Warwickshire Health and Wellbeing Board

Agenda

21st January 2015

A meeting of the Warwickshire Health and Wellbeing Board will take place at **Shire Hall, Warwick** on **Wednesday 21st January 2015 at 13:30.**

The agenda will be:-

1. (13.30 – 13.35) General

(1) Apologies for Absence

(2) Members' Disclosures of Pecuniary and Non-Pecuniary Interests.

Members are required to register their disclosable pecuniary interests within 28 days of their election of appointment to the Council. A member attending a meeting where a matter arises in which s/he has a disclosable pecuniary interest must (unless s/he has a dispensation):

- Declare the interest if s/he has not already registered it;
- Not participate in any discussion or vote;
- Must leave the meeting room until the matter has been dealt with (Standing Order 43); and
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

Non-pecuniary interests must still be declared in accordance with the new Code of Conduct. These should be declared at the commencement of the meeting.

(3) Minutes of the Meeting of the Warwickshire Health and Wellbeing Board on 19th November 2014 and Matters Arising.

Draft minutes of the meeting are attached for approval.

2. (13.35 – 13.55) Warwickshire Safeguarding Children's Board Annual Report 2013-14

David Peplow, Independent Chair of WSCB

3. (13.55 – 14.10) Warwickshire Data Sharing Protocol

Chris Lewington / Gareth Wrench

4. (14.10 – 14.25) Priority Families Update & Outcomes Plan 2015-2018

Nick Gower-Johnson

5. (14.25 – 14.40) Housing Related Support Services – Verbal Update

Chris Lewington

6. (14.40 – 14.50) JSNA Review

John Linnane

7. (14.50 – 15.05) Health and Wellbeing Strategy – Updates from Districts and Boroughs

District and Borough Council Representatives

8. (15.05 – 15.20) Update from Clinical Commissioning Groups on the Better Care Fund

Representatives of Clinical Commissioning Groups

9. (15.20 – 15.25) Winter Pressures

Chris Lewington

10. Any other Business (considered urgent by the Chair) Further Information, Future Meetings and Events:

Health and Wellbeing Board Newsletter Link to Newsletter
Healthwatch Newsletter Link to Newsletter

Minutes of Safeguarding Boards, Joint Commissioning Boards and Health Protection Committees Link to Minutes

Health and Wellbeing Board Membership

Chair: Councillor Izzi Seccombe (Warwickshire County Council)

Warwickshire County Councillors: Councillor John Beaumont, Councillor Jose Compton, Councillor Bob Stevens,

Clinical Commissioning Groups: Karen Ashby (Warwickshire North), David Spraggett (South Warwickshire), Adrian Canale-Parola (Coventry and Rugby)

Warwickshire County Council Officers: John Dixon – Interim Strategic Director, People Group, Monica Fogarty - Strategic Director, Communities, John Linnane - Director of Public Health

NHS England: David Williams.

Healthwatch Warwickshire: Phil Robson

Borough/District Councillors: Councillor Neil Phillips (NBBC), Councillor Belinda Garcia (RBC), Councillor Michael Coker (WDC), Councillor Derek Pickard (NWBC), Councillor Gillian Roache (SDC)

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Minutes of the Meeting of the Warwickshire Health and Wellbeing Board held on 19th November 2014.

Present:-

Chair

Councillor Izzi Seccombe

Warwickshire County Councillors (In addition to the Chair)

Councillor John Beaumont
Councillor Jose Compton
Councillor Bob Stevens

Clinical Commissioning Groups

Dr Adrian Canale-Parola (Coventry and Rugby CCG)
Karen Ashby (Warwickshire North CCG)
David Spraggett (South Warwickshire CCG)

Warwickshire County Council Officers
Monica Fogarty – Strategic Director for Communities
Dr John Linnane – Director of Public Health

Healthwatch Warwickshire

Phil Robson – Chair

Borough/District Councillors

Councillor Michael Coker (Warwick District Council)
Councillor Derek Pickard (North Warwickshire Borough Council)
Councillor Gillian Roache (Stratford District Council)

In Attendance
Judith Hurcombe and Ami Beeton, Programme Managers for the Local Government Association's Health and Wellbeing Peer Challenge

1. (1) Apologies for Absence

Wendy Fabbro – Strategic Director, People Group
Councillor Belinda Garcia (Rugby Borough Council)
Councillor Neil Phillips (Nuneaton and Bedworth Borough Council)
David Williams (NHS England)

(2) Members' Declarations of Pecuniary and Non-Pecuniary Interests

Councillor Derek Pickard declared a non-pecuniary interest, as a member of the County Council's Adult Social Care and Health Overview and Scrutiny Committee.

(3) Minutes of the meeting held on 22nd September 2014 and matters arising.

The Minutes were agreed as a true record. Councillor Stevens provided an update on the Multi Agency Safeguarding Hub item raised at this meeting. An operational manager had been recruited and good progress was being made.

2. Peer Challenge

Judith Hurcombe, the Local Government Association (LGA) Programme Manager for the Health and Wellbeing Peer Challenge gave a presentation to the Board. This outlined the approach to the Peer Challenge, its purpose and methodology. Headline questions would be posed and a position statement be provided on behalf of the Board. Additionally, a data analysis and survey would be undertaken. The four days on site would comprise a mix of interviews, focus groups and observations. The reporting process was explained, leading to the sign-off of the Peer Challenge and follow up arrangements.

A report was presented by Richard Maybey, Performance & Improvement Officer on the preparations to date. The Board was asked to approve the positioning statement and to agree the key themes to be explored through the peer challenge. Appended to the report was the list of proposed core participants. A Board meeting was scheduled for Wednesday 21st January, which the peer challenge team would attend. A draft timetable for the peer challenge was provided. The LGA had requested significant background information, which was currently being compiled. Partners were asked to consider further information sources that might be of benefit to the peer team.

The Chair felt the peer challenge provided the opportunity to make a step change to improve the Board's performance. The Board reviewed the documentation, discussing the positioning statement and the list of participants. Some minor alterations were required to the latter document prior to its submission, which Monica Fogarty, Strategic Director for Communities offered to assist with. Councillor Gillian Roache advised that Stratford District Council had produced its own strategy for health and wellbeing and it was agreed that this document be provided to the peer challenge team. Karen Ashby of Warwickshire North CCG welcomed involvement in the process.

Resolved

1. That the Board endorses the preparatory work undertaken for Warwickshire's Health and Wellbeing Peer Challenge.

2. That the Positioning Statement is approved for submission to the Peer Challenge Team.

3. That minor updates are made to list of participants, prior to its submission.

3. Briefing on Board Membership and Governance

Dr. John Linnane, Warwickshire's Director of Public Health, presented a briefing document to remind the Board of its governance arrangements. The shadow Board was formed in 2012, with the establishment of the statutory Board from 1 April 2013. The terms of reference of the Board, its membership and the role of active observers were reported. In addition to the Board, there were a number of subordinate bodies with functions relating to partnership working, engagement, infrastructure or governance and reporting. A further diagram had been circulated showing the range of groups supporting the Board.

Councillor John Beaumont questioned the political proportionality of Board members representing the County Council. He asked whether this had been reviewed after the 2013 County Council elections, as referred to in the minutes of the 21st March 2013 County Council meeting appended to this report. The Chair responded, offering to meet with Councillor Beaumont. It was noted that this was a wider partnership body with some statutory appointments and the need for certain Cabinet members to sit on the Board.

Phil Robson, Chair of Healthwatch Warwickshire addressed the Board about this item and the Health and Wellbeing Strategy. He acknowledged the wide consultation undertaken in producing the Strategy. Referring to the Strategy's themes, he spoke about partnership working, the sharing of risks and he stressed the importance of recognising the views of consumers. There were difficult decisions ahead, as a lack of additional monies would require the redesign of services and possibly removal of some services to fund others. Healthwatch would like to be involved in meetings between commissioners and providers when service redesign was considered, to represent the views of consumers. He talked about the Board's composition, the involvement of acute service providers and their current role as active observers. The involvement of Warwickshire Community and Voluntary Action (WCAVA), to represent the voluntary sector was suggested.

The Chair noted the points raised. The Peer Challenge in January may result in recommendations regarding the Board's size and composition.

She advised of her recent involvement in the peer challenge of Wiltshire's Health and Wellbeing system and had found similar arrangements regarding the involvement of service providers in a non-voting capacity. In Warwickshire, there were a number of other groups that represented the views of patients and the Board needed a coordinating voice for all such groups. Karen Ashby added that clinical commissioning groups were committed to hearing patients' views at all levels, not just via the Board. Further points were made regarding the role of councillors in representing the views of constituents and engaging at a local level, regarding operational aspects.

Paul Tolley, Chief Evecutive of WCAVA welcomed the community resilience priority within the Health and Wellbeing Strategy. He referred to Monitor, which was the sector regulator for health services in England, with the role to make the health sector work better for patients. He also felt there was a need to strengthen the mechanisms already in place to refer items up through the health and wellbeing system to the Board.

Monica Fogarty commented that the formal Board meetings were a small part of the health and wellbeing system in Warwickshire, with the vast majority of work occurring outside the Board. There was a need to focus on the networks, rather than who was represented on the Board.

Resolved

That the Health and Wellbeing Board endorses the structure and membership of the Board as submitted.

4. Health and Wellbeing Strategy

Nicola Wright, Public Health Consultant for Wider Determinants of Health presented this report. In July 2014, the Board agreed proposals for the review of the Health and Wellbeing Strategy, which now comprised three proposed priorities of promoting independence, community resilience and integration & working together. A process of stakeholder and public consultation followed with the results shaping the development of the Strategy. A copy of the Health and Wellbeing Strategy was circulated for comment and final approval. An equality impact assessment was also provided. Nicola Wright advised that a four page summary of the document would be produced, together with a glossary of the acronyms and abbreviations used. A further document would show how feedback through the consultation processes had shaped the final Strategy.

David Spraggett of South Warwickshire CCG commented that the Strategy contained many aspirations, but there would also need to be a mechanism for monitoring progress and outputs. Data was available from the CCGs to assist with this. Dr. John Linnane agreed there was a

need to monitor the effectiveness of the Strategy, in improving the lives of Warwickshire's residents. He hoped that CCG colleagues could see how the Strategy aligned to their respective commissioning plans. Dr Adrian Canale-Parola of Coventry and Rugby CCG endorsed the need to monitor progress, but also spoke of the need to change cultures and societal behaviour, so residents looked after their own health. He added that measuring cultural change would be less easy.

Resolved

That the Health and Wellbeing Board gives final approval to the Warwickshire Health and Wellbeing Strategy 2014-18.

5. Presentation on Social Care and Public Health Commissioning Intentions/Plans

The Board received presentations from Dr. John Linnane, and Chris Lewington, Head of Strategic Commissioning at Warwickshire County Council. The presentations provided an update on the commissioning intentions for Public Health and Social Care services.

Over the past 18 months Public Health had undertaken a strategic commissioning review. The commissioning plans and ongoing Public Health programmes had been aligned to the County Council's One Organisational Plan. Specific priorities included:

- Smoking cessation and tobacco control
- Weight management services
- Services focused on children
- Mental health and wellbeing (including dementia)
- Services for health protection

Chris Lewington presented the social care commissioning plans. The key message was to help people to maximise their potential for independence, before putting in place longer-term services. A diagram showed how the strategic commissioning approach to service delivery worked. There were three key drivers for change, through the Children & Families Act 2014, the Care Act 2014 and the Better Care Fund. The commissioning principles and priorities were reported together with the desired outcomes from service provision for Warwickshire's children and adults.

Resolved

That the Health and Wellbeing Board receives the presentations on the commissioning intentions for Public Health and Social Care services.

6. Coventry and Warwickshire's local response to Winterbourne View Hospital

It was reported that following the events that took place at Winterbourne View Hospital, "Transforming Care and the Winterbourne Concordat" had placed a number of requirements on local areas. This included the development of a joint plan for high quality care and support services for people of all ages with challenging behaviour.

Rebecca Hale, All Age Disabilities Commissioning Service Manager and Sue Davis, Head of Partnerships, Coventry and Rugby CCG presented this item, which reported Coventry and Warwickshire's joint plan in response to these requirements. This document described the way that Warwickshire County Council, Coventry City Council and CCGs would work together and in partnership with all stakeholders, to deliver care and support that promoted prevention and early intervention.

Two multi-agency groups had met regularly to progress the key milestones associated with the Winterbourne Concordat. A clinical review group focused on individual patient review and discharge and the Learning Disability and Autism Commissioner Group focused on the development of the joint plan.

Councillor Gillian Roache asked if the proposed response had been considered by Coventry's Health and Wellbeing Board. A similar report would be presented to its next Board meeting and it was confirmed that the work completed to date had been well received. Dr Linnane welcomed this report and felt it gave a tangible example of effective partnership working, where the measures put in place had gone further than the concordat requirements.

Resolved

That the Health & Wellbeing Board agrees the proposed response to the requirements of "Transforming Care and the Winterbourne Concordat" as submitted and endorses the work programme for 2014 – 2016.

7. Warwickshire Safeguarding Adults Board Annual Report 2013/14

The Board received the annual report of the Warwickshire Safeguarding Adults Board (SAB) for 2013/14. Mike Taylor, Independent Chair of the SAB presented the report. This provided evidence of the multi-agency partnership work to help protect vulnerable adults. Safeguarding activity increased each year with 2,307 alerts received in the report period, an increase of 17% from 2012/13. The referrals came from a wide range of sources. The most prevalent forms of abuse recorded related to financial, physical and emotional abuse. In line with national trends, most

perpetrators of adult abuse tended to be family members and most abuse occurred in the home. The Care Act 2014 introduced new legal powers for adult safeguarding such as the requirement to conduct serious case reviews, to 'require' a partner agency to supply information and SAB annual reports would be legal requirement from April 2015.

In light of the statutory requirements of the Care Act, it was proposed that the Warwickshire SAB develop a governance structure which included reporting to the Health and Wellbeing Board from April 2015. This would result in revised membership of the SAB and its working relationship with both the local authority and with other partner agencies. Responsibility for delivery would now rest with the Independent Chair of the Board, accountable to the County Council's Chief Executive.

Mike Taylor confirmed that the annual report gave a lot of operational detail. It was intended to produce a more outcome focussed document in future. The theme was to make safeguarding personal to each service user's needs. Councillor Jose Compton was impressed with the multi-agency approach of the SAB and she commended the annual report.

Resolved

That the Board approves the Warwickshire Safeguarding Adults Board Annual Report 2013/14.

8. Any Other Business

Councillor Bob Stevens gave a verbal report about the Ebola outbreak. He confirmed that there were well established systems in place to respond to any suspected cases and the risk to Warwickshire residents was low. He also referred to the screening of passengers at airports and a desktop exercise undertaken to test system arrangements in Coventry and Warwickshire.

Chris Lewington referred to the Better Care Fund and the need to agree a process for the sign off of future submissions. At a meeting with clinical commissioning groups, it was proposed that the CCGs nominate a single representative to sign off future Better Care Fund submissions and the Board agreed to this approach.

The Chair sought approval for the addition of the West Midlands Ambulance Service to the list of active observers. This was agreed.

The Chair also reported on plans to produce an End of Life Strategy. Government funding had been secured for the production of a strategy for the north of the County and through work with partners, it was hoped to extend this to cover all of Warwickshire. Dr David Spraggett advised that such a strategy was substantially complete for the South of

Warwickshire and there would be a benefit in joint work to avoid duplication and save time.

The Chair reminded of the recent statutory data request circulated to the Board and active observers, from the Children's Commissioner for England, Dr Maggie Atkinson. The County Council would be coordinating the response and contributions could be submitted to Gareth Wrench and Jenny Bevan at the County Council.

The meeting rose at 15.35

……..Chair

Item 2

Health and Wellbeing Board

21st January 2015

Warwickshire Safeguarding Children Board (WSCB) Annual Report 2013-14

Recommendation

1. The Health and Wellbeing Board considers and comments on the content of the report.

1.0 Key Issues

1.1 The independent chair of the Local Safeguarding Children Board (LSCB) is required to publish an annual report which evaluates the effectiveness of arrangements to safeguard and promote the wellbeing of children in the local authority area. This report must be submitted to the LA Chief Executive, the leader of the Council, the PCC and the chair of the Health and Wellbeing Board.

1.2 The substance of the WSCB report is set out in three main parts. The first addresses progress against the WSCB strategic objectives, the second contains reports from partner agencies on their individual safeguarding activity during the year, and the final part contains performance data and an analysis of this. The main findings of the performance data are summarised at page 50.

1.3 A report of the Child Death review function of the LSCB is provided separately. This is because Warwickshire has a partnership arrangement with Coventry and Solihull Local authorities and a report is compiled in respect of the sub-region. The Child Death Review panel reviews all children who die in the County, and identifies modifiable factors in the services provided to the child and their family, which if changed might prevent future similar deaths.

1.4 A substantial finding of the report is that children with disabilities and children from black and minority ethnic backgrounds are under-represented at all levels of the safeguarding continuum. This raises the question of whether the safeguarding needs of these children are being recognised and addressed.

1.5 It was not possible to be provided with all the performance measures requested to assess child sexual exploitation (CSE) activity, because some agencies were not collecting data in a way that facilitated extracting the information requested. Partners have been asked to address this so that progress in this important area can be tracked.

1.6 Only a fifth of children reported missing to the police are receiving the 'return home' interview required by statutory guidance because the single Missing Children's practitioner has insufficient capacity to see more. The evidence suggests that where this intervention is offered it is effective in preventing or reducing further missing episodes, and these interventions have also resulted in potentially harmful CSE activity being identified and curtailed.

1.7 There has been a steady increase in private fostering activity during the time the specialist practice leader has been in post. This includes increasing numbers of consultations, referrals, and assessments of new private fostering situations, and means more of these vulnerable children are being appropriately supported.

1.8 Overall, safeguarding activity continues to rise. The increases are greater in the number of children receiving services at CAF/ early help and child in need levels, suggesting some success at intervening earlier.

Background papers

1. WSCB annual report 2013-2014
2. CDOP Annual report 2013-2014

	Name	**Contact Information**
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Portfolio Holder	Cllr Bob Stevens	cllrstevens@warwickshire.gov.uk

ANNUAL REPORT

2013-2014

Contents

1. Forward - Independent Chair.

I am delighted to introduce the Warwickshire Safeguarding Children Board (WSCB) annual report for 2013-2014.

As the newly appointed Independent Chair it is clear to me from this report that I am taking over a strong and committee partnership. The key work of a Safeguarding Children Board is to coordinate the work of local agencies for the purpose of safeguarding and promoting the welfare of children and to scrutinise and challenge the work of those agencies.

The Mission of WSCB is:

- To ensure that sound arrangements to protect children are in place in Warwickshire;
- To promote the welfare of children in Warwickshire;
- To achieve these objectives by promoting interagency cooperation and collaboration.

With that key role and mission in mind it is very pleasing to see the contributions from individual agencies which outline in an open way both the successes and challenges that they have faced in a climate of budget pressures and, for some partners, a period of significant organisational change. This report is a wonderful showcase for the work which is often hidden from view.

Throughout the year the WSCB has worked hard to retain its focus on effective safeguarding, to implement its business plan, and to keep the continuity of the local "story" of safeguarding. There is still much to be done as we move into the new year. The WSCB is about to embark on the final year of the three year delivery of our business plan and I look forward to being able to report further success next year.

I would like to thank all the front line practitioners for their dedicated work in safeguarding children, the members of the WSCB and the business team for all their work during the last year. Finally, I wish the outgoing Chair, Chris Hallett all the very best for the future and thank him for the strong partnership he has created.

David Peplow

2. Local background and Context.

2.1 Warwickshire is a two tier County Council in the West Midlands composed of five District/Borough Councils. The demography of the county varies markedly from District to District, with the south of the county in general being more affluent than the north, which features significant deprivation in parts. The total 0-17 population of Warwickshire is 111,872, with the breakdown by age group and District / Borough shown in the table 1, below. The January 2014 school census found that 14.8% of school age children (reception to year 11) were from a black or minority ethnic background.

Table 1: Breakdown of Age group and District / Borough.

Age	Warwickshire	North Warks	Nun & Bed	Rugby	Stratford	Warwick
0-4 years	31,364	3,285	7,925	6,269	5,965	7,920
5-9 years	29,180	3,209	7,019	5,648	6,176	7,128
10-14 years	31,267	3,730	7,412	6,149	6,849	7,127
15-17 years	11,061	1,913	4,893	5,251	4,217	4,517
Total (0-17)	**111,872**	**12,407**	**27,249**	**23,317**	**23,207**	**26,692**

2.2 Socio-economic picture.

Deprivation covers a broad range of issues and refers to unmet need caused by a lack of resources of all kinds, not just financial. The English Indices of Deprivation use various indicators across seven distinct domains of deprivation, which can be combined to calculate an overall relative measure of deprivation - The Index of Multiple Deprivation 2010 (IMD 2010) - although it should be noted that much of the data used to construct the indices relate to the year 2008.

The Indices of Deprivation 2010 show that Nuneaton & Bedworth Borough has the highest levels of deprivation in Warwickshire with a ranking of 108 out of 326 Local Authority Districts in England, according to the rank of average score measure of deprivation (where a rank of 1 indicates the most deprived authority). This means Nuneaton & Bedworth falls within the top third most deprived Local Authority Districts in England. There are nine Lower Super Output Areas (LSOAs) in Warwickshire ranked within the top 10% most deprived SOAs nationally on the overall Index of Multiple Deprivation 2010. These are all located within Nuneaton & Bedworth Borough. Stratford on Avon District is the least deprived District in the County, ranked 278th out of 326 Local Authority Districts. In between, North Warwickshire is ranked 182nd, Rugby 219th and Warwick District 257th.

The table below (table 2) contains additional socio economic contextual indicators highlighting the disparity between the North and the South of the County in terms of unemployment, worklessness and economic hardship, impacting on family cohesion, educational outcomes, health and general wellbeing. Like any District level measure, local variations and concentrations of deprivation will be masked across all five Districts and Boroughs. For example, eleven wards in Warwickshire had at least 1 in 5 children estimated to be living in poverty (20%) – including five wards in Nuneaton and Bedworth, and specific areas of Atherstone in North Warwickshire, Rugby Borough, and Leamington Spa in Warwick District.

Table 2: Socio economic indicators in Warwickshire

District	Jobseekers Allowance (Feb 14) % working age population	All DWP working age benefit claimants (Aug 13) % working age population	Estimated % of Children in "Poverty"* (2012)	Free School Meal Eligibility (Jan14) % pupils attending maintained school in Warwickshire eligible for FSM	CP per 10,000 at 31 March 2014
North Warks	1.7%	10.9%	11%	10.8%	52 per 10,000
Nun. & Bed.	3.3%	14.9%	17%	15.1%	82 per 10,000
Rugby	1.6%	9.7%	11%	9.5%	31 per 10,000
Stratford on Avon	0.9%	7.5%	7%	6.5%	27 per 10,000
Warwick	1.3%	7.9%	9%	8.3%	40 per 10,000
Warwickshire	1.8%	10.1%	11%	10.1%	47 per 10,000
England	3.5%	13.2%	20%	18.3%^	TBC

Source: NOMIS, School Census, CRSP

**Child Poverty data compiled by the Centre for Research in Social Policy (CRSP), using Tax Credit data ^National FSM figure as at January 2013*

It is also worth noting that as part of Troubled Families programme, which aims to tackle the root cause of problems that cause truancy, youth crime, anti-social behaviour and worklessness, over 900 families have been identified that meet three of the identified criteria (national and local criteria) within Warwickshire. Half of these families (476 in total) reside in Nuneaton and Bedworth Borough. Child protection was one of the local criteria used to identify these families.

2.3 Strategic Partnership Working

The Joint Strategic Needs Assessment (JSNA)

The JSNA in Warwickshire has five themes, two of which are Children and Young People, and Vulnerable communities. An number of activities in the work programme under these themes overlap with WSCB priorities, including the Helping Vulnerable Children needs assessment, which aims to agree criteria for 'vulnerable children' and devise a methodology for identifying them so that Early Help services can be commissioned and targeted most effectively.

The JSNA undertook a needs assessment in 2013-14 to understand the scope of CSE (Child Sexual Exploitation) in Warwickshire, this needs assessment was sponsored by WSCB.

Safer Warwickshire Partnership Board

Countywide Community Safety priorities for 2013-14 included violent crime, focusing on alcohol-related, domestic-related and town centre related violence. Domestic abuse is a feature of about half the families where children are the subject of a child protection plan, and the underlying reason for a great many police referrals to children's social care, so this aspect of community safety work is of great interest to WSCB. In 2013-14, the work plan for 'violent crime' included the development of the Violence against Women and Girls strategy, which WSCB engaged in.

3. Statutory and Legislative context for LSCBs.

Local Safeguarding Children Boards (LSCBs) were established by the Children Act 2004 which places the responsibility on Local Authorities to co-ordinate an LSCB in their area.

The roles of the Board are to co-ordinate local multi-agency safeguarding arrangements, and evaluate the effectiveness of these arrangements. To do this the Board has several functions it must perform, including:

- producing local inter-agency safeguarding procedures,

- reviewing the deaths of all children in its area to identify learning which may prevent future child deaths, conducting Serious Case Reviews into the deaths of any children where child abuse or neglect are known or suspected, or cases where children are seriously harmed by abuse or neglect and poor multi-agency working may have been a factor,

- and publishing an annual report on the effectiveness of child safeguarding arrangements in the area.

Safeguarding Boards must include senior members of staff from Local Authority children's and adult's services, District/Borough Councils, Police, Health Service, Education, Youth Justice and Probation, and they should be chaired by someone suitably experienced in safeguarding children who is independent of the partner agencies.

4. Governance and Accountability arrangements.

4.1 Warwickshire Safeguarding Children's Board has an independent chair, who in 2013-2014 was Chris Hallett. In addition to the Chair, the Board directly employs three members of staff, the Development Manager, Inter-agency Training officer, and an Administrator, these posts are hosted by the County Council and funded by the contributions made by member organisations as set out below.

The Child Death Overview functions are managed and supported by a team of two staff, the CDOP Manager and an assistant. This arrangement is made in co-operation with Solihull and Coventry, with the CDOP team working on behalf of all three CDOP panels. The posts are funded jointly by Warwickshire County Council, Coventry City Council and Solihull MBC, in addition to the funding provided by the local authorities directly to the respective Safeguarding Children Boards.

4.2 Recorded Attendance at WSCB meetings May13-Feb14.

Agency	Board Member (s)	May 2013	Sept. 2013	Dec. 2013	Feb 2014
Independent Chair	Chris Hallett	√	√	√	√
WCC	Wendy Fabbro (DCS Strategic Director)	A	A	√	A
	Phil Sawbridge, Safeguarding Head of Service	√	n/a	n/a	n/a
	Sue Ross (Interim Head of Service, Safeguarding)	n/a	n/a	A	√
	Heather Timms: Participant Observer (Lead Portfolio Holder for Children)	A	√	A	√
	Jenny Wood (Head of Service, Social Care and Support)	D	√	√	A
	Helen King (Deputy Director, Public Health)	n/a	A	√	A
	Hugh Disley (Head of Service, Early Intervention)	√	√	A	√
	Jenny Butlin-Moran (Service Manager, Child Protection)	√	√	√	√
	Calvin Smith (Service Manager, Rugby)	√	√	√	√
	Maria Barnes (Service Manager, North)	√	√	√	√
	Sue Ingram (Domestic Abuse Services Manager)	√	√	√	√
	Adrian Over (Education Safeguarding Manager, representing schools and colleges)	√	√	√	A
	Cornelia Heaney: Adviser (WSCB Development Manager)	√	√	√	√

	Victoria Gould -Adviser (Legal Services)	√	√	√	√
	Mark Simmonds (Inter-Agency Training Officer, WSCB)	√	√	n/a	n/a
	Rachael Boswell (Learning and Improvement Officer, WSCB)	n/a	n/a	n/a	√
Warwickshire and West Mercia Police	Steve Cullen (Detective Superintendent)	n/a	n/a	√	D
	Amanada Blakeman (Detective Superintendent)	√	n/a	n/a	n/a
	Damian Barratt (Acting Detective Superintendent)	n/a	√	n/a	n/a
	Richard Long (Detective Chief Inspector)	√	√	√	√
	Nigel Jones (Detective Inspector)	√	A	n/a	n/a
Warwickshire Youth Justice Service	Lesley Tregear (Warwickshire Youth Justice Service)	√	D	√	√
Warwickshire Probation Trust	Andy Wade (Ass Chief Probation Officer)	√	√	√	A
Rugby Borough Council	Stephen Shanahan (Head of Housing Services)	√	A	√	A
North Warwickshire Borough Council	Simon Powell (Ass Director – Community Development)_	√	√	√	D
Stratford-upon-Avon Distict Council	Martin Cowan Housing Advice Manager	√	√	√	√
Nuneaton and Bedford Borough Council	Craig Dicken (Equality and Child Protection Officer)	√	√	A	√
Warwick District Council	Jameel Malik (Head of Housing/Property)	√	DNA	D	n/a
South Warwickshire CCG	Alison Walshe (Director of Quality and Performance)	DNA	D	A	D
Coventry and Warwickshire Partnership Trust	Jamie Soden (Deputy Director of Nursing)	√	√	D	√
Coventry, Solihull and Warwickshire Partnership	Steve Stewart (Executive Director)	A	A	DNA	A
NHS England	Helen Hipkiss Ass. Director Patient Experience.	√	√	√	D
Designated Nurse for Child Protection	Jackie Channell: Adviser	√	A	√	A
Designated Doctor, Child Protection	Dr Peter Sidebotham: Adviser	√	√	√	A
Warwickshire North CCG and Coventry and Rugby CCG	Jacqueline Barnes (Executive Nurse)	D	√	D	√
Lay Member	Keith Drinkwater (Vice Chair)	√	√	√	√
Lay Member	Angela O'Boyle	√	√	√	A
Voluntary Sector (nominated by WCVYS)	Mike Haywood	n/a	√	√	√

Attendance Key:
√ - Attended, D – Deputy, A – Apologies, DNA – Did not attend
n/a – not a board member for this meeting

In addition to the main board, WSCB has several sub-committees which carry out much of the work undertaken by WSCB.

WSCB sub-committees.

Chairs sub-committee - Chris Hallett

Child Death Review Panel - Nigel Jones / Cornelia Heaney

Schools, Learning and Education - Adrian Over

Health - Jackie Channell

Systems Procedures and Guidelines - Maria Barnes

Performance, Monitoring and Evaluation - Jenny Butlin-Moran

District Councils - Craig Dicken

CSE (Child Sexual Exploitation) - Lesley Tregear

Strategy and Communication - Calvin Smith

Special Cases - Richard Long

This year, the WSCB constitution has been reviewed to ensure it is compliant with the revised statutory guidance, Working Together to Safeguard Children 2013. The updated constitution is available on the WSCB website, http://www.warwickshire.gov.uk/wscb

4.3 WSCB Budget 2013 -2014

Table 4:

Income	WCC Safeguarding Business Unit	51,497	
	Health (CCGs)	32,952	
	Police	17,508	
	Probation	8,295	
	CAFCASS	550	
	District Councils	10,260	
	CSWP	1,025	
	WCC Learning and Development	40,000	
	Sales		
	Training income	800	
	Learning and Improvement money carried forward from 2012-13	45 059	
		£207 946	
Expenditure			
Staffing including travel and subsistence, DBS etc.			145 572
Services and supplies (desks, PC, phone, stationery, photocopying, postage)			3871
Subscriptions (BASCPAN and NWG for CSE)			750
Interagency Training Delivery			5600
WSCB meetings, workshop and training			1950
WSCB Standing Conference			992
Serious and Local Case Reviews: Billed			8100
Committed:			32,000
			£198 835

In the work plan for 2013-14 it was planned that some independent multi-agency audits would be commissioned in 2013-14. A commission has now been made for these to begin, but delays caused by identifying someone suitable, and the demands on the WSCB team of undertaking case reviews mean that at the year-end no costs had yet been billed for this. Despite this, it can be seen that the WSCB has slightly overspent relative to income from contributions. This overspend has been met using the reserves which have been reported in previous annual reports.

Under the Learning and Improvement framework two serious case reviews were initiated, and two other reviews have been commissioned from independent reviewers. In addition to the costs reflected in the table above, which were invoiced during the financial year, WSCB is committed to around £32 000 to complete these reviews. WSCB has also taken on a part-time temporary administrator to provide some additional capacity to the permanent staff in respect of the very considerable time commitment required to manage these reviews. These costs demonstrate the impact of the changing agenda for LSCBS, and the increase in expectations on them to carry out learning and quality assurance activity. In this context, it will be necessary to look again in 2014-15 at the resources provided to the WSCB by each partner, and consider whether they are sufficient to enable the Board to be strong and effective.

5. Progress against Strategic Objectives.

WSCB is at the end of the second year of a three strategic plan which has four objectives derived from the Munro Review of Child Protection in England:

Create and Maintain a Learning System

Strengthen Accountabilities

Promote Effective Practice

Promotion of Early Help for Children, Young People and Families.

The work undertaken by WSCB and its sub-committees is clustered under these overarching objectives, and progress against them is set out below.

5.1 Create and Maintain a Learning System.

5.1.1 Learning and Improvement Framework.

Working Together requires LSCBs to have a Learning and Improvement Framework, and WSCB's Framework was agreed in December 2013. It builds on the Performance Framework which was already in place, but develops this by articulating the cyclical nature of learning and improvement.

The first stage is gathering information about the performance of the safeguarding system from a range of sources, including performance data, case reviews, inspections and audits. From the analysis of this, improvements are identified. These need to be communicated and implemented, and in turn tested through the collection of data as above.

The Learning and Improvement Framework also identifies how WSCB makes connections with a range of other partnerships and organisations, including the Safeguarding Adult Board, the Health and Wellbeing Board, MARAC, and the Violence and Against Women and Girls Strategy.

The full document is available from the WSCB website:

http://www.warwickshire.gov.uk/wscb

5.1.2 Learning and Improvement Officer.

In October 2013, sadly WSCB lost Mark Simmonds as its Training Officer, as his secondment came to an end.

The opportunity was taken to review the responsibilities of this role, and it was agreed that these would be expanded to include a wider range of learning and improvement activities in support of the new Learning and Improvement Framework, the job title was changed accordingly to that of Learning and

Improvement Officer. The revised post continues to design, co-ordinate and quality assure the delivery of inter-agency training, but it is intended that more of the training will be delivered by a pool of staff from partner agencies. The Learning and Improvement Officer will additionally develop new ways of communicating key messages from WSCB reviews and audit activities, including electronic media, short briefings in agency meetings, and newsletters.

5.1.2 Provision of Safeguarding Training.

Between April 2013 and April 2014 there have been 58 Multi-agency training courses provided for professionals within Warwickshire. A total 658 delegates have attended these courses from a wide range of agencies. The Child Protection Awareness course was attended by 380 delegates; 51 of these were representatives from District Councils, 198 were attended from WCC services and 52 were from voluntary sector agencies. The Police and Probation services were less well represented in this years' courses with a total of 3 delegates from Warwickshire Police Force and 1 from the Probation Service, similarly Health had a low level of attendance with only 2 delegates attending. However, these low figures could be attributed to the Police Force and Health Trusts attending 'in-house' Child Protection Awareness Training.

Other courses offered through the Directory last year evidence an increased representation from multi agencies. Working Together To Safeguard Children face to face training course was delivered to 43 delegates over 2 sessions, 3 delegates from Education settings, 13 delegates from Health, 21 from WCC services (predominately Social Care Teams), 2 from voluntary sector agencies, and 3 from substance misuse agencies. In addition to the Working Together course, Emotional Abuse and Attachment Training courses both witnessed an increased representation from multi-agencies including: Health, Education, Probation and Police.

One concern arisen form this evaluation refers to the imbalance of multi-agency representation on the Core Group training sessions. 2 sessions were planned during the 12 month period identified but 1 session was unfortunately cancelled due to low delegate numbers. The 1 session delivered was attended by 14 WCC services (predominately children's social care), 3 representatives from education and 2 Family support workers – Children's Centre Staff. There was no representation from Health, and no representation from Youth Justice, Probation or Police. This is disappointing, because effective child protection plans and core groups rely on commitment and contribution from the whole multi-agency group. The Core Group training materials are currently under review and will reflect the knowledge gained from the Dartington project and work is being done to encourage a greater representation from multi agencies on this course.

During the period identified a total of 8 training sessions had to be cancelled; 1 Core Group Training session, 2 Child Protection Awareness sessions and 5 Trafficking sessions. The Trafficking sessions at that time were designed and planned for a target audience, predominately Health sector agencies, and were delivered at George Elliot Hospital. All course cancellations were as a result of low delegate numbers, in respect of the Trafficking training this might represent saturation of demand as there had been good take up of this programme, and high demand, in the previous year.

This year efforts have been made to enhance the promotion of available courses through the website, Training Directory, WILMa, WSCB Mailbox emails as well as promotional materials of upcoming sessions and availability provided in delegate handbooks handed out in training sessions.

There were a total of 40 DNA's across all courses between April 2013 and April 2014, There are a number of possibilities for this, including stretched resources and unavoidable individual circumstances. However what has been identified is that none of these 40 DNA's were charged for not attending. Following this the charging policy has come under review. Current enforced changes include delegates being made aware that a cancellation up to 14 days prior to the session will not result in a charge; however cancellations or not attendance after this time may result in subsequent charges. The charging policy remains to be executed at the discretion of the WSCB Interagency Learning & Improvement Officer and charges will be assessed on a case by case basis.

5.1.3 Training Evaluation.

The format used to gain feedback form delegates attending WSCB multiagency courses was through traditional paper feedback forms. This format will change for 2014-2015 and thereafter. A collation of feedback is provided below.

Course – Domestic Abuse and child protection: exploring links between domestic abuse and harm to children.

"A good mix of learning throughout the day, it was very informative"

"Very intense training and useful. Enabled me to feel a lot more confident in this area. Live presentation was particularly useful as it gave an insight into the way in which both parties felt in detail"

"Information on HBV and Forced marriages was very useful"

Course - Working Together to update on child protection and improve Inter-agency communication:

"Meeting colleagues from different agencies and hearing their perspectives enhanced the training"

"It has been really useful to talk through the case studies…in a group with a mixture of professionals"

"Participation exercises were interesting and rewarding offering opportunity to engage with wider networks"

Course - Emotional Abuse – Identification and case management:

"Really useful training, a good refresher and has made me re-think some of my cases, or consider them more"

"Very beneficial training especially coming into new role as a newly qualified, enabled me to reflect on own practice and identify areas of change"

"Frameworks for assessing impact of emotional abuse was so helpful – I am going straight back to use it in 2 cases"

Course - Effective child protection planning and core group working:

"Greater insight into how to establish and lead a core group in an effective manner which encourages the full participation of all members and sets out from the beginning the expectations of all members…"

"Should form part of induction programme for new staff"

Feedback from the core group sessions in the main has identified the need to incorporate more 'active' learning in to the session plan. The programme is currently under review and this feedback will assist in shaping the new programme.

Feedback gained across all multi-agency sessions identified in the main that delegate's knowledge had increased post training. In order to provide a better analysis of the impact of training in the future the WSCB will be implementing a 3 month post training 'Evaluation on practice' form. It is envisaged that delegates will complete their evaluations as they do currently immediately after the training event but in addition both the delegate and their manager will receive an evaluation form 3 months post training. This will provide enable the WSCB team to test more effectively the impact of training.

5.1.4 10th WSCB Annual Conference

Another successful WSCB annual conference was held, this year in December, and the theme was 'Safeguarding Children and Young people from Sexual Exploitation.' The conference aimed to support the implementation of the CSE strategy, and included a presentation from Warwickshire Police about what is known at the moment in relation to the extent and spread of CSE in Warwickshire, which showed CSE being identified in all areas of the County.

There was a speaker from Barnardos, who have a long track record of working to tackle CSE and learning, who shared the approach taken in another local authority which has had a high profile police investigation and trial.

Some important messages about hearing young people shared by a member of the Children in Care Council were heard, along with a presentation about preventative work being done by Respect Yourself in Warwickshire. This includes developing resources for young people to use themselves to be better informed about healthy relationships, and material to be used in schools.

5.1.5 WSCB Training- Systems Review methodologies

Work to embed systems thinking in local and serious case reviews continued during the year, and this included some training for Board members in September to learn about systems reviews, and particularly to prepare the Board for making a response to systems review findings, which make more demands on a Board than conventional 'SMART' recommendations.

5.1.6 MASH Workshop

A joint workshop was held with the Safeguarding Adults Board in October for members of both Boards to learn about different models of Multi-Agency Safeguarding Hubs (MASHs) around the country to inform debate in Warwickshire about whether such an arrangement would enhance partnership working in the safeguarding arena.

Following the workshop, discussions have been held between the key partners who would lead in a MASH (Police, County Council and CCGs) and the County Council Safeguarding Business unit has appointed a consultant to make some proposals about the scope of a Warwickshire MASH.

5.1.7 Child Death Overview Panel. (CDOP)

During 2013-2014, Warwickshire CDOP reviewed 33 deaths, and modifiable factors were found in 22 (36%) of the reviews. 38 deaths were notified, an increase of 36% on the notifications in the previous year. About half of these were neo-natal deaths, frequently of premature infants, about a quarter were sudden and unexpected, and were investigated under the rapid response protocol, and the remainder were the deaths of children with life limiting conditions. A detailed report of the CDOP panel activity and findings in the sub-region is produced by the Panel Manager, and published on the WSCB website.

SIDS deaths with modifiable factors remain a concern, and as reported last year most of the SIDS deaths reviews held in the sub-region are able to establish that safe sleeping advice was given to the parents. The CDOP Panel Manager has continued to support work to support the local adoption of a safe sleeping

assessment used effectively in Derby, and to facilitate discussion to agree a version of the risk assessment to be incorporated into the 'red book' child health record.

Other significant local learning has included the promotion of advice to parents about the risk of strangulation from objects hanging from bunk beds, and advice to health trusts about the transfer of information in a co-coordinated way when a child's care passes from one service another. The 'headsmart' information for GPs was promoted following reviews across the sub-region, including Warwickshire, where doctors were slow to consider that a brain tumour was a possible cause of presenting symptoms.

5.1.8 Serious Case Review.

Two serious case reviews were initiated during the year. Neither of these are yet complete. The first may be delayed significantly by criminal processes running in parallel, but the second is expected to be complete in December 2014.

The membership of the Special Cases sub-committee was reviewed, and given the large crossover between domestic abuse and child abuse, now includes the WCC Domestic Abuse Manager. This has been very valuable as it has enabled the sharing of learning and ideas between the SCR and domestic homicide review processes, and also the identification of some common themes emerging from these reviews.

5.1.9 Local Case Reviews.

One case review was completed during the year. A systems review methodology was used for this, and it made a number of findings which WSCB is working on a response to. This includes:

- Clarifying what is meant by the statement 'safeguarding is everyone's responsibility', in terms of the culture of practice the Board wishes to promote, and consideration of how escalation might be used within agencies as well as between agencies to support accountability.
- Work being led by the County Council to ensure the 'front door' to social work and social care services is effective and robust.
- Work to increase the offer and take up of CAF to assess early help needs and to structure interventions offered at this level,
- Work to promote 'respectful uncertainty' and 'professional curiosity' amongst health practitioners particularly, but not exclusively; to ensure that the role of adults in a child's life are understood, whether they are supportive or risky, and that pregnant women in problematic or abusive relationships are identified.

- Reinforce minimum standards for locum doctors,
- Develop WSCB procedure and policy on the supervision of staff who work with children, including professional supervision for staff with family support roles.
- Support effective and timely record keeping.

The Board has taken a new approach to these findings, which aims to be more developmental than procedural, and use a range of strategies to create the changes looked for. This new way of working requires a great deal of support, which is being offered by the Special Cases sub-committee.

A review was conducted focusing on the health response to a non-mobile baby with a bruise, in co-operation with another LSCB, which has resulted in new guidance being drafted to clarify advice to practitioners in this situation.

There are two other case reviews currently in progress. This includes the review of a case involving domestic abuse of the mother from more than one partner, this is being used to understand how effective our MARAC and social care systems are for addressing risks to women and children in these situations, including where the information is held across local authority boundaries.

The other review has been initiated to look at the effectiveness of inter-agency working to protect looked after children placed in Warwickshire by other local authorities from sexual exploitation.

5.2 Strengthen Accountabilities.

5.2.1 Quality and Effectiveness of Practice.

WSCB has continued to develop its approach to evaluating the quality and effectiveness of practice, using the Learning and Improvement Framework as a structure. This has included the development of a revised performance data set, which draws on a wider range of partner data, and also more comparative data to enable the information to have some context. In 2014-2015 it is planned to use this to develop a 'scorecard' that will be shared quarterly at WSCB meetings.

5.2.2 External Inspection.

- **Ofsted Thematic Inspection: Early Help.**

In January 2014 Ofsted visited Warwickshire as part of a thematic inspection of Early Help services. The full report is not yet published, but verbal feedback was provided at the end of the visit. There were several strengths identified, which included:

Strong partnership working and information sharing across agency and geographical boundaries, clear belief held by staff in the importance of early help, and the enthusiasm and passion shown by all professionals for children and families. The support available for CAF was highly rated, and the health and schools safeguarding leads were seen as knowledgeable and helpful. These factors represent a strong foundation for the continued development of early help.

As an area for development, the inspectors endorsed the plan already in place to re-launch the Threshold document to ensure it is widely understood and used.

The inspection included some case file audits, which found that decision making on the level of intervention required was appropriate, there were good examples of information sharing and multi-agency attendance at meetings, strong efforts to engage fathers and male carers, and strong partnership working between health and children's centres.

The audits also identified some areas for development; these included more focus on the child rather than just the parents in early help assessments, making better use of existing early help assessments to inform statutory social work assessments, ensuring referrers to social care get feedback on the referral, and developing a protocol for sharing police domestic abuse information with schools.

These themes are being picked up in relevant strands of the work plan.

- **HMIC Inspection of Police responses to Domestic Violence and Abuse**

Her Majesty's inspectorate of constabulary undertook a National inspection, published in March 2014, of police responses to Domestic violence and abuse. In general, this found that responses were frequently not good enough and there was a lot that needs to improve. Warwickshire Police Force was identified as an exception, providing a good service in this important safeguarding area, and identifying the Force works well with partners to tackle domestic abuse and keep victims safe.

There were some areas identified where the response could be strengthened, these included developing a quality assurance process to monitor the response to domestic abuse calls as they are received, addressing uneven levels of training in domestic abuse throughout the Force, commissioning a Warwickshire domestic abuse problem profile, and developing a programme to identify and manage serial perpetrators of domestic abuse.

5.2.3 Audit activity

Audits are undertaken or commissioned by the Performance Monitoring and Evaluation sub-committee of WSCB. As part of the implementation of the Learning and Improvement Framework, an audit programme is being developed which combines undertaking multi-agency audit with reviewing the findings of relevant single agency audits undertaken by partner agencies.

In response to the requirements of Working Together 2013, the WSCB annual report and business plan is being produced earlier this year than it has previously, hence a number of audits for which a plan was made in the business plan last year are still underway and will report in 2014-2015.

- **Audit of compliance with statutory safeguarding requirements ('s.11')**

An audit of statutory safeguarding responsibilities is underway. A new tool is being used for this, which makes more enquiry about the sufficiency and reach of safeguarding training and the request for more illustrative evidence. The responses will be returned in early July 2014, and a report will be made to WSCB in October 2014.

- **Audit of safeguarding arrangements for deaf children.**

An audit is in progress using the tool developed for the purpose by the National Deaf Children's Society.

- **Audit of child protection plans lasting for three months or less.**

This audit, also in progress, is being undertaken to examine the reasons why plans are ended at the first review case conference.

- **Audit of strategy meeting minutes distribution.**

Following a finding from the local case review, an audit is underway to find out more about practice around the county in relation to the distribution of the minutes of strategy minutes, and specifically to establish if it is compliant with the WSCB procedures.

- **Audit of cases at the threshold between 'early help' and statutory social work intervention.**

An independent safeguarding consultant has been commissioned to undertake this audit, which aims to understand what sort of interventions are offered to families who are referred to social care but are considered by social care not to meet the threshold for a social work intervention.

5.2.4 Warwickshire Safeguarding Children Board Escalation Panel

The arrangements for reviewing third child protection plans under the escalation procedure were amended this year, and these cases are now reviewed by a panel on behalf of the Performance, Monitoring and Evaluation sub-committee, with the sub-committee remaining responsible for oversight of learning about systems issues arising from the cases as a whole..

During the year 2013 -2014 the panel considered the cases of seven families and 17 children. In three cases Independent audits were carried out to understand better any issues contributing to delay.

In all seven cases the child protection issues for the children were resolved via legal intervention on average within a twelve month timescale. This involved either full care orders being obtained by the local authority, parental agreement being given to voluntary accommodation for the children or private law proceedings resulting in the children being placed with family members.

As at April 2014 there is an overall reduction in the numbers of children subject to a third plan. This equates to four families and 11 children. The escalation panel has reviewed all these cases and been satisfied that all plans are making appropriate progress.

Themes and issues: Common themes emerging within repeat periods of children being subject to plans are re-emerging, parental dependencies on

alcohol or drugs, mental health issues for parents or issues of domestic violence. Chronic neglect is often evidenced through a series of failed interventions with families that result only in superficial change which is not sustainable. This finding will be taken into account in the development of the neglect strategy, which is on the work plan for the Strategy and Communication sub-committee.

Timeliness of interventions: The data and scrutiny processes now in place provides evidence that once a historical pattern of behaviour is evidenced multi-agency plans focus on timely interventions and permanency plans being achieved without delay. Whilst there is some increase in the number of second plans, the reduction in third plans suggests that there is overall progress in this area.

5.2.5 Other Quality Assurance activity.

- **Scrutiny of the SARC paediatric arrangements**

WSCB has worked with Public Health, NHS England and the staff at the new SARC (Sexual Assault Referral Centre) at George Eliot Hospital to ensure that the arrangements for providing services to children in this excellent new facility are robust, and that they are integrated into the multi-agency safeguarding system in Warwickshire. As a result of this, there are now arrangements in place for sharing information with health visitors and school nurses when children are seen, forensic medicals linked with strategy meetings where required and the arrangements for paediatric cover are being aligned with local need.

- **LSCB 'health check'**

As a result of the 'health check' undertaken last year using the Ofsted tool, membership of WSCB has been reviewed. Participation of children and young people was identified as a significant weakness, and proposals are being considered for developing this area of work.

5.3 Promote Effective Practice.

5.3.1 Provision of Policies, Procedures and Guidance.

A full review of the inter-agency safeguarding procedures was completed in the autumn of 2013, and these have been published on the WSCB website only. (http://www.warwickshire.gov.uk/wscbresources)

Although many people prefer consulting a printed manual, case review activity had come across examples of different editions of the printed procedures in use at the same time. Asking professionals to access a single source of the procedures on line ensures that they will always be using the most up to date material.

5.3.2 Child Sexual Exploitation Strategy

- **JSNA needs assessment**

A key strand of the CSE strategy was to obtain more detailed information about the prevalence and nature of CSE in Warwickshire by sponsoring a JSNA needs assessment. This piece of work was initiated in the autumn of 2013, and the data collection was carried out at the start of 2014, using a tool developed by the University of Bedfordshire for the purpose.

The needs assessment received information pertaining to t around 100 children judged to be experiencing, or at risk of experiencing CSE. As many children again were reported informally to the project board, but not submitted formally in the data collection. The varying levels of return from professionals in different parts of the same sector, e.g. secondary schools with a similar demographic profile, suggest that the level of reporting tells as much about how well equipped staff are to recognise CSE as it does the number of children at risk. Agencies were asked to make a 'nil return' if they didn't think they had children to report, but lots of agencies made no return at all suggesting that either the information request was not sent to the right person in the organisation, or that it was not considered to be a priority task.

Bearing all these considerations in mind, it is likely that the exercise has captured some, but by no means all, of the current picture in Warwickshire. The variance in the data is going to be explored in a multi-agency workshop in the autumn of 2014 as a first step towards increasing capacity in the children's workforce to recognise signs of CSE.

- **Contribution of Licensing**

The District Council's sub-committee members have begun working with their licencing departments to looking at how they can contribute to the prevention and detection of CSE. This is a new area of work, and the first stage has been to

provide information to these colleagues, to explore training needs, and agree how they will be met. The long term aim is for them to be equipped to use the licensing system to contribute to disrupting CSE and provide intelligence to the police.

5.3.3 CDOP Protocol for the Involvement of Parents, Families and Carers.

Warwickshire, Coventry and Solihull began implementing a new protocol for involving families in reviews this year. 10 families have taken up the invitation to participate, 6 of these in Warwickshire and the remainder in the other areas of the sub-region. Some parents have contributed by meeting with the CDOP manager and some by sending written information for the panel to consider, and in one case parents met with the Designated Doctor, who is a panel member. In some of these situations, the parents' perspectives on service delivery were very different from the professionals, meaning that their participation enabled the panels to have information available to them that they would not otherwise have had, adding to the rigour of the reviews.

5.3.4 Work with the Dartington Social Research Unit to safely reduce the number of children with CP plans.

WSCB was represented on the steering group driving the work the County Council commissioned from the Dartington Steering group to look at ways to safely reduce the number of children with child protection (CP) plans. The scope of this included development work aiming to increase the effectiveness of child protection plans, a tool to enable reviewing officers to record the progress of a CP plan and the multi-agency contribution to the plan, and work to support early help which could divert families from the CP system altogether. This last strand is addressed in more detail under the next section of the report.

Following work which had been done to identify the different groups of need which resulted in children being made the subject of a CP plan, some exemplar plans have been produced for each group. These are to be used for training and development of all staff who could be asked to be part of a core group. The profiling exercise found that the largest group of children with CP plans were those where there was domestic abuse between their parents, coupled with substance misuse and/or mental health problems, but the exercise also found that adult mental health and substance misuse services were involved with fewer CP plans than would be expected based on this profile. The exemplar plans demonstrate the contribution to be made by the wider network, not just the social work team. Similarly, one of the purposes of the 'RAG' tool for reviewing officers is to record the contribution of professionals from all agencies so that non-participation can be identified and tackled where required.

5.3.5 Private Fostering.

The County Council recruited a Practice Leader for Private Fostering, Jenny Packeer, in December 2012. It was reported last year that this has increased capacity for awareness raising activities reaching a wide range of organisations.

The data included in this report (section 7) on the number of open private fostering cases and enquiries relating to possible private fostering cases to the practice leader show a significant increase during the year, suggesting that this work is having an impact.

A full report on private fostering is made annually to WSCB, the 2013 report was received in December.

5.3.6 E-Safety Forum

The E-Safety Forum, which reports to the Schools and Learning sub-committee, has this year been developing guidance for all agencies on the use of images of children.

The group has also developed a Facebook page ‘Staying safe on-line’ which aims to reach a much wider audience of parents and carers that can be accessed by delivering briefings in school.

5.4 Promotion of Early Help.

WSCB has continued to develop the approach it takes to supporting and evaluating the effectiveness of early help services to children and families.

The work with the Dartington Social Research Unit included looking at the types of early help that might contribute to addressing difficulties experienced by families before they develop into child protection or result in a child coming into care. 'Triple P' and 'Teen triple P' had been chosen, and considerable investment made in this, Further work done this year has been targeted on providing solutions to the resource difficulties that meant some families were not receiving help swiftly when the need was identified.

The number of CAF / early help assessments being undertaken in Warwickshire is rising, and compares well to other authorities in the region, but the numbers are still very low compared with the number of referrals to social care which do not progress to a service. The case review completed in October 2013 identified some points where an early help assessment could have helped to crystallise the concerns, and either focus intervention more effectively, or made it clearer that a statutory social work assessment should be completed. As a result of this learning, further work is being led by the WSCB representative for the WCC Early Intervention service to look into the barriers to using CAF experienced by professionals.

The WSCB performance framework is continuing to be developed to provide more information about the range of early help.

WSCB has debated a draft of the WCC Early Help and Support strategy, and is continuing to shape this developing document. It has also requested to participate as a stakeholder in the Vulnerable Children JSNA needs assessment, which will be important in determining how early help is offered and to whom, including ensuring that it reaches all children and families who meet the criteria.

Consideration of early help as part of the safeguarding continuum is now becoming embedded in the ordinary business of WSCB, for example the CSE strategy includes consideration of prevention and early help, and the Neglect Strategy that is in development aims to support effective assessment and intervention before cases become child protection, as well as at this level.

6. Contribution of WSCB Partner Agencies.

6.1 Warwickshire Youth Justice Service.

WYJFIS is a multi-agency service and all staff receive child protection and safeguarding training. Managers within the service are fully integrated with mainstream social care services, attending meetings with their peers.

WYJFIS is responsible for safeguarding young people in police custody and undertaking the role of appropriate adult. During 2013/14 Charles Bell the author of Youth Justice Matters, undertook a national study of the provision of appropriate adult services to young people in police custody and their effectiveness in safeguarding young people. As a result of this study Warwickshire was described as an excellent service and best practice nationally, unique in its multi-agency approach which is led by the WYJFIS. Particular recognition was given to procedures between WYJFIS, Warwickshire Police and Warwickshire County Council's Emergency Duty Team. This agreement includes quarterly 'Safeguarding in Custody' meetings to ensure ongoing service improvement for all partners and discussion of non-urgent issues, themes and patterns

In order to prevent young people being detained in custody any longer than necessary the WYJFIS has introduced a triage process to assess the needs of young people and ensure their needs are met swiftly. Once a child or young person is charged with an offence, the police may decide that it is necessary to deny them bail. The WYJFIS has ensured these young people have been released (under PACE) for placement in community placements or secure establishments; keeping the community safe whilst supporting the young people within appropriate child.

During the 2013/14 financial year, 9 young people were transferred to WYJFIS in this way, six of these were placed in secure accommodation and three in community placements

Custodial sentences for young people should only be imposed where the sentence is so serious that a community sentence is inappropriate or where the safety of victims cannot be assured. During 2013/14 11 young people received 14 custodial sentences, representing 6.9% of all court disposals as a result of credible community sentences being provided by the WYJFIS. Re-offending rates for young people supervised by the service are amongst the six lowest in the country.

Challenges.

As a result of keeping young people out of the criminal justice system through prevention and reducing re-offending interventions the service is managing a

cohort of young people with more complex needs, with notable issues around safeguarding, substance misuse, child sexual exploitation, education and parenting. This has resulted in an increase in the number of intensive court orders used to manage chaotic and disengaged young people. As a result the workforce was reviewed and the number of social workers within the service was increased.

A key aspect of safeguarding in custody was to implement the triage approach that had been previously agreed. Triage is a joint assessment between the WYJFIS, the emergency duty service, and the Police, when a young person enters custody. Failure to contact the service led to a number young people remaining in custody. The Police have now committed to this process and agreed a monitoring process to ensure that it is happening, with an immediate escalation to senior managers if matters are delayed. All agencies involved have reflected on the cases that were delayed and agreed points of learning and improvements. Young people are either dealt with quickly or bailed back to a more suitable time when everything is in place to avoid the young person spending time in custody.

Safeguarding priorities for 2014/15

• Custody (remand and sentence) is only imposed where a community alternative is not appropriate.

• Further development of the triage model for young people in custody

• All looked after requirements are met and vulnerabilities managed effectively

• Identification of all young people who are victims of/or at risk of CSE

• Evaluation of interventions measured against the Youth Justice Board Key Elements of Effective Practice Principles.

6.2 Cafcass

Cafcass have a national improvement service (NIS), who have worked with groups of practitioners, and through 1:1 coaching, to improve the quality of practitioner's practice across the organisation. This year the work undertaken included:

- 2 national audits a year are carried out to measure the amount of work graded "good". The last audit, September 2013 saw an increase in the % of work graded good, from 30 to 40% nationally. The next audit is to be undertaken in November 2014, where the target is 60% good.

- The emphasis of supervision has shifted to quarterly performance and learning reviews, and situational supervision is provided as and when required on cases, so both case discussion and review of individual performance are both assessed.
- Quality assurance tools have been implemented that incorporate quality improvement, so there are clear guidelines for practitioners to follow to assist in producing "good" work.
- Learning from IMR's is circulated for learning purposes
- Tools for assessment have been established to enhance evidence based assessment and analytical report writing.

Cafcass were inspected by Ofsted in February/March 2014, with the outcome that the public and private law was graded "good".

Challenges to achieving outcomes.

Cafcass' work is limited to Court Social Work. This can be quite isolating, and there isn't another agency that undertakes this work, so peer benchmarking is not an option.

In public law, with the challenges of the PLO, the need to improve working between Cafcass guardians and IRO's has been a challenge, but this has been addressed by the implementation of a protocol between Cafcass and IROs, and through the Local Family Justice boards.

The safeguarding priority for this year 2014/15 is to improve the quality of work to 60% good.

6.3 WCVYS (Warwickshire Children and Voluntary Youth Services.)

WCVYS continues to invest and build on our commitment to safeguarding in Warwickshire and supporting the voluntary and community sector (VCS) across the county. Within this we recognise the changing needs and are proactive in meeting the demands. This year, this included developing a response around bullying and e-safety, a major concern to children and young people and early developments around child sexual exploitation.

Promoting Safeguarding in the Voluntary and Community Sector (VCS)

WCVYS is a Local Delivery Partner (LDP) for Safe Network:

We have worked closely with NSPCC and Children England to be a LDP (Local Delivery Provider) for Safe Network, which is the National Safeguarding Unit for

the Third Sector. It seeks to build common standards for the VCS around safeguarding by providing information and resources to create a culture of safe practice and to help keep children safe. It provides an excellent online self-assessment tool to help organisations and groups audit their arrangements. We have offered one to one support to organisations to develop their policies and procedures including bespoke training to organisations to support a whole organisation approach.

We have engaged with development workers from infrastructure organisations across Warwickshire to increase their knowledge and understanding and build their skills and confidence in supporting groups and signposting them to Safe Network. We have worked with the LADO, both in signposting organisations to share concerns and then supporting voluntary groups with additional support using Safe Network for those that need to improve their practices.

