Public Document Pack

MEETING: CABINET

DATE: Thursday 26th March, 2015

TIME: 10.00 am

VENUE: Town Hall, Bootle

Member

Councillor

Councillor Peter Dowd (Chair)
Councillor Cummins
Councillor Fairclough
Councillor Hardy
Councillor Maher
Councillor Moncur
Councillor Tweed

COMMITTEE OFFICER: Steve Pearce
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The Cabinet is responsible for making what are known as Key Decisions, which will be notified on the Forward Plan. Items marked with an * on the agenda involve Key Decisions

A key decision, as defined in the Council's Constitution, is: -

- any Executive decision that is not in the Annual Revenue Budget and Capital Programme approved by the Council and which requires a gross budget expenditure, saving or virement of more than £100,000 or more than 2% of a Departmental budget, whichever is the greater
- any Executive decision where the outcome will have a significant impact on a significant number of people living or working in two or more Wards

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.

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A G E N D A

Items marked with an * involve key decisions

	Item No.	Subject/Author(s)	Wards Affected	
	1.	**Apologies for Absence**		
	2.	**Declarations of Interest** Members are requested to give notice of any disclosable pecuniary interest, which is not already included in their Register of Members' Interests and the nature of that interest, relating to any item on the agenda in accordance with the Members Code of Conduct, before leaving the meeting room during the discussion on that particular item.		
	3.	**Minutes of Previous Meeting** Minutes of the meeting held on 26 February 2015		(Pages 5 - 16)
*	4.	**Public Health Annual Report 2014** Report of the Director of Public Health	All Wards	(Pages 17 - 82)
*	5.	**Adult Substance Misuse Contract Extension** Report of the Director of Public Health	All Wards	(Pages 83 - 88)
*	6.	**Better Care Fund - Section 75 Agreement** Report of the Deputy Chief Executive	All Wards	(Pages 89 - 98)
	7.	**Child Sexual Exploitation Post Rotherham** Report of the Director of Young People and Families	All Wards	(Pages 99 - 136)
*	8.	**Procurement Proposals for the Annual Service Contracts for Highway Maintenance Works** Report of the Director of Built Environment	All Wards	(Pages 137 - 142)

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THE "CALL IN" PERIOD FOR THIS SET OF MINUTES ENDS AT 12 NOON ON WEDNESDAY 11 MARCH 2015. MINUTE NO's 67, 68 AND 69 ARE NOT SUBJECT TO "CALL – IN."

CABINET

MEETING HELD AT THE TOWN HALL, SOUTHPORT ON THURSDAY 26TH FEBRUARY, 2015

PRESENT: Councillor Peter Dowd (in the Chair)
Councillors Cummins, Fairclough, Hardy, Maher, Moncur and Tweed

ALSO PRESENT: Councillors Ball, Dawson, Lord Fearn, McKinley and Shaw

61. APOLOGIES FOR ABSENCE

No apologies for absence were received.

62. DECLARATIONS OF INTEREST

No declarations of interest were made.

63. MINUTES OF PREVIOUS MEETING

Decision Made:

That the minutes of the Cabinet meeting held on 5 February 2015 be confirmed as a correct record.

64. PUBLIC PETITION - SOUTHPORT POLICE STATION

The Chair reported that Councillor Dawson had submitted a petition containing 42 signatures on behalf of a local deputation which:

"Petitions Sefton Council to press the Police and Crime Commissioner to ensure that no plans are made to sell off Southport Police Station until there is a confirmed better-situated Police Station facility within Southport."

Councillor Dawson was not present at the time that this agenda item was considered and was unable to make any representations on the petition.

The Chair also reported that Jane Kennedy, the Merseyside Police and Crime Commissioner had attended the meeting of the Southport Area Committee on 3 December 2014 to present the Merseyside Police Estate Strategy and Stakeholder Consultation and the response of the Committee to the consultation had been submitted to the Police and Crime

Commissioner. Upon receipt of the petition, the response of the Merseyside Police and Crime Commissioner to the petition from Councillor Dawson had been sought and the following response had been received:

"It has always been my intention that current police stations will not close until there is a Community Police Station, or a Neighbourhood Patrol Hub in place to replace them. In Southport, the intention is to develop a new Neighbourhood and Patrol Hub as well as a new Community Police Station with a General Enquiry Office and then dispose of the existing station. I will bring forward the business cases and site locations when we are in a position to do so."

Decision Made:

That the petition and response from the Merseyside Police and Crime Commissioner to the petition be noted.

Reasons for Decision:

The Merseyside Police and Crime Commissioner had submitted her response to the petition.

Alternative Options Considered and Rejected:

None.

65. ADULT SOCIAL CARE CHANGE PROGRAMME - REMODELLING OF DAY OPPORTUNITIES AND CARE ACT UPDATE

The Cabinet heard representations from Lindsay Scott who had submitted a petition containing 2,028 signatures on behalf of the Friends of Brookdale which stated:

"Our campaign is to challenge the proposed closure of the Brookdale Resource Centre in Ainsdale. We need the Council and MP's to listen and work out a way to keep this centre open."

The Cabinet also heard representations from Mrs Margaret Mathieson who had submitted a petition containing 27 signatures on behalf of a deputation which states:

"We ask that the Elected Members investigate the administrative process in order to ensure that both the monitoring and scrutinisation of the outcomes of the questionnaire relating to the remodelling of the day services provision is truly representative of the recipients."

The Cabinet then considered the report of the Director of Older People which provided details of the outcome of the Remodelling of Day Opportunities consultation and sought approval for associated planned

activity. The report also detailed the required changes associated with the Care Act 2014.

The Director of Older People referred to the following key issues, with regard to the proposals set out in the report:

1. The Health and Wellbeing Strategy for 2013 - 2018 sought the provision of care facilities and services closer to the home of the service user, through the use of direct payments, which allowed great choice and control on the use of facilities and services.

2. The Sefton Strategic Needs Assessment (SSNA) indicated a decline in the number of people using day centres. More people were using personal budgets and the direct payments system to improve their choice and control. The latest data in the SSNA indicated that the average unit cost in 2012/13 was £193, which was 45% higher than the average Metropolitan Authority and represented a 14% increase on 2010/11.

3. The day care provision provided by the Council had steadily declined over the last three years. He stated that this trend was a national one with average attendance numbers falling by 28% between 2011/12 and 2013/14.

4. The majority of day care facilities in the Borough were in need of significant repair and maintenance. The facilities needed to be modernised and re-modelled to accommodate people with highly complexed needs in order to provide a more efficient and effective service.

5. The consultation process had been agreed by the Public Consultation and Engagement Panel and the Cabinet Member – Older People and Health. Since July 2014, he had met monthly with a wide range of voluntary organisations, User Groups and Advocacy Organisations to discuss a wide range of issues as set out in the report.

6. The first stage of the consultation had been held in October 2014 to discuss the vision, the provision of activities and transport provision. The second stage had commenced at the end of November 2014 on the various options for the two year programme of modernisation after taking into account the responses to the first stage consultation.

7. 404 responses to the second stage consultation were received, of which 302 were from service users or carers and a dip analysis was undertaken to ensure probity. As a result of the consultation responses, a number of changes were proposed which included Brookdale Resource Centre remaining open; Chase Heys day centre closing, but the other provision for intermediate care and respite care at Chase Heys would remain unaffected and Mornington Road would become a centre of excellence for people with complex needs with physical and learning disabilities, as set out in paragraph 2.19 of the report;

Members of the Cabinet raised questions on the following issues referred to during the representations made by the Lead Petitioners and in the report and the Director responded to the issues as indicated below:

An increased number of people appear to be using personal budgets – what are the alternative service options available to service users? Response: In addition to the use of day centres, service users can use personal budgets to provide assistance with their day to day living and access to leisure activities and training opportunities and the direct payments system allows greater choice on service provision.
How will the assisted transport policy be refreshed to meet the needs of service users? Response: The transport needs of service users would be reviewed and reassessed based on their personal needs and circumstances to ensure that they have access to day centres.
How will we move forward on the consultation on the programme of modernisation? Response: A commitment has been given that all service users, stakeholders and staff would be consulted and engaged on the design and modernisation of the day centres.
How will we communicate the decision taken by the Cabinet to all of the service users to remove any uncertainty? Response: All service users would be advised of the Cabinet decision, given an assurance that their individual needs and circumstances would be reviewed and reassessed by a new team of Social Workers to be established and be offered the use of Advocacy services, where appropriate. They will also be informed of the proposals for the modernisation of day centres and their views will be sought in the coming months. Information would be provided on the Council's website; and Sefton New Directions, other private service providers and all of the organisations involved in the consultation process would be informed of the Cabinet decision.

The Cabinet Member - Older People and Health indicated that the provision of day care facilities had to be re-modelled in view of the poor state of repair of some centres, the need for modernised facilities, the falling attendances at day centres and service users using alternative services. He reiterated that the Council had been fully committed to engaging with all service users and other stakeholder groups on the consultation process and refuted the view made by some people that “the decision was already made” and indicated that the changes to the proposals consulted upon for the Brookdale Resource Centre and Chase Heys day centre demonstrated that was not the case.

The Cabinet Member also referred to the organisations involved in the consultation process listed on page 28 of the report and the positive comments he had received from them on the process undertaken. He indicated that the Council was fully committed to the “Challenge on Dementia” and a Dementia Strategy would be submitted for approval in the near future.

The Chair commented that the consultation exercise had reflected that there was a wide range of needs by service users and a different provision of services was required by people who do not want to use day centres. The report set out proposals for a programme of modernisation to a reduced day centre estate based on the models of support described in the report. He gave an assurance that the Council would continue to listen to the views of service users during the forthcoming consultation on the re-modelling of the service provision at day centres.

Decision Made:

That:

(1) the petitions be noted and the petitioners be thanked for their contributions;

(2) it be noted that the current understanding of assessed needs; the forecasted demographic changes, the current and forecast usage rates and the usability and sustainability of the New Direction Day Centres had been considered and taken into account;

(3) it be noted that the detail within the consultation feedback set out in Annex A in respect of day care and transport together with the Public Sector Equality Duty analysis report set out in Annex B of the report had been considered and taken into account;

(4) the risks and the mitigating actions identified be noted;

(5) approval be given to the progression to a modernised but reduced day centre estate based on the models of support described in the report;

(6) approval be given to the closures and modernisation as described in paragraphs 2.8 to 2.10 of the report and Officers be authorised to implement the plan immediately;

(7) the intention to engage further with the users and all interested parties of the Chase Heys Day Centre be noted;

(8) the refreshed Assisted Transport policy set out in Annex C of the report be approved for implementation with effect from 1 April 2015;

(9) the potential impact of the programme of modernisation on the Specialist Transport Unit be noted and Officers be authorised to implement the programme in line with the plan including the issue of relevant statutory and contractual notifications, if appropriate to achieve change; and

(10) it be noted that the financial and other risks to the Council had been considered and taken into account.

Reasons for Decision:

The Council had significant existing responsibilities for Adult Social Care (ASC) and invested considerable resources (£92 million per annum) into this service. The Adult Social Care Change Programme's overall aim was to develop a model for Sefton Council's Adult Social Care that was sustainable, modern and flexible, delivering the four strategic priorities as set out in the ASC Strategic Plan 2013-20 as approved in November 2013, and the delivery of the changes associated with the Care Act 2014.

In developing future plans against a background of reducing resources the core purpose of the Council was assumed to be

- Protect the most vulnerable i.e. those people who have complex care needs with no capacity to care for themselves and no other networks to support them.
- Commission and provide core services which meet the defined needs of communities and which are not and cannot be duplicated elsewhere.
- Enable/facilitate economic prosperity i.e. maximise the potential for people within Sefton to be financially sustainable through employment/benefit entitlement.
- Facilitate confident and resilient communities which are less reliant on public sector support and which have well developed and effective social support networks.

In February 2013, the Council approved a proposal to remodel day opportunities so that in the future opportunities would be shaped by how best to meet assessed eligible needs and made more appropriate to people who use them. The proposed programme of modernisation had been developed by taking account of the current understanding of assessed needs, the forecasted demographic changes, current and forecast usage rates and the usability and sustainability of the New

Direction day centres. In addition to this the feedback from both phases of the consultation and impact assessment had informed the decision.

The Cabinet took in to account the following principles

- Efficiency before cuts – Protect the impact on communities
- Focus on our core purpose.
- Keep the needs of our citizens at the heart of what we do rather than think and act organisationally.
- Proactively manage demand not just supply.
- Ensure we provide services strictly in line with eligibility criteria.
- Pursue growth/investment as well as savings.
- Communicate and engage with people to expect and need less

New requirements, duties and responsibilities associated with the Care Act 2014 would be designed, developed and implemented from April 2015 with full implementation planned for April 2016. In the light of the timescale, breadth of changes and associated risks, it was important that the Council prepared for implementation despite of the lack of clarity about some of the key features.

Alternative Options Considered and Rejected:

The proposed programme to deliver the modernisation of day opportunities was based on the current understanding of assessed eligible needs, forecasted demographic changes, the impact assessment, feedback from both phases of the consultation, the current and forecast usage rates and the usability and sustainability of the New Directions (ND) day centres. The ND day centre buildings require in the region of £2.7m capital expenditure to maintain them and incur significant general operating costs.

Maintaining the status quo is not an option due to demographic and budgetary pressures and new legislation.

66. TOWN CENTRES WORKING GROUP - FINAL REPORT

The Cabinet considered the report of the Director of Corporate Service which incorporated the report of the Town Centres Working Group which had been appointed by the Overview and Scrutiny Committee (Regeneration and Environmental Services) to undertake a review in to development of town centres in the Borough.

Councillor McKinley, the Lead Member of the Working Group outlined the key findings and recommendations set out in the report. He also thanked the witnesses and the Scrutiny Support Officer, Ruth Harrison for their support and professionalism throughout the scrutiny process.

Decision Made:

That the recommendations of the Town Centres Working Group be referred to the Cabinet Member – Regeneration and Tourism for consideration; and the views of the Cabinet Member on the recommendations be submitted to the meeting of the Cabinet to be held on 16 April 2015.

Reasons for Decision:

To enable the recommendations of the Working Group to be considered in more detail by the Cabinet Member, prior to the Cabinet making its formal response to the recommendations set out in the report.

Alternative Options Considered and Rejected:

None.

67. TREASURY MANAGEMENT POLICY AND STRATEGY 2015/16

The Cabinet considered the report of the Head of Corporate Finance and ICT which provided details of the proposed procedures and strategy to be adopted in respect of the Council's Treasury Management Function in 2015/16.

The Head of Corporate Finance and ICT referred to the proactive work undertaken by the Treasury Management Team which had enabled reductions in debt management costs of over £3m to be achieved in the last three years.

Decision Made:

That the Council be recommended to give approval to:

(1) the Treasury Management Policy Document for 2015/16 as set out in Annex A of the report;

(2) the Treasury Management Strategy Document for 2015/16 as set out in Annex B of the report;

(3) the amendment to the Banking arrangements contained within the Financial Procedure Rules of the Constitution, as referred to in paragraph 3 and Annex A of the report; and

(4) the basis to be used in the calculation of the Minimum Revenue Provision for Debt Repayment in 2015/16.

Reasons for Decision:

To enable the Council to effectively manage its treasury activities.

Alternative Options considered and Rejected:

None

68. THE PRUDENTIAL CODE FOR CAPITAL FINANCE IN LOCAL AUTHORITIES - PRUDENTIAL INDICATORS

The Cabinet considered the report of the Head of Corporate Finance and ICT on proposals to establish the Prudential Indicators required under the Prudential Code of Capital Finance in Local Authorities. This would enable the Council to effectively manage its Capital Finance Activities and comply with the Chartered Institute of Public Finance and Accountancy Prudential Code of Capital Finance in Local Authorities.

Decision Made:

That the Council be recommended to:

(1) approve the Prudential Indicators as detailed in the report, and summarised in Annex A of the report, be approved as the basis for compliance with The Prudential Code for Capital Finance in Local Authorities;

(2) give approval to the relevant Prudential Indicators being amended, should any changes to unsupported borrowing be approved as part of the 2015/16 Revenue Budget;

(3) note that estimates of capital expenditure may change as grant allocations are received, as indicated in paragraph 2.2 of the report; and

(4) grant delegated authority to the Head of Corporate Finance & ICT to manage the Authorised Limit and Operational Boundary for external debt as detailed in Section 5 of the report.

Reasons for Decision:

To enable the Council to effectively manage its Capital Financing activities, and comply with the CIPFA Prudential Code for Capital Finance in Local Authorities.

Alternative Options Considered and Rejected:

None

69. CAPITAL PROGRAMME 2014/15 AND CAPITAL ALLOCATIONS 2015/16

The Cabinet considered the report of the Head of Corporate Finance and ICT which provided an update on the Capital Investment Plan 2014/15; details of the Government Capital Allocations for 2015/16 that had been received to date and their use in the development of a new starts programme for 2015/2016. The report also outlined £16.1m of new investments which were aimed to improve the facilities and services to residents throughout Sefton.

Decision Made:

That:

(1) the 2015/16 capital allocations received to date, as set out in paragraph 3.2 of the report be noted;

(2) the Council be recommended to approve for inclusion within the Capital Investment Plan, the Capital schemes to be funded from the 2015/2016 Single Capital Pot as outlined in Appendix A and the Prudential Borrowing Scheme in Appendix B of the report; and

(3) approval be given to an increase in the existing Capital Programme for business growth grants from £1.3m to £1.55m, to be met from external funding.

Reasons for Decision:

To update Members on the 2014/2015 Capital Investment Plan; inform Members of the 2015/16 Capital Allocations received to date; to allow Members to consider how these allocations should be utilised and to seek approval for a scheme to be funded from Prudential Borrowing.

Alternative Options Considered and Rejected:

The options available to Members for the use of non ring-fenced capital grant allocations are included in the body of the report.

70. COMMITTEE IN COMMON (HEALTHY LIVING PROGRAMME) - COUNCIL REPRESENTATION

Further to Minute No. 28 of the meeting of the Health and Wellbeing Board held on 21 January 2015, the Cabinet considered the report of the Director of Corporate Services which provided sought approval to the appointment of a Council representative to serve on the Committee in Common (Healthy Living Programme).

Decision Made:

That Councillor Cummins be appointed as the Council's representative to serve on the Committee in Common (Healthy Living Programme).

Reasons for Decision:

The Cabinet has delegated powers to approve the Council's representatives to serve on Outside Bodies.

Alternative Options Considered and Rejected:

None.

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Report to:	Cabinet Council	**Date of Meeting**:	26 March 2015 23 April 2015
Subject:	Public Health Annual Report 2014		
Report of:	Director of Public Health	**Wards Affected:**	All
Is this a Key Decision?	No	**Is it included in the Forward Plan?**	Yes
Exempt/Confidential	No		

Purpose/Summary

To present the Annual Report of the Director of Public Health 2014

Recommendation(s)

Cabinet

The Cabinet is asked to receive the report and recommend it to Council for publication.

Council

(1) That Council receive the annual report of the Director of Public Health; and

(2) That Council notes that the report will be published.

How does the decision contribute to the Council's Corporate Objectives?

	Corporate Objective	Positive Impact	Neutral Impact	Negative Impact
1	Creating a Learning Community	✓		
2	Jobs and Prosperity	✓		
3	Environmental Sustainability	✓		
4	Health and Well-Being	✓		
5	Children and Young People	✓		
6	Creating Safe Communities	✓		
7	Creating Inclusive Communities	✓		
8	Improving the Quality of Council Services and Strengthening Local Democracy	✓		

Reasons for the Recommendation: The report is the statutory independent report of the Director of Public Health and identifies key health issues affecting the Sefton population.

What will it cost and how will it be financed?

(A) Revenue Costs – No direct costs associated with the report

(B) Capital Costs – No direct costs associated with the report

Implications:

The following implications of this proposal have been considered and where there are specific implications, these are set out below:

Legal Section 73B (5) and (6) of the National Health Service 2006 Act, inserted by Section 31 of the Health and Social Care Act 2012, provides that a Director of Public Health must produce an annual report and the local authority must publish the report.
Human Resources No specific implications
Equality The report identifies a number of health inequalities issues. 1. No Equality Implication [√] 2. Equality Implications identified and mitigated [ ] 3. Equality Implication identified and risk remains [ ]

Impact on Service Delivery: This report should be taken into account in all service plans.

What consultations have taken place on the proposals and when?

The Head of Corporate Finance and ICT has no comments on this report. The report is for information only and there are no decision arising from the contents of the report that have any direct financial implications for the Council. (FD3438/15)

The Head of Corporate Legal Services has been consulted and has no comments on the report. (LD 2730/15)

Are there any other options available for consideration?
No

Implementation Date for the Decision

Immediately following the Council meeting.

Contact Officer: Dr Janet Atherton
Tel: 0151 934 3608
Email: Janet.atherton@sefton.gov.uk

Background Papers:

There are no background papers available for inspection.

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Public Health Annual Report 2014

Introduction

Welcome to Sefton's Health 2014, my annual report on the health of people in Sefton. Under the Health and Social Care Act, I have a statutory responsibility to produce an annual report and Sefton Council has the statutory duty to publish it. The report does not aim to be comprehensive as a regularly updated overview of needs is provided by the Sefton Strategic Needs Assessment. Instead each year I aim to focus on a key issue, reviewing progress and highlighting future challenges.

This year, my report focuses on one of our Joint Health and Wellbeing Strategy's key objectives - giving every child the best possible start in life. From October 2015, we will take on a new role for commissioning children's public health services from 0-5, as well as those we already commission for 5-19 year olds. By doing this role well we can make a big difference to long-term health and long-standing health inequalities. We know that good health and wellbeing, from pregnancy to five years old, has a massive impact on later life. We also know a lot can be done to improve it.

Many people have contributed to this report and have a part to play in making the improvements necessary to ensure our children really do get the best start in life. I would particularly like to take this opportunity to thank elected members, my public health team, staff from across all council departments and partner organisations and the public for all they are doing to improve health and wellbeing in Sefton. I hope that you find the report informative and that you use it to take action to improve children's lives.

This will be my final annual report as Director of Public Health for Sefton, after thirteen years as DPH in the borough. It has been a great privilege to serve the people of Sefton and to play a small part in the big improvements in people's health that we have seen over that time. People can now expect to live three years longer on average, heart disease death rates have halved, teenage pregnancy rates are at their lowest and immunisation rates at their highest. But there is much more to do, especially to tackle health inequalities in the borough which will need a concerted sustained focus over many years to shift. This is inevitably even more difficult to achieve in financially challenging times for local communities and their public services but it is vital that we have a continued focus on keeping people healthy despite the challenges.

I have been fortunate to work with some really committed people during my time in Sefton and I would like to take this opportunity to thank them for their support and to wish everyone well for the future.

Examining the evidence: why should we act?

The evidence that early health and wellbeing is vital for life-long health is clearly set out in a succession of reports including *Health for All Children* (2006), the Marmot report (2010) and the Allen report (2011). The science is clear and the economic case even more compelling. As shown in recent Chief Medical Officer for England's reports we can no longer afford the huge cost resulting from preventable disease and injury. We must refocus on prevention.

“Women are less likely to have a pre-term baby if they don’t smoke: if a pre-term baby is breastfed, they have fewer complications.” & “Every pre-term birth costs the public-sector around £25,000 and society another £52,000”

“Reducing speed limits can help prevent childhood injuries” [20-MPH sign] & “A single traumatic brain injury can cost society £1.4 to £5 million over the long term”

Commissioning: New Roles for Sefton Council

From October 2015, Sefton Council will take over responsibility for commissioning children’s public health programmes for 0 to 5 year olds from NHS England. We will be responsible for commissioning the Healthy Child Programme that provides universal programmes like immunisation and screening to all families and additional targeted support for those with the greatest need. The programme is delivered by Health Visitors and the Family Nurse Partnership and aims to prevent illness through immunisation and picks up problems with child development early through screening programmes and health checks. Catching problems early.

Healthy Places: Thriving in Sefton

Children do best when they have safe places to play, be active, learn and grow. They need safe homes and neighbourhoods to live in, families and communities that help them thrive, and high quality health care. We need to build health into the way we do things that impact on children's everyday lives to make healthy living the norm rather than a struggle.

"We're supporting residential 20 mph zones for safer play"

The Directors of Public Health for Cheshire and Merseyside are working together through the champs public health collaboration to promote the healthy places approach with a wide range of organisations who can have a positive impact on the places where children are starting their journey in life.

