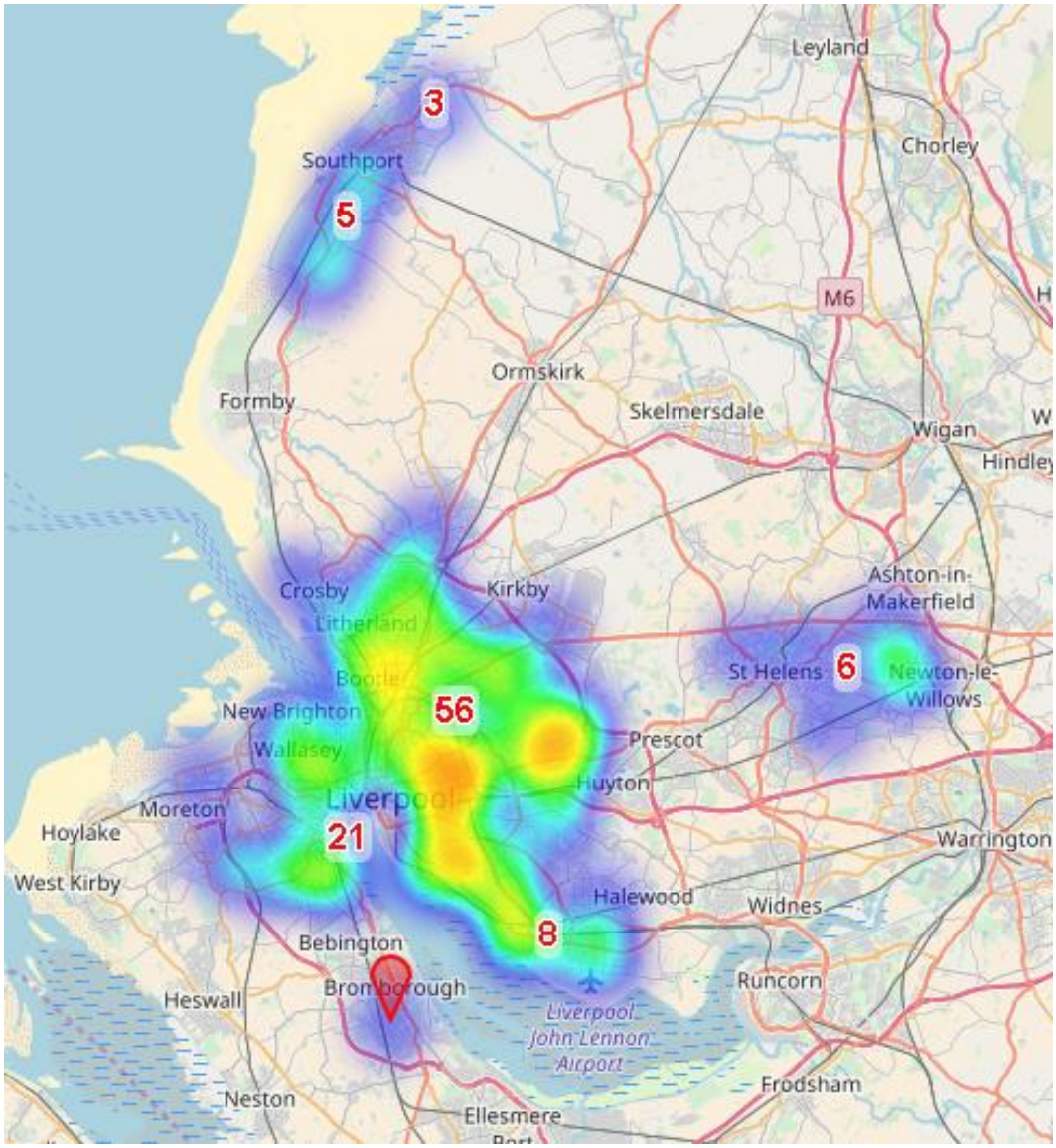
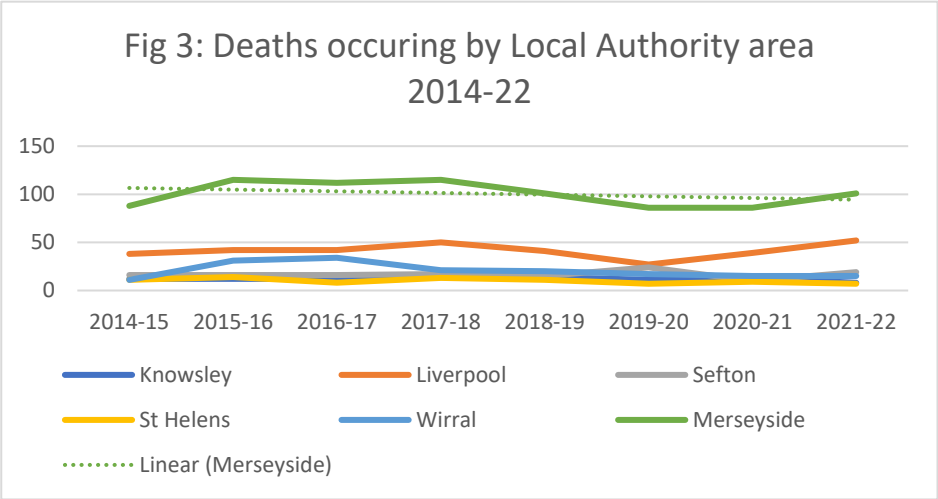


Figure 2

Figure 3 below shows the pattern of child death notifications over this period, for each of the Local Authority areas. One can see that the trend across Merseyside has decreased only slightly. In view of the relatively small number of notifications in the IOM, it is not possible to map the IOM deaths at this time as they may be identifiable.



Child Population

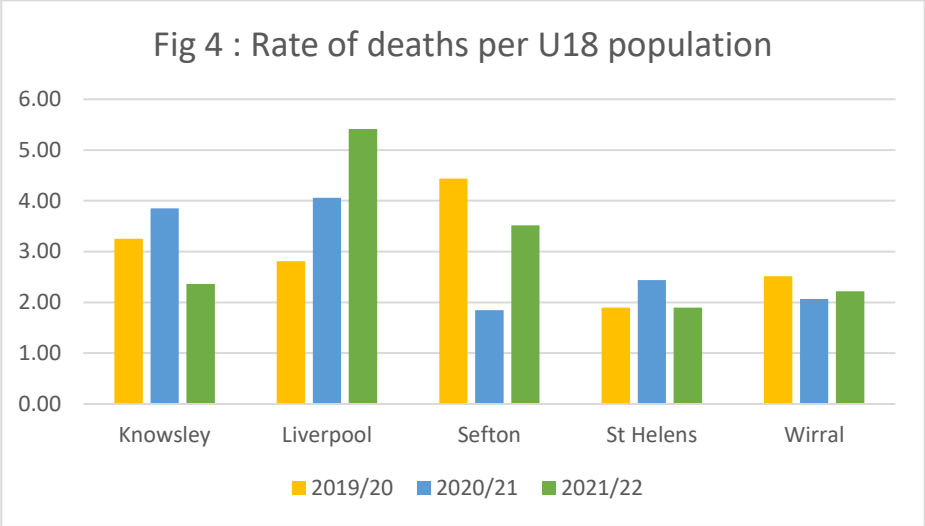
When considering relatively small numbers of deaths amongst the five Local Authority areas across Merseyside, it is appropriate to also consider the U18 population from each area and consider the rate per U18 population.

Local Authority Area	Total Population	U18 Population	U18 year olds as % of total
Knowsley	148,560	33,802	22.8%
Liverpool	491,549	96,052	19.5%
Sefton	274,589	54,057	19.7%
St Helens	179,331	36,868	20.6%
Wirral	322,796	67,508	20.9%
Total for Merseyside	1,416,825	288,287	20.3%

Table 4: Child population for Merseyside areas
Source: 2019 Mid-Year Population Estimates – Office of National Statistics (ONS)

Normally, one would expect to see the numbers of deaths in each geography, to be proportionate to the number of under 18-year-olds living in each, but there may be differences according to deprivation levels for instance. Previous reports have highlighted the link between child deaths and Indices of Multiple Deprivation (IMD), where high IMD is linked to higher childhood mortality. This strong association continues across Merseyside and the NW.

Figure 4 below shows the rate of deaths per 10,000 U18 years population over the last three years. Latest figures show that Liverpool has the highest rate, with St Helens the lowest. Liverpool appears to have seen an increase in this rate over the last three years, although small numbers mean that there can be wide annual fluctuations.



Merseyside CDOP, along with other CDOPs across the NW has been collecting information on the presence of Adverse Childhood Experiences (ACEs) on each death reviewed at panel. Research into adverse childhood experiences (ACEs) consistently shows that a set of 10 adverse experiences in childhood are associated with an increased risk of poor health and other problems in later life. Fig 5a provides a summary of the presence of ACEs identified throughout the reporting year, irrespective of the cause of death, or whether the death was expected or not. Care must be taken in attributing ACEs to deaths directly from this preliminary analysis, despite links identified between ACEs during childhood and increased vulnerability in adulthood.