We have seen an increase in knowledge of Safe Network within the sector and an increasing number of organisations seeking support, undertaking the audit and reviewing their policies and procedures. A number of VCS organisations operate under national and regional frameworks but have also made use of some elements of Safe Network such as the code of conduct for staff and volunteers.

Delivery and range of training:

WCVYS has delivered the following 11 free training courses over the past year with a total of 193 participants from the voluntary and community sector:

Safeguarding Workshop:
Disclosure and Barring,
Working Together
Including the following Safe Network courses;
Thinkuknow Introduction Course
E-Safety (2 courses);
Child Protection Awareness Training (2 courses);
Safeguarding for Trustees (Children and Young People's Organisations);
Working Together: Learning from Serious Case Reviews
Safe Network Xtra Standards;
Introduction to Safe Network Awareness Training;
Safer Recruitment Training for Voluntary Sector Partners supported by Adrian Over.

We maintain positive links with the WSCB Interagency Learning & Improvement Officer and we have a VCS representative on the Training Sub-Committee. Our courses complement those offered by the WSCB and are provided at accessible times including evenings and weekends.

In addition we hosted a focused Voluntary and Community Forum looking at Domestic Violence and Abuse and the services available across the county and how to develop proactive work with young people around relationship abuse, which 34 people attended.

"The information given on the Safeguarding training and Safe Network has been invaluable to our organisation."

WCVYS Satisfaction Survey 2014.

Keeping Safeguarding on the Agenda:

WCVYS maintains a high profile on safeguarding, with information, relevant reports and training opportunities regularly shared through our weekly bulletin and website. Our website front page has a section on safeguarding, incorporating the Disclosure and Barring Service, WSCB, LADO, Child Protection Referral and Safe Network. We have also blogged and tweeted key stories to raise awareness, for example, changes to the Child Protection Procedures and promoting Exploited - a training resource for young people on exploitative relationships. We also supported a Community Forum to host a focus on bullying and e-safety in Rugby, based on a community need identified. This evidenced excellent work being undertaken in some local schools and how best to support children and families.

VCS representatives sit on the WSCB and key Sub-Committees. This encourages an awareness of the needs of the VCS, an appreciation of the wide range of provision they offer, from positive activities to services commissioned by the public sector for some of the most vulnerable children and young people and the contribution the VCS makes to safeguarding in Warwickshire. The learning from these meetings is fed into training and developments across the county. A number of VCS organisations are developing expertise in Child Sexual Exploitation and training and support for those that work with young people. We have supported and encouraged WREP to join the Faith Forum and work is underway to plan events to take place next year.

*"**Receive regular updates such as the abolition of the blue book, Domestic abuse information and CEOP legislation/training"*** WCVYS Satisfaction Survey 2014.

Impact:

By evaluating our training and annual satisfaction survey we can see that the high profile given by WCVYS to safeguarding has supported positive outcomes for organisations and young people:

- Positive feedback from training, evidenced by an increase in knowledge and learning pre and post training; knowing how to respond to concerns remains a key gap at the start of training
- Increase in requests for help, via telephone and brought up in one to one visits (anecdotal)
- Increase in Safe Network audits undertaken by organisation
- Increase of organisation aware of safe network – 44% of both WCVYS and partners know about Safe Network (taken from WCVYS Satisfaction Surveys)
- Working with LADO to support change and improve practice
- Organisations are signposted to WCVYS for support from a wide range of partners across the voluntary and public sector

"79% said the support received from the WCVYS team around safeguarding and keeping children and young people safe was very good or good." WCVYS Satisfaction Survey 2014.

Challenges

WCVYS is a charity and has limited resources so capacity and funding to support safeguarding remains a challenge. Uncertainty of funding beyond 2015 may impact negatively on our ability to offer continued support to the VCS. We are committed to multi-agency working and work hard to ensure we link in partners as appropriate and maintain dialogues across the VCS and public sector. Offering free training is a key need for the VCS and this may remain a barrier for those exploring the WSCB training and developments offered. In addition looking at accessibility in terms or times, venues and language may also impact.

WCVYS will continue to maintain a priority for safeguarding next year in line with our Strategic Business Plan with a focus on Safe Network and meeting collective and individual needs of those in the VCS and working in partnership to improve outcomes for children and young people.

6.4 Public Health

Achievements

The Public Health Team are working to improve children's safeguarding through their health improvement programmes and via the contracting process. The Coventry and Warwickshire Sexual Assault Referral Centre – The Blue Sky Centre – commenced services for children and young people in April 2013. The centre has been designed with the help of SARC partners and clients and provides a specialist paediatric forensic medical examiner to work with children and young people. In the first year of operation the centre has assisted 108 young victims of sexual assault as follows: Under 13 = 41 children, 13-15 years

54 young people and 16-17 years 36 young people. This compares with a total of 12 children and young people aged 13 – 18 in 2012-13. The centre has followed national guidelines in the development of its services with the focus on making it easier for victims and their families to both report sexual assault and to receive follow up support and treatment.

The Respect Yourself Programme has established a successful website, designed by and with young people, as a safeguarding tool. The Respect Yourself Website has been backed by the UK Internet Safety Partnership. Five Relationship and Sex Education Boards have been established with school students across the county including: the George Elliott, Avon Valley, Kenilworth, Nicholas Chamberlin and Stratford High Schools. The students have developed a number of resources to improve resilience in relationships and sexual health including a 'relationship checker' to help young people to recognise and deal with violence and abuse in their relationships. The 'relationship checker' is available on the Respect Yourself website. The website and its programmes have recently been purchased by another local authority.

Public Health commissions a number of sexual health services for residents of the county and for general practitioners. Safeguarding requirements are included in all contracts and these are reviewed regularly with all providers.

Public Health also commissions the School Nursing Service delivered by South Warwickshire Foundation trust. School Nurses provide health assessments for all children about whom there are child protection concerns.

Challenges

The Blue Sky Centre and the Respect Yourself programme have both been made possible by very effective partnership working with young people, voluntary organisations, schools, two police services and two local authorities. It has and continues to require good communication between partners and investment in support to young people so that they may participate fully in designing effective programmes and commissioning them.

Priorities for 2014/15

To maintain support for the five RSE Boards to tackle child sexual exploitation, sexting, pornography, consent and healthy relationships

To develop innovative approaches for school nursing management of safeguarding.

6.5 North Warwickshire Borough Council

Achievements

A total of seven child protection referrals were made to Children's Services from three different divisions within the Borough Council.

Two additional reports are held on file, one of which required no further action. The other did not have sufficient information provided.

One safeguarding concern related to Highway issues and the person making the query was advised to raise the concern with the Highways Department at Warwickshire County Council.

One serious case review request for information was received and the documents reviewed. This, however, produced a "nil" return from the Borough Council.

The Borough Council has four members of staff trained by Warwickshire Safeguarding Children Board to deliver Level 1 Awareness Training as part of the Warwickshire Training Pool. Staff were made available to deliver five multi-agency training courses throughout 2013/14 and a total of eight North Warwickshire Borough Council staff received the training (in 2013/14 – most are due to start refresher courses in 2014/15).

Safeguarding was the key principle through which the design and development of the new Coleshill Leisure Centre was undertaken. This building is located at The Coleshill School. The building contractor's policy, procedures and practices relating to safeguarding were formally reviewed and approved prior to their appointment.

Children and young people, parents and guardians and the local community have all been consulted as part of play area improvements undertaken at Long Street, Dordon, and Abbey Green Park, Polesworth, and within the context of developments due to take place in Grendon, Alvecote and Bretts Hall, Ansley Common.

Challenges

Despite its best endeavours, the Borough Council struggles to engage children and young people throughout the various stages of all aspects of its service design, development and delivery.

With regard to the development of the new Coleshill Leisure Centre on the Coleshill School site, and the need to promote the safety and welfare of all vulnerable people, there have been difficulties in balancing, occasionally competing design priorities and in respect of the programming of future activity (including daytime, term-time periods, when the Leisure Centre will be accommodating both education and community use).

At times we have had difficulty ensuring the procedures set out in the Homeless Young Persons Protocol are enacted locally. Where we have had issues relevant team leaders have met to address issues.

Over the year the 5 District and Borough Councils have met with the County Council to address service gaps with regard to 16 and 17 year old homeless young people. We have scoped the problems and these are well documented. Unfortunately we have not yet resolved how to solve them. The multi agency work to address the issues is continuing – strategically across the county and locally.

Safeguarding priorities for 2014/15

There is a need to address those actions that have been identified following completion of the Strategic and Organisational Self Assessment Tool (Section 11 Audit), which clarifies the arrangements in place for Safeguarding and Promoting the Welfare of Children and Young People.

Key actions include:

- Ensuring that members of staff who are safeguarding "leads" have the responsibility identified in their job description.
- Updating the Statement of Particulars for all staff to identify the fact that they have a responsibility for safeguarding and promoting the welfare of all vulnerable people (including children and young people).
- Identifying a training opportunity for the officer responsible for dealing with allegations (preferably through WSCB).
- Providing copies of the Borough Council Child Protection "Quick Guide" to all new staff as part of their induction programme.
- Obtaining and distributing copies of the "What to do if you're worried a child is being abused" (2006) booklet?
- Working in partnership to assist young people with their housing, training and employment issues.

Staff are again going to be made available to deliver five Level 1 training courses throughout 2014/15. Additional in-house courses may also be necessary to cover the number of staff requiring refresher training.

All staff that come into contact with children and young people during the normal course of their duties will be required to complete Warwickshire Safeguarding Children Boards' e-learning package on Child Sexual Exploitation.

The Council's own Child Protection Policy will be reviewed and, subject to the need for change, adopted in 2014/15.

6.6 Stratford District Council

From a Stratford District Council point of view, the biggest challenge we have had is with working with Children's Services in relation to homeless 16/17 year olds.

We identified as part of a county wide review that the Young Persons protocol was not operating consistently across the county, with particular difficulties being experienced in the Stratford District area. Following this review, the existing protocol was reviewed and a programme of training has been developed to educate staff on the updated protocol and provide training in order to create consistency. The District Council are in the process of arranging a rollout of this training. As the revised protocol is embedded it is expected that engagement and joint working within the District Council will continue to improve, achieving better outcomes specifically for homeless 16/17 year olds.

6.7 Rugby Borough Council

Achievements

Rugby Borough Council continued to put the safety and wellbeing of children at the centre of its concerns during 2013/14. The Council has played an active role as a member of the Warwickshire Safeguarding Children Board as well as part of the district and borough sub-group.

Front-line services have continued to take a vigilant and involved approach to children's welfare, not just making safeguarding referrals but also initiating and participating in the Common Assessment Framework arrangements: a key element in intervening early and so preventing harm further down the line.

Challenges

In conjunction with a broader push on safeguarding (ie in relation to vulnerable adults as well), the challenges include having a better understanding of the people we serve so that we have a better insight into risks to the welfare of children. A range of service reviews have helped in this area. As an example, a review of the ability of Council tenants to pay their rent has revealed a range of opportunities to intervene at an earlier stage to alleviate poverty, enable improved independence and engage other agencies in areas such as ensuring a stable home and school attendance.

Arrangements for dealing with homeless children aged 16 or 17 were not being implemented effectively and consistently across the county. The districts and boroughs have worked collectively to review these arrangements with the County Council and will re-launch the countywide protocol shortly, with training,

monitoring and auditing of the effectiveness of the implementation of the protocol being part of this.

Safeguarding Priorities for 2014/15?

Rugby Borough Council will consider the review of the S.11 audit of its arrangements for working in partnership to safeguard children and develop and action plan of improvements to be overseen by the Council's senior management team. In response to the audit, the Council is already taking steps to refresh the training of its staff in relation to safeguarding children to ensure that all relevant posts are occupied by someone who has had the relevant training.

6.8 Safer Schools Partnership.

Safer Schools Partnership group delivers all its work in partnership with other services which reduces barriers to positive outcomes.

Data sharing between partner agencies has been highlighted as a challenge.
Partners have identified:

- Further and on-going training to ensure all staff have received updated training and understand safeguarding risks,
- Ensuring young people we work with understand risks
- Raising more awareness in our programmes of work with young people about levels and understanding safeguarding risks
- Safeguarding is a criteria that young inspectors are reviewing as part of their inspection programmes
- Greater targeting of resources

6.9 Nuneaton and Bedworth Borough Council

Nuneaton and Bedworth Borough Council continues to work towards meeting its requirements under legislation and being an effective partner of the Warwickshire Safeguarding Children's Board and other statutory and third sector organisations.

Achievements during 2013/14

Referrals – The Council made a total of 16 referrals during 2013/14 in addition to sharing other pieces of key information with Children's Services.

Training – The Council has continued to play an active part in participating and delivering Child Protection Training. In the last financial year, the Council has had its employees trained in Safeguarding Children, Domestic Abuse, and Common Assessment Framework (CAF). The Council's Equality and Child Protection Officer is a part of the WSCB Training Pool and has delivered several Safeguarding Children courses over the last financial year.

Safeguarding Meetings Attended – The Council is regularly represented at the main Board meetings by the Equality and Child Protection Officer. In addition to this, the Equality and Child Protection Officer currently chairs the District Sub Committee and is a member of the Child Sexual Exploitation Sub Committee.

DBS Policy – The Council has developed and approved a Disclosure and Barring Policy. This Policy was introduced in light of the changes in legislation and the introduction of the definition of regulated activity for working with children and adults. This was approved by Single Member Decision by the Leader of the Council (Portfolio Holder for Finance and Civic Affairs) in January 2014.

SLIP Case Review – The Council took part in a SLIP Case Review during 2013/14. It contributed key information to the Review and as a result of this has been identified as a key partner for other agencies when working with families.

FAQ's Referrals – A frequently asked questions document was produced by the Council to cover employee's questions in connection with the referral process for safeguarding.

Cabinet – The Council approved the funding for the financial year 14/15 to the Board via a decision by its Cabinet. It also included statistics from the county to make members aware of the issues in the borough in comparison to the county.

Address Anti-social behaviour – As part of our duty to address ASB, where the Council has identified safeguarding issues, referrals have been made and/or the Council has participated in multi-agency meetings to address issues.

Addressing challenges to improve Safeguarding outcomes

Working and addressing safeguarding issues with other agencies – The Council will continue to work with other statutory and third sector agencies in order to fulfil safeguarding obligations. Other agencies are seeking the Council's input more into multi-agency meetings & cases due to the information the Council holds on families and the assistance this can provide in safeguarding the welfare of children.

Ensure appropriate referrals are made through to Children's Services – It is important that the right referrals with the key information are made through to Children's Services. The Council will try to act as a filter to ensure only appropriate referrals are made when concerns are disclosed to and identified by the authority.

Ensuring Safeguarding within services – It is key the Council promote awareness of Safeguarding Children and ensure all its employees know what to look out for to identify possible child abuse. Promotion and training will be key to fulfilling this requirement.

Safeguarding priorities for 2014/15

Focus on Action Plan as a result of Section 11 Review – The Council has positively embraced the Section 11 Review recently carried out by the WSCB. The Council will form an action plan for internal improvement following the Review to ensure it is meeting the requirements set under Section 11.

Revise Child Protection Policy & Guidance – The Council will also take the opportunity following the Section 11 review to update its Child Protection Policy & Guidance. The Policy will reflect the current legislative requirements as well as refresh Council Policy on its operational practices within the Guidance.

Carry out programme of DBS checks – Following the introduction of the Disclosure and Barring Policy, the Council will ensure the posts identified under the definition of regulated activity will be subject to a DBS check and programmed in for 3 yearly checks (subject to the post holder being in position).

Promotion of Safeguarding agenda – In addition to the work above, it is vital that the Council promote the Safeguarding agenda to ensure all employees are aware of the signs and symptoms of child abuse and know what to do should they have concerns. Posters and promotional material will be produced in addition to the updating of internal and external websites.

Deliver training to employees & elected members – It is important that Council employees who come into contact with children are trained to the appropriate level required. The Council will develop a training schedule for Safeguarding courses to ensure all relevant employees are trained and receive refresher training every 3 years. For the majority of these employees, this will result in Level 1 training being received with Housing Officers and Housing Advice Officers receiving Level 2 training where required. Appropriate employees will also receive CAF training.

Obtain Leadership approval – All the activities mentioned above will be carried out with approval from the Council Senior Management and Elected Members. The Council's Child Protection Policy & Guidance will be developed in conjunction with the Officer Children's Champion, the Elected Member Children's Champion and the Central Services Portfolio Holder. The Protection Policy & Guidance will then be subject to approval by its Management Team, followed by approval by Elected Members. Following this, the Policy, Guidance, Action Plan and other Safeguarding activities will be reported to and scrutinised by the Council's Economic and Corporate Overview Scrutiny Panel.

6.10 Coventry, Solihull and Warwickshire Partnership (CSWP).

CSWP delivers a range of services to support young people into employment, education or training. These services include careers guidance, mentoring support, placement into vacancies, negotiating tailored learning programmes to enable young people to re-engage with learning and employment.

We manage, on behalf of Warwickshire County Council, a client database of all 13-19 year olds known which is a statutory requirement and has been renewed as part of serious case reviews. The client database contains confidential information and meets all data protection requirements plus there are in place the relevant and appropriate data sharing agreements, particularly with reference to safeguarding.

A major area of our work is with 16-18 year old people who are not in education, employment or training (NEET). In this area the greatest challenge continues to be the sharing of information with other professionals. The challenge is to constantly be vigilant and aware of safeguarding issues.

During the past year, as many services have downsized and restructured as a consequence of funding reductions, the biggest challenge has been to maintain close working relationships between agencies i.e. staff changes and new relationships to be forged.

Our safeguarding priorities for 2014/15 are to continue to ensure our staff are trained and confident about this safeguarding responsibilities and up to speed with all challenges and threats i.e. from indoctrination of young people to trafficking etc.

6.11 Warwickshire Probation Trust.

Achievements.

In its latest Offender Management Inspection Report, Warwickshire Probation Trust was recognised by Her Majesty's Inspectorate of Probation (HMIP) as having high overall standards in the assessment and management of risk of harm to both Children and Adults. One potential area identified for improvement however was the management oversight of cases with child protection concerns. During the course of the year the Trust established a process for informed management oversight of Child Protection cases. The % of such cases with active management oversight increased from 58 % to 88%.

Challenges

The Trust underwent significant organisational change in preparation for the split of Probation functions into either the new National Probation Service or Community Rehabilitation Company. During this period of change we have been concerned to continue to focus on child safeguarding issues and to prepare the two new organisations to effectively undertake their duties.

Our management oversight of Child protection cases highlighted the need for a clear escalation process where agencies had different perspectives on risk and need. This has been incorporated into the WSCB procedures.

Safeguarding priorities for 2014/15

Community Rehabilitation Company:

The newly created Warwickshire and West Mercia Community Rehabilitation Company (CRC) includes public protection as a strategic priority and will work towards designing and implementing an intelligence led strategy to improve responses to Safeguarding Children - this will include ensuring good, effective attendance by CRC at Safeguarding Children partnership meetings. The CRC has been created as a result of the Transforming Rehabilitation reforms and although now separate from the National Probation Service (NPS), and subject to a proposed transfer to new ownership during 2014/15, it will continue to work closely with the NPS to ensure quality risk assessment and review of those cases that require joint involvement.

National Probation Service:

The National Probation Service (NPS) will be responsible for public interest decision making and the management of high risk of harm offenders. Its priority will be to ensure information relevant to the safeguarding needs of children is sought at sentence commencement and used to inform sentence planning in both the NPS and CRC. The NPS structures mean that local senior managers will participate in 3 sets of child safeguarding arrangements and so the organisation will prioritise incorporating the learning this generates into both its own work and the Warwickshire Safeguarding Board partnership.

6.12 Coventry and Rugby Clinical Commissioning Group/Warwickshire North Clinical Commissioning Group / South Warwickshire Clinical Commissioning Group

- NHS Warwickshire and NHS Coventry were formally replaced by three Clinical Commissioning Groups in April 2013. Each of the CCGs have a defined area of Warwickshire for which they commission services for their

local populations. This is predominantly achieved through contracts with the four large local providers University Hospitals NHS Coventry and Warwickshire, Coventry and Warwickshire Partnership NHS Trust, South Warwickshire Foundation NHS Trust and George Eliot Hospital.

- Coventry and Rugby CCG host the safeguarding team with clear provision of time allocated to each of the three CCGs.
- The CCGs are committed to ensuring that there are robust, co-ordinated safeguarding systems in place which ensures children are safe, healthy and achieve their life chances.
- All three CCGs are represented on the WSCB at board level and within the sub groups demonstrating a clear intent to work closely with other agencies to safeguard children.

Achievements

- The Clinical Commissioning Groups have taken action to ensure that learning from serious case reviews is progressed within the Warwickshire health economy through provider organisations and primary care. The designated nurse chairs the health sub group of the board and good practice and learning is shared readily across health providers in Warwickshire to ensure the best outcomes for children and their families.
- The CCGs have reviewed the revised document on Safeguarding children and young people: Roles and competencies for health care staff. Intercollegiate document. (2014) to ensure that training for all staff both within the CCGs and across provider organisations is at the required level. Each of the CCGs has a mandatory training programme to ensure that all staff receive child protection training.
- The Designated Nurse and Safeguarding trainer have delivered child protection training to all GP practices in Warwickshire and support GP's to demonstrate that they and their staff are trained to the appropriate level. The Level 3 sessions have specifically addressed key WSCB priorities such as Child sexual exploitation, domestic violence and abuse, and learning from serious case reviews. As a result, GP's report increased awareness and confidence in detection of abuse and escalation of concerns to designated professionals where appropriate. This can be evidenced through an increased number of relevant contacts with Designated professionals and increased involvement in serious case review processes.
- The CCGs are using a self-assessment tool called the "markers of good practice" for safeguarding children to review child protection provision within the services that it commissions.
- The Designated Nurse for Safeguarding has been working in collaboration with the Domestic Abuse Co-ordinator in Warwickshire County Council to

increase awareness raising and confidence in responding to issues relating to Domestic violence and abuse across the Warwickshire health economy.

- The CCGs Designated Nurse and the Designated Doctor for Child Protection are WSCB's health advisors and are actively engaged in all of the WSCB sub groups. The impact of this is that there is expert input from safeguarding health professionals into the sub groups of the WSCB, which is independent of providers, to challenge, identify good practice and support the development of quality assurance mechanisms such as audit and provide safeguarding leadership in relation to health practice.
- The CCGs have been represented in the research and development of a number of multi-agency Safeguarding initiatives across Warwickshire including work on child sexual exploitation and the multi-agency safeguarding hub.

Challenges

- One of the most important issues for all three of the CCGs is to ensure that the voice of the child is evidenced in all aspects of work. There will be on-going work to address and develop the involvement of young people to inform safeguarding service development.

Priorities for 2014/2015

- The Designated Nurse will engage with current children and young people's advisory groups to inform safeguarding service development and understand the needs and diversity of the population across Warwickshire.
- The CCGs are committed to the review of the section 11 audit and will work with WSCB to further improve services.
- South Warwickshire Clinical Commissioning Group is leading on a review, on behalf of all three CCGs, of health services for Looked After Children in Warwickshire .
- The CCGs will coordinate a review of child deaths across Warwickshire to address key areas of service provision across each geographical area.
- The CCGs will continue to work effectively in partnership with all agencies across Warwickshire to protect children and young people.

6.13 Warwickshire County Council Communities Group

Achievements.

Gypsy and Travellers: The Gypsy and Traveller service deals with one of the most vulnerable communities in our society today and over the years we have built up the trust required to break down the communication barriers. The service

has engaged the community in issues around safeguarding and what to report and how. Over the last year we have support families going through Domestic abuse, needing to be re-housed, finding accommodation, getting children into education and with other professionals provided a safe haven when required. We have become the link between the traveller communities and other agencies.

Trading Standards: Warwickshire Trading Standards, working in partnership with other enforcement bodies undertook intelligence led action to protect the health of children and young people by preventing the sale of alcohol and tobacco products to under 18's. Eighty test purchase exercises were conducted with child volunteers and six sales were made. Enforcement action was taken against sellers and licensees/owners, including the prosecution of a nightclub owner who allowed under aged drinking and employed young people under 18 to sell alcohol. Premises were also advised to operate 'Challenge 25' proof of age scheme. Sniffer dogs were used to find fake and illicit tobacco products hidden on retail premises. Sellers of illegal products are less likely to seek to prevent sales to children and counterfeit cigarettes (and also alcohol) can pose a very serious risk of damage to health (even above that posed by genuine products). Officers also participated in over 100 licence application checks and made representations on 22 occasions to request additional conditions for the protection of children from harm.

Environmental Health and Trading Standards visited 59 High Street sunbed salons, both to test the safety of the sunbeds in use, but also to ensure that the owners were complying with the law and preventing under 18's using sunbeds. Over one-third of sunbeds tested had UV emissions in excess of permitted levels.

Trading Standards help ensure that toys do not pose a danger to babies and children. Recently, officers targeted the manufacturers and sellers of unsafe soother clips following a rise in the sale of these products on social networking sites.

Trading Standards have been working in school to educate children about the dangers posed by fireworks. Over 1000 children entered a firework poem and poster competition. Through 'Talkingshop', Trading Standards have provided secondary school students with educational inputs on consumer rights and financial literacy, helping protect young people from scams and avoid debt problems in the future.

Drugs & Alcohol Action Team (DAAT):

- We have direct input in to the adult treatment provider clinical & social governance group. All clients are provided with secure drug boxes e.g. to facilitate the safe storage of methadone and other medication in the home.
- Self-audit against ADFAM Medications In Drug Treatment: Tackling the Risks to Children report http://www.adfam.org.uk/cms/docs/adfam_ost_fullreport_web.pdf
- Ongoing monitoring of incidents through monthly incident reporting from the adult and YP treatment services.
- All clients entering service are assessed and regularly reviewed in respect of their parental status and contact with children.
- Joint working of cases with social care and instigation of CAFs as required.
- There is a local organisation lead within the treatment service.

Youth Justice & Family Intervention:
The Youth Justice Service is a statutory board member, and a separate report is provided.

Domestic Abuse:
Warwickshire launched a new approach to tackling violence against women and girls in November 2013. Warwick University undertook an in depth consultation and analysis with professionals and service users to draw together a new strategic approach to not only domestic and sexual violence but also stalking and harassment, forced marriage, honour based violence, FGM, forced prostitution and trafficking for sexual exploitation. The move from looking purely at domestic abuse and sexual violence to a wider, co-ordinated VAWG agenda ensures a more integrated approach to those affected by violence and abuse that more accurately reflects a victim's experiences and offers potential for more effective interventions and responses. A new VAWG Board is developing in order to ensure the new approach is developed and delivered effectively.

During 2013-14 we supported Warwickshire's four Community Safety Partnerships by co-ordinating responses to 2 new referrals for a Domestic Homicide Review while continuing to support with reviews that already started. Actions relating to the safeguarding of children and young people have arisen from Warwickshire DHRs and following Home Office approval will be included in the published reviews.

Safeguarding of children is central to the Multi-Agency Risk Assessment Conferences (MARAC) process. 538 cases were heard at Warwickshire MARACS over the year and these worked to protect 710 children (368 cases). The MARAC was able to remove or reduce the levels of risk in 37% of cases. As of October 2013 MARACS began accepting referrals of 16 and 17 year olds

assessed as being at high risk of serious harm or homicide from domestic abuse. Over quarter 3 and 4 of the year there were 3 referrals for victims aged 16-17 and 2 where the offender was 17 or under.

A two day workshop on Provision of Freedom Programme for Professionals training
is aimed at professionals who want to increase their knowledge and deepen their understanding of domestic abuse.

Aims:

- To provide an opportunity for professionals to experience, cognitively and emotionally, what it would be like to live with domestic abuse
- To leave a lasting emotional impact, deeper understanding and greater awareness of the psychology and beliefs that underpin domestic abuse

Objectives:

- To enable professionals to make more informed, robust and realistic assessments
- To increase child safety

During 2013-14 we trained 160 practitioners. Feedback included:

- I have been working in the field for 5 1/2 years and this is the first bespoke course that has been so informative on DA and the process that victims go through."
- "This was the most powerful and enlightening training I have ever attended. …all professionals who deal with victims of DV should attend. I thought I had a really good understanding already of DV and victim issues, how wrong I was. This training really looks at the whole thing through the eyes of the victims."

We were successful in bidding to the Police and Crime Commissioner's Innovation Fund for 2013-14 in order to develop 2 new resources for young people in partnership with the Respect Yourself Campaign. Both resources have been designed by young people, for young people.

- UR Decision: Life's not a rehearsal is an on-line interactive resource covering abuse, sexting, consent and child sexual exploitation. www.urdecision.info
- Relationship Health Checker is designed to get you thinking about your personal relationships and will try to point you in the right direction. www.respectyourself.info/rhc

Community Safety: The community Safety Team have been supportive of the Blue Sky Centre (SARC) and in particular instrumental in providing a garden

space (haven). 131 children have accessed the SARC in its first year. Anecdotal reports included in the first annual report cite the garden as having particular positive effects on young people.

In Nuneaton and Bedworth as part of a wider initiative to reduce problems from nuisance motorcycles led by Community Safety Project Officers, young people (14-19yrs) are referred to the 'Two Wheels in Motion' project where they take part in a 3 session course aimed at ensuring they are able to ride cycles responsible and safely and leave understanding the dangers and consequences of their previous behaviour.

Public Health
Public Health is a Board partner and a separate report is provided.

Challenges

Gypsy and Travellers: The main challenges for the Gypsy and Traveller service is prejudice from professionals and agencies. Getting children registered with GP's, schools refusing to take children or putting barriers in the way and providing accommodation. There is a lack of understanding of cultural issues and sensitivities which this community believe in

Trading Standards: The consumption of ‘legal highs’ (including by children), has often led to illness, hospitalisation and sometimes death. Trading Standards are working with Warwickshire Police to tackle this issue.

Priority Families: The Priority Families Programme is now two thirds through its first Phase and is performing well. We recognise the need for close working links with the Board and those involved in the safeguarding agenda and are keen play our full part. The successes and learning derived from the first Phase of the Programme will provide us with a solid foundation for the future and the proposed new eligibility criteria augur well for even close working relationships.

Drugs & Alcohol Action Team (DAAT): Communication and information sharing is always an issue. For example, it is often the case that the treatment service is only aware of social care involvement when the client discloses it. We have attended social care team meetings to raise the profile of services and highlight how to refer and the importance of doing so.

Domestic Abuse:
The biggest single challenge has been reduced resources accompanied by continuously increasing demand. Services we commission report individuals presenting with more complex cases which require more intensive, support, reducing the capacity for new clients.

We are working to address this through working with the Office of the Police and Crime Commissioner who has domestic and sexual violence as a priority in the updated Police and Crime Plan. From April 2015 the OPCC will be responsible for commissioning victim support services. We worked with the OPCC to successfully bid for funding to establish the IRIS Programme across the county in 2014. IRIS supports General Practitioners in identifying and responding to domestic abuse and provides direct support for GP’s to refer victims to.

There is a perception that domestic abuse is ‘done’ by Community Safety. Domestic abuse, and now VAWG must be everybody’s business, as is safeguarding children. Frontline practitioners across the board must be skilled in identifying and responding appropriately.

Reduced resources across the multi-agency landscape have left reduced capacity and a reduced ability to undertake the intensive work sometimes required. This will of course impact on the ability of those affected by DA to cope, recover and safeguard their children effectively.

Safeguarding priorities for this year 2014/15

Gypsy and Traveller Service:

- Refresher trainer for the team.
- Continue to work with agencies to understand the cultural differences and communication issues within the community.
- Apply for funding to support this community getting access to other agencies.
- Project lead on a health study.

Drugs & Alcohol Action Team (DAAT): We have recently been made aware of concerns regarding sexual exploitation and drug misuse amongst secondary school children at a number of Rugby schools. We responded to this by holding an initial multi-agency meeting involving social care, schools, YP services, Council safeguarding and police. This will be followed up by an action plan with appropriate interventions that will be overseen by this group over the course of the year.

Localities & Partnerships:

- We will be undertaking a refresh of the Warwickshire Child Poverty Strategy.
- We will also be building on work to ensure that vulnerable families have access to financial advice, affordable warmth and affordable food.
- Both of these initiatives may have implications for safeguarding.

Domestic Abuse:

- Further develop work to keep young people safe in their relationships.
- Embed the new approach to tackling violence against women and girls.
- Deliver the actions arising from Domestic Homicide Reviews and MARAC Self-Assessment.

Community Safety:

- Continue to provide support to the SARC (Action day completed 21/5/14).

- Continue support for diversion schemes such as 'Two Wheels in Motion' project.

6.14 Warwickshire County Council Children's Social Care

The promotion of safeguarding is a core statutory function of children's social care and is evidenced throughout the data in the annual report relating to referrals, assessments and service provision.

As a single agency we have been challenged by the continuing high rate of cases referred to social care .which impacts upon our ability to manage these effectively. During 2013/14 we continued to work more closely with our colleagues in WCC Early Help and Targeted Support in order to offer families early help at the earliest opportunity to prevent the need for social work services unless this was felt to be the most appropriate service.

During 2013/14, much of the focus of our work was in developing a child protection strategy which focused upon reducing the number of children who need to be subject to child protection plans through intervening earlier and refining our processes. This was an extension to the work already being undertaken to safely reduce the numbers of children who need to become looked after with the Dartington Social Research Unit (SRU). The work undertaken with the Dartington Social Research Unit (SRU) has enabled Children's Social Care to explore more fully how the child protection system is used with families and to explore more effective ways to work with families in order to safeguard children.

With regards to multi-agency working we are redesigning our front door with the objective of improving the consistency and effectiveness of the response to referrers. This aims to provide the right services at the right time for children and families, using early intervention services much more readily and providing more effective social work services which better safeguard children and their families.

During 2013/14 we continued to see an increase in the number of children subject to a child protection plan for 2 years or more or for a second or subsequent time during 2013/14. Further work is being undertaken by the Performance Monitoring and Evaluation Sub-committee in relation to these child protection plans as well as understanding better those children who are subject to a child protection plan for 3 months or less. As part of our work with the Dartington SRU the Independent Reviewing Service has developed a RAG system to assist in identifying blocks to achieving the outcomes of the child protection plan. Further work is needed to engage wider WSCB agencies in this process.

In 2014/15 our key priorities will continue to focus upon safeguarding children and their families in accordance with statutory guidance and legislation. A key

priority will be to continue to focus upon reducing the numbers of children who need to be subject to child protection plans and also to safely reduce the numbers of children who become looked after. We will continue to embed the “Think Family” protocol in our work with vulnerable children and adults to ensure that we are providing a joined up approach to families' needs and ensuring that universal and specialist services improve the identification of children in need and in need of protection through increased understanding of the impact of an adult's problems on a child's life. The implementation of The Care Act 2014 and The Children and Families Act 2014, provides an opportunity to more closely respond to the transition issues that some vulnerable children experience when they become adults.

Another key priority is to continue to develop the proposals for the design of a Multi-agency Safeguarding Hub (MASH) which aims to bring professionals together to share information and to provide support for families more effectively.

Underpinning the key priorities are the significant financial challenges that the County Council will face during 2014-18 which will impact upon the way in which we deliver services to children and their families. Children’s Social Care is redesigning a number of services in order to provide an effective service to children and families within the context of the financial challenges.

6.15 Warwickshire Police

Warwickshire Police do not have any targets set by the Police & Crime Commissioner (PCC) and instead focus all efforts on achieving our single vision to 'protect people from harm'. To achieve this we seek to provide the best possible protection with the resources available to us, and reduce harm by managing the risk of it happening. This way of working allows us to achieve our vision by managing and responding to real time threats and risks. This is more effective in protecting communities than the traditional method of setting annual objectives and targets. It is about doing the right thing and focusing on those issues that really matter to local communities. This empowers our workforce to concentrate on delivering the maximum protection possible to those communities.

As part of achieving our vision to 'protect people from harm', Warwickshire Police undertakes activity to safeguard and promote the welfare of children at both a strategic and operational level. In doing so it works closely in partnership with other statutory and third-sector agencies. At the strategic level, duties and responsibilities are exercised through active membership of Warwickshire Safeguarding Children Board (WSCB) and through the development of Police policy and standard operating procedures that take cognisance of legislation and statutory guidance, national strategy and research, and local need.

At the operational level, Warwickshire Police work closely in partnership on a day-to-day basis to undertake activity to safeguard children, taking primacy for the investigation of cases where it is believed a criminal offence may have taken place. This activity is done in compliance with the *'WSCB Inter-Agency Safeguarding Procedures'*, and in line with operational guidance issued by the Association of Chief Constables (ACPO) and the College of Policing. This includes working closely with agencies at a local level when delivering neighbourhood-policing services and the Safer Schools programme, as well as the provision of specialist 'Protective Services' resources.

A particular focus of Warwickshire Police over the last 12 months has been the continuing development of policing services in alliance with neighbouring West Mercia Police. Our two forces now deliver all services together within a single policing framework across Warwickshire, Herefordshire, Worcestershire, Shropshire and Telford & Wrekin. This includes a single 'Protecting Vulnerable People' (PVP) department with responsibility for child protection and abuse investigation, safeguarding vulnerable adults, domestic abuse, missing persons, and the management of registered sexual offenders and violent offenders.

A Detective Superintendent heads the overall PVP department for Warwickshire Police and West Mercia Police, with a Detective Chief Inspector leading PVP within each of three geographical areas: Warwickshire, Herefordshire/Worcestershire, and Shropshire/Telford & Wrekin. Operational responsibility for overseeing child protection matters within each area is led by a PVP Detective Inspector, who has specialist investigative resources at their disposal.

As part of enhancing the work of Warwickshire PVP in respect of safeguarding children, an increase in the level of supervision with our Child Protection Units has now been implemented. In addition, a new role of 'Child Protection Liaison Officer' has been introduced, with a primary responsibility for dedicated attendance at Child Protection Conferences. Safeguarding activity is supported by an already well-established 'Harm Assessment Unit', which manages and coordinates all referral activity into and out of the Warwickshire Policing area and acts as the gateway to other agencies, including child safeguarding pathways. Over recent years an investment has been made in providing better training for staff on child safeguarding matters, in particular in the context of domestic abuse, and this improved awareness has resulted in an increase in referrals from the Police. This in turn improves the opportunities for a multi-agency approach to identify vulnerable children and take action to safeguard and promote their welfare.

Warwickshire Police external referral/notification activity for this period was as follows:

Warwickshire Police PVP HAU External Referrals 2012-2014* (DOMESTIC ABUSE)	Children's Social Care			Children's Social Care (2+ criteria)			Adult Social care			Mental Health			GP/Other NHS			DA Support Services (first review only)			Alcohol/Drugs Services			Total		
	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-
April	337	187	-45%	36	119	231%	19	7	-63%	106	121	14%	225	158	-30%	145	128	-12%	5	6	20%	873	726	-17%
May	288	202	-30%	72	144	100%	20	12	-40%	87	147	69%	216	192	-11%	144	134	-7%	17	3	-82%	844	834	-1%
June	255	195	-24%	49	158	222%	11	12	9%	80	109	36%	180	203	13%	128	122	-5%	19	6	-68%	722	805	11%
July	365	279	-24%	38	175	361%	19	11	-42%	116	165	42%	263	252	-4%	151	182	21%	17	6	-65%	969	1070	10%
August	365	176	-52%	20	162	710%	18	11	-39%	104	135	30%	244	182	-25%	144	122	-15%	21	3	-86%	916	791	-14%
September	299	178	-40%	2	191	9450%	10	12	20%	81	131	62%	198	182	-8%	105	149	42%	11	3	-73%	706	846	20%
October	368	181	-51%	28	187	568%	7	9	29%	94	135	44%	226	176	-22%	134	118	-12%	11	3	-73%	868	809	-7%
November	296	144	-51%	31	177	471%	10	6	-40%	111	115	4%	185	172	-7%	134	113	-16%	5	4	-20%	772	731	-5%
December	326	168	-48%	36	174	383%	10	11	10%	91	99	9%	194	168	-13%	117	148	26%	6	5	-17%	780	773	-1%
January	266	204	-23%	63	153	143%	9	15	67%	85	109	28%	176	185	5%	108	153	42%	2	0	-100%	709	819	16%
February	222	129	-42%	70	185	164%	13	16	23%	102	89	-13%	172	170	-1%	98	128	31%	3	1	-67%	680	718	6%
March	204	138	-32%	80	185	131%	21	12	-43%	124	93	-25%	164	181	10%	101	123	22%	5	3	-40%	699	735	5%
	3591	2181	-39%	525	2010	283%	167	134	-20%	1181	1448	23%	2443	2221	-9%	1509	1620	7%	122	43	-65%	9538	9657	1%

*Does not include referrals to MARAC

Warwickshire Police PVP HAU External Referrals 2012-1014 (OTHER INCIDENTS)	Children's Social Care			Children's Social Care (2+ criteria)			Adult Social care			Mental Health			GP/Other NHS			CAMHS			Alcohol/Drugs Services			Total		
	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-	2012/13	2013/14	% +/-
April	34	83	144%	0	1		17	49	188%	9	32	256%	5	0		1	1		2	1		68	167	146%
May	51	62	22%	0	0		28	57	104%	6	33	450%	2	0		0	0		0	1		87	153	76%
June	55	51	-7%	0	1		42	44	5%	24	26	8%	0	0		1	1		1	1		123	124	1%
July	66	68	3%	0	1		48	31	-35%	30	36	20%	0	0		0	0		0	1		144	137	-5%
August	72	71	-1%	0	0		37	45	22%	26	38	46%	0	0		1	0		1	2		137	156	14%
September	50	53	6%	0	0		48	40	-17%	34	39	15%	0	0		0	0		2	1		134	133	-1%
October	54	70	30%	2	0		37	40	8%	19	36	89%	1	0		0	0		1	1		114	147	29%
November	42	58	38%	0	0		32	27	-16%	27	18	-33%	0	0		0	0		0	0		101	103	2%
December	55	53	-4%	0	0		50	37	-26%	27	22	-19%	0	0		0	0		2	0		134	112	-16%
January	55	45	-18%	1	0		47	45	-4%	29	36	24%	0	0		1	0		1	0		134	126	-6%
February	67	78	16%	0	0		36	33	-8%	40	33	-18%	2	1		2	0		1	0		148	145	-2%
March	52	65	25%	2	0		31	30	-3%	20	27	35%	0	0		0	0		0	1		105	123	17%
	653	757	16%	5	3		453	478	6%	291	376	29%	10	1		6	2		11	9		1429	1626	14%

Warwickshire Police particularly recognises the importance of tackling Child Sexual Exploitation (CSE) and the need to protect very vulnerable children from significant sexual offending. In line with many other Police Forces' nationally and together with our partners we are redefining how we manage and investigate these cases. Much has been progressed already but this work will continue to be prioritised over the next 12 months and includes the scoping of a dedicated multi-agency CSE team.

As part of the ongoing development of partnership working, Warwickshire Police are closely supporting scoping activity that is considering the development of a Multi-Agency Safeguarding Hub (MASH), which could be an important step forward for more dynamic information sharing and decision making.

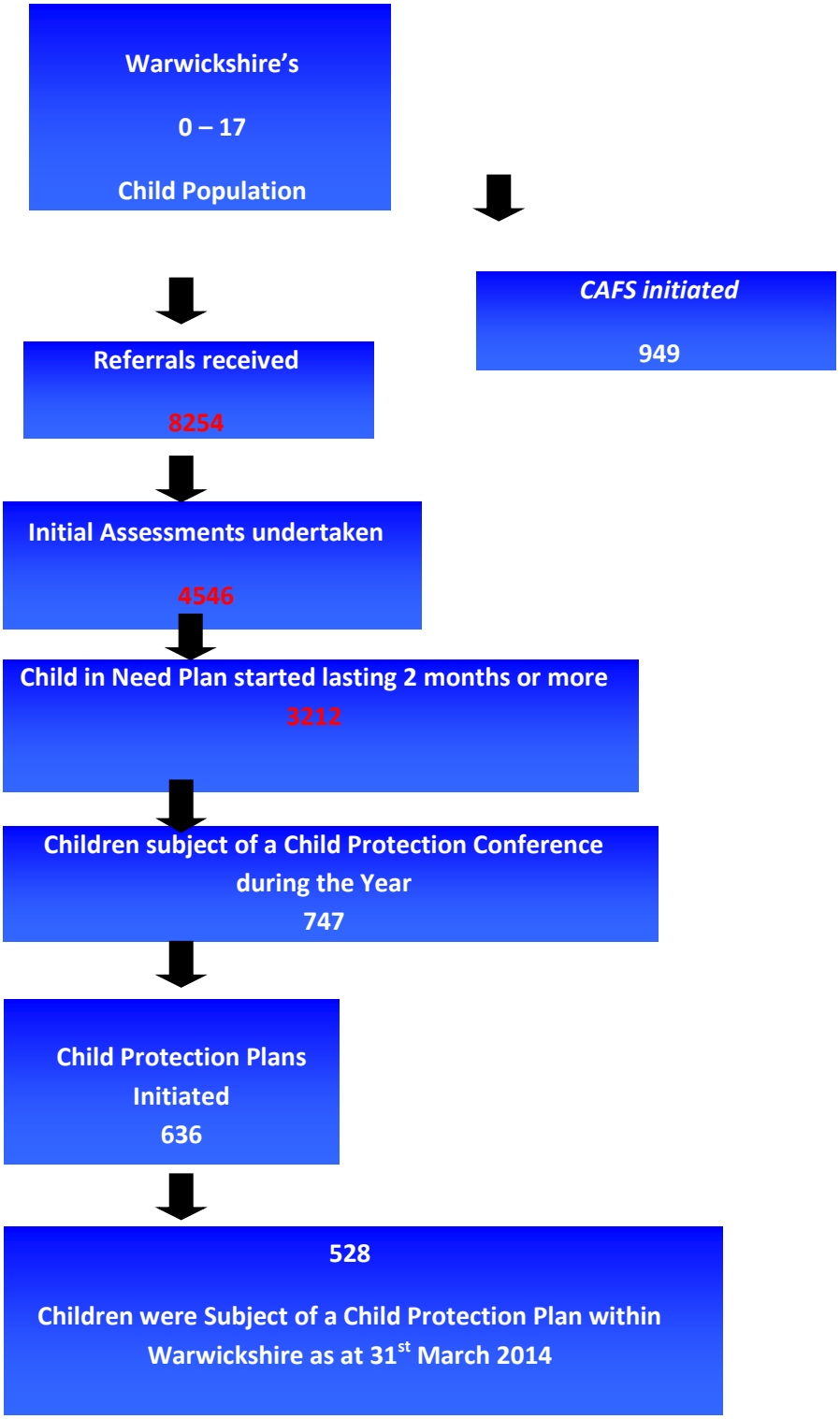
7. Effectiveness of Safeguarding Arrangements in Warwickshire.

Warwickshire Safeguarding Statistics 2013/14

Summary of Key Issues

- In 2013-14 there has been an increase of 45.3% in the number of CAFs initiated.
- There has been a 25% increase in the number of referrals received by Children's Social Care.
- A similar proportion of referrals in 2013-14 received an initial assessment (54%) compared with 2012-13, but there has been increase in the proportion of referrals which result in a service lasting for more than 2 months, from 30% to 39%.
- There has been a smaller increase in the number of children who were made subject of a Child Protection Plan with 636 plans initiated during 2013/14 in comparison to the 609 initiated in 2012/13, which is an increase of 4%. However, despite this fewer plans were initiated than closed this year which is the reason the number at year end saw a decrease.
- As at 31 March 2014, 528 children were subject of a Child Protection Plan in Warwickshire. This is a 4% decrease on the 550 children subject of a plan as at 31st March 2013.
- As at 31 March 2014, the largest group of children who were subject of a Child Protection Plan were those aged 5-9 years. This is the same as the previous year.
- 8.1% of children who are subject of a CP Plan in Warwickshire at 31 March 2014 were from black or ethnic minority families . This is slightly lower than the overall proportion of the general 0-17 population in Warwickshire that are BME (14.8%).
- 2.1% of children with CP plans were recorded as having a disability, compared with an estimated 6% of children in the general population having a disability.
- The number of child protection plans closed during the year which had been open for two years or more (long plans) saw an increase this year up from 8.0% to 9.3%. This is a slight deterioration in performance.
- The percentage of children becoming subject of a child protection plan for a second or subsequent time (Previously NI65) during 2013/14 saw a slight deterioration in performance this year, up from 13.3% to 16.7%.

SUMMARY OF ACTIVITY DURING 2013/14



SECTION 1. INTRODUCTION

1.1 This report summarises safeguarding activity in Warwickshire between 1 April 2013 and 31 March 2014.

1.2 Warwickshire's Safeguarding Children Board has agreed the dataset on which this report is based.

SECTION 2: EARLY HELP

2.1 CAFS initiated over the last 2 years

During 2013/14 a total of 949 CAFS were initiated within Warwickshire which is a 45.3% increase on the number initiated in the previous year. This is a welcome increase, as it suggests that more children who are causing concern to professionals but whose needs are below the threshold for statutory social work services are receiving co-ordinated early help.

The biggest increase in CAF activity as a proportion of the relevant population was in Stratford, which previously had a very low level of CAF initiation The largest number and highest % per 10,000 of CAFS initiated were within the most deprived district within Warwickshire, Nuneaton & Bedworth, but CAF activity across the county is now broadly aligned with the deprivation indicators, as would be expected. The exception is Warwick, where CAF activity is higher relative to the deprivation indicators than elsewhere in the county.

	2012/13		2013/14	
District	Number of CAFS initiated	Number of CAFS initiated per 10,000 of the 0-17 child population	Number of CAFS initiated	Number of CAFS initiated per 10,000 of the 0-17 child population
North Warks	99	79 per 10,000	130	104 per 10,000
Nun. & Bed.	192	70 per 10,000	294	108 per 10,000
Rugby	165	75 per 10,000	225	102 per 10,000
Stratford on Avon	88	38 per 10,000	146	62 per 10,000
Warwick	109	41 per 10,000	154	58 per 10,000
Warwickshire	653	58 per 10,000	949	85 per 10,000

2.2 CAFS by area mapped against poverty indicators

District	Jobseekers Allowance (Feb 14) % working age population	All DWP working age benefit claimants (Aug 13) % working age population	Estimated % of Children in "Poverty"* (2012)	Free School Meal Eligibility (Jan14) % pupils attending maintained school in Warwickshire eligible for FSM	Number of CAFS initiated per 10,000 of the 0-17 child population
North Warks	1.7%	10.9%	11%	10.8%	104 per 10,000
Nun. & Bed.	3.3%	14.9%	17%	15.1%	108 per 10,000
Rugby	1.6%	9.7%	11%	9.5%	102 per 10,000
Stratford on Avon	0.9%	7.5%	7%	6.5%	62 per 10,000
Warwick	1.3%	7.9%	9%	8.3%	58 per 10,000
Warwickshire	1.8%	10.1%	11%	10.1%	**85 per 10,000**
England	3.5%	13.2%	20%	18.3%^	N/A

Source: NOMIS, School Census, CRSP

**Child Poverty data compiled by the Centre for Research in Social Policy (CRSP), using Tax Credit data*

^*National FSM figure as at January 2013*

2.2 Breakdown of CAFS by Initiating agency

Education initiated almost two thirds of all CAFS during the year.

Agency	**As a % of all CAFS initiated during 2012/13**	**As a % of all CAFS initiated during 2013/14**
Education - Primary	33.10%	36.50%
Education - Secondary	24.00%	25.80%
Education - School Health	1.70%	3.20%
Social Care	13.80%	13.10%
Children's Centre	6.90%	7.10%
Health Visitor/Midwife	3.10%	3.10%
Health Other	0.90%	0.40%
EIS (Early Intervention Service)	3.50%	1.90%
Youth Justice Service	2.30%	1.20%
Parent Support Advisor	1.80%	0.90%
Other Organisations (10 or less CAFS initiated)	8.90%	6.80%
Total	**100%**	**100%**

In general, the initiating agency is continuing to provide the lead professional for the family support plan. Where the initiating agency is a Children's Centre or school, the provision of a lead professional from another agency almost always happens because the family support plan follows the child into the next school as they get older. Youth Services and school nurses generally assume the role of lead professional when they initiate a family support plan.

Where Children's social care is the initiating agency, they most frequently do not assume the role of lead professional, doing so only in 11 out of 119 cases. These family support plans will generally be part of a 'step down' arrangement at the end of a statutory assessment or intervention. Other agencies initiating small numbers of CAFs but not taking on the role of lead professional are CAMHS (1 case out of 5 initiated) and police (1 out of three initiated).

2.4 Breakdown of CAFS by Ethnicity

The largest proportion of children who had a CAF initiated during 2013/14 were White British/Irish/Other accounting for 91.6%. Last year the number of children with no ethnicity recorded was extremely high whilst this year there has been considerable improvement with only 3 children with no ethnicity recorded.

The proportion of children from a black or minority group with a CAF during the year was lower than the proportion of school children described as BME in the school census. (8%; or 11.86% if the 'not recorded' category is included, compared with 14.8% in the school population). This raises the question of whether all black and minority ethnic children who would benefit from co-ordinated early help are receiving it.

Ethnicity of Children who had a CAF initiated during the year	**2012/13**	**2013/14**
White British/Irish/Other	262	869
BME	12	77
Not Recorded	379	3
Total	**653**	**949**

2.5 Family Group Conferencing - 2013/2014

Family Group Conferencing is an intervention offered by the County Council to families at a range of points on the safeguarding spectrum, from early help to edge of care. The aim is to support families to find their own solutions to problems which could result in a child coming into care, or being at risk of harm. 52 families received this service in 2013-14.

Engagement of Fathers	**Total**	**% Total**
Birth father involved	**67**	**55%**
Father figure involved (inc. birth father)	**78**	**64%**
Father engaged with FGC process	**75**	**96%**
Father involved but didn't engage	**3**	**4%**

Outcomes	**Total**	**% Total**
No. at risk of care	**26**	**-**
Care Avoided	**23**	**88%**
Improved Safeguarding Arrangements	**18**	**55%**
Reduced Conflict in Home	**12**	**36%**
Improved Health & Wellbeing	**16**	**48%**
Improved Family Relationships	**24**	**73%**
CYP Evaluations	**Total**	**% Total**
No. Submitted feedback (from attendees)	**19**	**86%**
Had an advocate	**17**	**89%**
Felt advocate helped a lot	**17**	**100%**
Felt listened to	**17**	**89%**
Said what they wanted	**15**	**79%**
FGC helped to make changes	**14**	**74%**

Adult Evaluations	Total	% Total	
No. Submitted feedback (from attendees)	**179**	**66%**	
Process helped	**168**	**94%**	
Enabled family to communicate better	**144**	**80%**	
Felt opinion mattered	**173**	**97%**	
Felt important to decisions made	**169**	**94%**	
Enabled all issues of concern to be resolved	***83**	**52%**	**92% combined**
Enabled some issues of concern to be resolved	***65**	**40%**	

** This question was not included in the Evaluation form in Qtr. 1*

2.6 CAF Family Support Work - 2013/2014

202 families received an intervention from a CAF family support worker, as part of a CAF, during 2013-14.

Engagement of Fathers	Total	% Total
Birth father involved	**131**	**65%**
Father figure involved	**162**	**80%**
Father engaged with FSW process	**105**	**65%**
Father involved but didn't engage	**57**	**35%**

Outcomes	Total	% Total
Improved Behaviour in school	**92**	**61%**
Improved School Attendance	**38**	**25%**
Improved Health/ Wellbeing	**64**	**43%**
Improved Parenting	**104**	**69%**
Reduced Conflict in the home	**68**	**45%**
Improved Family Relationships	**83**	**55%**

Adult Evaluations	Total	% Total
No. submitted feedback	**58**	**29%**
Highly rated the help they got from the FSW	**57**	**98%**
Think they have been helped?	**57**	**98%**
Help has made a difference to them and their family?	**55**	**95%**

CYP Evaluations	Total	% Total
No. submitted feedback	**24**	****
Highly rated the help they got from the FSW	**24**	**100%**
Think they have been helped?	**24**	**100%**
Help has made a difference to them and their family?	**24**	**100%**

*** Not all children involved in the process would be expected to give feedback, for example they might be too young.*

2.7 Parental Satisfaction Rates for 1:1 Triple P Programmes 2013/14

Triple P parenting programmes are provided by the WCC Parenting Development Team to families where this has been identified as a suitable service by other professionals. This is one of the evidence based interventions being offered to reduce the number of children coming into care and needing a child protection plan. In 2013/2014 162 families were offered the programme. Evaluation overwhelming shows that parents value this intervention. To increase the number of Teen Triple P programmes that can be provided, an additional practitioner has been recruited.

Parental Satisfaction Rates for 1:1 Programmes	Total	% Total
Number Evaluations Submitted	137	85%
Programme met child's needs?	124	91%
Programme met parents' needs?	129	94%
Able to deal with child's behaviour?	130	95%
Parents were satisfied with programme?	121	88%
Parents would come back to Triple P?	119	87%
Child's behaviour improved?	110	80%
Satisfied with child's progress?	116	85%

Verbal feedback from Ofsted at the end of the Thematic inspection of early help included positive feedback on the efforts to engage fathers in these early help interventions.

Parents and young people providing feedback on these services are positive about their impact, but it is not known whether participants who don't provide feedback are equally positive.

2.8 Children reported 'missing' to Police.

	2012-2013	2013-14
Number of police reports of missing children (number of missing episodes)	603	533
Number of children reported missing to police one or more times	262	265
Number of children reported missing 2 or more times	82	84
Number of missing children receiving 'return home' interview from missing children's practitioner	51	42
Percentage of all missing children receiving service from missing children's practitioner	19%	16%

Warwickshire County Council employs a missing children practitioner, who is located with the Police missing person co-ordinator at the police station in Leamington Spa, to undertake return home interviews with some children reported missing. Generally a little under 20% of children reported missing are seen, a risk assessment model is used to decide which children will be seen. There has been a short period this year when the post was unfilled, resulting in a reduction in the number of children receiving the service.

An evaluation of the missing practitioner post published in 2013 found that it had been effective in reducing the number of missing children. In the current year, the trend has continued, but importantly, individual 'high risk' children who receive the service are much less likely to be reported missing after intervention.

The statutory guidance for responding to children who runaway or go missing from home was updated this year, and this requires that all children who are reported missing should have a return home interview from an independent practitioner. In the light of this, and also the proven benefit of the limited service currently available in Warwickshire, WSCB in concerned that such a small percentage of missing children are receiving a return home interview.

SECTION 3. REFERRALS & STATUTORY ASSESSMENTS

3.1 Referrals & Assessments

During 2013/14, there were 8177 referrals to children's social care teams. This is a large increase on the number of referrals seen in the previous year. Of these referrals, 54% resulted in an initial assessment and 39% resulted in a child in need plan lasting 2 months or more compared with 30% in the previous year..

	2011/12	2012/13	2013/14
Number of referrals received during the year	6998	6524	8154
Number of referrals moved on to initial Assessments started during the year	4216/6998=60.2%	3525/6524=54%	4427/8177=55.8%
Number of Core Assessments started during the year	918	847	822
Number of new child in need cases opened during the year that stayed open for 2 months or more	2068	1982	3212

3.2 Referrals by District

The largest number of referrals received during 2013/14 was by Nuneaton & Bedworth, accounting for 31.9% of all referrals received and also saw the highest rate of referrals per 10,000. Stratford had the second highest volume of referrals during 2013/14 and the second highest rate of referrals per 10,000.

District	Number of referrals received during 2011/12	Number of referrals during 2011/12 per 10,000 of the 0-17 child population	Number of referrals received during 2012/13	Number of referrals during 2012/13 per 10,000 of the 0-17 child population	*Number of referrals received during 2013/14	*Number of referrals during 2013/14 per 10,000 of the 0-17 child population
North Warks	739	590 per 10,000	619	494 per 10,000	668	533 per 10,000
Nun. & Bed.	2354	862 per 10,000	1775	650 per 10,000	2610	956 per 10,000
Rugby	1164	527 per 10,000	1136	514 per 10,000	1318	596 per 10,000
Stratford on Avon	1240	530 per 10,000	1710	731 per 10,000	1922	822 per 10,000
Warwick	1031	388 per	1035	389 per 10,000	1435	540 per 10,000

		10,000				
Warwickshire	**6998**	**625 per 10,000**	***6524**	**583 per 10,000**	***8177**	**731 per 10,000**

*The Warwickshire total includes referrals received by countywide teams and IDS.

Comparing referral rates with estimated figures for the number of children living in poverty in each area shows that this consideration alone does not account for the variation in referral rates.

District	**Referral rate as percentage of 0-17 population**	**Estimate of children living in poverty***	**Ratio of referrals to children in poverty**
North Warks	5.3%	11%	0.48
Nun & Bed	9.56%	17%	0.56
Rugby	5.96%	11%	0.54
Stratford	8.22%	7%	1.17
Warwick	5.40%	11%	0.60

**Child Poverty data compiled by the Centre for Research in Social Policy (CRSP), using Tax Credit data ^National FSM figure as at January 2013*

It can be seen that the referral rate in Stratford is much higher than would be expected by deprivation alone; and the referral rate in North Warwickshire is a little lower.

3.3 Referrals by Ethnicity, First Language & Disability

	Referrals 2011/12		**Referrals 2012/13**		***Referrals 2013/14**		**Warwickshire School Age Children (Reception to Yr 11)** **Source: School Census – January 2014**
Ethnicity	**Number**	**%**	**Number**	**%**	**Number**	**%**	**%**
White British/Irish/Other	5425	77.5%	5141	78.8%	6754	82.6%	85.2%
BME	598	8.5%	541	8.3%	735	9.0%	14.8%
Not Recorded	908	13.0%	769	11.8%	616	7.5%	N/A
Unborn	67	1.0%	73	1.1%	72	0.9%	N/A
Total referrals	**6998**	**100%**	**6524**	**100%**	**8177**	**100%**	**100%**

	Referrals 2011/12		Referrals 2012/13		*Referrals 2013/14		Warwickshire Profile 0-17 (Census 2011)	
Language Preferred	**Number**	**%**	**Number**	**%**	**Number**	**%**	**^Number**	**%**
English	6171	88.2%	5546	85.0%	7045	86.2%	77,452	95.2%
Non English Speaking	95	1.4%	138	2.1%	181	2.2%	3,868	4.8%
Not Recorded	665	9.5%	767	11.8%	879	10.7%	N/A	N/A
Unborn	67	1.0%	73	1.1%	72	0.9%	N/A	N/A
Total referrals	**6998**	**100%**	**6524**	**100%**	**8177**	**100%**	**111,913**	**100%**

^Please note that the Warwickshire profile numbers/percentage for language preferred is based on the main language for age groupings of 3-15 as provided on OMS/NOMIS. This is as detailed as is currently available.