Top 10 for Number 10: Keeping Health on the Agenda

There is a lot that we can do to improve children's lives through work in Sefton, but national policy also has a major role to play. That is why the North West Directors of Public Health published our "Top Ten for Number Ten" - ten evidence-based public health policy priorities. All ten affect child health, but five are especially important:

- Taxing sugar sweetened beverages: to help the fight against child obesity
- Banning unhealthy food adverts before 9pm: to reduce unhealthy food choices
- Getting schools to provide at least one hour of physical activity a day
- A commitment to eradicate child poverty: a preventable cause of physical and emotional problems
- Acting on the "1001 critical days" report: to give all babies the best possible start during a key period for brain development.

Targeted Support: Improving health where it is most needed

Sefton has big health inequalities between richer and poorer areas. We need to ensure that public health services give most support to those with the greatest need. These families will be concentrated in areas with high levels of child poverty, but it is important that we use the Healthy Child Programme effectively to identify families in need of support wherever they live. The Maternity Services Liaison Committee and the local breastfeeding programme have had a clear focus on reducing health inequalities in young children while helping all mothers and babies in Sefton.

Stronger Communities: Working together for health

Strong communities and strong families are vital for health. Organisations like Children's Centres, Healthy Living Centres and a diverse network of voluntary organisations have an important role to play in local communities. Developing community resilience is about communities having the things they need to withstand unexpected problems. It includes things like knowing where to go to get health advice and treatment, having good support networks available for times of individual need, and being prepared for emergencies.

FIND OUT MORE...

Sefton's joint health and wellbeing strategy [hyperlink http://modgov.sefton.gov.uk/moderngov/documents/s44151/Summary%20Health%20and%20Wellbeing%20Strategy%20-%202013-18.pdf]

The Public Health Outcomes Framework [hyperlink http://www.phoutcomes.info/]

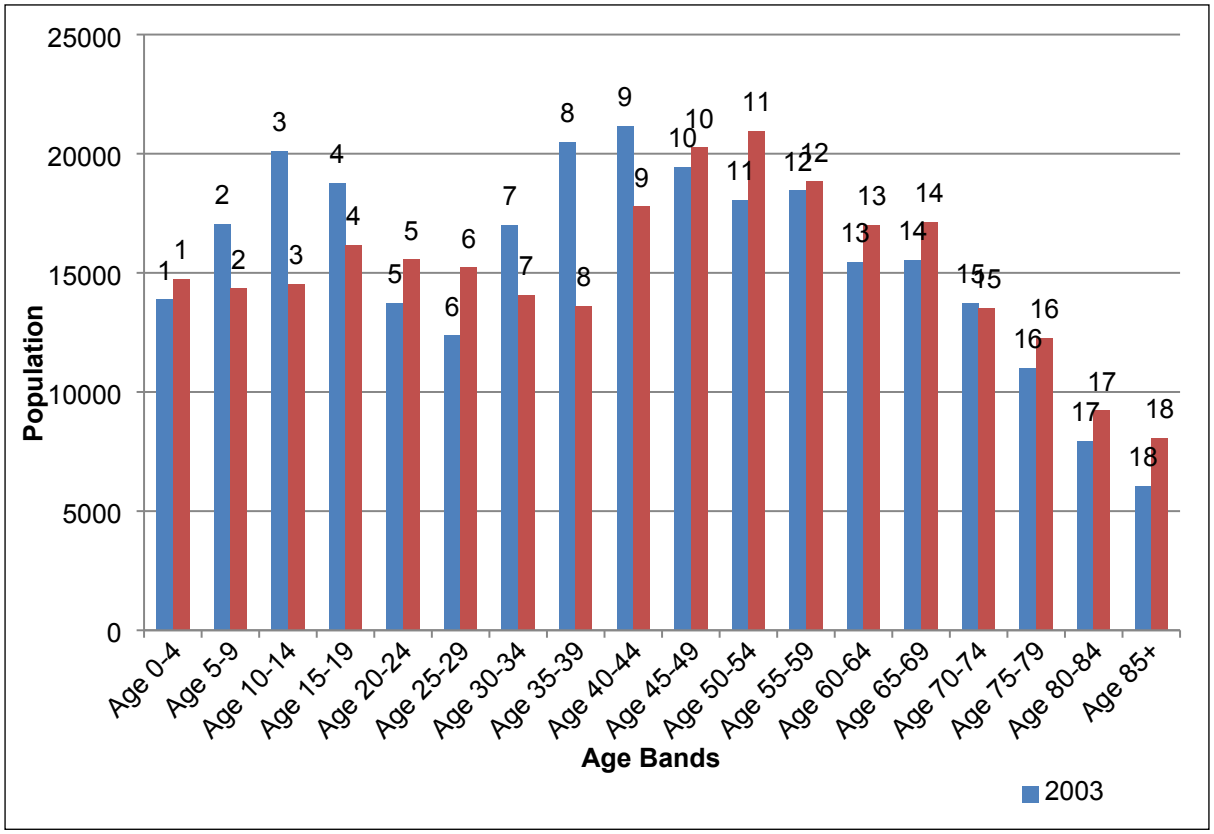
The Champs public health collaborative [hyperlink http://www.champspublichealth.com/]

The Northwest directors of public health group's 'Top Ten for Number Ten' [hyperlink http://phlive.org.uk/wp-content/uploads/Manifesto.pdf]

Chapter 1 - Health Needs in Sefton

Population

Sefton's population has changed markedly over the last ten years, with a growing older population and fewer children. However, whilst the numbers of older children have fallen, the number of 0 to 5s living in Sefton today is about the same as ten years ago: 17,000 children.



Source: Office of National Statistics

The Office for National Statistics has forecast that Sefton's population will grow by about 1% between 2011 and 2021, and that there will be fewer secondary school age children, more primary school age children, and around 450 more 0 to 5 year olds.

Life expectancy for both men and women in Sefton continues to improve. On average, Sefton men can expect to live for 77.5 years, and women 82.8 years. Over the past 10 years, life expectancy has increased by 2.6 years for men and 2.9 years for women. In terms of living a healthy life, Sefton men can expect to live an average of 62.5 years in good health, and women 63.9 years. Over the past 10 years, healthy life expectancy has increased by 1.8 years for men and 1.5 years for women. This means that whilst people are living longer, the time they spend in poor health has increased over this time.

Life expectancy varies a lot between different areas in Sefton. The most recent ward level life expectancy data for period 2009-13 shows that in the ward with the highest life expectancy (Ainsdale) men live, on average, 12.2 years longer and women 13.1 years longer than those in the lowest scoring ward (Linacre). The inequalities in health within Sefton were highlighted in Due North: the report of the Inquiry for Health Equity in the North published in 2014.

Table – Life expectancy at birth for men and women across Sefton wards by Deprivation			
Ward	Male Life Expectancy (Years)	Female Life Expectancy (Years)	Deprivation Quintiles
Linacre	70.5	76.6	Most Deprived Wards
Derby	74.1	80.7	
St Oswald	73.8	78.7	
Litherland	75.7	81.9	
Ford	77.1	84.1	
Church	73.6	79.3	Second Most Deprived Wards
Netherton and Orrell	76.5	82.2	
Dukes	75.1	81.5	
Manor	78.2	83.3	
Cambridge	75.4	80.6	Third Most Deprived Wards
Kew	78.2	80.1	
Norwood	76.1	83.4	
Molyneux	81.7	87.4	
Victoria	81.8	83.1	
Ainsdale	82.7	89.7	Fourth Most Deprived Wards
Sudell	81.0	86.7	
Birkdale	82.6	84.1	
Park	80.7	85.5	Least Deprived Wards
Meols	80.4	85.1	
Ravenmeols	81.6	84.8	
Blundellsands	81.8	85.3	
Harington	80.3	87.3	

Public Health Outcomes Framework - Sefton's Position

- In England there is a national public health outcomes framework that enables local areas to check their progress across four groups of outcomes: Wider determinants of health
- Health improvement
- Health protection
- Healthcare and premature mortality

Public Health England also produces a child health profile for every Local Authority area. An overview of Sefton's latest position against the public health outcomes framework and the child health profile is included in the appendix.

Improving the Wider Determinants of Health

The wider determinants of health are all those things in society that affect health - like poverty, the work environment, education, housing and being able to access healthy food easily.

Living in poverty can have a significant impact on early child development and health. One in five Sefton children lives in a low-income household. Children living in poverty are more likely to have slower development and poorer health than those who are better off. The proportion of Sefton children living in low income households is similar to the national average, but varies considerably across the borough.

In Linacre ward, about half of children live in low income families, yet in Harrington ward, the figure is only 1 in 20.

Children from poorer backgrounds are less likely to thrive and develop as quickly as other children in their first years of school. Across Sefton, just over half of all children achieve the minimum expected level of development by the end of reception year, which is worse than the England average. Among children receiving a free school meal, however, only 40% achieve the minimum. This is significantly worse than the England average of 45%.

Health Improvement

In 2013/14, 57% of Sefton babies were breastfed at birth. This is about the same as the last three years, and is still significantly lower than the England average of 75%. By 6 to 8 weeks, only 27% of are breastfed. This has improved slightly over the last three years, but remains significantly worse than the England average of 47%. The breastfeeding chapter explains how this will be targeted in coming years.

More women in Sefton smoke during pregnancy than the England average. Over the last three years, 15.3% of mothers were smoking at the time of delivery, compared with 12% nationally.

Recent information from the National Child Measurement Programme (2013/14) shows that fewer Sefton children aged 4 to 5 are overweight or obese compared with previous years. Across Sefton, 14.3% of 4 to 5 year-olds are overweight and 10.4% obese. These figures are higher than the national averages for England, but not significantly so, where 13.1% are overweight and 9.5% obese.

In 2013, the rate of hospital admission for accidental and deliberate injury for 0 to 4 year olds in Sefton was 117 per 10,000 children. This rate has decreased over the past three years and is now lower than the England average (135 per 10,000).

Health Protection

The proportion of Sefton children receiving their routine immunisations on time is better than the national average, with uptake of most vaccinations over 95%. In 2013/14, around 9 out of every 10 Sefton 5 year-olds received both doses of the measles, mumps and rubella (MMR) vaccine. This rate has improved over the past three years.

During winter 2013/14, all Sefton children aged 2 and 3 years old were offered the new nasal flu vaccine for the first time. Uptake of this was higher amongst children living in the Southport and Formby area (51.9% for 2 year olds and 46.4% for 3 year olds) than South Sefton area (36.8% for 2 year olds and 36.8% for 3 year olds).

Health Care

Between 2010 and 2012, fewer Sefton babies died before their first birthday than between 2008 and 2010. This infant mortality rate is currently 4.8 per 1,000 live births, which is not statistically significantly different to the England rate (4.1 per 1,000).

Childhood tooth decay in Sefton is similar to the England average. In 2011/12, the average number of teeth per child that were actively decayed, filled or had been extracted at 5 years old was 0.9, similar to the England average of 0.94.

Further resources & Useful Information

National Obesity Observatory, Public Health, England: http://www.noo.org.uk/

National Child Measurement Programme: http://www.hscic.gov.uk/ncmp

The Due North Report

http://www.cles.org.uk/wp-content/uploads/2014/09/Due-North-Report-of-the-Inquiry-on-Health-Equity-in-the-North-final1.pdf

Chapter 2 - Sefton as a place to thrive

Creating the right environment in which children can thrive is really important. Good education, excellent public planning and support for healthy living all contribute to healthier places and people. All children in Sefton should have access to good education and live in a decent and safe home, near to a park or open space, with opportunities to explore, play and have fun. These things make a huge difference to the short and long term health of developing children.

Places where children spend most of their time are a vital part of healthy child development. These places include the child's home, early years' settings (like nurseries and playgroups), and outside with parents or carers in the built and natural environment. Communities that have good quality open and green space, accessible public transport and opportunities for active travel e.g. walking and cycling, as well as access to affordable and healthy food enjoy better health than those who do not. Similarly, a safe and warm home is crucial to health and happiness especially for young children who spend a lot of their time at home. A home that is damp, mouldy, too cold, or over-crowded, can seriously affect their health and development. Being part of a homeless family can have an even greater effect. Improved housing conditions and support for households who struggle financially to heat their homes will enhance the health of children in Sefton.

Several chapters in this report describe the far reaching impact of living and growing up in poverty as a child. Over the last few years there have been a number of changes to the welfare and benefits system and a recent analysis of austerity policy in the UK suggests that children are amongst the groups most affected. Increasing family income through employment or maximising benefits reduces the negative impact of child poverty on lifelong health.

What is happening in Sefton

Sefton Council is working with our partners to make Sefton a place where more children can thrive and have a better start in life. Examples of this include:

- Sefton's Local Plan promotes accessible open and green space so children and families can enjoy the outdoors. This should improve child physical development and mental wellbeing.
- The roll out of 20 miles per hour speed limit areas will make residential areas safer for children to play.
- 'Healthy homes, Healthy people' is a pilot scheme to improve housing focusing on households with children vulnerable to poor health outcomes through their home environment.
- Over sixty parks and greenspaces in Sefton have signed up to the voluntary code for smokefree play areas. A survey of residents conducted in local parks (a quarter of them smokers), showed that 94% supported not smoking in playground areas.

- Volunteers and Sefton Council staff have been worked together over the last few years to get local organisations to sign up to be a breastfeeding-friendly venue. This scheme will get a welcome boost following the Council resolution to encourage local organisations to become breastfeeding friendly.

What more could we do in Sefton?

Local authorities, alongside health and community partners, have a key contribution to make in ensuring housing, education, environment, planning, transport and regulatory services promote good health. The following actions from local partners would support children and families in Sefton to thrive:

- All public sector organisations adopting a Health in All Policies approach - building health and wellbeing in all new plans and policies, including the Local Plan and Neighbourhood Plans.
- Reducing the number of children living in poverty by maximising incomes, job creation with a focus on young people and boosting the local economy.
- Improve the quality of housing in the private rented sector and addressing fuel poverty.
- Develop transport infrastructure to make physically active travel the norm and minimise injury and death.
- Ensure access to universal early years services including health and education provision.

Find out more...

Sefton's local plan http://www.sefton.gov.uk/localplan

Breastfeeding in Sefton http://www.healthysefton.nhs.uk/Breastfeeding.htm

Austerity Policy – link to doc

Chapter 3 - School Readiness: Getting the best start in education

Getting the best possible education can have a profound impact throughout a person's life, health, and emotional wellbeing. Early education has a huge impact on later life chances, income, and health. In England, children at the end of reception year (aged 5 years old) are assessed against the government standard "good level of development". This looks at child development, a marker of school readiness.

We know that gaps in educational attainment between poor children and other children of the same age already exist at school entry age. As noted in the health needs chapter just over half of all children in Sefton achieve the minimum expected level of development by the end of reception year, which is worse than the England average. Among children receiving a free school meal, however, only 40% achieve the minimum. This is significantly worse than the England average of 45%. These figures have improved from the previous year.

By understanding what works in improving school readiness, we can prioritise what we can do to improve it most effectively.

School readiness depends on every child achieving the best possible early physical health, development, and mental wellbeing. This can be supported through things like the national Healthy Child Programme and through targeted work to improve school readiness. The Healthy Child Programme helps through;

- Early identification of need and risk
    - Identifying those at risk of poor development and outcomes because of child, family, and environmental factors
- Universal health and development reviews
    - Identifying and addressing difficulties early in life
- Supporting the family unit
    - An important part of early child development
- Supporting parenting
- Preventing obesity
- Promoting breastfeeding and good nutrition

Improving school readiness means working to improve all of those things that impact on a child's early health, wellbeing, and development. This includes;

- The child's nutrition
- The home environment
- The family environment, parenting, and the home environment
- Early language development
- Recognising developmental delay
- Screening for visual and hearing impairments, and other medical problems
- Creating opportunities for safe play, and health promoting physical environments
- Improving dental health
- Reducing exposure to hazards like passive smoke, home accidents, and road collisions.

In Sefton Council, the school readiness team works with schools, nurseries, children's centres, child minders and families to improve partnership between organisations and improve school readiness. This team especially targets their approach to those children and families who are most vulnerable.

What more could be done?

The scope for closer working between early years services and the delivery of the Healthy Child Programme should be reviewed as the Council takes on responsibility for commissioning the HCP in 2015. Improving school readiness should be a key aim of this closer working.

Find out more

Health for All Children
(http://www.dhsspsni.gov.uk/guidance_and_principles_of_practice_for_professional_staff__health_for_all_children.pdf)

The Healthy Child Programme

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

Chapter 4 - Pregnancy in Sefton

Local picture

The Maternity Services Liaison Committee – known as the MSLC - works to ensure a healthy start and healthy future for all new-born babies and their families living in Sefton. The MSLC is made up of parents, health professionals and representatives from Sefton Council, Sefton Clinical Commissioning Groups and the local Community and Voluntary Sector (CVS).

Almost 3000 babies are born in Sefton each year. Sefton's maternity services are there to support all mothers through a healthier pregnancy and birth. Support is needed throughout pregnancy as we know that some women find it difficult getting to appointments or antenatal classes, while some vulnerable families are more likely to have premature babies and need extra help. The focus of the MSLC is on promoting a healthy pregnancy and reducing health inequalities by making sure everyone can get the care and support they need. This involves:

- Engaging parents to promote healthy eating, and to support them to quit smoking and book early at maternity services to prevent problems like low birth-weight.
- Promoting choice in antenatal care and place of birth. We know that home birth is a safe option for women with low risk pregnancies. Women who plan a home birth are half as likely to have a caesarean section or forceps delivery, yet fewer than 2% of women in Sefton have a home birth.

We know that more women would choose this option if they were fully aware and supported in planning the birth.

- Developing better working together across health services, social care, children's centre's and the voluntary sector to that we all work to meet the needs of Sefton families. This includes those who may have extra needs for example young or single parents, or parents with disabilities.

Sefton midwives work together with health visitors and others to deliver the Healthy Child Programme. At the booking appointment between 8 and 12 weeks of pregnancy they give mothers information about screening tests, immunisations, healthy eating, breastfeeding support, and help with stopping smoking. At this and future appointments they also help prepare mothers and partners for parenthood, including preparing for the birth, and safe care of their baby. This includes a discussion on safe sleep to help prevent sudden infant death. Midwives also support mum's emotional wellbeing and mental health, and improve parent and baby attachment which improves the baby's mental wellbeing.

This year the MSLC supported Liverpool Women's NHS Foundation Trust's successful bid to the Department of Health to refurbish the midwifery led unit and low risk postnatal area. The bid focused on improving choice for women and encouraged normal birth and will provide additional birthing pools and improved rooms to let partners stay. This will help to make birth a more normal and less medical experience.

We also recognise the importance of joined up services between maternity services, health visiting, general practice and our children centre colleagues. Later chapters will describe some of the positive examples of this work.

Looking forward

The MSLC recognises that involving parents is essential in shaping services that are responsive to Sefton communities. Year on year, they have worked on increasing parent participation and engagement. Over the last few years the MSLC has supported Southport and Ormskirk baby day. This has led to more parents contacting and joining the parent task group of the MSLC. The challenge going forward is to maintain the enthusiasm and commitment of all, but in particular the parents. This will allow them to create a sustainable group for improving Sefton's high quality maternity services. The MSLC will develop a strategy to ensure new parents join the MSLC and maintain its vibrancy.

The MSLC parent task-group recently surveyed local parents to find out what really mattered to them during their pregnancy: this will directly inform future commissioning and improvements to maternity services. A number of challenges for maternity providers and commissioners were identified by the survey. They include:

- The need for sensitive healthy lifestyle advice and support for women who are overweight or obese
- A need for increased support in completing and implementing birth plans
- The need for more breastfeeding peer support whilst on the maternity unit

- The need to increase the offer and uptake of antenatal classes

In response to these and other findings from the survey, the parents have decided to develop a parent charter, setting out what mothers and their partners can expect from all the statutory services during pregnancy. This has the support of the CCG who commission maternity services and the maternity services themselves. It will also involve those partner services mentioned earlier.

MSLC recommendations for Sefton based on feedback from parents in the survey

- All partners must endorse the parent charter and ensure services provide the level of care agreed within it.
- Providers and commissioners should improve the choice and uptake of antenatal classes, particularly amongst those groups who have experienced difficulty attending.
- Maternity providers should develop a more robust system to ensure consistent and maintained birth plans.
- Providers and commissioners should increase the level of breastfeeding peer support in maternity units
- Sensitive support should be provided to those women who need to achieve a healthier weight.

In July 2014 a number of parents from the MSLC attended the Faculty of Public Health Annual Conference in Manchester. They presented a poster showcasing how local parents got involved with the MSLC.

Sefton MSLC now has growing, creative and inclusive parent participation. A dynamic and positive relationship exists between parents, local government, voluntary sector, health commissioners and maternity providers. The impact can be seen in:

- Parents taking the lead, e.g. chairing the committee
- The creation of a parent task-group, with work plan directed by the parents
- Parent attendance and contribution at related events, e.g. the launch of 'Cheshire and Merseyside Children, Young People and Maternity Clinical Network'
- Parents challenging providers and raising issues relevant to families
- The task-group completion of a parent survey and commitment from providers to respond to findings.
- Active parent Twitter and Facebook account.
- Fund raising activities

Chapter 5 - Emotional Wellbeing

Pregnancy and childbirth should be a happy time for both mother and baby. But it is not without its stresses and strains. Having good mental wellbeing gives mothers and carers the skills and strength they need to cope with the physical and emotional changes they go through. It also helps them cope with the normal fears and excitement about having a baby and of course the sleepless nights. However, around 1 in 7 mothers experience mental health problems. These range from low mood to clinical depression. This can happen any time before, during, or after the baby is born. Left untreated, they can lead to serious consequences, such as neglect of the baby, behavioural problems in older children and at its most tragic a mother attempting to take their own life. However, it is important to remember that with the right support this does not need to happen.

The evidence for supporting mothers

The National Institute for Health and Care Excellence (NICE) has produced guidance that sets out the care mothers and their families should receive. This starts with support from the Health Visitor and where appropriate goes onto include more specialist mental health support. It is widely accepted that effective and timely prevention, detection and treatment can have a positive impact on mothers and their families and reduce long-term difficulties. Health Visitors are trained to assess mental wellbeing and have an extensive knowledge of local support. All mothers receive a patient information leaflet called ‘Your emotional wellbeing in pregnancy and beyond’. This provides the health visitor with an opportunity to help mums talk

about how they have been feeling. If the health visitor thinks the mum needs additional help, they will refer mothers for psychological therapy and or other support services, for example, an exercise programme.

At the moment, the mental wellbeing assessment happens after the birth. But from early 2015 all pregnant women in Sefton will be offered a visit from the health visitor by 28 weeks of pregnancy. This will help health visitors identify and provide appropriate support earlier if it is needed.

Sefton's Health Visitors have developed resources to support maternal mental wellbeing and these are available in thirteen languages spoken in Sefton. This ensures that mums who do not speak English as their first language have equal access to mental wellbeing support.

Some of Sefton's Children's Centres now offer short 'Think differently, cope differently' courses to support mums with mild to moderate depression and anxiety. These provide a great resource for health visitors to refer parents to. Some of the Children's Centres also offer a 'Positive Thoughts' Course which has proven popular with mums.

Case Study

Jane is a made-up person, but her story is typical of some of the clients our health visitors support.

The Health Visitor visited first-time-mum Jane, with her 3 month old baby Dylan. She has been Jane's Health Visitor since Dylan's birth and has visited them at home a couple of times, and has also seen Jane and Dylan in clinic. Sefton Health Visitors routinely assess maternal mental health when the baby is 3 to 4 months old. During the assessment, Jane was tearful and said that her partner had left her. She said there had been some domestic violence and that she felt depressed and anxious. Jane was isolated, had little family-support locally and had low confidence. Jane said that Dylan was difficult to settle and cried a lot. The assessment tools identified mild clinical depression and moderate levels of anxiety. For the next few weeks the Health Visitor visited Jane at home to undertake 'Listening Visits' and she also accompanied her to her local Children's Centre, where Jane enrolled on the 'Positive Thoughts' Course which really helped to lift her mood and lessen her anxiety. She continued to attend the Children's Centre and became involved in the Community Garden there. A year on, her confidence has increased and she has now started a part time job. Dylan is settled in a local nursery. The support for Jane outlined in this case study will have provided long term benefits to Dylan in relation to his educational outcomes, his behaviour and his long term wellbeing.

What more could be done?