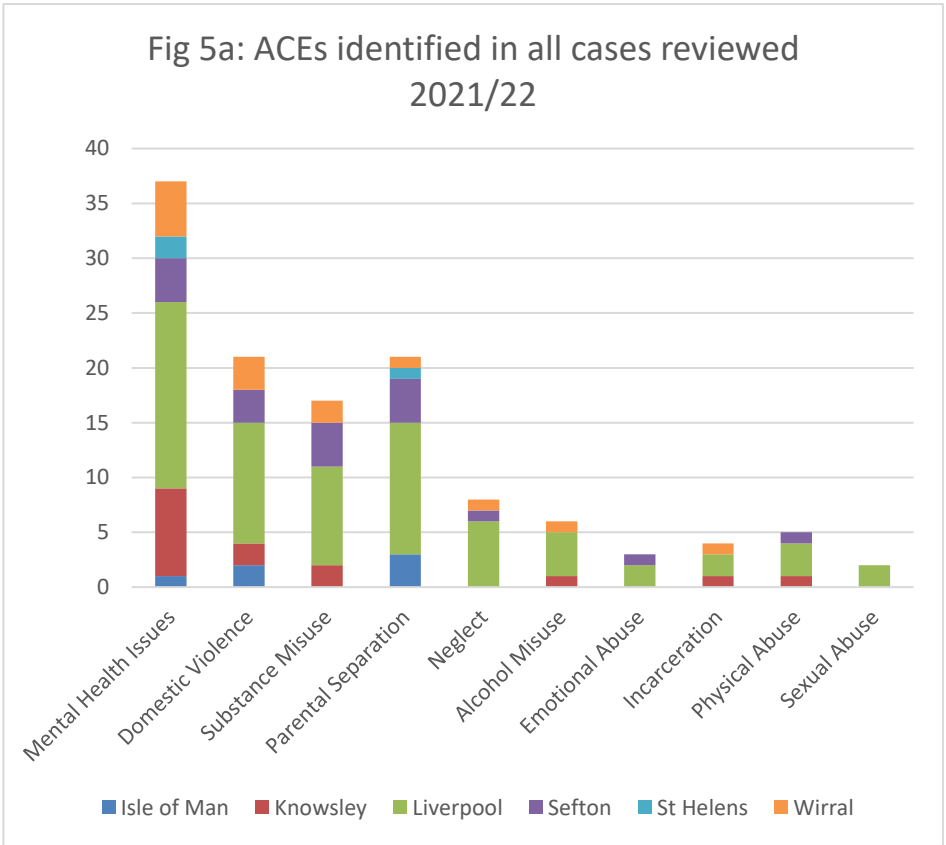
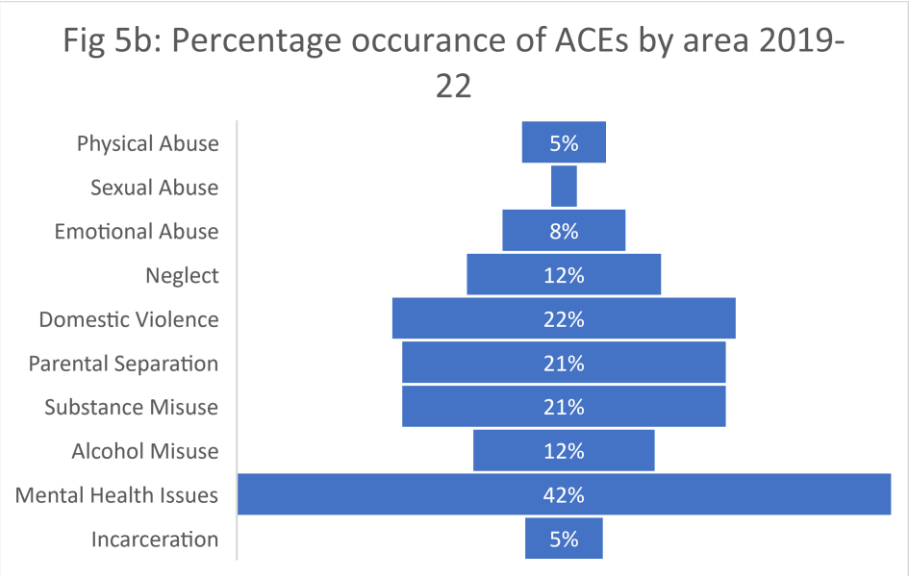


Figure 5b shows the occurrence of ACEs over the last three years for Merseyside as a percentage. The most common occurring ACEs include mental health issues, domestic violence, substance misuse and parental separation. What is clear is that the prevalence of ACEs amongst families where children have died appears high, although it is not clear without comparative data, whether this is any different to the general prevalence across Merseyside.



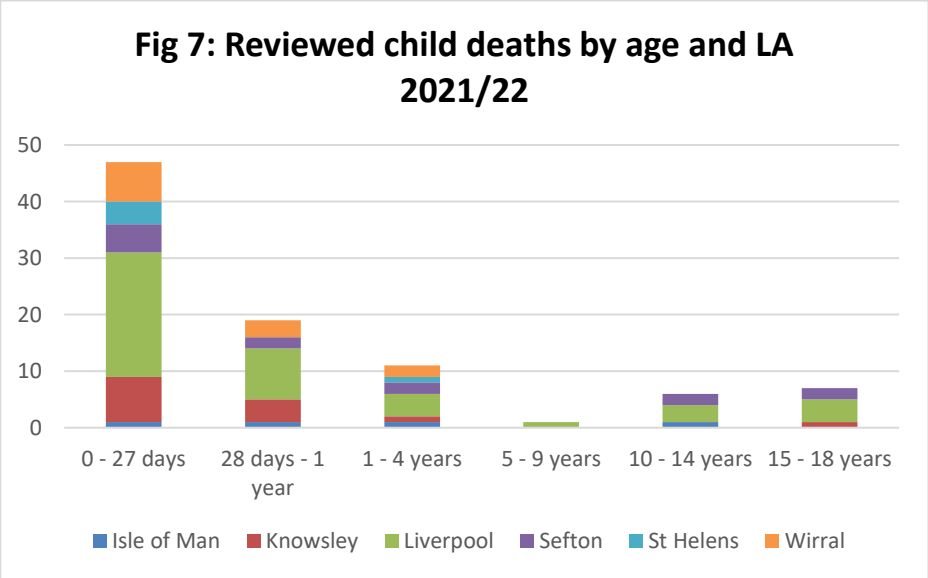
ACEs can have lasting, negative effects on health, well-being, as well as life opportunities such as education and job potential. These experiences can increase the risks of injury, sexually transmitted infections, maternal and child health problems (including teen pregnancy, pregnancy complications, and fetal death), involvement in sex trafficking, and a wide range of chronic diseases and leading causes of death such as cancer, diabetes, heart disease, and suicide.

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

The following narrative describes the various elements contained in Appendix I which is the third report from the NCMD. All tables described are included in Appendix I, with figures providing more nuanced outcomes included in the text below.

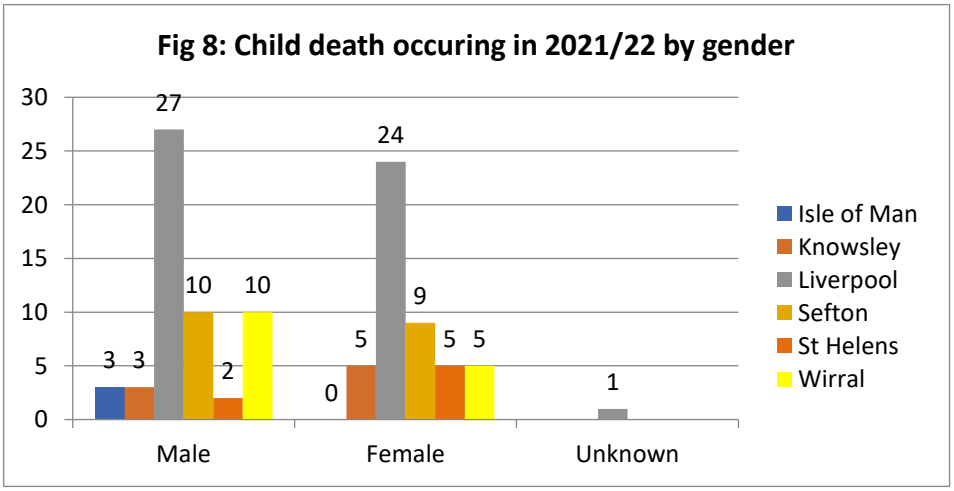
Deaths and Case Completions (Table A; Tables 1-4 – Appendix I)

There was a total of 104 deaths notified during the last year, and 91 cases closed (completed by CDOP including IoM). At 31st March 2022, 109 cases were ongoing. **Table 2** highlights the breakdown of closed and open cases by local authority area. Figure 7 shows how the Local Authority figures contribute to the age totals seen in Table 3. The number of closed/ open cases by age group covered in **Table 3** broadly reflects the expected distribution of deaths by age, with the majority occurring under the age of one year old. **Table 4** provides a breakdown of cases completed by local authority areas.

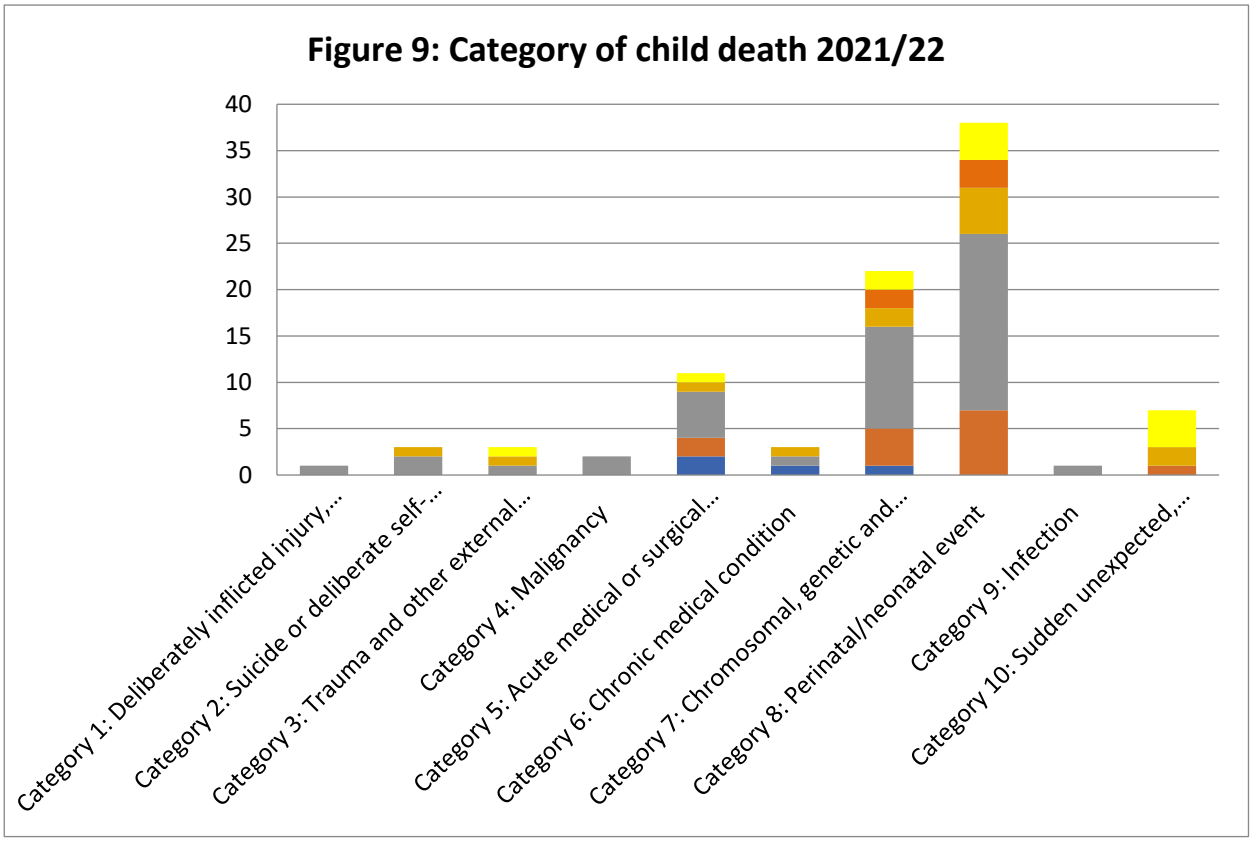


Deaths by Gender (Table 5)