	Referrals 2011/12		Referrals 2012/13		*Referrals 2013/14		^^National average of disabled children
Disability	**Number**	**%**	**Number**	**%**	**Number**	**%**	**%**
Referrals received	283	4.0%	233	3.6%	244	3.0%	6%

^^ National average of disabled children. Source: Department for Work and Pensions (2013) Family resources survey: United Kingdom 2011/12 (PDF). The DWP does not define everyone under the age of 18 as a child. The DWP defines a child as an individual aged under 16, or aged from 16 to 19 years old and: not married nor in a Civil Partnership nor living with a partner; and living with parents/a responsible adult; and in full-time non-advanced education or in unwaged government training

The first two sections of this data were sought to try and understand whether children from black and minority ethnic families and new immigrants from Europe were being identified as possible children in need by referrers. This question is raised because children who are not white appear to be under-represented in CAF and CP numbers. Unfortunately the high level of referrals in which the referrer does not provide information about ethnicity and preferred language makes it hard to draw firm conclusions.

The numbers for whom this information is provided strongly suggest that children from minority ethnic and linguistic groups are not having needs recognised, as they are lower than would be expected compared with the general Warwickshire population. Failure by agencies to request or record information about ethnicity and language suggests that these issues have a lower profile than they should in the mind-set of professionals.

Similarly, the proportion of children described as disabled being referred, compared with the prevalence of children with disabilities in the general population, raises the question of whether their safeguarding needs are being recognised. The difference is marked – half as many children with disabilities referred as would be expected based on the number of children with disabilities in the general population. Although differences of definition may be a factor, and possibly also some children not having their disability recorded at the time of referral, these figures suggest further enquiry should be

undertaken for WSCB to seek to understand whether the safeguarding needs of children with disabilities are being recognised fully.

3.4 Breakdown of Referrals by Source of Referral

As part of the CIN Census 2013/14 the DfE will be collating data on the source of referrals from all local authorities. This will mean in future years we will be able to compare our referral source rates. Please note that the DfE asked local authorities to change the names of their referral source as part of this return so that they can be directly compared. Therefore we are not able to directly match the referral source for 2013/14 to that in 2012/13.

Source of Referral	**Number of Referrals during 2013/14**	**As % of all Referrals received in 2013/14**
Individual - Family member/relative/carer	500	6.1%
Individual - Acquaintance (including neighbours and child minders)	44	0.5%
Individual - Self	120	1.5%
Individual - Other (including strangers, MPs)	46	0.6%
Schools	**1322**	**16.2%**
Education Services	89	1.1%
Health services - GP	98	1.2%
Health services – Health Visitor	198	2.4%
Health services – School Nurse	25	0.3%
Health services – Other primary health services	388	4.8%
Health services – A&E (Emergency Department)	167	2.0%
Health services – Other (e.g. hospice)	68	0.8%
Housing (LA housing or housing association)	151	1.9%
LA services – Social care e.g. adults social care	303	3.7%
LA services – Other internal (department other than social care in LA e.g. youth offending (excluding housing))	489	6.0%
LA services – External e.g. from another LAs adult social care	239	2.9%
Police	**2371**	**29.1%**
Other legal agency – Including courts, probation, immigration, CAFCASS, prison	236	2.9%

Other – Including children's centres, independent agency providers, voluntary organisations	500	6.1%
Anonymous	471	5.8%
Unknown	352	4.3%
Total	**8177**	**100%**

The largest number of referrals was from the police (29%) which is the same proportion as the previous year (29.6%). The second largest number of referrals was received from schools accounting for 16.2% of all referrals which is again similar to the previous year (16.5%).

Many of the police referrals relate to their attendance at domestic abuse incidents where there are children in the household. It is not possible to identify what percentage of police referrals are domestic abuse related. However in 2013/14 the police made 4,191 reports to children's social care of domestic abuse incidents, a small increase on 2012/13 when it was 4,116. 2371 of these notifications were recorded as referrals by children's social care.

SECTION 4: CHILDREN IN NEED

4.1 PRIVATE FOSTERING

A privately fostered child is defined as a child under the age of 16 (18 if disabled) that is cared for by someone other than a close relative (i.e. a grandparent, brother, sister, uncle, aunt, or step-parent). A child is not privately fostered if the person caring for him or her has done so for fewer than 28 days and does not intend to do so for longer than that. Local Authorities have a responsibility to ensure that the welfare of privately fostered children is promoted

	2011/12	2012/13	2013/14
The number of notifications of new private fostering arrangements received during the year	9	12	24
Number of new arrangements that began during the year	8	11	20
Number of private fostering arrangements that ended during the year	11	11	11
Number of children in private fostering arrangements as at year end (31 March)	**4**	**4**	**13**

Between 01 April 2013 to 31 March 2014, in addition to queries relating to procedures and process, there were 43 specific queries to the practice leader, Private Fostering, to clarify if a child was privately fostered. Of which, **8** progressed to Notifications made to Warwickshire Children Teams. The source of these queries is indicated in the chart below.

Source of Enquiry	**01 April 2013 to 31 March 2014.**
Birth Parent	1
CAF officer	4
Children team	13
Education	14
Family Group Conference Service	2
Health Visitor	1
IRO	2
Language school	2
Member of the public	1
Outreach Development Worker Family Information Service	1
Prison Service	1
Private foster carer	1

The records of consultations with the Practice Leader in 2012-2013 are from 29-11-2012 to 31 March 2013. A comparison with the same period over the year 29-11-2013 to 31-03-2014 is shown below evidencing an increase over the same time period. Notifications also increased from **1 to 4** in this period.

Source of Enquiry	29-11-2012 to 31 March 2013	Source of Enquiry	29-11-2013 to 31 March 2014
Birth Parent	0	Birth Parent	1
CAF officer	0	CAF officer	1
Children Team	1	Children Team	8
Education	4	Education	5
Health Visitor	0	Health Visitor	1
TOTAL	**5**	**TOTAL**	**16**

This data suggests that the concerted efforts being made by social care to promote awareness of private fostering and increase notifications is having a positive impact.

4.2 Number of MASE meetings convened by social care: 27

4.3 Number of MASE meetings for LAC including those placed in Warwickshire by other LAs: 11

Of the 14 held before the end of September 2013 (the first 6 months of the period) 8 young people were LAC (of these 5 were placed in a residential establishment), 1 placed in supported accommodation, 2 initially lived with parents but then became LAC, and 3 young people lived with parents. In the second 6 months of the year, 3 young people were LAC, and the other 10 lived with parents.

This is the first year the CSE procedure has been in operation, and the information gathered from professionals via the Joint Strategic Needs Assessment showed very variable understanding about CSE and how it can be identified. If the CSE strategy is being successful it would be expected that the numbers of 'MASE' meetings (multi-agency sexual exploitation meetings) would be greater in 2014-2015.

4.4 Police Investigations into CSE.

The police are not currently able to provide data about the numbers of new or concluding investigations into CSE. Work is being done in Warwickshire and Wes Marcia to enable this information to be extracted from police records so that it can be reported on in the future. This data is required so that the success of the CSE strategy in bringing prosecutions can be measured.

4.4 Number of Warwickshire LAC missing, identifying repeat episodes

During 2013/14 a total of 25 episodes of looked after children missing from their agreed placement for 24 hours or more were recorded on Carefirst by children's social care teams. These 25 episodes related to 17 children of which 5 of these went missing twice or more during 2013/14.

Number of LAC missing during 2013/14	Number of Episodes of LAC missing during 2013/14	Number of Children who had repeat missing episodes in the year
17 children	25 episodes	5 children

Source: Carefirst

Data on looked after children missing from their placement is returned to the Department for Education on an annual basis and this data is then published on the government's statistics website. Comparisons with other data sources, including numbers of missing children reported to the police, indicate that the figures presented in this publication may be an undercount of the true figure and should be treated with caution. As a result of this the DfE are asking all local authorities to look at improving the quality of the data they record around missing looked after children.

Going missing from care can be an indicator of serious harm such as sexual exploitation or trafficking, as well as an indicator of factors such as the child being unhappy about their care plan or their placement.

These figures record the numbers of children looked after by Warwickshire who have been missing from their placement for more than 24 hours, wherever the placement is. Warwickshire police are not currently able to extract figures from their missing children data about looked after children placed in Warwickshire by other local authorities, however the missing children's practitioner and missing person's co-ordinator know that some children they have provided a service to were placed in Warwickshire children's homes by other local authorities, and that CSE was known or suspected for these children. The police have been asked to look at how they can produce this data for 2014-15.

4.5 Number of Warwickshire LAC in out of area residential placements on the last day of last quarter

The number of children who are placed out of county in a residential setting has seen an increase throughout the year with only 24 at 30 June 2013 compared to 27 at 31 March 2014.

Number of Warwickshire LAC in out of area residential placements			
At 30 June 2013	At 30 September 2013	At 30 December 2013	At 31 March 2014
24	22	25	27

Source: Carefirst

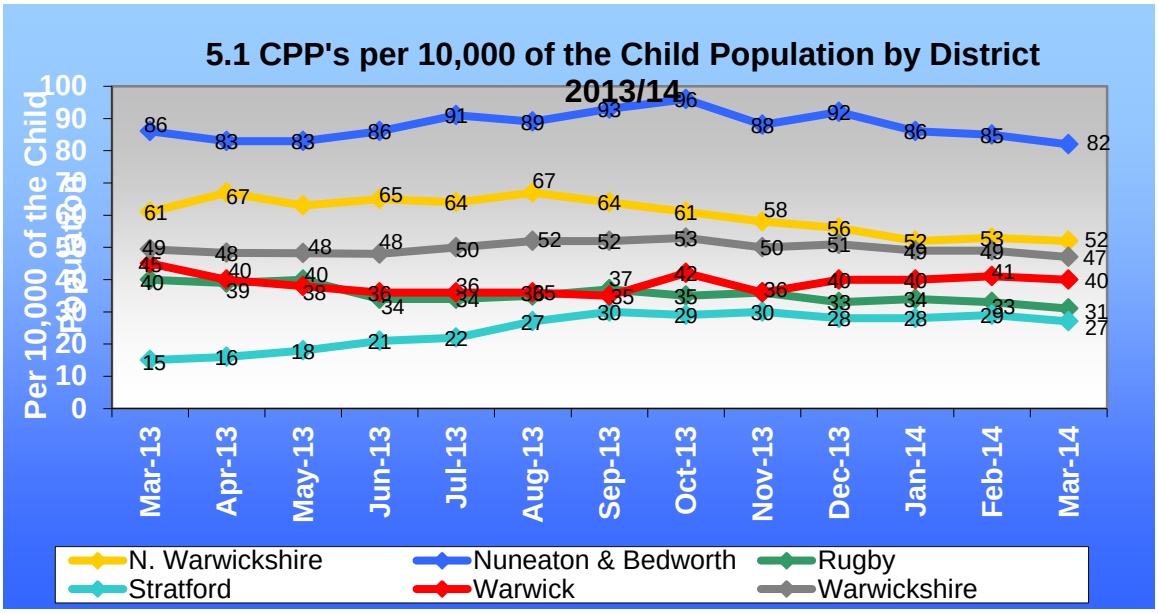
Residential care is used for looked after children with the greatest level of need, and who are therefore potentially particularly vulnerable to a range of risks. There are a range of measures used to monitor these placements to try and ensure the children in them are safe, these include monitoring of the establishment provided by Ofsted regulation and inspection, and monitoring of the child's care plan via social work visits and statutory reviews.

The revised guidance for children who runaway and go missing strengthens the requirement on LSCBs to scrutinise safeguarding arrangements for these children, and for groups of children such as those looked after who are more likely to runaway. This data should therefore be regarded as benchmarking data for future work.

SECTION 5 CHILD PROTECTION ACTIVITY

5.1 NUMBER OF CHILDREN SUBJECT OF A CHILD PROTECTION PLAN PER 10,000 OF 0-17 POPULATION

Child Protection plans are a multi-agency intervention, led by social care, and initiated when children are suffering or at risk of suffering significant harm. The plan aims to ensure the child is safe, prevent the child from suffering further harm and to support the family to safeguard and promote the wellbeing of the child, provided it is in the best interests of the child for them to remain with their family.



Source: Carefirst

The county rate per 10,000 has decreased from 49 at 31 March 2013 to 47 at 31 March 2014. The highest rates per 10,000 continue to be within the north of the county as would be expected given the higher rates of deprivation in these districts. However, during 2013/14 North Warwickshire District saw a significant decrease (down from 61

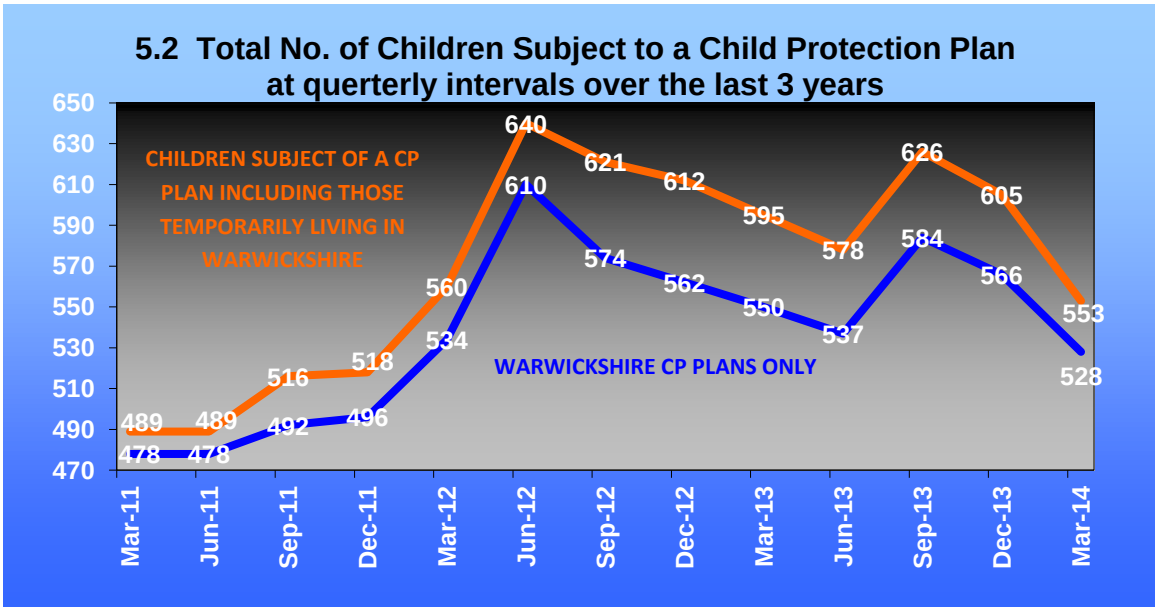
per 10,000 to 52 per 10,000) whilst at 31 March 2014 Nuneaton & Bedworth saw its lowest rate per 10,000 since December 2011 when there were 80 children subject of CP Plans per 10,000. The most significant rise this year has been seen in Stratford District (up from 15 per 10,000 at 31 March 2013 to 27 per 10,000 at 31 March 2014).

The table below shows these figures compared with the estimated rates of child poverty used at 2.2 and 3.2 for CAFs and referrals respectively:

District	Number of CP plans on 31st March per 10 000 children	Estimate of children living in poverty*	Ratio of CP plans to children in poverty
North Warks	52	11%	4.73
Nun & Bed	82	17%	4.82
Rugby	31	11%	2.82
Stratford	27	7%	3.86
Warwick	40	11%	3.64

5.2 CHILDREN SUBJECT OFF A CHILD PROTECTION PLAN AS AT 31st MARCH 2014

As at 31 March 2014, 528 Warwickshire children were subject of a Child Protection Plan in Warwickshire. This is a 4% decrease on the 550 children subject of a plan as at 31st March 2013.



Source: Carefirst

5.3 CHILD PROTECTION POPULATION DEMOGRAPHICS

	31-Mar-12		31-Mar-13		31-Mar-14	
	Number	**%**	**Number**	**%**	**Number**	**%**
Total CP Plans at 31 March	**534**	**100%**	**550**	**100%**	**528**	**100%**
Gender						
Male	276	51.7%	260	47.3%	272	51.5%
Female	249	46.6%	276	50.2%	246	46.6%
Unborn	9	1.7%	14	2.5%	10	1.9%
Age						
Unborn	9	1.7%	14	2.5%	10	1.9%
Under 1	64	12.0%	54	9.8%	55	10.4%
1 to 4	167	31.3%	152	27.6%	148	28.0%
5 to 9	150	28.1%	175	31.8%	156	29.5%
10 to 15	128	24.0%	132	24.0%	139	26.3%
16 - 17	16	3.0%	23	4.2%	20	3.8%
Ethnicity						
White British/Irish/Other	456	85.4%	479	87.1%	473	89.6%
BME	66	12.4%	49	8.9%	43	8.1%
Not Recorded	3	0.6%	8	1.5%	2	0.4%
Unborn	9	1.7%	14	2.5%	10	1.9%
Language Preferred						
English	472	88.4%	476	86.5%	473	89.6%
Non English Speaking	13	2.4%	18	3.3%	9	1.7%
Not Recorded	40	7.5%	42	7.6%	36	6.8%
Unborn	9	1.7%	14	2.5%	10	1.9%
Disability	10	1.9%	8	1.5%	11	2.1%

Source: Carefirst

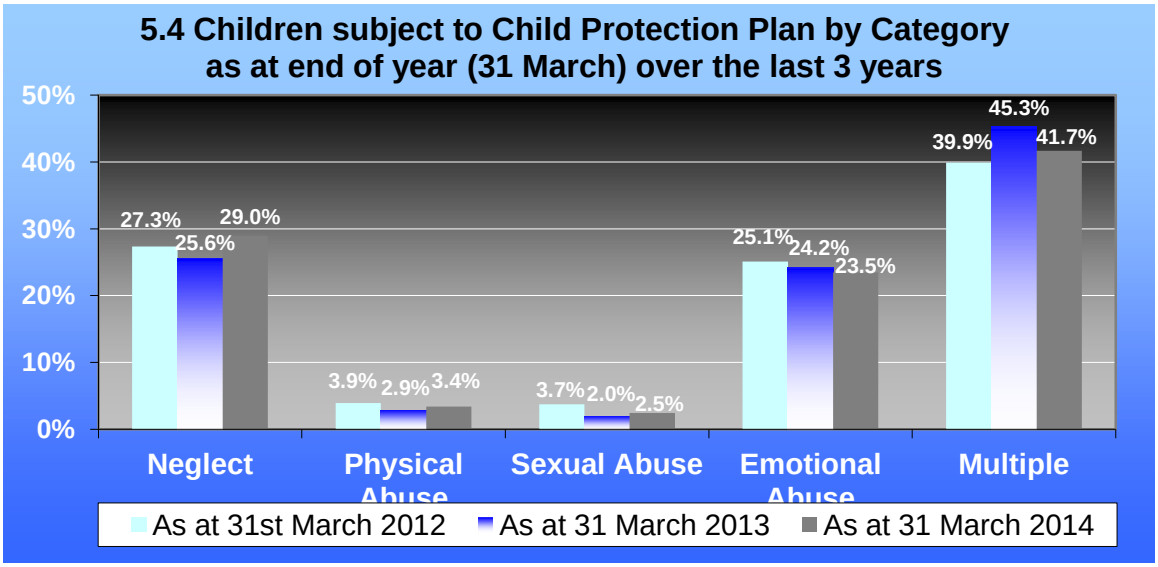
The higher ratio of males than females subject of a CP Plan mirrors the national picture, although last year the reverse was the case in Warwickshire.

As at 31 March 2014, the largest proportion of children subject of a Child Protection Plan in Warwickshire were those aged 5 to 9 which is the same as the previous year. In comparison the largest age group subject of a CP plan nationally were those aged 1 to 4 which is the second largest group in Warwickshire as at 31 March 2014. It is also interesting that the largest proportion of the local Warwickshire 0-17 population are aged 10 to 15 whilst this is the third largest age group of children subject of a CP Plan.

8.1% of children who are subject of a CP Plan in Warwickshire at 31 March 2014 were BME. This is slightly lower than the overall proportion of the general 0-17 population in Warwickshire that are BME (10.6%) but is significantly lower than the national proportion of BME children that are subject of a CP Plan (21.0%). As noted in earlier sections of this report the figures at all points of the safeguarding continuum suggest that the safeguarding needs of some black and minority ethnic children in Warwickshire are not being recognised by the professionals working with them.

The percentage of children with CP plans who are described as having disabilities is also lower than their representation in the general population, mirroring the comments made in section 3, referrals. Whilst the percentage has been increasing slightly over the last three years, it remains about a third of the rate that might be expected based on data about the proportion of children generally who have disabilities. Again, this raises questions about whether this group of children are having their safeguarding needs recognised.

5.4 Chart 5.4 shows the categories under which children were subject of a Child Protection Plan as at 31st March 2014 with the previous year's figures shown for comparison. Increases were seen this year in children under categories of 'Neglect', 'Physical Abuse' and 'Sexual Abuse'. However, a slight decrease was seen in children subject of Child Protection plans under the category of 'Emotional Abuse' and those under 'multiple' categories.



Source: Carefirst

5.5 Number of children who were the subject of a CP Plan at 31 March 2013, by initial and latest category of abuse

	Number of children who were the subject of a child protection plan at 31 March 2013	Initial category of abuse					Latest category of abuse				
		Neglect	Physical Abuse	Sexual Abuse	Emotional Abuse	Multiple[4]	Neglect	Physical Abuse	Sexual Abuse	Emotional Abuse	Multiple[4]
Warwickshire	**550**	**182**	**20**	**11**	**101**	**236**	**141**	**16**	**11**	**133**	**249**
(Percentage)	**100.0**	**33.1%**	**3.6%**	**2.0%**	**18.4%**	**42.9%**	**25.6%**	**2.9%**	**2.0%**	**24.2%**	**45.3%**
England	43,140	17,930	4,670	2,030	13,640	4,870	17,980	4,280	2,030	14,730	4,120
(Percentage)	100.0	41.6%	10.8%	4.7%	31.6%	11.3%	41.7%	9.9%	4.7%	34.1%	9.6%
West Midlands	5,240	2,280	400	290	1,800	470	2,230	390	290	1,910	430
(Percentage)	100.0	43.5%	7.6%	5.5%	34.4%	9.0%	42.6%	7.4%	5.5%	36.5%	8.2%
Statistical Neighbours											
Cheshire East	160	64.4%	x	x	30.0%	0.0%	61.9%	0.0%	x	35.6%	x
Cheshire West and Chester	212	36.3%	21.7%	4.2%	37.7%	0.0%	27.8%	18.4%	4.2%	49.5%	0.0%
East Riding of Yorkshire	234	54.3%	15.0%	6.4%	24.4%	0.0%	52.1%	14.5%	6.4%	26.9%	0.0%
Essex	547	46.4%	6.9%	4.4%	23.2%	19.0%	48.4%	5.3%	4.0%	27.8%	14.4%
Hampshire	909	51.9%	25.0%	6.4%	16.7%	0.0%	51.4%	21.2%	5.9%	21.5%	0.0%
Kent	999	34.7%	2.7%	3.2%	12.8%	46.5%	35.3%	2.0%	3.6%	17.1%	41.9%
Leicestershire	393	13.0%	5.9%	4.8%	9.2%	67.2%	19.6%	3.6%	4.3%	14.5%	58.0%
Northamptonshire	469	28.4%	7.7%	2.1%	24.1%	37.7%	29.6%	7.0%	2.1%	23.0%	38.2%
Staffordshire	535	55.5%	6.9%	5.0%	29.9%	2.6%	55.5%	6.0%	5.4%	30.3%	2.8%
Worcestershire	428	49.5%	6.1%	9.3%	31.8%	3.3%	49.1%	4.2%	8.6%	34.8%	3.3%

Source: Characteristics of Children in Need in England 2012-13 (Published by Department for Education based on Children in Need Census returns for 2012/13)

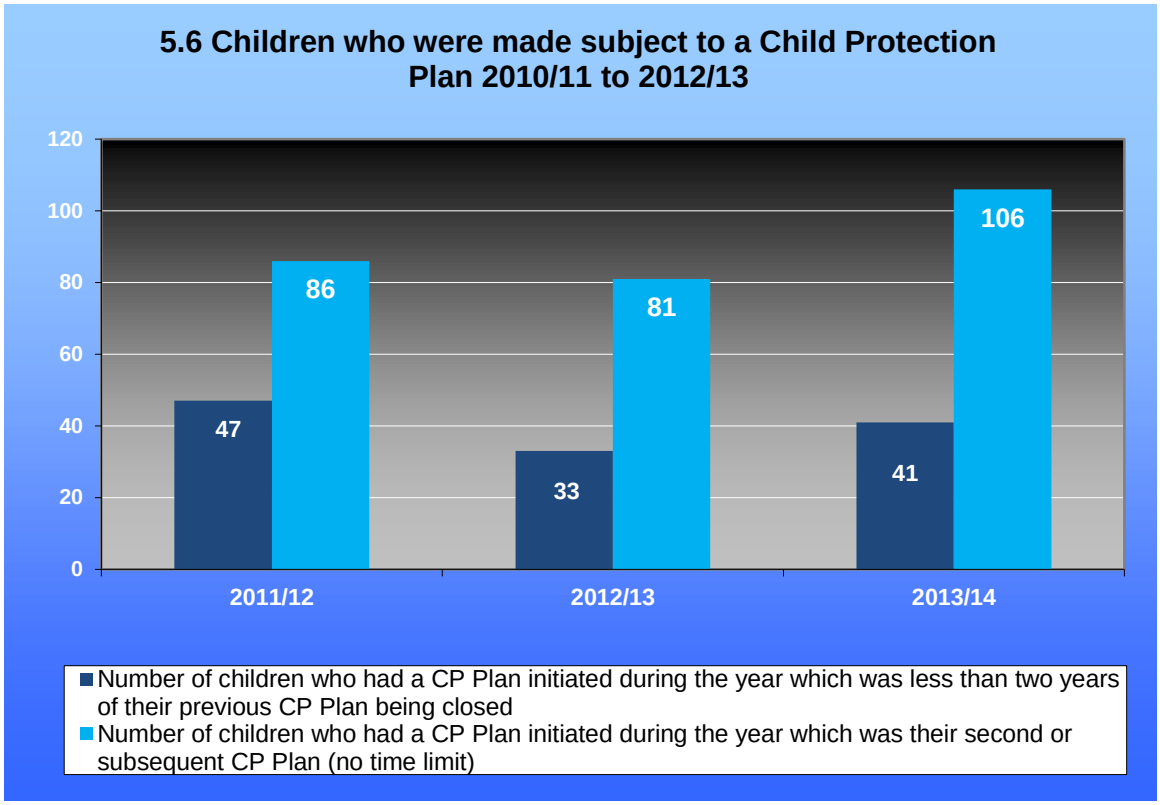
4. The multiple category is for when more than one category of abuse is relevant to the child's current protection plan. It is not for children who have been the subject of more than one child protection plan during the year.
x Any number between 1 and 5 inclusive has been suppressed and replaced by x. There may be some secondary suppression to preserve confidentiality
Source: Carefirst

Warwickshire has a higher proportion of children subject of CP Plans on 'multiple' categories compared to the England/West Midlands average. Of our statistical neighbours, we have the third highest number of children subject of multiple categories both by initial/latest category of abuse (lower than Kent and Leicestershire). From April 2014 we will collect information showing the breakdown of 'multiple' plans so that the underlying reasons for the plan can be better understood.

The comparison, above of the categories of plans of Warwickshire's statistical neighbours shows where 'multiple' is not used, or is little used, neglect and emotional abuse make up a majority of plans.

5.6 Repeat Child Protection Plans.

Chart 5.6 shows the number of children who became the subject of a child protection plan for a second or subsequent time over the last three years. This chart also identifies those who became subject of a child protection plan for a second or subsequent time within less than two years of their previous plan, subject of suggesting the original issues may have been insufficiently resolved.



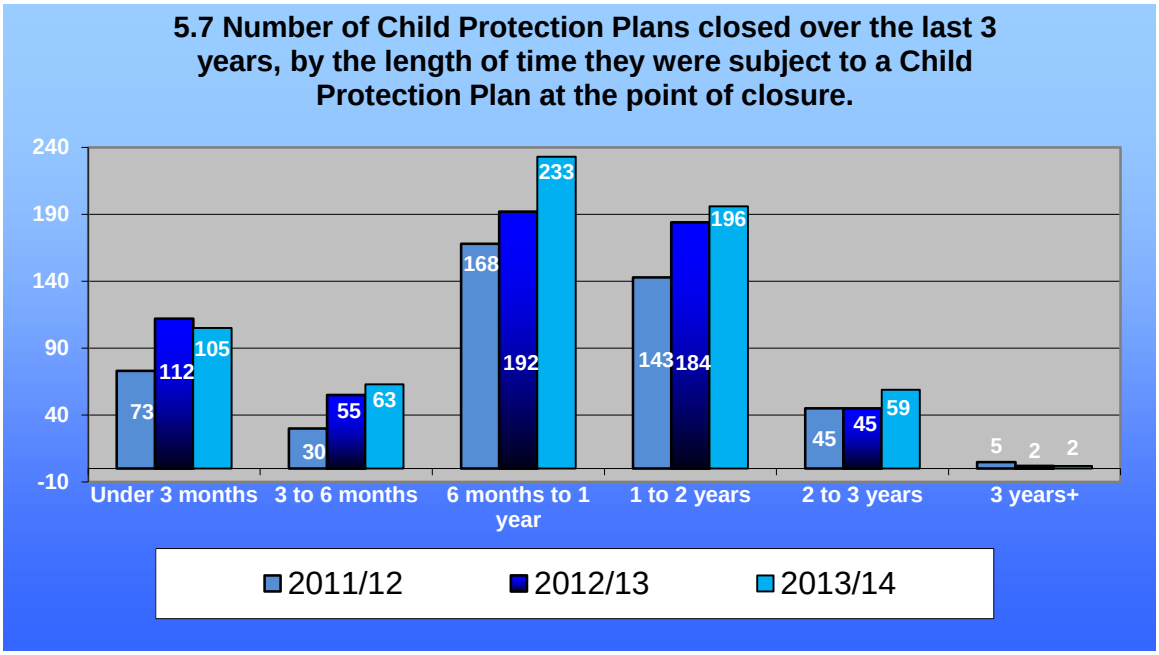
Source: Carefirst

The number of children who became subject of a plan for a second or subsequent time has increased from 81 (13.3%) last year to 106 (16.7%) this year. The number for whom a second or subsequent plan was initiated within 2 years or less of their previous plan having been closed also saw an increase, up from 33 to 41, though it is still lower than in 2011-2012. A large majority of the repeat plans are initiated more than 2 years after the last plan.

Third plans are subject of audit by the Performance panel, but the causes of second plans are currently not well understood. Some of these could be required because of completely new circumstances, but they could also reflect chronic difficulties which re-emerge when professional help is reduced or withdrawn.

5.7 Length of CP Plans.

658 children had their plans closed during the year ending 31st March 2014. This is an increase of 68 (11.5%) when compared with the 590 discontinued during the previous year. Chart 5.7 shows the number of children who had their Child Protection Plans closed during 2013/14, by the length of time they were subject of a Child Protection Plan at the point of closure compared to the previous 2 years.



Source: Carefirst

During 2013/14 the number of child protection plans closed during the year which had been open for two years or more (long plans) saw an increase, up from 8.0% to 9.3%. This is a slight deterioration in performance.

5.8 Long Plans (Closed after 2 years or more)

The table below shows the number of plans closed after being open for 2 years or more as a percentage of all plans closed in the year. In contrast to short plans (lasting 3 months or more) Warwickshire has a much higher rate of children who have their plan closed after being open for 2 years or more when compared to our statistical neighbours (apart from Kent), West Midlands and England out-turn data for 2012/13. This means that the length of time for which professionals judge that the children are suffering or likely to suffer significant harm before a resolution is found is in the main longer than our statistical neighbours.

	Number of Child Protection Plans closed after 2 years or more during 2012-13	Number of children who ceased to be the subject of a plan throughout 2012-13	Percentage of Plans closed after 2 years or more during 2012-13
Warwickshire	**47**	**590**	**8.0**
England	2,690	52,120	5.2
West Midlands	330	6,540	5.1
Statistical Neighbours			
Cheshire East	6	288	2.1
Cheshire West and Chester	8	262	3.1
East Riding of Yorkshire	x	266	X
Essex	28	891	3.1
Hampshire	54	1,031	5.2
Kent	94	1,172	8.0
Leicestershire	31	667	4.6
Northamptonshire	11	497	2.2
Staffordshire	35	556	6.3
Worcestershire	23	479	4.8

Source: Characteristics of Children in Need in England 2012-13 (Published by Department for Education based on Children in Need Census returns for 2012/13)

x Any number between 1 and 5 inclusive has been suppressed and replaced by x. There may be some secondary suppression to preserve confidentiality.

The length of a CP plan is influenced by a range of factors, but the effectiveness of multi-agency assessment, planning and intervention is clearly critical. The Dartington Project initiated some work to better understand what a 'good' plan would look like for children with the profiles of need seen in Warwickshire. This material is going to be used in the inter-agency Core Group training delivered by WSCB, and a new monitoring tool for Reviewing Officers will monitor the engagement of the agencies required for each case in core groups and conferences.

5.9 Short CP Plans (Closed after 3 months)

The table below shows the number of plans closed after 3 months as a percentage of all plans closed in the year. It is worth noting that Warwickshire has a lower rate of children who have their plan closed after being open for only 3 months when compared to the West midlands and England out-turn data for 2012/13. In comparison to our statistical neighbours we are middle of the table compared to the lowest (12.7%) and the highest (23.3%).

	Number of Child Protection Plans closed in 3 months or less during 2012-13	Number of children who ceased to be the subject of a plan throughout 2012-13	Percentage of Plans closed in 3 months or less during 2012-13
Warwickshire	**112**	**590**	**19.0**
England	10,080	52,120	19.3
West Midlands	1,490	6,540	22.7
Statistical Neighbours			
Cheshire East	67	288	23.3
Cheshire West and Chester	39	262	14.9
East Riding of Yorkshire	41	266	15.4
Essex	173	891	19.4
Hampshire	203	1,031	19.7
Kent	219	1,172	18.7
Leicestershire	134	667	20.1
Northamptonshire	99	497	19.9
Staffordshire	113	556	20.3
Worcestershire	61	479	12.7

Source: Characteristics of Children in Need in England 2012-13 (Published by Department for Education based on Children in Need Census returns for 2012/13)

5.10 MARAC

A Multi-Agency Risk Assessment Conference (MARAC) is a multi-agency meeting which domestic abuse victims who have been identified as at high risk of serious harm or homicide are referred to. The MARAC is attended by representatives from a range of statutory and voluntary sector agencies. The primary focus of the MARAC is to safeguard the adult victim. However, taking in to account the UK law which prioritises the safety of children, the MARAC will also make links with other multi-agency meetings and processes to safeguard children and manage the behaviour of the perpetrator. Warwickshire operates three localised MARACs each month which are overseen at county level.

National Indicator: Cases discussed at MARAC Meetings during 2013/14

Total number of cases discussed at MARAC	538	
Number that were repeat cases (within last 12 months)	85	14.95%
Total number of children* in MARAC case households	710	

National Indicator: MARAC cases during 2013/14 by Referring Agency

Referring Agency	**Number**	**%**
Police	468	87.24%
IDVA	16	3.18%
Children's Social Care	1	0.16%
PCT	0	0.00%
Secondary Care/ Acute trust	0	0.00%
Education	0	0.00%
Housing	0	0.00%
Mental Health	1	0.16%
Probation	18	3.36%
Voluntary Sector	12	2.10%
Substance Abuse	0	0.00%
Adult Social Care	0	0.00%
Other	22	3.80%
Total MARAC cases	**538**	**100%**

Currently the police are the main referrer into MARAC, and work is being done in Warwickshire to try and increase the number of referrals from other agencies. Not all victims of domestic abuse report the abuse to the police, and so relying on the police to initiate consideration of cases at MARAC risks failing to intervene in cases which are high risk.

National Indicator: Diversity of MARAC cases

Diversity	Number	%
Number of cases from B&ME community	62	11.53%
Number of LGBT cases	0	0%
Number of cases where victim has registered disability	6	0.98%
Number of male victims	31	5.65%

Local Indicators

Diversity	Number	%
Number of cases with children * in household	368	67.44%
Number of cases with victim over 65 years of age	7	1.30%
Number of cases where victim is pregnant	14	2.49%
Number of cases where HBV reported	2	0.31%
Number of cases with familial DA (non partner)	19	3.46%

*= Under 18 years of age who are not themselves referred as a victim. Does not include pregnancies.

Outcome	Number	%
Risk 'Removed'	48	9.97%
Risk 'Reduced'	113	26.75%
Risk 'Transferred'	5	1.17%
Risk 'Accepted'	256	62.11%
Total = *	422	100.00%

MARAC Attendance 2013/14

AGENCY	No. of MARACs (Total 36)	%
Police	31	86.11%
IDVA	35	97.22%
Children's Social Care	35	97.22%
PCT*	32	88.89%
Secondary Care/ Acute trust	9	25.00%
Education	9	25.00%
Housing	29	80.56%
Mental Health	17	47.22%
Probation	29	80.56%
Voluntary Sector	18	50.00%
Substance Abuse	23	63.89%
Adult Social Care	14	38.89%
Other	13	36.11%

* Still asked to report this although they no longer exist. We record the named nurses against this.

Note there are arrangements in place to receive written information from agencies who are unable to attend.

5.11 SARC Data – number of children seen by age, gender and ethnicity who have been referred

A SARC is a 'one stop location where victims of rape, sexual abuse and serious sexual assault, regardless of gender or age, can receive medical care and counselling, and have the opportunity to assist a police investigation, undergoing a forensic examination, if they so choose.'

(Source: Home Office, Dept of Health, ACPC)

The Blue Sky Centre SARC opened on 27th March 2013, so this data describes its first year of operation. These numbers do not distinguish between children with home addresses in Warwickshire or elsewhere.

Clients seen by age and gender.

Age	
Under 13	41
13-15	54
16-17	36

Gender	
Female	110
Male	21

Vulnerability Factors:

Looked after children	13
Care leaver	2
Mental health needs	9
Language needs	4
Self-injury	3
More than one factor	3

Many children seen are brought in by police or social workers as part of a s.47 child protection investigation, but on 2 occasions Blue Sky Centre made safeguarding referrals for children where this had not already been done. They also raised 130 'safeguarding alerts' in respect of children seen i.e. shared information with other service providers to enable them to safeguard the child concerned.

8. WSCB Business Plan 2014-15

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
A. Create and Maintain a Learning System *Actions continuing from 3 year plan 2012-2013*:			
Hold 11th Annual Conference – theme to be Neglect.	Strategy and Communications subcommittee .	October 2014	Support the development of a WSCB Neglect strategy that supports practice throughout the safeguarding continuum.
Develop Participation strategy in conjunction with WCC	Strategy and Communication sub-committee, with Learning and Improvement Officer		To build the experience of children and young people into our assessment of the effectiveness of safeguarding services, to promote the development of services which children and young people experience positively.
Complete the actions agreed by WSCB in response to the SILP review of Child A; develop action plans in respect of the more complex findings.	'Champions' .	April 2015	Develop the understanding of weaknesses in the safeguarding system identifies in the review; make changes to address these; test how the system is functioning now.
Develop the role of the 'link' WSCB members to ensure WSCB has effective voice in HWBB activities	Chair of WSCB and Chair of H and WB Board	April 2015	To promote mutual understanding of the roles of the two Boards and to facilitate bi-lateral communication, to promote the alignment of priorities between the two Boards.

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
Actions arising out of Learning and Review Activities:			
Undertake review of the WSCB Training strategy.	Inter-agency Learning and Improvement Officer	December 2014	To ensure WSCB partners have clear guidance about the requirements for safeguarding training of their staff. To ensure training offered by WSCB is useful, accessed by the right staff, and results in better safeguarding practice on the front line
Develop new methods of evaluating WSCB Training using WILMA	Inter-agency Learning and Improvement Officer	April 2015	Ensure training is effective in delivering messages and improving practice
Agree new Strategic plan to begin April 2015	Independent Chair	April 2015	To provide focus and clarity to the work undertaken by WSCB.
B. Strengthen Accountabilities *Actions continuing from 3 year plan 2012-2015*:	-		
Implement routine use of performance data at WSCB meetings, including requirement for some agencies to capture new data	Development Manager with Performance, Monitoring and Evaluation sub-committee		Better understand the effectiveness of safeguarding activity

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
Actions arising out of learning and review activities:			
Request update information about agency action plans following inspection recommendations: Probation, Youth Justice, HMIC DA/DV .	Performance, Monitoring and Evaluation sub-committee.		Ensure learning is put into practice and outcomes for children and young people improved
Undertake audit of Deaf children's services	Interim IDS Manager for Performance, Monitoring and Evaluation sub-committee	August 2014	WSCB understand whether the particular safeguarding needs of deaf children are recognised and addressed
. Feed into the action plan for the 'Think Family' Board, and request regular feedback on the progress of this work	WSCB members who sit on Think Family Board	Ongoing	Promote and support effective safeguarding of children whose parents have mental health, drug and substance misuse difficulties
Commission multi-agency audits: Cases on the cusp between early help and statutory social work; effectiveness of MASE meetings; repeat CP plans.	Performance, Monitoring and Evaluation sub-committee	Ongoing	Establish whether children who might benefit from coordinated early help are getting this, and evaluate its effectiveness; Evaluatioin of CSE procedures; understand reasons for repeat plans and therefore increase the effectiveness of first plans.
Develop a framework to support partners undertake audit in respect of the DfE Children's Safeguarding Performance Framework question L10, and request this audit be undertaken. ('How do you know whether children and parents/carers feel that referrals were made at the right time, for the right reasons, by the right agencies?'	Performance, Monitoring and Evaluation sub-committee		To inform the development of service delivery which is appropriately offered to parents and carers and to children and young people in a way which maximises the likely effectiveness.

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
Develop a new training course supporting staff to make and receive referrals for child in need and child protection services, incorporating an understanding of Warwickshire's Thresholds statement and Escalation procedure.	Inter-agency Learning and Improvement Officer	November 2014	Promote understanding of the Thresholds document and Escalation Procedure, improve timely response to families in need.
Actions arising out of new and revised statutory guidance:: Review the impact of new arrangements for WSCB to work with JSNA Programme manager .	Strategy and Communications sub-committee	April 2015	Ensure that WSCB bases its work on needs assessment done by the JNSA, and that need identified by WSCB is fed back to the JSNA for consideration by the Health and Wellbeing Board and Children's
Request information from Coventry and Rugby CCG about their enquiries into how Health provider trusts are satisfying themselves that named and designated staff for child protection have sufficient time, funding, supervision and support to carry out their safeguarding duties	Health sub-committee on behalf of WSCB	August 2014	For WSCB to be satisfied that this statutory requirement is being met, and that arrangements are as required by the Inter-collegiate safeguarding guidance.
Develop arrangements for implementing the scrutiny requirements in the revised guidance on children who runaway or go missing from home	Performance Monitoring and Evaluation sub-committee		Evaluate the effectiveness of interventions to reduce the incidence of children running away, maintain oversight of safeguarding arrangements for looked after children who are the responsibility of Warwickshire agencies,

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
Seek information about the implementation in Warwickshire of the revised Children's Homes regulations, in particular as these relate to the missing children protocol and the CSE strategy.	CSE sub-committee	January 2015	Promote effective safeguarding of looked after children in Warwickshire, and Warwickshire looked after children.
Monitor the implementation of the duties to young carers set out in the Children and Families Act 2014.	Chairs sub-committee	April 2015	For WSCB to be satisfied that this vulnerable group of children and young people are receiving the required support.
Develop performance management structure for the independent chair.	DCS with chairs and Development Manager		To put in place arrangements in Warwickshire which comply with statutory requirements, to ensure that WSCB enjoys strong leadership and is able to carry out its responsibilities to a high standard
Review financial contributions made by partner agencies to WSCB	WSCB, lead by Chair	January 2015	Ensure WSCB has sufficient resources to be strong and effective.
C Promote Effective Practice *Actions continuing from 3 year plan 2012-2015* .	.		
Convene Safer recruitment task and finish group when new LADO in post (expected to be September)	LADO and representatives of partner agencies		To support compliance with statutory guidance, to ensure recruitment practices keep children safe

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
Actions arising out of learning and review			
Produce and disseminate new and revised inter-agency procedures and guidance as required: Recruitment and supervision of staff who work with children Bruising to non-mobile babies Homeless 16 and 17 year olds Recording principles	Systems and Procedures sub-committee		To ensure practitioners have clear guidance supporting sound inter-agency practice
Promote the use of the learning from the Dartington Project to improve the effectiveness of CP plans.	Training sub-committee	April 2015	Reduce the harm caused to children when CP plans are prolonged or repeated.
Provide joint training for adult's and children's practitioners to ensure that needs arising for children as a result of parents' mental health and drug problems are understood, assessed and met	Inter-agency Learning and Improvement Officer and Training subcommittee	*Awaiting guidance from the Think Family Board*	Support "Think Family" protocol and promote effective partnership working
Support the implementation of the' Violence against women and girls strategy'	Independent chair; sub-committees as relevance identified.	continuing	To reduce the number of children living in households where domestic abuse is a feature, reduce sexual exploitation of girls and young women..
Develop a 'Neglect' strategy	Strategy and Communications sub-committee	December 2014	To provide a coherent response to the issues uncovered in case reviews, to increase the effectiveness of responses in Warwickshire to chronic deficits in parenting capacity across the safeguarding continuum, to reduce the harm done to children caused by drift in the management of their services.

Action Required	By Whom	Complete by	Reason for Action and Outcomes Required
Raise awareness of signs and symptoms of child sexual exploitation with parents/carers and the wider community	Strategy and Communications sub-committee	April 2015	CSE strategy – prevention and identification strands
Initiate face to face CSE training in accordance with training strategy..	Learning and Improvement officer and Training sub-committee	.April 2015	• enables professionals to identify signs and risk factors; • ensures practitioners respond in accordance with WSCB procedures; • Increase effectiveness of the response from professionals in Warwickshire to children and young people displaying signs they may be at risk of CSE.
Develop use of WSCB website as a tool for communicating key messages.	WSCB team	April 2015	Increase the effective dissemination of learning, research and information across the partnership.
Develop programme of targeted activities, including a multi-agency workshop, to address the deficits in professionals' knowledge and awareness of CSE identified by the JSNA needs assessment *Actions arising out the revised statutory guidance 'Working Together'*	CSE sub-committee, supported by CSE Working Group		Increase effectiveness of the response from professionals in Warwickshire to children and young people displaying signs they may be at risk of CSE
Monitor the development of procedures for single social work assessment of children in need	Systems and Procedures sub-committee		Required by WT 2013, remove the distinction between initial and core assessments
Monitor the development of protocols for statutory assessment	Systems and Procedures sub-committee		Required by WT2013,Provide clarity for referrers about what to expect when a referral is accepted by Social Care

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Coventry, Solihull & Warwickshire Safeguarding Children Boards

CHILD DEATH OVERVIEW PANELS

ANNUAL REPORT

2013 - 2014

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Appendices

1 The focus for 2013-2014 continued very much as in previous years by aiming to review cases in a timely manner, finalise outstanding areas of work, progressing actions arising from reviews and continually reviewing and improving the process as a whole. The added element for this reporting year is the involvement of parents in the process which is covered in more detail in paragraph 15.1.

2 Deaths reviewed by Child Death Overview Panels (CDOPs) during 2013-2014

18 panels were held across the sub-region during 2013-2014 and **78** deaths were reviewed (87 reviewed in 2012-2013). Of the **78** deaths reviewed, **29** (37%) were identified as having modifiable factors, i.e. where there are factors which may have contributed to vulnerability, ill health or death. This figure is slightly higher than the previous year where **23** (26.4%) had modifiable factors. The breakdown for each LSCB is detailed in the table below:

LSCB	Panels held	Deaths Reviewed	Modifiable Factors
Coventry	6	28	10 (36%)
Solihull	4	17	7 (59%)
Warwickshire	8	33	12 (36%)
Total	**18**	**78**	**29 (37%)**

2.1 Of the 6 Coventry panels held, 5 were full CDOPs and one a Fast Track CDOP. Solihull held 4 full CDOPs. Warwickshire held 6 full CDOPs and 2 Fast Tack CDOPs.

3 Recommendations and actions arising from Coventry CDOP during 2013-2014

12 actions arose from deaths reviewed during 2013-2014. The following is a summary of the learning identified from the deaths reviewed:

3.1 Sudden Infant Death Syndrome (SIDS)

Coventry CDOP reviewed 2 deaths from SIDS during 2013-2014. Both had modifiable factors as unsafe sleeping, i.e. co-sleeping was a contributory factor in both and both families were considered to be vulnerable. One death which identified further contributory factors including alcohol consumption, was subject of a Serious Case Review (SCR) and CDOP endorsed the learning and recommendations identified in the SCR. One recommendation from the SCR was to write to the Department for Education and Department of Health to commission research in this area so that a more targeted approach might become national policy in relation to particularly vulnerable families as these are clearly preventable deaths and action is required to remedy this. The CDOP Manager assisted with the letter sent to the Secretary of State, Mr Gove, by providing the LSCB Chair with SIDS data and learning from CDOP reviews, which supported the need for a targeted approach with vulnerable families.

3.1.1 A reply was received from Mr Gove who stated that as part of their work on the national repository of SCRs, the NSPCC published a thematic briefing on learning from the review of cases involving parental substance misuse. This briefing also includes several references to the risks of co-sleeping and a number of recommendations around assessment, professional awareness and skills. Mr Gove stated that his department would continue to maintain an overview of the key messages which are emerging from SCRs for both local agencies and central government.

3.1.2 CDOP commenced a review into a 3rd SIDS death but this was postponed and referred to the Serious Case Review Subgroup for consideration of a Serious Case Review, due to the risk factors identified. A response was subsequently received from the LSCB Chair

outlining why the criteria for an SCR was not met and welcomed any findings from the CDOP review, which will now take place during year 2014-2015.

3.1.3 Further work has been conducted across the sub-region in 2013-2014, in relation to SIDS, focusing on the more vulnerable families. This is outlined in more detail in paragraph 7.5.

3.1.4 CDOP also reviewed the unlawful death of a child which was also subject of a criminal investigation and a Serious Case Review. CDOP endorsed the learning, recommendations and actions arising from the Serious Case Review.

3.2 Modifiable deaths where no actions were identified.
The learning highlighted in paragraph 3.1 relates to deaths where CDOP concluded there were modifiable factors. There were however additional deaths reviewed where modifiable factors were identified but CDOP did not identify any actions. These deaths included:

3.2.1 Neonatal deaths due to prematurity where maternal smoking during pregnancy contributed to premature labour and where the review identified that appropriate referrals were made antenatally to smoking cessation.

3.2.2 Third party or parental misjudgement resulting in accidental deaths, i.e. road traffic collisions and drowning.

3.2.3 Where consanguinity (parents are blood related) was a factor in a chromosomal/genetic condition.

3.3 Learning identified where no modifiable factors were identified
Conversely there was learning and actions identified in reviews where no modifiable factors were identified, in other words, deaths which were not preventable, as follows:

3.3.1 Following on from the work conducted in 2012-2013 to promote the 'Headsmart' project to raise GP's awareness of brain tumour symptoms in children, CDOP reviewed a further death where a child made a number of presentations to a GP prior to diagnosis. Although the outcome for this child would not have changed, a further opportunity was taken to raise the awareness of 'Headsmart and CDOP learning at a Paediatric 'Protected Learning Time' session for GPs.

3.3.2 In the review of a neonate who died at a hospital outside the area, the Health Visitor conducted a home visit, unaware that the baby had died. Notification protocols were ascertained with the hospital concerned and were found to be robust. The delay in communication was due to internal processes and Coventry Child Health was reminded of the urgency to share such information.

3.3.3 In the review of a baby who died from a life limiting condition shortly after birth, the panel considered that Mother should have been on a 'high risk' care pathway due to her previous obstetric history as opposed to a 'low risk' care pathway and this was conveyed to the hospital concerned.

3.3.4 In the review of a premature baby, it was identified that a partogram (a graph used during labour which at a glance identifies changes and deviations from the norm) was not used during labour. This was fed back to the Head of Midwifery at the hospital concerned.

3.3.5. The review of an infant who died suddenly whilst an in-patient from an undiagnosed congenital heart condition was subject of an internal review by a senior Consultant

Paediatrician at the hospital concerned. It was observed that the standard of medical and nursing notes/observation charts were high and as expected the overall clinical responsibility for this child moved from one consultant to another from day to day where in the main handovers were good, however there was some learning identified as follows: (i) a cardiac diagnosis was considered but not re-visited (ii) some x-rays were not reviewed with the radiologists and (iii) some investigations marked urgent were not followed through or not commented on by subsequent Consultants doing the ward round.

3.3.5.1 No actions were identified from the internal review but this case has been discussed internally at the hospital's Quality Improvement and Patient Safety Committee (QIPS) and will also be discussed at a future audit meeting.

3.3.5.2 When this case was reviewed at CDOP an action was identified to enquire if surviving siblings had been investigated for this condition

3.3.6 In a 'Root Cause Analysis' investigation conducted by the hospital concerned following the death of a full term baby from intrapartum hypoxia (lack of oxygen during delivery) one of the recommendations was 'The use of ultrasound scan to confirm the fetal heart in a woman with a raised BMI > 35 and to update the Obesity guideline. Following the review CDOP sought how this would be achieved as there is no facility to conduct ultrasound scanning at certain times of the day. A response was received from the hospital stating the service would be available 24 hours a day.

4 Recommendations and actions arising from Solihull CDOP during 2013-2014

27 actions arose from deaths reviewed during 2013-2014. The following is a summary of the learning identified from the deaths reviewed:

4.1 CDOP reviewed the death of a young person who accidentally asphyxiated by becoming entangled with an object suspended from their bunk bed. This death was also subject to a 'Significant Incident Learning Process' (SILP) review which identified learning and recommendations to Solihull LSCB which the CDOP endorsed.

4.1.1 It was also identified that this was the 4th death in similar circumstances across the sub-region. A recommendation was therefore made to Solihull LSCB that the learning be disseminated to all Early Year practitioners to advise parents and carers of the dangers.

4.1.2 The CDOP learning was also shared with other CDOPs across the country and contact made with the Child Accident Prevention Trust (CAPT) who highlighted the dangers in their monthly newsletter.

4.2 CDOP ascertained that a young driver killed in a road traffic collision was undergoing neurological investigations for vacant episodes at the time but had not been advised against driving as his locum Consultant believed the minimum age for driving in the UK was 18 years. CDOP sought reassurance from the hospital concerned that locums, particularly those coming to work in the UK are conversant with UK laws. CDOP also sought assurance from the hospital concerned that in addition to advice against driving, the advice given should include abstaining from certain sports and operating machinery etc.

4.3 The review of a neonate who required surgery identified that no PICU beds were available at the local specialist hospital and the child was too unstable to transfer to the nearest bed available 100 miles away. Although the unavailability of a PICU bed locally did not contribute to the death, CDOP did highlight this to the local specialist hospital who informed CDOP that a regional review of PICU beds had taken place, the outcome of which will be shared with CDOP when completed.

4.4 In the review of a neonate who died shortly after birth at 21 weeks gestation, contributory factors were identified as maternal smoking during pregnancy and other physical health issues including a raised BMI of 44. CDOP sought reassurance that Mother was referred to smoking cessation and for weight management support.

4.5 In the review of another neonate who died shortly after birth at 29 weeks gestation, it was ascertained that the GP had referred Mother to the Alcohol Service due to her drinking 6 weeks before her pregnancy was confirmed, however this information was not communicated by the GP Practice to the Community Midwifery Services. Although alcohol consumption was not a contributory factor to prematurity (maternal smoking was) CDOP communicated with the GP practice to ensure that processes were in place to ensure that all relevant information is passed on to Midwifery Services.

4.6 *Modifiable deaths where no actions were identified.*
The learning highlighted in paragraphs 4.1 to 4.5 relate to deaths where CDOP concluded there were modifiable factors and actions were identified. There was however a further neonatal death reviewed where excessive alcohol consumption pre-pregnancy and maternal smoking during pregnancy were known links to the medical condition which caused death, however no actions were identified as Mother had been referred to smoking cessation but had declined the service.

4.7 Learning identified where no modifiable factors were identified
Conversely there was learning and actions identified in reviews where no modifiable factors were identified, in other words, deaths which were not preventable, as follows:

4.7.1 In the review of a child who died from a brain tumour, CDOP identified that this child had presented to A&E with frontal band type headaches which were considered to be a migraine. A further presentation to the GP with the same symptoms also concluded migraine. A diagnosis was made following a second visit to A&E. Whilst it was acknowledged that an earlier diagnosis would not have changed the outcome for this child, contact was made with the GP Practice and A&E concerned to ascertain if there were any 'red flag' symptoms present which may have prompted an urgent referral.

4.7.2 An action was also identified to disseminate information to GPs on 'Headsmart' a project aimed at raising the awareness of brain tumour symptoms in children, as was done in Coventry.

4.8 In the review of an infant who died unexpectedly from an undiagnosed heart condition, a number of learning points were identified by the 'Rapid Response' investigation as per the Sudden and Unexpected Death in Children (SUDC) Protocol and the CDOP review namely; swabs taken during a previous hospital admission were mislaid and during resuscitation more than the recommended dose of adrenaline was given. Whilst neither of these factors contributed to this child's death, CDOP enquired from the hospital concerned if both were flagged as incidents, what learning has been identified and if any measures have been put in place to prevent a reoccurrence.

4.8.1 The same review also identified that an infant blood pressure cuff was not available in the ambulance conveying the child to hospital. As before, this did not contribute in any way towards the death but an action was identified to clarify with West Midlands Ambulance Service their policy on infant blood pressure cuffs in ambulances.

4.9 Miscellaneous actions:

4.9.1 A number of actions were identified to ascertain the welfare and on-going support for bereaved siblings.

4.9.2 Specific actions were identified to raise awareness of the requirements of a multi-agency 'Rapid Response' investigation as per the Sudden and Unexpected Deaths in Children (SUDC) Protocol.

4.9.3 A number of actions were identified for specific service providers, either to (ii) request additional information, (ii) seek clarification on local learning and practices put in place or (iii) feedback learning from CDOP reviews.

5 Recommendations and actions arising from Warwickshire CDOP during 2013-2014

33 actions arose from deaths reviewed during 2013-2014. The following is a summary of the learning identified from the deaths reviewed:

5.1 Following the death of a toddler who climbed onto an insecurely fixed fireplace which came away from the wall and fell on the child, links were made with Trading Standards, the Royal Society for the Prevention of Accidents (RoSPA) and the Child Accident Prevention Trust (CAPT) to raise awareness of the importance of having fireplaces and surrounds professionally fitted.

5.2 The review of a death from Sudden Infant Death Syndrome (SIDS) where baby was co-sleeping with Mum on a sofa was referred to Warwickshire LSCB Special Cases Subgroup for consideration of a Serious Case Review after the review ascertained that a number of professionals were involved with Mum, who at the time of death was staying with relatives after being made homeless. The criteria for a Serious Case Review was met and is ongoing.

5.3 In the review of another SIDs death where baby was co-sleeping with Mum, actions were identified to ensure Mum received professionals support due to a history of mental ill health and to look for any research published with regards to the use of anti-depressants and a link with excessive drowsiness or sleepiness (no published research was found).

5.4 The review of a young person who died from a brain tumour identified that 7 presentations were made to a GP and a further 3 with other health professionals in a two week period before diagnostic investigations were conducted. A recommendation was made for all GPs to be made aware of 'Headsmart' a project aimed at raising the awareness of brain tumour symptoms in children and young persons. This was an action already pursued by Coventry CDOP after reviewing deaths in similar circumstances and you will note a similar action arising from Solihull CDOP which demonstrates the effective sub-regional arrangement of sharing learning and actions across the three LSCB areas.

5.5 Another example of where learning has been shared across the sub-region relates to the review of 4 deaths across the sub-region from accidental asphyxiation as a result of children becoming entangled in objects suspended from bunk type beds. A recommendation was made initially by Coventry CDOP in 2012-2013 to disseminate the learning to all Early Years Practitioners to advise parents and carers of the dangers. This was also endorsed by Solihull CDOP when reviewing a similar death, as outlined in paragraph 4.1. As Warwickshire CDOP had reviewed two deaths in previous years a recommendation was made to Warwickshire LSCB to disseminate the learning to all Early Years practitioners.

5.5.1 Contact was also made with the Child Accident Prevention Trust (CAPT) who highlighted the dangers in their monthly newsletter.

5.6 The review of a young person with a complex medical history who died from complications three weeks after undergoing a high risk surgical procedure, identified that

this young person had been discharged from an out of area specialist hospital without a clear structured discharge plan which resulted in (i) poor communication between the hospital and community health service providers (ii) limited direct follow up in the three weeks following the operation, relying on Mum to initiate any further medical contact (iii) no indication as to what advice Mum was given by the discharging hospital.

5.6.1 CDOP wrote to the Clinical Director of the hospital concerned to ascertain what their procedure is with regards to providing structured plans on discharge.

5.6.2 It was noted that the Community Children's Nursing Service (CCNS) were aware of this young person's discharge and feedback was given to the CCNS to advise that if a child is being discharged from hospital into the community and a discharge summary/plan is not received they should be proactive and make contact with the hospital.

5.7 Neonatal deaths:

A number of reviews were conducted where learning was identified. The following cases were all subject of an internal review conducted by the hospital concerned, either by a Root Cause Analysis or at an internal review meeting. The learning and actions identified were shared with CDOP.