Health Visitors will soon be able to measure the level of maternal emotional wellbeing across Sefton. This will help to identify areas of greatest need in Sefton and enable health visitors to target their support during pregnancy and the early years to those who need it most.

Find out more

FIND OUT MORE

Guidance from NICE on care after birth - https://www.nice.org.uk/Guidance/QS37

Sefton Children's Centres - http://www.sefton.gov.uk/schools-learning/early-years-and-childcare/childrens-centres.aspx

Chapter 6 - Protecting mothers and babies: antenatal and newborn screening

The NHS provides world class health screening for health problems in pregnancy and for newborn children. This is part of the routine, free, and universal care offered to women who are pregnant and to their children. Pregnant women are asked for permission by their midwife, and then they are offered blood tests, ultra sound scans, and a questionnaire.

For newborn babies, the heel prick blood spot test, a hearing test, and a physical examination are offered to every baby.

There is lots of information about these screening programmes on the internet – links to useful information can be found at the end of this chapter.

Six screening tests offered:

Pregnant women are offered screening for:

- infectious diseases that could harm the mother or baby, such as syphilis and HIV;
- inherited blood-disorders related to family origin, such as sickle cell disease;
- abnormalities such as spina-bifida or chromosome disorders (the commonest being Down's syndrome);

Babies are offered screening for:

- the heel-prick blood spot test for rare diseases that can be treated if picked up early - they are phenylketonuria, MCADD, thyroid underactivity, cystic fibrosis, and sickle cell/ thalassemia and from January 2015 this has been expanded to include four more inherited metabolic diseases.
- inherited hearing impairment (deafness)
- congenital problems at birth such as hip or heart problems

Over 97% of pregnant women cared for by Liverpool Women's Hospital and Southport and Ormskirk Hospital have screening blood tests. Approximately 46% of women are screened for Down's syndrome at Liverpool Women's and 42% are screened at Southport and Ormskirk.

Pregnant women are screened for sickle cell disease if they have a family origin from certain African or Mediterranean countries. It's important for women to book early with their midwife so that this can be done in good time.

Just over 98 per cent of babies get their hearing tested, and more than nine out of ten have the heel prick blood spot test in good time after birth. Almost three in every hundred babies need a second heel prick test because the first sample was too small. Local midwives are working hard to get this figure down to one in two hundred.

We don't yet have good data on how many children get their full physical examination, but local hospitals are starting to collect this.

An example: the heel prick test (new born blood spot)

At about a week old, the midwife gets a drop of blood from the baby's heel and soaks it onto a special piece of blotting paper. This paper strip is sent to Alder Hey Hospital where a sophisticated laboratory runs a series of tests for the five diseases: phenylketonuria, MCADD, thyroid underactivity, cystic fibrosis, and sickle cell/ thalassemia.

If any of the tests is positive, then the result is checked further, and parents are contacted for a specialist opinion. For each of the diseases, picking them up early makes a huge difference to the baby as they grow up. In the case of thyroid underactivity, for example, a simple daily treatment means that the baby develops completely normally. In contrast, if it wasn't picked up early, the baby's mental and physical development are affected.

What could be improved?

- More women could benefit from screening if local maternity teams improve the uptake of infectious disease and Down's syndrome screening tests.
- Women should be booked with their midwife early enough in their pregnancy so that sickle cell tests can be offered quickly when needed.

- The heel prick test should be given in good time and without delay to almost every baby, not just nine out of ten babies.
- The sample should be “right first time” so that babies do not need to have it repeated.
- Local hospitals should collect and report data on the newborn physical examination.

Childhood vaccinations in Sefton

The NHS infant vaccination programme protects children from more than 20 common and serious infectious diseases, such as tetanus, polio, diphtheria, some forms of meningitis, mumps, measles, rubella (german measles), rotavirus diarrhoea, and pneumonia. Teenage girls also get the HPV vaccine in school year 8, which protects them against the genital warts virus – a major cause of cervical cancer. Next to clean drinking water, good nutrition and good parenting, vaccinations are one of the most important things that keep children healthy.

Most children in Sefton complete their recommended course of vaccines, and uptake of routine vaccinations has improved over the last few years. The number of 5 year olds getting their second dose of MMR still needs to be improved, however, as two doses are needed to ensure immunity. The good uptake in Sefton is down to parents ensuring they bring their children for vaccination, hard work by local doctors and nurses, and good organisation of the immunisation programme by Public Health England to make sure the vaccines are available. The table shows how well Sefton did in 2013/14.

2013/14 was the first year that children were offered immunisation against flu. The uptake rate for Sefton as a whole was similar to the national rate but further work is needed to improve this for future years.

FIND OUT MORE...

Sefton's joint health and wellbeing strategy [hyperlink http://modgov.sefton.gov.uk/moderngov/documents/s44151/Summary%20Health%20and%20Wellbeing%20Strategy%20-%202013-18.pdf]

The Public Health Outcomes Framework [hyperlink http://www.phoutcomes.info/]

The Champs public health collaborative [hyperlink http://www.champspublichealth.com/]

The Northwest directors of public health group's 'Top Ten for Number Ten' [hyperlink

http://www.screening.nhs.uk/annbpublications . There is information in other languages at www.screening.nhs.uk/languages.

Childhood Vaccinations April 2013 to March 2014: uptake as % of all invited infants. Sefton children are some of the best protected in the North of England.

For best protection, 95% (nineteen out of twenty) children need to be up to date with their vaccinations

	England	North West	Sefton
Diphtheria, tetanus, polio and Hib meningitis at 12 months old	94.3%	95.7%	96.3%
Pneumococcal vaccine at 12 months old	94.1%	95.3%	96.0%
Diphtheria, tetanus, polio and Hib meningitis at 2 years old	96.1%	97.3%	97.2%
Pneumococcal vaccine at 2 years old	92.4%	94.2%	95.0%
Hib meningitis at 2 years old	92.5%	94.3%	94.9%
MMR (mumps, measles, rubella vaccine) at 2 years old	92.7%	94.9%	94.7%
MMR (mumps, measles, rubella vaccine) at 5 years old	88.3%	92.0%	90.3%
Note: Source is NHS England data analysis, collated by Merseyside Screening and Immunisation Team			

Flu Vaccination Uptake: 2013/14

	England	South Sefton CCG	Southport & Formby CCG
Flu vaccination coverage in ALL 2 year olds combined	42.6%	38.1%	54.1%
Flu vaccination coverage in ALL 3 year olds combined	39.5%	34.8%	50.7%

Chapter 7 - Health Visiting and the Family Nurse Partnership

Health Visiting and Family Nurse Partnership

Local picture

Every family with a new baby or a child under the age of five will have a health visitor. Health visitors are qualified nurses or midwives who have specialist training in child health and health promotion. The health visitor can provide practical support and confidential health advice.

In Sefton, health visitors take over from midwives and deliver the Healthy Child Programme (HCP) for ages 0 to 5. Health visitors are supported in delivering the HCP by child health practitioners and nursery nurses. They also work closely with midwives, Family Nurse Partnership, school health, children's centres, social care and the voluntary sector. The Healthy Child Programme is a series of reviews, screening tests, vaccinations and information to support parents and help them give their child the best chance of staying healthy and well. The HCP is based on a model of 'progressive universalism'. In other words, there are standard services available to everyone (universal), and additional services available to those who need them most or are at risk (progressively more services provided according to need). The programme is offered in GP surgeries, local clinics, and Children's Centres. Some reviews can be done at home which enables the health visitor to assess the child in the family environment.

Because health visitors have specialised knowledge of community health, health promotion and child health they are able to provide specialist care from birth through to starting school. Health visitors play a pivotal role in safeguarding children and addressing issues like neglect. As part of the Healthy Child Programme, health visitors have recently started contacting families shortly before the birth to offer early support and advice, and set out the support families can expect once their baby is born.

During child development reviews, the health visitor asks how the child is doing and about any concerns parents may have. The first home visit will usually take place when babies are 10 to 15 days old. During the check-up the health visitor examines the baby and records the details in the baby's red book (Personal Child Heath Record). After the first visit, a development review takes place at 6 to 8 weeks old. Further routine reviews are at three months, four months, one year, between two and two and a half years, and at school entry (four to five years). Once the child reaches school age, the school nursing team and school staff help support the child's ongoing health and development.

Looking forward

From 2015, some of Sefton's most vulnerable families will be supported by the more intensive Family Nurse Partnership support programme. This is a targeted programme offered to first time mothers aged 19 or under. Unlike the regular health visiting service, it begins in early pregnancy; with the Family Nurse offering weekly and fortnightly visits right up until the child is two years old. The aim is to work with

young parents, helping them to understand about their pregnancy and how to care for themselves and their baby. The focus is on partnership, nurses do not tell parents what they should do, but work with them to help them make decisions about giving birth, looking after their baby and toddler and deciding what is best for them.

The programme has three major goals

- To improve antenatal health
- To improve child health and development
- To improve economic self-sufficiency

The programme is aspirational, helping young parents become the best parents they can be, and in turn helping their baby to grow, develop and learn. Nurses will also help parents explore childcare options, education and training and provide support to help parents manage household finances and setting up home.

Work is underway to recruit and train the Family Nurse Partnership Team that will work in Sefton. Liverpool Community Health already provides this service in Liverpool where it has shown positive health outcomes. The programme originated in the United States where it has been shown to provide the following benefits.

- Reduction in smoking whilst pregnant
- Fewer subsequent births and greater intervals between births
- Fewer accidents
- Increase in employment

- Reduction in child abuse and neglect
- Improved child language development
- Increased access to education and training
- Greater involvement of fathers

From October 2015, Local Authorities will take over responsibility for commissioning health visiting and FNP services from NHS England. The staff that provide the services will remain in the NHS provider services. This is the final component of transferring responsibility for public health to the council and it provides a real opportunity to align these core services along with its other key early years staff, e.g. children's centres, staff working in social care, disabilities team, and to ensure good links with public health programmes for older children.

The 2010 'Fair Society, Healthy Lives' review by Professor Sir Michael Marmot showed that investing in early years is vital to reducing health inequalities and that the returns on investment in early childhood are higher than in older age groups. The Healthy Child programme provides a blend of services, some of which are universal, with an ability to scale-up the service where need is highest. By having a universal service like this, we can support the most disadvantaged in Sefton and prevent families who might have "hidden" problems, e.g. post natal depression falling through the net. This approach has potentially huge benefits for the long-term health of Sefton's children.

What more should we do?

The local authority should work with the NHS to ensure a safe transfer of commissioning responsibility and the quality of the Health Visiting service and Family Nurse Partnership is maintained or improved post transfer.

Opportunities for building stronger links with early years services and with 5-19 public health programmes should be created.

FIND OUT MORE

The Healthy Child Programme - https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

Fair Society Healthy Lives Report (The Marmot Review) - http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

Chapter 8 - Healthy Lifestyle Choices

The earlier healthy lifestyle choices are started, the more of a habit they become throughout childhood and into later life. This chapter describes what we are doing locally to give children a healthy start in life.

Smoking & Pregnancy

The Local Picture

Smoking during pregnancy is a serious public health concern because it damages the health of both mother and baby. A Royal College of Physicians' Report (2010) said that in the UK each year, maternal smoking during pregnancy impairs the growth and development of the unborn child and leads to miscarriages, perinatal deaths, premature births and low birth weight babies.

Smoking during pregnancy is measured nationally through Smoking At Time of Delivery data (SATOD). Sefton's rate for 2013/14 was 15.3%, with higher rates in South Sefton CCG at 17.1% than in Southport and Formby at 12.2%. Overall Smoking At Time of Delivery has seen only a slight decrease from 15.6 % to 15.3% between 2012/13 and 2013/14.

During 2013/14 there were 292 pregnant women who set a quit date with the Sefton stop smoking service, an increase of 28 pregnant women compared to the previous year. 47% of the women who set a quite date went on to successfully stop smoking, an increase of 3 percentage points on the previous year.

What is being done to address these issues

We are using the latest scientific evidence and recommendations to reduce smoking in pregnancy with the aim of:

- Improving the health of mothers who smoke
- Reducing the risk of harm to her unborn child

Following NICE guidance: the Merseyside 'stop smoking in pregnancy pathway'

We know from NICE guidance that midwives play a key role in identifying, referring and supporting pregnant smokers. The NICE recommendations have been applied by organisations working together across Merseyside. This includes organisations like local councils and NHS maternity services. This partnership approach has been crucial to ensure there is a consistent approach to help pregnant women to quit smoking across Merseyside.

The Merseyside 'stop smoking in pregnancy pathway' helps ensure that NHS maternity services have an evidence-based comprehensive approach to stop smoking. This means that pregnant smokers in Sefton are identified and supported to quit smoking wherever they choose to give birth.

Specialist stop smoking support

Pregnant women in Sefton can access a specialist stop smoking service through SUPPORT, Sefton's local NHS stop smoking service. They provide one-to-one quit support, including the option of home visits for pregnant women. During 2013/14, 138 pregnant women went on to successfully stop smoking.

Incentive scheme for vulnerable pregnant quitters

Pregnant women at risk of relapse can be offered rewards to continue on their quit attempt for at least four weeks. Once on this incentive programme clients can be rewarded if they sustain their quit attempt throughout the pregnancy and for at least 8 weeks after birth. Women take a carbon monoxide breath test to demonstrate they are smokefree.

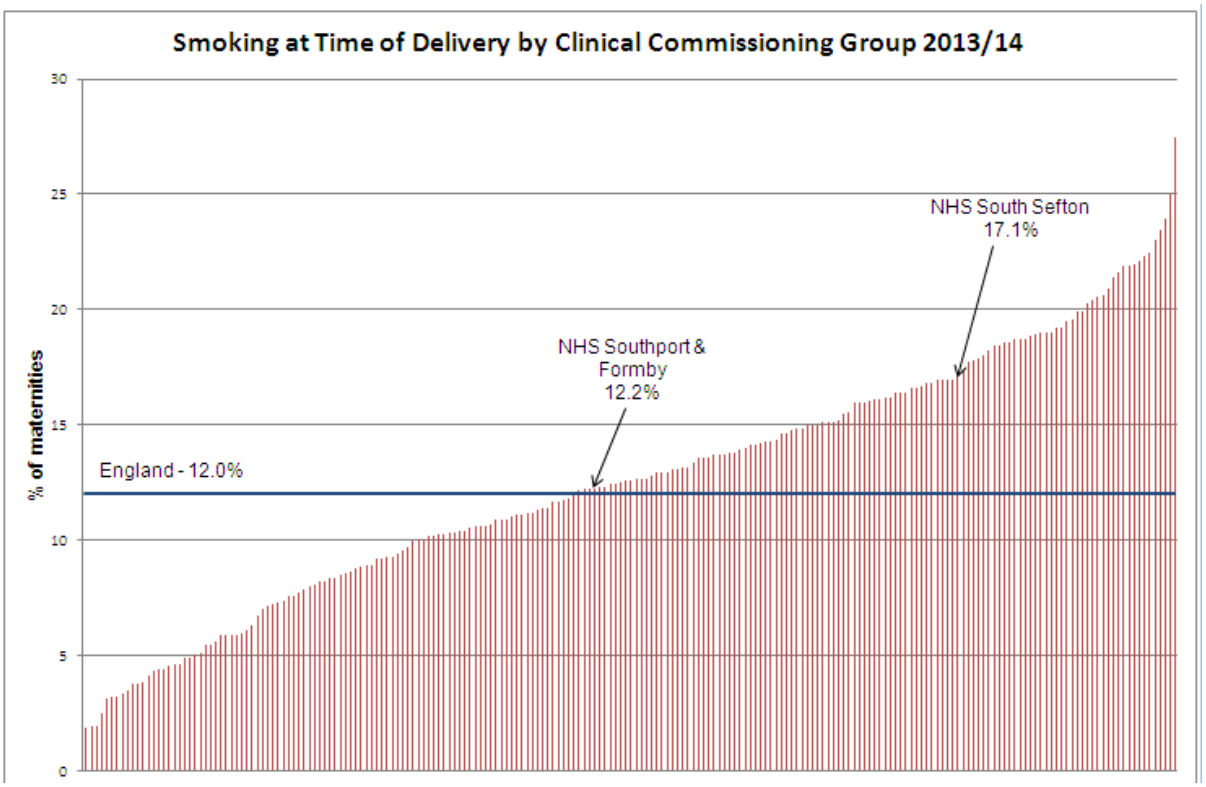
<u>What more could be done in Sefton?</u>

- We should work with partners to support young women to quit smoking before they have children. More importantly, work should be done to prevent young women from starting to smoke.

- Sefton Council should work in partnership with maternity service commissioners, to audit current practice against national smoking in pregnancy guidance and take action to improve compliance where needed in Sefton.

- We need to understand better why some women in Sefton opt out of using specialist stop smoking services to support them to stop smoking during pregnancy, and use this information to tailor the service better to their needs.

- We should identify new ideas that can support pregnant women to quit smoking, such as finding examples of good practice and innovative delivery in other areas.



Breastfeeding

Local picture

Breastfeeding is the healthiest way to feed a baby. Breastfeeding contributes to the health of mother and child in both the short and long term and provides all the nutrients a baby needs. The current UK policy is to promote exclusive breastfeeding (feeding only breast milk) for the first 6 months, and then continuing for as long as the mother and baby wish while gradually introducing a more varied diet.

The percentage of Sefton mothers deciding to breastfeed (the breastfeeding initiation rate) increased from 54% to 57% between 2012/13 and 2013/14. The percentage still breastfeeding at 6 to 8 weeks did not change over the same period remaining at 27%. This compares to national rates of 74% and 47% respectively so although we have seen improvement in breastfeeding initiation over the last year there is more to be done to improve rates further.

What are we doing to address these issues?

Sefton's Baby Friendly Initiative

Sefton achieved international recognition from the United Nations Children's Fund (UNICEF) in 2014, by successfully passing the accreditation process for Stage 3 of the Baby Friendly Initiative (BFI). Stage 3 is the final stage of the BFI award and acknowledges the commitment, support and dedication that staff and volunteers in Sefton offer to mum's and families. The BFI award process involved professionals being interviewed and assessed: pregnant women and new mothers were asked about their experience and the care they had received in over thirty different aspects

of breastfeeding. More than 80% of mothers reported positive feedback in each of the areas.

Southport & Ormskirk hospital have achieved their certificate of commitment for BFI status and are currently working to achieve the next stage of this award through the delivery of training programmes to staff in the hospital and ensuring that hospital policies and procedures promote the most supportive environment to encourage breastfeeding. Improvements may take time to be reflected in the statistics.

Breast Start

Sefton's breastfeeding peer support programme called Breast Start, is made up of paid staff and volunteers. Sefton women have found this service valuable - during 2013/14, 68% of mum's supported by Breast Start were still breastfeeding at 6 weeks. The service provides antenatal workshops, support on post natal wards, postnatal support groups, home visits and telephone support.

Breastfeeding Friendly Venues

Sefton runs a programme to encourage businesses in Sefton to actively welcome breastfeeding on their premises. 43 venues in Sefton have so far committed to providing a welcoming and supportive environment to breastfeeding mothers. Further work is underway to build on increasing the number of breastfeeding friendly venues, and to highlight to all Sefton organisations how important it is to provide a welcoming and supportive breastfeeding environment.

Breast milk – it's amazing

The 'Breast milk- it's amazing' campaign was launched in 2009 across Sefton, Knowsley, Liverpool and Wirral. It is a high profile health promotion campaign that aims to improve breastfeeding uptake in the region. The campaign was later adopted by Champs – Cheshire and Merseyside's public health collaborative service. Champs have since developed the campaign with a relaunch and a series of related events that link parents into support groups.

The Healthy Start Scheme: Providing access to free fruit, vegetables, and vitamins

Good nutrition is vitally important for early child development. The Department of Health's 'Healthy Start' scheme provides free weekly vouchers for fruit, vegetables, milk, and infant formula. It also offers free vitamin tablets for pregnant mothers and free vitamin drops for children at around 6 months old (when they are weaning onto solid foods and need vitamin supplements). The vitamins offered are tailored to the needs of pregnant mothers (providing folic acid, Vitamins C & D) and (Vitamins A, C & D) to young children, to help prevent birth defects and rickets. Vitamins are distributed via children's centres and nurseries – this helps introduce mothers to the other health improving services available at children's centres.

The fruit and vegetable voucher element of Healthy Start can assist with establishing healthier eating habits to help with maintaining a healthy weight.

The Healthy Start scheme is a statutory duty for the local authority, and is offered to families on specific benefits and all mothers under 18 years old.

In Sefton, the scheme has been supplemented by a local offer since 2009; so that all of Sefton's pregnant mothers and children under two have access to free vitamin supplements. This local offer has improved the uptake of the national Healthy Start programme in Sefton. Sefton's supplementary local offer has been shared as a model of good practice with other local public health teams and with the NHS England.

Future plans are for Sefton Council to work in partnership with food banks to improve the opportunity for eligible young families to access the necessary vitamins and food options to maintain a healthy diet.

Future Challenges

- The first few hours after delivery is a crucial time for breastfeeding support to be provided. Given the loss of Council funding for a comprehensive service, it will be important to work with Sefton Clinical Commissioning Groups, maternity and health visiting services and Breast Start to find ways of supporting breastfeeding effectively. Any voluntary activity or service supported by mainstream NHS services would have most impact if focussed in the immediate post natal period.

- Maintaining the BFI status in Sefton's community settings and ensuring that the guidance is being adhered to and new staff are trained.

- Achieving BFI status at Southport and Ormskirk hospital to ensre consistent support for new mothers wishing to breastfeed.

- Maintenance and expansion of breastfeeding friendly venues across Sefton to ensure that women feel comfortable to breastfeed and know that they will get a positive welcome when they do.

FIND OUT MORE

Healthy Sefton: Stop Smoking Service -

http://www.healthysefton.nhs.uk/Stop_Smoking.htm

Healthy Sefton: Breastfeeding Support -

http://www.healthysefton.nhs.uk/Breastfeeding/Local_Breastfeeding_Support.htm

Chapter 9 - Keeping Children Safe

When a child dies in Sefton: lessons for the future

Government legislation requires every Local safeguarding Children Board (LSCB) to review the death of each child or young person who lived in their area. By doing this, we can find ways of preventing future deaths and help support families. Each child death is a personal tragedy for the individual family, but looking at deaths collectively across Merseyside helps agencies identify interventions that may prevent further deaths or injury.

Sefton is part of the 'Mersey Child Death Overview Panel'. This panel receives a short report about each child and how they died. The information comes from records held by hospitals, local health services, schools, police, children's services or other agencies whose staff knew the child. The panel, which includes public health specialists, medical doctors, other health specialists, children's services staff, education staff, and police, meets monthly to review the reports.

The panel is not concerned with blame but focuses on finding out if anything can be changed to prevent similar deaths in the future. They also look at what support was offered to the child and their family before and after the death. The panel can recommend changes to these arrangements if needed.

The process is confidential and information about the panel should be given to parents by the registrar when they register the death of a child. Parents can contact the panel if they wish to receive individual feedback about their child, or want to contribute extra information that they feel may help to improve the care of children.

During 2013/14, the deaths of 14 Sefton children were considered by the Mersey Panel. Twelve of the deaths occurred in babies less than one year old, and of those six were neonates, that is babies less than 28 days old. For Merseyside as a whole, deaths in the neonatal and infant age groups continue to be much greater than in any other age group. Across Mersey, the commonest causes of death at this age are:

- complications associated with prematurity,
- genetic and congenital anomalies,
- and in older babies - sudden unexpected, death in infancy (also known as SUDI)

Other chapters in this year's report highlight the importance of women booking early in pregnancy. This ensures that all women get early offered pregnancy screening to identify medical conditions during pregnancy. Supportive midwifery and health visiting care can also help mothers improve their chance of a healthy pregnancy and birth through quitting smoking, healthy eating, and starting and continuing to breastfeed. Smoking and poor maternal diet is connected to low birthweight babies.

And we know that breastfeeding offers positive protection to babies from infection and allergy.