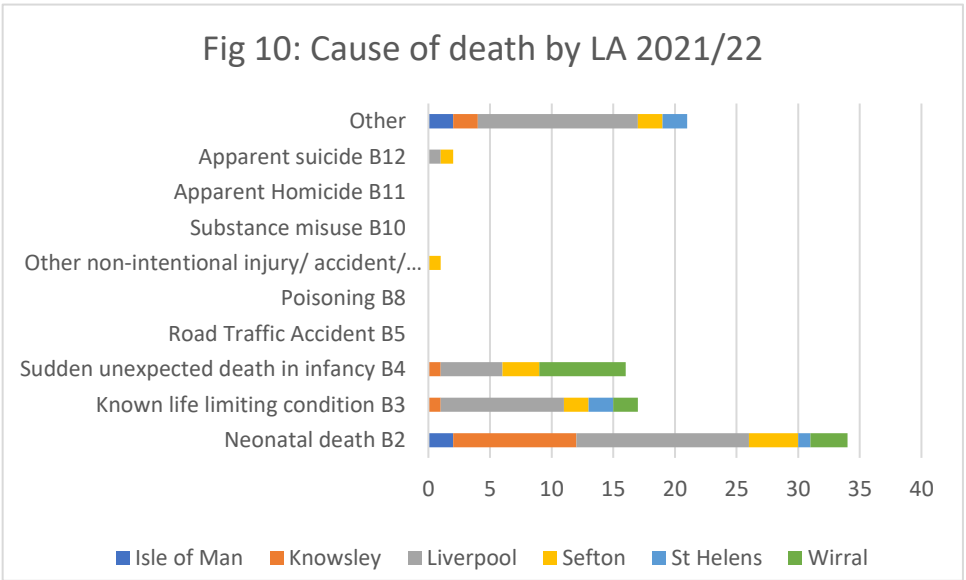
From April 2021 – March 2022 of the 91 child deaths reviewed by the CDOP, 48 were male (53%) and 43 (47%) were female. The breakdown by local authority is provided below in figure 8.



Completed reviews by primary category of death and by age (Tables 6-7)
The majority of all deaths (67%) [61.5%] had a cause associated with chromosomal, genetic, congenital anomaly or as a result perinatal/neonatal event **(Table 6)**, and 72.5% [62.8%] of all deaths occurring under the age of one year **(Table 7).** A full description of the categories of death are provided at Appendix II, and the breakdown by area is provided in Figure 9.

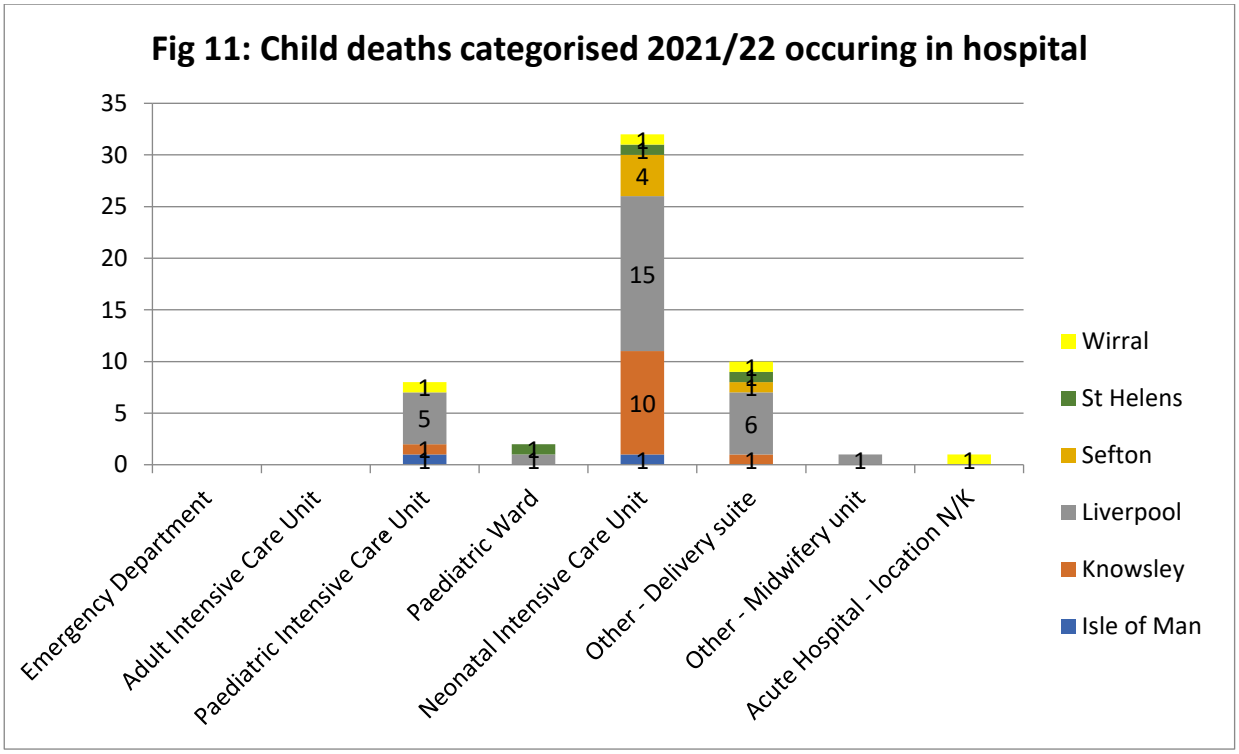


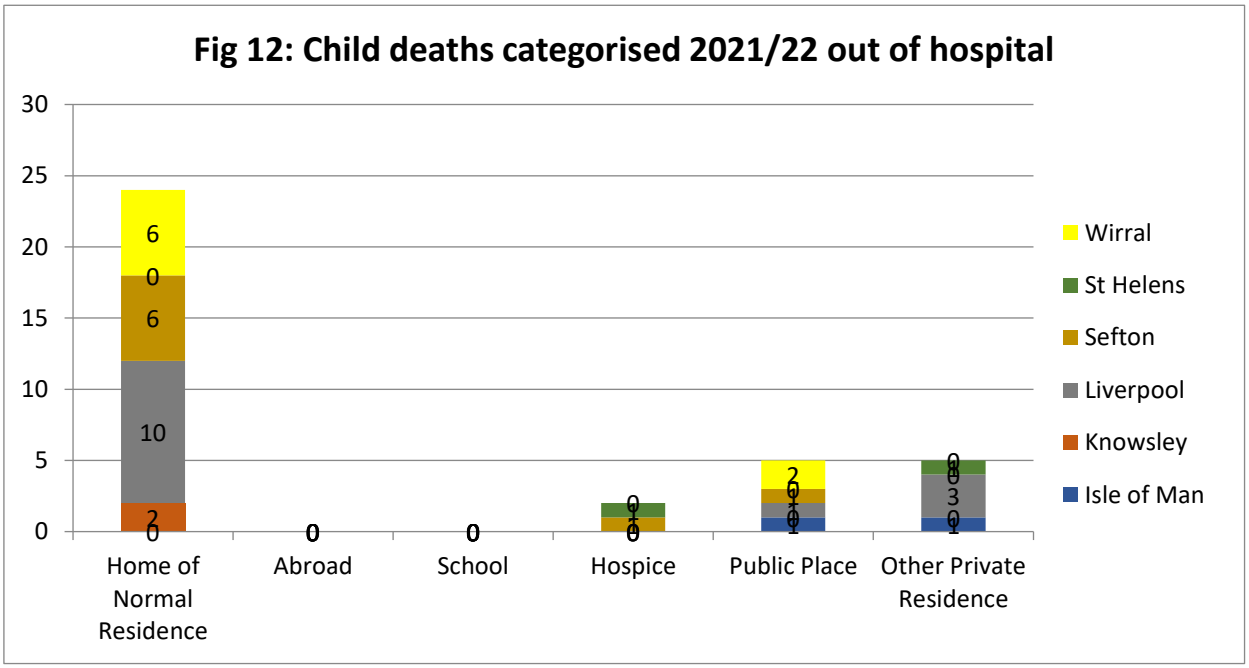
Causes of Child Death
Figure 10 shows the cause of death, with the largest proportion occurring neonatally, followed by a known life-limiting condition and Sudden Unexpected Deaths.



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

As one might expect, the majority of deaths occur within a hospital **(Table 8)** and of these who die in hospital, the majority die in the perinatal/neonatal/maternity/labour units. Fig 11 and Fig 12 shows the make-up of these figures both inside and outside the hospital setting, by Local Authority area. It highlights that the highest number of deaths occurring out of hospital occur in the home of normal residence, which includes children subject to palliative care plans as well as sudden deaths**.** With regard to palliative care the majority of family and child/ young person's wishes as to where they wanted to die were adhered to and, only in exceptional circumstances, for clinical reasons, was this not achieved. **Table 9** provides the breakdown of where the onset of illness or incident occurred, which is a new feature.