5.7.1 Following the review of a premature baby who died within a day of birth from Intra Ventricular Haemorrhages, a Root Cause Analysis identified sub-optimal care following Mum's admission with abdominal pain at 27 weeks gestation. The root cause was due to human error by not assessing the baby's condition accurately, poor documentation with no clear management plan and failing to fully inform the on call consultant. Recommendations made were to (i) Reinforce the importance of accurate documentation through meetings with junior and senior clinicians in both Maternity and Neonatology (ii) Review key policies to provide explicit guidance to staff (iii) Educate staff on communication regarding their interactions with each other and patients (iv) Reinforce the need to involve the most senior available Obstetrician and Neonatologist in the management plan and attend delivery when it is anticipated to be difficult.

5.7.2 CDOP endorsed the learning and actions but requested that in future, action plans include an audit column to outline updates.

5.8 A premature baby transferred to an out of area hospital at 26 weeks gestation subsequently died following an outbreak of Serratia Marcescens Infection (a deadly bacterium) in the intensive care room of the neonatal unit. An internal review and a coronial investigation identified that the infection was spread on the unit by human contact. The hospital concerned identified a number of recommendations to improve hygiene as well as learning on how the infection was controlled. This learning was endorsed by CDOP and a recommendation was made to share the learning with all of our sub-regional Neonatal Units.

5.9 The review of a 6 day old full term baby who died from a form of meningitis identified that Mum had telephoned the postnatal ward at the hospital concerned on two occasions voicing concerns. The member of staff who took the second call wasn't aware that Mum had telephoned previously and as a consequence the serious nature wasn't recognised and appropriate advice was not given, which delayed treatment. The Root Cause Analysis identified the following learning: (i) All telephone assessments and advice given should be documented as this will ensure high quality, safe care. (ii) If a person calls for advice on more than one occasion the records of previous telephone calls must be reviewed to ensure that safe and appropriate advice is given.(iii) The hospital's guideline 'Early Onset Neonatal Infection Detection and Management' needs to be ratified and implemented into clinical practice as soon as possible. (iv) The changes made to the

hospital's 'Care of Women in Labour Guideline' needs to be disseminated and implemented into clinical practice as soon as possible. Recommendations made were to: (i) Develop a telephone assessment form for the postnatal ward (ii) Ensure that there is a process in place for the review of previous calls made to the postnatal ward (iii) Complete and disseminate the guidelines referred to.

5.10 A premature baby at 23 weeks and 5 days gestation, born at a local hospital and transferred shortly after birth to an out of area hospital, was reviewed at the local hospital's Critical Incident meeting. One of the learning points related to the use of antenatal steroids. (Steroids are prescribed to Mums likely to have a premature birth to promote the development of baby's lungs together with other benefits). Giving steroids to Mum was considered on her admission and a decision was made not to give them. In retrospect, whilst it was recognised that steroids would only have had a minimal effect, it was felt that Mum should have been given steroids at 23 and 5 days gestation. The internal review also identified that in retrospect Mum should have been transferred 'in-utero' to a hospital with a Neonatal Unit. Current hospital policy stipulated that transfers should not be done before 24 weeks gestation, however in light of this review the hospital's guidelines and care pathway has been amended to reflect this.

5.11 Modifiable deaths where no actions were identified.
The learning highlighted in paragraphs 5.1 to 5.10 relate to deaths where CDOP concluded there were modifiable factors and actions were identified. There were however a further three neonatal deaths reviewed where modifiable factors were attributed to a combination of (i) maternal smoking during pregnancy (ii) use of cannabis during pregnancy and (iii) maternal obesity. No actions were identified as appropriate referrals were made and CDOP acknowledged Warwickshire Public Health's ongoing campaign to reduce maternal smoking.

5.12 Learning identified where no modifiable factors were identified
Conversely there was learning and actions identified in reviews where no modifiable factors were identified, in other words, deaths which were not preventable, as follows:

5.12.1 Following the review of a young person at secondary school who had a known congenital heart disease, CDOP sought to establish the process for involving the School Nursing Service and how medical information was shared after it was ascertained that the School Nursing Service had not been fully involved. An action was identified for the Education Safeguarding Manager to write to all Head Teachers to remind schools to be proactive and link in with the School Nursing Service when a pupil has, or is diagnosed with a medical condition.

5.13 The review of a toddler who died unexpectedly from cardiac failure was admitted on three occasions in the month prior to their death. During admission the possibility of a heart condition was considered but not followed through. A root cause analysis conducted by the hospital concerned identified that there was (i) a delayed recognition of the development of cardiac failure (ii) an incomplete interpretation of an echocardiogram (ECG) conducted on the third admission (iii) a failure to regularly measure blood pressure and include this in the Paediatric Early Warning Score (PEWS - a system used in A&E and acute wards to assess the severity of symptoms according to the score).
(iv) use of single episode notes used on the ward leading to a lack of availability of past clinical records (v) a poor transfer of information across healthcare organisations leading to the over reliance on information from parents (vi) a different Consultant covering the ward each day resulting in a lack of continuity of care.

5.13.1 Some of the recommendations and actions made are as follows: (i) Implement a 'Consultant of the Week' system as part of the service design (ii) Implement a documented 'Consultant to Consultant' handover (iii) Improve the documented discharge processes to involve Parents/Guardians (iv) Improve healthcare records and improve accessibility to them (v) Ensure improved access to echocardiography for inpatients built into service redesign pathways (vi) Regular refreshment of all Paediatrician's ECG interpretation skills (vii) A refreshment of Clinical Staff's understanding of PEWS.

5.13.2 Having reviewed all of the information CDOP conclude that death would not have been preventable but the child's care would have been managed better if a diagnosis had been made sooner.

5.13.3 CDOP also identified that this was a poorly child who was under the care of a number of specialists and had been subject to numerous investigations and it was clearly documented that this child was distressed and in pain whilst in hospital. CDOP made an observation of the importance of taking into consideration a child's wellbeing when being investigated for medical conditions and wished this to be noted in the annual report. CDOP also identified an action that the learning be shared at a future Continuous Professional Development (CPD) meeting attended by Warwickshire Paediatricians.

5.14 In the review of a premature baby born at 23 weeks gestation who died from prematurity and sepsis contracted from Mum, it was known that Mum was taken to hospital by ambulance the day before giving birth, feeling unwell with a high temperature, abdominal pain and reduced fetal movements. Mum was given oral antibiotics and discharged home with a plan to be seen in the antenatal outpatients clinic the following day. Mum however was admitted again the following day via ambulance with pain and a high temperature and went into spontaneous labour. Resuscitation was attempted but due to the poor prognosis treat was withdrawn. This death was reviewed at the hospital's internal Clinical Incident meeting and the learning concluded that Mum should have been admitted following her first presentation to hospital and given intravenous antibiotics. Following the review it was also agreed to increase Consultant presence to 60 hours per week on the labour ward, providing an additional two Consultants. Feedback was also given to clinical and midwifery staff providing care to Mum.

5.14.1 CDOP concluded that this baby's death could not have been prevented but acknowledged the learning identified and actions put in place.

5.15 In the review of a neonate born prematurely at 27 weeks and diagnosed with a number of complex medical conditions following birth, the panel was aware that this baby had been diagnosed antenatally with a medical condition. Mum was referred to a specialist hospital but remained on a low risk Midwifery led care pathway. Although this did not contribute to baby's death, the panel concluded that Mum's risk should have been re-assessed and changed to Consultant led care. This was fed back to the hospital concerned and shared with staff.

5.16 In the review of a neonate born very early at 22 weeks gestation, CDOP noted that Father was used as an interpreter for Mum at the initial pre-booked antenatal appointment and on subsequent occasions. Whilst CDOP acknowledged that this may have to be the case in dynamic situations, the panel was concerned that an interpreter was not used at the first pre-booked appointment which inhibited the midwife booking the pregnancy to ask the routine question around domestic abuse. CDOP therefore wrote to the hospital concerned to clarify they had a policy on the use of interpreters (which they did) and to reinforce compliance with hospital staff.

5.17 In the review of a young person who was a front seat passenger in a stolen vehicle and ejected from the vehicle due to not wearing a seat belt, the panel was aware that this young person had a background of offending and risky behaviour and was known to Warwickshire Youth Justice Service (WYJS) as an active case at the time of death. In view of this WYJS conducted a 'Critical Learning Review' which was shared with CDOP. CDOP was also made aware of the complex family history of this young person as well as the young driver and passenger who survived the collision. The Operations Manager from WYJS and the Police Senior Investigating Officer attended to assist and contribute to the review. CDOP concluded that there were no modifiable factors however actions were identified to (i) ensure support for the family which included contact with the school to ascertain the well-being of surviving siblings and support offered (ii) enquiries to ensure that appropriate referrals and action were made and taken in relation to historical domestic violence (which they were). (iii) The Critical Learning Review also identified some internal learning for Warwickshire Youth Justice Service with regards to their processes and actions identified.

5.17.1 Every review is a holistic review, not just looking into the circumstances relating to death but also encompassing family and environment, parenting capacity, service provision and follow up plans for the family and this particular case demonstrates this, as well as the benefits of inviting professionals involved with the death and/or family to contribute to the review.

5.18 Miscellaneous actions:

5.18.1 A number of actions were identified to make contact with schools to ascertain the welfare and on-going support for bereaved siblings.

5.18.2 Actions were identified to ensure professional support was in place for bereaved parent(s).

5.18.3 Actions were also identified to ensure the safeguarding of siblings and effective communication between professionals.

15.8.4 A number of actions were identified for specific service providers, either to request additional information or feedback learning from reviews.

5.18.5 Warwickshire CDOP has made contact with the NHS Area Team with a view to securing GP representation on the panel, recognising that there is a gap in expertise in this area.

5.18.6 Dialogue is taking place with West Midlands Ambulance Service in relation to transporting deceased children to hospital as opposed to utilising undertakers which has impacted on the timeliness of obtaining necessary samples in some cases.

5.18.7 Specific actions were identified to raise awareness of the requirements of a multi-agency 'Rapid Response' investigation as per the Sudden and Unexpected Deaths in Children (SUDC) Protocol in deaths where the protocol was not followed.

5.18.8 A working group has been agreed to review the Warwickshire Multi Agency Sudden and Unexpected Deaths in Children (SUDC) Protocol.

Generic themes identified in the categories of deaths reviewed during 2013-2014

6 Neonatal deaths

As in the previous year, neonatal deaths were the highest category of deaths reviewed during 2013-2014 accounting for 36% (**31**out of **87**) of the total reviewed. Of the **31** deaths reviewed, modifiable factors were identified in **12** (39%) deaths and no modifiable factors were identified in **19** (61%). This ratio is slightly higher than 2012-2013 (31% modifiable, 69% no modifiable factors). In **9** out of **12** neonatal deaths reviewed where modifiable factors were identified, maternal smoking during pregnancy was identified as a contributory factor to premature labour and subsequent vulnerability of baby. To a lesser extent maternal obesity and maternal alcohol consumption and substance misuse during pregnancy were also contributory factors.

6.1 In the other 3 neonatal deaths reviewed where modifiable factors were identified, contributory factors were suboptimal intra-partum or neonatal care and access to health care as outlined in more detail in paragraphs 3 - 5.

6.2 The findings in 2013-2014 are in complete contrast to the previous year where in 2012-2013 the majority of modifiable factors (9 in 13 of deaths reviewed) related to service provision, compared to 4 out of 13 where modifiable factors attributed to maternal lifestyle.

6.3 We are fortunate as a sub-region to continue to have the complete co-operation of our local hospitals (and out of area hospitals for that matter) in providing their 'Root Cause Analysis' reports and action plans as well as feedback from internal review meetings, which greatly assists the CDOP review.

6.4 With regards to the number of neonatal deaths notified during 2013-2014, there were 43 neonatal deaths notified across the sub-region which is a collective increase of 28% across the region compared to 2012 -2013 (31 in 2013-13 and 43 in 2013-2014). The increases have notably risen in Solihull and Warwickshire.

7 Sudden and Unexpected Deaths

18 deaths were reviewed during 2013 – 2014 across the sub-region; the next highest category to neonatal deaths. **5** of the deaths reviewed occurred in the year 2011-2012 and were all subject of lengthy investigations, i.e. Police, Coronial, Serious Case Review, Significant Incident Learning Process (SILP), or a combination, prior to the CDOP review which accounts for the delay. **8** deaths occurred in 2012-2013 and **5** in 2013- 2014. A breakdown of the type or cause of death is as follows:

5 = Medical cause ascertained (i.e. previously undiagnosed heart condition, meningitis, and septicaemia)
5 = Road Traffic Collision
3 = Accidental death due to external factors (i.e. drowning, accidental asphyxiation and other trauma)
4 = Sudden Infant Death Syndrome
1 = Unlawful killing

7.1 With regards to the deaths from medical causes, all are outlined in paragraphs 3 - 5 as learning was identified from them all irrespective of whether modifiable factors were identified.

7.2 It is worthy of mention that the 3 deaths from a previously undiagnosed heart condition were all subject of ongoing tests, were in-patients in hospital either at the time of death or discharged shortly prior and in two cases a heart condition had been considered

whilst the children were in-patients but not pursued. It is also important to point out that this learning has, or will be, discussed and shared at internal Paediatric Continuous Professional Development meetings by the hospitals concerned.

7.3 Of the 5 deaths reviewed as a result of road traffic collisions, no patterns were identified with regards to location as they occurred in different areas (two outside the West Midlands region) and were a combination of passengers and drivers in a varied age group. That said, non- compliance with wearing seat belts by passengers was a contributory factor in 2 of the deaths.

7.3.1 Since the start of the child death review process in April 2008, CDOPs have reviewed a total of **5** deaths (including the 2 mentioned in 7.3) where the non-wearing of seatbelts was identified as a contributory factor. 4 occurred in the Coventry or Warwickshire area and one out of area. From the discussions at the review, police officers from the Road Fatality Investigation Unit, do routinely enforce the non-wearing of seatbelts and therefore no additional actions have been identified to date.

7.3.2 Two of the deaths from road traffic collisions were caused by collisions from the rear, due to the offending vehicle travelling too fast for the circumstances. In both cases the children that died were sitting in the rear, correctly restrained and in both cases the offending drivers were convicted of causing their deaths by dangerous driving.

7.3.3 CDOP has reviewed a total of **4** deaths caused by rear collisions since April 2008 (including the 2 mentioned in paragraph 7.3.2.) All of them occurred out of the sub-regional area, either on motorways or dual carriageways. It has been difficult for panels to identify any actions to prevent against these collisions but if there is anything positive to be gleaned from these tragic deaths, the offending drivers in all 4 deaths were convicted of causing death by dangerous driving and the dangers highlighted in the media.

7.4 *Rapid Response investigations*

7.4.1 **9** of the 18 unexpected deaths were subject of a multi-agency rapid response investigation under the Sudden and Unexpected Deaths in Children (SUDC) Protocol.

7.4.2 A further **5** (the 5 road traffic collisions) were subject of a police investigation on behalf of the Coroner. In 3 deaths prosecutions for causing death by dangerous driving followed. No prosecutions were pursued in the other two.

7.4.3 Of the remaining 4 deaths, **3** children died whilst either an inpatient or shortly after presentation at A&E. All were subject of an internal review conducted by the hospitals concerned and learning identified, as outlined in paragraphs 3.3.5, 5.9 and 5.13.

7.4.4 The remaining death occurred abroad whilst on a family holiday. Attempts were made to obtain information from the police where death occurred but unfortunately this was not forthcoming. Obtaining information on deaths occurring abroad is problematic and this is highlighted further under ‘Processes’ in paragraph 15.2

7.4.5 The 2012-2013 CDOP Annual Report highlighted a review where a ‘Rapid Response’ investigation was not initiated and an action was identified to raise awareness with the police. Rather than wait for the review which can take several months, any operational issues in relation to the multi-agency SUDC Protocol are now highlighted at the next available panel under ‘Operational Issues’ so that timely action can be initiated. The actions outlined in paragraphs 5.18.6- 5.18.8 relate to operational issues highlighted from deaths in 2013-2014 which are yet to be reviewed.

7.4.6 Further information on what a 'Rapid Response' investigation entails is outlined in Appendix 'D'.

7.5 Sudden Infant Death Syndrome (SIDS)

4 SIDS deaths were reviewed during 2013-2014. An unsafe sleeping environment i.e. co-sleeping with an adult in either an adult bed or on a sofa was identified as a contributory factor in all 4 deaths and in 2, maternal smoking was also a contributory factor.

7.5.1 The 2012-2013 CDOP Annual Report makes reference to work being conducted around implementing a SIDS Risk Assessment Tool which Community Midwives would complete at the first home visit post discharge, conduct a physical check of where baby sleeps (both night and day time sleeps) and agree an action plan with parent(s) if any risks are identified. The Health Visitor will then follow up and any other professionals involved with the family will also be made aware of any risks so that safe sleeping messages can be reinforced.

7.5.2 In November 2013 Solihull Public Health, Children's Health Team, organised a conference to highlight their priorities for 0-5 year olds which includes the prevention of SIDS. The conference was supported by The Lullaby Trust (formerly the Foundation into the Study of Infant Deaths) who gave an excellent presentation on the evidence based research on the risks and characteristics of SIDS. The conference was well attended by a good cross section of health professionals and was well received. It was proposed that Solihull Health Visiting Service would conduct the initial risk assessment at the primary visit and views were sought from delegates. This is still being considered by the Health Visiting Service.

7.5.3 In March 2014 the CDOP Manager arranged training for key Midwifery and Health Visiting leads from Coventry and Warwickshire so they could cascade the training within their own services. The training provided them with evidence based research on the risks of SIDS and the key elements of conducting the SIDS risk assessment. Delegates were also given Coventry and Warwickshire SIDS data from 2008- 2013, outlining the most prevalent risks. This was based on a model produced by Rotherham NHS which identifies the 15 most prevalent risks and characteristics of SIDS. Rotherham Public Health kindly transposed our local data onto their model free of charge, which is a useful tool for health professionals when conveying the risks to parent(s). (Data was produced for Coventry and Warwickshire only as Solihull figures are too small). The documents are linked to this report in paragraph 7.5.6

7.5.4 The CDOP Manager has also liaised with the Chair of the West Midlands Parent and Child Health Record (red book) Forum to get a risk assessment form bound into the red book. The CDOP Manager obtained consensus from the West Midlands to develop this and has formed a working group with representatives from the West Midlands region to progress this.

7.5.5 **30** SIDS deaths have been reviewed across the sub-region from 2008-2013 (14 each at Coventry and Warwickshire CDOP and 2 at Solihull CDOP). Of the 30, **27** (90%) were preventable with modifiable factors being identified. It is known that in **17** (57%) of deaths, parent(s) were given clear safe sleeping advice by a health professional which was not followed. That's not to say that advice wasn't given in the other 13 deaths but that it could not be verified by the information provided for the review. In many cases, parent(s) were considered to be vulnerable and/or leading chaotic lifestyles.

7.5.6 The following data highlights the risk factors and characteristics of the 30 SIDS reviewed, as per the Rotherham tool mentioned in paragraph 7.5.3:

- In 25 (83%) co-sleeping or an unsafe sleeping position was a contributory factor
- In 21 (70%) one or both parents smoked (15 were co-sleeping with baby at time of death)
- In 11 (37%) one or both parents had consumed alcohol prior to the death (8 were co-sleeping with baby at the time)
- In 5 (17%) one or both parents had taken an illegal substance prior to the death and in all 5 cases parent(s) were co-sleeping with their baby at the time of death

Characteristics of SIDS:

- In 21 (70%) deaths, parent(s) were living in poverty (unemployed or on low income)
- In 19 (63%) babies were not breastfed
- In 11 (37%) Mother had a history of mental ill health
- In 9 (30%) of deaths, Mothers were young, aged between 16-21 years

The full documents can be viewed by clicking on the following:


Coventry SIDS Data 2008-2013.pdf


Warwickshire SIDS Data 2008-2013.pdf

7.5.7 The above information only relates to the deaths that have been reviewed at CDOP. Further deaths did occur in 2013-2014 (and also in 2014-2015) which have the characteristics of SIDS but are still being investigated. Derbyshire and Stoke who have been conducting risk assessments for some time have seen a reduction in SIDS but it is difficult to quantify if this is wholly or partly due to the risk assessment. That said, the Lullaby Trust recognise this as good practice and are promoting its use across the county. We also know from our own data that safe sleeping messages are clearly not being followed and there is a will across the sub-region to address this.

8 Chromosomal, Genetic and Congenital Anomalies.

20 deaths reviewed during 2013-2014 came under this category. The vast majority were congenital defects identified antenatally or shortly after birth and where death occurred during the neonatal period. Modifiable factors were identified in **4** (20%) deaths, these being consanguinity; sub-optimal post discharge care following complex surgery (as outlined in paragraph 5.6) and two where maternal smoking and/or alcohol consumption during pregnancy were contributory factors. Learning and actions were also identified in deaths categorised as non-modifiable as outlined in paragraphs 3.3.5, 4.8, 5.12.1, 5.13 and 5.15.

9 Malignancy

8 deaths were reviewed during 2013-2014 with **1** identified as having modifiable factors (outlined in paragraph 5.4). In all deaths from malignancy, information is obtained from health practitioners to capture the timeline from early presentation(s) to referral, diagnosis and treatment in order to identify any learning. As outlined in paragraphs 3.3.1 and 4.7.1 learning was identified with regards to the recognition of 'red flag' symptoms of brain tumours and awareness being raised with GPs.

9.1 As in previous years, what has been consistent is the excellent cross-agency working between tertiary hospitals, GPs and community palliative care services in supporting the child/young person and their family during the end of life stage and again, as in previous years, the dedication of the Community Children's Nursing Teams and palliative leads in providing 24 hour care when required.

10 Trauma and other external factors

8 deaths were reviewed during 2013-2014, **5** as a result of road traffic collisions and the remainder were accidental. **5** of the 8 were identified as having modifiable factors which are referred to in paragraphs 3.2.2, 4.1 and 4.2.

11 Serious Case Reviews

Of the **78** deaths reviewed, **3 (**4%) were subject of a serious case review. Two of the deaths occurred in 2011-2012 and one in 2013-2014. One of the deaths is the remaining one reviewed during 2013-2014, referred to in paragraph 3.1.4.

12 Additional information on deaths reviewed where modifiable factors were identified

Of the **29** deaths reviewed during 2013-2014 where modifiable factors were identified, the following information provides a breakdown with regards to age, gender, ethnicity, category of death and place where events leading to death occurred.

12.1 *Age*

15 were 0-27 days, **5** were 28-364 days, **3** were 1-4 years and **3** were 15-17 years. The remainder are not categorised further because the number is too small and individuals might be identifiable.

12.2 *Gender*

15 were male and **14** female.

12.3 *Ethnicity*

23 were White British, **4** were of Asian origin. The remainder were too small a number to categorise.

12.4 *Category of death*

12 were categorised as death from a 'Perinatal/neonatal event', **6** from 'Trauma and other external factors', **4** from Chromosomal, Genetic and Congenital Anomalies and **4** from Sudden unexpected, unexplained death'. The remainder were too small a number to categorise.

12.5 P*lace of event which led to the child's death*

17 were in hospital at the time of death, either in the Neonatal Unit, Paediatric Intensive Care Unit or Delivery Suite. It should be noted that in **14** of these deaths, modifiable factors did not relate to the medical care given but were due to maternal lifestyle choices, i.e. smoking, obesity, drink or drug consumption during pregnancy and mother's physical condition which contributed to premature labour and vulnerability of the child. In the other **3** deaths prior medical intervention was a contributory factor.

12.5.1 Of the remaining deaths, **8** took place at the home address and **4** in a public place.

12.6. At the time of death **2** children were subject of Child Protection Plans. None of the deaths with modifiable factors identified were of asylum status.

13 West Midlands CDOP Region

Dr Ann Aukett the former Clinical Lead for Safeguarding Children NHS West Midlands and Chair of the West Midlands Regional CDOP Forum, produced a 4 year regional annual report covering 2008-2012 which was reported on in this annual report last year. A regional CDOP report for 2012-2013 is being produced by Birmingham Public Health but has not been completed in time for this annual report.

13.1 With the retirement of Dr Aukett and the reorganisation of the NHS, it was assumed that the West Midlands Regional CDOP Forum would be supported by the Maternity and Children's Service of the newly formed West Midlands Strategic Clinical Network. So as not to lose momentum, the CDOP Manager took on the role of Interim Chair and organised two regional meetings during 2013-2014. A business case was presented to the Strategic Clinical Network outlining the remit of the forum, work completed and ongoing work. The CDOP Manager also met with the Clinical Director of the Maternity and Children's Service and with Public Health, England (West Midlands) however a decision is yet to be made with regards to responsibility for the regional forum and who will chair it. This is unfortunate particularly as one of the key findings from a study in 2013 by the National Perinatal Epidemiology Unit, University of Oxford, commissioned by the Department for Education, related to the importance of regional working, as follows: "*There is evidence of beneficial regional sharing and learning between some CDOPs with meetings to exchange knowledge, information and concerns, and develop similar preventive approaches. However, this is not a universal activity. Furthermore, because of the demise of Regional Government Offices (RGOs) and NHS restructuring, organisations, such as RGOs and strategic health authorities, which arranged regional meetings in some areas in the past, no longer exist; regional leadership has yet to re-emerge. Recommendation: 'The continuation in some places and re-establishment in others of regional meetings is essential to facilitate shared learning across CDOPs. Funded national meetings would support one aspect of shared national learning and could be stand alone or form part of the remit of a national database provider.'*

14 National learning from deaths reviewed during 2013-2014

The annual returns on deaths reviewed during 2013-2014 were submitted to the Department for Education in May 2014, as requested. As this year's annual report is being produced earlier than in previous years it does not contain the DfE report. This is usually published by DfE towards the end of July and will be circulated separately when received.

15 Processes

15.1 *Involving families in the child death review process*

A protocol has been produced on how the sub-region will engage with families, which has been endorsed by the three Local Safeguarding Children's Boards. The sub-region has agreed that an appropriate professional will be identified to inform families in person and give them the opportunity of contributing to the review and/or asking any questions. Where a professional is no longer involved with the family, the CDOP Manager will make contact in writing. A sub-regional information leaflet has been produced for families which explains the process and also provides details of support organisations.

15.1.1 The CDOP Manager prepared a briefing note for professionals to assist with this process and met /made contact with key professionals to explain the process and their responsibility. The process was implemented on 1 July 2013 and as of 31 March 2014, the end of the reporting year, **65** families were informed and given leaflets. In **48** deaths (74%), the leaflet was given to the family by a professional known to the family and/or involved in the death. Of the 48, 2 (4%) have provided information to the CDOP review. In the other 17 deaths (26%), a leaflet was sent directly to parent(s) by the CDOP Manager with a covering letter as a professional was no longer involved with the family. Of the 17 deaths, 6 (35%) families have responded. In addition to this, 2 families made contact with the CDOP Manager prior to the start of the process and contributed information.

15.1.2 In all cases where families responded they had concerns and questions they wished to ask. This information was sought from professionals and answers provided to them. Having the perspective of families has added value to the reviews in the following ways:

15.1.3 Additional information has been provided by parents that would not have been known to the panel by gathering information from professionals only. This has resulted in:

(i) More learning being identified with regards to service provision and actions identified as a result

(ii) The panels being made aware of complaints made by parents and other reviews being undertaken, that would not have been readily known without parents' information

(iii) Recommendations have been suggested to the panel, with those more appropriate as national recommendations forwarded to the Department for Education

(iv) Parents' perspective on the rapid response process in unexpected and unexplained deaths and contact with specific agencies, both positive and negative.

15.2 *Deaths occurring abroad:*

To date the sub-region has reviewed 2 deaths where children have died abroad whilst on holiday visiting relatives. In the first death the child and family were under the care of a local paediatrician so information with regards to the circumstances and hospital involved were by obtained by the paediatrician from the family. In the second death, the CDOP Manager only became aware of the death through the media. Contact was made with the Foreign and Commonwealth Office who were not aware of the death and suggested contacting the police directly in the country where the death occurred. This was done twice, with no response. The information provided to the review on the circumstances of death was therefore taken solely from reports in the local and national British media.

15.2.1 From discussions at the West Midlands Regional CDOP forum, this is a problem across the whole region (and no doubt across the country) and extremely frustrating to say the least when the information can be obtained by the media but not by a statutory body. Unfortunately Working Together to Safeguard Children 2013, our statutory guidance, is non-specific, stating 'LSCBs should use sources available, such as professional contacts or the media, to find out about cases when a child who is normally resident in their area dies abroad.'

15.2.2 West Midlands Police informed the Regional CDOP Forum in September 2013 that West Mercia Police were leading on a proposal being put to the Association of Chief Police Officers (ACPO) for the police to be specific points of contact for countries when UK citizens die (contact would be with the police area covering the home address) who would then conduct safeguarding checks and notify all agencies. An update on this proposal has been requested from West Midlands Police

15.3 *Assisted conception:*

Following the review of a neonate conceived by assisted conception, the panel felt they didn't have sufficient information on the rationale used by the fertility service when implanting embryos. It was therefore agreed that where it is known that pregnancy resulted from assisted conception, information will be requested from the fertility service involved as we do for other medical information.

15.4 *Independent neonatologists attending neonatal reviews:*

In 2013 the West Midlands Strategic Clinical Network, Maternity and Children's Service canvassed all CDOPs in the West Midlands region on how they reviewed neonatal deaths. Following a submission of our sub-regional process the CDOP Manager was invited to a meeting with the Clinical Lead, Central Newborn Network as it was ascertained that our sub-regional CDOPs were further ahead in reviewing neonatal deaths than other areas. The Central Newborn Network is keen to be involved in the review of neonatal deaths at CDOPs and is proposing that Consultant Neonatologists attend CDOP reviews away from their host Trust to provide an independent view. It was

suggested that our sub-region could 'pilot' this in the first instance. Whilst we are fortunate that our local Consultant Neonatologists are very objective, they cannot always attend CDOPs so the sub-region welcomes the opportunity of trialling this proposal.

15.5 *Dissemination of CDOP learning to support the Learning and Improvement Framework:* Learning identified at individual CDOPs is routinely shared across the sub-region and actions replicated as illustrated in the learning identified in paragraphs 3 – 5. Where appropriate, learning and recommendations are also shared wider with other CDOPs across the country and this will continue. When actions are identified to share learning the CDOP Manager will follow these through to ensure that the learning has been shared. CDOPs will also ascertain how individual organisations ensure that the learning is disseminated to all professionals.

15.6 *CDOP Membership:*
The new Head of Safeguarding at West Midlands Ambulance Service (WMAS) has offered to become a permanent member of sub-regional CDOPS and attend when cases involving WMAS are being reviewed. This is very welcomed and will further enhance the exchange of information when queries or actions arise in relation to WMAS.

15.7 *Collating information for the child death review process:*
Excellent co-operation in providing information continues across the sub-region and beyond. A detailed covering letter sent to GPs explaining why certain information is required has improved the information received from GPs.

15.8 *Collation of national child death data and national CDOP learning:*
The absence of a national database to collate national child death data and national learning/recommendations was reported in last year's annual report and despite the Department for Education commissioning work in this area and issuing a statement in 2013 that it will be progressed, no update has been received to date. The only indication that this is being progressed was given by the Secretary of State, Mr Gove who alluded to this in his response to Coventry LSCB as outlined in paragraph 3.1, stating; 'The Department of Health is leading on work to establish a database which will enable the collection, analysis, interpretation and reporting at a national level of the data produced by Child Death Overview Panels. We anticipate that this will provide a good basis at national level for considering deaths from specific conditions, including those associated with co-sleeping.'

15.9 The generic form used to record the findings of the review (known as Form C) was reviewed by the Department for Education in 2011, but as reviews and learning have evolved the form is no longer adequate to record all information, particularly around prematurity. There is no 'tick box' to record prematurity and the other boxes do not accurately reflect conditions intrinsic to premature babies. Parents' mental/emotional/ behavioural condition is catered for but not physical conditions, therefore obesity, or other physical conditions contributing to the prematurity and vulnerability of baby have no specific place for recording. The CDOP Manager has fed this back to the Department for Education on three occasions but it appears that there is no one at DfE responsible for driving or changing processes.

16 CDOP Working Group

The CDOP Working Group, formed in 2007 to progress the operational elements of the child death review process met twice during 2013-2014. All on-going work is reflected in the CDOP Manager's work plan, which is monitored by the CDOP Working Group.

17 CDOP Budget

17.1 Expenditure 2013 – 2014

Salaries: CDOP Manager and CDOP Officer.		£59 119
Staff travel		£786
Office costs (stationary, photocopying, phones, IT charges.)		£2894
Printing (Leaflet for parents)		£166
Contribution from Warwickshire	£26 000	
Contribution from Solihull	£13 000	
Contribution from Coventry	£24800	
Total Income	**£63800**	
Total expenditure		**£62965**

18 Sub-Regional data on child deaths notified in 2013 – 2014

18.1 During 2013-2014, **81** deaths were notified to the child death review process across the sub-region, a 20% increase compared to the **65** deaths notified in 2012-2013. The data contained in Appendix 'E' gives a breakdown of deaths reported year on year. The increases have been seen in the following categories:

18.2 *Neonatal deaths*
Both Solihull and Warwickshire have seen an increase in Neonatal deaths compared to 2012-2013. Solihull's have doubled (5 in 2012-2013 and 10 in 2013-2014). Warwickshire has seen a slight increase (13 in 2012-2013 and 19 in 2013-2014). Coventry has remained fairly static (13 in 2012-2013 and 14 in 2013-2014).

18.3 *Sudden and Unexpected Deaths*
Warwickshire has seen an increase in the number of sudden and unexpected deaths, (6 in 2012-2013 and 10 in 2013-2014) the increase has been in deaths from Sudden Infant Death Syndrome (SIDS). Warwickshire were fortunate not to have had any SIDS in the previous 2 years, i.e. 2011-2012 and 2012-2013 but had 3 in 2013-2014. The other slight increase was due to external factors (2 in 2012-2013, a drowning and road traffic collision and 4 in 2013-2014, 3 road traffic collisions and 1 non-accidental injury).

18.4 Coventry's sudden and unexpected deaths remained static. Solihull saw a reduction in their sudden and unexpected deaths.

18.5 *Life Limiting Conditions*
Warwickshire has seen an increase in the number of deaths from life limiting conditions (2 in 2012-2013 and 9 in 2013-2014) however no inferences can be drawn from this.

18.6 Coventry and Solihull's have remained fairly static.

18.7 A breakdown of all categories year on year is contained in Appendix 'E' and a breakdown of the types of sudden and unexpected deaths year on year is outlined in Appendix 'F'.

18.8 Although these figures have been reported on it must be emphasised that we are dealing with very small numbers and no real inference can be drawn from them.

18.9 Sub-regional deaths by Category 2013-2014 (Total 81)

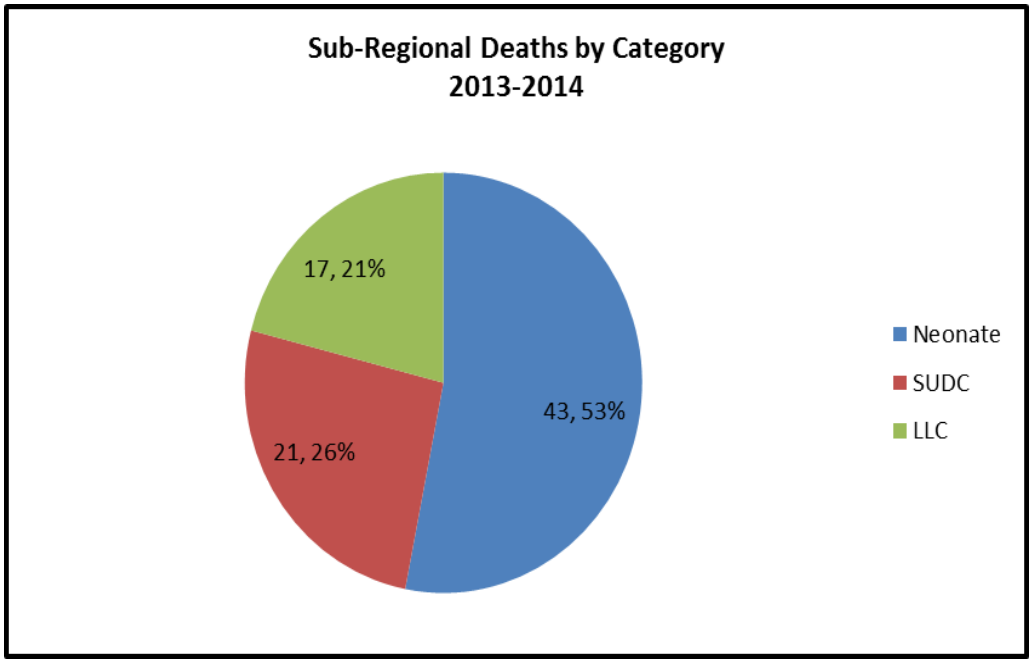
Definitions of the categories used are as follows:

Neonate: 0-28 days of age very often born prematurely and in the vast majority of cases have never left hospital.

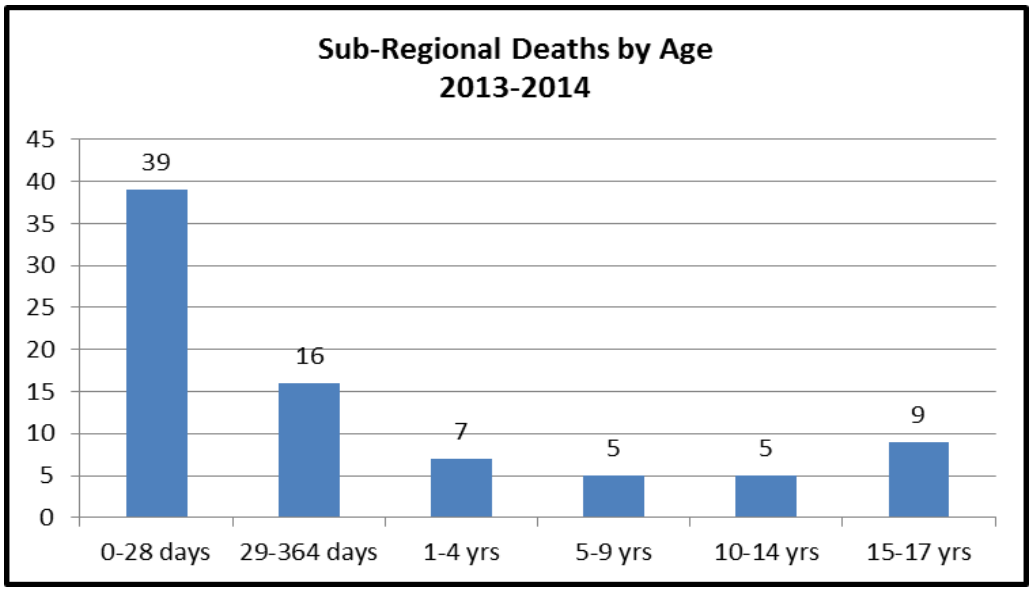
SUDC – Sudden and Unexpected Death requiring an Inquest to establish cause of death and where either a multi-agency 'Rapid Response' investigation under the SUDC Protocol has been conducted or a police investigation.

Medical - An unexpected death but where the cause of death is known and a death certificate is issued, e.g. epilepsy, asthma.

LLC – expected death from a life limiting condition where the cause of death is known and a death certificate is issued.

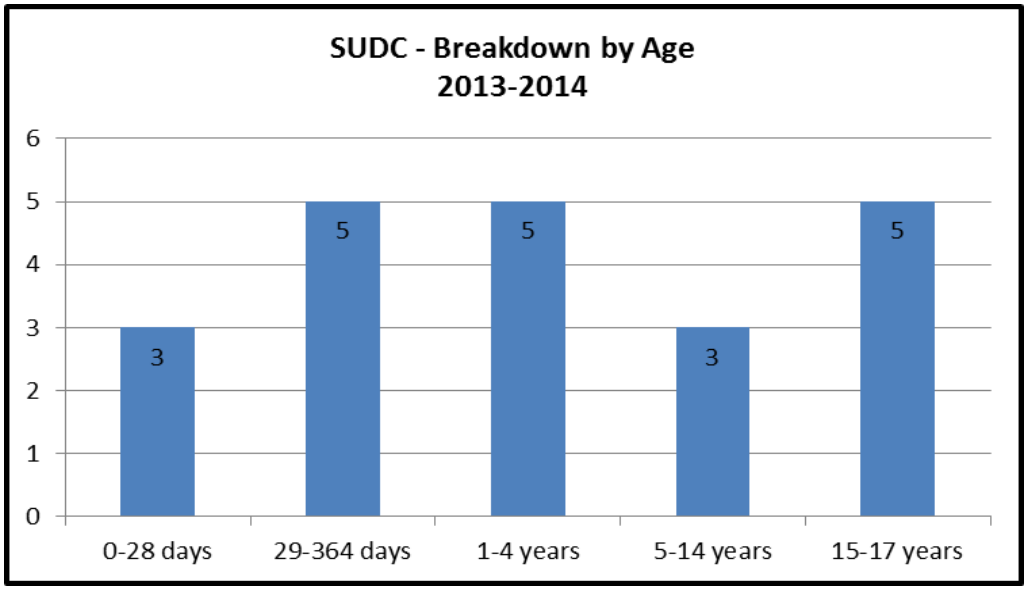


18.10 Sub-regional Deaths by Age 2013-2014 (Total 81)



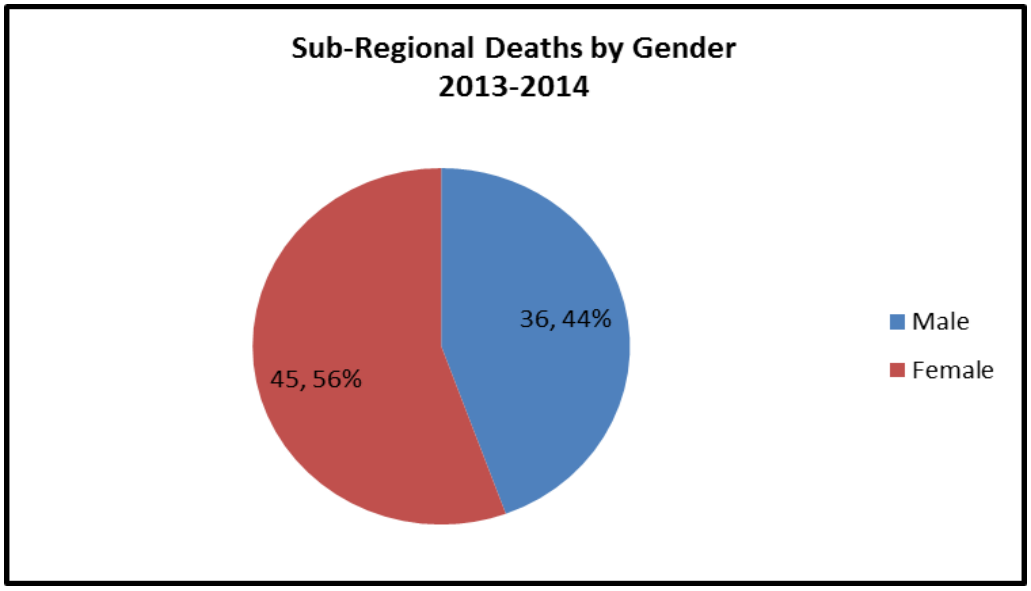
18.11 The breakdown of ages in 2013-2014 mirrors that of 2012-2013 in the first 5 groups. The variance is in the 15-17 year group which is the 3rd highest category in 2013-2014 compared to being joint lowest in 2012-2013 (with the 5-9 year category). The reason for this is that 2 deaths from an unexpected medical condition were aged in this group as were 3 of the young persons who died in road traffic collisions.

18.12 The following chart gives a breakdown by age of the sudden and unexpected deaths notified in 2013-2014. N.B. Not all of have been reviewed.



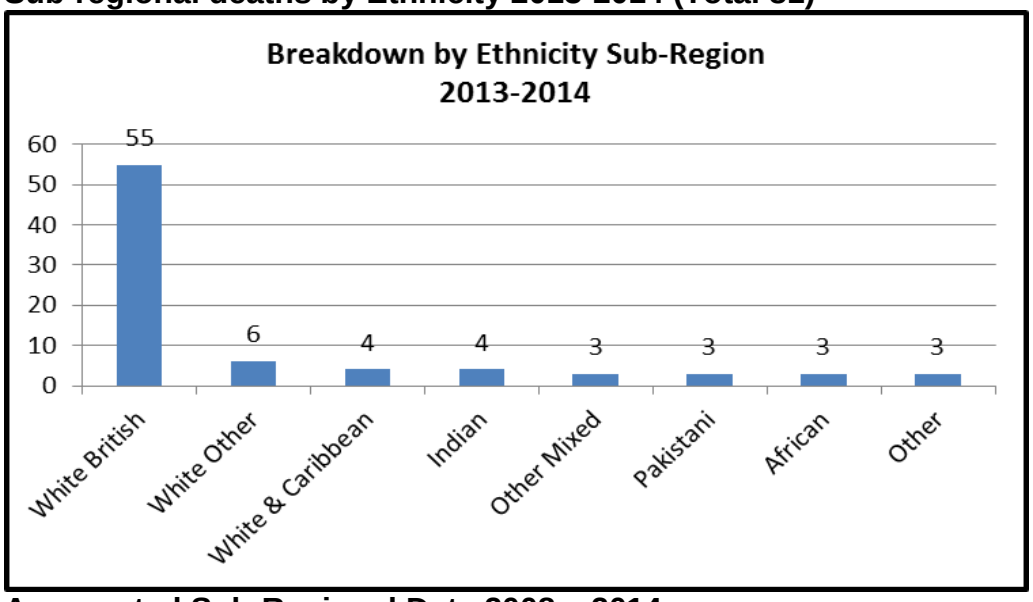
18.13. **0-28 days:** **2** SIDS and **1** medical cause
29 – 364 days: **4** SIDS and **1** medical cause
1-4 years: **3** external (drowning and non-accidental injury) and **2** medical
5-14 years: **2** medical and **1** external (RTC) (5-9 and 10-14 ages combined)
15-17 years: **3** external (RTC) and **2** from medical causes

18.14 Sub-Regional Deaths by Gender 2013-2014 (Total 81)



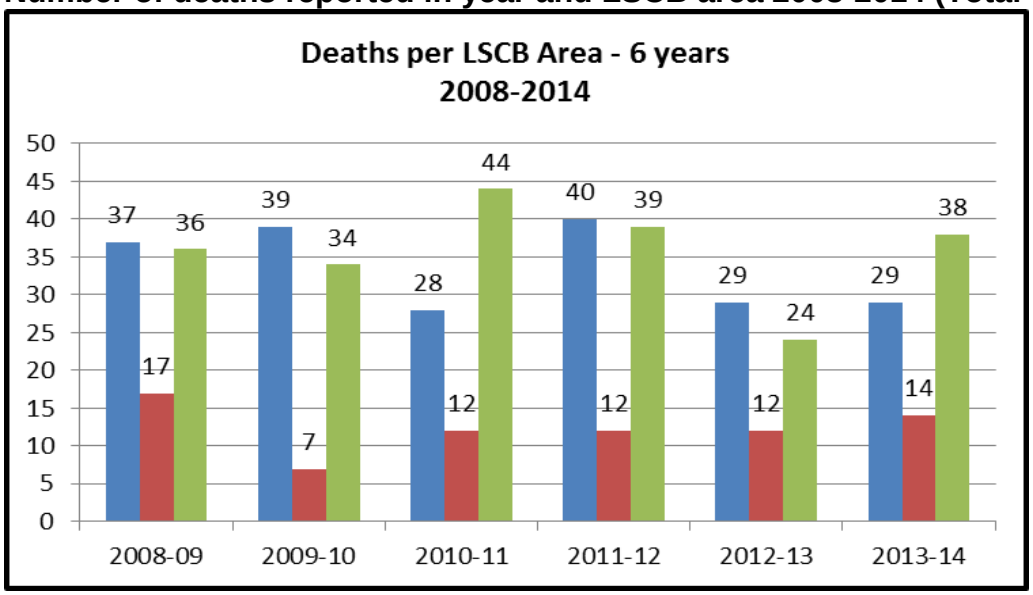
18.15 Regional and national data for 2013-2014 is not yet available however trends in previous years have shown more male than female deaths. Our sub-regional data for this year, 2013-2014, therefore bucks this trend by having more female than male deaths.

18.16 Sub-regional deaths by Ethnicity 2013-2014 (Total 81)

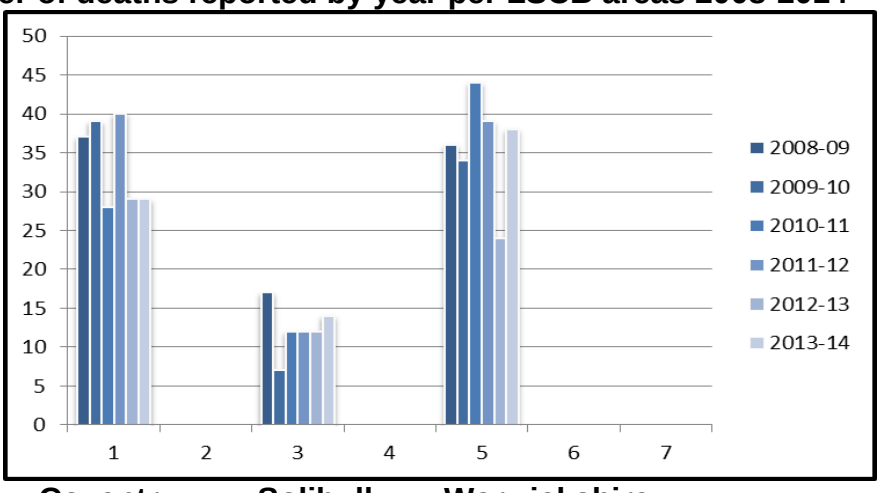


19 Aggregated Sub-Regional Data 2008 – 2014

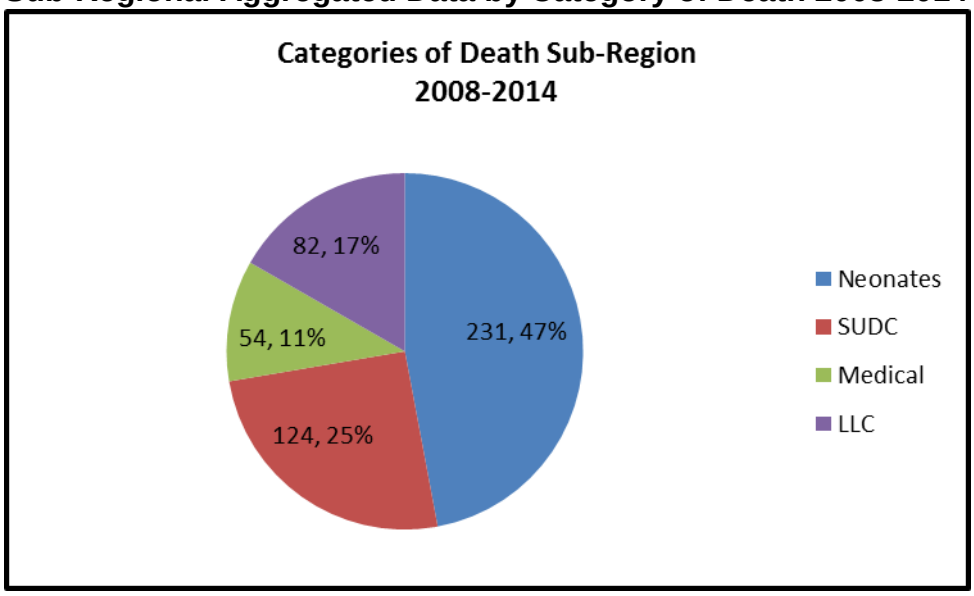
19.1 Number of deaths reported in year and LSCB area 2008-2014 (Total 491)



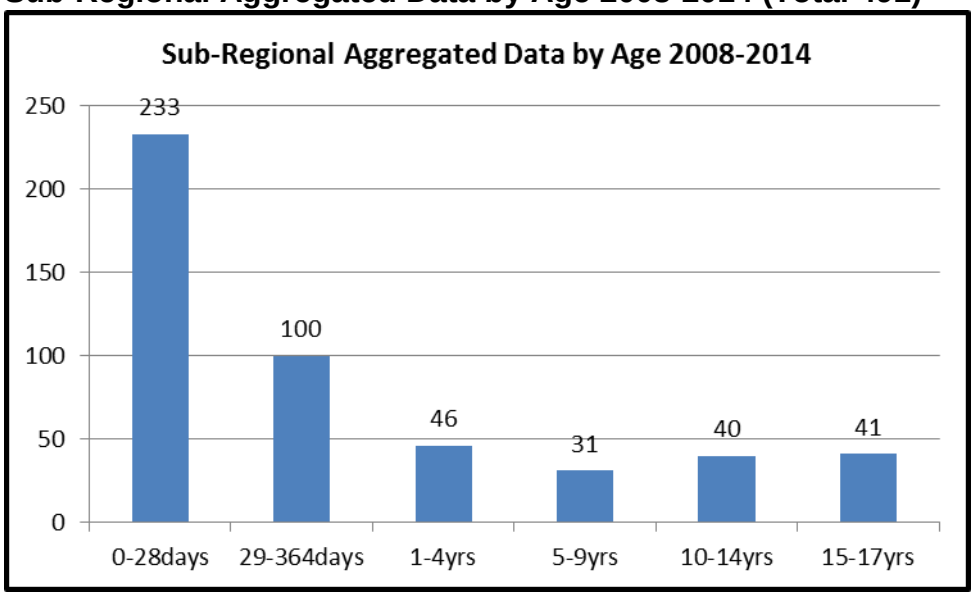
19.2 Number of deaths reported by year per LSCB areas 2008-2014



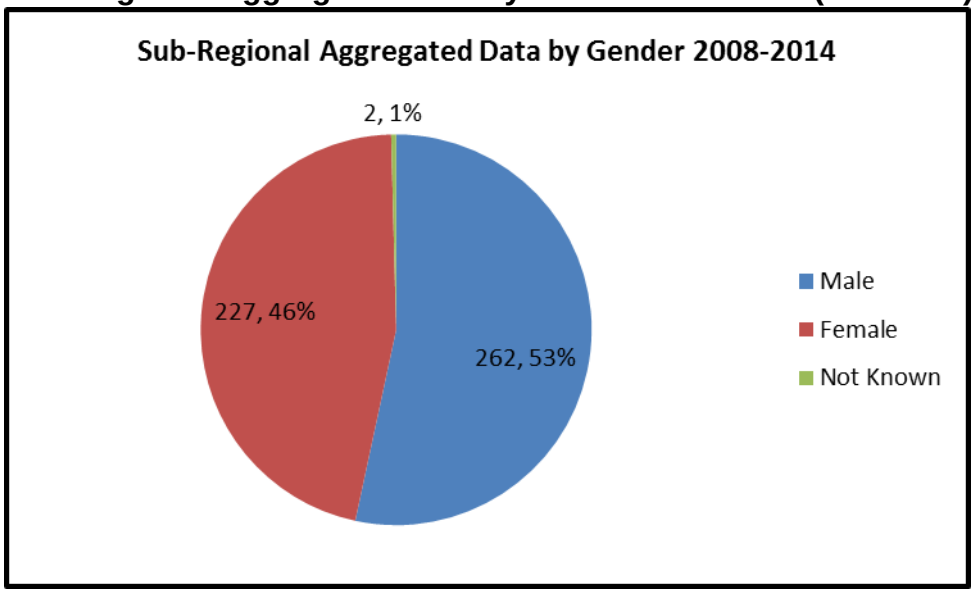
19.3 Sub-Regional Aggregated Data by Category of Death 2008-2014 (Total 491)



19.4 Sub-Regional Aggregated Data by Age 2008-2014 (Total 491)

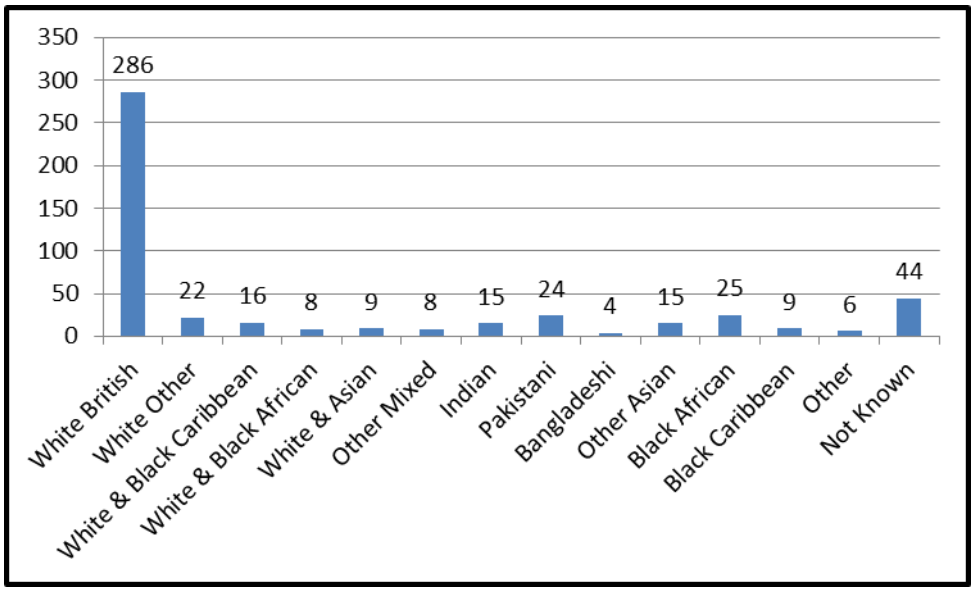


19.5 Sub-Regional Aggregated Data by Gender 2008-2014 (Total 491)



19.5.1 The 2 unknown were extreme premature babies where gender could not be determined.

19.6 Sub-Regional Aggregated Data by Ethnicity 2008-2014 (Total 491)



19.6.1 The 'Not Known' are deaths from 2008-2009 and a few from 2009-2010 when ethnicity was not requested on the national template forms. This changed in early 2009-2010 and ethnicity has been captured since.

Author: **Dara Lloyd**
Child Death Overview Panel Manager for,
Coventry, Solihull and Warwickshire

Appendix 'A'

Coventry Child Death Overview Panel

1 CDOP Members during 2013-2014:

John Forde, Consultant in Public Health (Chair)
Gillian Attree, Named Nurse for Child Protection, UHCW
Dr Supratik Chakraborty, Consultant Paediatrician (Community)
Lesley Cleaver, Support Nurse for Vulnerable Families
Detective Inspector Chris Hanson/ Jayne Gooderidge, West Midlands Police
Sandra Kerr, Manager, Children's Social Care
Nichola Lamb, Named Midwife for Safeguarding, UHCW
Jayne Phelps, Designated Nurse for Child Protection
Amanda Reynolds, Manager, Early Years
Dr Brian Shields, Consultant Paediatrician (Acute Services) UHCW
Dr Miriam Wood, GP

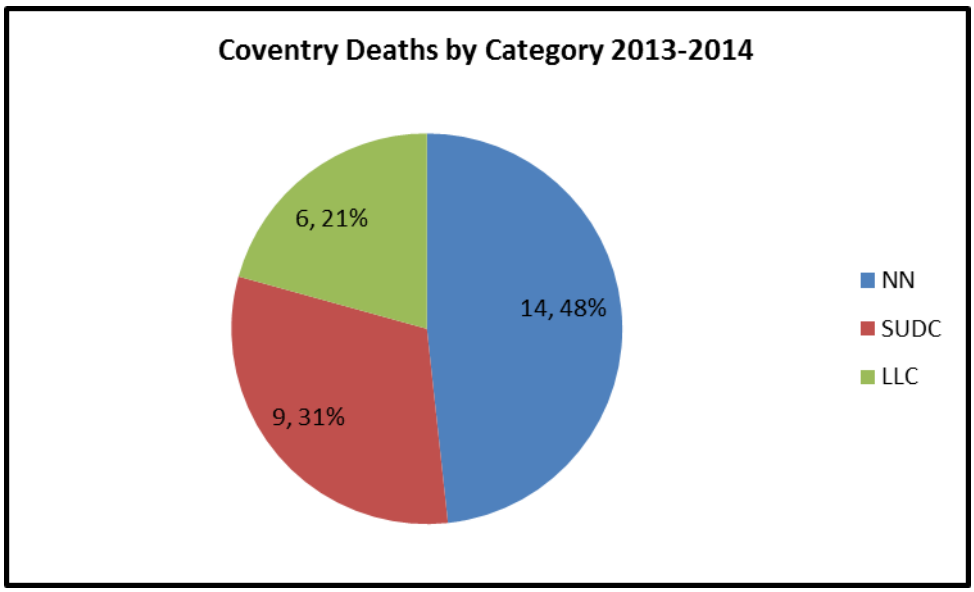
1.1 Co-opted Members:
Dr Kate Blake, Consultant Neonatologist

2 Details of the number of CDOPs held and the number of deaths reviewed is outlined in in paragraph 2 of the annual report. One CDOP meeting was cancelled (August 2013) as there were not enough cases ready to make the meeting viable. A summary of the recommendations and actions arising from Coventry CDOP are outlined in paragraph 3.