Sadly, sudden infant death often remains unexplained. But we know that the risk is greatly reduced if parents do not smoke, if babies are breastfed, and if they are placed to sleep in a safe environment. Sudden unexpected death is, thankfully, rare but it can happen. To help prevent it, all Sefton health staff advise the following:

Things to do

- Always place your baby on their back to sleep
- Keep your baby smoke free during pregnancy and after
- Place your baby to sleep in a separate cot or Moses basket in the same room as you for the first six months
- Breastfeed your baby
- Use a firm, flat waterproof mattress in good condition

Things to avoid

- Never sleep on a sofa or armchair with your baby
- Don’t sleep in the same bed as your baby
- Avoid letting your baby get too hot
- Don’t cover your baby’s face or head while sleeping or use loose bedding

Domestic violence: preventing harm to children

There are national and local strategies and programmes designed to support families and looked after children in their living and social environments. These include programmes to reduce the impact of domestic abuse on children, the government's 'Troubled Families' programme, and local programmes that support community social networks. Although only very rarely implicated in the death of children, panel reviews have identified a significant number of domestic violence incidents. In response, Sefton Council is researching the experience and impact of domestic violence on the health and wellbeing of people, including children who are affected by domestic violence.

Looking Forward

The Mersey panel is planning a series of training sessions for all front line staff who support parents and carers of babies. This will ensure they are able to discuss safe sleeping arrangements with families and give clear advice. The training will use a common protocol currently being developed across Merseyside NHS Trusts.

Sefton also plan to work with panel partners across Cheshire and Merseyside to develop a media campaign promoting safe sleeping practice.

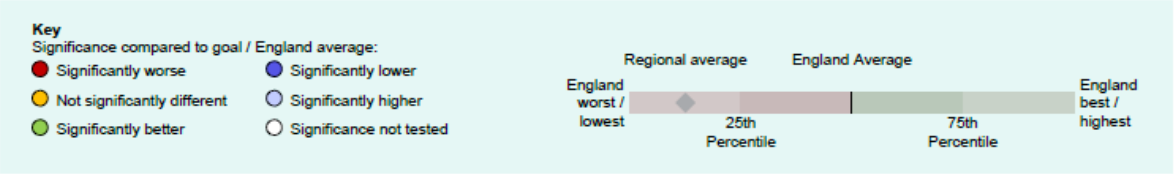
Members of the panel are also delivering updates on the work and findings of the panel across Merseyside. Feedback from staff working in Sefton has been positive. Sharing learning will hopefully help protect children from potential harm and avoidable risks to health.

Find out more

Merseyside Child Death Overview Panel (including annual reports) - http://www.liverpoolscb.org/sub_child_death_overview_panel.html

Vulnerable Victims Advocacy Team - http://www.sefton.gov.uk/advice-benefits/crime-and-emergencies/domestic-violence.aspx

Spine Charts



Overarching indicators

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
0.1i - Healthy life expectancy at birth (Male)	2010 - 12	62.5	63.4	52.5		70.0
0.1i - Healthy life expectancy at birth (Female)	2010 - 12	63.9	64.1	55.5		71.0
0.1ii - Life Expectancy at birth (Male)	2011 - 13	78.1	79.4	74.3		82.6
0.1ii - Life Expectancy at birth (Female)	2011 - 13	82.5	83.1	80.0		86.2
0.1ii - Life Expectancy at 65 (Male)	2011 - 13	18.2	18.7	16.0		21.1
0.1ii - Life Expectancy at 65 (Female)	2011 - 13	21.1	21.1	18.8		24.0
0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Male)	2011 - 13		9.1			
0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Female)	2011 - 13		6.9			
0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Male)	2011 - 13		80			
0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Female)	2011 - 13		73			
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male)	2011 - 13	12.2	-	2.4		17.3
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Female)	2011 - 13	10.4	-	0.6		11.4
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Male)	2011 - 13	-1.3	0.0	-5.1		3.2
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Female)	2011 - 13	-0.6	0.0	-3.1		3.1
0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Male)	2010 - 12		19.4			
0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Female)	2010 - 12		19.8			
0.2vii - Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area (Male)	2011 - 13		-			
0.2vii - Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area (Female)	2011 - 13		-			

Wider determinants of health

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
1.01i - Children in poverty (all dependent children under 20)	2012	19.2	18.6	39.0		6.4
1.01ii - Children in poverty (under 16s)	2012	20.1	19.2	37.9		6.6
1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception	2013/14	57.8	60.4	41.2		75.3
1.02i - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2013/14	39.5	44.8	31.7		68.1
1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2013/14	72.3	74.2	64.3		82.5
1.02ii - School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2013/14	58.7	61.3	31.8		76.9
1.03 - Pupil absence	2012/13	5.65	5.26	6.31		4.36
1.04 - First time entrants to the youth justice system	2013	413	441	847		171
1.05 - 16-18 year olds not in education employment or training	2013	5.7	5.3	9.8		1.8
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Persons)	2013/14	83.5	74.8	47.7		94.5
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Male)	2013/14	88.0	74.5	46.2		94.9
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Female)	2013/14	76.1	75.3	50.0		94.0
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons)	2013/14	62.7	60.9	12.6		93.3
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Male)	2013/14	60.7	59.5	10.7		92.8
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Female)	2013/14	65.1	62.5	15.2		94.2
1.07 - People in prison who have a mental illness or a significant mental illness	2012/13		4.35			
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	2013/14	12.9	8.7	-2.5		24.2
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	2013/14	71.0	65.1	46.7		79.1
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2013/14	69.4	64.8	55.3		75.0
1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week	2010 - 12	2.0	2.5	4.6		0.8
1.09ii - Sickness absence - The percent of working days lost due to sickness absence	2010 - 12	1.5	1.6	3.1		0.4
1.10 - Killed and seriously injured (KSI) casualties on England's roads	2011 - 13	32.6	39.7	78.9		16.6
1.11 - Domestic Abuse	2012/13	30.2	18.8	5.6		30.2
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	2010/11 - 12/13	92.3	57.6	167.8		9.3
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	2013/14	6.6	11.1	4.6		27.8
1.12iii- Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	2013/14	0.64	1.01	0.38		2.43
1.13i - Re-offending levels - percentage of offenders who re-offend	2012	28.8	25.9	19.9		35.6
1.13ii - Re-offending levels - average number of re-offences per offender	2012	0.82	0.77	0.52		1.27
1.14i - The rate of complaints about noise	2012/13	3.3	7.5	80.4		2.5
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2011	4.2	5.2	0.8		20.8
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2011	6.2	8.0	1.2		42.4

Wider determinants of health continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
1.15i - Statutory homelessness - homelessness acceptances	2013/14	0.4	2.3	0.1		12.5
1.15ii - Statutory homelessness - households in temporary accommodation	2013/14	0.1	2.6	29.7		0.0
1.16 - Utilisation of outdoor space for exercise/health reasons	Mar 2013 - Feb 2014	13.0	17.1	0.3		30.8
1.17 - Fuel Poverty	2012	11.4	10.4	21.3		4.9
1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like	2013/14	48.5	44.5	35.4		54.4
1.18ii - Social Isolation: % of adult carers who have as much social contact as they would like	2012/13	40.1	41.3	23.9		58.5
1.19i - Older people's perception of community safety - safe in local area during the day	2012/13		97.5			
1.19ii - Older people's perception of community safety - safe in local area after dark	2012/13		61.9			
1.19iii - Older people's perception of community safety - safe in own home at night	2012/13		94.3			

Health improvement

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
2.01 - Low birth weight of term babies	2012	2.4	2.8	5.0		1.5
2.02i - Breastfeeding - Breastfeeding initiation	2013/14	56.8	73.9	36.6		93.0
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	2013/14	27.2	-	19.4		77.4
2.03 - Smoking status at time of delivery	2013/14	15.3	12.0	27.5		1.9
2.04 - Under 18 conceptions	2012	28.0	27.7	52.0		14.2
2.04 - Under 18 conceptions: conceptions in those aged under 16	2012	5.2	5.6	15.8		2.0
2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2013/14	24.8	22.5	29.5		15.9
2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2013/14	35.0	33.5	43.8		24.4
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2012/13	100.9	103.8	191.3		61.7
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2012/13	117.4	134.7	282.4		76.0
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2012/13	150.3	130.7	277.3		63.8
2.08 - Emotional well-being of looked after children	2013/14	10.8	13.9	10.5		22.3
2.09ii - Smoking prevalence age 15 years - regular smokers	2013		8			
2.09iii - Smoking prevalence age 15 years - occasional smokers	2013		10			
2.12 - Excess Weight in Adults	2012	68.7	63.8	74.4		45.9
2.13i - Percentage of physically active and inactive adults - active adults	2013	54.4	55.6	43.4		66.3
2.13ii - Percentage of active and inactive adults - inactive adults	2013	31.5	28.9	39.2		16.3
2.14 - Smoking Prevalence	2013	18.7	18.4	29.4		10.5
2.14 - Smoking prevalence - routine & manual	2013	29.3	28.6	47.5		16.5
2.15i - Successful completion of drug treatment - opiate users	2013	7.3	7.8	3.5		15.8
2.15ii - Successful completion of drug treatment - non-opiate users	2013	48.4	37.7	7.6		60.2
2.16 - People entering prison with substance dependence issues who are previously not known to community treatment	2012/13	41.4	46.9	69.8		19.7
2.17 - Recorded diabetes	2013/14	6.39	6.21	3.69		8.66

Health improvement continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
2.18 - Alcohol related admissions to hospital - narrow definition (Persons)	2012/13	731	637	1121		365
2.18 - Alcohol related admissions to hospital - narrow definition (Male)	2012/13	989	829	1425		454
2.18 - Alcohol related admissions to hospital - narrow definition (Female)	2012/13	511	465	839		269
2.19 - Cancer diagnosed at early stage (Experimental Statistics)	2012	46.1	41.6	34.4		60.3
2.20i - Cancer screening coverage - breast cancer	2014	73.2	75.9	57.4		83.7
2.20ii - Cancer screening coverage - cervical cancer	2014	71.6	74.2	59.5		79.7
2.21i - Antenatal infectious disease screening – HIV coverage	2013/14		98.9			
2.21iii - Antenatal Sickle Cell and Thalassaemia Screening - coverage	2013/14		98.9			
2.21iv - Newborn bloodspot screening - coverage	2013/14	98.4 ^	93.5	81.9		99.9
2.21v - Newborn Hearing screening - Coverage	2013/14	98.8	98.5	92.7		99.9
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	2012/13	- x	79.1	66.0		94.8
2.21viii - Abdominal Aortic Aneurysm Screening	2013/14	50.1	95.9	39.3		100
2.22iii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check	2013/14	20.7	18.4	0.8		44.4
2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2013/14	44.4	49.0	14.6		100
2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS Health check	2013/14	9.2	9.0	0.9		29.1
2.23i - Self-reported well-being - people with a low satisfaction score	2013/14	8.4	5.6	12.7		3.3
2.23ii - Self-reported well-being - people with a low worthwhile score	2013/14	5.4	4.2	7.7		2.9
2.23iii - Self-reported well-being - people with a low happiness score	2013/14	10.6	9.7	15.0		5.8
2.23iv - Self-reported well-being - people with a high anxiety score	2013/14	24.9	20.0	29.3		9.3
2.23v - Average Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) score	2010 - 12		37.7			
2.24i - Injuries due to falls in people aged 65 and over (Persons)	2012/13	2119	2011	3508		1178
2.24i - Injuries due to falls in people aged 65 and over (males/females) (Male)	2012/13	1860	1602	2975		903
2.24i - Injuries due to falls in people aged 65 and over (males/females) (Female)	2012/13	2377	2420	4041		1452
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79	2012/13	1118	975	1826		544
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+	2012/13	5021	5015	9119		2876

Health protection

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
3.01 - Fraction of mortality attributable to particulate air pollution	2012	4.0	5.1	3.0		7.7
3.02i - Chlamydia detection rate (15-24 year olds) - Old NCSP data < 2000 2000 to 2400 ≥ 2400	2011	1994	2092	948		4911
3.02ii - Chlamydia detection rate (15-24 year olds) - CTAD < 1900 1900 to 2300 ≥ 2300	2013	1770	2016	840		5758
3.02ii - Chlamydia detection rate (15-24 year olds) - CTAD (Male)	2013	1023	1387	599		4262
3.02ii - Chlamydia detection rate (15-24 year olds) - CTAD (Female)	2013	2505	2634	1094		6358
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2013/14	- *	-	13.6		100
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2013/14	- ^	-	-100.0		100
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old) < 90 ≥ 90	2013/14	96.3 ^	94.3	78.6		98.4

Sefton

Health protection continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old) < 90 ≥ 90	2013/14	97.2 ^	96.1	81.6		99.1
3.03iv - Population vaccination coverage - MenC < 90 ≥ 90	2012/13	95.5 ^	93.9	75.9		98.8
3.03v - Population vaccination coverage - PCV < 90 ≥ 90	2013/14	96.0 ^	94.1	78.2		98.3
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old) < 90 ≥ 90	2013/14	94.9	92.5	76.6		98.1
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years) < 90 ≥ 90	2013/14	91.7 ^	91.9	72.7		98.1
3.03vii - Population vaccination coverage - PCV booster < 90 ≥ 90	2013/14	95.0 ^	92.4	76.4		98.5
3.03viii - Population vaccination coverage - MMR for one dose (2 years old) < 90 ≥ 90	2013/14	94.7 ^	92.7	78.3		98.3
3.03ix - Population vaccination coverage - MMR for one dose (5 years old) < 90 ≥ 90	2013/14	96.3 ^	94.1	74.8		98.6
3.03x - Population vaccination coverage - MMR for two doses (5 years old) < 90 ≥ 90	2013/14	90.3 ^	88.3	63.8		97.4
3.03xii - Population vaccination coverage - HPV < previous years England average ≥ previous years England average	2013/14	90.6	86.7	51.1		96.6
3.03xiii - Population vaccination coverage - PPV < previous years England average ≥ previous years England average	2012/13	69.6 ^	69.1	55.3		77.0
3.03xiv - Population vaccination coverage - Flu (aged 65+) < 75 ≥ 75	2013/14	75.8	73.2	62.9		80.5
3.03xv - Population vaccination coverage - Flu (at risk individuals) < 75 ≥ 75	2013/14	53.2	52.3	38.9		68.6
3.04 - People presenting with HIV at a late stage of infection < 25 25 to 50 ≥ 50	2011 - 13	39.1	45.0	77.3		25.9
3.05i - Treatment completion for TB < 85 ≥ 85	2012	- x	82.8	22.6		100
3.05ii - Incidence of TB	2010 - 12	4.0	15.1	112.3		0.0
3.06 - NHS organisations with a board approved sustainable development management plan	2013/14	50.0	41.6	0.0		83.3
3.07 - Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies	2014/15	100	95.2	0.0		100

Healthcare and premature mortality

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
4.01 - Infant mortality	2010 - 12	4.8	4.1	7.5		1.1
4.02 - Tooth decay in children aged 5	2011/12	0.90	0.94	2.10		0.35
4.03 - Mortality rate from causes considered preventable (Persons)	2011 - 13	216.6	183.9	319.7		130.3
4.03 - Mortality rate from causes considered preventable (Male)	2011 - 13	273.9	233.1	409.1		166.5
4.03 - Mortality rate from causes considered preventable (Female)	2011 - 13	164.8	138.0	235.2		93.7
4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons)	2011 - 13	80.8	78.2	137.0		52.1
4.04i - Under 75 mortality rate from all cardiovascular diseases (Male)	2011 - 13	112.7	109.5	184.9		75.0
4.04i - Under 75 mortality rate from all cardiovascular diseases (Female)	2011 - 13	52.7	48.6	91.2		29.9

Healthcare and premature mortality continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2011 - 13	52.2	50.9	89.0		30.7
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2011 - 13	79.6	76.7	130.9		46.2
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2011 - 13	27.9	26.5	57.1		14.5
4.05i - Under 75 mortality rate from cancer (Persons)	2011 - 13	161.9	144.4	198.9		104.0
4.05i - Under 75 mortality rate from cancer (Male)	2011 - 13	181.1	160.9	230.7		113.8
4.05i - Under 75 mortality rate from cancer (Female)	2011 - 13	145.3	129.2	182.3		95.5
4.05ii - Under 75 mortality rate from cancer considered preventable (Persons)	2011 - 13	98.6	83.8	126.9		52.7
4.05ii - Under 75 mortality rate from cancer considered preventable (Male)	2011 - 13	107.5	91.3	148.1		46.9
4.05ii - Under 75 mortality rate from cancer considered preventable (Female)	2011 - 13	90.9	76.9	118.2		55.6
4.06i - Under 75 mortality rate from liver disease (Persons)	2011 - 13	26.9	17.9	43.4		11.3
4.06i - Under 75 mortality rate from liver disease (Male)	2011 - 13	38.7	23.6	58.9		14.3
4.06i - Under 75 mortality rate from liver disease (Female)	2011 - 13	16.1	12.5	27.7		7.4
4.06ii - Under 75 mortality rate from liver disease considered preventable (Persons)	2011 - 13	24.5	15.7	39.5		9.6
4.06ii - Under 75 mortality rate from liver disease considered preventable (Male)	2011 - 13	35.3	21.1	54.4		12.4
4.06ii - Under 75 mortality rate from liver disease considered preventable (Female)	2011 - 13	14.7	10.5	24.5		6.4
4.07i - Under 75 mortality rate from respiratory disease (Persons)	2011 - 13	35.4	33.2	78.1		19.5
4.07i - Under 75 mortality rate from respiratory disease (Male)	2011 - 13	38.7	39.1	94.6		23.0
4.07i - Under 75 mortality rate from respiratory disease (Female)	2011 - 13	32.4	27.6	67.1		14.2
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Persons)	2011 - 13	18.7	17.9	46.6		7.6
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Male)	2011 - 13	19.6	20.4	52.9		10.6
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Female)	2011 - 13	17.9	15.5	41.4		7.6
4.08 - Mortality from communicable diseases (Persons)	2011 - 13	56.3	62.2	93.8		36.0
4.08 - Mortality from communicable diseases (Male)	2011 - 13	67.0	72.1	117.0		46.9
4.08 - Mortality from communicable diseases (Female)	2011 - 13	50.8	56.2	91.4		30.9
4.09 - Excess under 75 mortality rate in adults with serious mental illness	2012/13	368.6	347.2	564.2		139.4
4.10 - Suicide rate (Persons)	2011 - 13	9.7	8.8	13.6		4.5
4.10 - Suicide rate (Male)	2011 - 13	16.2	13.8	21.9		8.0
4.10 - Suicide rate (Female)	2011 - 13	- x	4.0	6.6		2.2
4.11 - Emergency readmissions within 30 days of discharge from hospital (Persons)	2011/12	11.9	11.8	14.5		8.8
4.11 - Emergency readmissions within 30 days of discharge from hospital (Male)	2011/12	12.2	12.1	14.9		8.7
4.11 - Emergency readmissions within 30 days of discharge from hospital (Female)	2011/12	11.7	11.5	14.7		8.3
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2012/13	125.1	104.4	31.7		221.3
4.12ii - Preventable sight loss - glaucoma	2012/13	11.6	12.5	2.8		29.3
4.12iii - Preventable sight loss - diabetic eye disease	2012/13	2.9	3.5	1.1		14.0
4.12iv - Preventable sight loss - sight loss certifications	2012/13	54.1	42.3	13.5		79.8

Sefton Child Health Profile — March 2014

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

25th percentile — England average — 75th percentile

	Indicator	Local no.	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	**1** Infant mortality	14	5.0	4.3	7.7	1.3
	2 Child mortality rate (1-17 years)	3	5.5	12.5	21.7	4.0
Health protection	**3** MMR vaccination for one dose (2 years)	2,757	95.8	92.3	77.4	98.4
	4 Dtap / IPV / Hib vaccination (2 years)	2,822	98.1	96.3	81.9	99.4
	5 Children in care immunisations	275	84.6	83.2	0.0	100.0
	6 Acute sexually transmitted infections (including chlamydia)	1,124	34.8	34.4	89.1	14.1
Wider determinants of ill health	**7** Children achieving a good level of development at the end of reception	1,488	51.1	51.7	27.7	69.0
	8 GCSEs achieved (5 A*-C inc. English and maths)	2,121	60.9	60.8	43.7	80.2
	9 GCSEs achieved (5 A*-C inc. English and maths) for children in care	5	18.4	15.3	0.0	41.7
	10 16-18 year olds not in education, employment or training	630	6.7	5.8	10.5	2.0
	11 First time entrants to the youth justice system	142	550.7	537.0	1,426.6	150.7
	12 Children in poverty (under 16 years)	9,770	20.9	20.6	43.6	6.9
	13 Family homelessness	35	0.3	1.7	9.5	0.1
	14 Children in care	420	78	60	166	20
	15 Children killed or seriously injured in road traffic accidents	12	26.1	20.7	45.6	6.3
Health improvement	**16** Low birthweight of all babies	196	7.0	7.3	10.2	4.2
	17 Obese children (4-5 years)	276	10.2	9.3	14.8	5.7
	18 Obese children (10-11 years)	516	20.0	18.9	27.5	12.3
	19 Children with one or more decayed, missing or filled teeth	-	26.5	27.9	53.2	12.5
	20 Under 18 conceptions	153	30.3	30.7	58.1	9.4
	21 Teenage mothers	35	1.2	1.2	3.1	0.2
	22 Hospital admissions due to alcohol specific conditions	40	73.2	42.7	113.5	14.6
	23 Hospital admissions due to substance misuse (15-24 years)	24	72.9	75.2	218.4	25.4
Prevention of ill health	**24** Smoking status at time of delivery	426	15.6	12.7	30.8	2.3
	25 Breastfeeding initiation	1,479	54.0	73.9	40.8	94.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	760	27.5	47.2	17.5	83.3
	27 A&E attendances (0-4 years)	16,179	1,106.9	510.8	1,861.3	214.4
	28 Hospital admissions caused by injuries in children (0-14 years)	440	100.9	103.8	191.3	61.7
	29 Hospital admissions caused by injuries in young people (15-24 years)	485	150.3	130.7	277.3	63.8
	30 Hospital admissions for asthma (under 19 years)	197	344.4	221.4	591.9	63.4
	31 Hospital admissions for mental health conditions	53	98.5	87.6	434.8	28.7
	32 Hospital admissions as a result of self-harm (10-24 years)	172	355.8	346.3	1,152.4	82.4

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2010-2012
2 Directly standardised rate per 100,000 children age 1-17 years, 2010-2012
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2012/13
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2012/13
5 % children in care with up-to-date immunisations, 2013
6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2012
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012/13
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2012/13
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2013 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2012
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2012
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2011
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2012/13
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2013
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2010-2012
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2012
17 % school children in Reception year classified as obese, 2012/13
18 % school children in Year 6 classified as obese, 2012/13
19 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
20 Under 18 conception rate per 1,000 females age 15-17 years, 2011
21 % of delivery episodes where the mother is aged less than 18 years, 2012/13
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2010/11-2012/13
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2010/11-2012/13
24 % of mothers smoking at time of delivery, 2012/13
25 % of mothers initiating breastfeeding, 2012/13
26 % of mothers breastfeeding at 6-8 weeks, 2012/13
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2011/12
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2012/13
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2012/13
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2012/13
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2012/13
32 Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2012/13

Report to:	Cabinet	**Date of Meeting:**	26th March 2015
Subject:	Adult Substance Misuse Contract Extension	**Wards Affected:**	All
Report of:	Director of Public Health		
Is this a Key Decision?	Yes	**Is it included in the Forward Plan?**	Yes
Exempt/Confidential	No		

Purpose/Summary

To report the key findings of the Adult Substance Misuse Contract review.

Recommendation(s)

The Cabinet agrees to extend the contract of Lifeline to provide Adult Substance Misuse services in Sefton for an additional 12 months until 30th September 2016.

How does the decision contribute to the Council's Corporate Objectives?

	Corporate Objective	Positive Impact	Neutral Impact	Negative Impact
1	Creating a Learning Community	√		
2	Jobs and Prosperity	√		
3	Environmental Sustainability		√	
4	Health and Well-Being	√		
5	Children and Young People	√		
6	Creating Safe Communities	√		
7	Creating Inclusive Communities	√		
8	Improving the Quality of Council Services and Strengthening Local Democracy		√	

Reasons for the Recommendation:

Since taking over the contract 18 months ago the provider has addressed underperformance. Further time is required to see the full benefits of changes in the service model.

The current contract expires at the end of September 2015. A decision must be made by the end of March 2015 at the latest on whether the contract should be extended or retendered. This will provide Lifeline with the minimum 6 months notice period.

The contract was originally awarded for 2 years with the option to extend annually up to 3 years. This is therefore an extension within the existing contract.

Alternative Options Considered and Rejected:

Extend contract for a longer time period. A longer extension would require measurable improvements over the next 12 months.