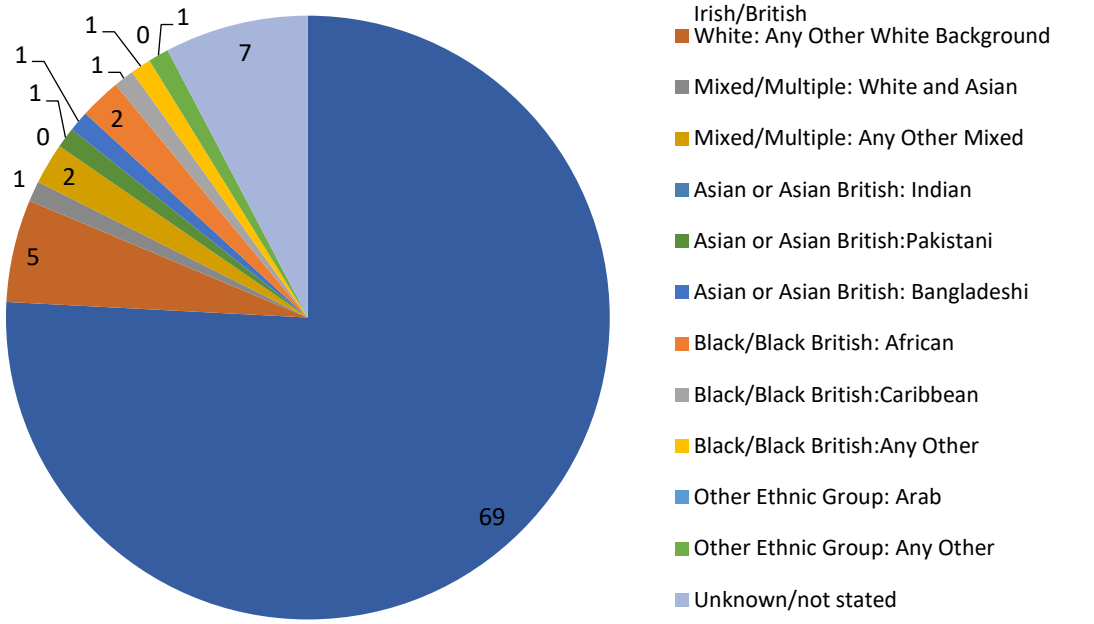




Ethnic groups and category of death (Tables 10-11)

61.5% (56) of those children who died where categorised as white, with 28% (26) having their ethnicity un-recorded **(Table 10).** CDOP will explore the reasons why so many cases do not contain ethnicity information. **Table 11** shows the primary category of death by ethnicity, although there appears to be no pattern in relation to category of death and ethnicity during one year. Fig 13 provides a population split by ethnicity.

Fig 13: Ethnicity of child deaths categorised 2021/22



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

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

It can be seen that from **Table 12**, 44% [40%] of cases reviewed (40) had modifiable factors identified, which is ***higher*** than the national average of 37%. Of these, 51% [59%] were linked to deaths under 28 days of age **(Table 14).** Fig 14 below shows the proportion of deaths where modifiable factors have been identified by Local Authority area.

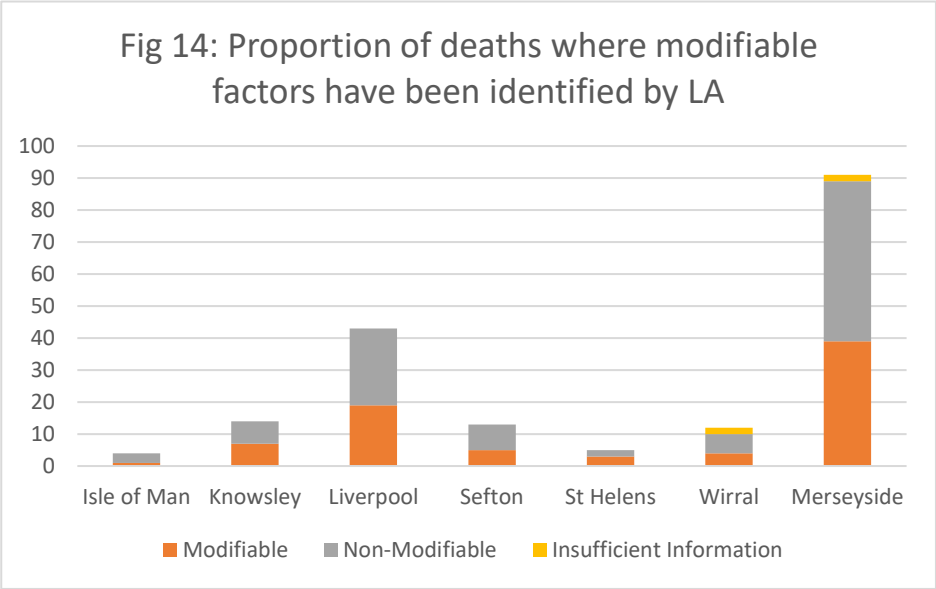
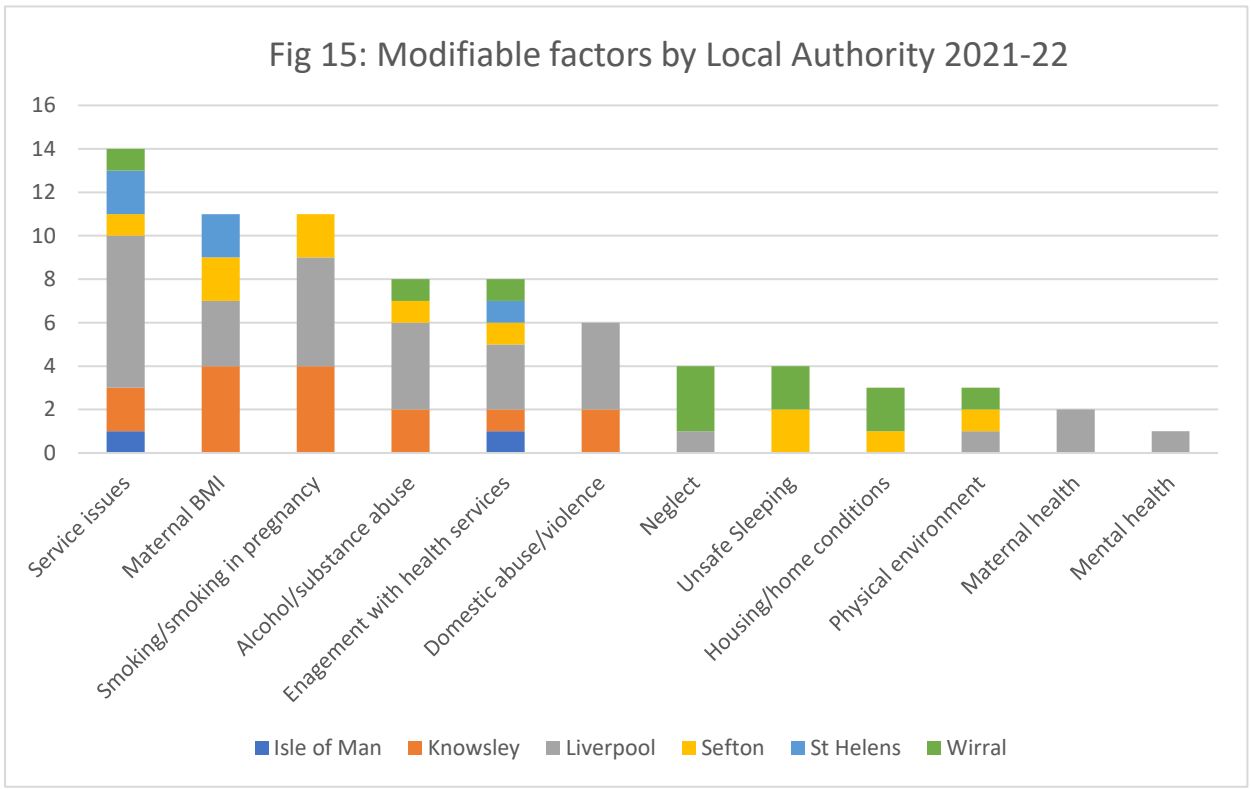


Table 13 shows the spread of modifiable factors across the category of death. 62% of the most common category (Perinatal/perinatal event) have modifiable factors. Fig 15 shows the modifiable factors identified for Merseyside as a percentage (%) [previous %] of all cases where modifiable factors were found:



Overall, the modifiable factors identified for Merseyside during 2021/22 (in order of prevalence) include:

- Service issues (19%) [22%]
- Maternal Body Mass Index BMI (15%) [4%]
- Smoking/smoking in pregnancy (15%) [6%]
- Alcohol/substance abuse (11%) [22%]
- Engagement with health services (11%) [0%]

- Domestic abuse/violence (8%) [4%]
- Neglect (5%) [3%]
- Unsafe Sleeping (5%) [4%]
- Housing/home conditions (4%) [0%]
- Physical environment (4%) [0%]
- Maternal health (3%) [0%]
- Mental health (1%) [5%]

Modifiable factors associated with Service issues remains the highest, partly due to the majority of deaths occurring in hospital, many before the age of one year old. Most of the learning from service issues are identified prior to coming to CDOP and are picked up through internal (and often external) reviews. Frequently, CDOP will identify additional learning that is fed back to individual services. Engagement with health services is likely to have been impacted by covid due to restrictions and anxieties regarding mixing.

Eleven cases reviewed identified maternal BMI as a modifiable factor, all of which were associated with perinatal/ neonatal events. BMI, smoking, alcohol, and substance misuse have a significant impacts on neonatal/ perinatal outcomes, as well as clinical care, which the NHS is leading. If we are to make a difference to the neonatal/ perinatal outcomes, we need to ensure that we have coordinated health and wellbeing as well as high quality clinical interventions. Representatives at CDOP panel have a responsibility to flag such issues up with their organisations and professional peers, but strategic partnerships e.g. Health and Wellbeing Boards and Childrens Safeguarding Partnerships should be assured that there are coordinated initiatives to reduce the impact of these factors. The CDOP annual report has flagged these issues in the past and this will be followed up.

Modifiable factors by ethnicity are shown in **(Table 15)**, but with such a significant proportion of ethnicity not being recorded, no conclusions can be made**.**

Death notifications (Tables 16 – 20)

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

Table 17 shows the number of Joint Agency Responses (JARs) undertaken. A JAR is a coordinated multi-agency response which is triggered if a child's death:

• is or could be due to external causes
• is sudden and there is no immediately apparent cause (including SUDI/C)
• occurs in custody, or where the child was detained under the Mental Health Act
• where the initial circumstances raise any suspicions that the death may not have been natural or
• in the case of a stillbirth where no healthcare professional was in attendance.

There has been a significant improvement in the number and percentage of death notifications where it was not clear whether a JAR had taken place, and CDOP will continue to monitor this to minimise this data gap. The Business Group will explore solutions to this.

Table 18 shows death notifications by month/age, where it can be seen that the highest number of notifications occurred in October, December, and February [July, September, and April], and this differs from the previous year when the top 3 months were October, January and March.