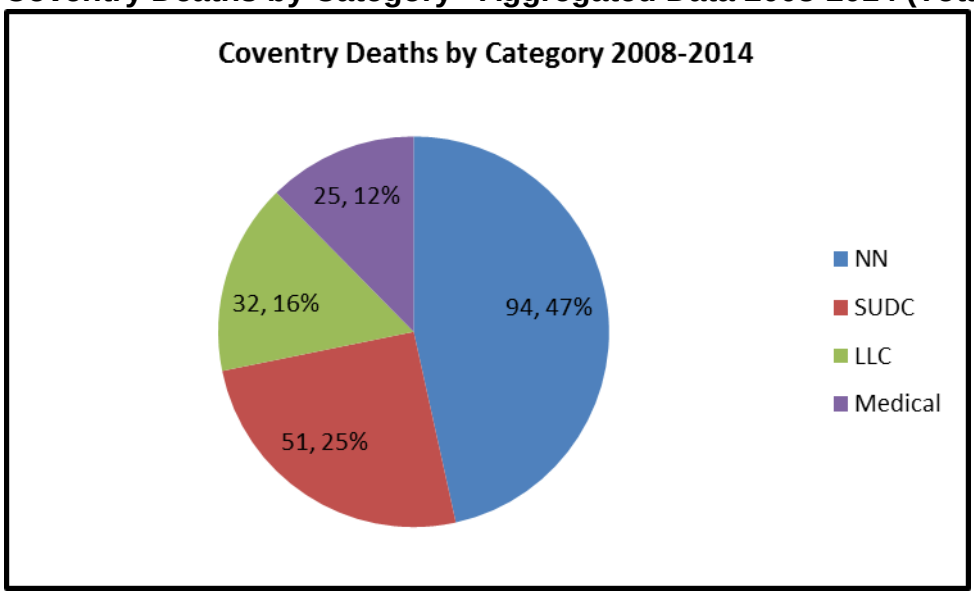
3 **Coventry Child Death Data:**
29 deaths were notified in 2013-2014, the same number as in 2012-2013. Deaths reported year on year since the process began in 2008 are shown in paragraph 19.1.

3.1 Categories that have a total of 2 or less have been merged in accordance with disclosure control guidance issued by the NHS Information Centre for Health and Social Care.

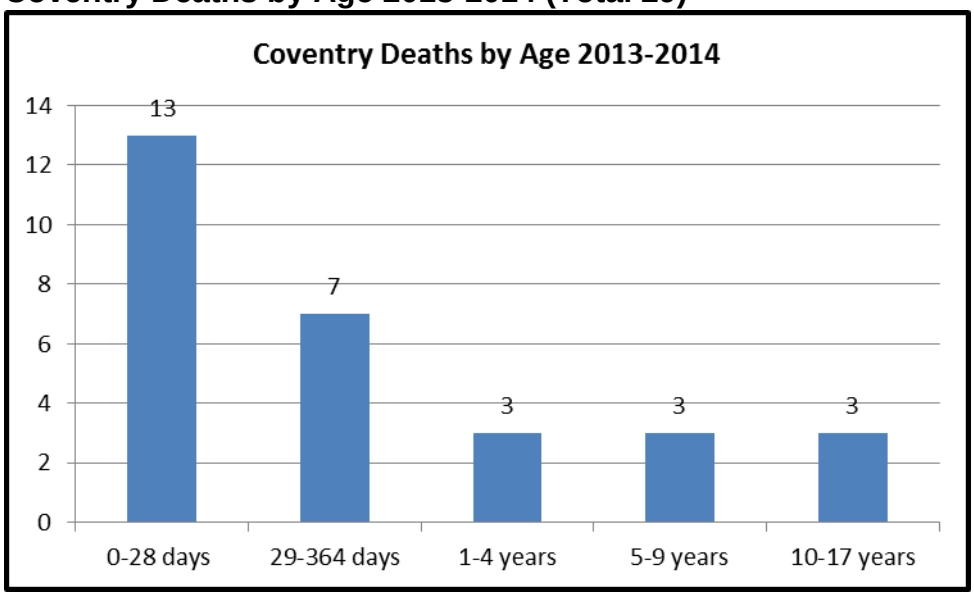
3.2 Coventry Deaths by Category 2013-2014 (Total 29)



3.3 Coventry Deaths by Category– Aggregated Data 2008-2014 (Total 202)

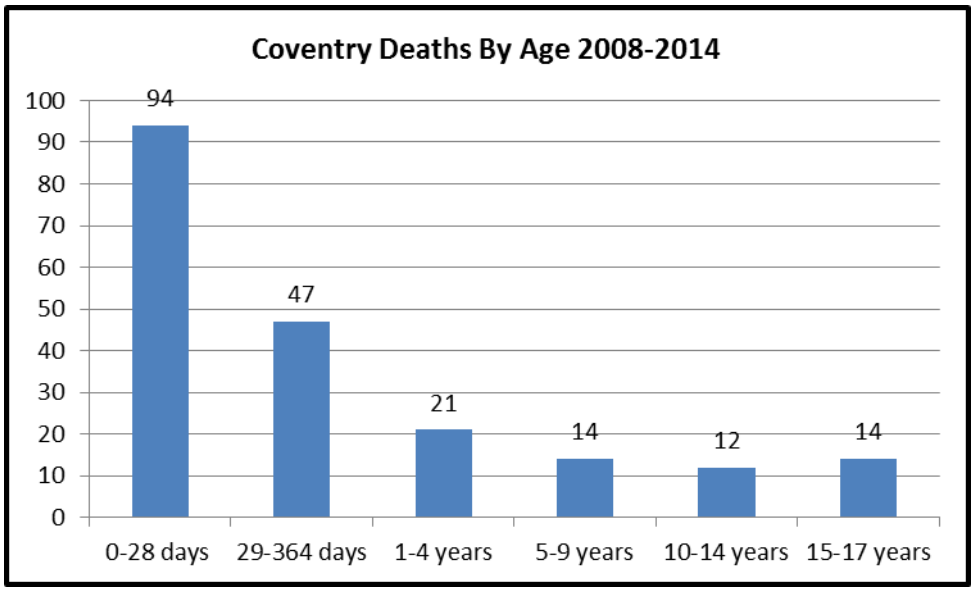


3.4 Coventry Deaths by Age 2013-2014 (Total 29)

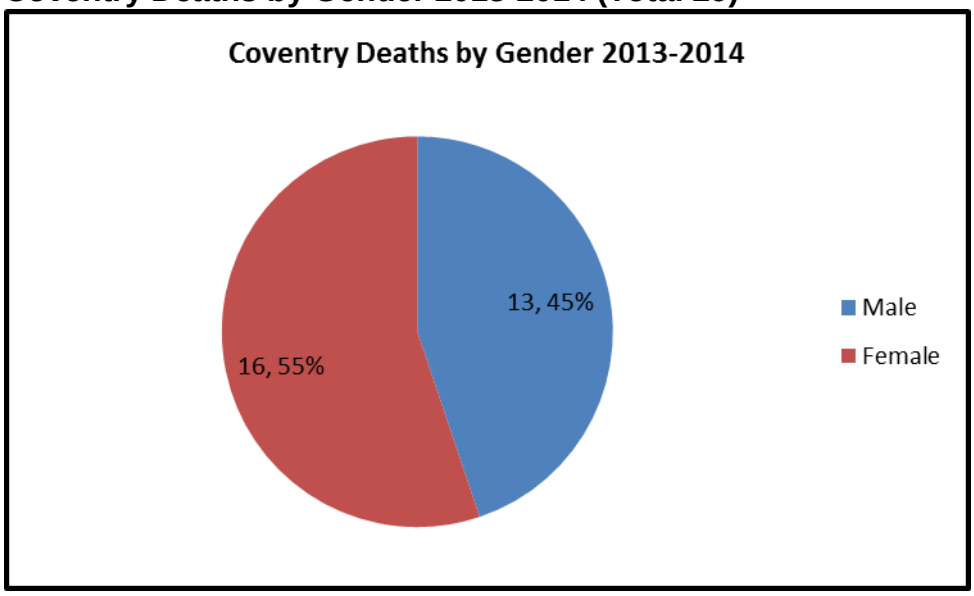


Age groups 10-14 and 15-17 years have been merged due to the low numbers.

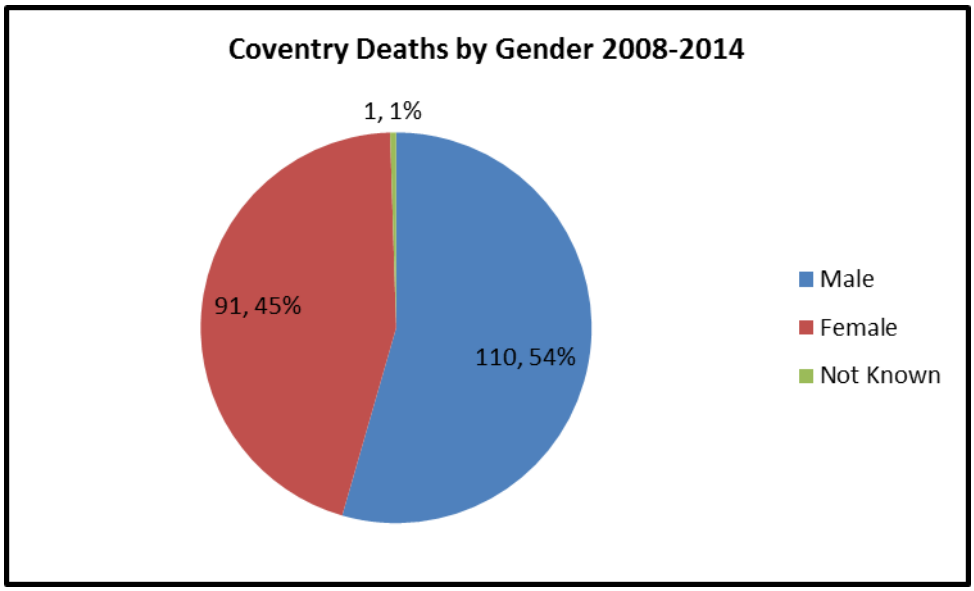
3.5 Coventry Deaths by Age - Aggregated Data 2008-2014 (Total 202)



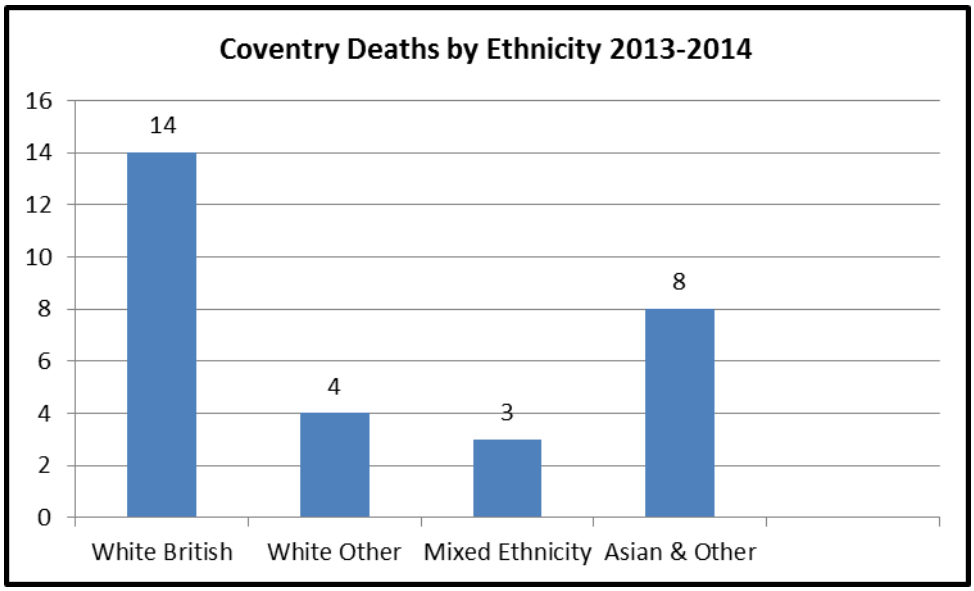
3.6 Coventry Deaths by Gender 2013-2014 (Total 29)



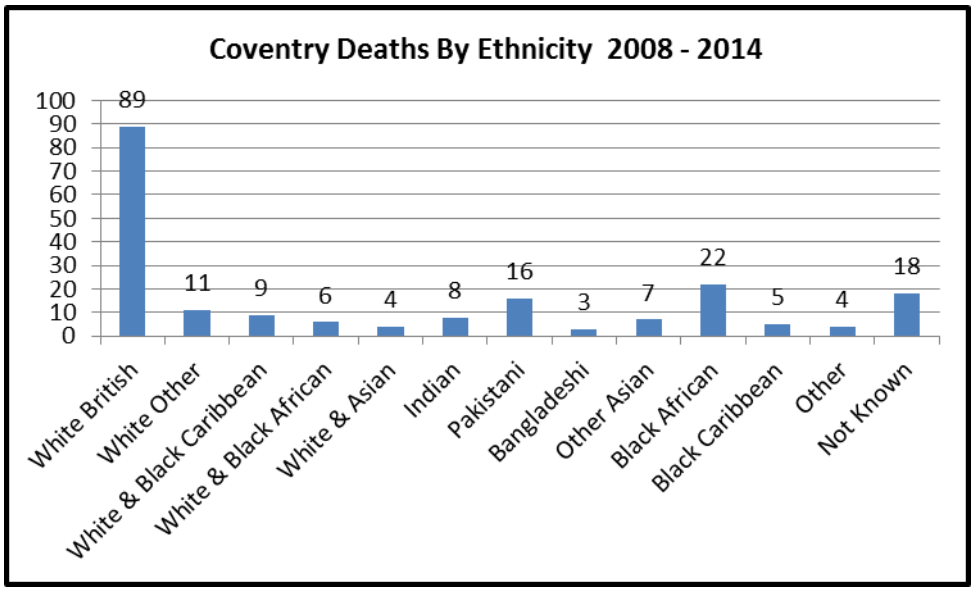
3.7 Coventry Deaths by Gender – Aggregated Data 2008-2014 (Total 202)



3.8 Coventry Deaths by Ethnicity 2013 – 2014 (Total 29)



3.9 Coventry Deaths by Ethnicity – Aggregated Data 2008 – 2014 (Total 202)



4 Summary:

4.1 Neonatal deaths continue to be the highest category as expected.

4.2 The highest age group is 0-28 days which incorporates the neonatal deaths and therefore expected.

4.3 The graph in 3.2 shows 14 neonatal deaths but the graph in 3.4 showing a breakdown of ages shows there were 13 aged 0-28 days. The reason for this is that one neonate lived outside the 28 days but was still categorised as a neonatal death as the child was born prematurely and never left hospital.

4.4 Looking at the 6 year data, 70% of deaths (141 out of 202) occurred within the first year of life. This is also mirrored by Solihull and Warwickshire.

4.5 Coventry has bucked the national and regional trend regarding gender in 2013-2014 but aggregated data for 2008-2014 shows overall more male deaths than female deaths which is in keeping with national and regional trends.

4.6 With regards to ethnicity, children of White British' origin remains the highest category. Children of 'White Other' origin has shown a slight increase since 2011 which may be due to the increase in population from Eastern European countries.

4.7 The 'Not Known' are deaths from 2008-2009 and a few from 2009-2010 when ethnicity was not requested on the national template forms. This changed in early 2009-2010 and ethnicity has been captured since.

Appendix 'B'

Solihull Child Death Overview Panel

1 CDOP Members during 2013-2014:

Ian Mather, Consultant in Public Health (Chair)
Paul Nash, Solihull LSCB (Vice Chair)
Alison Frost, Team Leader, Solihull MBC Legal Services
Detective Inspector Jayne Gooderidge / Jim Foy
Steve Martin, Chief Education Welfare Officer / Mohammed Bham, Principle Education Psychologist
Carol Owen, Midwifery Services, Heartlands Hospital
Eleni Prodromou, Assistant Team Manager, Solihull Children's Social Care
Dr Alan Stanton, Consultant Paediatrician (Community)

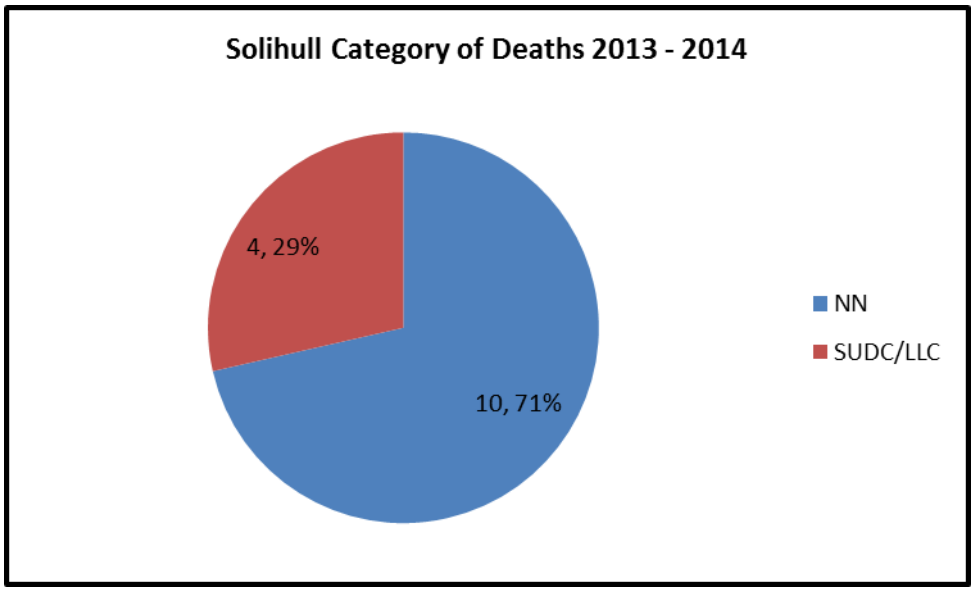
1.1 Co-opted member:
Dr Richard Mupanemunda, Consultant Neonatologist, Heartlands Hospital.

2 Details of the number of CDOPs held and the number of deaths reviewed is outlined in in paragraph 2 of the annual report. To date it has not been necessary to convene a Fast Track CDOP but this will be considered if the numbers demand. A summary of the recommendations and actions arising from Solihull CDOP are outlined in paragraph 4.

3 Solihull Child Death Data
14 deaths were notified in 2013-2014, a small increase on the **12** deaths notified in 2012-2013. Deaths reported year on year since the process began in 2008 are shown in paragraph 19.1.

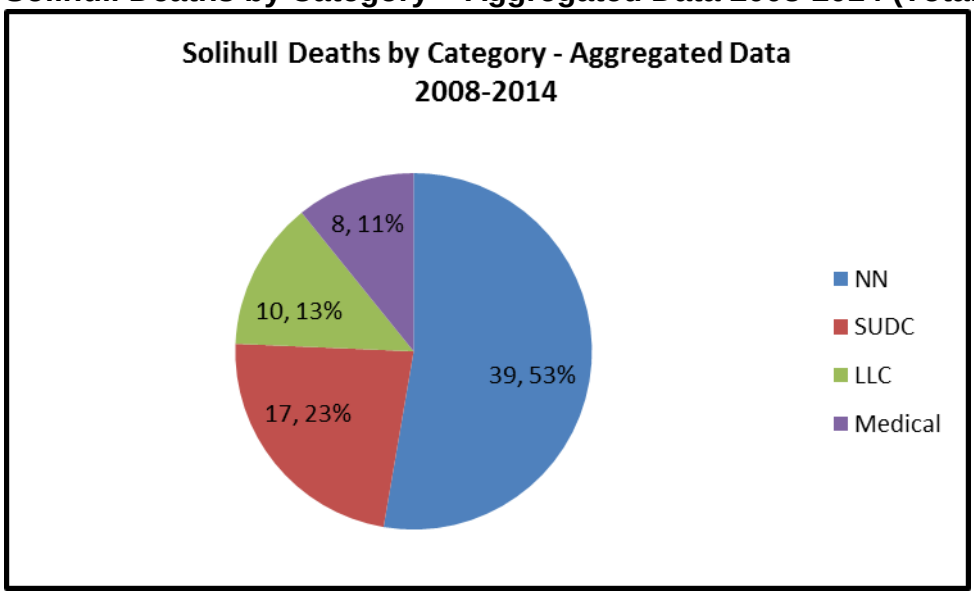
3.1 Categories that have a total of 2 or less have been merged in accordance with disclosure control guidance issued by the NHS Information Centre for Health and Social Care.

3.2 Solihull Deaths by Category 2013-2014 (Total 14)

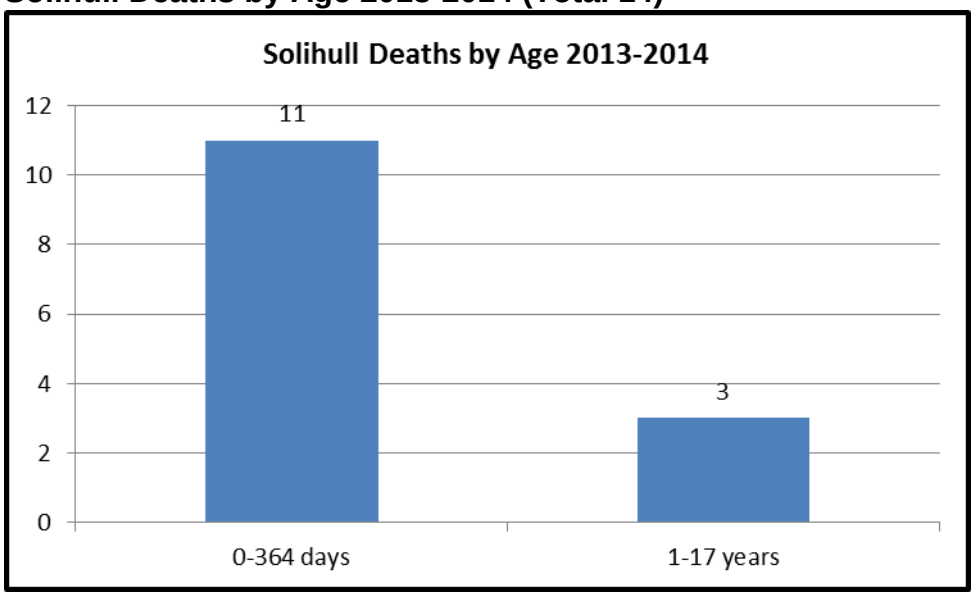


3.2.1 Categories of SUDC and Life Limiting Conditions have been grouped together due to the low numbers.

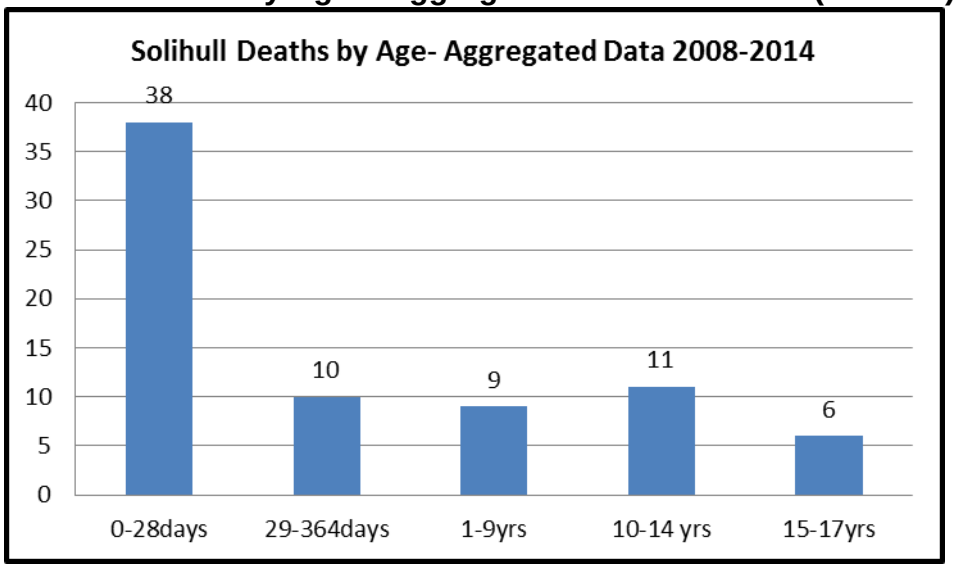
3.3 Solihull Deaths by Category – Aggregated Data 2008-2014 (Total 74)



3.4 Solihull Deaths by Age 2013-2014 (Total 14)

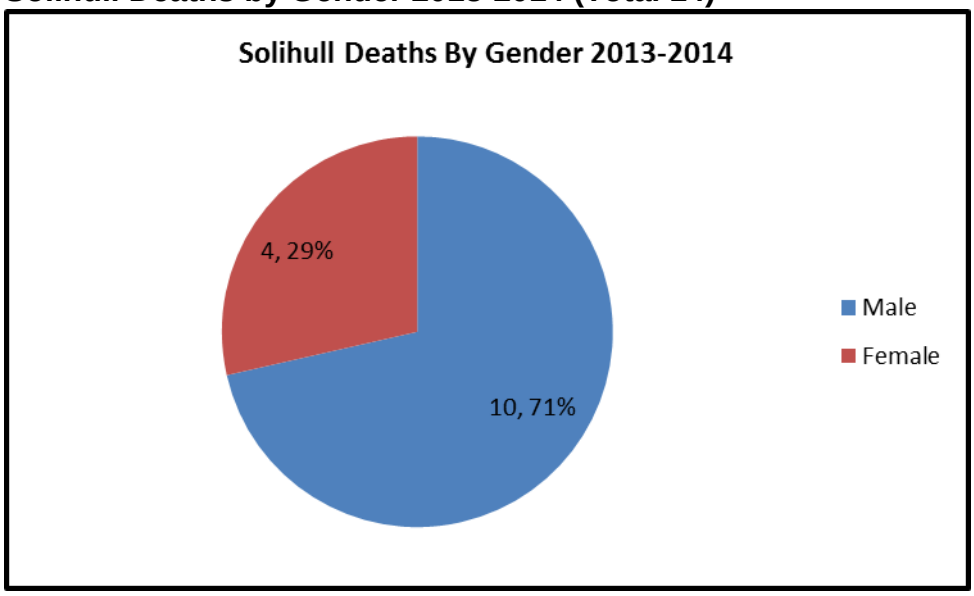


3.5 Solihull Deaths by Age – Aggregated Data 2008-2014 (Total 74)

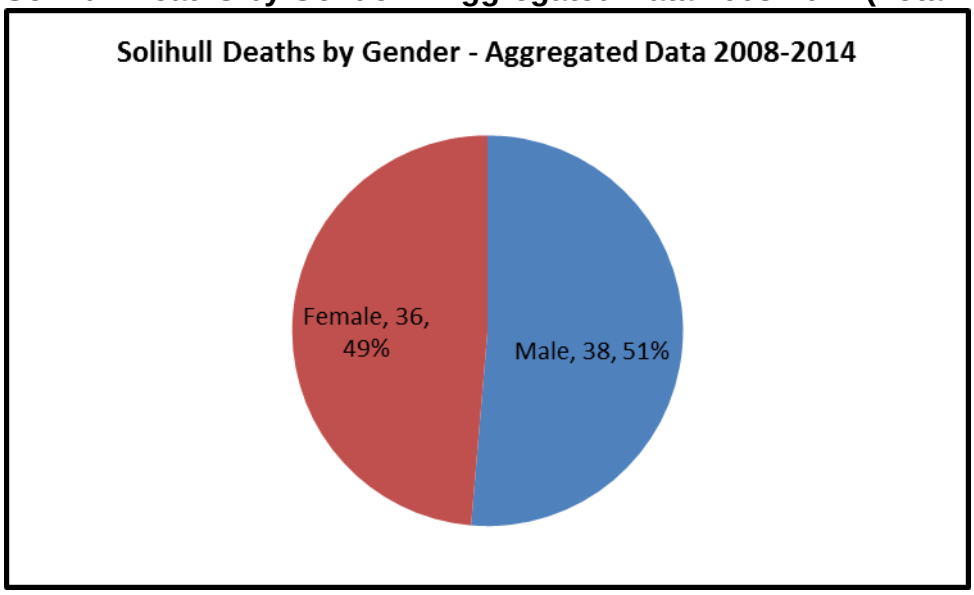


3.5.1 Age groups 1-4 and 5-9 years have been merged due to the low numbers.

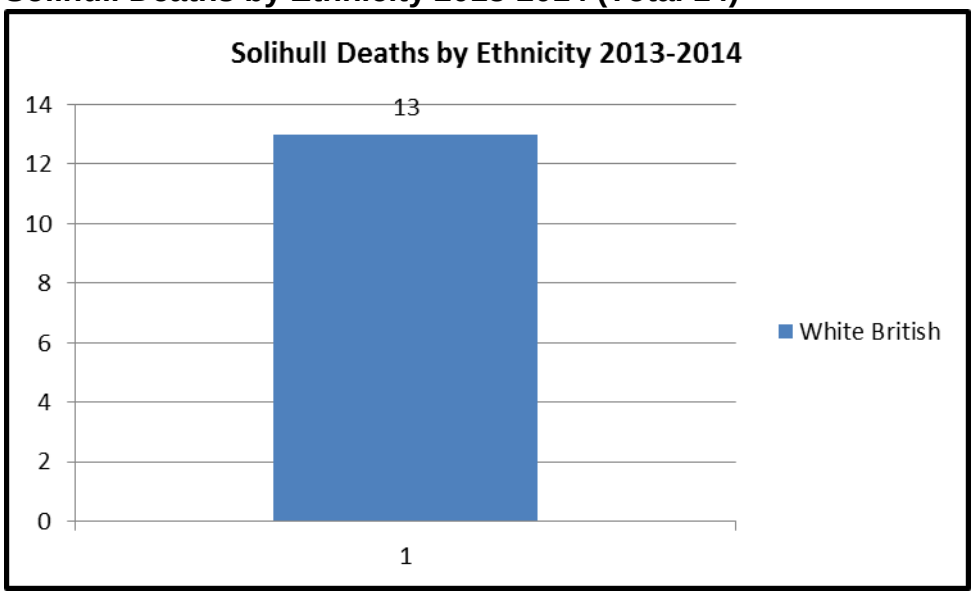
3.6 Solihull Deaths by Gender 2013-2014 (Total 14)



3.7 Solihull Deaths by Gender – Aggregated Data 2008-2014 (Total 74)

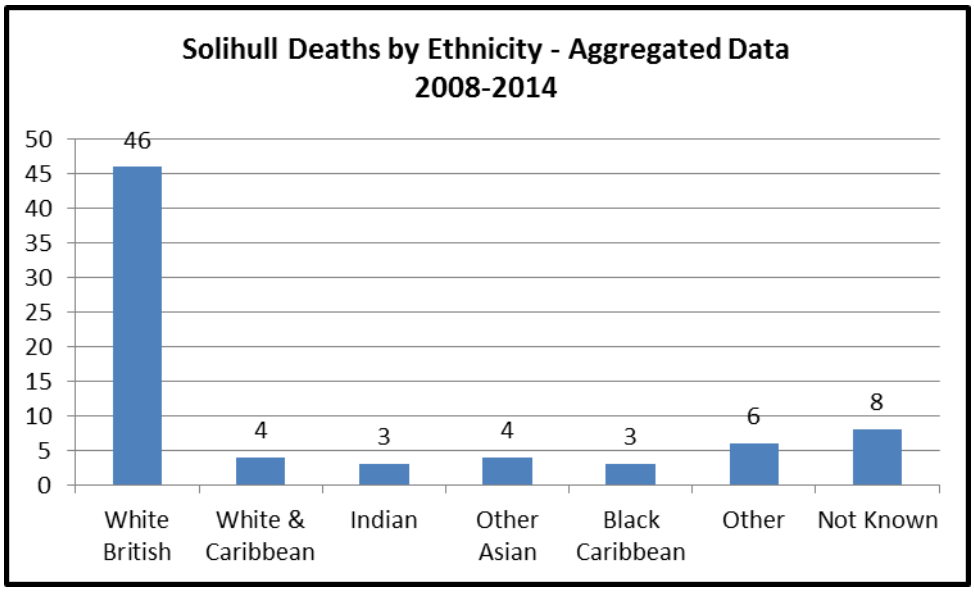


3.8 Solihull Deaths by Ethnicity 2013-2014 (Total 14)



3.8.1 The remaining death cannot be categorised due to its lone number.

3.9 Solihull Deaths by Ethnicity – Aggregated Data 2008-2014 (Total 74)



4 Summary

4.1 Neonatal deaths continue to be the highest category as expected.

4.2 The highest age group is 0-28 days which incorporates the neonatal deaths and therefore expected. Due to the low numbers in the 29-364 day category, these have been merged with the 0-28 day category. The other categories have also been merged together due to the low numbers.

4.3 The 6 year aggregated data gives a better picture. As can be seen, 65% of deaths (48 out of 74) occurred within the first year of life, which is also mirrored by Coventry and Warwickshire.

4.4 Aggregated data on gender bucked the national and regional trend up to 2013 by having more female deaths overall than male. However with 2013-2014 data added, male deaths now slightly outweigh those of females, which is in keeping with national and regional trends.

4.5 With regards to ethnicity, children of White British' origin remains the highest category as it has done over previous years.

4.6 The 'Not Known' are deaths from 2008-2009 when ethnicity was not requested on the national template forms. This changed in early 2009-2010 and ethnicity has been captured since.

Appendix 'C'

Warwickshire Child Death Overview Panel

1 CDOP Members during 2013-2014:

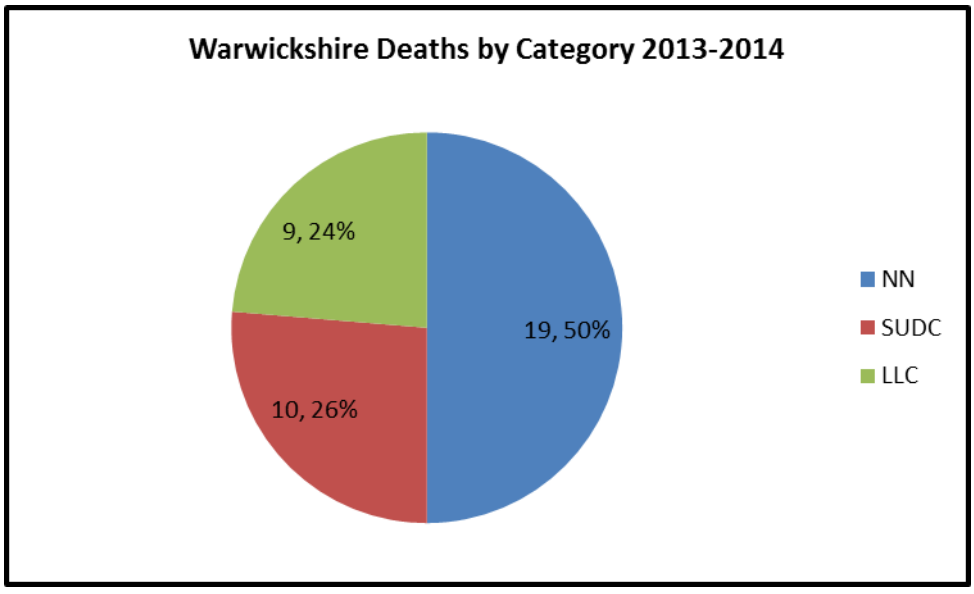
Cornelia Heaney, Development Officer for WSCB (Chair)
Jenny Butlin-Moran, Service Manager, Child Protection
Jackie Channell, Designated Nurse for Child Protection
Cathy Ellis, Consultant in Child Health
Victoria Gould, Young People Legal Services Manager, Warwickshire County Council
Detective Inspector Nigel Jones, Warwickshire Police
Dr Kathryn Millard, Consultant in Public Health
Angela O'Boyle, LSCB Lay Member
Adrian Over, Safeguarding Children's Manager for Education
Janet Pollard, Clinical Governance Midwife, South Warwickshire NHS Foundation Trust
Dr Peter Sidebotham, Consultant Paediatrician (Community)
Linda Watson, Assistant Head for of Children, Young People and Family Service,

2 Details of the number of CDOPs held and the number of deaths reviewed is outlined in in paragraph 2. A summary of recommendations and actions arising from Warwickshire CDOP are outlined in paragraph 5.

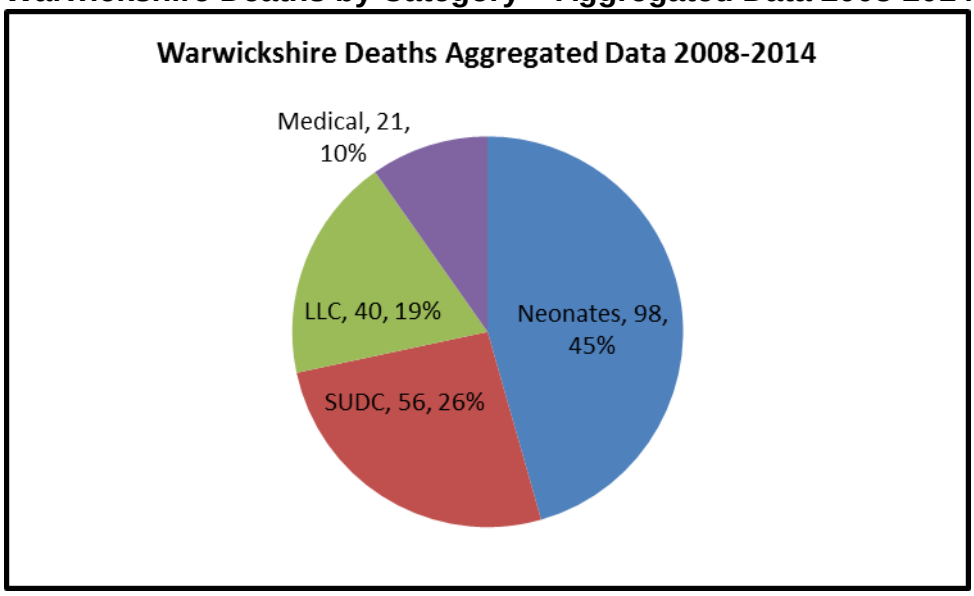
3 **Warwickshire Child Death Data:**
38 deaths were notified in 2013-2014, a 36% increase to the **24** deaths notified in 2012-2013. Deaths reported year on year since the process began in 2008 are shown in paragraph 19.1.

3.1 Categories that have a total of 2 or less have been merged in accordance with disclosure control guidance issued by the NHS Information Centre for Health and Social Care.

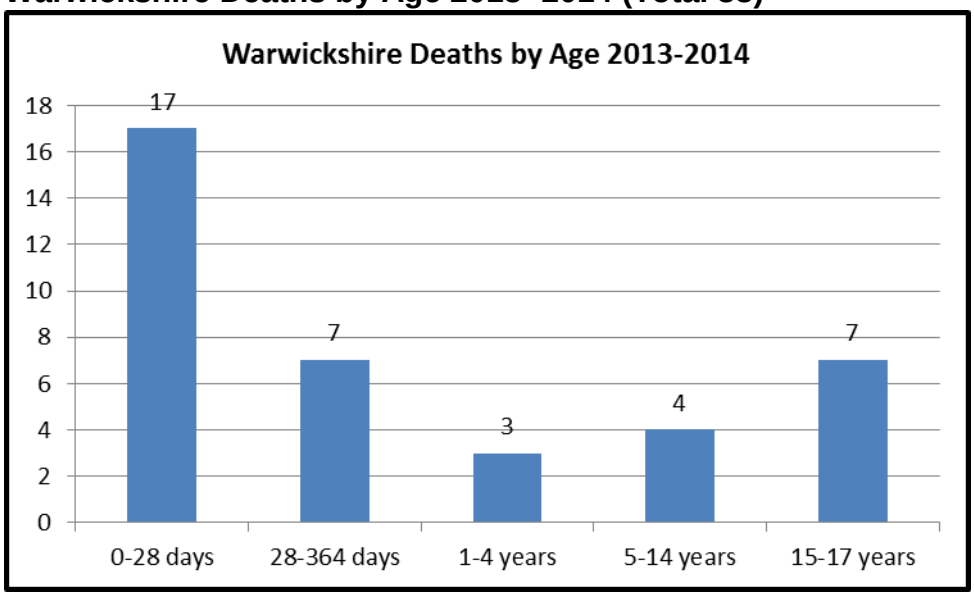
3.2 Warwickshire Deaths by Category 2013-2014 (Total 38)



3.3 Warwickshire Deaths by Category – Aggregated Data 2008-2014 (Total 215)

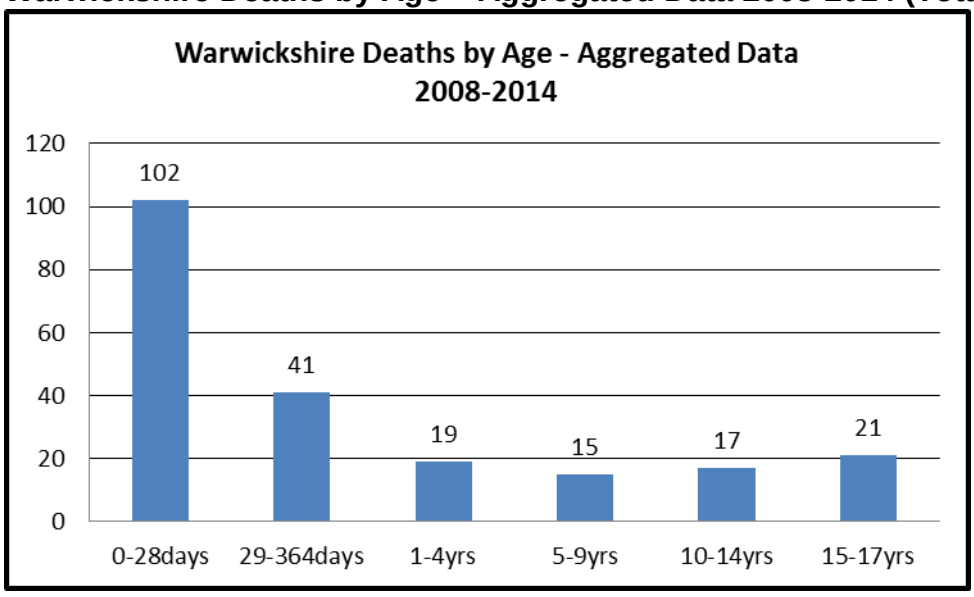


3.4 Warwickshire Deaths by Age 2013 -2014 (Total 38)

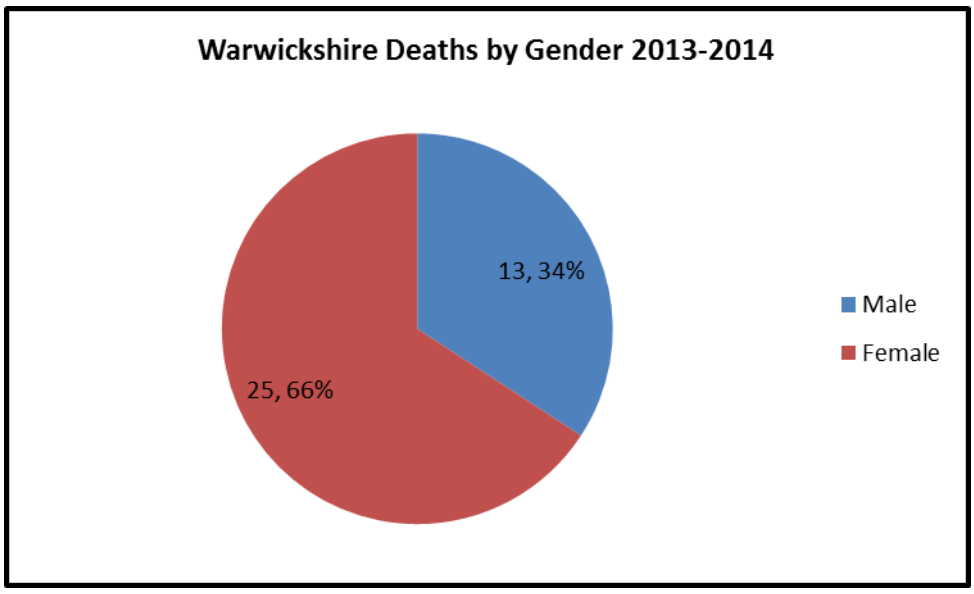


3.4.1 Age groups 5-9 and 10-14 years have been merged due to the low numbers.

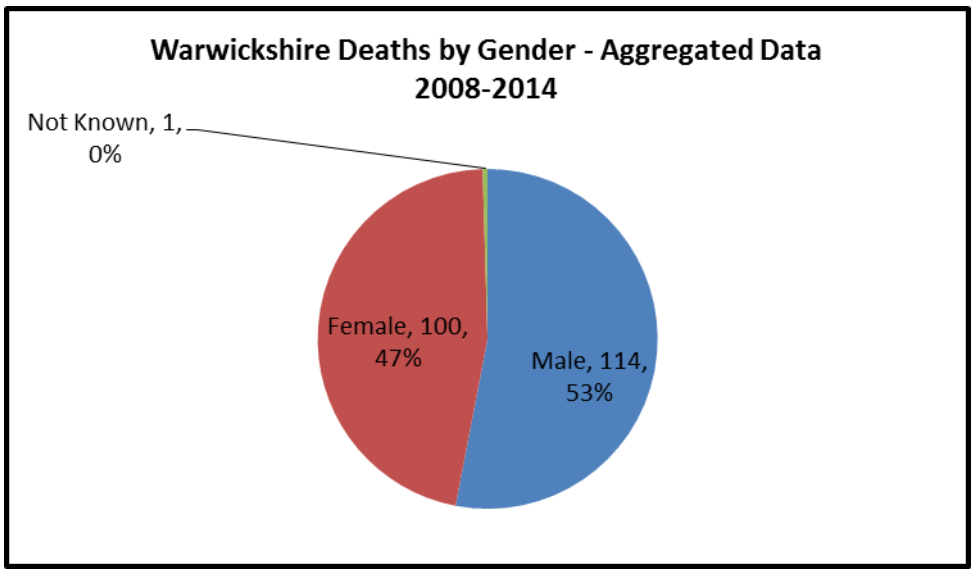
3.5 Warwickshire Deaths by Age – Aggregated Data 2008-2014 (Total 215)



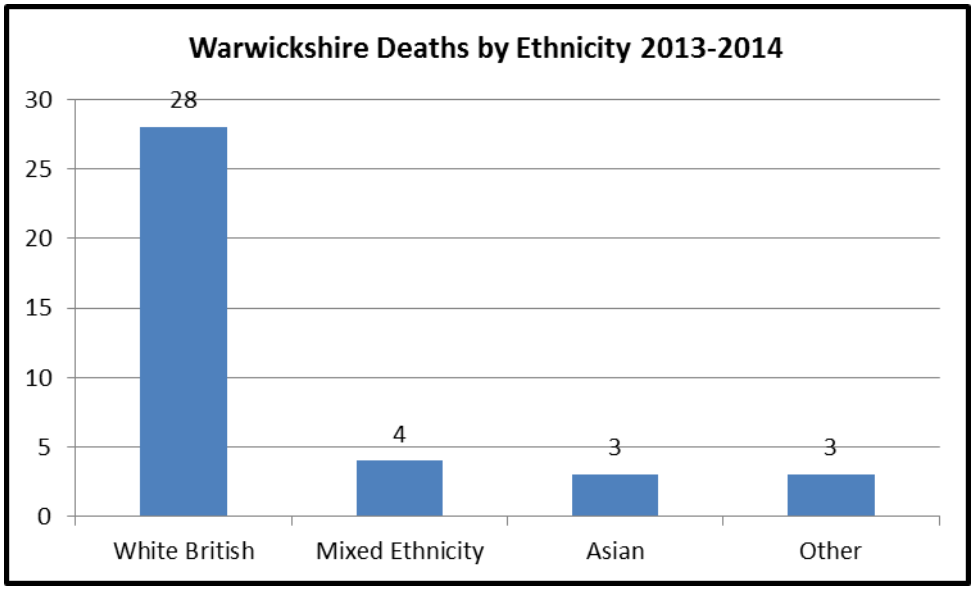
3.6 Warwickshire Deaths by Gender 2013-2014 (Total 38)



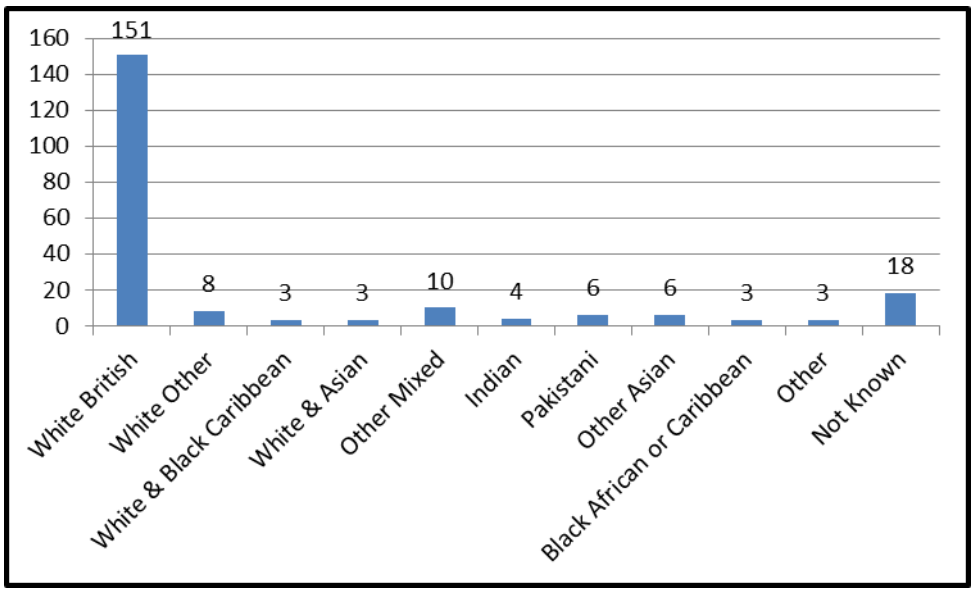
3.7 Warwickshire Deaths by Gender – Aggregated Data 2008-2014 (Total 215)



3.8 Warwickshire Deaths by Ethnicity 2013-2014 (Total 38)



3.9 Warwickshire Deaths by Ethnicity – Aggregated Data 2008-2014 (Total 215)



4 Summary

4.1 Neonatal deaths continue to be the highest category as expected.

4.2 The highest age group is 0-28 days which incorporates the neonatal deaths and therefore expected.

4.3 The graph in 3.2 shows 19 neonatal deaths but the graph in 3.4 showing a breakdown of ages shows there were 17 deaths aged 0-28 days. The reason for this is that 2 neonates lived beyond 28 days but were still categorised as neonatal deaths as they were born prematurely and never left hospital.

4.4. The aggregated data for ages shows that 67% of deaths (143 out of 215) occurred within the first year of life. This is also mirrored by Coventry and Solihull.

4.5 The proportion of male and female deaths in 2013-2014 bucked the national trend as more females died in 2013-2014 than male. The aggregated data however is in keeping with the national trend of more male then female deaths.

4.6 With regards to ethnicity, children of White British' origin remains the highest category as it has done over previous years.

4.7 The 'Not Known' are deaths from 2008-2009 when ethnicity was not requested on the national template forms. This changed in early 2009-2010 and ethnicity has been captured since.

Appendix 'D'

Rapid Response Investigation – Sudden Unexpected Death in Children Protocol

Chapter 5 of Working Together to Safeguard Children 2013, defines the unexpected death of an infant or child (less than 18 years old) as a death:

- Which was not anticipated as a significant possibility for example, 24 hours before the death; or

- Where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death

Response to Unexpected Deaths

All Local Safeguarding Children's Boards are expected to have procedures in place to ensure there is a co-ordinated multiagency response to unexpected deaths. Where a death is sudden, unexpected and unexplained a 'rapid response' investigation will be instigated, as follows:

a) The immediate history taking, examination of the child and investigations will be carried out and support provided to the family.
b) The designated paediatrician will notify the Coroner, Police Senior Investigating Officer, Children's Social Care and immediate information sharing will take place.
c) A home visit will take place within 24 hours, by the Police and a health professional, i.e. a Paediatrician or specialist nurse to visit the scene of death; obtain a more detailed history; explain the process to parents/families and facilitate support to the family.
d) A post- mortem examination will take place.
e) An initial multi-agency information and planning meeting will take place chaired by the designated paediatrician, after the initial post-mortem results are known. This can take place verbally over the telephone if there are no concerns.
f) A final multi-agency case discussion meeting will be convened and chaired by the designated paediatrician when all of the information has been obtained, including the final post mortem report. All agencies known to the child and/or involved in the rapid response investigation are invited. At this meeting any contributing factors will be identified and on-going support for the family. The minutes of this meeting will be provided to H.M. Coroner prior to the Inquest (if being held) and to the Child Death Overview Panel.
g) A meeting will be arranged with the parents to; discuss the cause of death and any contributing factors, identify and facilitate any on-going needs and advise re tissue retention. The professional(s) identified to meet with the family is agreed at the final case discussion meeting and is usually the designated paediatrician. If the family decline a meeting, the findings will be conveyed by letter by the designated paediatrician.
h) An Inquest may be held by the Coroner but changes to the Coroner's Rules states that the Coroner does not have to hold an Inquest if death from natural causes has been ascertained.

West Midlands and Warwickshire have both produced a 'Best Practice Multi-Agency Protocol for Sudden Unexpected Deaths of Infants and Children under 18 years of age' (SUDC Protocol)

Warwickshire Health & Wellbeing Board
21 January 2015
Data Sharing Protocol

Recommendations

That the Warwickshire Health and Wellbeing Board (HWB):

1. **Consider, note and endorse the approach taken.**
2. **Promote the use of responsible data sharing to facilitate more detailed and robust needs assessment as part of core planning.**

1.0 Background

1.1 An overarching data sharing protocol for the County has recently been developed by Arden Commissioning Support Unit. The local Clinical Commissioning Groups, Warwickshire County Council (People Group and Public Health) and local Acute Trusts have all signed up to this.

1.2 This is the culmination of many months of discussions and represents the first stage necessary to begin accessing detailed health data for the purposes of producing more robust, timely and comprehensive needs assessments, which will form part of the wider Joint Strategic Needs Assessment (JSNA) work programme.

1.3 The importance of information and data sharing to facilitate the improvement of services was recently highlighted in the newly adopted Warwickshire Health and Wellbeing Strategy 2014-2018.

2.0 Purpose

2.1 The agreement sets out the basic premise of sharing data to enable population-based epidemiological data analysis, whilst adhering to relevant legislative information governance requirements and Caldicott principles.

2.2 It should be stressed that this protocol does not provide the basis for the sharing of all data between partner organisations; it instead sets out the legislative requirements to which everyone agrees to abide to. The precise details of information to be shared between organisations need to be separately agreed in the form of an 'Appendix E (Data Sharing Agreement)' which is part of the overarching protocol. The Appendix E is then formally and separately signed off by the Caldicott Guardians of the participating organisations, if it meets the relevant legislative requirements and guidelines.

2.3 There is an expectation that partners in the data sharing protocol should achieve 'level 2 compliance' with the Health & Social Care Information Centre (HSCIC) 'Information Governance Toolkit', and Warwickshire County Council is now working towards the Local Authority version of this.

2.2 The ability to share data with health partners will be particularly important in our work relating to the Better Care Programme. The data sharing protocol, along with compliance with the Information Governance Toolkit, will ensure we are in a position to share the information we need to deliver further integration between health and social care.

3.0 Next Steps

3.1 The protocol is currently being used to progress data sharing for the Discharge to Assess programme and the Transforming Domiciliary Care programme, and further applications have also been identified.

3.2 It is intended that the agreement will be signed shortly by other relevant health partners across Coventry and Warwickshire. There is also an aspiration to extend the agreement to cover a broader range of other partners.

4.0 Background Papers

4.1 Appendix I – Data Sharing Protocol – August 2014

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Appendix A

INFORMATION SHARING PROTOCOL

Arden Commissioning Support

Coventry and Rugby Clinical Commissioning Group

South Warwickshire Clinical Commissioning Group

Warwickshire North Clinical Commissioning Group

South Warwickshire NHS Foundation Trust

Coventry and Warwickshire Partnership NHS Trust

University Hospital Coventry & Warwickshire NHS Trust

Warwickshire County Council

Coventry City Council

CONTENTS

1. Introduction

1.1 This document is a Data Sharing Protocol (for the purpose of this protocol, the terms data and information are synonymous). The aim of this document is to facilitate sharing of information between Arden Commissioning Support Unit and it's customer CCG's so that members of the public receive the services they need.

1.2 Organisations involved in providing services to the public have a legal responsibility to ensure that their use of personal information is lawful, properly controlled and that an individual's rights are respected. This balance between the need to share information to provide quality service and protection of confidentiality is often a difficult one to achieve.

1.3 The legal situation regarding the protection and use of personal information can be unclear. This situation may lead to information not being readily available to those who have a genuine need to know in order for them to do their job properly. See Appendix B for Relevant Legislation.

2. Scope

2.1 This overarching Protocol sets out the principles for information sharing between Partner Organisations (Appendix A).

2.2 This Protocol sets out the rules that all people working for or with the Partner Organisations must follow when using and sharing information.

2.3 The Protocol applies to the following information:

2.3.1 All personal information processed by the organisations including electronically (e.g. computer systems, CCTV, Audio etc), or in manual records.

2.3.2 Anonymised, including aggregated, personal data. The considerations, though less stringent, must take into account factors such as commercial or business, sensitive data, and the effect of many data sets being applied.

2.4 This Protocol will be further extended to include other public sector, private and voluntary organisations working in Partnership to deliver

services.

2.5 The specific purpose for use and sharing information will be defined in the Data Exchange Agreements that will be specific to the Partner Organisations sharing information.

3. Aims and Objectives

3.1 The aim of this Protocol is to provide a framework for the Partner Organisations and to establish and regulate working practices between Partner Organisations. The Protocol also provides guidance to ensure the secure transfer of information, and that information shared is for justifiable 'need to know' purposes (see 6.3 and 11.6).

3.2 These aims include:

a. To guide Partner Organisations on how to share personal information lawfully.

b. To explain the security and confidentiality laws and principles of information sharing.

c. To increase awareness and understanding of the key issues.

d. To emphasise the need to develop and use Data Exchange Agreements.

e. To support a process, this will monitor and review all data flows.

f. To encourage flows of data.

g. To protect the Partner Organisations from accusations of wrongful use of sensitive personal data.

h. To identify the lawful basis for information sharing.

3.3 By becoming a Partner to this Protocol, Partner Organisations are making a commitment to:

a. Apply the Information Commissioner's Code of Practice's 'Fair Processing' and 'Best Practices' Standards;

b. Adhere to or demonstrate a commitment to achieving the appropriate compliance with the Data Protection Act 1998; (See Appendix B).

c. Develop local Data Exchange Agreements that specify transaction details. (See Appendix E for template).

d. To apply NHS Caldicott confidentiality standards.

3.4 All Partners will be expected to promote staff awareness of the major requirements of Information Sharing. This will be supported by the production of appropriate guidelines where required that will be made available to all staff via the Partners' Intranet sites and/or via other communication media.

4. The Legal Framework

4.1 The principal legislation concerning the protection and use of personal information is listed below and further explained in Appendix B:

• Human Rights Act 1998 (article 8)
• The Freedom of Information Act 2000
• Data Protection Act 1998
• The Common Law Duty of Confidence

4.2 Other legislation may be relevant when sharing specific information. For example, the sharing of information relating to children may involve (but not limited to) consideration of any of the following:

- The Children Act 1989
- The Children Act 2004
- Education Act 2002
- Education Act 1996
- Learning & Skills Act 2000
- Education (SEN) Regulations 2001
- Children (Leaving Care) Act 2000
- Protection of Children Act 1999
- Immigration & Asylum Act 1999
- Local Government Act 2000
- Criminal Justice Act 2002
- Crime and Disorder Act 1998

- National Health Service Act 1977
- Health Act 1999
- The Adoption and Children Act 2002
- Health and Social Care Act 2012

5. Data covered by this Protocol

5.1 All personal and anonymised information as defined in the Data Protection Act 1998 (DPA) and as amended by the Freedom of Information Act 2000 (Section 68). **Anonymous data should be used wherever possible.**

5.2 **Personal Information**

5.2.1 The term ‘personal information’ refers to **any** information held as either manual or electronic records, or records held by means of audio and/or visual technology, about an individual who can be personally identified from that information.

5.2.2 The term is further defined in the DPA as:

- Data relating to a living individual who can be identified from those data, or

- Any other information which is in the possession of, or is likely to come into the possession of the data controller (person or organisation collecting that information).

- Consideration should also be given to relevant case law that has defined personal data such as the Durant ruling.

5.2.3 The DPA also defines certain classes of personal information as ‘sensitive data' where additional conditions must be met for that information to be used and disclosed lawfully.

5.2.4 An individual may consider certain information about themselves to be particularly ‘sensitive’ and may request other data items to be kept especially confidential e.g. any use of a pseudonym where their true identity needs to be withheld to protect them.

5.2.5 All medical data is deemed to be sensitive personal data and is

held under a duty of confidence.

5.3 **Anonymised Data**

5.3.1 Partners must ensure anonymised data, especially when combined with other information from different agencies, **does not** identify an individual, either directly or by summation.

5.3.2 Anonymised data about an individual can be shared without consent (subject to certain restrictions regarding health/social care records), in a form where the identity of the individual cannot be recognised i.e. when:

- Reference to any data item that could lead to an individual being identified has been removed

- The data cannot be combined with any data sources held by a Partner to produce personal identifiable data.

6. Purposes for Sharing Information

6.1 Information should only be shared for a specific lawful purpose, basis or where appropriate consent has been obtained.

6.2 Staff should only have access to personal information on a justifiable **need to know** basis, in order for them to perform their duties in connection with the services they are there to deliver.

6.3 Having this agreement in place does not give license for unrestricted access to information another Partner Organisation may hold. It lays the parameters for the safe and secure sharing of information for a justifiable **need to know** purpose.

6.4 Every member of staff has an obligation to protect confidentiality and are responsible to ensure that information is only disclosed to those who have a right to see it.

6.5 All staff should be trained and be fully aware of their responsibilities to maintain the security and confidentiality of personal information. Staff contracts also contain a clause on confidentiality and all employees are bound by this.

6.6 All staff should follow the procedures and standards that have been agreed and incorporated within this Information Sharing Protocol and any associated Data Exchange Agreements.

6.7 Each Partner Organisation will operate lawfully in accordance with the 8 Data Protection Principles, see Appendix B.

6.8 Clinical/Social Care staff are also bound by their appropriate professional codes of conduct.

7. Restrictions on use of Information Shared

7.1 Information must only be used for the purpose(s) specified at the time of disclosure(s) as defined in the relevant Data Exchange Agreement. It is a condition of access that it must not be used for any other purpose without the permission of the Data Controller who supplied the data, unless an exemption applies within the Data Protection Act 1998 or the information is required to be provided under the terms of the Freedom of Information Act 2000 and any subsidiary regulation.