Retender. The current provider has only been in place for 18 months. Changing providers in such a short time is likely to cause disruption to the care of clients and confusion within the network of substance misuse partners, i.e. primary care, acute services, residential rehabilitation and detoxification agencies.

What will it cost and how will it be financed?

(A) Revenue Costs

There are no additional costs. The contract is agreed: £3,599,574 per annum

(B) Capital Costs

There are no additional costs

Implications:

The following implications of this proposal have been considered and where there are specific implications, these are set out below:

Financial		
Legal		
Human Resources		
Equality		
1.	No Equality Implication	
2.	Equality Implications identified and mitigated	√
3.	Equality Implication identified and risk remains	

Impact of the Proposals on Service Delivery:

Service delivery would continue as planned.

What consultations have taken place on the proposals and when?

The Head of Corporate Finance and ICT has been consulted and comments have been incorporated into the report (FD 3427/15)

Head of Corporate Legal Services have been consulted and any comments have been incorporated into the report. (LD 2719/15)

Implementation Date for the Decision

Following the expiry of the “call-in” period for the Minutes of the Cabinet.

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Background

In line with Department of Health and NICE commissioning guidance, Sefton Council commissions a range of services and interventions to respond to drug and alcohol-related harm. These include:

- Community based, inpatient and residential treatment services
- Early intervention and specialist treatment or young people with substance misuse problems, and
- Advice and support concerning employment, education, training, accommodation and welfare

In 2013, following consultation, a system re-design took place with a re-tendering of the adult community drug and alcohol services. As a result a recovery-focused integrated treatment model was awarded to Lifeline Project in July 2013. The re-tendering did not include residential recovery and rehabilitation services or young people's services. The contract was agreed for 2 years and is due to end on the 30th September 2015. The service provides a range of specialist treatment and recovery interventions:

- Comprehensive assessment and health checks
- Blood borne virus testing and vaccination
- Opiate replacement treatment and medically assisted withdrawal programmes
- Community opiate detoxification programmes
- Structured psychosocial interventions (including cognitive behaviour type interventions and motivational interviewing)
- Relapse prevention programmes
- Criminal Justice an drug Intervention Programmes (DIP)
- Access to residential detoxification and residential rehabilitation programmes
- Needle and syringe programmes
- SMART recovery groups
- Alcohol support and extended Brief Intervention Groups
- Strengthening families
- Recovery support including assisted access to mutual aid groups (Narcotics Anonymous and Alcoholics Anonymous)

The service currently operates from two offices: Bootle and Southport as well as community outreach satellite venues.

A decision must be made by the end of March 2015 on whether the contract should be extended. This will provide Lifeline with the minimum 6 months notice period. As such the public health commissioners have reviewed Lifeline performance, consulted with key partners in primary care, safeguarding, legal and Public Health England to inform the cabinet decision on contract extension.

Approach Adopted and Key Elements of the Lifeline Assessment

Performance has been measured against agreed Key Performance Indicators. These are based on national benchmarks and local parameters developed in partnership with amongst others the Council children's safeguarding lead.

Complaints and compliments made by service users and other stakeholders are regularly

reviewed, along with the provider response and implementation of learning.

Partnership working and client care pathway development is monitored. This is evidenced at monthly performance meetings and through the work of the Substance Misuse Strategy Group chaired by the DPH.

Patient safety incidents, e.g. controlled drug errors (these include errors in prescribing or dispensing methadone or other substance misuse medication)

Other considerations include

- Market of alternative providers – there is a limited pool of potential providers.
- Financial cost of re-commissioning. A new provider is likely to require start up costs which would add to the 15/16 budget.
- Impact on clients, provider and other stakeholders of changing provider. Previous tendering processes have led to early loss of key staff and reliance on agency staff when the new provider takes over the service.

Key Findings

Commissioners have noted underperformance against some key indicators. In response, Lifeline has implemented changes to service delivery aimed at improving performance. Further administrative and working practice changes should see continued improvements.

The provider has been open and transparent in discussing feedback from clients and stakeholders. This has facilitated service development.

Significant improvements have been made over the last 6 months in partnership working. This includes developing joint working protocols with children's social care, discharge planning from hospital care and integrated pathways with other treatment services.

The current service has been in place for 18 months. Service users and those partners who refer clients have now come to recognise the service as the main provider of adult substance misuse treatment and recovery support in Sefton. The cost and disruption of tendering for a new service has the potential to distract from the provision of a vital service to a vulnerable client group.

Conclusions

Progress has been made in achieving the desired redesign in adult substance misuse services. Commissioners are satisfied, that with the implementation of agreed and time specific service developments improvements to client outcomes will continue.

Extending the contract within the current agreement will enable a fuller evaluation of whether the current specification has been successful in delivering the desired outcomes of integrating the service, i.e. increased engagement with those who misuse alcohol and greater focus on recovery. A review of the contract at the end of 15/16 would enable 30 months of activity and stakeholder feedback to be assessed.

Commissioners therefore recommend extending the contract for an additional 12 months until the 30th September 2016.

Report to: Cabinet **Date of Meeting:** 26 March 2015

Subject: Better Care Fund - Section 75 Agreement

Report of: Deputy Chief Executive **Wards Affected:** All

Is this a Key Decision? Yes **Is it included in the Forward Plan?** No

Exempt/Confidential No

Purpose/Summary

This report seeks approval from the Cabinet for the Council to enter into partnership arrangements under section 75 of the National Health Act 2006 ('section 75 agreements') with each of the two Clinical Commissioning Groups (CCGs) of Southport and Formby and South Sefton covering the population of Sefton, enabling pooled budgets to be established to support the delivery of the Sefton Better Care Fund (BCF) plan for 2015/16

Recommendation(s)

That the Cabinet:

1) Cabinet is requested to note the work to date on the BCF plan and Section 75 agreement for the pooled budget.

2) Cabinet is asked to delegate authority to the following officers, Head of Corporate Finance and ICT, Head of Vulnerable Adults and the Head of Corporate Legal Services to complete the Section 75 agreement with Southport and Formby Clinical Commissioning Group and South Sefton Clinical Commissioning Group to enable pooled funds to be established and to govern the delivery of the Sefton Better Care Fund Plan 2015/16.

3) notes that the proposal was a Key Decision but had not been included in the Council's Forward Plan of Key Decisions. Consequently, the Leader of the Council and the Chair of Overview and Scrutiny Committee (Performance and Corporate Services) have been consulted under Rule 27 of the Access to Information Procedure Rules of the Constitution, to the decision being made by the Cabinet as a matter of urgency on the basis that it was impracticable to defer the decision until the commencement of the next Forward Plan because of the tight timescales involved in the submission of the Better Care Fund submission, and any delay in the submission could involve the loss of financial income for the Council.

How does the decision contribute to the Council's Corporate Objectives?

Corporate Objective		Positive Impact	Neutral Impact	Negative Impact
1	Creating a Learning Community	X		
2	Jobs and Prosperity		X	

3	Environmental Sustainability	X		
4	Health and Well-Being	X		
5	Children and Young People	X		
6	Creating Safe Communities	X		
7	Creating Inclusive Communities	X		
8	Improving the Quality of Council Services and Strengthening Local Democracy	X		

Reasons for the Recommendation:

Under the auspices of the Health and Wellbeing Board, Sefton submitted its successful Better Care Fund plan in November 2014. One of the conditions of the approval of the plan was a standard condition relating to the development of a section 75 agreement for managing the budgets identified within the Better Care Fund Plan

This is reflected in the Care Act 2014 which requires that funds allocated to local areas for the Better Care Fund must be put into pooled budgets established under section 75 agreements. Authority is required from the Council's Cabinet and each CCG Governing Body to enable each organisation to enter into the section 75 agreements.

These agreements need to be in place by 1st April 2015 to allow the funds to be pooled and invested in line with the Sefton Better Care Fund plan.

What will it cost and how will it be financed?

The pooled budget will total £24.231m and will be funded by the transfer of £21.423m from the Department of Health to the Council and the inclusion of £2.808m ring-fenced Council capital funding (£1.959m disability Facilities Grant and £0.849m Social Care Capital Grant).

Implications:

The following implications of this proposal have been considered and where there are specific implications, these are set out below:

Legal The relevant legislation is cited in the report.	
Human Resources None	
Equality	
1. No Equality Implication	X
2. Equality Implications identified and mitigated	
3. Equality Implication identified and risk remains	

Impact on Service Delivery:

Positive

What consultations have taken place on the proposals and when?

The Head of Corporate Finance and ICT (FD3495/2015) has been consulted and any comments have been incorporated into this report.

Head of Corporate Legal Services (LD2787/2015) have been consulted and any comments have been incorporated in the report.

Are there any other options available for consideration?

No alternative options have been considered.

Implementation Date for the Decision

Immediately following the Cabinet meeting.

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Background Papers:

Better Care Fund submission (September 2014 – amended November 2014)
Approval Letter (19th December 2014)

Background

1. The Better Care Fund (BCF) is a national programme announced by the Government in June 2013 with the aim to incentivise the NHS and Local Government to work more closely together focussing on the health and wellbeing of residents through health and care services. Funding for the Programme comes from existing funding streams, the majority of which from health budgets.

2. Agreement on the finalised BCF plan for the area was a local decision; however guidance placed six national conditions to all BCF plans, namely:

    - the joint agreement by councils, CCGs and the area's Health and Wellbeing Board, to the plan;
    - demonstration on how local adult social care services will be protected;
    - confirmation how local plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends;
    - support and enable better data sharing between health and social care providers, based on universal use of the NHS number;
    - set out a joint approach to assessments and care planning, and ensure that where funding is used for integrated packages of care, there will be an accountable professional; and
    - identification - provider-by-provider - what the impact will be in their local area, including if the impact goes beyond the acute hospital sector.

3 The Council, through the Health and Wellbeing Board, has established a clear policy direction to promote and encourage the integration of health and social care using the development of the Better Care Fund as its basis.

4 In Sefton, the Council has worked with both of the CCGs covering the population of the area to develop the local BCF Plan. The Plan brings together a range of complementary local schemes that have been developed with each of the CCGs under three strategic aims. Namely:

- *Self Care, Wellbeing and Prevention* – providing comprehensive holistic and different approach to improve health and wellbeing. Services will be developed that will strengthen community resilience, provide choice in terms of where and when people can access services and will be needs led to address individual and community need;
- *Integrated Care at locality level building on Virtual Ward and Care Closer to Home Initiatives* – building on the existing Virtual Ward and Care Closer to Home initiatives, the aim is to have comprehensive, fully integrated model of care built around our communities in localities, with the patient/client at the centre; and
- *Intermediate Care and Reablement* – seeking to reduce hospital admissions and readmissions, reduce the need for ongoing care and support and reduce the number of long term residential and nursing care. Achieved through commissioning a range of intermediate care provision across the borough and a redesigning services to ensure they better meet the needs of local people in an increasing integrated way

5 Sefton's 3rd Better Care Fund plan was submitted to the Department of Health, NHS England and DCLG by the 28th November 2014 deadline. By letter of 19th December 2014 to Councillor Moncur as Chair of Health and Wellbeing Board (amongst others) NHS England confirmed that following due consideration and *"… the subsequent Nationally Consistent Assurance Review (NCAR) process, your plan has been classified as 'Approved'…essentially, your plan is clear and ambitious and we support your ambitions….This puts you in a strong position for delivering the change outlined…"*

6 The approval letter further goes on to set a condition on "…*the Fund being used in accordance with your final approved plan and through a section 75 pooled fund agreement*". To satisfy this condition, and take forward the development of a section 75 agreement, a task and finish group, under the leadership of Sefton Council's Head of Service for Vulnerable People , was formed, consisting of finance, business intelligence, legal and commissioning officers of the Council and CCGs. Its remit was to pull together details for the agreement seeking formal sign off before 1st April 2015.

The section 75 Agreement

7. Section 3 of the Care Act 2014 requires a Local Authority to carry out their responsibilities under Part 1 of the Act with the aim of integrating services with those provided by the NHS and other health related services. It is up to the Local Authority to determine how this integration should take place. In this instance integration means a pooled budget under the auspices of Section 75 of the National Health Act 2006.

8. The section 75 agreement forms the basis of the governance arrangements and sets out clearly and precisely what the overall aims of the Plan are; who is responsible for what; the financial arrangements; and the associated plans for reporting and accountability. It allows the Local Authority and CCGs to work in partnership to improve the way NHS and health related functions are exercised. The agreement includes arrangements for pooling resources and delegating certain NHS and local authority health related functions to the other partner(s), details of the services to be provided under the partnership arrangements, and any staff, goods services or accommodation to be provided by the partners to support the services

9. The Health and Wellbeing Board has considered the governance arrangements which will form the basis of the section 75 agreement - as part of the agreed Sefton BCF plan. This includes the contributions to the pooled funds; roles and responsibilities; governance arrangement and headline reporting requirements; and risk sharing arrangements.

10. At its meeting on 5th March 2015, Council report included general details of the section 75 agreement. It has also been discussed by the Health and Wellbeing Board, at its meeting on 18th March 2015. CCG arrangements will include the sign off through their respective Boards.

Principles of the section 75 agreements

11. The total amount of funding to be pooled within the section 75 agreement is £24.231m for 2015/16, consisting of £21.423m revenue and £2.808m capital funding.

12. The key principles of the section 75 agreement – as set out in detail within the Sefton BCF plan and the Sefton Governance Framework - include:

- the Council being the host of the pooled fund, split into three distinct schemes (as outlined in Paragraph 4);
- specified contributions to the pooled funds from each of the partners (as set out in the Governance Framework);
- the funds being allocated proportionally to each pooled fund in line with the contributions made by each CCG:
- Risk sharing arrangements in place, set out under two main headings:
    - shared risks for the 'Health commissioned in hospital services' (£1.811m) elements of the pooled funds where funds will only be contributed to the pooled fund once the 3.5% reduction in emergency admissions target has been achieved (this is in line with national guidance);
    - partner risks for the 'protection of adult social care' (£7.951m), 'Care Act' (£0.834), 'Carers' (£0.949m) and 'Health commissioned out of hospital services' (£9.878m) elements of the pooled fund where each partner will manage the pressures associated with these programmes and retain any 'knock on' benefits. As part of the BCF plan for 2015/16 there is a requirement to invest a further £3m to support the 'protection of adult social care' provision.
- Agreed assurance and reporting mechanisms to help ensure robust and proper management of the fund and important conditions placed upon the funds to mitigate risks including:
    - establishment of the Health and Wellbeing Board as the Governing body responsible for oversight and review of section 75 agreements per se and the local plans established in the agreements, from within the agreed pooled budget and monitoring and ensuring delivery of the agreed metrics;
    - map joint resources, review delivery of outcomes generally and individual schemes conducted under the framework of the agreement. The Board will need to establish a set of principles against which commissioning takes place ensuring that these are allied to the parties to the Agreement's commissioning principles.

- There are a number of executive actions associated with the administration of these Section 75 Agreements. Examples of these are set out below:

    - Where the Council is to become Lead Commissioner as defined by the Agreements then any such commissioning will need to be considered by the Cabinet Member or Cabinet dependent on the value of the proposed function or service and must use the Council's procurement processes.

- Consideration of variation, renewal or termination of the Agreement will be a delegated function and again dependent on the nature of the variation could be agreed by the relevant officer, the Cabinet Member and/or Cabinet.
- As the Council manages the budgets on behalf of the Clinical Commissioning Group and the Council it will need to ensure that approval for expenditure from the budgets pooled accordingly are embedded into the Council's financial management systems.

It is important that the executive elements of the management of any Section 75 agreements are embedded into the Council's processes.

Necessary Constitutional amendments will be considered by the Audit and Governance Committee at their meeting on the 25 February 2015. If necessary, a verbal update will be provided to Members of Cabinet at the meeting. The Constitutional amendments will be reported to Council for approval at their meeting on 23 April 2015.

13. The Board will undertake the functions and role for oversight and review of the agreement, as set out, either directly or through a specially commissioned/nominated working group. Membership of such a group will be defined as necessary and supplemented, as required, by any and all of the three Integration Scheme Leads and, separately, the Pooled Fund Managers for Sefton MBC and CCGs or a deputy to be notified in writing to Chair in advance of any meeting, senior Adult Social Care lead, Council finance lead and other local stakeholders, as appropriate

14. Regular performance, activity and finance reports will also be prepared for the Health and Wellbeing Board, and shared with each relevant CCG and the Council to track progress

15. The agreement will allow flexibility for the arrangements to continue for a number of years, or be terminated if the funding stream is discontinued. It also enables additional services or funding to be added to the agreement (subject to agreement by the Council and the relevant CCG) to support further health and social integration.

16. The Sefton BCF plan sets out the schemes that the pooled funds will be invested in. These schemes are all aligned to the strategic aims set out in paragraph 4 above.

Consultation

17. The Sefton BCF plan has been reported to the Sefton Health and Wellbeing Board on a regular basis in its development, and the agreed plan was approved by the Board at its meeting in November 2014. This has ensured that the BCF plan and associated governance arrangements have been shared at various points through their development with the Cabinet Member - Older People and Health, Cabinet Member - Children, Schools, Families and Leisure, senior accountable officers of Sefton Council, CCGs, Public Health England, NHS England, Sefton CVS and Healthwatch.

18. Local Joint Commissioning Groups have also been established in each CCG area which enabled more detailed review and comment on the local elements of Sefton's BCF plan. Further, the Sefton BCF plan details significant engagement of provider organisations (acute hospitals, primary care and social care providers) and wider service providers.

Risk Management and Implications

19. The section 75 agreement is an essential part of the governance arrangements for the BCF and will set out the range of mechanisms that will be in place to manage the BCF pooled fund and the associated risks. The BCF plan itself includes a detailed risk log which captures the key risks, risk owners and mitigating actions.

20. There are a number of risks that are associated with the integration of health and social care services – these include financial risks associated with managing activity and demand, workforce and staffing risks, and the risks to the continuity and quality of services during a period of change.

21. The scale and complexity of the changes being developed in Sefton, and the pace at which they have to be implemented, increases the risk that the full benefits of integration will not be achieved either in total or within the required timeframe. Robust governance arrangements are in place to help to mitigate the risks including the use of partnership groups (e.g. the Health and Wellbeing Board), and the BCF plan has been subject to national and local assurance processes.

Financial and Value for Money Implications

22. The Sefton BCF Governance Framework sets out the financial implications of the BCF pooled fund. This includes the contributions to the pooled funds (which total £24.231m - £21.423m revenue and £2.808m capital funding) and what the funds can be spent on.

23. There are four main elements of the overall fund:

    - £1.401m allocated to Self Care, Wellbeing and Prevention
    - £13.731m allocated for Integrated Care at locality level building on Virtual Ward and Care Closer to Home Initiatives (this includes £6.49m currently allocated for the 'protection of adult social care');
    - £6.291m allocated for Intermediate Care and Reablement Services (this includes 0.834m funding to support implementation of Care Act); and
    - £2.808m capital funding allocated for Disabled Facilities Grants, Care Act and other adult social care requirements.

24. Successful implementation of the Sefton BCF plan is vital to support the financial sustainability of the health and social care system in Sefton.

Section 151 Officer Commentary

25. Sefton Council's Head of Finance and ICT has worked closely with the Clinical Commissioning Group Chief Finance Officer to develop the financial aspects of the governance framework. The principles of the framework will now be developed into a formal section 75 agreement which will then ensure transparency regarding the detailed financial arrangements, including monitoring and reporting of progress.

26. The Council's Medium Term Financial Plan (2015-17) reflects the agreed pooling arrangements as set out in the approved Better Care Fund plan.

27. The Head of Finance and ICT confirms that both of the above need to be in place ahead of finalising the plans for integration and that, in view of the risks associated with the arrangements, regular reporting is essential so that early management action can be put in place if necessary.

28. All governance arrangements and procedural policies in support of this pooling arrangement will be kept under review and, if applicable, appropriate recommendations to any changes will be brought back through the Health and Wellbeing Board and Cabinet

Legal Implications

29. The main body of the report highlights the relevant legislation in relation to the requirement to establish pooled budgets for the BCF.

30. Legislation and associated national policy is placing a duty on local authorities to promote and encourage the integration health and social care integration, including the Health and Social Care Act 2012 and the Care Act 2014 which places a duty upon local authorities to "*promote integration between care and support provision, health and health related services, with the aim of joining up services*". These, and other specific duties placed on the Council, are specified and properly managed through the section 75 agreement.

Equalities and Diversity

31. Equality Impact Assessments (EIAs) form an important part of any planning for changes to services across health and social care to assess the impact upon residents, people who use services, carers and staff with protected characteristics. Individual schemes and programmes that are part of the BCF will have EIAs which will be included as part of the local plans.

Safeguarding responsibilities for vulnerable children and adults implications

32. Improving and strengthening joint working will support the Council and its partners to meet their responsibilities around safeguarding vulnerable children and adults – the Sefton Better Care Fund plan is an important example of this through its focus on improving services for the frail elderly population.

Public Health implications

33. A fundamental principle of the Sefton Better Care Fund Plan is the focus on helping older people to stay well through a focus on prevention and early intervention. This focus is essential to ensure that the plans deliver improved outcomes for individuals and support the shift from more expensive care in acute hospital settings to care provided at home or within the community.

Conclusion

1) Cabinet is requested to note the work to date on the BCF plan and Section 75 agreement for the pooled budget.

2) Cabinet is asked to delegate authority to the following officers, Head of Corporate Finance and ICT, Head of Vulnerable Adults and the Head of Corporate Legal Services to complete the Section 75 agreement with Southport and Formby Clinical Commissioning Group and South Sefton Clinical Commissioning Group to enable pooled funds to be established and to govern the delivery of the Sefton Better Care Fund Plan 2015/16.

Report to:	Cabinet Overview and Scrutiny Committee (Children's Services)	**Date of Meeting:**	26th March 2015 31st March 2015
Subject:	Child Sexual Exploitation (CSE) - Post Rotherham	**Wards Affected:**	All Wards
Report of:	Director of Young People and Families		
Is this a Key Decision?	No	**Is it included in the Forward Plan?**	No
Exempt/Confidential	No		

Purpose/Summary

A report was prepared in October 2014 as immediate response to announcements in Rotherham and presented to Overview and Scrutiny Management Board in January 2015 on "CSE in Sefton: Evaluation of Current and Past Practice".

The current report provides an outline of the learning from Rotherham and other child sexual exploitation reviews which have taken place since the publication of the Professor Jay report. Information is provided as to the actions that have, and are, taking place in Sefton to address the national lessons learned and to safeguard children and young people in Sefton from child sexual exploitation.

The report is intended to inform Members of the work undertaken to safeguard children from Child Sexual Exploitation in respect of their duties under the Local Government Act 1999 regarding governance and scrutiny of children and young people's services.

Recommendation(s)

Cabinet

To note the work taking place in Sefton regarding Child Sexual Exploitation

To refer the report to Overview and Scrutiny Committee (Children's Services) for consideration

Overview and Scrutiny Committee (Children's Services)

To note and consider the work taking place in Sefton regarding Child Sexual Exploitation

How does the decision contribute to the Council's Corporate Objectives?

Corporate Objective		Positive Impact	Neutral Impact	Negative Impact
1	Creating a Learning Community	x		
2	Jobs and Prosperity	x		
3	Environmental Sustainability		x	
4	Health and Well-Being	x		
5	Children and Young People	x		
6	Creating Safe Communities	x		
7	Creating Inclusive Communities	x		
8	Improving the Quality of Council Services and Strengthening Local Democracy		x	

Reasons for the Recommendation:

To ensure Cabinet members are aware of the partnership activity undertaken to safeguard children from child sexual exploitation in Sefton.

Alternative Options Considered and Rejected:

N/A

What will it cost and how will it be financed?

(A) Revenue Costs N/A

(B) Capital Costs N/A

Implications:

The following implications of this proposal have been considered and where there are specific implications, these are set out below:

Financial		
Legal		
Human Resources		
Equality		
1.	No Equality Implication	x
2.	Equality Implications identified and mitigated	
3.	Equality Implication identified and risk remains	

Impact of the Proposals on Service Delivery:

N/A

What consultations have taken place on the proposals and when?

The Head of Corporate Finance and ICT (FD 3502/15) and Head of Corporate Legal Services (LD 2794/15) have been consulted and any comments have been incorporated into the report.

Implementation Date for the Decision

Immediately following the Committee meeting.