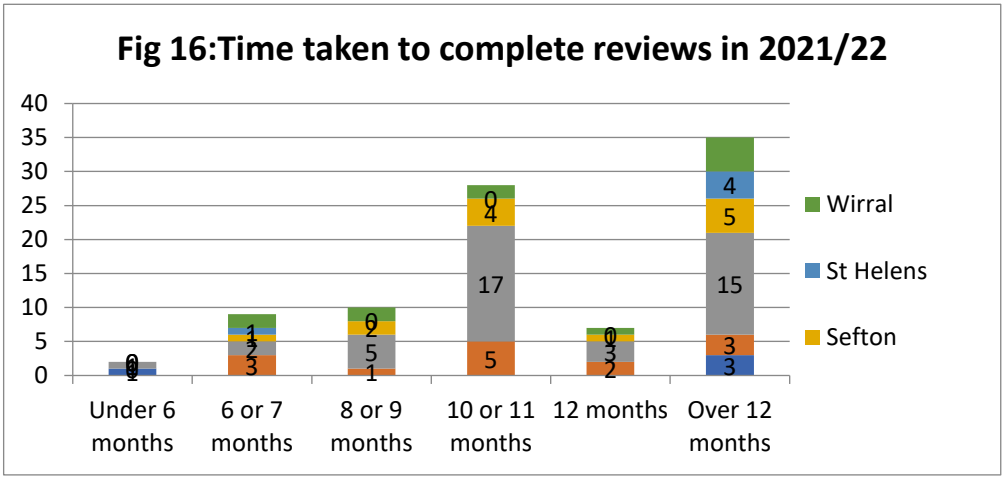
Table 23 illustrates that there appears to be no seasonal pattern developing. Notifications by age group feature in **Table 19** which clearly indicates that the majority of deaths occur the first year of life 69.2% [74%] compared to 60% nationally. The highest annual number of deaths occur neonatally (under 28 days), often as a result of complications through prematurity. Smoking, alcohol consumption, high maternal BMI, and domestic abuse all are known to increase the risk of prematurity and low birth weight, resulting in an increased level of vulnerability and risk of early infant death. It is important that all parts of the health and social care system reinforce messages that reduce risk of prematurity and low birth weight, especially during pregnancy. It can be seen from the **Table 19** that Merseyside has a similar pattern to national distributions for age, and lower rate for 15-15 year olds.

Table 20 shows death notifications by place of death with the majority occurring within a hospital setting.

Data completeness – Annual Comparison (Tables 21-23)
Tables 21 and 22 show the death notifications/age groups by year.

Data completeness- Notifications and Completed Reviews (Tables 24-27) (Previous years' figures in brackets)

The NCMD Report is a national repository for data from all CDOPs across England, and consequently provided an opportunity to provide comparative data. Clearly, there will be longer term benefits each year new data is gathered. In the first report, there has been an attempt to established national standards for completion of certain information.



Merseyside CDOP has tended to take less time to bring cases to panel from initial notification but this has now reversed with the cases taking an average of 344 [287] days compared to 335 [274], nationally. The significant increases in completion time both locally and nationally is partly due to delays in some of the processes as a result of covid. Local Authority comparisons are provided in Figure 16.

Acknowledgements

As noted in the foreword much of the business of the CDOP is dependent on the continued support of panel members and the administrative support. I would like to take this opportunity to thank the panel members for their continued support and especially Irene Wright, and Helen Fleming-Scott who ensure the panel runs smoothly.

Mike Leaf
Independent CDOP Chair
Autumn 2022
CDOPTeam@liverpool.gov.uk

APPENDIX I

NCMD
National Child Mortality Database

NCMD Monitoring Report for CDOPs

Merseyside CDOP

Report created on: 09/06/2022

Quarter 4 2021/22

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

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

1

Overview

Data on this page relates to deaths after 01/04/21 or where CDOP review was outstanding at 01/04/21, up to and including 31st March 2022

NCMD National Child Mortality Database

Number of cases reviewed 21/22:	Total cases with review ongoing:
91	109

Number of deaths during 21/22:
104

Table A

umber of ongoing cases entered by LSCB

SCB name	Cases
sle of Man	4
nowsley	11
iverpool	53
Sefton	17
St Helens	8
Wirral	16
Total	**109**

Table 2

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

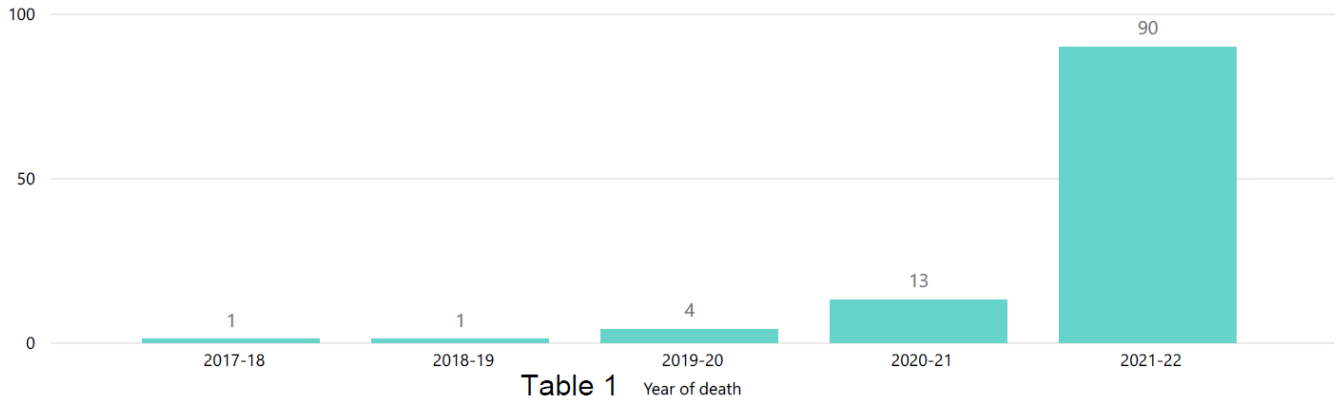


Table 1 Year of death

Number of ongoing cases by age group and status of case

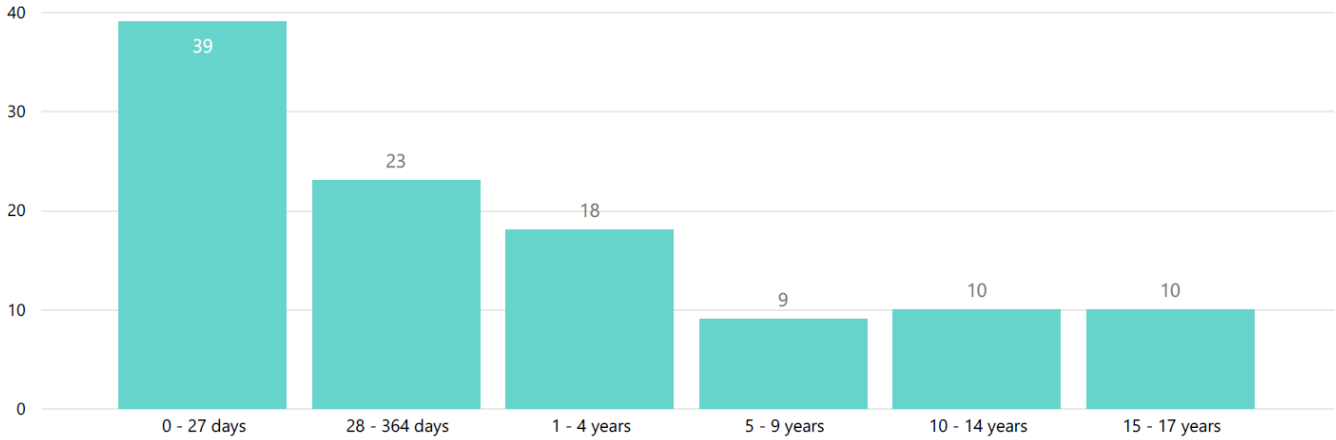


Table 3 Age group

Merseyside

2

Completed Reviews - Overview 1

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2021 and 31st March 2022

NCMD National Child Mortality Database

Number of cases reviewed 21/22:

91

Completed CDOP Reviews by LSCB

LSCB name	Cases
Isle of Man	4
Knowsley	12
Liverpool	45
Sefton	12
St Helens	5
Wirral	13
Total	**91**