7.2 Additional Statutory restrictions apply to the disclosure of certain information for example Criminal Records, HIV and AIDS, Assisted Conception and Abortion, Child Protection. Information about these will be included in the relevant DEA.

8. Consent

8.1 Consent is not the only means by which data can be disclosed. Under the Data Protection Act 1998 in order to disclose personal information at least one condition in schedule two must be met. In order to disclose sensitive personal information at least one condition in both schedules two and three must be met. See Appendix B and Glossary for explanation (Appendix C).

8.2 Where a Partner Organisation has a statutory obligation to disclose personal information then the consent of the data subject is not required; but the data subject should be informed that such an obligation exists. However common law duties of confidentiality may still exist.

8.3 If a Partner Organisation decides not to disclose some or all of the personal information, the requesting authority must be informed. For example the Partner Organisation may be relying on an exemption or on the inability to obtain consent from the data subject.

8.4 Consent has to be signified by some communication between the organisation and the Data Subject. If the Data Subject does not respond this cannot be assumed as implied consent. When using sensitive data, explicit consent must be obtained subject to any existing exemptions. In such cases the data subject's consent must be clear and cover items such as the specific details of processing, the data to be processed and the purpose for processing.

8.5 If consent is used as a form of justification for disclosure, the data subject must have the right to withdraw consent at any time.

8.6 Specific procedures will apply where the data subject is either under the age of 16, or where the data subject does not have the capacity to give informed consent. In these circumstances the relevant policy of the Partner Organisation should be referred to. Consideration should also be given to other case law, such as Gillick, and the requirements of the Mental Capacity Act 2005.

9. Organisational Responsibilities

9.1 Each Partner Organisation is responsible for ensuring that their organisational and security measures protect the lawful use of information shared under this Protocol.

9.2 Partner Organisations will accept the security levels on supplied information and handle the information accordingly.

9.3 Partner Organisations accept responsibility for independently or jointly auditing compliance with the Data Exchange Agreements in which they are involved within reasonable time-scales.

9.4 Every organisation should make it a condition of employment that employees will abide by their agreed rules and policies in relation to the protection and use of confidential information. This condition should be written into employment contracts and any failure by an individual to follow the policy should be dealt with in accordance with that organisation's disciplinary procedures.

9.5 Every organisation should ensure that their contracts with external service providers abide by their rules and policies in relation to the protection and use of confidential information.

9.6 The Partner Organisation originally supplying the information should be notified of any breach of confidentiality or incident involving a risk or breach of the security of information.

9.7 Partner Organisations should have documented policies for retention, weeding and secure waste destruction.

9.8 Partner Organisations should be committed to having procedures in place to ensure the quality of information. It is suggested that they consider having a Data Quality Strategy. A Strategy will secure and ensure the maintenance of good quality standards and identify areas for improvement.

9.9 Partner Organisations must be aware that a data subject may withdraw consent to processing (i.e. Section 10 DPA) unless an available exemption applies. Where the Partner Organisations rely on consent as the condition for processing then withdrawal means that the condition for processing will no longer apply. Any such withdrawal of consent should be communicated to Partner Organisations and processing cease as soon as possible.

9.10 Partner Organisations must be committed to having procedures in place to address complaints relating to inappropriate disclosure or failure to disclose personal information. Individuals must be provided with information about these procedures.

9.11 The sixth principle of the Data Protection Act 1998 provides individuals the right to have access to information held about them with limited exemptions. Partner Organisations must ensure that only appropriate access to information is granted therefore appropriate procedures must be in place to ensure individual's rights are met.

10. Individual Responsibilities

10.1 Every individual working for the organisations listed in this Partnership Agreement is personally responsible for the safekeeping of any information they obtain, handle, use and disclose.

10.2 Every individual should know how to obtain, use and share information they legitimately need to do their job.

10.3 Every individual has an obligation to request proof of identity, or takes steps to validate the authorisation of another before disclosing any information.

10.4 Every individual should uphold the general principles of confidentiality follow the rules laid down in this Protocol and seek advice when necessary.

10.5 Every individual should be aware that any violation of privacy or breach of confidentiality is unlawful and a disciplinary matter that could lead to their dismissal. Criminal proceedings might also be brought against that individual.

11. General Principles

11.1 The principles outlined in this Protocol are recommended good standards of practice or legal requirements that should be adhered to by all Partner Organisations.

11.2 This Protocol sets the core standards applicable to all Partner Organisations and should form the basis of all Data Exchange Agreements established to secure the flow of personal information with strict adherence to Health and Social Care Information Centre (HSCIC) guidelines.

11.3 This Protocol should be used in conjunction with local service level agreements, contracts or any other formal agreements that exist between the Partner Organisations.

11.4 All parties signed up to this Protocol are responsible for ensuring that organisational measures are in place to protect the security and integrity of personal information and that their staff are properly trained to understand their responsibilities and comply with the law.

11.5 This Protocol has been written to set out clear and consistent principles that satisfy the requirements of the law that all staff must follow when using and sharing personal information.

11.6 The specific purpose for use and sharing information will be defined in the Data Exchange Agreements that will be specific to the Partner Organisations sharing information.

12. Review Arrangements

12.1 This overarching Agreement will be formally reviewed annually by the Arden Commissioning Support Unit, unless new or revised legislation or national guidance necessitates an earlier review.

12.2 Any of the signatories can request an extraordinary review at any time where a joint discussion or decision is necessary to address local service developments.

Appendix A - Signatures and Contact Information

Agreement: We the undersigned do hereby agree to implement the terms and conditions of this Protocol .
Contact Information

Organisation	Print Name	Signature	Date	Job Title	Telephone	Email

APPENDIX B - LEGAL CONTEXT.

THE DATA PROTECTION ACT 1998

Data Protection legislation governs the standards for the processing of personal data including the collection, use of and disclosure of such information. The legislation requires that data controllers meet certain obligations. It also give individuals or 'data subjects' certain rights with regard to their own personal data. The main standard for processing personal data is compliance with the eight data protection principles summarised as follows:

i) All personal data will be obtained and processed fairly and lawfully.

ii) Personal data will be held only for the purposes specified.

iii) Only personal data will be held which are adequate, relevant and not excessive in relation to the purpose for which the data are held.

iv) Personal data are accurate and where necessary, kept up to date.

v) Personal data will be held for no longer than is necessary.

vi) Personal Data will be processed in accordance with the Rights of the Data Subject.

vii) Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

viii) Personal data shall not be transferred to countries outside the European Economic area except in limited circumstances

The first principle states that personal data shall be processed fairly and lawfully and shall not be processed unless at least one Schedule 2 condition and in the case of 'sensitive personal data', at least one Schedule 3 condition is also met.

The type of information being disclosed for the purposes of this exchange agreement may constitute 'sensitive personal data' which means that at least one of both Schedule 2 *and* Schedule 3 conditions must be satisfied.

Even in the event that the *prevention and detection of crime* exemption (Section 29 Data Protection Act) is being relied upon, or other power such as S.115 Crime and Disorder Act, Schedules 2 and 3 conditions must still be satisfied.

Data Protection Act 1998 (Principle 1) Schedules 2 and 3.

The most relevant schedules are:

- The processing is however likely **to be necessary for compliance with any legal obligation** (3), such as the Police Acts and the Local Government Act 2000.
- It is likely that the most relevant condition will be that the processing **is necessary for the exercise of any other functions of a public nature exercised in the public interest by any person (5)(d).**
- The **legitimate interests (6)** condition *may* be appropriate but cases are likely to arise whereby a service user could clearly challenge this, depending upon the circumstances.

The most relevant conditions in Schedule 3 are s3 and s7.

Section 3. The processing is necessary

(a) in order to protect the **vital interests of the data subject, or another person**, in a case where:

(i) consent cannot be given by, or
(ii) on behalf of the data subject, or the data controller cannot

reasonably be expected to obtain the consent of the data subject, or

(b) in order to protect the vital interests of another person, in a case where consent by or on behalf of the data subject has been unreasonably withheld.

Section 7. (1) Processing is necessary:

(a) for the administration of justice,
(b) for the exercise of any functions conferred on any person by or under an enactment.

Although the aforementioned conditions are likely to apply to any or all of the variable circumstances, it is likely that for the purposes of this exchange agreement one of the additional conditions specified in secondary legislation, for example: S.I No 417 The Data Protection (Processing of Sensitive Personal Data) Order 2000 and (Draft) The Data Protection (Processing of Sensitive Personal Data) Order 2006, may apply.

S.I 417 Data Protection (Processing of Sensitive Personal Data) Order 2000

The Order lists additional circumstances in which sensitive personal data may be processed. For example, it covers processing for the purposes of the prevention or detection of any unlawful act, where seeking the consent of the data subject would prejudice those purposes. It also covers processing required to discharge functions involving the provision of services such as confidential counselling and advice where the subject's consent has not been obtained.

In each of the examples above processing would have to be "in the substantial public interest". This could mean, for example, that processing is necessary to protect public safety or to protect vulnerable people.

Draft S.I Data Protection (Processing of Sensitive Personal Data) Order 2006

The Order specifies that information about a criminal conviction or caution may be processed for the purpose of administering an account relating to the payment card used in the commissioning of one of the listed offences relating to indecent images of children.

THE HUMAN RIGHTS ACT 1998

The UK Human Rights Act 1998 gives further effect in domestic law to Articles of the European Convention on Human Rights (ECHR). The Act requires all domestic law be compatible with the Convention Articles and places a legal obligation on all public authorities to act in a manner compatible with the convention. Should a public authority fail to act in such a manner then legal action can be taken under Section 7 of the Act.

Article 8 of the Act states that:

> "Everyone has the right to respect for his private and family life, his home and his correspondence and that there shall be no interference by a public authority with this right except as in accordance with the law". It is likely that this exchange of information will be for the purposes of one of the following legitimate aims:

- In the interests of national security.
- Public Safety.
- Economic well being of the country.
- The prevention of crime and disorder.
- The protection of health or morals.
- The protection of the rights or freedoms of others.

FREEDOM OF INFORMATION ACT 2000

Information held by or on behalf of a public authority may be disclosed to a party requesting it except where a statutory exemption applies. For example, personal data is normally exempt

under the Act (but may be disclosable under DPA 1998); as is information provided under a duty of confidence.

LOCAL GOVERNMENT ACT

The main power specific to local authorities is section 2 Local Government Act 2000 - the power of "well-being". This enables LA's to do "anything" to promote social, economic, or social well-being in their area provided the act is not specifically forbidden by other statute (including the Data Protection Act) and that in carrying out the act it gives regard to its own community strategy. For example, all councils are taking measures, including data sharing, to reduce crime in its area in order to promote well-being. In addition S111 Local Government Act 1972 enables local authorities to do anything conducive or incidental to the discharge of any of its functions, providing it has specific statutory authority to carry out those main functions in the first place. The above are general powers available to local authorities. In addition, authorities are granted statutory powers relating to specific activities and these should be referred to as appropriate in the Data Exchange Agreement.

POLICE ACT 1996

The Police Act 1996 gives a Constable certain powers. Section 30(1) gives constables all the powers and privileges of a constable throughout England and Wales and Section 30(5) defines these powers as powers under any enactment when ever passed or made. These powers include the investigation and detection of crime, apprehension and prosecution of offenders, protection of life and property and maintenance of law and order. Under the Police Reform Act 2002, the Chief Constable can delegate certain powers to police staff.

In addition, the Code of Practice on the Management of Police Information 2005 defines the policing purpose as:-

- protecting life and property,
- preserving order,
- preventing the commission of offences,
- bringing offenders to justice,
- any duty or responsibility arising from common or statute law

The policing purpose set out in the Code does not replace or supersede any existing duty or power defined by statute or common law. In addition, this does not define every policing activity and does not mean that there is no legal basis for performing such activities. For example, roads policing, public order, counter-terrorism or protection of children or other vulnerable groups while not referred to explicitly are non the less

legitimate policing functions.

THE CRIME AND DISORDER ACT 1998

Section 115 of the Crime and Disorder Act 1998 confers a power on any 'relevant authority' (which are the police, local authority, health authority and probation service or to any other person acting on behalf of such authority) to exchange that information which is 'necessary' or 'expedient' to help implement the provisions of the Act which includes contributing to local strategies to reduce crime and disorder. The parties to this exchange agreement are relevant authorities for the purposes of this legislation.

Section 17 Crime and Disorder Act 1998 requires that all Local Authorities consider crime and disorder reduction while exercising their duties. Sections 5 and 6 of the Crime and Disorder Act imposes a general duty upon local authorities to formulate and implement a strategy for the reduction of crime and disorder in its area.

COMMON LAW DUTY OF CONFIDENCE

The duty of confidence falls within common law as opposed to statutory law and derives from cases considered by the courts. There are generally three categories of exception to the duty of confidence:

- Where there is a legal compulsion to disclose.
- Where there is an overriding duty to the public.
- Where the individual to whom the information relates consented.

Partners should consider which of these conditions are the most relevant ones for the purposes of this exchange agreement. The guidance from the Information Commissioner states that because such decisions to disclose 'in the public interest' involves the exercise of judgement it is important that they are taken at an appropriate level and that procedures are developed for taking those decisions. The partners to this agreement should document within this agreement how this duty will be maintained, e.g. need to know.

CALDICOTT

Where Health Data is concerned; when sharing information with others, due regard must be given to the Caldicott principles listed below. Ensure that all the conditions are met before sending the data. If unsure then speak to your line manager, or the appropriate Caldicott Guardian.

Caldicott Principles:

- Justify the purpose before sharing information.
- Only use patient identifiable data when absolutely necessary.
- Use the minimum that is required, do not share more data than is necessary, i.e. do not send the whole patient record when only the request relates to a recent event.
- Access to the data should be on a strict need to know basis.
- Be aware of your responsibilities in complying with organisational policies relating to confidentiality.
- Understand the law, if uncertain, speak to you line manager.
- The duty to share information can be as important as the duty to protect patient confidentiality.

Where Health Data is concerned Health staff, and others working in partnership with them, should be aware of the concept of Safe Haven**.**

Safe Havens will:

- Provide a secure location restricting access to only authorised staff and will be locked outside normal hours.
- Be staffed by those individuals with authority to access confidential information and who are under contractual and statutory obligations to maintain confidentiality.
- Ensure that no confidential information will be released to parties outside the partner organizations unless it is deemed appropriate. Staff should make reference to the Caldicott Principles listed above and seek advice from the relevant Caldicott guardian where uncertain.
- Ensure that wherever possible the NHS number is present and person identifiable data has been removed.

Appendix C - Glossary of Terms

Accessible Record – unstructured personal information usually in manual form relating to health, education, social work and housing.

Agent – acts on behalf of the data subject.

Aggregated – collated information in a tabular format.

Anonymised data –data where an Organisation does not have the means to identify an individual from the data they hold. If the Data controller has information, which allows the Data Subject to be identified, regardless of whether or not they intend to identify the individual is immaterial - in the eyes of the Information Commissioner this is not anonymous data – see **Pseudonymised data**. Data Controller must be able to justify why and how the data is no longer personal.

CCTV – close circuit television.

Consent – The Information Commissioner's legal guidance to the Data Protection Act 1998 is to refer to the Directive, which defines consent as "…any freely given specific and informed indication of his wishes by which the data subject signifies his agreement to personal data relating to him being processed" (3.1.5).

Data/Information –

a) Information being processed by means of equipment operating automatically or
b) Information recorded with the intention it be processed by such equipment.
c) Recorded as part of a relevant filing system or
d) Not in a or b or c, but forming part of an accessible record.
e) Recorded information held by a public authority and does not fall within any of paragraphs (a) to (d).

Data Controller – a person or a legal body such as a business or public authority who jointly or alone determines the purposes for which personal data is processed.

Data Exchange Agreement – the local information sharing agreement based on the attached template Appendix E.

Data Flows – the movement of information internally and externally, both within and between organisations.

Appendix C: Glossary of Terms Continued…

Data Processing – any operation performed on data. The main examples are collection, retention, deletion, use and disclose.

Data Processor – operates on behalf of the Data Controller. Not staff.

Data Set – a defined group of information

Data Subject – an individual who is the subject of personal information.

Disclosure – the passing of information from the Data Controller to another organisation / individual

Duty of Confidentiality – everyone has a duty under common law to safeguard personal information.

European Economic Area (EEA) – this consists of the fifteen EU members together with Iceland, Liechtenstein and Norway.

Fair processing – to inform the Data Subject how the data is to be processed before processing occurs

Fully informed implied consent - In order to comply with the Data Protection Act, to validate implied consent if necessary and to satisfy moral obligations, the sender must always strive to fully inform the subject wherever possible of the uses to which their information will be put, what disclosures could be envisaged and what the consequences of the processing are. All parties must strive to be open and transparent.

Health Professional – In the Data Protection Act 1998 "health professional" means any of the following who is registered as:

A medical practitioner, dentist, optician, pharmaceutical chemist, nurse, midwife or health visitor, and osteopaths.

and

Any person who is registered as a member of a profession to which the Professions Supplementary to Medicine Act 1960 currently extends to, clinical psychologists, child psychotherapists and speech therapist, music therapist employed by a health service body, and scientist employed by such a body as head of department.

Health Record – any information relating to health, produced by a health professional.

Need to know – to access and supply the minimum amount of information required for the defined purpose.

Personal Data – means data relating to a living individual who can be identified from those data (including opinion and expression of intention).

Processing – any operation performed on data. Main examples are collect, retain, use, disclosure and deletion.

Pseudonymised data – where personal information has been “de-identified” i.e. personal information which directly identifies an individual, e.g. name or date of birth and address used together, has been replaced by non-identifying, artificial data, e.g. NHS number or other code. Pseudonymised data is partially anonymised data and the identification of an individual can be re-established using other available data held by the Data Controller organisation. See also **Anonymised data**

Purpose – the use / reason for which information is stored or processed.

Recipient – anyone who receives personal information for the purpose of specific inquiries

Relevant Filing System – two levels of structure, (i) filing system structured by some criteria (ii) each file structured so that particular information is readily accessible.

Sensitive Personal Data – The DPA defines sensitive personal data as:

(a) the racial or ethnic origin of the data subject;

(b) his/ her political opinions;

(c) his/ her religious beliefs or other beliefs of a similar nature;

(d) whether he/ she is a member of a trade union (within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992);

(e) his/ her physical or mental health or condition;

(f) his/ her sexual life;

(g) the commission or alleged commission by him/ her of any offence; or

(h) any proceedings for any offence committed or alleged to have been committed by him/ her, the disposal of such proceedings or the sentence of any court in such proceedings.

Serious Crime – There is no absolute definition of "serious" crime, but section 116 of the Police and Criminal Evidence Act 1984 identifies some "serious arrest-able offences".

Appendix C: Glossary of Terms Continued…

These include:

Treason
Murder
Manslaughter
Rape
Kidnapping
Certain sexual offences
Causing an explosion
Certain firearms offences
Taking of hostages
Hijacking
Causing death by reckless driving
Offences under prevention of terrorism legislation (disclosures now covered by the Prevention of Terrorism Act 1989).

Subject Access – the individual's right to obtain a copy of information held about themselves.

Third Party – **any person who is not the data subject, the data controller, the data processor (includes Health, Housing, Education, Carers, Voluntary Sector etc. as well as members of the public).**

Appendix D - Confidentiality Statement

To enable the exchange of information between ……and ……. to be carried out in accordance with the Data Protection Act 1998, the Human Rights Act 1998 and the common law duty of confidentiality, all attendees are asked to agree to the following. This agreement will be recorded.

This information sharing activity contains confidential patient/ person identifiable information. In order to comply with the law protecting confidentiality the information can only be supplied subject to the following conditions.

1. A senior member of staff in your organisation must take personal responsibility for maintaining confidentiality.

2. The information is stored in a secure environment at all times (e.g. in a locked cupboard, or where stored electronically protected by passwords).

3. Once the task has been completed the original information and all copies will be destroyed or returned to Arden Commissioning Support Unit as soon as possible.

4. Only members of staff legitimately involved in the work should have access to this information in order to carry out the agreed task(s).

5. Members of staff accessing this information are aware of the conditions under which it is supplied, and have signed an honorary contract with this organisation.

6. The information will only be used for the purpose for which it is supplied.

7. Information supplied will not be disclosed to any other organisation or individual.

This agreement must be signed by a member of the organisation with sufficient seniority to ensure that these terms are met.

I have read, understood and agree to abide by these conditions.

Signature……..Date……..…

Name……

Representing…Name and/or Organisation……..

……..

Copies of this signed agreement are to be held by the Arden Commissioning Support Unit lead in this work.

Appendix E - Data Exchange Agreement (DEA) Template

All wording in bold should be included in your Data Exchange Agreement and all sections need to be included. If the wording is not in bold it will give you guidance on what you will need to agree with your partners.

1. Policy Statements and Purpose of this Data Exchange Agreement

This section should include a policy statement that should explain why there is a need to exchange data with each of the Partner organisation(s) and the aims and objectives that this will achieve.

2. Legal Basis for Data Exchange

Each partner organisation should be able to identify their lawful basis to exchange this data. This lawful basis may come from common law, statute or legal precedence, which may be supported by Home Office guidance, professional/executive bodies, e.g. Dept of Health, Association of Chief Police Officers, Dept of Education, etc. This will enable partners to defend a challenge with regard to the Data Protection Act 1998 and/or the Human Rights Act 1998. The lawful basis for some of the relevant authorities is listed in Appendix B, you should delete those which do not apply and add any others depending on which organisation are represented in your data exchange process.

It is also important to ensure that any partner/individual which receives information and holds and processes such information is able to identify a paragraph in Schedule 2 of the Data Protection Act 1998 to ensure that the processing is fair and lawful. If the information is sensitive information a paragraph in Schedule 3 will also need to be identified.

Where the legal basis for data exchange is based on consent, partners should include, within this agreement, details relating to:

- Obtaining consent.
- Establishing fitness to give consent.
- Checking on whether consent already exists.
- Recording consent.
- Time limits for consent.

This DEA has been developed to achieve the objectives as set out in Section's 1. It is the intention that all aspects of information exchange and disclosure relating to this

exchange agreement shall comply with legislation that protects personal data - see Appendix B**.**

3. Data

3.1 What data is it necessary to exchange?

The data you exchange must be proportionate and should be the minimum amount needed to achieve the purpose identified in Section 1. You should decide if you could do this using data which does not identify individuals (anonymising/ pseudonymising the data).

If data which identifies individuals must be used you should specify as closely as possible the details and the type of data that each partner will disclose and to which other partner. For example, client name, home address, date of birth. If forms are used to request or disclose the data, attach them as an appendix.

You may find that completing the form below will assist, alternatively you could list each partner in turn and specify what data they will exchange and to whom. This is to ensure that it is clear who the data controller is for each data item and that any records which are subsequently created from information exchanged under this agreement should identify the source of that data.

The data sets shown are **for example** only and you use that which applies and add any specific data sets not listed here

Data Set	Who from	Who to	Why	Which Organisation owns the information	Frequency of Sharing	How will information be exchanged	How long will data be held for
Name							
D.O.B							
Address1							
Address2							
Address3							
Postcode							
Contact Number							
Gender							
Religion							
Occupation							
Language							
Type of Occupancy							
Ethnic Origin of victim							

Further to this the ……. will exchange the following additional data:

Geographical information system co-ordinates to within 200
square metres.
Incident reference numbers
The date that the incident was first reported
The date of the incident

Ensure that all data items to be exchanged are listed with a clear ‘data definition’. All parties to the agreement should have a common understanding of the information to be provided / received.

For example: **Contact Name = the name of the client’s carer (usually relative or family friend) who may be contacted by professional carers.**

3.2 Who is going to be responsible for exchanging this data and ensuring data is accurate?

Each partner should identify the post holder(s) responsible on a day-to-day basis for this data exchange along with their contact details. This person should also be responsible for the accuracy of any data exchanged.

3.3 How will you keep a record of what information has been exchanged?

The partners should document in the DEA how they will record what information has been exchanged.

3.4 How is this information going to be exchanged?

The partners should give consideration to how this information will be exchanged and document that process in the DEA. E.g. during XXX meetings, face to face contact. This must take account of the security classification of the information, for example personally identifiable information should not be sent by email.

3.5 Who will have access to this data and what may they use it for?

The DEA should identify who in the receiving agencies can have access to the data and what it can be used for.

3.6 Timescales

If there are any statutory or organisational time limits by which the data is required these should be included in the DEA.

3.7 How securely does the data need to be stored?

Each Partner Organisations should ensure that the minimum standards of security, that they require, are agreed with Partner Organisations with whom their data will be exchanged and included in the DEA. This should take account of the security classification of the data

Each partner signing this DEA and any individual signing the confidentiality agreement agree to adhere to the agreed standards of security. If there is a security breach in which data received from another party under this DEA is compromised, the originator will be notified at the earliest opportunity via the post holder identified at 3.2 who must forward details to the Information Security Section.

If you do not have a security classification scheme which includes handling rules, the following points should be considered to assist you - add and delete them as necessary:

- Ensure that unauthorised staff and other individuals are prevented from gaining access to personal data.
- Ensure visitors are received and supervised at all times in areas where personal data is stored.
- Ensure that all computer systems that contain personal data are password protected. The level of security should depend on the type of data held, but ensure that only those who need to use the data have access.
- Do not leave your workstation/PC signed on when you are not using it.
- Lock away disks, tapes, other removable media or printouts when not in use.
- Ensure all new software is virus-checked prior to loading onto organisations machines. Do the same for disks, memory sticks and any other similar removable device.
- Exercise caution in what is sent via email and to whom it is sent, do not transmit personal data by email.
- Check that the intended recipient of a fax containing personal data is aware that it is being sent and can ensure security on delivery.
- Ensure your paper files are stored in secure locations and only accessed by those who need to use them.
- Do not disclose personal data to anyone other than the Data Subject unless you have the Data Subject's consent, or it is a registered disclosure, required by law, or permitted by a Data Protection Act 1998 exemption.
- Do not leave information on public display in any form. Clear your desk at the end of each day and lock sensitive material away safely.

3.8 How long are you going to keep the data?

Each partner should agree and document in the DEA how long they are going to keep the paper based and electronic data having given consideration to the retention and disposal policy of the other partners. This information must be included for every item in the table above or, where appropriate, the complete data set.

3.9 Further Use of Data

This section should specify whether the Partners agree to any further use of the Data and the process to be followed if a Partner wishes to use the Data for purposes other than defined in this agreement.

4 Breach of confidentiality

This section should explain the procedure the Partners will follow if there is a breach of this Agreement by a Partner or a third party who has received data under this agreement. You should include: -

How partners will be notified and which post holder should be notified in each agency.

- ***How this will be investigated e.g. Data Commissioner, police?***
- ***Agree what action will be taken e.g. disciplinary action, criminal proceedings.***

5 Complaints procedures

Each partner must be committed to having procedures in place to address complaints relating to inappropriate disclosure or failure to disclose personal information. Individual must be provided with information about these procedures.

6 Access to Information

The sixth principle of the Data Protection Act 1998 provides individuals the right to have access to information held about them with limited exemptions. It is necessary to ensure that only appropriate access to information is granted therefore the agreement must detail the responsibilities of each organisation to ensure individuals rights are met appropriately.

7 Indemnity

Each partner will keep each of the other partners fully indemnified against any and all costs, expenses and claims arising out of any breach of this agreement and in particular, but without limitation, the unauthorised or unlawful access, loss, theft, use, destruction or disclosure by the offending partner or its sub-contractors, employees, agents or any other person within the control of the offending partner of any data obtained in connection with this agreement.

8 Individuals who cannot be covered by the Indemnity

The parties to this DEA understand that in keeping with Government initiatives to invite a wider spectrum of society to assist the relevant authorities to implement the Crime and Disorder Act 2000, it is likely that there will be individuals present at certain

meetings who are not employed by an organisation and therefore are not in a position to sign this DEA due to the liability of the indemnity.

In order to ensure that the data controllers who are supplying personal information to the meeting fulfil their duties under Data Protection Act 1998 and that the principles are complied with, it is recommended that the first time any individual attends a meeting covered by a DEA is required to sign a confidentiality agreement as at Appendix D. The responsibility for ensuring that this takes place and for retaining the signed copies lies with the Chair of the meeting.

7 Review of Data Exchange Agreement

All DEAs will be reviewed and subjected to a risk based audit. This section should define how and when the DEA will be reviewed and audited. It is recommended that each DEA is reviewed one year after signature and at an agreed period thereafter. This review is the responsibility of the individuals who own the applications where the data originates from and should be carried out in consultation with the Data Protection/Information Security Section. Guidance on how to carry out the review is attached as Appendix F.

8. Closure/termination of agreement

Any partner organisation can suspend this DEA for 45 days if security has been seriously breached. This should be in writing and be evidenced.

Any suspension will be subject to a Risk Assessment and Resolution meeting, the panel of which will be made up of the signatories of this agreement, or their nominated representative. This meeting to take place within 14 days of any suspension.

Termination of this Data Exchange Agreement should be in writing to all other Partner Organisations giving at least 30 days notice.

9 Freedom of Information Act 2000 (FOIA)

“Each Partner Organisation (PO) shall publish this DEA on its website and refer to it within its Publication Scheme. If a PO wishes to withhold all or part of the DEA from publication it shall inform the other PO’s as soon as reasonably possible. Partner Organisations shall then endeavour to reach a collective decision as to whether information is to be withheld from publication or not. Information shall only be withheld where, should an application for that information be made under FOIA 2000 it is likely that the information would be exempt from disclosure and the public interest

lie in favour of withholding. However, nothing in this paragraph shall prevent the individual Partner Organisations from exercising its obligations and responsibilities under FOIA 2000 as it sees fit.

10 Requests for Disclosure of Information received under this DEA

All recorded information held by public sector agencies is subject to the provisions of the Freedom of Information Act 2000 and the Data Protection Act 1998. While there is no requirement to consult with third parties under FOIA, the parties to this DEA will consult the party from whom the information originated and will consider their views to inform the decision making process. All decisions to disclose must be recorded by the disclosing organisation.

11 Appropriate Signatories

Each Partner should identify who is the most appropriate post holder within their agency to sign the DEA having taken account of their organisational policy and the fact that the signatory must have delegated responsibility to commit their organisation to the indemnity. It is the responsibility of the individuals identified at 3.2 to ensure that copies of the DEA are made available as necessary to ensure adherence to the DEA.

I confirm that this DEA has been prepared in consultation with the Data Information Governance Team/ Caldicott Guardian **(delete as appropriate)** for each signatory.

Appendix F- Process for Review of a Data Exchange Agreement

The aim of a review is to ensure that the DEA is achieving its purpose and that the actual process of exchanging data is operating efficiently.

1 Policy Statements and Purpose of this Data Exchange Agreement

Is the policy statement and the purpose as identified in the DEA still accurate in relation to the present use of the data?

2 Legal Basis for Data Exchange

Do the legal bases in the DEA cover all the parties?

3 What data is it necessary to exchange?

Is the data which is exchanged by the parties in accordance with the DEA?

4 Who is going to be responsible for exchanging this data and ensuring data is accurate?

Is the contact list up to data and accurate?

5 How will you keep a record of what information has been exchanged?

How are the parties keeping a record of what information has been exchanged? Random samples of the data exchanged could be checked against the source record to see if there is evidence of the data exchange

6 How is this information going to be exchanged?

Is data still being exchanged in accordance with the DEA?

7 Who will have access to this data and what may they use it for?

What use of the data is made by the parties receiving data and is access restricted in accordance with the DEA?

8 Timescales

Are any timescales in the DEA being adhered to?

9 How securely does the data need to be stored?

Are all the parties applying the security measures in accordance with the DEA?

10 How long are you going to keep the data?

Are all the parties retaining and destroying the data in accordance with the DEA?

11 Further Use of Data

Is there any evidence that data is being used by any party for purposes other than in accordance with the DEA without consent from the originator?

12 Breach of confidentiality

Have there been any breaches of confidentiality which have not been reported to the other parties? How have any breaches been dealt with?

13 Indemnity/confidentiality agreements

Is there evidence that any individual who is not covered by an organisation which is a signatory to the DEA has signed a confidentiality agreement and are these held on behalf of the Chair?

14 Freedom of Information Act 2000 (FOIA)

Is this DEA publicly available and also available internally for relevant staff?

15 Requests for Disclosure of Information received under this DEA

Have there been any instances where a party has disclosed information received under this DEA without consulting the originating party?

16 Appropriate Signatories

Is the DEA signed by appropriate staff?

Review was carried out by:

Name ……

Signature……

Organisation……

Date……

Name ……

Signature……

Organisation……

Date……

A copy of this review should be stored with the DEA, any deficiencies should be brought to the attention of the Signatories as appropriate.

Distribution This document has been distributed to:

Name	Title	Date of Issue	Version

Item 4

Warwickshire Health and Well Being Board

21st January 2015

Warwickshire Priority Families Programme Phase 2

Recommendation(s)

Recommendation1:

That the Board notes and comments on the progress made in relation to Phase One of the Priority Families Programme

Recommendation 2:

That the Board makes such comments as it thinks fit in relation to Phase 2 of the Programme and, in particular, the draft Priority Families Outcomes Plan

Recommendation 3:

That the Board notes the strong links between work with Priority Families and the Health and Well Being Strategy 2014-2018

Recommendation 4

That the Board suggests appropriate ways of enhancing the engagement of Phase 2 of the Programme with Health commissioners and providers and ways in which individual agencies represented on the Board can support this process

1 Introduction and Background

1.1 Phase One of the national Troubled Families Programme (in Warwickshire known as the Priority Families Programme) commenced on 1st April 2012 and is due to run until 31st March 2015. .

1.2 We are scheduled to achieve 100% of our target to turn around 805 families by the end of January 2015

1.3 As at October 2014 we have 'turned around' 730 families, 91% of our 3 year Phase One target. This is a good level of performance which places us as the

21st best performing authority out of 152 nationally, and the 2nd best authority in the West Midlands.

The phrase 'Turned Around' means:

Either

That all children in the family are now attending school with an attendance level of 85% or more and have maintained that progress for at least 2 school terms AND that crime /anti-social behaviour has either stopped or substantially reduced over a minimum six month period

Or

That an adult in the family previously receiving a work-rated benefit has gained full time employment and stayed in the job for at least six months

1.4 There will be a second phase to the Programme that will run from 1st April 2015 through to 31st March 2016, and then ,subject to the outcome of the May 2015 General Election, on to 31st March 2020.

1.5 On 22 July 2014, the County Council's Cabinet signed up to join Phase 2 which is open to all upper tier local authorities subject to satisfactory performance in relation to their Phase 1 targets by 31st March 2015.

1.6 In view of our strong Phase One performance, we are a pilot authority (called a 'First Wave Early Starter') and are, as a result, working closely with other local authorities and Government to define the terms and processes that will apply to the Programme from April 2015 and are required to identify 405 new families by 31 March 2015.

1.7 As at the end of December 2014, we have identified a total of 390 families that are eligible for Phase 2 and are certain to reach our target of 405 families well ahead of schedule

2. Phase 2 in Outline

2.1 Phase 2 will be significantly different to Phase 1 in that:

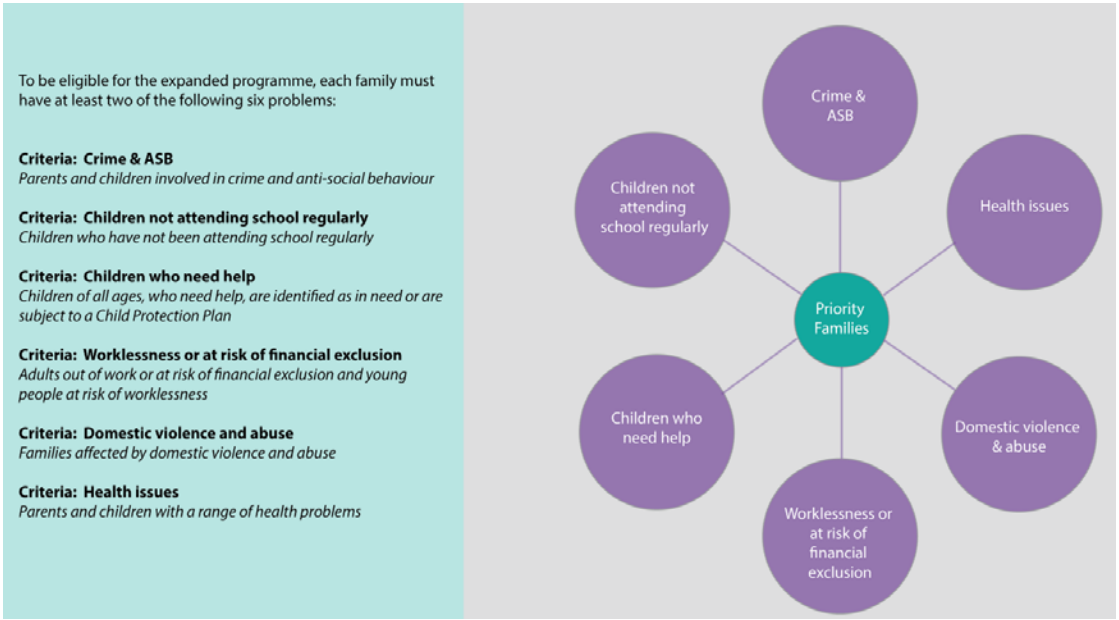
- The headline criteria (see 2.2 below) for the identification of families are broader and more flexible

- The notion of ‘local criteria’ to be viewed alongside national criteria has been removed (although there is considerable local discretion in the setting of local indicators under the headline criteria)
- There is an emphasis on earlier intervention, working with vulnerable families which have multiple problems, and those that are a high cost to the taxpayer.
- The numbers of families to work with and turn round are significantly higher than in Phase One (2,680 families over 5 years / 536 families per year)
- The amount ‘invested’ by the Department for Communities and Local Government (DCLG) in the Programme on a per family basis has been reduced by 55%

2.2 The headline criteria for Phase 2 are:

- Parents and children involved in crime and anti-social behaviour
- Children who have not been attending school regularly
- Children who need help
- Adults out of work or at risk of financial exclusion and young people at risk of worklessness
- Families affected by domestic violence and abuse
- Parents and children with a range of health problems

In order to be eligible for the Programme a family must ‘fit’ at least two headline criteria. The headline criteria are described in the chart below:



2.3 These headline criteria are currently being further defined and developed through the work that we are doing on our Priority Families Outcomes Plan.

2.4 There are a number of critical distinctions between those criteria for Phase 2 that are comparable to the Phase One criteria around Crime / Anti-Social Behaviour, Education and Worklessness in that:

- In relation to Crime / Anti-Social Behaviour the emphasis has been changed to include adult crime as well as youth crime, and a focus on families where there is a member with parenting responsibility is in prison or on licence

- In relation to Education, changing the basis for identifying families through poor school attendance from Unauthorised Absence to the DfE definition of Persistence Absence which aggregates both authorised and unauthorised attendance.

- In relation to Worklessness broadening the criteria beyond families in receipt of DWP Work Related Benefits to families with adults claiming Universal Credit and subject to work conditions, families with young people who are NEET (Not in Education, Employment and Training) or RONI (at risk of NEET) and families at risk of financial exclusion

2.5 Overall, Phase 2 of the Programme has an increased emphasis on:

- Earlier Intervention (and families with younger children)
- Families with multiple problems
- Families that are a high cost to the tax payer (identified through the use of a mandatory cost: savings calculator)
- Bringing about service transformation

2.6 The breadth of the new criteria, combined with the increased numbers of families to work with and turn around, and the likely duration of the Troubled Families Programme nationally, means that our work with Priority Families should now move from a programme management phase to the centre stage of our main-stream delivery with families, vulnerable young people and adults.

2.7 This assertion has been confirmed by Louise Casey C.B. (Director General of the Families Team at DCLG) in a recent message to Programme Coordinators when she said:

'Our focus will also turn increasingly toward ensuring the troubled families work is properly mainstreamed and at the forefront of local public service reform'.

3 The Priority Families Outcomes Plan

3.1 We are required to produce an Outcomes Plan in line with the DCLG Financial Framework that was finalised in November 2014. The Framework is available via the following link:

https://www.gov.uk/government/publications/financial-framework-for-the-expanded-troubled-families-programme

And the latest draft of the Plan is attached as Appendix One to this report.

3.2 It should be noted that this is the latest in a series of versions of the draft Plan and that this draft is currently subject to ongoing consultation and engagement.

3.3 Since September 2014, we have been engaging with a range of partners, organisations and front-line staff regarding the preparation of the draft Plan. Additionally, we were invited by DCLG to attend a Peer Review Workshop with eight other authorities when we compared and contrasted our Plans. We have engaged with the six Local Coordinating Groups for Priority Families, our Programme Board and others to get to this stage and the latest draft of the Plan sets out a clear set of arrangements for consultation, engagement and endorsement at Paragraph 13.

3.4 The main purposes of the Plan are:

- To set out what the County Council and its partners aim to achieve with each family in respect of the six headline criteria (see 2.2 above)
- To provide a basis against which the Council can determine when significant and sustained progress has been achieved with the family, and therefore a result claim may be made for the family
- To provide a framework against which our internal auditors (and Government spot checks) may establish whether a results claim is valid
- To anchor our service transformation objectives in our outcomes for families

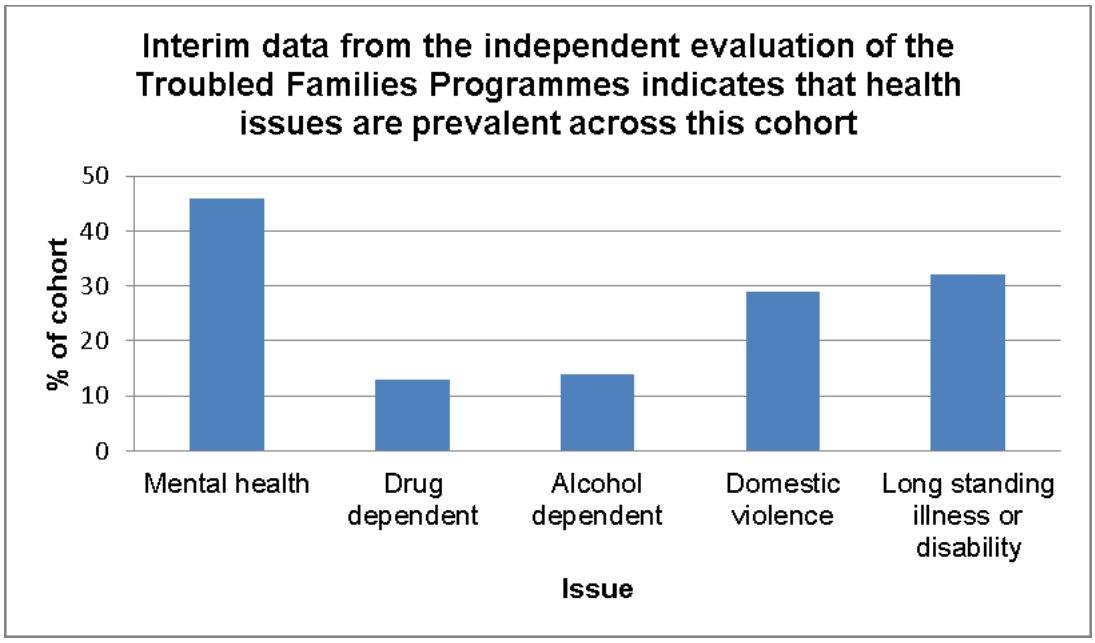
4 Supporting Health Teams to engage with the Programme

4.1 Engagement with the Programme by colleagues in Health is a top priority of DCLG. In recognition of the difficulties that had been experienced within local authority settings across the country, DCLG produced, in November 2014, a number of documents geared towards encouraging the engagement in the Programme by local health teams.

4.2 These can be accessed via the following link:

https://www.gov.uk/government/publications/troubled-families-supporting-health-needs

The most significant of these is **The Troubled Families Leadership Statement**: Produced and endorsed by DCLG, Department of Health, NHS England, Public Health England and the Local Government Association, the Statement makes the point that physical health, mental health and well-being, substance abuse and domestic / family abuse are key issues for Troubled (Priority Families), with the chart below (derived from national data) illustrating the incidence of these issues on them



4.3 These figures broadly match our local situation and our findings that the predominant presenting issues faced by our Phase One families which have been:

Presenting Issues Affecting Priority Families

Source: Warwickshire Priority Families Programme

4.4 During the course of Phase One, we have made extensive efforts to fully engage with health commissioners and providers, including engagement with:

- The 3 Clinical Commissioning Groups
- Individual GP's
- Health visitors and school nurses
- Colleagues in Public Health
- Colleagues in the Coventry and Warwickshire Partnership Trust and South Warwickshire NHS Foundation Trust

4.5 Whilst some of these efforts have proved productive, overall progress has been slow. We have attributed this to the limited appeal of the Phase One national criteria to health colleagues (Crime/ ASB, Education & Worklessness) and very much hope that a combination of the recently published Government guidance and the new Phase 2 criteria will help us to ensure that there is more synergy with the health sector generally.

4.6 This can only be in the interests of both parties and, more importantly, our families who often are not able to access appropriate services without support.

4.7 In particular, we would like to be able to move forward with our relationship with Warwickshire GP practices so that, in every case, a practice is:

a) Aware of the Programme and how to make referrals (by way of a 'social prescription or otherwise')

and

b) Aware of the patients within their practice (i.e. flagged) who have been identified as living with a Priority Family

4.8 To achieve this level of joint working would be very helpful, and we are actively pursuing discussions with the Local Medical Committee to take this forward. Unfortunately, it seems that the national, guidance from NHS England and others has not so far filtered through. We have made clear to DCLG that they should, on a national basis, engage with professional bodies such as the B.M.A, and RCGP

4.9 We are aware of recent progress made in relation to information sharing for the Joint Health and Social Care Learning Disability Self-Assessment Framework where the Local Medical Council has encouraged local GP's to share information that will help to improve services for people with learning disabilities living in our area and we are keen to build on this encouraging development. These arrangements have also been agreed between the County Council, and the three Warwickshire Clinical Commissioning Groups via this Board.

4.10 In the draft Plan, reference is made to the many ways in which our work with Priority Families converges with the following key priorities set out in the Health and Well Being Strategy 2014-2018:

- Ensure the best possible start in life for children young people and families
- Support those young people who are most vulnerable and ensure their transition into adulthood is positive
- Enable people to effectively manage & maintain their physical and mental health and wellbeing
- Provide additional support to other vulnerable groups people
- Improve educational attainment and access to learning at all ages
- Support people to remain healthy and independent in their own homes for longer
- Improve partnerships across the wider social determinants of health

4.11 The Health and Wellbeing Strategy is drawn together using evidence from the Joint Strategic Needs Assessment which sets out current and future health and wellbeing priorities in Warwickshire. The Priority Families Programme is one of the mechanisms to help deliver the Strategy and, if successful, will

reduce the amount of public resources needed to work with families and individuals over the longer term and throughout their lives.

5. Current Work Priorities

5.1 Our current work priorities are:

Ensuring that we have a ***Strong Finish*** to Phase One – we are hoping to achieve the 805 families turned around target during January / February 2015
and

Doing what we can to make sure that we have a ***Flying Start*** to Phase 2 This involves:

- Defining with partners what the Phase 2 'headline' criteria will mean in practice
- Ensuring that we have data / evidence sources in place to enable us to guarantee the eligibility of families for the Programme
- Building on partnerships and enhancing them – to include schools, GP's, Clinical Commissioning Groups, the Family Nurse Partnership and with Health Visitors
- Working out the financial and delivery model for the new Programme
- Putting together the 'Priority Families Outcomes Plan' (required by Government) that will form the basis of our planning and delivery for Phase 2
- Negotiating with partners regarding their contributions to the Programme (in terms of money, people and shared actions)
- Identifying our first cohort of 405 families for Phase 2 by 31 March 2015 (390 already identified)

- Making sure that we have the capacity to coordinate and manage the Programme

6 Background papers

1. DCLG Financial Framework
2. DCLG Documentation on Health Needs and the Troubled Families Programme (both cited above)

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Appendix One

Warwickshire Priority Families Outcomes Plan 2015 – 2018
……. 3rd *draft (23 12 14)*

1 Our Vision

Our work with Priority Families is concerned with:

- ✓ Ensuring that our families get the support they need at the right time in a way that enables them to achieve greater independence and stability
- ✓ A focus on the earliest possible intervention, preventing vulnerable families and individuals within them from developing complex needs which can become expensive to address
- ✓ A focus at the community level to help improve communities who are most in need

This requires us to:

- ✓ Ensure that the activities delivered through the work are based on a co-ordinated, assertive and challenging but nonetheless supportive approach
- ✓ Arrange the various initiatives that are aimed at families in need to make sure that they are joined up and complement each other.
- ✓ Work with families and all services to reduce the cost of interventions across the public sector and save tax payers money
- ✓ Do everything we can to help families to maintain the progress that they have made into the future

Our aim and commitment is to

- ✓ Make sure that the voices of families and front-line staff working with them are heard and that they are active partners in the development of services
- ✓ Have a much better understanding of all the priority families in the county and improve their outcomes, life chances and opportunities
- ✓ Have a new joined up way of identifying and meeting the needs of all these families
- ✓ Save us all money by removing the inefficiency lack of coherence and excessive bureaucracy in the current system

- ✓ Have a simplified system for sharing and recording information about our families in a way that helps them get the support they need without them having to complete separate forms and assessment

- ✓ Have in place effective arrangements to enable families, depending on their current circumstances, to both step up to and step down from appropriate levels of support and challenge

- ✓ Make sure our resources are focused on the families that need them most

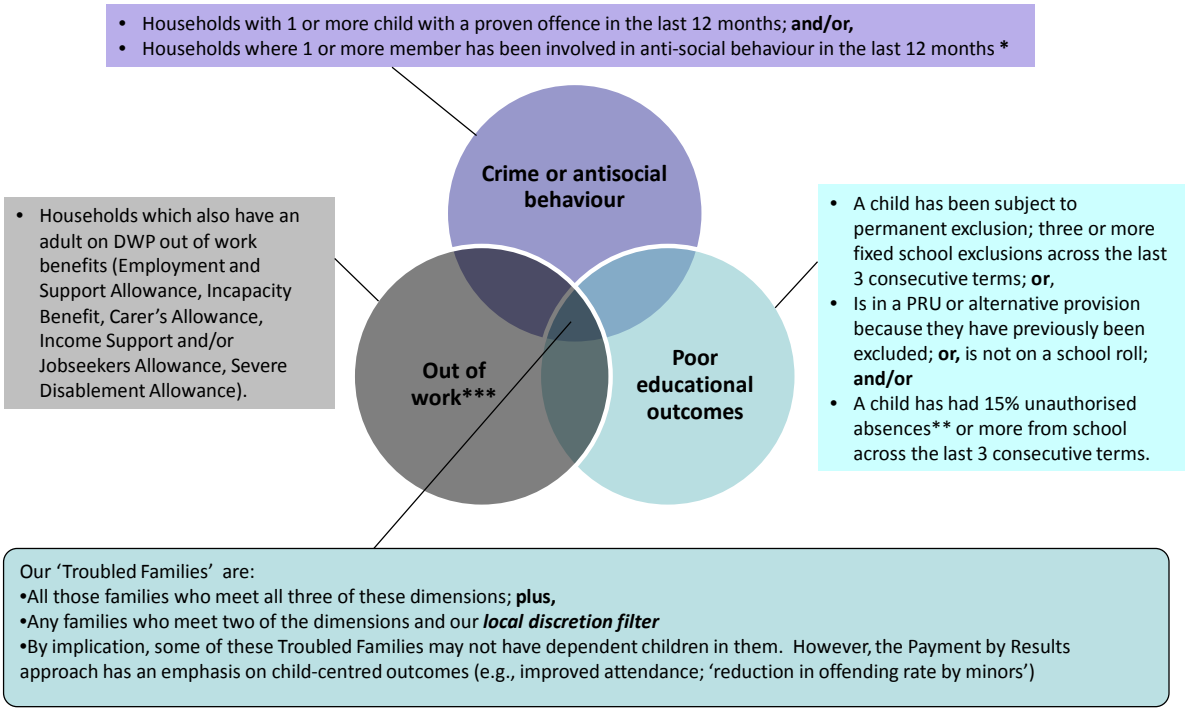
- ✓ Build a sustainable model for work with priority families beyond the duration of this Programme

2 Context for this Plan

2.1 Phase One of the national Troubled Families Programme (in Warwickshire known as the Priority Families Programme) commenced on 1st April 2012 and is due to run until 31st March 2015.

2.2 Our Phase One target has been to identity and 'turn around' 805 families using a combination of national criteria as follows:

Figure 2: Government criteria for identifying 'Troubled Families'



* A range of measures are suggested, but local discretion is advised
** We intend to use 15% absence to measure this
*** This dimension should be considered after the other two have been considered, and for those household who meet one or two of the other dimensions, for data sharing reasons
Source: CLG

2.3 We are scheduled to achieve 100% of our target. As at October 2014 we had 'turned around' 730 families, 91% of our 3 year Phase One target. This compares favourably with the current national success rate of 70%

2.4 There is a second phase to the Programme that will run from 1st April 2015 through to 31st March 2016, and then, subject to the outcome of the May 2015 General Election, on to 31st March 2020. Phase 2 is open to all 152 upper tier local authorities subject to satisfactory performance in relation to their Phase 1 targets by 31st March 2015.

2.5 We are a pilot authority (called an 'Early Starter') for Phase 2 and are therefore have already been accepted for Phase 2 and are working closely with other local authorities and Government to define the terms and processes that will apply to the Programme from April 2015.

2.6 Phase 2 will be significantly different to Phase 1 in that:

- The headline criteria for the identification of families are broader and more flexible
- There is an emphasis on earlier intervention, working with vulnerable families which have multiple problems, and those that are a high cost to the taxpayer.
- The numbers of families to work with and turn round are significantly higher than in Phase One (2,680 Warwickshire families over 5 years)

2.7 The headline criteria for Phase 2 are:

- Parents and children involved in crime and anti-social behaviour
- Children who have not been attending school regularly
- Children who need help
- Adults out of work or at risk of financial exclusion and young people at risk of worklessness
- Families affected by domestic violence and abuse
- Parents and children with a range of health problems

2.8 This image represents the headline Phase 2 criteria:

To be eligible for the expanded programme, each family must have at least two of the following six problems:

Criteria: Crime & ASB
Parents and children involved in crime and anti-social behaviour

Criteria: Children not attending school regularly
Children who have not been attending school regularly

Criteria: Children who need help
Children of all ages, who need help, are identified as in need or are subject to a Child Protection Plan

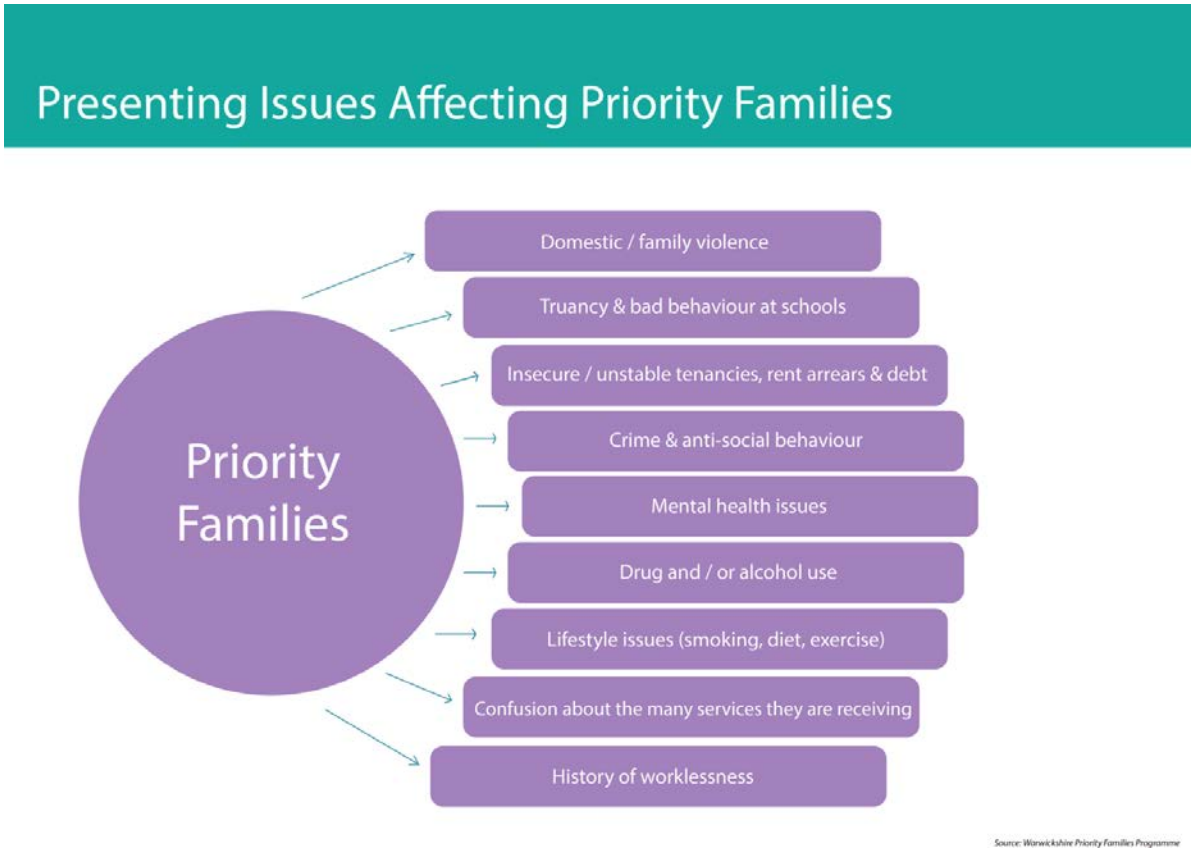
Criteria: Worklessness or at risk of financial exclusion
Adults out of work or at risk of financial exclusion and young people at risk of worklessness

Criteria: Domestic violence and abuse
Families affected by domestic violence and abuse

Criteria: Health issues
Parents and children with a range of health problems

2.9 In order to eligible for the Programme a family must meet at least two of the above. Further definition of the criteria is contained at **Appendix Three** of this Plan. This includes indicators, sources of evidence, and the definition of 'significant and sustained progress'.

2.10 The headline criteria developed for Phase 2 match well with the list of Presenting Issues experienced by our Phase One families:



3 Local Strategic Context

3.1 There is a wide variety of strategic plans and objectives to which Phase 2 of the Programme will relate. Via our consultation on this draft Plan, we intend to identify these fully, but in the meantime, include references to these strategic documents:

- Warwickshire County Council's One Organisation Plan 2014-2018
- Warwickshire Health & Well Being Strategy 2014 – 2018
- Warwickshire Vulnerable Learners Strategy

3.2 The main links are set out in **Appendix One:** At the time of preparing this latest draft of the Plan, we consider that reference to and strategic support for the Programme should be formalised to include specific reference in the Plans of all relevant partners.

4 Purposes, Principles and Ways of Working

4.1 The Purposes of the Plan can be summarised as follows:

- To set out what the County Council and its partners aim to achieve with each family in respect of the six headline criteria
- To provide a basis against which the Council can determine when significant and sustained progress has been achieved, and therefore a result claim may be made for the family

- To provide a framework against which our internal auditors (and Government spot checks) may establish whether a results claim is valid
- To anchor our service transformation objectives in our outcomes for families

4.2 The underlying Principles of this Plan are:

- There will be a focus on achieving and demonstrating outcomes, not inputs, processes and outputs
- Relevant family outcomes will be set after the identification of the family and only when a fuller picture of the family is known
- All children in the family must be receiving a suitable full time education
- Health outcomes will be developed and agreed with local health partners
- We will reference Family Monitoring and Progress Data

4.3 We fully endorse the ways of working reflected in key family intervention factors as follows:

- Dedicated Workers dedicated to families
- Practical 'hands on' support
- A persistent, assertive and challenging approach
- Considering the family as a whole
- A common purpose and agreed action

5 Duration of this Plan & Review Arrangements

5.1 We have prepared this Plan on a three year basis to coincide with the County Council's One Organisational Plan and other current funding arrangements. Accordingly the Plan will run from 1 April 2015 to 31 March 2018.

5.2 An initial review of the Plan will take place on or about 1st September 2015 to take into account both progress to date and the impact (if any) of new policies introduced by the Government elected on May 2015.

5.3 Further reviews will be carried out by the Priority Families Programme Board on or about 1st September 2016, and 1st September 2017 when consideration will be given to the production and endorsement of a new Plan to guide the progress of the Programme beyond 31st March 2018.

6 Partnership and Governance

6.1 We are justifiably proud of the strong partnerships and governance arrangements that underpin our work at every level:

- Strategically via the Priority Families Programme Board:

- Operationally via the six Local Coordinating Groups that have been established

- Technically, via the hard work and commitment of a range of individuals and agencies in relation to data identification, analysis, information sharing, finance, audit and performance management

- Democratically via the County Council's Cabinet, Portfolio Holders and the Overview and Scrutiny Committees of Children and Young People and Communities respectively.