Contact Officer: Colin Pettigrew
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Email: colin.pettigrew@sefton.gov.uk

Background Papers:

There are no background papers available for inspection

1. Introduction/Background

1.1 A report was prepared in October 2014 as an immediate response to the publication of the report regarding Professor Alexis Jay's Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013)[1]. The report entitled "CSE in Sefton: Evaluation of Current and Past Practice" was presented to Overview and Scrutiny Management Board in January 2015. This was also reported to the Local Safeguarding Children Board in December 2014.

1.2 The current report provides an outline of the learning from Rotherham and other child sexual exploitation reviews and government announcements which have taken place since the publication of the Jay report. Information is provided as to the actions that have, and are, taking place in Sefton, to address the national lessons learned and to safeguard children and young people in Sefton from child sexual exploitation.

2. National reviews and government announcements regarding child sexual exploitation

2.1 Since the publication of the Jay Report there has continued to be a focus on learning lessons from young people's experience of being sexually exploited and the practices of agencies in safeguarding them and bringing offenders to justice.

2.2 In response to Professor Jay's report, the Secretary of State for Communities and Local Government appointed Louise Casey CB to carry out an inspection of Rotherham Metropolitan Borough Council (RMBC) under section 10 of the Local Government Act 1999. The Sectary of State subsequently wrote to Leaders of Councils, copying the letter to Chairmen of Health and Wellbeing Boards in England to confirm this announcement. The Secretary of State asked that all Leaders read Professor Jay's report and consider whether adequate measures were in place to ensure they could not be accused of similar findings. The Home Secretary wrote in similar terms to Chief Constables and Police Crime Commissioners.

2.3 In September 2014 Her Majesty's Inspectorate of Constabulary (HMIC) published the report of its inspection (as part of a national program) of the child protection work of South Yorkshire Police[2].

2.4 In October 2014 a report 'Real Voices'[3] was published. Ann Coffey, MP for Stockport (and Chair of the All Party Parliamentary Group for Runaway and Missing Children and Adults) outlined in the report findings of an inquiry which had been commissioned by the PCC for Greater Manchester, Tony Lloyd. The terms of reference for the inquiry were to look at the changes made in safeguarding children from child sexual exploitation by Greater Manchester Police (GMP) and partner agencies since the 2012 Rochdale sexual grooming case and identify what more needed to be done in the future.

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[1] Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013)' http://www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham

[2] 'National Child Protection Inspections South Yorkshire Police 12 – 22 May 2014' http://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/south-yorkshire-national-child-protection-inspection.pdf

[3] 'Real Voices'http://www.gmpcc.org.uk/wp-content/uploads/2014/02/81461-Coffey-Report_v5_WEB-single-pages.pdf

2.5 In November 2014 Ofsted published the findings of the CSE thematic inspection 'The Sexual Exploitation of Children: It couldn't happen here could it?' [4].

2.6 In January 2015 findings were published of an inspection led by Louise Casey of Rotherham Council's compliance with the requirements of the Local Government Act 1999 in relation to its exercise of functions on governance, children and young people and taxi and private hire licensing[5].

2.7 On 3rd March 2015 Oxfordshire Safeguarding Children Board published the Serious Case Review (SCR) into child sexual exploitation in Oxfordshire, which had been initiated in September 2012[6]. The SCR Overview Report made 13 recommendations, which sit alongside the 14 individual agency action plans to address child sexual exploitation.

2.8 On 3rd March 2015 the Government published a report 'Tackling Child Sexual Exploitation'[7]. The report set out the government's commitment to; ensuring accountability and leadership, changing the culture of denial, improving joint working and information sharing, protecting vulnerable children, stopping offenders and supporting victims and survivors. The report includes reference to a consultation on extending the criminal offence of 'willful neglect', which carries a maximum jail term of five years, to children's social care, education and elected members as part of its national response to reports by Alexis Jay, Ann Coffey, Louise Casey and others. The report makes a commitment to child sexual abuse being prioritised as a national threat, like serious and organised crime, which means police forces now have a duty to collaborate with each other across force boundaries to safeguard children including more efficient sharing of resources, intelligence and best practice, supported by specialist regional CSE police coordinators.

2.9 On the 3rd March 2015 the Chief Social Worker for Children and Families, Department for Education, wrote to Directors of Children's Services, copying in Chief Executives and Lead Members[8]. This letter asked that an immediate review is undertaken of the assessment and decision making tools used to support professionals making decisions about risk.

2.10 The National Working Group (NWG) Network, a charitable membership organisation has published a summary of recommendations which draws many of the lessons learned together[9].

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[4] The Sexual Exploitation of Children: It couldn't happen here could it? http://www.lgcplus.com/Journals/2014/11/18/x/v/z/Ofsted-CSE-report.pdf

[5] 'Report of Inspection of Rotherham Metropolitan Borough Council' https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/401125/46966_Report_of_Inspection_of_Rotherham_WEB.pdf

[6] http://www.oscb.org.uk/2015/03/serious-case-review-published/

[7] 'Tackling Child Sexual Exploitation' https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408604/2903652_RotherhamResponse_acc2.pdf

[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408960/Letter_from_the_Chief_Social_Worker_for_Children_and_Families_-_Review_of_assessment_tools.pdf

[9] Summary of Recommendations – All Agencies draws many of the lessons learned together http://www.nwgnetwork.org/resources/resourcespublic?cat=97

2.11 Barnardo's and the LGA have also published guidance for local authorities on developing effective responses to child sexual exploitation entitled 'Tackling Sexual Exploitation'[10].

3. National lessons learned and activity undertaken in Sefton

3.1 Sefton has been working closely with other Merseyside Local Authorities and Merseyside Police to develop a co-ordinated response to CSE. The PAN Merseyside CSE Strategy (Appendix 1) has been developed with key priorities, the words highlighted in bold refer to Sefton Safeguarding Children's Board's associated CSE Strategy on a Page (Appendix 2) and CSE Implementation Plan:

- **Governance** – Make sure that CSE remains a high strategic priority.
- **Profile** – Identify those at risk of being sexually exploited to improve the lives of young people.
- **Prevent** – Apply pro-active problem solving to address risks associated with victims, perpetrators and locations and ensure the safeguarding and welfare of children and young people who are or may be at risk from sexual exploitation.
- **Protect** – Ensure timely and effective interventions with children and families to safeguard those vulnerable to sexual exploitation.
- **Prosecute** – Take action against those intent on abusing and exploiting children and young people in this way.

3.2 The lessons learned from reviews outlined in Section 2 of the report are presented in accordance with each of the Sefton Local Safeguarding Children Board CSE Strategy priorities. The remainder of this report provides detail of the activity which has, and is, being undertaken in Sefton to address the lessons learned by the reviews.

3.3 Governance

3.3.1 The Jay Report stated that Rotherham Safeguarding Children Board had good inter-agency CSE policies and procedures in place, but that members of the Board rarely checked whether they were being implemented or were working. The challenge and scrutiny function of the Safeguarding Board and the Council were found to be lacking. The subsequent Casey Report concluded that the Council were in denial about serious and on-going safeguarding failures. Subsequent to the Casey Report the Secretary of State for Communities and Local Government decided to put an intervention package in place, consisting of a team of Commissioners, providing them with functions and roles to oversee actions which the Authority is to perform.

3.3.2 In Sefton there is an established Children's Services Continuous Improvement Board, chaired by the Chief Executive, attended by a challenge partner, Chief Executive for Halton, the Portfolio Holder for Children's Services, the Director of Children's Services and Independent Chair of the Local Safeguarding Children Board. The Board provides scrutiny of Children's Social Care and the Local Safeguarding Children Board activity and effectiveness across a range of safeguarding concerns, child sexual exploitation is a focus of this scrutiny.

[10] Tackling Sexual Exploitation http://www.barnardos.org.uk/tackling_child_sexual_exploitation.pdf

3.3.3 Merseyside Police Assistant Chief Constable, responsible for vulnerable children, meets bi-monthly with Directors of Children's Services, LSCB Board Managers and Family Crime Unit senior police officers. The group have developed a PAN Cheshire / Merseyside Strategy (2014-2017), to which Sefton is a signatory (Appendix 1). The implementation of this Strategy is overseen by an independently chaired Pan Merseyside CSE Gold Group. Sefton's representatives on this group are the Director of Children's Services, as the Local Safeguarding Children Board CSE Sub Group Chair, LSCB Business Manager and Safeguarding Children Unit Service Manager, who is Sefton's representative on the CSE National Working Group.

3.3.4 The Sefton Local Safeguarding Children Board and Sefton 0-19 Forum of the Health and Wellbeing Board both have safeguarding children and young people from child sexual exploitation as a Strategic Priority, as outlined in the respective current draft Local Safeguarding Children Board Business Plan and Children's Plan 2015-17.

3.3.5 Local Safeguarding Children Boards have a statutory responsibility, through their sub group structure, to scrutinise the effectiveness of individual agency's safeguarding arrangements and the effectiveness of partnership working. In Nov 2014 the Director of Children's Services took up the role of Chair to the LSCB Child Sexual Exploitation Sub Group, to better hold to account key agencies implementation of the CSE Strategy. The CSE Sub Group Chair provides reports to the Local Safeguarding Children Board, the Children's Services Continuous Improvement Board and the Pan Merseyside CSE Gold Group regarding the implementation of the CSE Strategy.

3.3.6 The Sefton Local Safeguarding Children Board CSE Strategy (Appendix 2) and CSE Strategy Implementation Plan have been developed and set out a clear shared vision to safeguard young people and bring offenders to justice. The Local Safeguarding Children Board CSE Strategy Implementation Plan continues to be developed by the learning from data analysis, qualitative audit and themes arising from the operational CSE concerns. The Implementation Plan evidences actions being undertaken across the partnership to identify CSE concerns, prevent and protect young people from CSE and profile and prosecute offenders.

3.3.7 The Child Sexual Exploitation Partnership Pathway has been revised and strengthened and became operational on 17th October 2014 (Appendix 3). This has been communicated to the workforce working with children and young people by members of the Local Safeguarding Children Board. Further detail as the operational practice of the CSE Pathway is provided in subsequent sections of this report.

3.3.8 The Sefton Local Safeguarding Children Board Escalation Procedure can be initiated, should one agency believe their concerns are not being taken seriously or there are concerns as to the safeguarding practice of another agency.

3.3.9 The Pan Cheshire / Merseyside CSE Strategy sets out the commitment for all agencies to have a CSE Single Point of Contact (SPoC). The CSE SPoC has a role to ensure their agency identifies CSE using the CSE 2 screening tool and

make a CSE referral to the Multi Agency Safeguarding Hub (MASH). The LSCB has a list of all agency CSE SPoCs.

3.3.10 The Ofsted CSE thematic inspection highlighted that Birmingham Local Safeguarding Children Board did not receive data on children missing from home, care or education and received insufficient data on child sexual exploitation. Birmingham local authority and partners did not collect, collate and analyse information in a systematic way. As a result partners could not be assured of the whereabouts or safety of the young people. The Sefton Local Safeguarding Children Board CSE Sub Group has extended its Terms of Reference to cover children missing from home, care and education.

3.3.11A Sefton Local Safeguarding Children Board CSE dataset has been developed to gather multi-agency data on a range of indicators that will enable the Board to understand the known prevalence of child sexual exploitation in Sefton. The dataset is reported on a monthly basis to the Local Safeguarding Children Board CSE and Missing Sub Group. Further detail as to this dataset is presented in para3.4.10.

3.3.12 A Strategic Missing Children Monitoring Group has been established and is chaired by the Service Manager for Safeguarding, who is also Co-Chair of the Multi-Agency Child Sexual Exploitation Panel (MACSE) and a member of the LSCB CSE and Missing Children Sub Group. Members of the Strategic Monitoring Group are senior managers responsible for all elements of Children's Social Care, the Detective Inspector responsible for missing people and CSE, Missing from Home and Child Sexual Exploitation Police Officers, Sefton Council Child Sexual Exploitation Business Officer / Analyst, Early Intervention Service representatives (who undertake the Independent Return Interviews), the Council Strategic Lead for Organised Crime Groups and Business Intelligence / Quality Assurance Officers.

3.3.13 The Strategic Missing Children Monitoring Group provides scrutiny as to whether agencies are complying with the revised Local Safeguarding Children Board Missing Children Procedure. The Group will also analyse data to identify patterns and trends arising from missing incident reports and information provided by children and young people during their independent return interviews. An integrated multi agency data set has been developed which analyses children missing from home, care and education.

3.3.14 The dataset also analyses children reported missing who have been placed in Children's Homes within the Sefton boundary by Other Local Authorities and whether there are any concerns regarding the safeguarding practice of the placing authority or the Care Home provider.

3.3.15 Assurance as to agencies compliance with the Local Safeguarding Children Board Missing Protocol is reported to the LSCB CSE and Missing Sub Group. Identified patterns and trends associated with CSE is reported to the Local Safeguarding Children Board and Multi-Agency Child Sexual Exploitation Panel, a Multi-Agency Child Sexual Exploitation operational panel chaired by the Detective Chief Inspector with responsibility for Sefton's Vulnerable Person Unit and Service Manager with responsibility for the Safeguarding Children Unit. Links identified to Organised Crime Groups are reported to the Multi-Agency Response to Gung and Gangs

(MARGG) meeting. Concerns as to the practice of placing Other Local Authorities and Children's Homes providers are reported to the Local Safeguarding Children Board Children in the Care of Other Local Authorities (CICOLA) Sub Group, which is chaired by the Director of Children Services (see Appendix 4 for the Local Safeguarding Children Board Governance Structure).

3.3.16 The Local Safeguarding Children Board Children In the Care of Other Local Authorities Sub Group has developed a Provider of Concern Protocol, which enables providers who are not safeguarding children in their care from CSE to be identified and reported to Ofsted as their Regulatory body. The Children In the Care of Other Local Authorities Sub Group Chair, the DCS, reports activity that has been undertaken to address providers of concern to the Local Safeguarding Children Board. In the last 12 months 3 Children's Homes have closed due to inadequate practice.

3.3.17 The Oxfordshire Serious Case Review recommended that the Local Safeguarding Children Board to continue rigorous multi agency case audits where CSE is suspected. Sefton LSCB Quality Assurance Sub Group is currently undertaking a qualitative case file audit of children who have been referred to the Multi-Agency Child Sexual Exploitation Panel on more than one occasion. The CSE and Missing Children Sub Group have requested that analysis be undertaken of the CSE Strategy Meetings which have not progressed to a Multi-Agency Child Sexual Exploitation Panel discussion, this analysis is currently being undertaken. The findings of these audits and any required recommendations will be reported to the Local Safeguarding Children Board Quality Assurance and CSE and Missing Sub Groups. The findings will inform further development of the CSE Strategy Implementation Plan.

3.3.18 The Government has announced an expectation that all Local Safeguarding Children Boards will conduct regular local assessments on the effectiveness of local arrangements to child sexual exploitation and publish the outcome of those assessments through their annual reports. The expectation is that the analysis should set out how local partners have used their data to drive their response to vulnerable children and families. The Local Safeguarding Children Board reporting template each agency is required to complete at the end of the financial year will require evidence to be provided of the work they have undertaken to safeguard children from CSE and bring offenders to justice. This evidence will inform a specific CSE chapter in Sefton Local Safeguarding Children Boards Annual Report (2014-15). The CSE chapter will also be informed by the Boards CSE and Missing datasets, qualitative case file analysis findings and provide evidence of the work of the Local Safeguarding Children Board Sub Groups. The CSE Chapter will provide an overview of activity undertaken with regard to the CSE Implementation Plan and how this has safeguarded children from CSE in Sefton.

3.3.19 The Oxfordshire Serious Case Review recommended that the Local Safeguarding Children Board review it's inter relationship with other partnerships. The work outlined in paragraphs 3.3.6 – 3.5.8, regarding Taxi Licensing and the CSE raising awareness campaign being undertaken via Taxi Drivers in Sefton, was reported to the Licensing and Regulatory Committee in January 2015 and the Community Safety Partnership in December 2014. Sefton Community Safety Partnership has sexual violence as a strategic priority. It is the Local Safeguarding Children Boards

statutory responsibility to ensure children and young people under the age of 18 are safeguarded. A presentation regarding the work undertaken by the Local Safeguarding Children Board CSE and Missing Sub Group is planned to be delivered to the Community Safety Partnership in June 2015.

3.4 Profile

3.4.1 The Coffey Report referenced the move from a definition of 'child prostitution' to 'child sexual exploitation'. The following definition, as stated in the Statutory Guidance 'Safeguarding Children from Child Sexual Exploitation'[11] is referenced in the Sefton Local Safeguarding Children Board CSE Procedure and all CSE training and raising awareness sessions.

'Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (a third person or persons) receive 'something' (e.g. food, accommodation, drugs or alcohol, cigarettes, affections, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment/gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships are characterised in the main by the child or young person's limited availability of choice resulting from their social / economic and /or emotional vulnerability.'

3.4.2 The Coffey Report stated 'One of the key issues in the Rochdale case was the failure of police and partner agencies to listen properly to young victims and their families and to adequately respond to them…It is clear that victims in Rochdale and elsewhere were not identified or taken seriously because of the negative and discriminatory attitudes of the police and other partner agencies towards them. Their behaviour was seen as a lifestyle choice and because of that they were not seen as vulnerable children and were not given the protection they should have expected from organisations with a responsibility to safeguard them.

3.4.3 Analysis has, and is, being undertaken of past practice to identify what lessons need to be learned in Sefton. Children's Social Care and the Police are working together to review past practice as evidenced within Strategy Meeting that have taken place over a 10 year period. The results of this activity will be presented in a future report. Lessons learned from this analysis, together with the findings of national inquiries and inspections, have informed the activity being undertaken which is outlined in this report.

3.4.4 Coffey stated that Britain needs a big change in attitudes towards child sexual exploitation and she believes that such exploitation should be declared as a priority

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[11] Safeguarding Children from Sexual Exploitation (DFE 2009:p9) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278849/Safeguarding_Children_and_Young_People_from_Sexual_Exploitation.pdf

public health issue, like smoking, obesity, alcohol and drug use, so that a more strategic approach can be developed.

3.4.5 A CSE Needs Review has been commissioned by Sefton Public Health. The findings of this Needs Review will be reported to the Local Safeguarding Children Board CSE and Missing Sub Group and the 0-19 Forum of the Health and Wellbeing Board. The finding will inform future commissioning of services to work with young people at risk of, and who are, a victim of CSE.

3.4.6 The Coffey Report makes further specific reference to 'a child' for these purposes being a young person under the age of 18. The responsibility to safeguard all young people under the age of 18 in Sefton from child sexual exploitation is explicit in the Local Safeguarding Children Board CSE Procedure, CSE training and raising awareness materials. The Local Safeguarding Children Board CSE dataset, referred to in para 3.3.10, analyses the age of young people referred due to CSE concerns and monitors any lack of reporting by agencies for young people aged over the sexual consenting age of 16. Specific work has been undertaken with sexual health services, and is planned to be undertaken with Pharmacists and GPs, to ensure they are aware of this responsibility.

3.4.7 The Coffey Report made a clear recommendation for the inclusion of 'boys and young men' in literature. Sefton Local Safeguarding Children Board CSE raising awareness and training materials use photographic images of, and references to, boys and young men to ensure they too are safeguarded from CSE.

3.4.8 The Oxfordshire Serious Case Review recommended that minutes of multi-agency meetings be clear about ownership, have consistent titles, and can be seen by their content to be of high value. In Sefton a CSE Strategy Meeting recording template has been developed and the recording of Sefton Multi-Agency Child Sexual Exploitation meetings has been reviewed. A clear template for a Multi-Agency Child Sexual Exploitation Action Plan has been developed, using the priorities of the CSE Strategy; Profile, Prevent, Protect and Prosecute as headings within the plan. The document records attendance at the Multi-Agency Child Sexual Exploitation meeting, discussions that took place, and outlines the responsibility of individuals to undertake actions clearly set out in the Multi-Agency Child Sexual Exploitation Plan and associated timescales. The Prosecute element of the Plan is recorded on the child's records and Police records but is not disseminated further, to ensure security of Police investigative techniques.

3.4.9 The Children's Social Care electronic data system has been reviewed to embed the CSE screening tool, CSE Strategy Meeting and Multi-Agency Child Sexual Exploitation Plans within the electronic system. The records provide evidence of the work undertaken to safeguard a young person from CSE and informs the CSE dataset.

3.4.10 The Local Safeguarding Children Board CSE dataset is based on numbers of young people 'at risk' or 'victims', and numbers of perpetrators who are known and/or have been prosecuted. The dataset also gathers information about related risk factors (i.e. homelessness, self-harm, repeat attendance at sexual health services and missing / absent reports) in order to provide a richer profile of CSE risks locally. Where the dataset highlights potential issues, qualitative case file

audits will be undertaken to investigate and understand the reasons behind the data.

3.4.11 In response to the letter sent by the Chief Social Worker to Directors of Children's Services, asking that an immediate review is undertaken of the assessment and decision making tools used to support professionals making decisions about risk, a review of the CSE 2 referral form and screening tool used in CSE and Strategy Meetings has commenced. An audit of all Strategy Meetings which have not progressed to Multi-Agency Child Sexual Exploitation is being undertaken to ascertain if this is related to the use of the screening tool. The findings of this Audit will be reported to the next Local Safeguarding Children Board CSE and Missing Children Sub Group and in turn the Local Safeguarding Children Board.

3.4.12 The Coffey Report suggested there is a significant underestimation of child sexual exploitation in Greater Manchester: GMP figures regarding recorded sexual offences under 18's between 1st June 2013 and 31st May 2014 shows that 111 cases out of 1,691 were flagged on the Police computer as child exploitation. The Report concluded that an under identification of CSE was evidenced by the lack of 'flags' on Police computer systems which identified young people at risk of or experiencing CSE. A system for tracking each CSE referral was introduced in Sefton in October 2014. The CSE dataset monitors that CSE flags are recorded within the Police electronic record of all young people considered to be at risk or experiencing CSE concerns. Work is being undertaken with the Police to ensure 100% of recording of CSE flags regarding young people referred to the Multi-Agency Child Sexual Exploitation. The Police undertake analysis of current investigations, sanctions and Court outcomes and report this to the Local Safeguarding Children Board CSE and Missing Sub Group.

3.4.13 Resource has been invested in a CSE Business Officer / Analyst post working across the MASH and MACSE. This role is located with the CSE and Missing from Home Police Officers. The function of this role is to analyse referral sources and report lack of agency referrals to the Local Safeguarding Children Board CSE and Missing Children Sub Group in the CSE data analysis report. This role takes minutes of all CSE Strategy Meetings and Multi-Agency Child Sexual Exploitation Meetings and reports to the Service Manager for Safeguarding, in their capacity as the Multi-Agency Child Sexual Exploitation Panel Co-Chair.

3.4.14 The Ofsted Social Care Annual Report (2013-14)[12] made reference to a key concern of their findings being that Councils are still not acting swiftly enough when children in care go missing, despite this group being among the most vulnerable to CSE. The Oxfordshire Serious Case Review recommended that the Board seek assurance from the Council that there are good arrangements for the transfer of information between schools about child vulnerability and that decisions around exclusion from school and its management take into account that the behaviour is, or may be, related to child sexual exploitation.

3.4.15 Paragraphs 3.3.9, 3.3.11 – 3.4.14 and 3.3.17 within the Governance section of this report present the activity undertaken in Sefton to address this lesson learned. Sefton Young Advisors are currently undertaking a review of the Independent

[12] Ofsted Social Care Annual Report (2013-14)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/410528/ofsted_social_care_annual_report_201314.pdf

Return Interview template, to provide their view as to whether this encourages children and young people to talk about their involvement in CSE or organised crime groups. The Independent Return Interview template will be developed on receipt of their feedback.

3.4.16 Within the CSE inquiries referenced in section 2 of this report, lessons have been learned of the experiences of 'looked after' children, placed in Children's Homes outside of their home authority, being victims of CSE. Sefton has a significant number of Independent Children's Homes located within its boundary, predominantly in the North. National Regulations were strengthened by Government in 2014 to ensure Local Authorities placing 'looked after' children outside of their boundary notify the area within which they are placing the child. If a child is being placed in an area which is not a Local Authority geographically next to the responsible placing authority, the placing Director of Children's Services must discuss this placement with the Director of Children's Services for the area in which the child is being placed.