Completed CDOP Reviews by year of death

Year of death	Cases
2018-19	3
2019-20	12
2020-21	62
2021-22	14
Total	**91**

Table 4

Completed CDOP reviews by gender

Table 5

Completed CDOP reviews by primary category of death

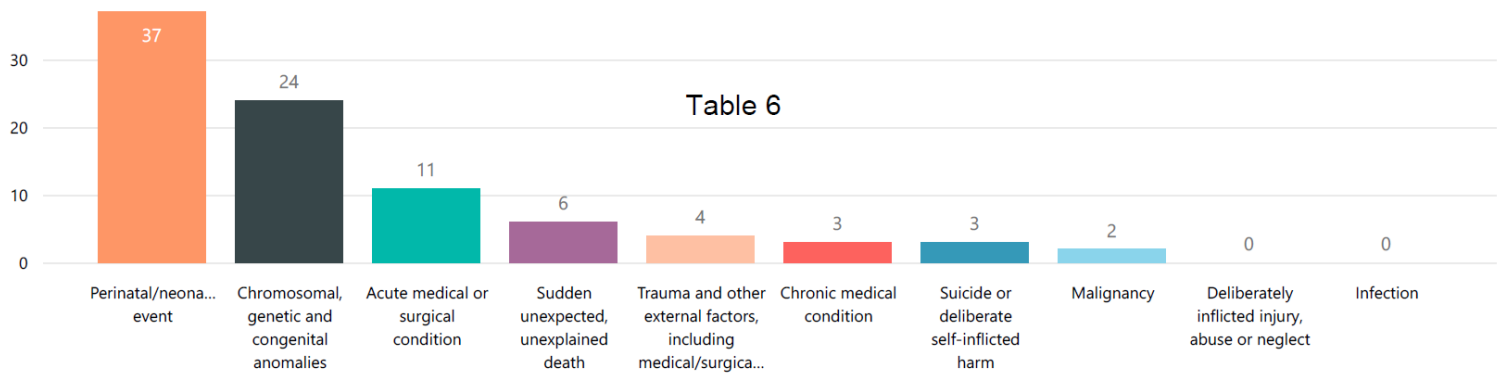


Table 6

Completed CDOP reviews by age group

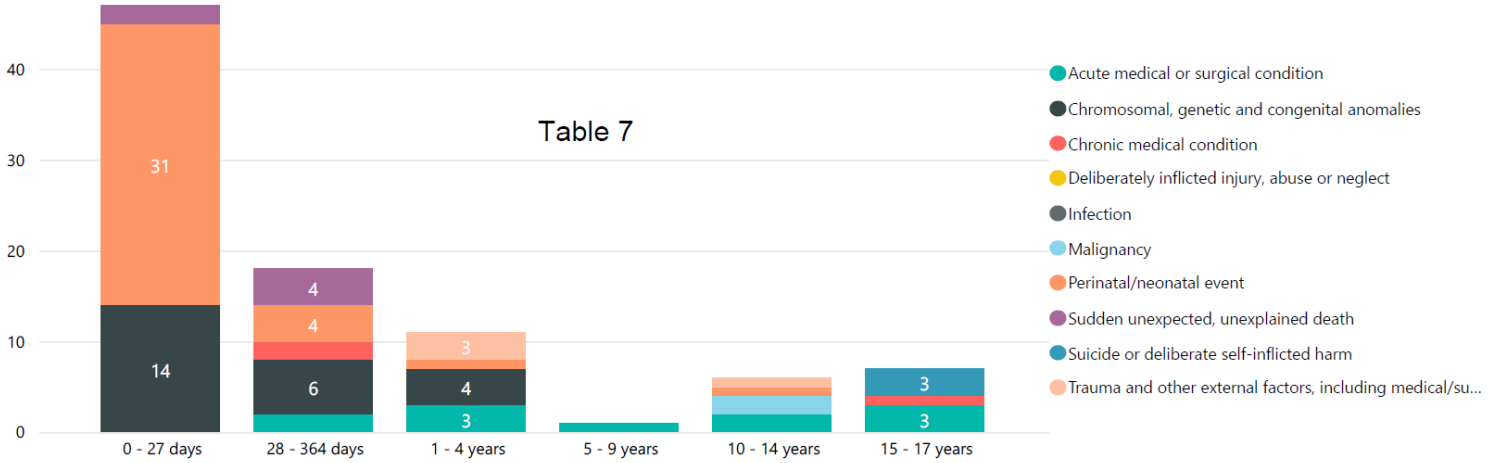


Table 7

Merseyside

Completed Reviews - Overview 2

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2021 and 31st March 2022

NCMD National Child Mortality Database

Number of cases reviewed 21/22:

91

Completed CDOP reviews by place of onset of illness/incident

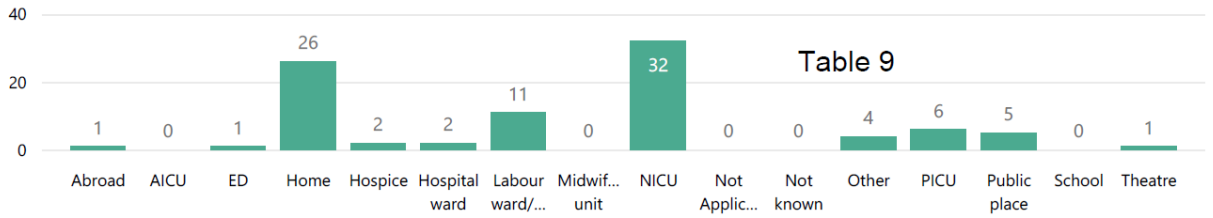


Table 9

Completed CDOP reviews by place of death

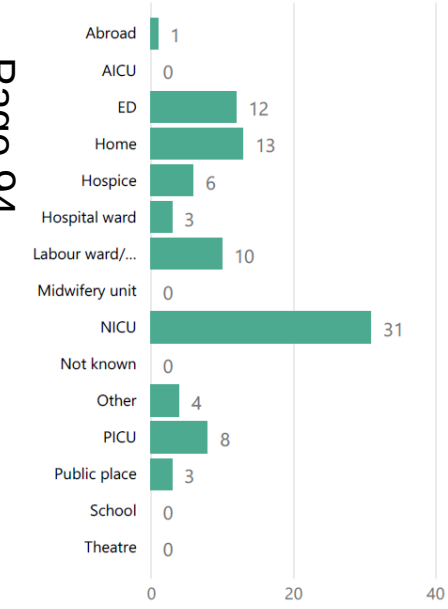


Table 8

Completed CDOP reviews by ethnic group and age group

Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	25	13	9	1	4	4	**56**
Unknown	17	4	1	0	2	2	**26**
Other	2	0	0	0	0	0	**2**
Mixed	0	0	0	0	0	0	**0**
Black or Black British	1	2	0	0	0	1	**4**
Asian or Asian British	2	0	1	0	0	0	**3**
Total	**47**	**19**	**11**	**1**	**6**	**7**	**91**

Table 10

Completed CDOP reviews by ethnic group and primary category of death

Ethnic Group	Acute medical or surgical condition	Chromosomal, genetic and congenital anomalies	Chronic medical condition	Deliberately inflicted injury, abuse or neglect	Infection	Malignancy	Perinatal/neonatal event	Sudden unexpected, unexplained death	Suicide or deliberate self-inflicted harm	Trauma and other external factors, including medical/surgical complications/error	Total
White	9	13	2	0	0	0	23	3	1	4	**55**
Unknown	1	7	1	0	0	2	10	3	2	0	**26**
Other	0	0	0	0		0	2	0	0	0	**2**
Mixed	0	0	0	0	0	0	0	0	0	0	**0**
Black or Black British	1	3	0	0	0	0	0	0	0	0	**4**
Asian or Asian British	0	1	0	0	0	0	2	0	0	0	**3**
Total	**11**	**24**	**3**	**0**	**0**	**2**	**37**	**6**	**3**	**4**	**90**

Table 11

Completed Reviews - Modifiable Factors

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2021 and 31st March 2022

NCMD National Child Mortality Database

Number of cases reviewed 21/22:	% cases with modifiable factors (CDOP):	% cases with modifable factors (England):
91	44%	37%

Were any modifiable factors identified?

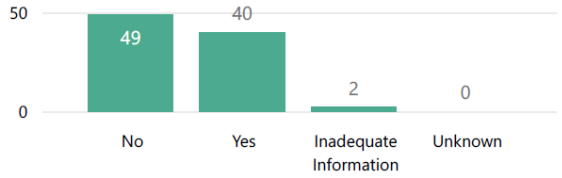


Table 12

% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	47	24	51%
28 - 364 days	19	9	47%
1 - 4 years	11	3	27%
5 - 9 years	1	0	0%
10 - 14 years	6	2	33%
15 - 17 years	7	2	29%
Total	**91**	**40**	**44%**

Table 14

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

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Trauma and other external factors, including medical/surgical complications/error	4	3	75%
Suicide or deliberate self-inflicted harm	3	2	67%
Sudden unexpected, unexplained death	6	4	67%
Perinatal/neonatal event	37	23	62%
Malignancy	2	0	0%
Infection	0	0	0%
Deliberately inflicted injury, abuse or neglect	0	0	0%
Chronic medical condition	3	0	0%
Chromosomal, genetic and congenital anomalies	24	4	17%
Acute medical or surgical condition	11	3	27%
Total	**90**	**39**	**43%**

Table 13

% of cases where modifiable factors were identified by ethnic group

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
White	56	28	50%
Unknown	26	10	38%
Other	2	0	0%
Mixed	0	0	0%
Black or Black British	4	0	0%
Asian or Asian British	3	2	67%
Total	**91**	**40**	**44%**

Table 15

Notifications during 2021/22

Data on this page relates to cases with a date of death between 1st April 2021 and 31st March 2022

NCMD National Child Mortality Database

Number of deaths during 21/22:

104

Death notifications by month of death

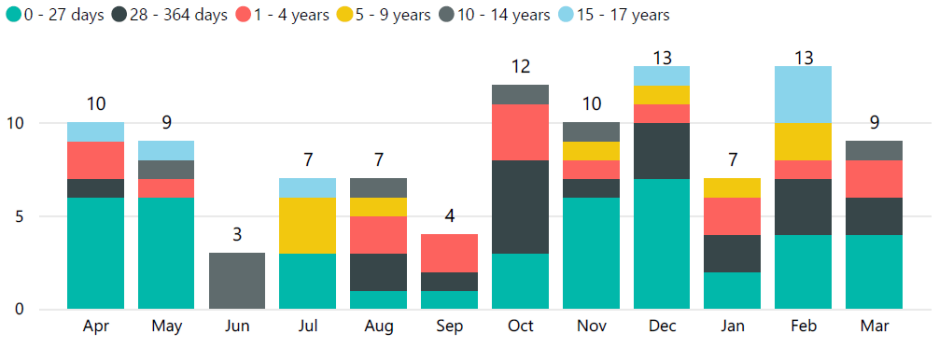


Table 18

Death notifications by place of death

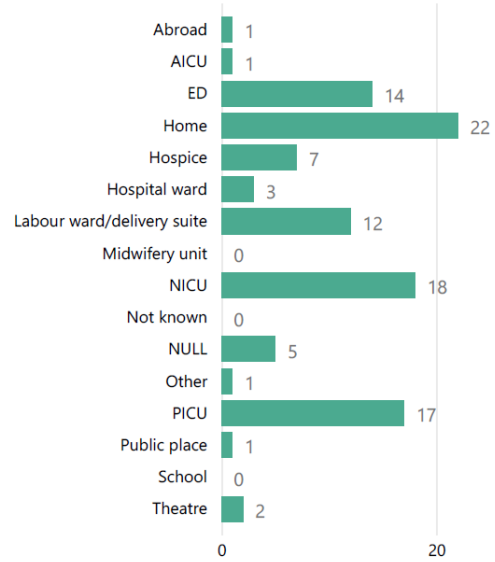


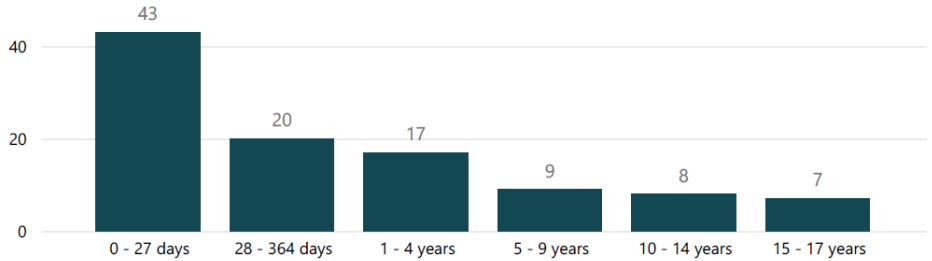
Table 20

Death notifications by LSCB

LSCB name	Cases
Isle of Man	3
Knowsley	8
Liverpool	52
Sefton	19
St Helens	7
Wirral	15
Total	**104**

Table 16

Death notifications by age group



% of death notifications by age group - CDOP

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

Table 19

Is there to be a Joint Agency Response?