6.2 Governance can be summarised as:

a) Priority Families Programme Board: The Board is made up of representatives of key stakeholders and agencies and provides strategic oversight for the Programme. The Board is accountable to: Warwickshire Health and Well Being Board and the Safer Warwickshire Partnership. The role of the Programme Board can be summarised as:

- Agreeing responsibilities and objectives
- Agreeing all major plans
- Authorising any major deviations from the agreed plans
- Ensuring required resources are available and allocated in line with agreed plans
- Providing guidance and direction to the programme, to ensure it remains within any specified constraints.
- Ensure risks are identified and managed
- Receive regular progress reports and agreeing remedial actions where appropriate
- The Quality Assurance for the project.
- Alignment of various families initiatives
- Resolving deviations from plan or escalating as necessary
- Oversee evaluation of the initiative

b) Local Coordinating Groups:

There are six Local Coordinating Groups, one for each District / Borough of the county and an additional group for Camp Hill (to build on the local community infrastructure there). We will consider establishing further Groups for communities at a ward level subject to suitability and capacity, and are currently considering the establishment of local arrangements for families residing in the Hill Top / Wembrook area of Nuneaton

6.3 Local Coordinating Groups:

- Use local knowledge and discretion to confirm the local Priority Families cohort
- Identify existing interventions, assessments and case management arrangements (e.g. FIP, MARAC, MAPPA, Integrated Offended Management, Social Care) in respect of each of the families, the level of intervention that is likely to be required and to begin the process of developing individual family plans

- Identify the worker / agency best placed to contact / liaise with each family and obtain their agreement to joining the Programme
- Identify the types of intervention that will be successful at a local level
- Develop and take ownership and management of family plans for each of the families included within the cohort – family plans to be outcomes driven with clear links to the Payment by Results (PBR) criteria
- Oversee the delivery of targeted interventions at a local level
- Take responsibility for the delivery of a more co-ordinated cross-agency approach to work with families at a local level

6.4 We are currently working out ways in which the Local Coordinating Groups might assist in the prioritisation of families that are eligible for Phase 2 using a Risk Factor Matrix that is under development

7 Finance

7.1 The following assumptions have been made:

- That the funding of Phase 2 via this Plan runs for **three years** from 1st April 2015 through to 31st March 2018 (to correspond with the County Council's One Organisational Plan)
- During the first three years of Phase 2, Warwickshire will be required to identify, work with and turn round a total of 1608 families and will be worked with in equal numbers for each year of the current three year Plan (536 per year)
- DCLG will pay £1800 per family with £1000 of that funding available as an up-front attachment fee and the remaining £800 on the basis of Payment by Results.

7.2 We have also assumed that:

- Approximately £800,000 will be available from Phase One to support our work on Phase Two.
- Any sums due in respect of redundancy costs arising from Phase One would need to be funded by (and would thus offset) the above figure
- There is no alteration made to the indicative allocation in the One Organisation Plan to allocate top-up funding in the form of an annual revenue allocation of £425k for each of the three years 2015/16 to 2017/18 subject to the continuation of Central Government funding.
- The forecast surplus relating to the Youth Justice Service's Family Intervention Project as at 31st March 2015 amounts to approximately £400,000 and is transferred over to the Programme in full.
- Public Sector Partners have been asked to identify any financial contributions they can make to the Programme but for planning purposes no contribution is included.

- The amount paid by DCLG to the County Council as a contribution towards programme coordination costs will be £200,000 per annum from 1st April 2015 and this amount is used solely towards the coordination and management of the Programme
- We will achieve 75% of the required three year target of turning round 1608 families. This would result in total income from DCLG over the first three years of the Programme of :

		£'000
Attachment Fees	£1000 X 1608 X 75%	1206
PbR £800 X 1608 X 75%		965
		2171

- Any income in excess of that identified above will be held in reserve to fund the Programme beyond 2017/18 and any winding up costs incurred at the end of the Programme.

  Unless it is specifically agreed with the awarding partner funding must be used to deliver additional specified delivery

An indicative and provisional budget for the three years 2015-2018 is set out in **Appendix Two**

8 Identification of families and prioritisation for inclusion within the Programme

8.1 Warwickshire is required to work with and turn around:

- 2680 families over 5 years 2015-2020

  Or

- 1608 families over the duration of this Plan (to 31 3 2018)

8.2 It is assumed that the families will be worked with at an even annual pace – 536 families per year.

8.3 As a First Wave Early Starter authority, Warwickshire is required to identify 405 families to work with in Phase 2 by 31st March 2015.

8.4 As at 23rd December 2014 we have identified a total of **390** families that are eligible for Phase 2 of the Programme.

8..5 To be eligible for the Programme, each family must have at least two of the six headline criteria referred to above. We are required to identify families across the six headline criteria and ensure that the Programme's resources are being used well

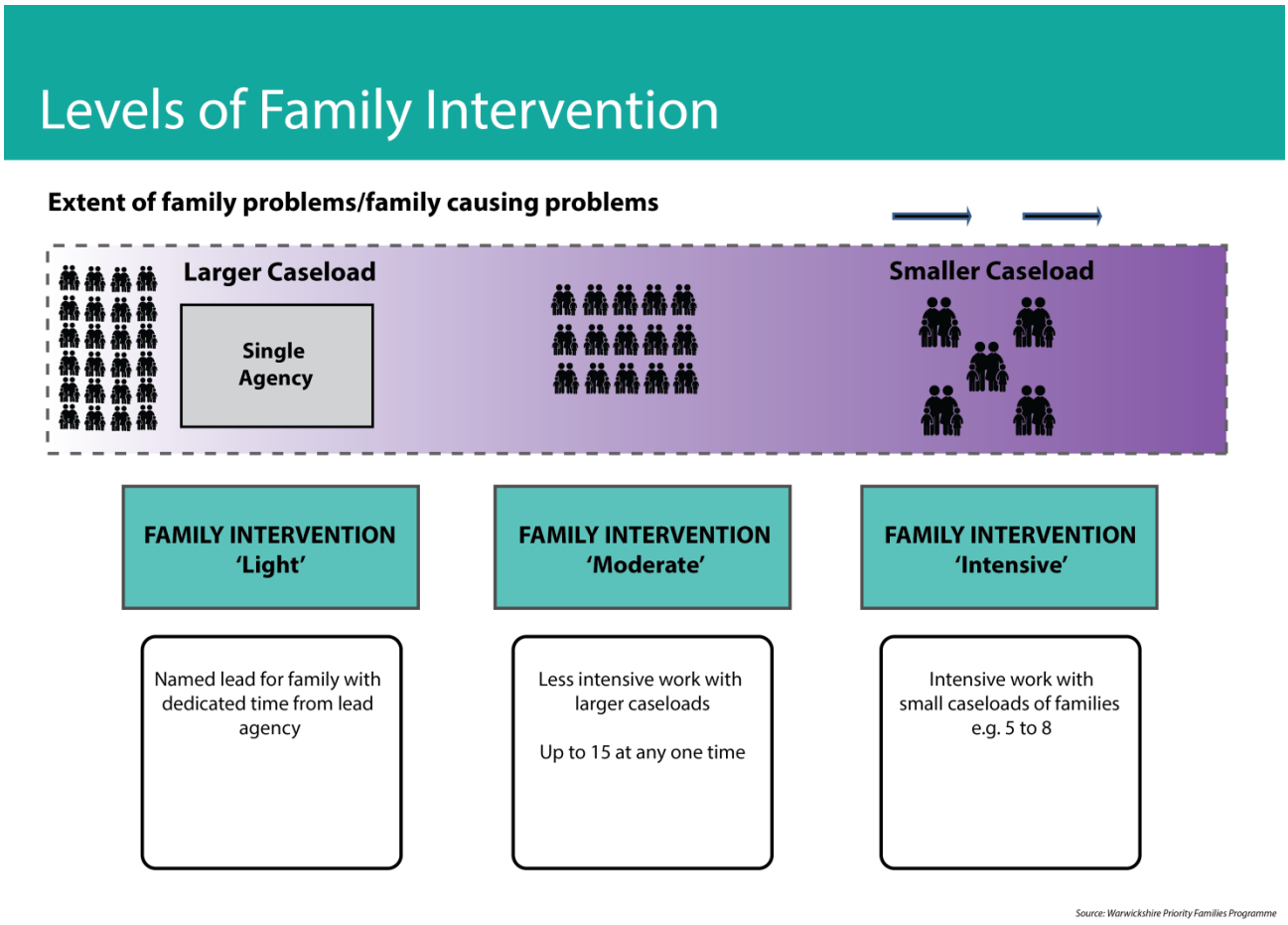
8.6 We intend to prioritise families for inclusion within the Programme on the following basis:

The family:

- Has multiple problems
- Is likely to benefit from an integrated whole family approach
- Is a high cost to the public purse

8.7 As stated above, we are currently developing a Risk Factor Matrix to help us have in place an objective criterion based method of carrying out this process of prioritisation and intend to work with the Local Coordinating Groups across the county to take this forward.

8.8 We will continue to use the following methodology



9 Indicators, Evidence and Significant / Sustained Progress

9.1 The indicators and nomination routed to assist in the identification of families are set out in **Appendix Three**

10 Use of the Cost Savings Calculator

10.1 In order to develop a better understanding of the financial benefits achieved through the Programme we will make full use of online troubled families costs savings calculator. This will show the complexity of families supported through the Programme and will enable us to report periodically on the benefits of the work to central government, councillors and others.

10.2 In particular we will complete the cost savings calculator

- By 28th February 2015 for a random sample of 80 families from the first Phase of the Programme

and

- By 31st March 2015, (As an Early Starter authority) for a further random 25% sample of families who enter the Programme in 2014/15 as Phase 2 families

10.3 Further points to be made are:

i. At the time of preparing this Plan we, alongside a number of other authorities, are investigating the use of the calculator and liaising with government over concerns and areas for its improvement #

ii. We are doing what we can to ensure that any proposed publications of the results from the use of the calculator are comprehensive, rigorous and representative.

iii. Effective use of the calculator is very much dependent on our ability to persuade a wide variety of partners both internal and external to provide the data required to populate the calculator.

iv. We will do what we can to support and train staff from relevant agencies (including the 3rd Sector) to make effective and timely contributions towards this process

v. We are concerned to ensure that any aggregation of cost: savings data by central government or otherwise follows a sound methodology (bearing in mind the likely individual variations in practice across Local Authorities) taking part in Phase 2

11 Performance Management and Data Returns

11.1 We are committed to the establishment of an effective set of arrangements for Performance Management and the completion of Data Returns.

11.2 At the time of preparing this Plan these are likely to include:

- Quarterly reports to government regarding the numbers of families identified for inclusion within the Programme, the numbers currently worked with coupled with a prediction as to the number of Payment by Results Claims likely to be lodged in the following quarter
- In January 2015, the completion of Family Monitoring Data for a random representative sample of at least 10% of families that have entered the Programme in 2014/15
- From April 2015, the completion of Family Progress data which includes a greater emphasis on the change achieved by family members
- Completion of the cost savings calculator as described in 9 above
- Regular reporting to the Programme Board, Local Coordinating Groups, strategic partnerships and other bodies as required

12 Service Development and Transformation

12.1 The probable duration of the Programme (to 2020), generality of the new headline criteria, and numbers of families to be worked with / turned around (2,680 over five years) mean that our work with Priority Families moves to the centre stage of delivery.

12.2 Increasingly, 'Our Families' will match the priority service users of a wide range of service providers and agencies. As a result, we need to specifically identify key service transformation priorities to be pursued in conjunction with the Programme Board and key delivery partners. These are summarised in **Appendix Four**

13 Time Line for the development of this Plan: Consultation, & Engagement

13.1 This Outcomes Plan has been developed in full collaboration with strategic and operational partners (both within and outside of the County Council) and via a specially formed Development Group which has overseen and directed the work. This lead to the production of a discussion draft in late November 2014. Subsequently, the discussion draft has been developed and amended as a result of further consultation and engagement with:

- Each of the six Local Coordinating Groups
- Significant Service Providers
- The Priority Families Programme Board
- WCC Corporate Board
- The Families Team at DCLG

13.2 Our **time line** for engagement / consultation on this Plan is:

Draft One	By 21 11 2014
DCLG Workshop	26 11 2014
Local Coordinating Groups	During December 2014

Draft 2	By 5 12 2014
Programme Board	19 12 2014
Draft 3	By 07 01 15
WCC Corporate Board	20 1 2015
Health & Well Being Board	21 1 2015
Programme Board	27 2 2015
Safer Warwickshire Partnership Board	10 3 15
WCC Communities OSC	11 3 2015
WCC Cabinet	12 3 2015
WCC CYP OSC	7 4 2015

Phase 2 Launch

Programme Board Partnership Event	By the end of April 2015

Appendix One

Strategic Context: Links between the Programme and Strategic Plans / Strategies

Plan / Strategy	Linked Priority	Commitment / Target	Target / Indicator
Warwickshire Health and Wellbeing Strategy 2014-2018	Ensure the best possible start in life for children young people and families	Reduce Ante Natal risk factors e.g. smoking in pregnancy & improved maternal and infant well being Positive parenting & an increase in the number of families receiving early help to tackle problems A reduction in the local variations in educational attainments in Warwickshire GCSE grades and improved destinations post 16 Fewer numbers of children living in poverty	
Warwickshire Health and Wellbeing Strategy 2014-2018	Support those young people who are most vulnerable and ensure their transition into adulthood is positive Enable people to effectively manage & maintain their physical and mental health and wellbeing Provide additional support to other vulnerable groups people	Integrated services across education, health, social care and the voluntary sector More young people remaining in education and training post 16 ensuring that they are ready to enter into the adult labour market More vulnerable children and young people helped to make positive life choices More people across all; ages to adopt healthier lifestyles to improve their health and wellbeing Enhanced services for the early prevention treatment and recovery of mental health problems across all ages People will have equitable access to screening and prevention services to help them avert ill health Health & care services that better meet the needs of vulnerable people to accelerate improvement in health and wellbeing outcomes	

Warwickshire Health and Wellbeing Strategy 2014-2018	Improve educational attainment and access to learning at all ages Support people to remain healthy and independent in their own homes for longer Improve partnerships across the wider social determinants of health	Better mechanisms for identifying vulnerable people and ensure that they are signposted to appropriate services Improved educational attainment & learning opportunities for all particularly those that are eligible for free school meals Reduction in emergency admissions and an increase in more appropriate use of primary care Improved working with housing planning and licensing to create healthy environments for individuals families and communities to live A continued focus to support families affected by crime unemployment and poor educational attainment Successful integrated working to tackle crime, reduce reoffending and excessive alcohol intake Create safer communities through the reduction of crime and the promotion of safety	
WCC One Organisational Plan 2014-208	Core Purpose Outcome 1: Our communities and individuals are safe and protected from harm and are able to remain independent for longer Outcome 2: The health & wellbeing of all in Warwickshire is protected	Develop and sustain a society that looks after its most vulnerable members, delivers appropriate quality services at the right time, and seeks opportunities for economic growth and innovation Our vulnerable individuals are safe protected from harm and are independent for longer Our children live in safe and supportive families Our communities and individuals are encouraged to help themselves and feel safe and secure	Reduced Level of harm caused by alcohol, drugs, violent crime & asb Reduced level of offending & reoffending Vulnerable families are supported % of eligible population vaccinated against flu (5 at risk groups / overall)

		Improved health and wellbeing for everyone Our residents have choice and exercise maximum control over their health & social care regardless of where they live Our residents are happy and have good levels of mental and physical health Young people understand the choices available to lead healthy lives Our residents enjoy an enhanced quality of life	% of women smoking in pregnancy Health inequalities in targeted areas are reduced (reduced obesity, increased breast feeding, reduced teenage pregnancies, increased physical activity) Increased uptake of low level support from mental health and wellbeing services Preventable causes of ill health are reduced (increased uptake of health checks, vaccinations and accessing information regarding affordable warmth)
	Outcome 3: Our economy is vibrant, residents have access to jobs, training, and skills development Outcome 5: Resources and services are targeted effectively whether delivered by the local authority, commissioned or in partnership	Our young people are supported to meet their needs and aspirations Our residents learn throughout their lives, are skilled and ready for employment and fulfil their potential High quality needs based public services are deployed effectively and efficiently no matter how they are provided Risk and change is managed effectively	
Draft Strategy for Vulnerable Learners 2015-2018	Warwickshire's Vision`	Warwickshire will be forward looking in education and learning, striving to ensure that every child and young person will attend a good or outstanding school setting ; achieve well whatever their starting point or circumstance; and go on to positive destinations so that, as young adults, they have an independent economic and social life	
Draft Priority Young People	To be Added	To be Added	To be Added

Strategy			
Warwickshire Community Safety Agreement / Police & Crime Plan (Safer Warwickshire Partnership Board combined with the Police & Crime Commissioner	To be Added	To be Added	To be Added
Community Safety Plans via the four district based Community Safety Partnerships	To Be Added	To be Added	To be Added
Drugs and Alcohol Implementation Plans	To be Added	To be Added	To be Added
Violence Against Women & Young Girls Strategy	To be Added	To be Added	To be Added
Revised Warwickshire Child Poverty Strategy 2015-2018 (Emerging)	To be Added	To Be Added	To be Added
District Based Strategies addressing Financial Inclusion / Social Inclusion	To Added	To be Added	To be Added

Appendix Two

Indicative Budget 2015 - 2018

Available Finances (over 3 years to 31 03 2018)

On the basis of these assumptions, the following finances should be available to support

Phase 2 delivery from April 2015 to March 2018

	£'000
Contribution from Phase One	800
DCLG Income	2171
WCC One Organisation Plan	1275
Family Intervention Project Surplus	400
	4646

This equates to an annual budget of **£1,548,667** for the delivery costs of the Programme, or £2,889 per family. In turn, this compares with the Phase One figures of an annual budget of £674,000 or £2,514 per family.

In Paragraph 4 below we set out an indicative annual expenditure budget based on these figures & assumptions aimed at achieving the turn round of 536 families per year equating to 1608 families up to 31st March 2018.

Indicative Annual Operating Budget for this 3 year Plan	**£'000**
Continuing to resource 29 Phase One Family Support Workers @ £32.5 per worker	943
Budget for additional delivery staff for Phase 2 – Contribution towards ACE (Attendance Compliance & Enforcement) Team	250
Other staffing for the management & delivery of the Programme	150
Contribution towards Programme Management	100
Family Expenses / Bespoke Interventions (£50 per family)	30
Contingency	26
	50
	1549

Appendix Three
(Schedule of Outcomes Indicators & Nomination Routes)

Warwickshire Priority Families Outcome Plan

Parents and Children involved in Crime and Anti-Social Behaviour

HP1: Parents and Children involved in Crime and Anti-Social Behaviour
HO1: There is a reduction in offending behaviour across Warwickshire households

Eligibility Priorities

- An adult prisoner, less than 12 months from release date, with parenting responsibilities
- A child with a proven offence in the last 12 months
- An adult currently subject to licence or supervision in the community with parenting responsibilities
- An adult currently serving a community order or suspended sentence with parenting responsibilities
- Households where a family member has an anti-social behaviour (ASB) order or has been subject to a housing related intervention in the last 12 months
- An adult or child that has been referred by professionals because their potential crime problem or offending behaviour is of equivalent concern to the above

Outcome Measures

- To have fully engaged with programmes in prison
- To remain out of prison from the start of the order for a period of 6 months and no proven offences recorded in this period
- At least a 33% reduction in offending in the last 6 months
- A 60% reduction in ASB across the household over the last 6 months

Sustainability

- Reduction in the re-offending behaviour of adults with parental responsibilities
- Reduction in re-offending by children
- Reduction in re-offending by adults with parenting responsibilities
- Reduction in ASB incidents

Evidence to Support Eligibility

Community Rehabilitation Company (CRC) records - Adults

National Probation Service (NPS) - Adults

Youth Justice Service database - Children

Anti-Social Behaviour Teams (District & Borough Councils & Police)

Police National Computer (PNC)

ECINS

Warwickshire Priority Families Outcome Plan

Children who have not been attending school regularly

HP2: Children who have not been attending school regularly
HO2: Across Warwickshire, children are sustaining attendance levels of over 85% in appropriate education provision, with less recorded fixed term and permanent exclusions, and instances of lateness

Eligibility Priorities

- A child with persistent (authorised and unauthorised) absence of 15% or more over three consecutive terms
- A child who has had 3 or more fixed term exclusions in the last 3 consecutive terms / or has been excluded for 5 days in a primary school or 10 days in another establishment in the last 3 consecutive terms
- A child who has been permanently excluded in the last 3 consecutive terms
- A child who is in an alternative provision for behavioural problems
- A child who is neither registered with a school, nor being educated otherwise
- A child referred by educational professionals as having school attendance problems of equivalent concern to the indicators above because he/she is not receiving a suitable full time education e.g. persistent lateness without sufficient proof and authorisation

Outcome Measures

- Child has less than 15% persistent absence over 3 consecutive terms
- Child has not received more than 2 fixed term exclusions over 3 consecutive terms
- Child is attending an alternative education provision as agreed (agreed on an individual basis) with less than 15% persistent absence over 3 consecutive terms
- Child is registered or is being otherwise educated and has less than 15% persistent absence over 3 consecutive terms
- Episodes of lateness are reduced over 3 consecutive terms

Sustainability

- Increase in number of children with over 85% attendance
- Less incidents of fixed term exclusions / no. of days recorded as fixed term exclusions
- Reduction in the number of children who are permanently excluded
- Less fixed term exclusions / no. of days recorded as fixed term exclusions across alternative provision providers
- Children are sustaining over 85% attendance at an appropriate education provision and number of exclusions are reduced
- Children attend education provision on time

Evidence to Support Eligibility

School Census

Teaching Staff / Education Welfare Officers

Warwickshire Priority Families Outcome Plan

Children who need help

HP3: Children who need help
HO3: Children are looked after in a safe, supportive and stable home environment

Eligibility Priorities

- A child who has been identified / assessed as needing early help because they:
  - are below the threshold for services under Section 17, Children Act 1989
  - are experiencing or at risk of poor parenting
  - have developmental delay
  - present with challenging behaviours
  - were previously accommodated and are returning home from care
- A child who meets the threshold criteria in the Warwickshire 'Thresholds for Services' document for:
  - Tier 2 - early help/prevention - children with additional needs (links to 'School Ready')
  - Tier 3 - targeted and enhanced support - children with complex needs
  - Tier 4 - statutory/specialist support - children with acute/ severe needs
- A household where a child is not school ready
- A young person in the household known to local services as either having previously experienced abuse via social media or is either currently experiencing or is at risk of experiencing abuse via social media or is known to local services as having perpetrated online abuse
- Young person identified as Red or Amber At Risk of Being Not in Education, Employment or Training (NEET) in Year 7
- A child referred by professionals as having problems of equivalent concern to the indicators above
- A young person at risk of/or affected by sexual exploitation

Outcome Measures

- Attending Triple P Parenting course and implementing new strategies over a 6 month period
- Receiving appropriate signposting and strategy/plan in place over a 6 month period e.g. Common Assessment Framework (CAF), single agency support
- CAF being implemented and family engaging with process over 6 month period
- Child in Need Plan or Child Protection Plan in place and family engaging with process over 6 months (no re-referral in a 12 month period - showing sustained progress)
- Household no longer subject to Child Protection Plan / does not return to CPP level over 6 months (no re-referral in a 12 month period)
- Two and three year old children are accessing and attending early education provision
- Education for family members on social media abuse within a 6 month period
- Attendance on the Youth Justice CHARM Programme within a 6 month period
- Young person is taking steps not to be at risk of being NEET
- Reduce risk of sexual exploitation

Warwickshire Priority Families Outcome Plan

Children who need help

Sustainability

- Children are safer
- Less children at a threshold level of concern progress to a Child in Need case under Section 17, Children Act 1989
- Children are being cared for by an adult with an adequate and appropriate level of parenting skills
- Children with a development delay have the relevant support in place to address needs
- Children with challenging behaviours are identified and receive appropriate and timely support
- Children experience a smooth and supported transition when returning home from care
- Young carers are supported to have the same opportunities as young people without caring responsibilities
- CAF plan in place
- Reduce time spent on plan
- Speedier decision making
- Reduce the number of children who are Looked After Children
- Reduce the number of children needing CP and divert cases from CP where it is safe and appropriate to do so
- Children are school ready
- Increased number of eligible 2 and 3 year olds accessing and regularly attending early education provision
- Less occurrences and increased reporting of online social media abuse
- Reduction in the number of RONIs/subsequent NEETs

Evidence to Support Eligibility

Key Workers

Children's Centres

Common Assessment Framework (CAF) database

Care First Database

Information provided by Children's Services

Housing Database

Family Matters Meetings

Warwickshire Priority Families Outcome Plan

Adults out of work or at risk of financial exclusion and young people at risk of worklessness

HP4: Adults out of work or at risk of financial exclusion and young people at risk of worklessness
HO4: Households are financially stable, with adults in sustainable employment and young people in positive destinations

Eligibility Priorities

- An adult in receipt of out of work benefits (ESA, IB, CA, IS, JSA, SDA) or an adult who is claiming Universal Credit and subject to work related conditions
- Young person is currently Not in Education, Employment or Training (NEET)
- Young person identified as Red or Amber At Risk of being NEET (RONI) - Year 10
- A child living in a household identified as living in poverty
- Parents and families referred by professionals as being at significant risk of financial exclusion e.g. debt issues / rent arrears

Outcome Measures

- Adult or young person has secured one or more of the following:
  - voluntary work and has regularly attended for 13 weeks
  - regularly attended an employment club at least once per week for a period of 6 weeks
  - undertook significant work experience over the last 13 weeks
  - achieved or is significantly working towards a recognised vocational qualification
  - is regularly attending an apprenticeship continuously for 26 or 13 weeks
  - is working part-time (less than 16 hours) continuously for 26 or 13 weeks
- Young person is taking steps to not be at risk of being NEET over a 6 month period
- Ensure that family are claiming free school meals and appropriate benefits
- Families working towards reducing the risk of financial exclusion over a six month period by:
  - debt / rent arrear reduction plan in place and being adhered to
  - eviction process suspended / on hold
  - reduced number of evictions
  - Number of people having debts written off via Debt Relief Orders / bankruptcy
  - number of people helped to reschedule their priority and non-priority debts to make affordable payments
  - income maximisation and take up of Free School Meals
  - number of people undertaking money management (financial capability support) either 1-1 or in groups
  - Families reporting an improvement in their health and well-being following advice intervention and problem resolution
  - number of parents/carers attending employment support sessions and/or economic well-being sessions supported by Children's Centres
  - percentage of parents/carers identified as requiring adult learning provision to support them back into employment who successfully completed an adult learning course

Warwickshire Priority Families Outcome Plan

Adults out of work or at risk of financial exclusion and young people at risk of worklessness

Sustainability

- Increased number of adults progressing towards work / sustaining employment
- Reduction in the number of NEETs
- Reduction in the number of RONIs / subsequent NEETs
- Reduction in the number of families identified as suffering financial exclusion, debt problems, rent arrears, evictions and repossessions
- Debts addressed and benefits maximised
- People prevented from being homeless
- Through advice and interventions - barriers moved towards moving towards employment

Evidence to Support Eligibility

Free School Meals Database

Department for Work & Pensions (DWP)

NEET Outcome Database

RONI Database

Housing Database

Citizens Advice Bureau

Work Club Provider

College

Key Workers

Verification with Voluntary Organisation

Self-reported

Warwickshire Priority Families Outcome Plan

Families affected by domestic violence and abuse

HP5: Families affected by domestic violence and abuse
HO5: Families are becoming free of violent / abusive experiences. Families are receiving support and 'coping and recovering' from these experiences

Eligibility Priorities

- A member of the household known to local services as:
  - having experienced domestic violence or abuse
  - currently experiencing domestic violence or abuse
  - being at risk of experiencing domestic violence or abuse
- A member of the household is identified as evidence of emotional impact i.e. anxiety, depression as a result of previous domestic violence or abuse
- A member of the household who is known to local services as:
  - having perpetrated an incident of domestic violence or abuse but has not been prosecuted in the last 12 months
  - having been prosecuted for an incident of domestic violence or abuse in the last 12 months
- An adult or young person in the household that has reported at least one domestic incident to Police in the last 12 months
- A member of the household who is subject to or at risk of a forced marriage, honour based violence and/or female genital mutilation

Outcome Measures

- Reduction of risk at exit as assessed by case worker
- Engagement with services
- Increased reporting of domestic violence and abuse incidents and crimes to Police
- Improved score on the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)
- Engaging in domestic violence programme
- Counselling for anxiety / depression and mental health has improved
- Victim or perpetrator engaging with support and has an understanding of their experience

Sustainability

- Improved emotional well-being and emotional resilience
- Increased number of prosecutions
- Reduced prevalence of domestic violence and abuse
- Increased reporting
- Less occurrences of online social media abuse

Evidence to Support Eligibility

Stonham
The Refuge
Safeline
ROSA
Police National Computer (PNC) and Incident Reporting System
Key Worker assessments
Self-reported
Youth Justice Service Database

Warwickshire Priority Families Outcome Plan

Parents and children with a range of health problems

HP6: Parents and children with a range of health problems
HO6: Parents and children are able and supported in managing health needs

Eligibility Priorities

- A child or adult with parenting responsibilities and physical health needs
- A child or adult with parenting responsibilities and mental health needs
- A new mother who has a mental health or substance misuse problem and other health factors associated with poor parenting. This could include mothers who are receiving a Universal Partnership Plus service
- A child eligible for an Education Health Care Plan
- An adult with parenting responsibilities or a child with a drug or alcohol problem
- Household members not registered with a GP
- A child with a concerning level of A&E admissions
- A child or adult with parenting responsibilities who is referred by health professionals as having any mental and physical health problems of equivalent concern to the indicators above. This may include unhealthy behaviours resulting in problems like obesity, malnutrition, diabetes or a long-term chronic condition
- An adult with parenting responsibilities and substance misuse problems. Also, with evidence of emotional impact i.e. anxiety, depression as a result of historical problems
- A child/young person with Attention Deficit Hyperactivity Disorder (ADHD)

Outcome Measures

- Receiving appropriate support within a 6 month period
- Reduced risk/concern for children over a 6 month period
- Plans and strategies in place and regularly reviewed on an annual basis
- Family member subject to a programme of support
- All household members now registered with a GP
- Reduced number of A&E admissions for children
- Within a 6 month period, household member referred and attached to relevant health service and/or household member is self-managed and has an improving level of functionality
- Engaged in support plan with an improving level of functionality over 6 months

Sustainability

- Improved mental health and increased emotional resilience
- Reduced risk / concern for children
- Completing substance misuse programmes
- Receiving appropriate support

Evidence to Support Eligibility

Worker assessment
Midwives
Health visitors
Self-reported
Known to agencies

Appendix Four

Change and Transformation Priorities for the Programme

Action Area	Goal	Review Date
Staffing & Organisation	a) To have in place coherent staffing arrangements for the coordination and delivery of the Programme b) To have in place arrangements for district leadership of family intervention teams and a single point of access for partners and service users at district level c) To develop & deliver a coherent range of training and professional development opportunities for family intervention teams and other professionals working with families d) To develop and deliver area based workshops bringing together all key agencies working with families to improve mutual understanding and improve the complementarity of our work e) To spread knowledge and awareness amongst partners of the five intervention factors and whole family working f) To ensure that all family intervention staff are aware of health, financial exclusion and benefit issues and make appropriate referrals as necessary g) To have in place appropriate agreements with funding recipients summarising the purposes and requirements of funding from the Programme	At each Programme Board Meeting
Employment & Work	a) To build on and embed a culture across services whereby it is recognised how 'work' can have a positive impact on issues within families such as improving health, reducing child poverty and improving parenting skills, particularly for families where worklessness is an issue. b) Services to consider work options by carrying out work related/employability assessments and then actively supporting families by signposting or supporting individuals to access existing provision to enable them to progress towards work goals c) To secure funding for a coherent and complementary programme funded via ESF and geared towards supporting family members to 'get closer to work' d) Having secured funding to roll the Programme out across Warwickshire	At each Programme Board Meeting
Parents and children involved in crime & anti social behaviour	a) To work with Police, Police & Crime Commissioner, Probation, the Community Rehabilitation Company, Prisons / Custodial Institutions & the 3rd Sector to develop a model approach to working with families affected by inter-generational criminal behaviour b) To gain financial support to implement / deliver the model approach	
Identification and Referral of Families	a) To develop and implement effective methods / processes for the identification & referral of eligible families currently worked with by delivery agencies – e.g. Social Care, CAF, Housing Providers, and other services that engage with and support families b) To work with partners to establish more effective and joined up arrangements for referral and triage arrangements	At each Programme Board Meeting
Data, Intelligence &	a) To identify and support key data managers / providers across all agencies of relevance to the Programme	By 1 4 15

Information Sharing	b) To identify the Programme's requirements in respect data and intelligence in order to identify eligible families and judge significant and sustainable progress c) To review existing information sharing protocols and ensure their suitability to Phase 2 of the Programme (including to new partners / stakeholders) d) To continue to develop and expand our information sharing arrangements with partner, with a priority emphasis on GP's and local health providers	
Case Recording & Communication (E-CINS)	a) To roll out the use of E-CINS to all agencies working with families b) To ensure compatibility / information transfer between E-CINS and WCC case management systems for Social Care and Education c) To load all Phase 2 families on to E-CINS from the start of the Programme replace existing Spread Sheets with use of E-CINS at Local Coordinating Groups and elsewhere d) To ensure that all family intervention staff use E-CINS for case recording and communication e) To use E-CINS as the prime referral method of families to the Programme f) To develop E-CINS to provide reports on families in respect of Payment by Results, Family Monitoring data and other performance / management information requirements	At each Programme Board Meeting
Audit	a) To gain Internal Audit approval for criteria, indicators, and progress measures b) To agree evidence requirements for the above c) To develop and agree processes in respect of Payment by Results claims d) To ensure that all of the above is 'Spot Check Proof	By 1 4 15
Finance	a) To finalise & implement the financial plan that underwrites our work through to March 2018 (subject to a formal review in September 2015) b) To have in place appropriate arrangements for regular financial reporting and analysis including cash flow forecasting c) To implement arrangements for regular financial reporting by serve providers funded through the Programme	By 1 4 15
Cost Benefit Analysis	a) To continue to learn about the on line calculator and become proficient in its use b) To identify relevant partners / stakeholders required to populate the unit costs element of the calculator c) To gain their support, and offer training and troubleshooting as required d) To complete the CBC work in respect of sample of 80- Phase One families e) To ensure that the CBC is applied to the circumstances of all Phase Two families from the commencement of the Programme	By 1 4 15
Performance Information and Data	a) To develop and publish an annual calendar of performance reports and data returns (including Cost Savings and PR) b) To ensure that robust arrangements are in place to satisfy fully government requirements in respect of Family Monitoring Data, Payment by Results, Progress Information and Cost Savings c) To develop and implement a new performance monitoring and evaluation framework d) To ensure that we regularly report on the performance of the Programme at a community level	By 1 4 15
Partnership	a) To continue to support and sustain existing partnerships	At each

Development	b) To continue to develop dynamic and effective partnerships with: Clinical Commissioning Groups, GP Practices and Community Health Providers Schools National Probation Service and the Community Rehabilitation Company and relevant Prisons The Troubled Families Programmes in Coventry, Solihull and Birmingham	Programme Board Meeting
Sustainability of Progress made by families	a) To develop our approach (including pursuing funding opportunities) to providing low level support / family mentoring to families (based in local communities) that have successfully completed the programme b) To identify appropriate funding opportunities to support this work c) To ensure that we check and report on the situation of families that have completed the programme at six monthly intervals for two years	At each Programme Board Meeting

Warwickshire Health & Wellbeing Board

21 January 2015

Warwickshire Joint Strategic Needs Assessment (JSNA) Review

Recommendations

That the Warwickshire Health and Wellbeing Board (HWB):

1. **Consider, note and approve the Warwickshire JSNA Review.**
2. **Consider, note and approve the Quality of Life in Warwickshire Report 2015 as a key part of the wider, contextual evidence base underpinning the JSNA.**
3. **Note and comment on the key health and wellbeing issues outlined in the update and ensure they are considered alongside the monitoring of Warwickshire's new Health and Wellbeing Strategy.**
4. **Champion the delivery of the proposed work programme for the full JSNA 3-year Review.**

1.0 Background

1.1 A Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, well-being and social care services within a local authority area. A JSNA should consider the needs arising from all the factors that impact on the health and wellbeing of the local population including economic, education, housing and environmental factors.

1.2 These are needs that could be met by local authorities, Clinical Commissioning Groups (CCGs), NHS England or a combination of organisations working in partnership. JSNAs are produced by Health and Wellbeing Boards, and are unique to each local area. They should be designed to inform the development of locally produced Joint Health & Wellbeing Strategies.

1.3 It is a statutory requirement for upper-tier local authorities to produce a JSNA, although local areas are free to undertake JSNAs in a way best suited to their local circumstances.

1.4 In Warwickshire, the evidence exploring these macro-level issues is highlighted annually in our Quality of Life Report. This forms a key part of the County's wider, contextual evidence base for strategic decision-making and is also a fundamental component of our JSNA.

Purpose

1.5 The purpose of Warwickshire's JSNA Review is to establish a shared, evidence-based consensus on the key local priorities across health and social care.

1.6 The needs of our population are complex, wide-ranging and varied. In order to focus on the areas of greatest need, Warwickshire's health and wellbeing priorities have been determined through the JSNA prioritisation process.

1.7 Every three years, we review the selection of priorities to ensure our JSNA is focused on the most pertinent health and wellbeing issues facing the local population. This involves analysing and reviewing all the latest data and evidence to highlight the most significant health and wellbeing issues in Warwickshire, both now and for the future.

1.8 The JSNA Review 2014/15 forms the first report in the 3-year Warwickshire JSNA cycle. Evidence supporting the priorities set during the Review process will be updated in the first Annual Update 2015/16 and second Annual Update 2016/17.

1.9 This full review of Warwickshire's JSNA priority topics has been used by the Health and Wellbeing Board as the underlying evidence base to inform the development of its new 2014-2018 Joint Health and Wellbeing Strategy.

Figure 1: Warwickshire's JSNA 'Cycle' and Health & Wellbeing Strategy Alignment

1.10 Due to the complex, multi-faceted nature of health and wellbeing, a huge number of

different issues required consideration as potential priority topics. In order to focus on the areas of 'greatest' need, a more robust, transparent and inclusive means of determining the County's health and wellbeing priorities has been developed. Over the past few months, this has involved the use of a prioritisation matrix and a series of workshops with partners in an attempt to reach a consensus on the key areas of focus.

1.11 This JSNA Review is the culmination of the prioritisation process and this summary document outlines the Warwickshire population's health and wellbeing priorities.

What are Warwickshire's JSNA Priorities?

1.12 The outcome of the prioritisation process highlighted the following as key areas of focus:

Vulnerable Young People	• Looked After Children • Educational Attainment of Disadvantaged Children • Vulnerable Young People
Mental Wellbeing	• Mental Health Adults & Children • Dementia
Long-Term Conditions	• Cancer • Cardiovascular Disease
Physical Wellbeing	• Weight Management • Smoking/Smoking in Pregnancy • Substance Misuse & Alcohol
Carers	• Young Carers • Adult Carers

3.2 For each of these individual priorities, a summary of the evidence used during the prioritisation process is presented in the Review document.

4.0 Next Steps

4.1 This JSNA Review also provides the basis for a more detailed and ongoing programme of work, which incorporates specific needs assessments on each of the aforementioned identified priority topics. These priorities constitute the three-year

JSNA work programme, and the delivery of the associated needs assessments will be led by the JSNA Commissioning Group.

5.0 Background Papers

5.1 Appendix I – Draft Warwickshire JSNA Review

5.2 Appendix II - Quality of Life Report 2015 – Key Messages

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Appendix A

Joint Strategic Needs Assessment (JSNA) Review 2014/15

North Warwickshire residents report higher proportions acting as unpaid carers (12.1%)

Up to half of all cases of cancer are thought to be preventable. In Warwickshire this equates to around 730 preventable deaths each year

730

1,400

Cardiovascular disease is the leading cause of death in Warwickshire accounting for approximately 1,400 deaths (28%) a year

In 2012/13, 17.6% of mothers in Warwickshire were estimated to be smoking at time of delivery...

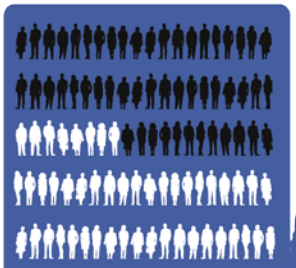
...this equates to around 1,000 babies born in Warwickshire who have effectively already been smoking for 9 months

1 in 3 people in Warwickshire are regularly drinking above the lower risk levels...

...that's an estimated 153,000 people

Almost 1 in 10 Warwickshire children are obese when they start school...

...by the time they are 11 years old, this increases to 1 in 6



Estimates suggest that only 48% of people with dementia in Warwickshire have been formally diagnosed...

... this means there could be nearly 4,000 undiagnosed dementia patients in the county

In Warwickshire 26,000 children require Child & Adolescent Mental Health Services

(This can be anything from sleeping diffioulties to severe mental health problems)

15,315 children were considered to be living in poverty in 2011. This equates to 14% of all children in Warwickshire.

There is a 32 percentage point difference between the proportion of 'disadvantaged children' and other children, in terms of those achieving 5+ A*-C GCSEs, including English and Maths

Warwickshire's rate of looked after children is 62 per 10,000...

...this is significantly higher than our statistical neighbours

Acknowledgements

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Contents

What is the JSNA?

A Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, well-being and social care services within a local authority area. A JSNA should consider the needs arising from all the factors that impact on the health and wellbeing of the local population including economic, education, housing and environmental factors.

These are needs that could be met by local authorities, Clinical Commissioning Groups (CCGs), NHS England or a combination of organisations working in partnership. JSNAs are produced by Health and Wellbeing Boards, and are unique to each local area. They should be designed to inform the development of locally produced Joint Health & Wellbeing Strategies.

It is a statutory requirement[1] for upper-tier local authorities to produce a JSNA, although local areas are free to undertake JSNAs in a way best suited to their local circumstances.

Statutory guidance on JSNAs has been produced by the Department for Health and can be accessed here.

What is Warwickshire's approach to the JSNA?

The purpose of Warwickshire's JSNA is to establish a shared, evidence-based consensus on the key local priorities across health and social care.

The needs of our population are complex, wide-ranging and varied. In order to focus on the areas of greatest need, Warwickshire's health and wellbeing priorities have been determined through the JSNA prioritisation process.

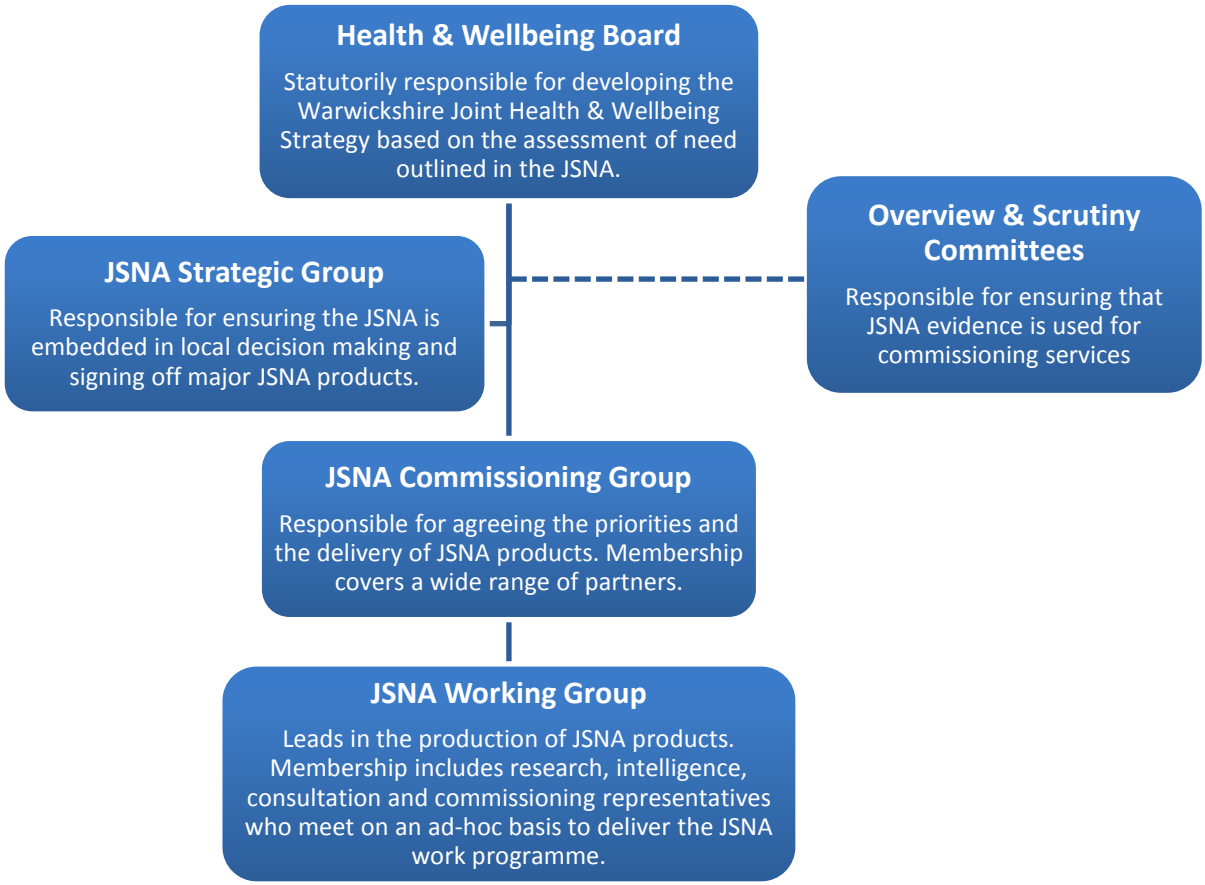
The data and evidence which underpins our JSNA is hosted on Warwickshire's Health & Wellbeing website. This site brings together information about health and wellbeing in the County, by integrating all of our JSNA, Health & Wellbeing Board, Public Health and Healthwatch web content.

[1] This statutory requirement was introduced by The Local Government and Public Involvement in Health Act (2007): Section 116 (as amended by The Health and Social Care Act (2012): Section 192) and section 116A (as inserted by The Health and Social Care Act (2012): Section 193).

Governance Arrangements

The governance arrangements for Warwickshire's JSNA are summarised in Figure 1. More detailed information can be found here.

Figure 1: Warwickshire's JSNA Governance Arrangements



What is the purpose of the JSNA Review?

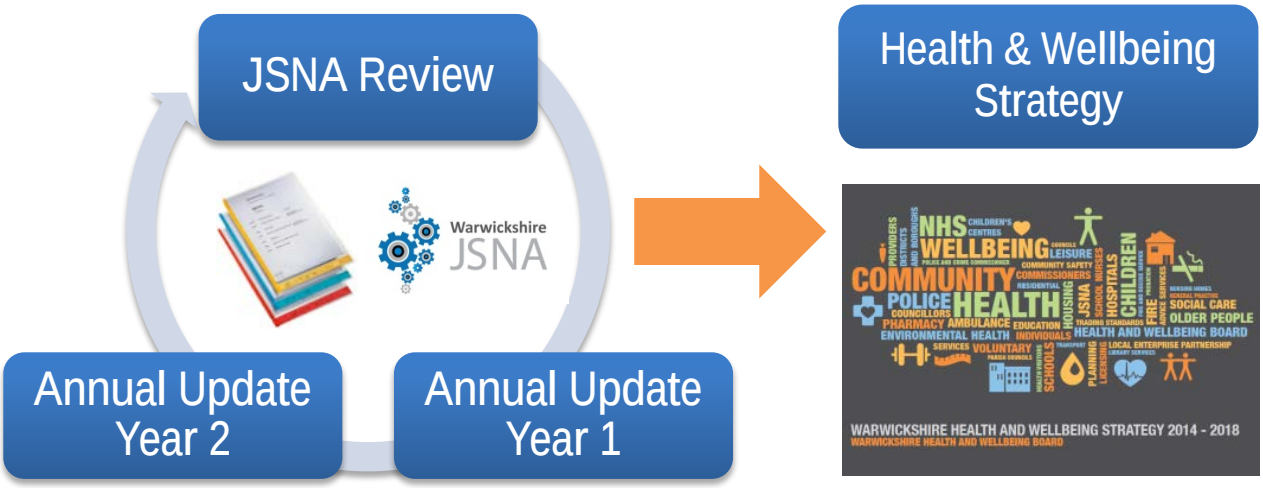
Every three years, we review the selection of priorities to ensure our JSNA is focused on the most pertinent health and wellbeing issues facing the local population. This involves analysing and reviewing all the latest data and evidence to highlight the most significant health and wellbeing issues in Warwickshire, both now and for the future.

The JSNA Review 2014/15 forms the first report in the 3 year Warwickshire JSNA cycle. Evidence supporting the priorities set during the Review process will be updated in the first Annual Update 2015/16 and second Annual Update 2016/17.

This full review of Warwickshire's JSNA priority topics has been used by the Health and Wellbeing Board to inform the development of its new 2014-2018 Joint Health and Wellbeing Strategy. Details of this process are available here.

Warwickshire's 3-year JSNA process and alignment to the Health and Wellbeing Strategy is outlined in Figure 2.

Figure 2: Warwickshire's JSNA 'Cycle' and Health & Wellbeing Strategy Alignment



Any new data, statistics and evidence on the identified priorities will be further analysed as part of two future annual JSNA update reports. This will be supplemented by detailed analysis on key macro-level demographic, socio-economic and environmental indicators, such as that contained within the Observatory's 'Quality of Life' reports to help to ensure that our JSNA is always based on the most timely, comprehensive and relevant information.

How did we decide on our JSNA Priority Topics?

Due to the complex, multi-faceted nature of health and wellbeing, a huge number of different issues required consideration as potential priority topics. In order to focus on the areas of 'greatest' need, a more robust, transparent and inclusive means of determining the County's health and wellbeing priorities has been developed. Over the past few months, this has involved the use of a prioritisation matrix and a series of workshops with partners in an attempt to reach a consensus on the key areas of focus.

The Review Launch Workshop

This work started on 29th April 2014, when the Warwickshire Health and Wellbeing Board hosted the 'Health and Wellbeing Strategy & Joint Strategic Needs Assessment Review Launch'. This session provided the opportunity for an initial discussion on what the priorities for Warwickshire's next full JSNA Review should be, and how they would contribute to the development of Warwickshire's new Health & Wellbeing Strategy.

A large number of priorities and themes proposed by stakeholders emerged from the day and it was felt that this long, initial list of potential topics needed to be rationalised.

The Prioritisation Process

As part of the JSNA Review process, a prioritisation matrix was developed to evaluate the level of 'need' and strength of evidence behind the range of suggested priority topics.

There is no single 'best' way of prioritising inherently complex and varied health and wellbeing issues and any such process involves a certain degree of subjectivity. However, the matrix introduced objectivity, robustness and transparency into the process so that stakeholders could hold more informed discussions on what should be the key focus of Warwickshire's JSNA.

What criteria were used to prioritise the topics?

Figure 3 outlines the key criteria which were used to assess the overall level of need for each suggested topic as part of the prioritisation process.

Each topic was run through the tool and the latest relevant evidence was assessed with 'high', 'medium' or 'low' scores being given for each particular criterion. Additional emphasis was placed on the level of need (severity and volume) and economic cost prioritisation criteria and therefore these were given greater weighting when the overall scores for each proposed priority area were calculated.

Figure 3: JSNA Prioritisation Matrix

	Criteria	High	Medium	Low	Zero	Weight-ing
		10 points	6 points	4 points	0 points	
Estimated Level of Need	Level of need – Volume	Topic covers an estimated large 'in need' population (>25,000 people).	Topic covers an estimated medium sized 'in need' population (10,000 – 24,999).	Topic covers an estimated small 'in need' population (<10,000).	-	1.5
	Level of need – Severity	The population concerned have 'severe' needs.	The population concerned have 'considerable' needs.	The population concerned have 'moderate' needs.	-	1.5
	Level of need – Trend	Available evidence suggests rapidly worsening situation over time.	Available evidence suggests worsening situation over time.	Available evidence suggests situation has remained stable over time.	Available evidence suggests improving situation over time.	1
	Level of need – Benchmarks	Available evidence suggests very high prevalence relative to comparator areas (the County is a clear statistical outlier).	Available evidence suggests above average prevalence relative to comparator areas.	Available evidence suggests prevalence in-line with comparator areas.	Available evidence suggests relatively low prevalence relative to comparator areas.	1
Early Intervention	Does the topic have early intervention implications? Is it an emerging issue which is likely to cause further problems in the future?	Clear, demonstrable evidence that there is a strong case for early intervention.	Some evidence which highlights areas suitable early intervention.	Weak evidence that the topic has areas suitable early intervention.	No evidence to suggest that the topic contains areas suitable early intervention.	1
Inequalities	What is the scale of inequality?	Persistent, wide scale geographic and population-based inequalities are clearly apparent.	Some notable geographic or population-based inequalities are apparent.	Some minor inequalities exist.	Little or no evidence of inequalities.	1
Cost Implications	Estimated economic cost associated with tackling the topic in Warwickshire	High levels (multi-millions of £s) of both direct and indirect estimated economic costs both now and in the future.	Medium levels (c. £5 million) of direct and/or indirect estimated economic costs both now and in the future.	Low levels (<£1 million) of estimated economic costs either now/and or in the future.	-	1.5

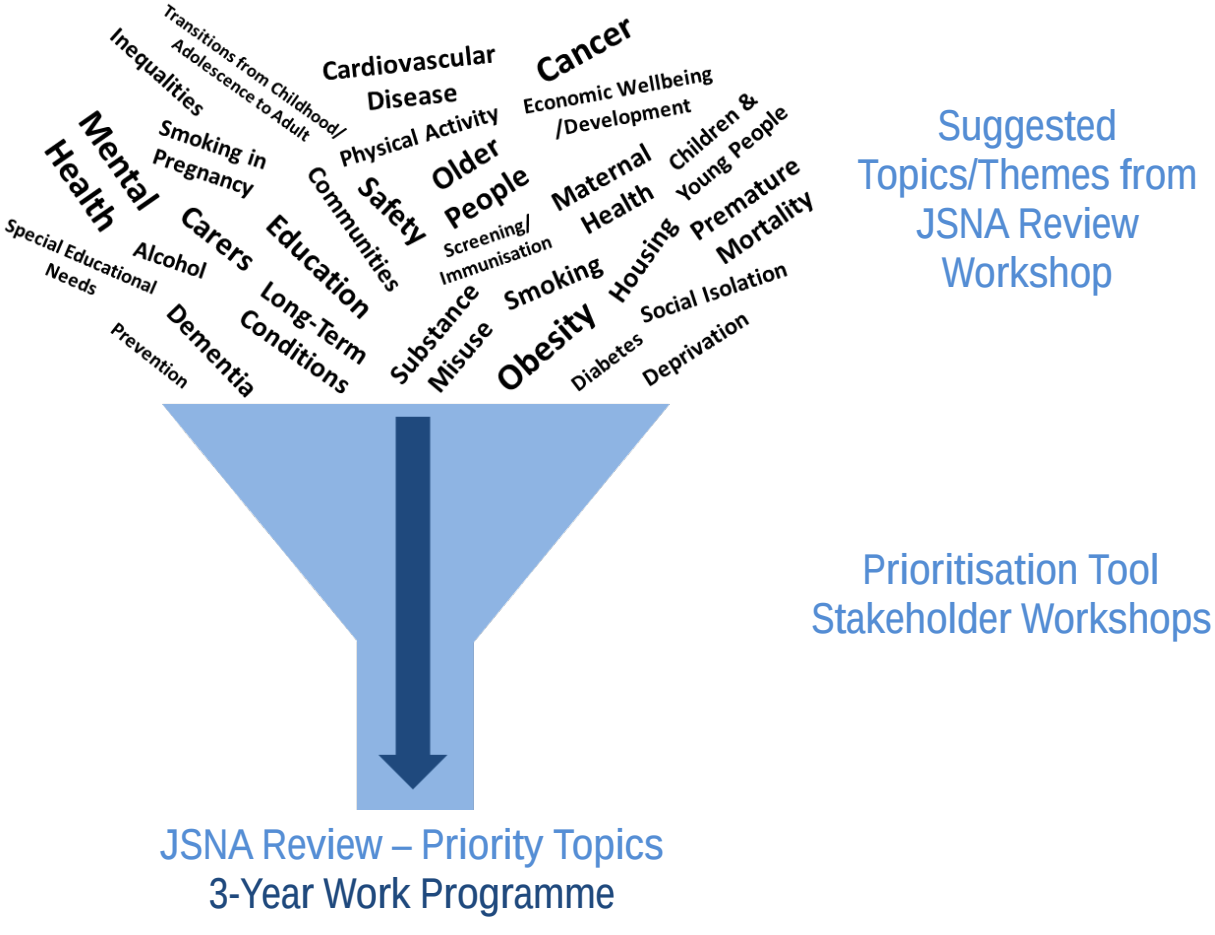
JSNA Prioritisation Workshop

On 23rd June 2014, a second Health and Wellbeing Board session was held to present the prioritisation matrix scoring of the proposed priorities. The main objective of the workshop was to agree a manageable list of Warwickshire's priority health and wellbeing needs, to be addressed through the Joint Health and Wellbeing Strategy. Eleven topics were taken forward to this workshop based on the scores they achieved. Attendees received short 'Dragon's Den-style' evidence-based presentations from topic 'champions' around why their topic should be considered as a priority in Warwickshire. Stakeholders then debated the case for the final selection. Each attendee was also given the opportunity to rank the priorities in order of importance. These individual rankings were then collated to produce a final, overall, ordered list of priorities. Partners (including Health & Wellbeing Board members) played a key role in determining the final set of priorities.

This JSNA Review is the culmination of the prioritisation process and this summary document outlines the Warwickshire population's health and wellbeing priorities.

It also provides the underlying evidence base for Warwickshire's new Joint Health and Wellbeing Strategy and a starting point for more detailed needs assessments to be undertaken as part of our 3-year JSNA work programme. Full details of our JSNA prioritisation process are available here.

Figure 4: JSNA Review Prioritisation Process



What are Warwickshire's JSNA Priorities?

The outcome of the prioritisation process highlighted the following as key areas of focus:

Vulnerable Young People	• Looked After Children • Educational Attainment of Disadvantaged Children • Vulnerable Young People
Mental Wellbeing	• Mental Health Adults & Children • Dementia
Long-Term Conditions	• Cancer • Cardiovascular Disease
Physical Wellbeing	• Weight Management • Smoking/Smoking in Pregnancy • Substance Misuse & Alcohol
Carers	• Young Carers • Adult Carers

For each of these individual priorities, a summary of the evidence used during the prioritisation process is now presented.

VULNERABLE YOUNG PEOPLE

Looked After Children (LAC)

Level of need - Volume	• 690 children were looked after by the local authority as at 31st March 2014 (including asylum seekers)[1].
Level of need – Severity	• Children who are looked after suffer some of the most serious negative life events including abuse, neglect and family dysfunction. • Their needs include poor educational attainment and poor emotional wellbeing, experiencing significantly worse mental health than all children[2].
Level of need – Trend	• Over the last 5 years, numbers of LAC have increased by 22% from 536 at 31st March 2009 to 690 at 31st March 2014[1].
Level of need – Benchmarks	• Warwickshire's looked after rate per 10,000 is significantly higher than our statistical neighbours; Warwickshire = 62.0, Statistical Neighbours = 48.8, England = 60.0[1]
Does the topic have early intervention implications?	• Safely preventing children from becoming LAC is one of the key aims of Warwickshire County Council in managing our looked after population. Diverting children to prevent them from being looked after was a key tenet of the Dartington Project which concluded in March 2014[3].
What is the scale of inequality?	• Looked after children can experience multiple harm factors which contribute to poorer outcomes than the non-looked after population. • In childhood, LAC are more likely to experience poor mental health and poor educational attainment. • Children who are looked after become adults who may have poor adult outcomes such as substance misuse, mental health issues, long term unemployment and offending behaviour. • Children who are looked after are 2.5 times more likely to become teenage parents and more likely to have those children taken into care. • Children whose parents are substance misusers are more likely to be looked after and families where there is domestic violence are more likely to have a child in care. • Nuneaton and Bedworth has the largest numbers of LAC as well as the highest levels of child poverty[4].
Estimated economic cost	• The average weekly cost in 2003-04 of a child in Local Authority foster care was £349, and £2,048 for children in residential homes Commissioning placements and services for looked after children and children with special educational needs and disabilities in residential placements[5] • The Dartington Project in 2011 worked on an estimated cost of £30,000 per child looked after.
Top areas of focus	• Warwickshire's looked after rate is significantly higher than our statistical neighbours. • Looked after children have significantly worse mental health than all children. • Looked after children have poorer educational attainment than children who have not been looked after.

Educational Performance of Disadvantaged Children

Level of need - Volume	• 0-17 mid 2013 population estimate for Warks - 111,900[1] • 2014 Spring School Census – Reception to Year 13: 75,104[2] FSM 4-17 = 7500[2] + LAC (535 4-17) =8,035[3] (DfE disadvantaged[4]=13,900)
Level of need – Severity	• Challenges lie in closing the gaps between disadvantaged and other pupils in Warwickshire. The disadvantaged 'gap' for Key Stage 2 pupils achieving Level 4 or above in R/W/M has grown from 21% to 23%, whilst the national gap has fallen by 1%[5]. Encouragingly, the attainment of disadvantaged pupils achieving above the nationally expected level (achieving a Level 5) has increased by 2% between 2012 and 2013, however the attainment of other pupils has also increased at the same rate maintaining rather than 'closing' the gap, which holds at 18%. The gaps widen as pupils continue their schooling standing at 32% in 2013 for those achieving 5+ GCSEs at A*-C, including English and Maths. The attainment of disadvantaged pupils achieving this KS4 measure has grown over the past 3 years up from 33% to 39%, however the attainment of other pupils has matched this, up from 66% to 71%, maintaining the gap between the two groups[4]. • Girls continue to outperform boys; however this underachievement is more pronounced and widening in certain areas of the County.
Level of need – Trend	• Gaps between disadvantaged and other pupils in Warwickshire are not improving. Although attainment of disadvantaged group is improving.
Level of need – Benchmarks	• Gender – Warwickshire Boys and Girls tend to perform better than national and statistical neighbour counterparts. Gender gap at County level similar to national/SN average
Does the topic have early intervention implications?	• Not achieving Level 4+ at KS2 means the child has a considerable amount of ground to make up to achieve at least a C at KS4. Not achieving the minimum number of expected GCSEs increases the likelihood of becoming NEET. School Readiness at EYFS is key to identifying those already at a disadvantage at an early stage.
What is the scale of inequality?	• The gender gap in North Warwickshire has widened over the last few years at KS2 with boys under achieving at 68% compared with 81% of girls attaining the expected level in reading, writing and maths. At the end of KS4 in Warwickshire there is an 8ppt gap in attainment between girls and boys, with girls continuing to out-perform boys, 69% attaining the expected level at the end of KS4 compared to 61%. As at the end of KS2, in North Warwickshire state funded schools there is also a more pronounced gap in attainment between boys and girls of 17ppts when compared with the other Districts and Boroughs, with 47% of boys achieving 5+ A*-C GCSEs including English and Maths, compared to 64% of girls.
Estimated economic cost	• Investing in education will save millions of pounds in the future in unemployment benefit, costs to the economy and costs to the health sector due to education affecting long term health.
Top areas of focus	• The disadvantaged 'gap' for educational attainment of pupils has increased in Warwickshire but decreased nationally. • Girls outperform boys, with a more pronounced gap between sexes in North Warwickshire.