3.4.17 Resource has been invested in an Other Local Authority (OLA) Placement Notification Officer. This role has responsibility for receiving all notifications of a looked after child being placed in Sefton by another Local Authority. The OLA Notification Form requires placing Local Authorities to inform Sefton of any CSE or missing from care risks and any involvement in offending, organised crime, substance misuse or mental health issues. All Notification Forms received are communicated to Health and Education Leads. Any young person who is known to be at risk of CSE is communicated to the CSE Police Officer, Missing from Home Police Officer and CSE Business Officer / Analyst. Any young person considered to be a perpetrator of CSE, offending or organised crime is communicated to the YOT. Any young person with a history of being missing is reported to the Missing from Home Police Officer. This notification process ensures that 'looked after' young people moving into Sefton can be safeguarded by Sefton agencies and support the placing authority in their statutory duty to safeguard the young person. Details of all notifications of 'looked after' young people placed in Sefton by another Local Authority are recorded on the Sefton Children's Social Care electronic data system. As of 11th March Sefton had received notifications that 203 looked after young people are placed in Sefton placed by the following Local Authorities:-

Birmingham	Blackburn with Darwen
Blackpool	Bristol
Bury	Cheshire East
Cheshire West & Chester	Cumbria
Darlington	Durham
Haringey	Kirklees
Knowsley *	Lancashire *
London Borough of Hammersmith & Fulham	
London Borough of Lewisham	
Liverpool *	Manchester
Rochdale	St Helens
Salford	Slough
Stockton	Thurrock
Warrington	Wigan

Wirral *

The * indicates that the Local Authority has more than 5 children placed within the Sefton boundary.

3.4.18 In cases of a placing Local Authority not adhering to the Notification Procedure the DCS is informed and is proactive in contacting the placing DCS to discuss this concern. If there are ongoing concerns that the Placing Authority is not acting in a way which safeguards a young person for which they are responsible, Sefton DCS escalates this concern to Ofsted. Sefton DCS has been proactive in initiating consultation with other DCS' on a national basis as to this approach.

3.4.19 Detail as to the number of children 'looked after' by other Local Authorities placed within the Sefton boundary, and action taken to address concerns regarding placing Local Authorities safeguarding practice, are reported to the Children in the Care of Other Local Authorities (CICOLA) LSCB Sub Group, chaired by the DCS, and in turn the LSCB.

3.4.20 The Coffey Report referenced the most well-known model of CSE, due to media coverage, being by organised gangs and groups. A previous report from the Office of the Children's Commissioner 'If only some has listened' (November 2013)[13] presented the findings of the Commissioners inquiry into child sexual exploitation and gangs and groups.

3.4.21 The Councils Strategic Lead for Organised Crime Groups is a member of the Local Safeguarding Children Board CSE and Missing Children Sub Group and the Strategic Missing Children Monitoring Group. Organised Crime Group data is shared with the MASH Manager and CSE Business Officer / Analyst, enabling potential links between young people being sexually exploited and organised crime groups to be identified at the earliest opportunity. From current analysis there is no evidence to suggest that organised crime groups, such as those observed in Rotherham, Rochdale and Oxfordshire, are undertaking sexual exploitation of children and young people in Sefton.

3.5 Prevent

3.5.1 A range of CSE raising awareness sessions have been held across the partnership, to ensure CSE concerns are identified and referred to the Multi Agency Safeguarding Hub (MASH):

- An Local Safeguarding Children Board event has been held with Managers of Children's Homes within Sefton (Nov 2014) to inform them of the CSE Pathway and how to refer concerns about children they are looking after to Sefton MASH.
- An Local Safeguarding Children Board event has been held with Taxi Companies (Dec 2014) to raise their awareness of lessons learned by the Jay Report, regarding taxi drivers involvement in CSE in Rotherham and the signs of CSE taxi drivers are likely to see within the local community.
- A presentation has been provided to Public Health Commissioners. As a result CSE related Key Performance Indicators (KPIs) have been developed for all agencies commissioned by Public Health and the Council to work with young

[13] 'If only some has listened' http://www.childrenscommissioner.gov.uk/content/publications/content_743

people e.g. Sexual Health Services and Children's Homes. These KPIs ensure that the agency practices in accordance with the Sefton Local Safeguarding Children Board CSE Pathway, ensures their workforce is trained and make referrals regarding CSE concerns to the MASH.

- A presentation has been provided to Sexual Health Service Strategic Leads, to ensure that the sexual health workforce identify CSE concerns when a young person requests sexual health advice and/or treatment.
- A presentation has been provided to Neighbourhood, Anti- Social Behaviour and Domestic Abuse Service staff within Sefton Council, to ensure that when they are working within local communities they raise community member's awareness of CSE. This will support community members to know what action they can take to protect young people from CSE in their local communities.
- A presentation has been provided to Adult Substance Misuse Services, so the workforce can raise awareness of CSE with the people they work with. As adults who use substances, they in a valuable position to identify situations when drugs are provided to individuals who are using this as a way of sexually exploiting young people.

3.5.2 This activity has led to an increase of child sexual exploitation referrals being received by the Multi Agency Safeguarding Hub (MASH). Analysis of agencies which have made CSE referrals evidences that a wider range of agencies than previously are now identifying potential signs of CSE and are taking proactive action to ensure children are appropriately safeguarded. 100 CSE referrals have been received by the MASH between 20th October 2014 -13th March 2015, compared to the 30 CSE referrals received between 1st January – 19th October 2014. As of 13th March 2015 Sefton has 12 children and young people who are the subject of a MACSE Plan.

3.5.3 The Local Safeguarding Children Board, through its Training Sub Group, has delivered a number of briefing sessions and full day CSE awareness raising sessions. The training has been delivered to a number of audiences including Police, Children's Social Care, Targeted Prevention staff, Rape and Sexual Abuse Centre (RASA) and young people involved in the Making a Difference Group. Prior to Oct 2014 approximately 4,200 staff had received information designed to raise awareness and understanding of issues relating to CSE in a variety of ways.

3.5.4 The Local Safeguarding Children Board has introduced the use of Parents against Child Exploitation (PACE) online course. Twilight sessions have been undertaken with Schools by the Local Safeguarding Children Board Independent Chair and Board Business Manager, to raise awareness of this to parents via School staff. Development of a specific page of the Local Safeguarding Children Board website dedicated to CSE is under discussion, to ensure links to this online course is accessible.

3.5.5 The Professor Jay Report, and subsequently the Casey Report, made reference to weak and ineffective arrangements for taxi licensing which have left the public at risk.

3.5.6 Specific work has been undertaken in Sefton with regard to Taxi Drivers. This work was reported to the Licensing and Regulatory Committee in Jan 2015.

3.5.7 The Sefton Taxi Licensing Handbook has been revised to include a Safeguarding Chapter which makes specific reference to CSE. Safeguarding children leads now become involved in the Licence Mitigation Panel, to address concerns regarding individuals applying to become a taxi driver.

3.5.8 An Local Safeguarding Children Board event was held with Taxi Companies, led by the DCS in December 2014. Lessons learned from the Professor Jay Report were presented. Taxi Companies were asked to identify a CSE SPoC to receive Local Safeguarding Children Board CSE Training which they can cascade to their drivers. Companies were asked to develop a Whistleblowing Policy, encouraging drivers to report any concerns regarding other drivers' involvement in CSE. A CSE raising awareness campaign involving taxi drivers commenced in Dec 2014:

- 100,000 credit sized cards highlighting the signs of CSE were provided to the Taxi Companies with a request that these be given to members of the local community accessing taxis over the Christmas and New Year period.
- 3,600 CSE car stickers were provided to be displayed on taxi windows.
- 3,600 credit card sized cards were provided for all taxi drivers. The cards state the signs of CSE taxi drivers are best placed to see in the local community and details of who to refer the concerns to, via telephoning 101 or 999.

3.5.9 The Coffey report refers to communities as being the best source of intelligence and information about children at risk of CSE, but that people need to understand better what to look for, what grooming is and how it operates. Coffey stated it is important to give communities information about CSE in their local areas; if offenders are portrayed in a particular way (e.g. Asian males) then the signs will be missed in people who don't fit that image, and so will the opportunity to protect children.

3.5.10 The 18th March 2015 is National CSE Day. A variety of materials have been developed via the Pan-Merseyside CSE Campaign, led by the Pan-Merseyside CSE Gold Group. These materials, together with additional materials resourced by member agencies of Sefton Local Safeguarding Children Board, have been cascaded across the partnership, ready to be provided to children and young people, members of the community and the workforce on CSE Day:

- Tri-fold CSE leaflet explaining the signs of CSE and how to make a CSE referral
- Young people advice cards
- Professionals advice cards
- General awareness posters (suitable for clinics, GP Practices and Children's Centres, etc.)
- Awareness Posters for Professionals
- A CSE Pull up Stand

3.5.11 Sefton Local Safeguarding Children Board issued a briefing paper to partner agencies on 10th March 2015 attaching resources; Email signature banners, suggestions for agency websites, prompts for organisations twitter feeds and a screen saver for internal intranet use. A micro-site has been developed, to support the pan-Merseyside CSE campaign; this can be accessed at www.listentomystory.co.uk

3.5.12 Resources have been forwarded to all Sefton Secondary Schools via the School Envelope.

3.5.13 Two full pages have been secured in the Liverpool Echo for 11th and 18th March to highlight the issue of CSE. Bus adverts will be live on 66 buses throughout whole of Merseyside area for a period of 4 weeks from 9th March 2015. A Radio debate on Radio Merseyside, involving Sefton DCS, is planned for 18th March 2015 12noon-2pm. A pre-recorded Radio City show, including a young people's panel will also be broadcast.

3.5.14 Sefton Communications Team will ensure resources are placed on the Sefton Council website, advertising screens within Council buildings for example, Bootle Town Hall, One Stop Shop, Libraries, and Leisure Centres etc.

3.5.15 The Oxfordshire Serious Case Review recommended that Headteachers on the Local Safeguarding Children Board to consider how to ensure better understanding and compliance with the CSE Statutory Guidance. In Sefton Designated Safeguarding Leads in Schools have been confirmed as the School CSE SPoC. Plans are in place for the School CSE SPoCs to receive CSE training from the Local Safeguarding Children Board between April - June 2015.

3.5.16 In Sefton RASA have received funding's from Sefton MBC to deliver 'Healthy Relationships' workshops in 10 secondary schools in Sefton. RASA also provide a workshop for parents and carers 'protecting our children' to raise awareness and help protect children from child abuse. The "Terriers Play" has been shown to schools Head Teachers, Designated Safeguarding Leads and School Governors, to encourage the commissioning of the drama which discusses the risks associated with gun and gang crime and makes reference to CSE.

3.5.17 The "CSE in Sefton: Evaluation of Current and Past Practice" October 2014 Report, presented to the Overview and Scrutiny Management Board in January 2015, provides details of other CSE raising awareness activity which had taken place prior to Oct 2014.

3.5.18The Oxfordshire Serious Case Review recommended that the Local Safeguarding Children Board seek assurance from health bodies, including GP practices, that staff consider child sexual exploitation when assessing a child's ability to consent to treatment and that referrals to statutory agencies will be made appropriately. A further recommendation was made that the Local Safeguarding Children Board should seek assurance from all member agencies that staff are aware of the guidance around consent to sexual activity and relationships.

3.5.19 Designated Nurses within the Clinic Commissioning Group (CCG) have undertaken work with health providers, to ensure they have analysed lessons learned from the Professor Jay Report and taken action to address lessons learned. This assurance has been reported to the Local Safeguarding Children Board.

3.5.20 Para 3.5.1 outlines the work undertaken with Sexual Health Services to ensure they are aware of the need to analyse young people presenting for sexual health advice and treatment for signs of CSE. In addition to this, work is being undertaken

with Pharmacist Leads at Southport and Ormskirk Hospital to embed CSE screening into the Pharmacist electronic Webstar system. Upon CSE signs being identified the electronic system will guide the Pharmacist to complete an online CSE referral to the MASH. A CSE raising awareness presentation is planned to be delivered to Pharmacists in April 2015.

3.6 Protect

3.6.1 A Multi-Agency Safeguarding Hub (MASH) has been in place in Sefton since February 2014. The Local Safeguarding Children Board CSE Partnership Pathway makes it clear that all professional concerns regarding CSE should be referred to the MASH using the CSE 2 and Professional Referral Form. This enables in depth screening to be undertaken, by a range of agencies based within the MASH, regarding referrals where CSE is known or suspected. Staff use an agreed CSE screening tool (CSE 2) to support identification of CSE. The screening tool was developed by Bedfordshire as an early forerunner of CSE development.

3.6.2 All Local Safeguarding Children Board CSE raising awareness materials advise members of the public to contact 101 or 999. The Police ensure that CSE concerns are reported to the MASH.

3.6.3 The Multi Agency Child Sexual Exploitation (MACSE) Panel has been reviewed and strengthened. The Panel is now co-chaired by Detective Chief Inspector responsible for Vulnerable People Unit and Service Manager responsible for the Sefton Council Safeguarding Children Unit. The co- chairs are members of the LSCB CSE Sub Group. The Multi Agency Child Sexual Exploitation Panel ensures all agencies working with young people are invited to attend a discussion regarding the young person they are working with. A multi-agency 'MACSE Plan' is developed, which ensures the young person is protected and offenders are disrupted and prosecuted. Regular review Panel meetings are held to ensure agencies are undertaking the safeguarding, disruption and investigation actions that were agreed.

3.6.4 Discussions have been held between co-chair for Multi Agency Child Sexual Exploitation safeguarding lead and the domestic abuse Multi-Agency Risk Assessment Conference (MARAC) Co-ordinator. The MARAC Co-ordinator will ensure that young people aged 16-18 who have been referred to MARAC as a victim of an abusive 'relationship' will be reviewed to ascertain if they are at risk or experiencing from CSE. Any CSE concerns will be referred to the Multi Agency Child Sexual Exploitation Panel for a Multi-Agency CSE Plan to be put in place to safeguard the young person.

3.6.5 The Children In the Care of Other Local Authority Sub Group have developed a data analysis report to inform the Children's Homes undertaking a Safe Area Assessment as per their regulatory requirement. This enables Children's Homes providers to understand the risks related to CSE in the area of the Children's Home and take appropriate action to safeguard the children they are looking after.

3.6.6 Following consultation with the Making a Difference Group (Children in care council), information regarding CSE is contained in packs given to children when

they become looked after. The Care Leaver's Centre provides 'Keeping Safe' workshops to raise awareness across a range of issue including CSE.

3.6.7 The Professor Jay Report recommended commissioning of specialist CSE post-abuse support. The Multi Agency Child Sexual Exploitation CSE Sub Group has undertaken mapping of services available to support sexually exploited children and young people. The Public Health CSE Needs Review, commissioned by Public Health to provide commissioners with a greater understanding of the needs of local young people, will inform commissioning of specialist post abuse support.

3.6.8 The Police Crime Commissioner (PCC) has commissioned Catch 22 to work with children and young people involved in child sexual exploitation in the Sefton area until the end of March 2015. Future commissioning arrangements are currently being considered.

3.6.9 The Oxfordshire Serious Case Review recommended for each agency to provide to the Local Safeguarding Children Board evidence of its supervision policies and how the agencies ensure they are effective. Supervision of staff will form part of the CSE qualitative audit currently being undertaken regarding young people who have been subject of a repeat Multi Agency Child Sexual Exploitation Plan.

3.7 Prosecute

3.7.1 All Police Operational Officers in Sefton have completed an interactive IT CSE awareness course.

3.7.2 All reports of violence and Sexual Crime are 'screened' by an experienced Detective Sergeant. Resource has recently been invested in a specialist CSE Detective Sergeant, who is taking responsibility for the CSE and Missing Police Officers and specialist CSE investigating Police Officers.

3.7.3 The Oxfordshire SCR made a recommendation for the Local Safeguarding Children Board to seek assurance from the Police about progress on recording crime related to sexual offences. The Police are required to provide regular reports to the Local Safeguarding Children Board CSE and Missing Sub Group as to disruption and investigative activity which has been undertaken to safeguard young people from CSE and bring offenders to justice.

3.7.4 Actions undertaken by Merseyside Police include:

- Intelligence and flagging – the Multi Agency Child Sexual Exploitation Panel collates CSE intelligence and ensure analysis of this is undertaken to inform police disruption and investigations.
- Police Briefing Sheets – All operational Police Patrol Officers in Sefton receive a briefing on CSE and missing before they go out on patrol. This identifies key areas and individuals of concern.
- CCTV – Regular briefings are provided to CCTV operators re: areas of concern, victims and suspected perpetrators.
- DNA and other forms of forensic examination and investigation.
- Financial investigation
- Home visits

- Patrol tasking, particularly around city centres, takeaways, taxi forms, Children's Homes and Schools.
- Multi-Agency Protection Panel Arrangements (MAPPA) referrals are made regarding high risk perpetrators.
- Search Warrants and analysis of technological devises and social media.
- Disruption interventions for example, Harbourers Warning Notices.

3.7.5 The Oxfordshire Serious Case Review recommended that the Local Safeguarding Children Board collaborate with the Crown Prosecution Service. This is an action in the Sefton Local Safeguarding Children Board CSE Strategy Implementation Plan that has a deadline of July 2015 for completion.

3.7.6 The Key Performance Indicators that have been agreed for commissioned providers ensure a clear expectation for agencies to provide intelligence of CSE concerns to inform Police investigations.

4. Conclusion

4.1 Learning from the inquiries and inspections referenced continues to be added to the Local Safeguarding Children Board CSE Strategic Implementation Plan. The LSCB Strategic Implementation Plan is available and the LSCB CSE Strategy on a Page is attached (Appendix 2).

5. Appendices

Appendix 1 PAN Merseyside CSE Strategy 2014-2017
Appendix 2 LSCB CSE Strategy on a Page
Appendix 3 LSCB Governance Structure
Appendix 4 LSCB CSE Partnership Pathway

Pan Cheshire/Merseyside Child Sexual Exploitation

Multi-Agency Strategy 2014 -2017

The Safeguarding Children's Boards of Cheshire (Cheshire East, Cheshire West and Chester, Halton and Warrington) and Merseyside (Liverpool, Sefton, Knowsley, St Helens and Wirral) have identified tackling the sexual exploitation of children as a key strategic priority. Child sexual exploitation is child abuse and is completely unacceptable. The Safeguarding Children's Boards of Cheshire and Merseyside are committed to combating the sexual exploitation of children via effective multi agency and partnership working.

Children who are subjected to sexual exploitation can have serious long term issues effecting their physical and mental health and their overall well being. Although young people aged 16, 17 and 18 are able to consent to sexual activity, they can still be subjected to exploitation and the exploitation can continue through to adulthood. The Safeguarding Children's Boards of Cheshire and Merseyside will therefore work closely with the Safeguarding Adult's Boards of Cheshire and Merseyside to ensure children and young people continue to receive support through the transition phase from childhood to adulthood. Child sexual exploitation can also effect the lives of the child or young persons family and carers and can lead to relationship breakdown.

Sexual exploitation of children and young people under 18 will normally, but not exclusively, involve an adult developing a relationship with the child or young person, groom or utilise violence, coercion and intimidation to sexually exploit the child or young person.

All agencies have a reponsibility to help identifiy those children and young people at risk of sexual exploitation; agencies also have responsibility both individually and collectively for ensuring that the child or young person is protected from any further risk of harm.

All agencies have a responsibiilty to do what they can to prevent children and young people becoming victims of child sexual exploitation. There are a number of ways this can be achieved including ensuring that our communities, especially the children and young people of Cheshire and Merseyside are aware of and understand the issues and risks involved in child sexual exploitation.

The aim of this strategy is to prevent and safeguard **all** children from child sexual exploitation and to prevent and safeguard individual children who are identified as at risk, or victims of child sexual exploitation.

Safeguarding children and young people from sexual exploitation is everyone's business.

The purpose of the strategy is;

- To focus and co-ordinate multi agency resources in tackling child sexual exploitation
- To ensure that children and young people and the wider community across Cheshire and Merseyside, in particular with parents and carers, are aware of child sexual exploitation and its effects
- To enhance training for professionals
- To ensure that young people and the community are made aware of the issues around exploitation
- To bring to justice the perpetrators of child sexual exploitation and to ensure that young people are properly safeguarded in the course of any criminal proceedings

Our shared key strategic priorities are:

- Self Assessment
- Prevention
- Safeguarding
- Bringing Offenders to Justice
- Governance

Self Assessment

What are we going to do?

Each Local Safeguarding Children Board will undertake a self-assessment to review the local response to child sexual exploitation. This review will involve;

Profiling

Assess the awareness and levels of understanding of professionals in relation to child sexual exploitation.

Identify the prevalence and models of child sexual exploitation in the area.

Service Provision

Map the availability of services for supporting sexually exploited children and young people, ensuring agencies, when planning and commissioning services, focus on the needs of children and young people who may be sexually exploited.

Prevention

What are we going to do?

There are three key features in preventing children and young people becoming subjected to sexual exploitation, they are awareness, training and disruption.

Awareness

Awareness Raising with Children and Families

It is extremely important to ensure that we focus on raising children and young people's awareness of sexual exploitation. Schools and youth services are key agencies and have a very important role to play in awareness raising and safeguarding children and young people from sexual exploitation.

Any work on raising the awareness of children and young people must be supported by work with parents and carers to supplement and reinforce that awareness.

Agencies who work with children need to;

- Engage with children and young people to ensure they have an understanding of the issues surrounding child sexual exploitation

- Develop activities which will dissuade children and young people becoming involved in child sexual exploitation

Awareness Raising in Communities / Community Engagement

Development of community intelligence is very important in preventing child sexual exploitation.

Raising awareness of targeted groups / organisations, for example, taxi, hotel and leisure organisations, is another key feature of prevention.

We will engage with our local communities and raise awareness of CSE and how it affects individuals.

We will undertake proactive communication with the media.

Training

A review is to be undertaken of all single and multi-agency training for professionals in terms of content and targeted delivery.

The Local Safeguarding Children Board will ensure the provision of appropriate multi agency training.

Single agency training needs to;

- Ensure staff working with or in contact with children are able to identify those children and young people at risk of child sexual exploitation

- Ensure staff working with or in contact with children are able to identify activities employed by offenders / abusers

- Ensure staff know what interventions are appropriate and how to implement and or signpost to appropriate agencies / services

Agencies must consider the provision of training for their agency that should be delivered in line with the role of the professional and the level of detail they require.

Disruption

Disruption of perpetrator activity is an important tool in preventing child sexual exploitation. All agencies need to work together to develop appropriate disruption tactics. Individual agencies must consider how they can contribute to disrupting perpetrator behaviour.

Safeguarding

What are we going to do?

Research and experience suggest that early intervention and a coordinated response by all agencies is a key factor in making a difference and safeguarding children and young people from sexual exploitation. The Cheshire and Merseyside Local Safeguarding Children Board;

- Will each developed a Child Sexual Exploitation multi-agency protocol which sets out the standards and provides guidance for multi-agency working in tackling child sexual exploitation
- Ensure that responses to concerns about child sexual exploitation are managed via a multi-agency process and in accordance with these protocols
- Ensure information is shared appropriately and especially with children's services and the Police
- Expect individual agencies to develop their own policies and practise guidance which sets standards relating to how that agency responds to / works towards tackling child sexual exploitation. This will be monitored by the Local Safeguarding Children Board
- Ensure agencies work together in recording and monitoring the prevalence of child sexual exploitation
- Evaluate the effectiveness of service provision and identify and fill any gaps in service provision in supporting children and their families
- Provide ongoing scrutiny and governance of policy, procedure and practice in service delivery

Bringing Offenders to Justice

What are we going to do?

Ensuring abusers are brought to justice is an effective and appropriate way to safeguard children and young people. Offenders must be held to account for their behaviour.

A clear understanding needs to be developed and agreed about the balance between the welfare of the child and the criminal justice considerations.

All agencies should;

- Ensure workers co-operate with Police investigations in relation to the detection and prosecution of crime

- Ensure appropriate information is shared with the police, information and intelligence sharing is a crucial part of the investigation process

The police should;

- Ensure that victims of child sexual exploitation are appropriately supported through the investigation and court process

- Ensure offenders are identified / targeted

- Ensure children involved in sexual exploitation are treated as victims and the focus of the investigation is on the abusers

Governance

What are we going to do?