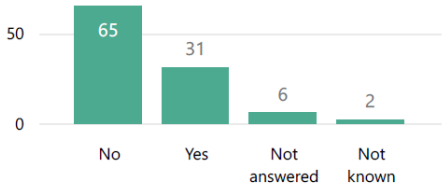


Table 17

Notifications - Annual comparison

Data on this page relates to cases with a date of death between 1st April and 31st March for all years. The table outlined in a blue box relates to all cases from 1st April 2019.

NCMD
National Child Mortality Database

Death notifications by LSCB and year

LSCB name	2019-20	2020-21	2021-22
Isle of Man	4	2	3
Knowsley	11	11	8
Liverpool	27	45	52
Sefton	24	8	19
St Helens	8	8	7
Wirral	17	14	15
Total	**91**	**88**	**104**

Table 21

Death notifications by age group and year

Age group	2019-20	2020-21	2021-22
0 - 27 days	35	46	43
28 - 364 days	20	19	20
1 - 4 years	19	7	17
5 - 9 years	4	1	9
10 - 14 years	4	8	8
15 - 17 years	9	7	7
Total	**91**	**88**	**104**

Table 22

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

Month of death	2019-20	2020-21	2021-22
Apr	3	10	10
May	7	3	9
Jun	5	7	3
Jul	6	13	7
Aug	7	4	7
Sep	10	11	4
Oct	11	2	12
Nov	6	8	10
Dec	9	8	13
Jan	11	8	7
Feb	5	7	13
Mar	11	7	9
Total	**91**	**88**	**104**

Table 23

1

Data Completeness - Completed Reviews

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2021 and 31st March 2022

NCMD
National Child Mortality Database

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

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

Notification fields - % completion of fields

CDOP Name	Cases	NHS No	DoD	Gender	Postcode	Suspected CoD	Place of Death	Hospital specified^	Joint agency response	Notification Details	Ethnicity	Gestational Age (Under 1s)	Investigated by Coroner	Post Mortem
Merseyside	91	96%	100%	100%	98%	100%	100%	100%	100%	100%	71%	97%	100%	100%

Table 24

Reporting fields - % completion of fields

CDOP Name	Cases	Events occurred selection	Circumstances of Death	Where at onset of illness	Known to social care	Subject to SCR	Mode of Death
Merseyside	91	100%	100%	100%	97%	93%	87%

Table 25

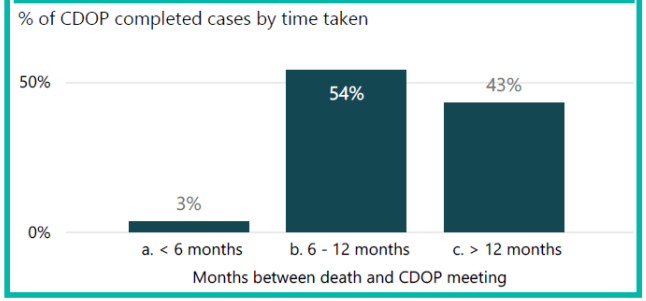
Analysis fields - % completion of fields

CDOP Name	Cases	CDOP category of death	CDOP meeting date	Cause of death	Domain factors recorded (at least 1)	Modifiable factors selection	Learning points text	Actions text
Merseyside	91	99%	100%	100%	100%	100%	100%	100%

Table 26

Table 27

Median number of days between death and CDOP meeting	CDOP	England
	344	335



^Where place of death was specified as hospital Not known or Not applicable not counted as complete

Data Completeness - 2021/22 Notifications

Data on this page relates to cases with a date of death between 1st April 2021 and 31st March 2022

NCMD National Child Mortality Database

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

90 - 100% Good level of data completeness

< 90% Data completeness requires improvement

Notification fields - % completion of fields (2021/22 notifications)

CDOP Name	Cases	NHS No	DoD	Gender	Postcode	Suspected CoD	Place of Death	Hospital specified^	Joint agency response	Notification Details	Ethnicity	Gestational Age (Under 1s)
Merseyside	104	98%	100%	96%	93%	100%	95%	97%	94%	100%	90%	95%

Appendix II: Category of Death

It is possible that deaths cover more than one category.

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

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

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

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

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Report to:	Health and Wellbeing Board	**Date of Meeting:**	7 June 2023
Subject:	**Sefton's Voluntary Community and Faith Sector: Supporting Sefton's Place Priorities**		
Report of:	Angela White, Chief Executive, Sefton CVS	**Wards Affected:**	(All Wards);
Portfolio:	Health and Wellbeing		
Is this a Key Decision:	No	**Included in Forward Plan:**	No
Exempt / Confidential Report:	No		

Summary:

The presentation provides the Health and Wellbeing Board with an update relating to how Sefton's Voluntary, Community and Faith (VCF) sector can contribute to the priorities and themes detailed in the emerging Sefton Place Plan. It outlines; the involvement of the VCF sector in developing the plan, the value the sector brings to local partnership working aimed at improving outcomes for local residents, a high level outline of the VCF Social Impact Tool and offers a number of relevant case studies.

Recommendation(s):

(1) That the Health and Wellbeing Board receive and note the update.

Reasons for the Recommendation(s):

To keep the Health and Wellbeing Board updated on Sefton's Voluntary, Community and Faith (VCF) sector's contribution to the Sefton Place Plan.

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Sefton's Voluntary Community and Faith Sector

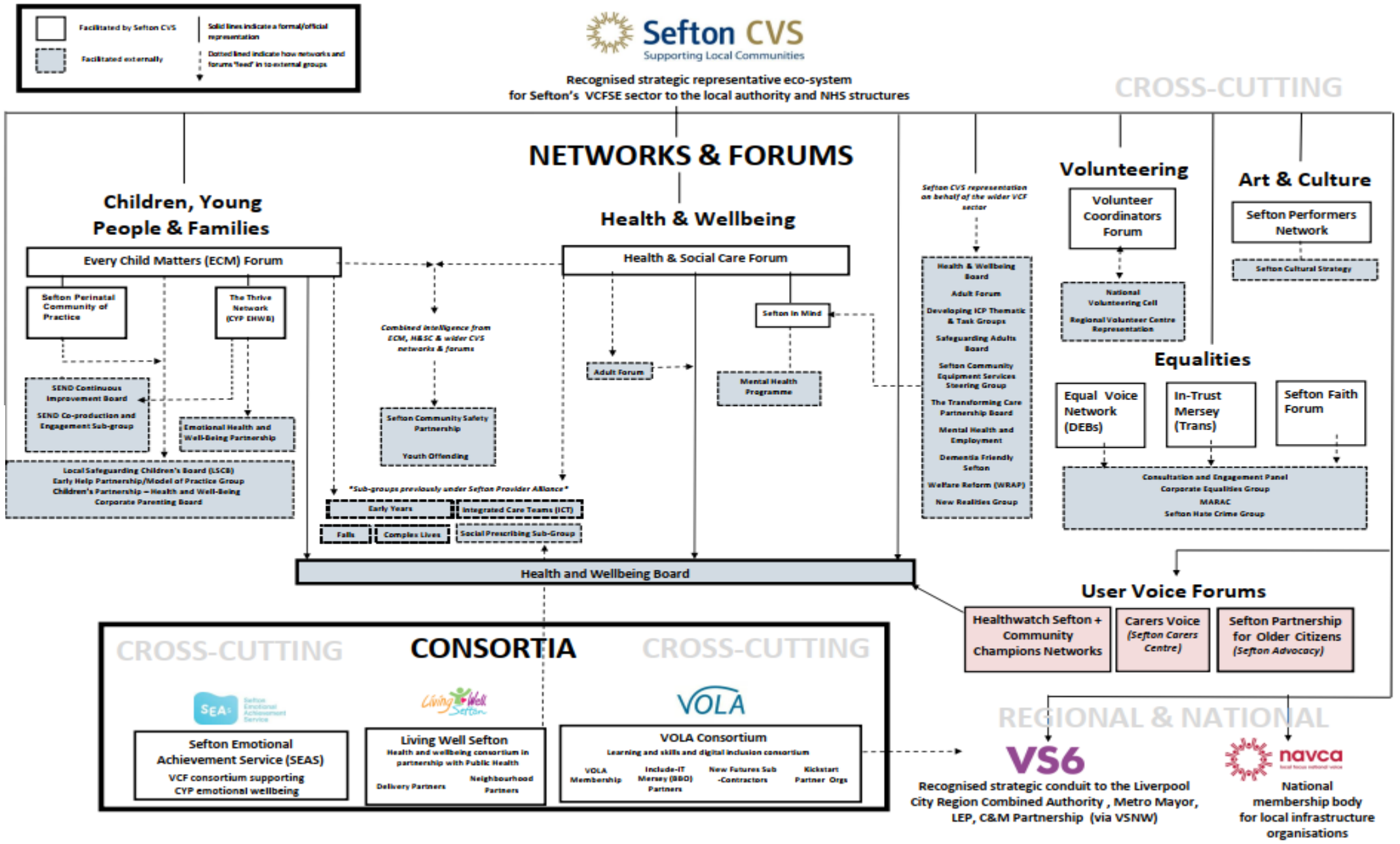
Supporting Sefton's Place Priorities

Angela White
Chief Excutive
Sefton CVS

Presentation to Sefton's Health and Wellbeing Board
Wednesday 7 June, 2022

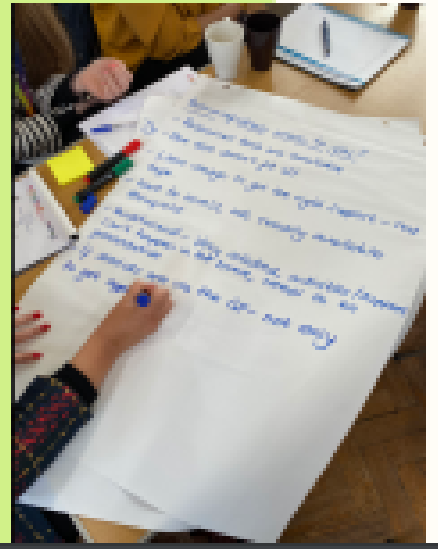
Introduction

1. Sefton VCF sectors invovlement in developing the Place Plan
2. How the VCF sector can support Place Plan Priorities
3. How can we capture the VCF sector's contribution to Place priorites?