- The Local Safeguarding Children Board will nominate a member of the board who will act as the 'lead professional'. Each agency of the Local Safeguarding Children Board will also nominate a lead professional, who will act as the agencies single point of contact for all matters relating to child sexual exploitation and will also be responsible for providing advice and support to their agencies workers

- The Cheshire and Merseyside Multi-Agency Child Sexual Exploitation Protocol will form part of the Pan Cheshire/Merseyside Safeguarding Children Procedures
-
- The Local Safeguarding Children's Boards are responsible for co-ordinating the activities of member agencies in relation to the effective implementation of these protocols

- The Local Safeguarding Children Board's lead professional for child sexual exploitation will, on behalf of the Local safeguarding Children's Boards organise a quarterly multi agency meeting. The purpose of this meeting will be;

  - To review performance in relation to the response of member agencies
  - To review the local implementation of the protocols
  - To identify areas of concern
  - To identify any patterns and trends in reports of child sexual exploitation
  - To develop local strategies / plans to address concerns / patterns / trends

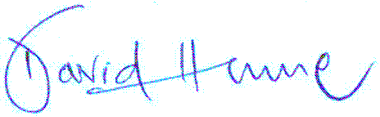
- A bi-annual strategic multi agency pan Cheshire/Merseyside meeting will take place with strategic representatives from the Local Safeguarding Children's Boards, the Local Authorities and the Police. Other professionals will be co-opted on to the group depending upon strategic needs. The purpose of this meeting will be;

    - To review the implementation of the Cheshire & Merseyside protocols
    - To consider the provision of services for children missing from both local authority care and home
    - To identify any patterns and trends in running / missing episodes and any cross border issues
    - To consider the provision of training for those responsible for management of, and services to, children missing from both local authority care and home
    - To monitor on a Pan Cheshire/ Merseyside basis the provision of single and multi-agency data collation and information sharing processes

- The meeting will be arranged and chaired by a nominated independent LSCB chair

- The representatives from the relevant Local Safeguarding Children's Boards will be responsible for updating their respective Board with any Pan Cheshire/Merseyside issues or areas for concern

Signatories to the Strategy

Liverpool Local Safeguarding Children's Board  **Signed** **Name Howard Cooper** **Title: Chair Liverpool LSCB**
Wirral Safeguarding Children Board  **Signed** **Name Bernard Walker** **Title: Chair Wirral LSCB**
St Helens Local Safeguarding Children's Board  **Signed** **Name Howard Cooper** **Title: Chair St Helens LSCB**
Knowsley Local Safeguarding Children's Board  **Signed** **Name David Hume** **Title: Chair Knowsley LSCB**
Sefton Local Safeguarding Children's Board  **Signed** **Name David Sanders** **Title: Chair Sefton LSCB**
Warrington Local Safeguarding Children's Board **Signed** **Name Audrey Williamson** **Title Chair Warrington LSCB**
Cheshire East Local Safeguarding Children's Board **Signed** **Name Ian Rush** **Title Chair Cheshire East LSCB**
Cheshire West Local Safeguarding Children's Board **Signed** **Name Gill Frame Chair Cheshire West LSCB**

Halton Local Safeguarding Children's Board

Signed

Name Richard Strachan Chair Halton LSCB

Sefton LSCB Child Sexual Exploitation 'Strategy on a Page'

GOVERNANCE

As a consequence, making sure that CSE remains high level, strategic priority throughout the sub-region to improve the lives of vulnerable young people.

- The Local Safeguarding Children Board will nominate a member of the board who will act as the 'lead professional'. Each agency of the Local Safeguarding Children Board will also nominate a lead professional, who will act as the agencies single point of contact for all matters relating to child sexual exploitation and will also be responsible for providing advice and support to their agencies workers. The Cheshire and Merseyside Multi-Agency Child Sexual Exploitation Protocol will form part of the Pan Cheshire / Merseyside Safeguarding Children Procedures.
- The Local Safeguarding Children's Boards are responsible for
- The Local Safeguarding Children Board's lead professional for child sexual exploitation will, on behalf of the Local Safeguarding Children's Boards organise a quarterly multi agency meeting. The purpose of this meeting will be:

  -To review performance in relation to the response of member agencies.

  -To review the local implementation of the protocols

  - To identify areas of concerns.

  -To identify any patterns and trends in reports of child sexual exploitation.

  -To develop local strategies/ plans to address concerns/ patterns/ trends.

PROFILE

STRATEGIC ACTION 1:
PROFILING

- Assess the awareness and levels of understanding of professionals in relation to child sexual ɔitation.
- tify the prevalence and els of child sexual ɔitation in the area.

STRATEGIC ACTION 2:
SERVICE PROVISION

- Map the availability of services for supporting sexually exploited children and young people.
- Focus on the needs of children and young people who may be sexually exploited when planning and commissioning services.

PREVENT

STRATEGIC ACTION 3:
PREVENTION

Awareness Raising with Children and Families:

Work with parents and carers to supplement and reinforce that awareness.

- Engage with children and young people to ensure they have an understanding of the issues surrounding child sexual exploitation.
- Develop activities which will dissuade children and young people becoming involved in child sexual exploitation.
- Awareness Raising in communities and Community Engagement.
- Develop community intelligence to understand child sexual exploitation.
- Raise awareness of targeted groups / organisations, for example, taxi, hotel and leisure organisations.
- Engage with our local communities and raise awareness of CSE and how it affects individuals.
- Undertake proactive communication with the media.

STRATEGIC ACTION 4:
TRAINING

- Undertake a review of all single and multi-agency training for professionals in terms of content and targeted delivery.
- As Local Safeguarding Children Boards, ensure the provision of appropriate multi agency training.

As single agencies, devise training to:

- Ensure staff working with or in contact with children are able to identify those children and young people at risk of child sexual exploitation.
- Ensure staff working with or in contact with children are able to identify activities employed by offenders / abusers.
- Ensure staff know what interventions are appropriate and how to implement and/or signpost to appropriate agencies / services.
- Ensure that the provision of training for their agency is delivered in line with the role of the professional and the level of detail they require.

PROTECT

STRATEGIC ACTION 5:
SAFEGUARDING

The Cheshire and Merseyside Local Safeguarding Children Boards will each:

- Develop a Child Sexual Exploitation multi-agency protocol which sets out the standards and provides guidance for multi- agency working in tackling child sexual exploitation.
- Ensure that responses to concerns about child sexual exploitation are managed via a multi-agency process and in accordance with these protocols.
- Ensure information is shared appropriately and especially with children's services and the Police.
- Ensure that individual agencies to develop their own policies and practice guidance which sets standards relating to how that agency responds to / works towards tackling child sexual exploitation. This will be monitored by the Local Safeguarding Children Board.
- Ensure agencies work together in recording and monitoring the prevalence of child sexual exploitation.
- Evaluate the effectiveness of service provision and identify and fill any gaps in service provision in supporting children and their families.
- Provide ongoing scrutiny and governance of policy, procedure and practice in service delivery.

PROSECUTE

STRATEGIC ACTION 6:
DISRUPTION

- Use disruption of perpetrator activity as an important tool in preventing child sexual exploitation.
- Work together across all agencies to develop appropriate disruption tactics Individual.
- Actively plan how each agency can contribute to disrupting perpetrator behaviour.

STRATEGIC ACTION 7 :
BRINGING OFFENDERS TO JUSTICE

- Ensuring abusers are brought to justice in an effective and appropriate way to safeguard children and young people. Offenders must be held to account for their behaviour.
- A clear understanding needs to be developed and agreed about the balance between the welfare of the child and the criminal justice considerations.

All agencies will:

- Ensure that workers co-operate with Police investigators in relation to the detection and prosecution of crime.
- Ensure appropriate information is shared with the police, information and intelligence sharing is crucial part of the investigation process victims child sexual abuse.

The police will:

- Ensure that victims of child sexual exploitation are appropriately supported through the investigation and court process.
- Ensure offenders are identified / targeted.
- Ensure children involved in sexual exploitation are treated as victims.

Child Sexual Exploitation—'A Crime that Knows No Borders and can be Global in Nature'

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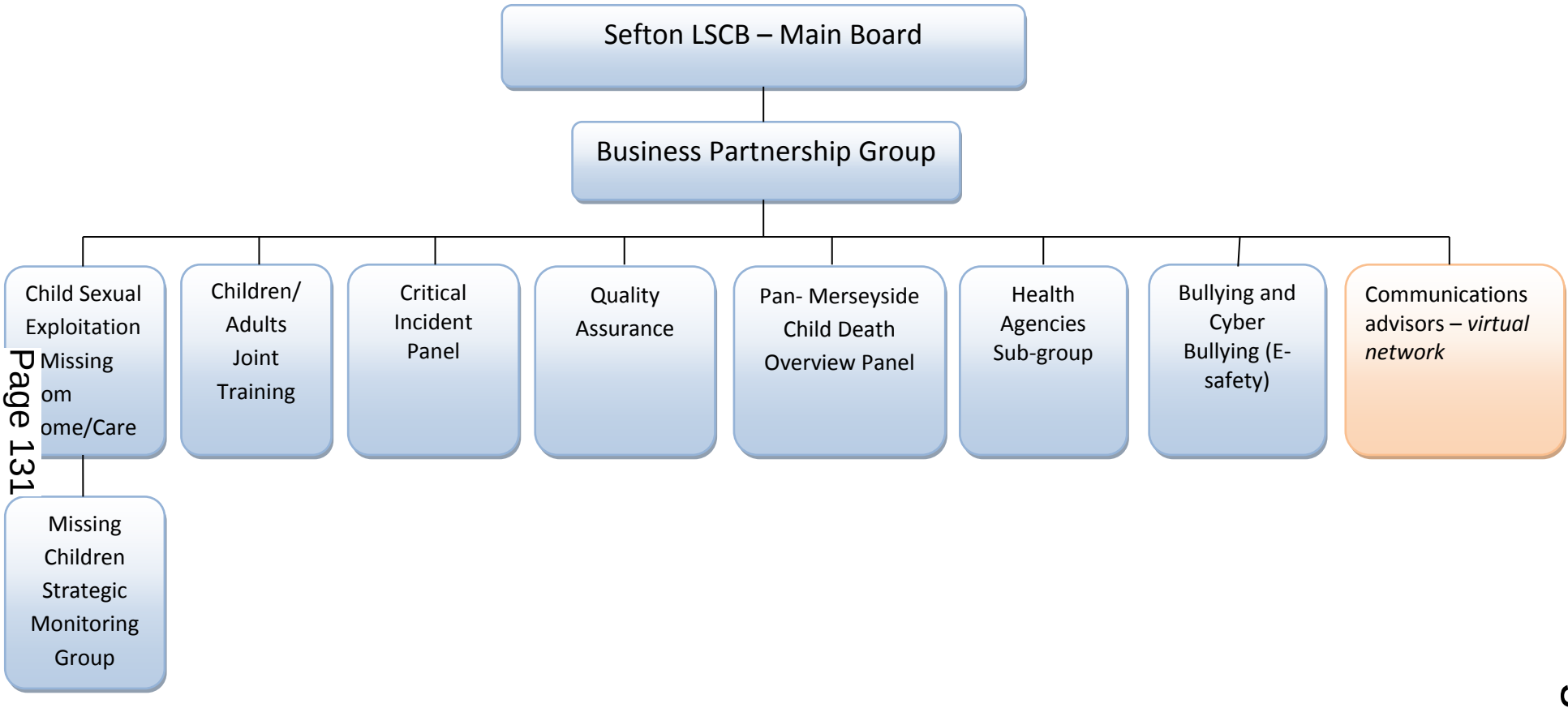
Sefton LSCB Structure 2015



Task and Finish Groups

- Signs of Safety Project Group
- Children in Care of Other Local Authorities
- Vulnerable Groups

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Sefton LSCB Partnership System

to address Child Sexual Exploitation concerns

October 2014

Glossary:

CSE	Child Sexual Exploitation
SPOC	Single Point of Contact. Each agency has a named individual who has responsibilities as a Single Point of Contact for supporting and challenging their organisation to identify CSE and make a referral to the MASH. A list of agency SPOCs is maintained by the LSCB.
OLA	Other Local Authority Placement – This is when a child is 'looked after' by another Local Authority and is placed in a care placement within the Sefton Boundary. A notification is sent by the Placing Authority to Sefton Safeguarding Children Unit. All Notifications are analysed for risk of CSE. Those with CSE identified are forwarded to the MASH CSE Police Officer.
MASH	Multi Agency Safeguarding Hub – MASH review all CSE professional referral forms and make a decision if this is a Child protection Matter which involves concern regarding parenting the young person receives, or, if there are no concerns regarding parenting refer the young person to the MACSE
MACSE	Multi Agency Child Sexual Exploitation Panel – This is a Panel which meets fortnightly to discuss all children and young people considered to be at risk of or experiencing child sexual abuse. This Panel is co-chaired by Merseyside Police Sefton DCI and Service Manager for Sefton Safeguarding Children Unit. The Panel invites SPOCS and individuals who are working with the child / young person and relevant Police Officers involved in the CSE investigation
IRO	Independent Reviewing Officers chair the Child Protection Case Conference as a Child Protection Chair.
CIN	Child in Need of additional support services at level 3a and 3b of the LSCB Thresholds.
CP	Child Protection. A child is placed in a Child Protection Plan (CP Plan) when they are considered to be at levels 3b or 4 of the LSCB thresholds in that they are at risk of or experiencing significant harm due to the parenting they receive.
LAC	Looked After Child –a child who is being cared for by the Local Authority
DCI	Detective Chief Inspector of Merseyside Police
BIP	Business Intelligence and Performance Service. Service within the Local Authority with responsibility for performance analysis to inform service delivery, planning and commissioning.
DCS	Director of Children's Services
LSCB QA	Local Safeguarding Children Board Quality Assurance Sub Group. A multi-agency Sub Group of the LSCB which analyses performance data, to identify patterns and trends to inform the focus of qualitative audit of single and multi-agency safeguarding practice.

Taxi's contact Police via '101'. Police send vulnerable person notification to FCIU / MASH

Other Local Authority Placement Notification identifies a looked after child is at CSE risk – Sefton Safeguarding Unit to send Notification Form to MASH CSE Police Officer

SPOCS for each agency

- List of SPOCs to be maintained by Safeguarding Unit
- SPOCS to monitor use of Safeguarding 1 form completion and challenge where lack of use across service
- SPOC provided with copy of all CSE 1 & 2 forms so has overview of CSE concerns within agency involvement
- CSE 1 &2 forms completed by agency working with child and e mailed to MASH with professional referral form

MASH

MASH to receive all completed CSE Safeguarding 1 forms (regardless of outcome) to review extra information accessed by MASH agencies and use Signs of Safety model.

If concerns regarding parenting Child Protection procedures to be implemented and Case Conference to be held if S47 investigation outcome concludes CP Plan required.

If CIN - use same planning template within C&F Assessment as revised MACSE CSE planning template and send referral to MACSE for overview.

If a child is already known to Social care – CIN, CP or LAC, and concerns **re: CSE arise**, contact to be sent to MASH for multi-agency MASH checks and commence decision re: above as to how CSE concerns should be addressed – CP (re: CIN), or via MASCE for ongoing CIN or LAC

If CSE concerns not identified – referral returned to SPOC with reasons why and proposed interventions, with request for ongoing monitoring and use of CSE

Child Protection Procedures

- Named IRO for CSE to attend MACSE to provide analysis of perpetrators identified via CP Meetings to MACSE & raise any concerns re: agency involvement in CP Plans to address CSE risk.
- CP Plan re: CSE to take same form of planning template as revised MACSE CSE Planning tool.

MACSE
(Joint Chair – DCI Police & Safeguarding Children Unit Service Manager

- All young people referred to MACSE.
- MACSE has allocated time slots to discuss each young person.
- Parent / carer and young person invited.
- SPOCS attend MACSE with operational staff from each agency to develop a CSE Safeguarding Plan.
- Business Officer / Analyst to organise allocation of slots for each young person & to minute NEW PLANNING TEMPLATE and send to all agencies involved to record on their records via secure email.
- Police analyst and BIP Rep to attend as standing members to analyse perpetrator data for patterns and trends analyst

LSCB QA Sub Group

QA Sub Group members to QA:
– CSE referrals to MASH, CP, CIN and MACSE CSE Plans every 6 months in 1 day multi agency case file audit.
- Analyse data from MACSE re: referral rates from agencies, trends and geographical patterns and sanction and detection rates.

MACSE CSE data& QA findings to be reported to LSCB & CSIB 1/4ly report by BIP and Police Analyst resources, data signed off by DCI & Safeguarding LA Lead as Joint MACSE Chairs

CSE PROSECUTE OPERATION

- Led by Merseyside Police - Joint Agency Operation with multi agency resources
- Decision to commence Operation led by MACSE Meeting
- All Operation updates and outcomes reported to DCS and Merseyside Police Assistant Chief Commander

CSE PREVENT OPERATION

- Led by Merseyside Police - Joint Agency Operation with multi agency resources
- Decision to commence Operation led by MACSE Meeting based upon trend – seasonal and place data analysis
- All Operation updates and outcomes reported to DCS and Merseyside Police Assistant Chief Commander

DCS, LSCB Independent Chair, Chief Executive & Elected Member Scrutiny

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Report to: Cabinet **Date of Meeting:** 26 March 2015

Subject: Procurement Proposals for the Annual Service Contracts for Highway Maintenance Works

Report of: Director of Built Environment **Wards Affected:** All Wards

Is this a Key Decision? Yes **Is it included in the Forward Plan?** Yes

Exempt/Confidential No

Purpose/Summary

To seek approval for the procurement of Annual Service Contracts for Highway Maintenance Work to begin in July 2016.

Recommendation(s) That

i) the procurement of the Annual Service Contracts for Highway Maintenance Work be agreed based on the specifications referred to in paragraph 2.6 of the report;

ii) the Director of Built Environment be authorised to approve the Short List of Tenderers for each Contract subject to the appropriate review of the Pre Qualification Questionnaire;

iii) the tenders be evaluated using the evaluation criteria set out in paragraph 2.4 of the report; and

iv) the Director of Built Environment be authorised to award the Contracts to the highest scoring Tenderer.

How does the decision contribute to the Council's Corporate Objectives?

	Corporate Objective	Positive Impact	Neutral Impact	Negative Impact
1	Creating a Learning Community		✓	
2	Jobs and Prosperity	✓		
3	Environmental Sustainability	✓		
4	Health and Well-Being	✓		
5	Children and Young People		✓	
6	Creating Safe Communities	✓		
7	Creating Inclusive Communities		✓	
8	Improving the Quality of Council Services and Strengthening Local	✓		

	Democracy			

Reasons for the Recommendation:

The existing Annual Service Contracts for Highway Maintenance Works are due to expire in July 2016. The Anticipated Scope of Works that are likely to be delivered under the Contracts are of sufficient value that Cabinet approval is required.

What will it cost and how will it be financed?

(A) Revenue Costs None. The cost of works awarded under tender will be to the level of annual budget as agreed by Council.

(B) Capital Costs
All the Works delivered using the Annual Service Contracts will be funded from the allocations in the Transportation Capital Programme

Implications:

The following implications of this proposal have been considered and where there are specific implications, these are set out below:

Legal Any legal implications are incorporated in the report	
Human Resources	
Equality	
1. No Equality Implication	✓
2. Equality Implications identified and mitigated	
3. Equality Implication identified and risk remains	

Impact on Service Delivery:

A timescale of Contract renewal has been established to ensure that new Contracts are signed some time in advance of the operational target date to ensure that any new Contractors are a familiar as possible with the Borough. However there may be some short term minor impacts on service delivery whilst the new Contractors fully establish themselves.

What consultations have taken place on the proposals and when?
The Head of Corporate Services & ICT has been consulted (FD 3489/15) and notes the report indicates no direct financial implications. To minimise risk it is proposed for this work is awarded to one contractor for each of the eleven Service Contracts with one reserve contractor, in case of poor performance by the primary contractor. One

OJEU notice will be placed inviting companies to express an interest in the one of more of the Lots.

Head of Corporate Legal Services (LD 2781/15) have been consulted and comments have been incorporated in the report

Are there any other options available for consideration?

There are a number of alternative proposals for delivering the Maintenance Work. Consideration has been given to engaging one Contractor for all the works that forms the Highway Maintenance Programme or by reducing the number of Contracts to a smaller number by joining similar activities together.

However, it is acknowledged that there is a risk that should the works be undertaken by one, or a small number of contractors, any poor performance of a Contractor would have a much greater impact both on service delivery and staff resources. As such, as the previous 5 year arrangement proved effective, it is appropriate to use this as a model for the Contracts going forward.

Implementation Date for the Decision

Following the expiry of the “call-in” period for the Minutes of the Cabinet.

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Tel: 0151 934 4222
Email: jerry.mcconkey@sefton.gov.uk

Contact Officer: Andy Dunsmore,
Tel: 0151 934 2766
Email: Andrew.Dunsmore@sefton.gov.uk

Background Papers:

None

1.0 Introduction

1.1 In May 2011 Cabinet Approved a Procurement Strategy for the setting up on 11 Annual Service Contracts (ASC) covering Highway related activities. This exercise was subsequently completed, Contractors appointed and Contracts formally established. These contracts are currently in operation and due to expire in July 2016.

1.2 As the Contracts are deemed to have worked well it is proposed to maintain the same number and scope of contracts and to adopt a very similar procurement process.

1.3 As the process advertising notice of tenders, shortlisting, assessing tenders returns and acting upon TUPE (where appropriate) can be reasonably time consuming it is intended to substantially complete the tender exercise during 2015, so that the new contractors are appointed, and can make the appropriate provision prior to the Contracts becoming live in July 2016.

2.0 Proposed Tender Process

2.1 It is proposed to seek tenders from suitably qualified contactors to deliver the following Contracts

HM1	Resurfacing
HM2	Road Markings
HM3	Weed Control
HM4	Signs Guardrail
HM5	Ground Maintenance
HM6	Gullies
HM7	Electrical Connections
HM8	Surface Treatments
HM9	Minor Works
HM10	Highway Maintenance
HM11	Pumping Station Maintenance

2.2 One OJEU notice will be placed inviting companies to express an interest in the one of more of the Lots.

2.3 Prospective contractors will then be required to complete a Pre Qualification Questionnaire. This will assess the contractor's financial standing and their relevant experience. A Panel, made up of 3 officers will assess the responses to the questions set out in the tender documentation for each of the ASCs and scores will be allocated to each contractor. Following this exercise a short list will be established for each contract.

2.4 Short listed Contractors will then be invited to submit a tender. These will be assessed on a price/quality basis in the ratio 85% price/15% quality. The Panel described above will assess and score the responses to the quality questions.

2.5 Due to the nature of the works the contracts have been priced as Schedules of Rates. Typical baskets of works have been developed for each contract (except Contract HM5 – Grounds Maintenance) to reflect the likely nature and volume of works to be undertaken. These baskets of work will be used to calculate a value of works for use in the assessment process for each contract.

2.6 The specification for each contract will be based upon 'Specification for Highway Works', as Volume 1 of the Manual of Contract Documents for Highway Works. These were adopted in the contracts currently being operated and were modified to include any specific local requirements.

2.7 As assessment of the operation of each of the current contracts is ongoing to determine the scope of any changes required to the Schedules of Rates and associated specifications to ensure that the contracts meet the Council's current requirements.

2.8 The value of each contract will be dependant upon the volume of work being delivered in the Transportation Capital Programme from 2016 onwards. As a guide, the annual spend for each contract in 2013/14 was as follows;

HM1	Resurfacing	£0
HM2	Road Markings	£304,803
HM3	Weed Control	£125,785
HM4	Signs Guardrail	£368,376
HM5	Ground Maintenance	£285,629
HM6	Gullies	£197,859
HM7	Electrical Connections	£188,890
HM8	Surface Treatments	£1,062,133
HM9	Minor Works	£494,161
HM10	Highway Maintenance	£4,336,656
HM11	Pumping Station Maintenance	£94,533

Note - As Contracts HM1 and HM10 were awarded to the same Contractor and HM10 included the relevant items included in HM1, HM 10 was used for all resurfacing work.

2.9 The baskets will be reviewed and checked against the full Schedules of Rates submitted to ensure that any incorrect or anomalous rates provided by tenderers or incorrect or anomalous quantities within the basket can be rectified as required. This may require changes to the quantities to ensure the best value for money solution for the council.

2.10 Lot 5 – Grounds Maintenance has been priced as a "shopping list". This will allow Sefton MBC to select the required extent of works (for example no. of grass cutting visits) to give the best value for money within the available budget.

2.11 This assessment will allow a financial score to be made and hence a combined price/quality score to be allocated to each Contractor

2.12 It is proposed that this Contract is awarded to one contractor for each of the Service Contracts with one reserve contractor, in case of poor performance by the primary contractor