VCF Sector Involvement in Developing the Place Plan

- Collaborative Process
- Invited to participate in workshops with partners to represent the VCF sector
- Joint event facilitated with Healthwatch Sefton to brief voluntary and community sector on the emerging Place Plan
- Collated feedback and committed to ongoing dialogue



How the VCF sector can support Sefton Place Priorities.....

Sefton CVS
Supporting Local Communities

healthwatch Sefton

Working with people and communities will help to better population health and wellbeing by:

- Reducing Health Inequalities
- Providing data and insights
- Capitalising on community assets
- ·Designing services
- Prioritising resources
- Develop approaches and solutions

NHS England: Working in Partnership with People and Communities Statutory Guidance

Contribution to Sefton's Life Course Approach

Start Well

VCF organisations work to enhance children and young people's emotional health and wellbeing

Provide opportunities for neurodiverse children and young people

Peri-natal Community of Practice established following VCF collaboration

Live Well

Particularly effective in reaching communities experiencing greatest health inequalities (new Cancer Alliance iniative)

•

The sector works holistically with people who fit the Complex Lives criteria – treating the **causes** rather than the **symptoms** of ill-health.

Age Well

Support people keep people well and remain at home. (Dementia Friendly Sefton, Enhanced Care Social Prescribing)

Provides practical and emotional support as people approach end-of-life

All Age

•Promote healthy lifestyles, create opportunities to engage in physical activity and provide information about health promoting behaviours.

Sector's offer supports Carers, directly and via wider provision (support groups, respite etc)

Community First

- Recognises the importance of community-centred approaches as well as the need to mobile assets, empower communities, promote equity and increase people's control over their health and lives.

- Effective collaboration with Sefton's VCF sector, will facilitate a stronger reach into local communities, which in turn will amplify the work of local health, care and community services.

- Aim to support people before they reach the health and social care system, which will help to reduce the numbers of local people falling into crisis.

- Supports our local communities to manage their own health and wellbeing, so that they do not have to unnecessarily access services for preventable health and social care concerns.

Why we need to put Community First

- No wrong door approach - the sector's strength lies in it's holistic, community embedded and personalised approaches
- Track record of trust - local people trust the sector!
- VCF organisation promote understanding of the specific needs of their communities
- It's diversity, flexibility and level of innovation helps it reach and support those hardest to engage
- Builds emotional resilience and promotes self-care and independence
- Facilitates asset-based approaches and co-production
- Expertise of lived experience in designing more effective, sustainable services

How can we capture the VCF sector's contribution to Place priorites?

Social Impact Tool aims to capture VCF contribution to wider determinants of health, Sefton's Place Priorities and Social Return on Investment.

Aligned to Place Plan life-course approach and wider determinants of health.

Social Impact Themes and Outcomes

Start Well	Live Well	Age Well
Where we lay the foundations for a healthy life, usually up to age18, but includes children up to age 25 years for some children with additional needs.	Where we ensure people have every opportunity to live a healthy life.	Where we consider the factors that help keep us healthy as we get older
1. Increased positive parenting 2. Reduced stress and adversity in households 3. Better able to manage behaviour and regulate emotions 4. Improved physical and mental health 5. Increased access to healthcare 6. Enable children's health and development 7. Improved emotional health and wellbeing 8.Enhanced school readiness	1. Improved general physical health 2. Improved wellbeing 3. Reduced anxiety and depression 4. Increased knowledge of healthy lifestyles/health promoting behaviours 5. Increased perception of control over Long-Term Condition/Illness 6. Increased confidence and motivation 7. Reduced drug and/or alcohol consumption	1. Reduced social isolation 2. Reduced loneliness 3. Increased independence 4. Increased safety and security at home 5. Increased referrals into health/social care services 6. Benefits maximisation 7. Improved housing suitability 8. Improved mental wellbeing

Social Impact Themes and Outcomes

Housing	Education and Skills	Employment and Volunteering	Social and Community
Changes in homelessness status, temporary accommodation need or evictions.	Formal education and skill development (personal or professional.)	New or sustained employment or volunteering and support that have helped individuals to reduce barriers to entering employment.	Outcomes that have supported individuals to be independent, reduced isolation and allow greater social mobility.
1. Reduction of rent arrears 2. Reduction in homelessness 3. Sustained tenancy 4. Access to housing advice 5. Access to better quality housing 6. Improved feeling of safety and security at home 7. Has suitable accommodation in a fit condition (adaptations, repairs, maintenance)	1. New employability skills developed 2. New qualifications achieved 3. Reduction of truancy 4. Increased engagement with education/training opportunities 5. Re-engagement with education/training opportunities 6. Improved access to skills development 7. Building of career aspirations 8. Increased motivation	1. Increased volunteering within communities 2. New volunteering opportunities 3. New employment opportunities 4. Participation in pre-employment training 5. Continued employability 6. New work experience opportunities	1. Development of new peer support networks 2. Development of new social networks 3. Reduced breakdown in relationships 4. Improved community engagement and involvement in the local area 5. Greater access to local, community and social activities 6. Improved signing to local services 7. Access/Use of Internet to access information and support

Social Impact Themes and Outcomes

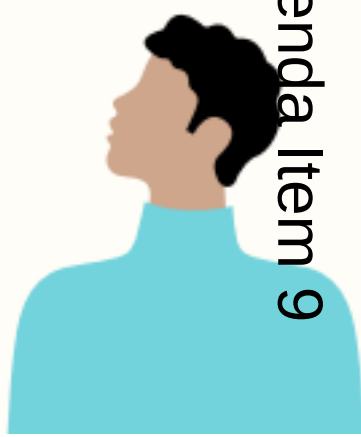
Finance and Legal Matters	Crime and Justice	Arts, Heritage, Sports and Faith	Environment and Conservation
Outcomes that are associated with the cost of living reduced or managed debt and reduced legal disputes.	Outcomes that are directly associated with the reduction in crime, anti-social behaviour or fear of crime.	Outcomes that are associated with community activities.	Improved relationship with the environment, including improved recycling, use of renewable energy, reduced travel and reduced use of single-use materials.
1. Has sufficient sustainable income, including benefits where appropriate 2. Reduced applications for credit 3. Improved financial management 4. Reduced Debt 5. Access to appropriate advice, products or services	1. Reduced fear of crime 2. Reduction of anti-social behaviour 3. Reduction of Domestic Abuse 4. Reduction in the fear of crime 5. Taking responsibility of actions	1. Improved confidence in an area of interest 2. Increased engagement and participation in art, heritage, faith and sport activities. 3. Improvements in own life following participation in art, heritage, faith and sport activities.	1. Increased recycling 2. Reduced carbon emissions 3. Accesses and enjoys the natural environment and heritage 4. Increased awareness and education of environmental issues 5. Benefits from environmental improvements to the local area 6. Increased enjoyment of parks, recreational and open spaces 7. Reduced travel by private vehicles

Case Studies

Age Well

A widower in his 80's attends Cosy Club (warm space) and has managed to establish a small network of friends. He says that it has been a **lifeline** to him and he now feels like he has regular contacts that encourages him to leave the house. He has become friends with a volunteer who lives close to him and has been able to offer support with transport to medical appointments and for shopping. He has been provided with **confidence** and reassurance from his newfound friendship group and he feels that it has **provided a purpose** for him and **prevented the loneliness** he was feeling before Cosy Club.

Friends of Maghull and District



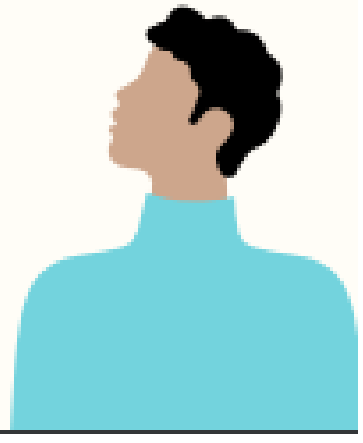
Case Studies

Live Well: Mental Health

Parenthood can be an isolating experience. Te Home-Start counselling service is always in demand. The waiting lists for NHS services can be long. If counselling is not available when someone is feeling desperate, things can escalate and put families at risk of breakdown.

One client who struggled with dark thoughts post-partum has, after counselling support, been able to return to work. She is extremely grateful for the support she received when needed.

At first assessment one client was identified as actively suicidal. A support plan was enacted to ensure that the client remained safe while the Mersey Care Crisis Team were contacted.



HOME START Southport & Formby

Case Studies

Complex Lives

John was a 65 year old male had repeated A&E attendances. He experienced: social anxiety, depression, loneliness, difficulty communicating with & accessing health services and alcohol addiction.

THE HIU Team worked with John to: develop coping strategies for social anxiety, engage with a rehabilitation program, rebuild family relationships, explore participation in positive activities and provided advice and encouragement to adopt a healthier lifestyle.

John has engaged in a rehabilitation programme and has not consumed alcohol for over eight months. ,John has started to manage his social anxiety, commenced adult learning courses and now volunteers as part of his rehabilitation programme .

John reports feeling more confident to manage his physical health and mental well-being. He can interact and communicate with clinical staff and services when he needs to. John is hoping to find accommodation which better suits hisneeds

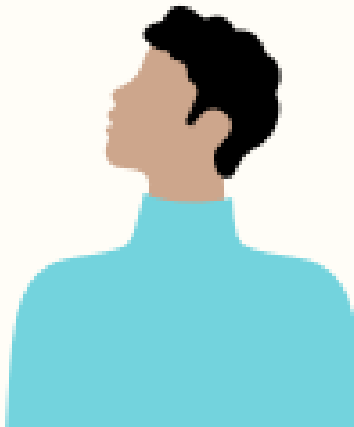
High Intensity User Service

Case Studies

Live Well: Mental Health

A whole family attended Sean's Place following an incident when their son unexpectedly made an attempt on his life. They wanted to talk openly and honestly about their pain. The son began accessing our 121 support whilst his nan, mum and younger brother attending our family support group. Since completing the programme their other son now volunteers for the charity

Sean's Place



Thank you!

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