Vulnerable Young People

Level of need – Volume	• 991 'Priority Families' in Warwickshire[1], 660 NEET[2], 190 new offenders[3] aged 10-17 (370.9 per 100,000)[2], 299 Under 18 conceptions (24.3 per 1,000)[2], 67 under 18 mothers[2], 14.1% children in low income families[2] • 550 children in Warks subject to a Child Protection Plan (CPP) (47.8 per 10,000)[4] • c.200 (local data collection[5]) or 4,900 (NSPCC estimates) children at risk of CSE. • 15,315 children considered to be living in poverty in 2011, ~14% of all children[6]. • 11% of secondary school pupils in Warks state they have smoked once or twice and a further 8% have smoked a few times. 1 in 5 college students are frequent smokers[7]. • 8% of those aged 11-16 say that they are drinking alcohol 'about every week' and 2.2% 'most days'. The proportion of young people who drink every week is higher in Warwickshire that national average[7]. • 2% of 11-16 year olds say they were taking drugs about every week, & a further 2% say they take illegal drugs most days. Those who regularly truant or are excluded from school are more likely to have used illicit drugs[7]. • Unknown numbers of: children of prisoners, children who are victims of domestic violence, children who have a parent with mental health issues, children who have parents who are substance misusers
Level of need – Severity	• Range of needs from those NEET, smoking and drinking alcohol who are at risk of having severe needs in the future to current severe needs of those being sexually exploited and child victims of domestic violence.
Level of need – Trend	• NEET – downwards trend - 2011=4.5%, 2012 = 3.6%[2] • First time entrants to youth justice system – downwards trend – 2011=545.7, 2012 =370.9[2] • Under 18 conception – downwards trend – 2011 = 30.9, 2012 =24.3[2] • CPPs – WORSENING trend – 2011 = 43.0, 2012 = 47.8[4] • Low income – stable trend – 2011 =14.6%, 2012 = 14.1%[2] • Poverty - The 2011 figures are lower compared to 2010, however four of the five districts/boroughs are higher compared to 2006 figures. (not Warwick)[6]
Level of need – Benchmarks (2012)	• NEET – lower than statistical neighbours (SN) and England average (EA): Warks =3.6% vs SN =5.% vs EA =5.8%[2] • Young offenders – lower than SN & EA: Warks= 370.9 vs SN= 516.4, EA =537.0[2] • Under 18 conceptions – lower than SN & EA: Warks= 24.3 vs SN = 25.3 vs EA =27.7[2] • CPP- WORSE than SN & EA: Warks= 47.8 vs SN= 31.4 vs EA= 37.8[4] • Low income better than SN & EA: Warks= 14.1% vs SN= 14.9% vs EA= 20.6%[2] • Poverty - 14% considerably below the national and regional equivalent figures of 20% and 23% respectively[6].
Does the topic have early intervention implications?	• Children who experience 4 or more Adverse Childhood Experiences (ACEs) are statistically more like to experience negative adult health outcomes. There would be considerable long term health benefits for the most vulnerable if the ACEs were prevented[8]
What is the scale of inequality?	• Poverty, NEETs, Under 18 conceptions, drinking alcohol, CPPs all higher in the North of the county[4,6]. • Some groups have higher vulnerability including looked after children.
Estimated economic cost	• Investing to prevent ACEs would have high level, wide reaching benefits for Warks[8]
Top areas of focus	• Preventing children from experiencing ACEs would drastically impact the numbers of adults with negative health outcomes. • Warwickshire has a significantly higher rate of children subject to a CPP than our statistical neighbours. • There are a number of vulnerable groups who we do not have any data on their group's size.

MENTAL WELLBEING

Mental Health Children and Adults

Level of need - Volume	• 26,000 children requiring CAMHS service across the tiers[1]: ▪ T1: 16,659 (may include sleeping difficulties or feeding problems) ▪ T2: 7,773 (may include family work, bereavement, parenting groups etc) ▪ T3: 2,055 (may be developmental, autism, hyperactivity, depression, early onset psychosis etc) ▪ T4: 82 (severe mental health problems) • There are 26,426 residents aged over 18 registered as having a mental health condition in Warwickshire[2].
Level of need – Severity	• Mental ill health falls across a spectrum of need from those with severe mental health illnesses who require a higher level of support from acute in-patient services to low level mental wellbeing issues which can be supported through Improving Access to Psychological Therapies (IAPT). • Severity can vary within different diagnoses; for example depression can be mild, moderate or severe.
Level of need – Trend	• Rise in number of CAMHS' referrals over past 3 years as well as increasing levels of complexity and need, with self-harm increasing significantly. • It is projected that those aged over 65 years with severe depression in Warwickshire will increase by 20.8% and across all districts/boroughs that those aged over 65 years with depression or severe depression will increase by around a fifth between 2012 and 2020[3].
Level of need – Benchmarks	• In-line with comparator areas (children and adult mental health) • Warwickshire will increase greater when compared to West Midlands and England for both depression and severe depression.
Does the topic have early intervention implications? Is it an emerging issue which is likely to cause further problems in the future?	• If the symptoms associated with common mental health conditions are identified, it is possible to reduce the severity of the condition[4] • Mental health disorders in childhood can have high levels of persistence. In children, 25% of those with emotional disorder and 43% of those with a conduct disorder are likely to have the problem three years later if not addressed, which can lead to poorer outcomes in education. Those experiencing anxiety in childhood are 3.5 times more likely than others to suffer depression or anxiety in adulthood[5] • Can be a predisposition to other unhealthy lifestyles (increased drinking, poor diet, sedentary lifestyle etc.)
What is the scale of inequality?	• Service users report barriers to accessing CAMHs by those from disadvantaged backgrounds. Whilst levels of need are believed to vary across the County, the service provision does not reflect this. • More likely to live 15-20 years less than the general population which is related to poorer health such as heart disease and stroke[6]
Estimated economic cost	• Prevention of mental disorder spending and promotion of mental health represents less than 0.1% of the annual NHS mental health budget[7]. • Mental ill health costs £105 billion each year in England. This includes £21 billion in health and social care costs and £29 billion in losses to business[8].
Top areas of focus	• Data relating to unmet need in wider population i.e. how many children and adults have a mental health issue who are NOT known to services, likely to be at the mild to moderate end of the need spectrum. Better Warwickshire specific information.

Dementia

Level of need - Volume	• There are 3,584 registered patients diagnosed with dementia in Warwickshire[1]. However, estimates suggest 7,521[2] are living with the condition, meaning that only 48% of patients have been formally diagnosed. • Modelled figures estimate that females over the age of 80 have the highest prevalence of dementia and account for 50% of total numbers[3]. • Figures suggest that dementia will affect 1 in 3 people who live to over the age of 65[4].
Level of need – Severity	• Dementia is a degenerative disease of the brain which over time can result in gradual loss of mental awareness, memory, general communication and skills to carry out daily activities, as well as personality change[5]. • The speed of progression is variable but typically develops slowly over a number of years.
Level of need – Trend	• From 2012-2020, dementia prevalence in Warwickshire is projected to increase by 27.7% for those aged 65 and over[6]. • The largest increase in prevalence is projected in North Warwickshire (+36.5%) for those aged 65+, followed by Stratford-on-Avon (33.4%)[6]. • In Warwickshire, dementia prevalence is projected to increase at a faster rate than that for the West Midlands Region (+24%) and England (+23.5%)[6]. • Trends in North Warwickshire suggest that there is expected to be an immediate drop in 2012-2014 followed by an increase from 2014 onwards in terms of percentage change[6].
Level of need – Benchmarks	• Estimates suggest that in England, the diagnoses rate is 48.7% (2012/13) which is comparable to Warwickshire (47.8%)[7].
Does the topic have early intervention implications?	• Currently, less than half of people living with dementia in Warwickshire have had a diagnosis, but an early diagnosis can be very important in ensuring that people are able to maintain the quality of life that they had previously enjoyed and have access to appropriate support and services. Although dementia is incurable, early diagnosis can allow access to medications that can be used to effectively slow down the progression of the illness[8].
What is the scale of inequality?	• Prevalence is more prominent amongst women and this is expected to continue in the future[6]. • Prevalence is higher in the south of the County, in terms of absolute numbers, but this due to having a larger and older population when compared to the north of the County[6]. • Percentage changes in females is greater than males across the years (actual and percentage change)[6].
Estimated economic cost	• Dementia UK[9] estimates* that the total annual cost per person with dementia in different settings in 2007 was as follows: ▪ People in the community with mild dementia: £14,540 ▪ People in the community with moderate dementia: £20,355 ▪ People in the community with severe dementia: £28,527 ▪ People in care homes: £31,263 *The breakdown of these for actual numbers is unknown and therefore may affect the total costs.
Top areas of focus	• Dementia prevalence is projected to increase by nearly a third for those aged 65 and over by 2020. • Improving the rate of diagnosis.

LONG-TERM CONDITIONS

Cancer

Level of need - Volume	• It is estimated that more than 1 in 3 people in the UK will develop some form of cancer during their lifetime[1]. • 2.0% of the population are recorded on GP registers as having been diagnosed with cancer (11,335 patients). • In Warwickshire, there are approximately 2,435 new cases of cancer each year. • In 2012, there were 1,461 deaths due to cancer (28.1% of all deaths). 1 in 4 people will die from cancer[2].
Level of need – Severity	• The level of need will vary depending on the "site" of the cancer and the "stage" of the cancer.
Level of need – Trend	• In line with national trends, there continues to be an overall increase in the number and rate of new cases of cancer each year, but a falling rate of deaths. This is due to increasing survival rates from cancer over the past decades.
Level of need – Benchmarks	• Warwickshire has a lower cancer incidence and lower mortality than the national average. Recorded prevalence is also lower than the England rate and compared to some neighbouring areas e.g. Staffordshire and Worcestershire
Does the topic have early intervention implications?	• Up to half of cases of cancer are thought to be preventable. As the population ages, diagnosis improves and more people survive from cancer, prevalence (i.e. the number of people living with cancer) is likely to increase[3].
What is the scale of inequality?	• The prevalence of cancer increases with age. In general, men are at significantly greater risk than women, with the exception of breast cancer. Black and Minority Ethnic (BME) groups are at a lower risk overall from cancer than the White population, but there is an increased risk of certain cancers in BME groups. Within Warwickshire, although mortality rates are lower than nationally, Nuneaton and Bedworth has significantly higher cancer mortality and premature mortality[4]
Estimated economic cost	• 5% of the NHS budget is spent on cancer care, with some estimates suggesting that the overall cost could increase by more than a third in the next decade[5].
Top areas of focus	• Early detection and diagnosis. • Reducing inequalities in access to and uptake of cancer services. • Prevention of people developing cancers which are amenable to changes in lifestyle.

Cardiovascular Disease (CVD)

Level of need - Volume	• CVD is an overarching term used to describe a family of diseases (including stroke, heart attack and peripheral vascular disease) which share a common set of risk factors. • 12.2% (53,100) of the population aged 16+ in Warwickshire are estimated to be living with CVD[1], whilst 5.6% (24,600) of the adult population are estimated to be living with Coronary Heart Disease (CHD), and 2.6% (11,300) with Stroke alone. • There are currently over 27,000 patients on GP registers for stroke and CVD[2] which suggests a notable gap between the estimated and the observed prevalence. • CVD is the leading cause of death in Warwickshire accounting for approximately 1,400 deaths (28%) a year[3].
Level of need – Severity	• The level of need will vary depending on the diagnosis. CVD is a chronic condition.
Level of need – Trend	• In line with national trends, there continues to be an overall decline in the number and rate of deaths from CVD across Warwickshire. • Early mortality (under 75 years) rates from cardiovascular disease are significantly lower than the national rate, and have decreased by 62.9% since 1995[4].
Level of need – Benchmarks	• Overall mortality rates for CVD in Warwickshire are significantly lower than the England average. However, prevalence is higher in parts of the County than nationally and regionally for CVD (the South) and higher for stroke.
Does the topic have early intervention implications?	• Most deaths caused by cardiovascular disease are premature and could easily be prevented by making lifestyle changes, such as eating a healthy diet, exercising regularly and stopping smoking. • The NHS health Check Programme was formally introduced in April 2009 as a key policy to reduce health inequalities and increase life expectancy from preventable CVD conditions.
What is the scale of inequality?	• There is considerable geographic variation across Warwickshire, and by age and gender. The under-75 mortality rate from CVD ranges from 37 per 100,000 population in Stratford-on-Avon to 63 in North Warwickshire. There is also variation in diagnosis and treatment by practice.
Estimated economic cost	• The combined cost of CVD to the NHS and the UK economy is £30 billion annually. The cost of CVD to the UK healthcare system in 2006 was £14.4 billion (around 48%); productivity losses account for £8 billion annually (26%) and the cost of informal care of people with CVD is also £8 billion annually[5].
Top areas of focus	• CVD is the leading cause of death in Warwickshire. • The emergency admission rate for CVD for people living in the most deprived areas of Warwickshire is significantly greater than for those living in the least deprived areas. • Health promotion in order to prevent premature death from CVD.

PHYSICAL WELLBEING

Weight Management

Level of need - Volume	• Estimates suggest 21.8% of adults in Warwickshire are classified as obese[1], equating to approximately 98,000 adults with a BMI ≥ 30kg/m^2. A further 43.0% of adults are estimated to be overweight (but not obese) meaning that almost 2 in 3 adults are defined as carrying excess weight. • In 2012/13, 45,664 adults in the county (9.9% of the total GP registered population aged 16+) featured on GP registers for obesity[2] highlighting a noticeable difference between numbers of people estimated to be obese and those with a formal diagnosis (actual prevalence). • Almost 1 in 10 children in Warwickshire are now obese when they start school and, by the time they are 11 years old, this increases to 1 in 6[3]. • 55.3% of adults in Warwickshire are physically active and 27% are inactive[4].
Level of need – Severity	• Obesity can have significant implications for health, social care, the economy and educational attainment. Obesity increases the risk of developing other serious diseases, e.g. heart disease, diabetes and cancers[5].
Level of need – Trend	• The prevalence of obesity across England has increased in the past 20 years. • The number of hospital admissions with a primary or secondary diagnosis of obesity has risen rapidly since 2002/03. • The percentage of adults who are physically active at recommended levels increased steadily between 1997-2008, from 26% to 36%.
Level of need – Benchmarks	• The percentage of excess weight in adults in Warwickshire (64.8%) is slightly higher than that for England, Coventry and Birmingham[1]. • Warwickshire has statistically significantly lower proportion of obese reception aged and Year 6 children than the England averages[4]. • Warwickshire has a slightly lower proportion of physically active adults than the England average (56.0%) but is higher than some nearby authorities.
Does the topic have early intervention implications?	• School-based interventions have been found to be effective in reducing obesity levels and longer-running programmes even more effective[6]. • Nutritional education and promotion of physical activity, together with behaviour changes, decrease in sedentary activities and collaboration of the family may be important factors in the prevention of childhood obesity[7,8]. • Evidence suggests that effective policies in reducing childhood obesity result in short term health benefits, e.g. reduction in Type 2 diabetes. Longer term benefits include reduce the progression of childhood obesity into adulthood.
What is the scale of inequality?	• Evidence suggests a strong link between obesity levels and deprivation: there is a higher prevalence of obesity in young deprived children compared to those from more affluent groups[9]. • Adults with lower qualifications have a higher prevalence of obesity, than groups with higher qualifications[5]. • In Warwickshire, there is a clear geographical trend of obesity ranging from 29.6% in North Warwickshire to 21.4% in Warwick[5].
Estimated economic cost	• In 2004, it was estimated that the projected cost of dealing with obesity and related diseases was to be £73.9 million in 2010 and £84.9 million in 2015[10]. • Including the economic costs to the wider community, it is estimated that these indirect costs could cost the UK economy £27 billion in 2015[5].
Top areas of focus	• Higher Body Mass Index (BMI) is associated with an increased risk of morbidity and mortality from a range of conditions including hypertension, heart disease & type 2 diabetes • There is a clear geographical trend of obesity in Warwickshire, with higher rates in the north of the county compared to the south.

Smoking/Smoking in Pregnancy

Level of need - Volume	• The prevalence of smoking among persons aged 18 years and over in Warwickshire, in 2012, was 17.9%[1]. NHS Stop Smoking Services data for 2013-14 indicates that 4,458 people had set a quit date between April 2013 and December 2013 and that 1,947 (43.7%) had successfully quit. • In 2012/13, 17.6% of mothers in Warwickshire were estimated to be smoking at time of delivery. This equates to around 1,000 babies born in Warwickshire who have effectively already been smoking for nine months[1].
Level of need – Severity	• Smoking is one of the biggest causes of death and illness in the UK and accounts for more than 80,000 premature deaths each year. In Warwickshire, every year, there are more than 800 preventable deaths as a result of smoking[2]. • Smoking causes about 90% of lung cancers, which in Warwickshire, leads to nearly 250 deaths per year. It also causes cancer in many other parts of the body.
Level of need – Trend	• Smoking prevalence trends suggest that the rate in Warwickshire has fallen from 19.8% in 2010 down to 17.9% in 2012. At a District/Borough level, rates have also fallen other than in Stratford-on-Avon District which has seen an increase from 17.4% to 19.8% in the same period. • The trend in smoking in pregnancy data is less clear with the rate having increased from 16.4% in 2010/11 to 19.6% in 2011/12 before declining to 17.6% in 2012/13[1].
Level of need – Benchmarks	• The adult smoking prevalence rate in Warwickshire in 2012 was lower than the England rate of 19.5%, although not statistically significantly. At District/Borough level, the rate varied from 10.4% in North Warwickshire to 19.8% in both Nuneaton & Bedworth and Stratford-on-Avon. However, the North Warwickshire rate is based on a sample size of just 107 people[1].
Does the topic have early intervention implications?	• Two thirds of smokers say they began before they were legally old enough to buy cigarettes and 9 out of 10 before the age of 19[3]. • At least 20% of our children live in a house where people smoke. Children of smokers are almost twice as likely to be admitted to hospital with breathing difficulties as those that live in a smoke free home[4]. • By quitting smoking, after 1 year, the risk of heart attack is half that of a smoker, and after 10 years, lung cancer risk is half that of a smoker[5]. • Warwickshire County Council was the first county council to sign up to the Declaration of Tobacco Control. As part of the declaration, the local authority promises to participate in local and regional networks for support and support the government in taking action at a national level to help local authorities reduce smoking prevalence and health inequalities in our communities[6].
What is the scale of inequality?	• Smoking is the biggest preventable cause of health inequalities & increases the risk of cancer, heart disease, stroke & chronic respiratory disease. • Over half of the health inequalities between the north and the south of the county are estimated to result from differential smoking behaviours. • There is a strong link between smoking and socio-economic group. For instance, the smoking prevalence rate in Warwickshire for those who are routine/manual workers was estimated at 29.2% in 2012[1].
Estimated economic cost	• Estimates suggest each year in Warwickshire, smoking costs society £119m. This includes lost productivity, treatment costs, accidental fires & waste[7]. • The cost per successful quitter, 2012/13, in Warwickshire, is calculated to be £208 against the West Midlands average of £351[8].
Top areas of focus	• Warwickshire has a significantly higher number of women who smoke during pregnancy compared to the England average. • 9 out of 10 smokers began smoking before the age of 19.

Substance Misuse (SM) & Alcohol (A)

Level of need - Volume	• (A): 35.2% of Warwickshire adults or 153,072 people are estimated to be drinking at 'risky' levels[1]. • (SM): It is estimated that just under 2,500 (6.3 per 1,000) Warwickshire residents aged 15-64 are dependent on crack or heroin[2]. It is more difficult to obtain local estimates of the numbers who use other drugs.
Level of need – Severity	• (A): A spectrum of need exists, ranging from low level support for those with 'harmful drinking' issues to acute medical and social care for those with alcohol dependency. • (SM): The associated physical health conditions include the risk of overdose, infections, poor mental/ physical / dental health, and injection site wounds. There are also wider personal needs that could be considered severe.
Level of need – Trend	• (A): The proportion of men drinking more than the recommended amount did not show substantial change between 2006 and 2012. Among women there was a decrease of the proportion drinking more than the recommended amount[1]. • (SM): From 2009/10-2010/11, it is estimated the number of Warwickshire residents addicted to heroin or crack increased by around 100[2].
Level of need – Benchmarks	• (A): No areas in Warwickshire rank within the worst performing areas nationally[3] and Warwickshire performs better than the national average in terms of alcohol-related admissions[4]. • (SM): Warwickshire has a lower rate than the national rate for opiate and/or crack dependency prevalence (6.3 per 1,000 compared with 8.7 per 1,000). However, in 2012 the percentage of successful completions of drug treatment for both opiate and non-opiate users in Warwickshire was significantly worse than the England figure[5].
Does the topic have early intervention implications?	• (A): Interventions aimed at individuals can help make people aware of potential risks at an early stage when they are most likely to change their behaviour[6]. • (SM): Drug use amongst rough sleepers usually reduces significantly when their housing problems are solved. Mental illness is also linked to drug use, and users are more likely to recover when treatment and mental health services work together.
What is the scale of inequality?	• (A): North Warwickshire and Stratford-on-Avon have the lowest figures of people affected by alcohol dependence, with Nuneaton & Bedworth followed by Warwick the highest. However, Warwick & Stratford-on-Avon have the highest levels of increased/higher risk drinking. The highest levels of alcohol-related recorded crime & sexual offences are in Nuneaton and Bedworth and the lowest in Stratford-on-Avon[7]. • Managers and other professionals self-report that they consume more alcohol than people in routine and manual groups. People in the most deprived fifth of the country are: 2-3 times more likely to die of causes influenced by alcohol; 3-5 times more likely to die of an alcohol-specific cause; 2-5 times more likely to be admitted to hospital because of an alcohol-use disorder, than those living in more affluent areas. • (SM): The age range for the largest proportion of crack or opiate users in Warwickshire has dropped from 35-64 in 2009-11 to 25-43 in 2011-12. The 15-24 year old age group make up the smallest proportion of crack and heroin users.
Estimated economic cost	• (A): Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually[8]. There is very limited local evidence. Some research suggests that alcohol usage creates more revenue than it costs to society. • (SM): The Home Office estimates that drug-related crime costs society £13.9bn a year; NICE estimates the lifetime crime and health bill for every injecting drug user is £480,000. In Warwickshire, for every £1.00 spent on the local treatment system in 2012-13, £3.23 was gained in benefits[9].
Top areas of focus	• Over a third of all adults in Warwickshire are estimated to be drinking at 'risky' levels. • The percentage of successful completions of drug treatment for both opiate and non-opiate users in Warwickshire is significantly worse than the England average

CARERS

Young Carers & Adult Carers

Level of need - Volume	• 59,240 (10.9%) people in Warwickshire provide some level of unpaid care each week. • Of these, over 3,500 are aged 0-24[1]
Level of need – Severity	• 12,452 people in Warwickshire provide 50 hours or more of unpaid care each week. Of these, almost 400 are aged 0-24. • Carers providing 50+ hours of unpaid care a week are more than twice as likely to report that their health is 'not good' compared with those who provide no care[11]
Level of need – Trend	• Three districts and boroughs recorded increasing numbers of unpaid carers between 2001 and 2011 - North Warwickshire, Stratford and Nuneaton & Bedworth; Warwick & Rugby's numbers are static. • However this masks the real picture as ALL areas recorded increasing numbers of carers providing 50+ hours between 2001 and 2011.
Level of need – Benchmarks	• England - 10.3% • Warwickshire - 10.9% • West Midlands - 11.0% • East Midlands - 10.8%[1]
Does the topic have early intervention implications?	• There is a particular need to reach out to groups providing high levels of weekly care who may be most at risk of their own health and well-being deteriorating. • Young carers need support to continue with their education and be supported to care for their sibling/parent.
What is the scale of inequality?	• North Warwickshire residents report higher numbers acting as unpaid carers (12.1%), followed by Nuneaton & Bedworth and Stratford (both 11.3%). Rugby (10.4%) and Warwick (9.8%) residents are least likely to be unpaid carers[1]. • Inequalities between young carers and their peers. • Inequalities between people providing 50+ hours of care compared with those providing no care.
Estimated economic cost associated with tackling the topic in Warwickshire	• Large cost to the authority if carers weren't able to care in an unpaid capacity. Large unpaid work contribution to the economy.
Top areas of focus	• Warwickshire has a higher percentage of people providing some level of unpaid care each week than the England average • People who provide high levels of weekly care are most at risk of their own health and well-being deteriorating. • Young carers often underachieve in the education system.

How will we deliver the JSNA work programme?

This JSNA Review also provides the basis for a more detailed and ongoing programme of work, which incorporates specific needs assessments on each of the aforementioned identified priority topics. These priorities constitute the three-year JSNA work programme, and the delivery of the associated needs assessments will be led by the JSNA Commissioning Group.

Further information on the JSNA work programme, including when each topic will be analysed in more detail can be found here.

Further Information

It is anticipated that the first JSNA Annual Update will be available by September 2015.

The Warwickshire Health & Wellbeing Strategy 2014-2018 can be downloaded here. Webpage needs updating – only links to consultation doc at the moment

Further information is available on the Warwickshire Health & Wellbeing website, or by contacting us through our dedicated JSNA inbox: jsna@warwickshire.gov.uk

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Physical Wellbeing

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Carers

Young Carers and Adult Carers

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QUALITY OF LIFE IN WARWICKSHIRE

Key Messages: 2014 / 15

Warwickshire County Council

Working for Warwickshire

Foreword

Despite the turbulent times of the past seven years Warwickshire remains one of the more dynamic parts of the country with good prospects for improvements in the quality of life of residents as we move through 2015 and beyond into the future. However, the changes taking places within the county in recent years have impacted on different communities and localities in different ways, and often at a different pace. A key challenge remains to ensure that the quality of life for all improves over time.

Our fifteenth annual 'Quality of Life in Warwickshire' report gives a comprehensive assessment of how these recent turbulent and dramatic changes have affected everyday life here. The report provides an easily accessible snapshot of how quality of life in Warwickshire compares with elsewhere, and shows the trends over time in factors which contribute to the quality of life for Warwickshire's residents.

You'll notice that we've made some changes to the format of this year's report. To give a more rounded analysis of topics we have grouped together what were previously stand-alone indicators. We hope this will provide you with a better understanding of the topics themselves, as well as how they are influencing the changes taking place in our county. The report explores the economic, social and environmental make-up of Warwickshire. It looks at issues as varied as incomes, housing, employment, education, health, well-being, natural environment, transport, crime, welfare reform, and deprivation. And importantly, it explores how trends in all of these can differ from place to place and within our different communities across the county.

Since 2000 the Quality of Life in Warwickshire report has been a vital part of the evidence base on which decisions about the future direction for the county have been made. It continues to provide local decision makers in the public, private, and voluntary sectors with that evidence base so that improving the quality of life for all of Warwickshire's residents remains our collective priority.

We hope you find the report valuable for your planning activities, decision making in Warwickshire, or just to help paint a picture of life in the County in 2015. All of the data from the report is available on the Warwickshire Observatory's website, **www.warwickshireobservatory.org** and there will also be regular postings around new and emerging evidence on the website over the coming months, where you can also keep up to date with all of the latest work from the team.

If you have any questions or feedback, please do get in touch by emailing **research@warwickshire.gov.uk**

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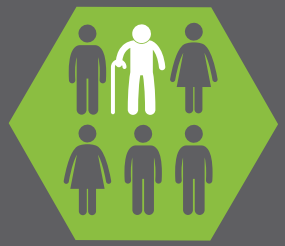
A bigger Warwickshire

- The population of Warwickshire is expected to increase to 624,000 by 2037, a 13.9% increase on the current population

- Population growth is not expected to be evenly distributed across the county; with North Warwickshire Borough witnessing the smallest increase (8.4%) and Rugby Borough seeing the highest (18.9%)

- Warwickshire's older population is projected to increase substantially; one in 12 Warwickshire residents are currently aged 75 or over, this proportion is expected to be one in six by 2037



- These changes can be partially attributed to people living longer; life expectancies in Warwickshire compare well to the regional and national averages with male and female life expectancies at 80 and 84 respectively

Whilst it is clearly positive that individuals are living longer, this demographic change presents many challenges to local authorities, particularly for health and social care services. It may lead to increased costs, or the growing number of older people may create new economic and social opportunities, or a combination of both. It's estimated that the over 65's make a net contribution to the UK economy of £40 billion through tax payments, spending power, donations to charity and volunteering.

The Warwickshire Health and Wellbeing Strategy for 2014 – 2018 has recently been launched. The aim of this strategy is to provide Warwickshire's residents and organisations with a picture of which key health and wellbeing issues need to be addressed over the next 5 years and how we will work together to achieve this.

A working Warwickshire

- The number of people claiming job seeker's allowance has returned to levels witnessed before the start of the economic downturn

- There are still over 1,100 residents who have been unemployed for over 12 months

- Median earnings in Warwickshire increased by 4% between 2012 and 2013, outperforming the equivalent regional and national figures

- Productivity figures also indicate the continuing recovery of the economy, with total GVA (Gross Value Added) in the county increasing by 2% between 2011 and 2012

Latest national figures suggest that UK growth slowed in the three months to September 2014, however the economy as a whole is now 3.4% bigger when compared to figures before the recession and economic downturn. The latest analysis of the UK economy suggests that whilst the UK's economic recovery is by no means over, it is entering a gentler phase.

Warwickshire County Council has made the pursuit of economic growth one of its priorities. With good communication and transport links, Warwickshire has a strong mix of employers across the automotive, engineering, manufacturing, logistics, construction, high-tech and professional services sectors.

The Coventry and Warwickshire Local Enterprise Partnership (CWLEP) promotes the area as a good place to do business by creating the right conditions and infrastructure for investment. In September 2014, CWLEP signed a Growth Deal with Government potentially worth over £100m to the local economy. This will help improve public transport, provide office space and launch start-up initiatives across the region, all of which should increase job opportunities and employment rates.

This positive economic activity along with the trends highlighted in this report, suggest that the outlook for Warwickshire's workforce and economy is strong. However, this has to be set against the backdrop of the Government's unprecedented welfare reform programme and, until very recently, increases in the cost of living outstripping increases in pay. We may therefore see more of our families living on or close to the breadline, which could result in the demand for our services increasing accordingly.

An accommodated Warwickshire

- Results from the Living in Warwickshire Survey showed that 'affordable decent housing' was ranked as the third most important issue needing improvement in Warwick District
- Housing affordability ratios in the county have increased from 3.93 in 1997, to 6.67 in 2013, making Warwickshire housing slightly less affordable than the national average
- Housing affordability ratios in the south of the county remain significantly higher than those in the north of the county
- From 1997 to 2013, average house prices have increased from £45,500 to £132,000

As the population of Warwickshire increases, so does the demand for housing in the county. At the same time, an increase in housing needs to be delivered in the context of a changed planning system, the adoption of the district/borough Local Core Strategies and historically low levels of housing completions across the county since 2008.

In the lead up to the 2015 General Election, housing is becoming a key policy area for the main political parties. This is in recognition of the shortage in both overall housing stock and affordable housing, which are both likely to remain issues in the county. Debates continue about developing on the green belt (which is particularly pertinent to Warwickshire) and the government has recently called for more brownfield sites to be developed with the promise of tax exemptions.

The five districts continue to develop their local plans which set out the numbers and location of new housing in each area – but this is highly complex process, with a number of consultations, drafts and options to be considered. The outlook for housing in Warwickshire may be clearer after the core strategies have been submitted to the Secretary of State and public examinations have been conducted in 2015.

An educated Warwickshire

- Warwickshire pupils are performing well at both Key Stage 2 and Key Stage 4, outperforming their regional and national counterparts

- However these figures mask the lower attainment record of 'disadvantaged' pupils

- In Warwickshire, 13.5% of children (13,515) were considered to be living in poverty in 2011, although this is considerably below the national average (20.1%)

In general, Warwickshire children perform well academically compared to the national average. The analysis suggests attainment is higher in the south of the county than the north, which supports the notion that educational attainment is linked to socio-economic conditions. Of course, pockets of deprivation exist right across the county, and when drilling down to ward level, the data shows that attainment does dip in more deprived areas, regardless of borough or district.

Nationally, the government is addressing the link between low attainment and deprivation via the Pupil Premium, which provides schools with additional funding for each "disadvantaged" child on their roll.

At the other end of the education cycle, the government has talked a lot about apprenticeships and getting young people ready and equipped for the workplace. Skills development is central to this, and recent education reforms have changed the landscape significantly. The Coventry and Warwickshire Local Enterprise Partnership (CWLEP) has played a key role in urging local businesses to offer apprenticeship opportunities, and the County Council now has a dedicated Apprenticeship Hub to recruit, support and promote apprentices across the council.

Over the last four years, an increasing number of schools have converted to academy status, which has seen the role of the local authority evolve to also inlcude a greater emphasis on skills development. As we approach the General Election in 2015, further reforms could be on the way. The outlook, both for local government and local people in Warwickshire, is therefore unclear at this stage.

An engaged Warwickshire

- Generally, respondents to the Living in Warwickshire Survey were happy with their local area as a place to live, with nearly nine out of ten reporting they were satisfied

- 'Road and pavement repairs' was the single issue in need of improvement in the local area, this was true for every district/borough in the county

- Nearly three in ten respondents report that they have been actively involved with at least one local community and voluntary organisation in the last 12 months

- Self-reported levels of life satisfaction in Warwickshire are lower compared to the national studies

Engaging citizens and local communities is key when it comes to developing a sense of ownership in local decision making and service delivery. Working with citizens allows providers to fine tune services based on actual needs. This is especially true during times of austerity, when building reputation and relationships, and maintaining engagement with service users is vital.

The pace of technological change is already influencing the way we deliver services. We are interacting with our residents in new ways and increasingly delivering services online. In 2010, around 20% of us owned smartphones, the latest estimates indicate that this figure has increased to approximately 60%. At the same time, we are seeing improvements in broadband speed and availability, providing even more opportunities to engage with and deliver services to residents in cost effective ways.

While actively encouraging residents to self-serve and adopt these new technologies, we understand that not all customers are receptive to this change. There is a distinction between those residents that will or will not adopt these new technologies. Those that are less likely to consider going online or using social media are also likely to be the most vulnerable members of our communities. They will be the more intensive users of our services and at the same time least willing or able to interact with us in the most cost efficient ways.

An unequal Warwickshire

- The Index of Multiple Deprivation highlights nine lower super output areas in Warwickshire that feature in the 10% most deprived communities in the country, all nine are in Nuneaton & Bedworth Borough
- Almost one-half of families on the Warwickshire Priority Families Programme reside in Nuneaton & Bedworth Borough
- The 'District Trends' in this report highlight the differences across the county in a number of key indicators, with the south of the county outperforming the north in the majority of measures
- One-half of all long-term unemployed residents in the county reside in Nuneaton & Bedworth Borough, 12 years ago the proportion was one-fifth.

Levels of inequality across Warwickshire are growing. Our more prosperous neighbourhoods have been better placed to deal with the impacts of the recession and associated trends, and have displayed higher levels of resilience in the face of downturns in the economy. This can be illustrated using unemployment as an indicator, where the proportion of long-term unemployed in the county is more skewed than ever, with Nuneaton & Bedworth Borough suffering the most.

The government has stated an ambition to eradicate child poverty by 2020. Its Child Poverty Strategy 2014-2017 focuses on: supporting families into work; increasing earnings; improving living standards; and breaking the cycle of poor children becoming poor adults. Its main thrust is ending the perceived culture of worklessness, and there are clear parallels with the welfare reform programme.

The last Index of Multiple Deprivation was produced in 2010, and includes information that is relatively out of date. In the Summer of 2015 a revised version of the index will be published, and will help us understand the effects of the economic downturn and whether our communities have become relatively more or less deprived over the last five years.

A positive Warwickshire

- In the 12 months to March 2014, crime in the county reduced by 4%, whilst anti-social behaviour fell by 1%
- The number of people killed or seriously injured on the roads has reduced by 4% since last year, and has more than halved in the last 12 years
- Just 25% of waste in Warwickshire is landfilled, the lowest level recorded in the last ten years
- Generally, Warwickshire compares well in many of the indicators compared to national and regional figures

Whilst this report highlights indicators that may give cause for concern, it should be noted that generally Warwickshire compares favourably on many quality of life indicators. The five issues that our residents consider most important in making somewhere a good place to live are; the level of crime, health services, clean streets, education and access to the countryside - all of which have a relatively high level of satisfaction.

The headline trends section of this report also shows that 12 of 14 key quality of life indicators have improved when compared to their baseline figures. Issues such as recorded crime, recycling, road safety, annual earnings and educational attainment have all witnessed significant improvements in recent years.

A future Warwickshire

- As the population of Warwickshire increases, more housing will be required; changing the character of existing towns and creating new communities in villages around the county.
- If recent trends continue, it is likely that our communities will become more culturally diverse; placing a greater emphasis on understanding the growing and varied needs of our residents.
- It is likely that further technological advancements will impact on the way that people live and work, changing the way that we engage and respond to our residents, and visa versa.
- We are expecting major infrastructure developments in the county over the next ten years, with improvements to the transport network and new employment sites key to Warwickshire's prosperity.

It is always difficult to predict what may or may not happen in the future, but there are several changes to the structure of Warwickshire's population that we can be fairly confident in predicting. The population of Warwickshire is expected to increase significantly over the next 25 years, increasing the demand for housing and public sector services across the whole county.

There are also major infrastructure projects expected, with HS2 in particular providing challenges and opportunities for residents and businesses in the county. Kenilworth Station and the Nuckle project, linking Nuneaton with Leamington, will make travelling around the county easier. New employments sites should also be well established in the next decade, with the Gateway Project, Ansty Park and developments at Bermuda Park providing job opportunities in the county.

The future role for the council as one of enabler rather than provider of services will also evolve quickly over the coming years, as will the need to work much more creatively with partner agencies. Furthermore, there will continue to be a lot more uncertainty in local government generally, not just in terms of funding but also in relation to future powers and responsibilities.

Finally, in addition to what we can predict and forecast, there will inevitably be issues or events that will act as a catalyst for change in Warwickshire and place changing demands on our services. However, Warwickshire remains a desirable place to live, and is well-placed to face the future.

Headline Trends

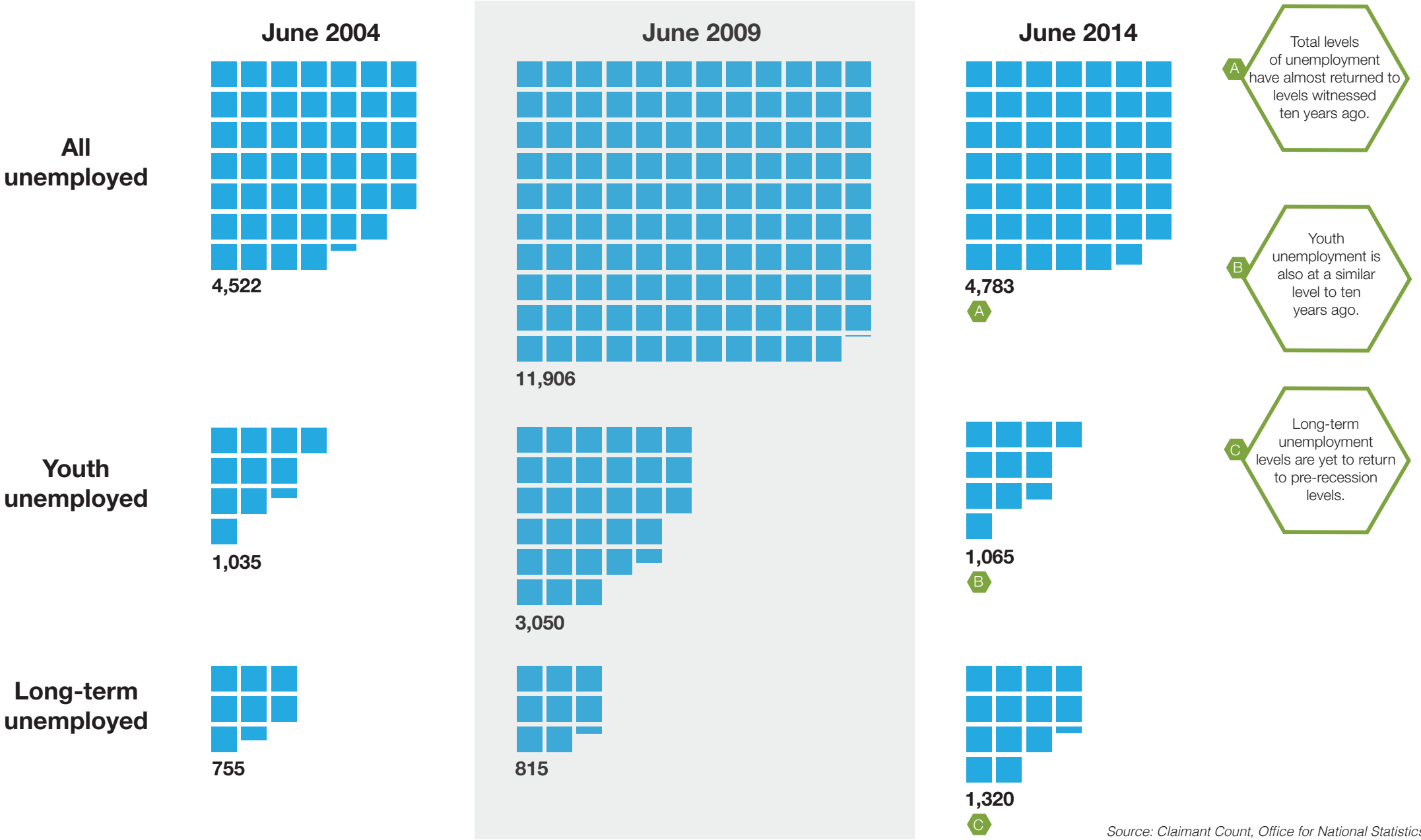
The indicators presented have been indexed based on their performance in 2001; where this data was not available, data from the earliest year was used, indicated by a thicker black outline. Strong performance compared with the baseline year is denoted with green hexagons, whilst weaker performance is indicated with purple hexagons. For further information about these indicators, please refer to the various sections in this report.

District Trends

The data presented here are some key indicators comparing each borough / district with the county average. Strong performance compared with the county is denoted with green hexagons, whilst weaker performance is indicated with purple hexagons. For further information about these indicators, please refer to the various sections in this report.

Workforce: The rise and fall of unemployment

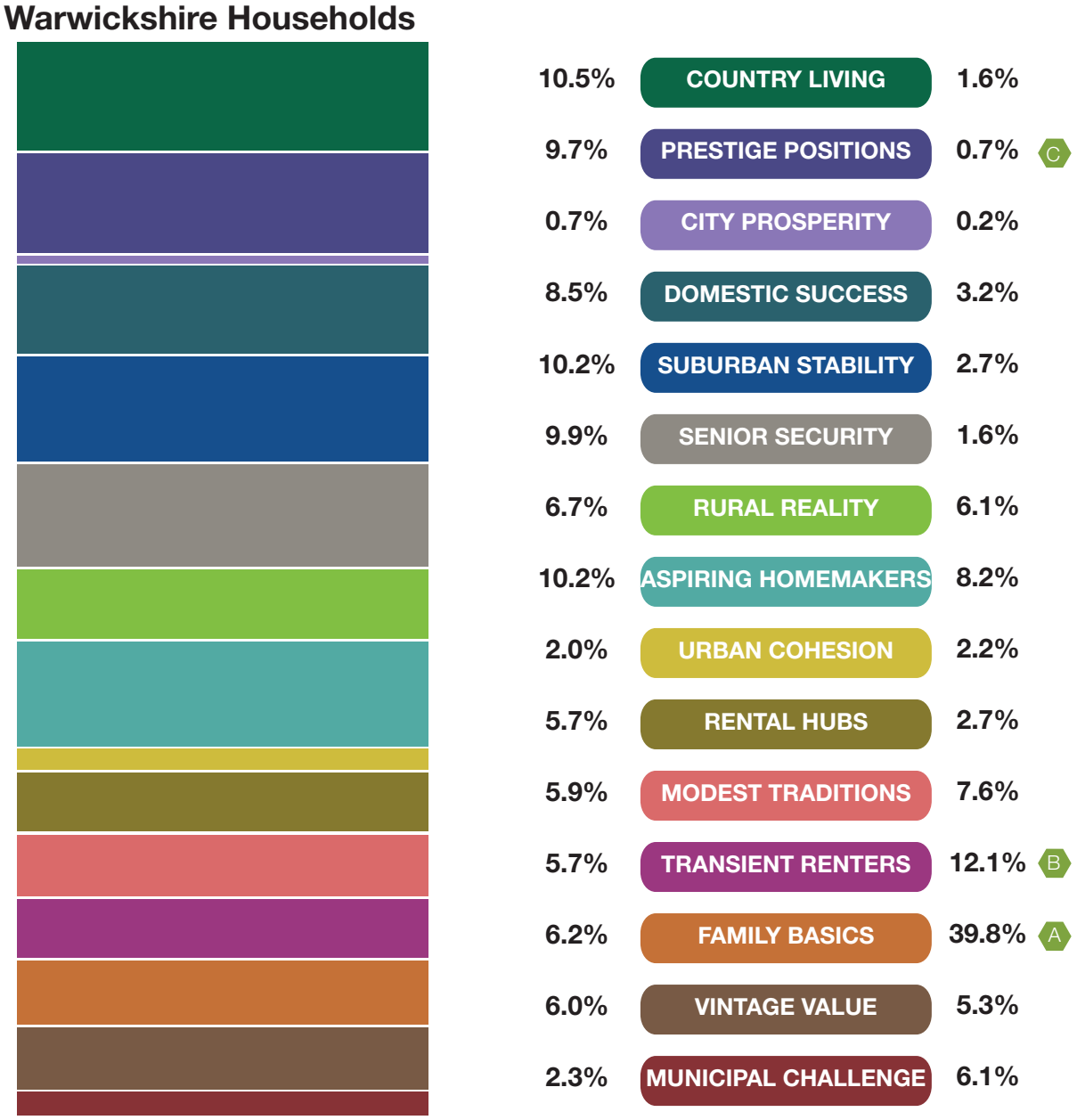
Levels of unemployment are measured through the number of residents claiming Job Seekers Allowance (JSA). The diagram below shows the number who were claiming JSA in 2004, 2009 and 2014. The graphic shows that in June 2004 the total number of Warwickshire residents claiming JSA was just over 4,500. At the height of the recession and economic downturn, this figure increased to nearly 12,000. However, JSA claimants have fallen significantly in the last five years and have returned to a similar level to ten years ago. A similar pattern can be witnessed when examining youth unemployment, this is residents aged 18 to 24 claiming JSA. However levels of long-term unemployment, the number who have been claiming for 12 months or more, are yet to return to pre-recession levels.



Source: Claimant Count, Office for National Statistics

Poverty and Deprivation: The Social Classification Of Priority Families

In 2011, the Government informed all local authorities of the need to 'turn around' the lives of 120,000 families in the UK. The Warwickshire response to this is the Priority Families Programme, co-ordinated by the County Council but delivered through a multi-agency approach. The diagram below aligns all of the families identified on the programme with the social classification tool Mosaic (further information about Mosaic can be found in the Communities chapter of this report). The graphic shows that nearly two out of every five priority families are classified as 'Family Basics' , described as families with limited resources who have to budget to make ends meet.



A Two out of every five priority families are classified by Mosaic as being 'Family Basics'.

B The proportion of Priority Families classified as 'Transient Renters' is double the proportion of all Warwickshire households.

C Less than 1% of Priority Families are classified as being 'Prestige Positions.'

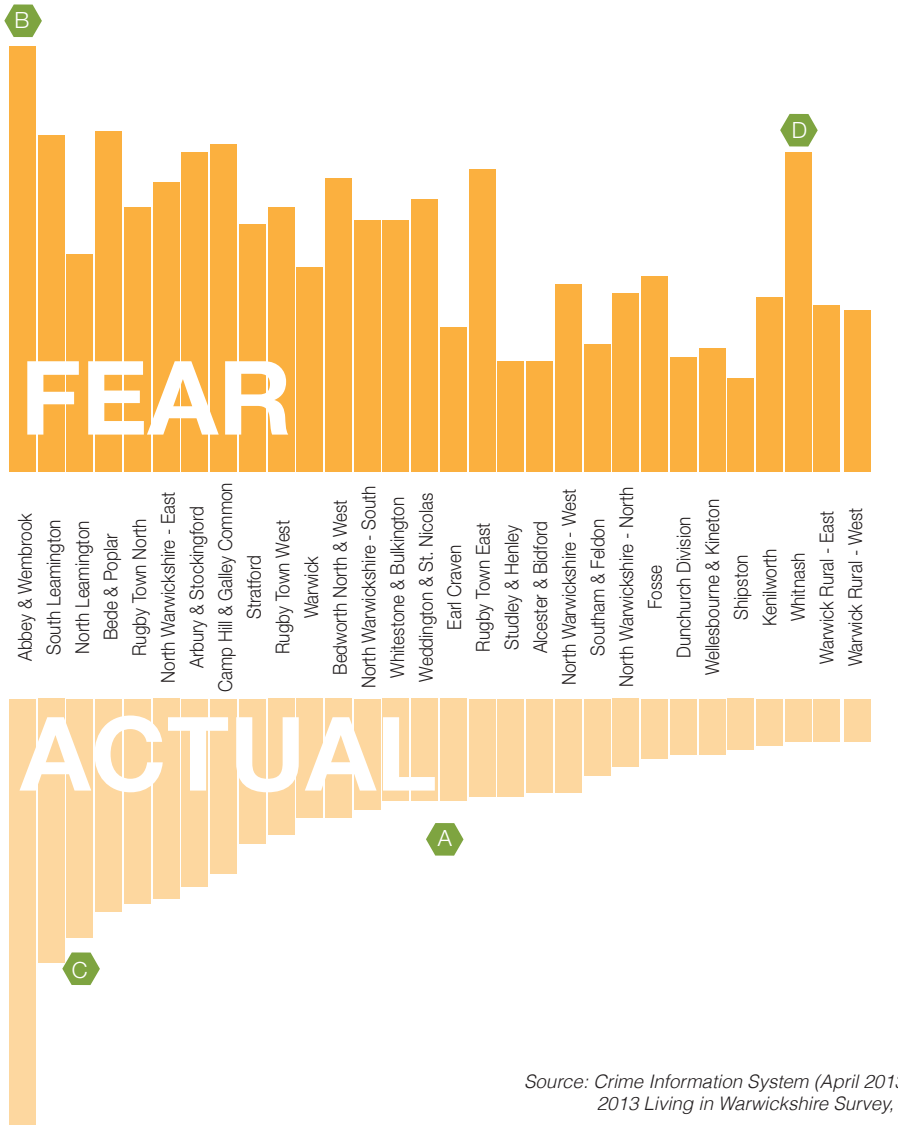
Source: Priority Families Programme Mosaic classification, Experian

Community Safety: The relationship between fear and actual levels of crime

Generally levels of crime in Warwickshire are relatively low, and have been reducing over the last ten years, but fear of crime levels remain relatively high. The diagram below seeks to explore whether residents most worried about becoming a victim of crime live in areas where crime levels are highest. Actual levels of domestic burglary and violence have been gathered from the Crime Information System, and correlated against levels of fear of crime from the 2013 Living in Warwickshire Survey. The information has been presented at a locality level and shows that, generally, residents who are most worried about becoming a victim of crime, live in areas where crime rates are highest. For both domestic burglary and violence, there was a correlation between the two measures of +0.7, suggesting a positive relationship. However, the relationship between fear and actual levels of crime is a complex one, and there will always be areas that go against the general trend, a couple are highlighted below.

Domestic Burglary

Violence



A — For both types of crime, there is a positive correlation between fear and actual crime levels.

B — For both types of crime, Abbey and Wembrook locality has the highest fear and actual crime levels.

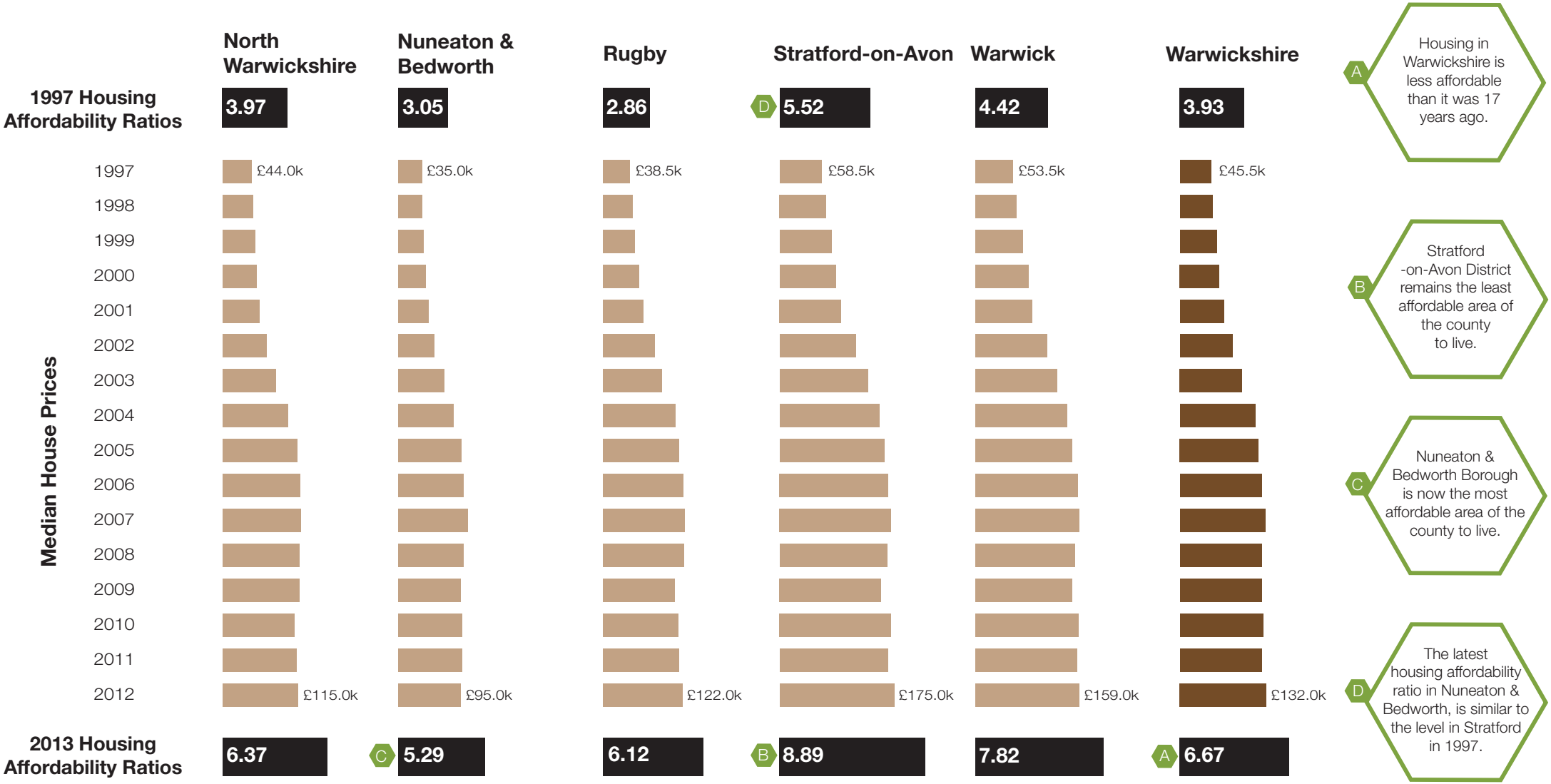
C — North Leamington locality has an unusually low fear of violent crime, given crime levels in the area.

D — Whitnash locality has an unusually high fear of violent crime, given crime levels in the local area.

Source: Crime Information System (April 2013 to March 2014, Warwickshire Police
2013 Living in Warwickshire Survey,

Housing: The Housing Affordability Gap

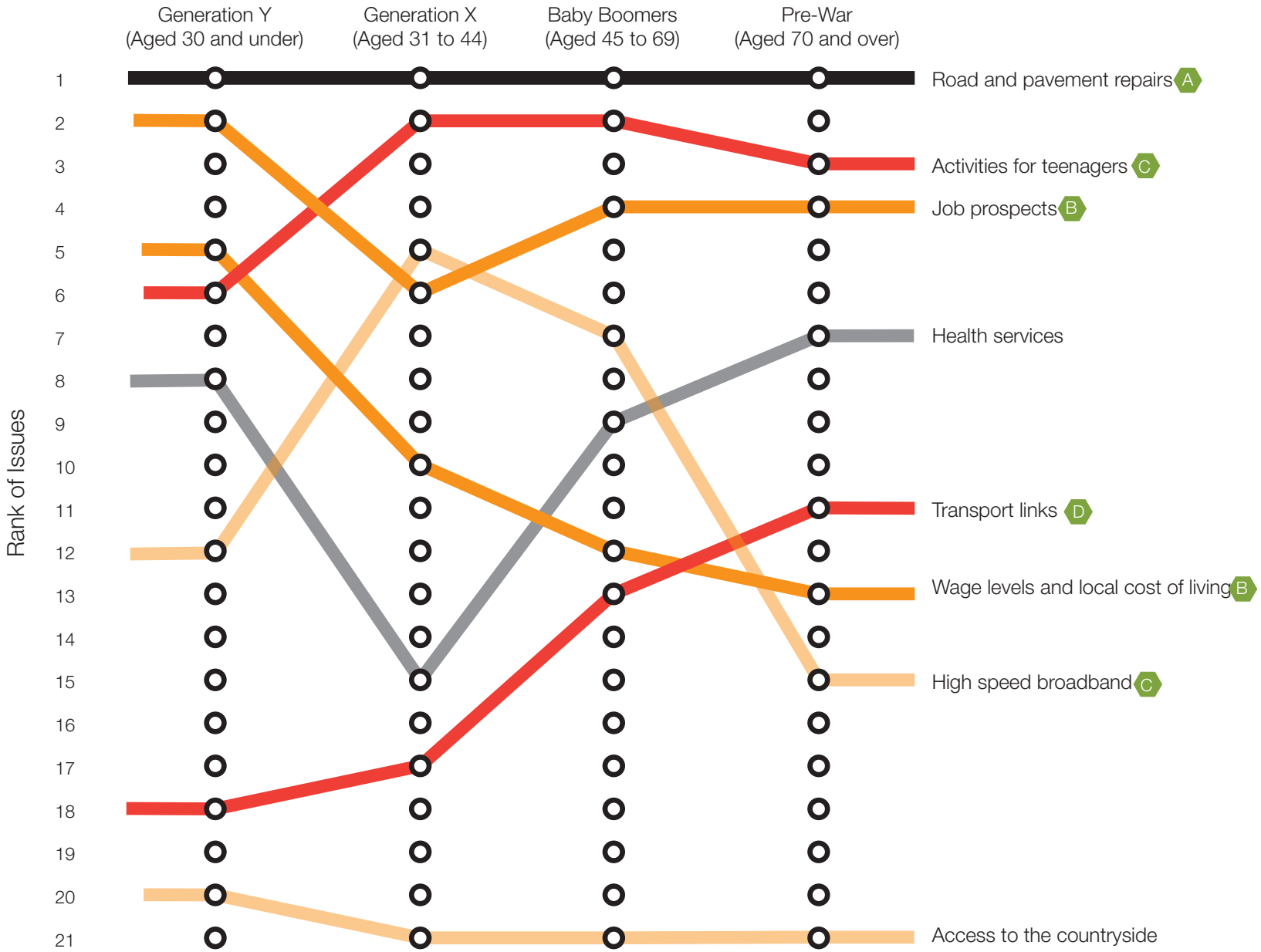
Housing affordability ratios are an economic indicator that determine whether people with the lowest incomes can afford to buy the lowest priced housing available in the area where they work. Specifically, the ratio examines the relationship between the lowest quartile of incomes and the lowest quartile of house prices within a particular area. In 1997, the housing affordability ratio for Warwickshire was just under four, meaning that somebody in the lowest quartile for earnings would need four times their annual income in order to purchase a property in the lowest quartile of house prices. Median house prices increased by more than £80,000 between 1997 and 2013, and the ratio increased to nearly 6.7, indicating that houses are now less affordable, compared to 17 years ago.



Source: Department for Communities and Local Government

Communities: Priorities for the local area, by generation

The Living in Warwickshire Survey asked respondents about what needed improving in their local area, from a list of 21 issues. The diagram below shows the results, highlighting significant variations between different generations of respondents. Other issues within the questionnaire that are not included on the graphic below were 'Affordable decent housing', 'Clean streets', 'Community activities', 'Cultural facilities', 'Education provision', 'Facilities for young children', 'Parks and open spaces', 'Public transport', 'Shopping facilities', 'Sports and leisure facilities', 'The level of crime', 'The level of pollution' and 'The level of traffic congestion'.



A 'Road and pavement repairs' is reported to be the issue that most needs improving by each generation.

B 'Job prospects' and 'Wage levels and local cost of living' are considered in need of most improvement by the younger generation.

C 'Activities for teenagers' and 'High speed broadband' are ranked relatively high by the middle generations.

D 'Transport links' are considered in need of improvement by the oldest generation of respondents.

Source: Living in Warwickshire Survey, 2013

Civic Engagement: Influencing decisions in the local area

The 2013 Living in Warwickshire Survey asked residents how strongly they agree or disagree that they can influence decisions in their local area; the diagram below shows the proportion of respondents who thought that they could influence decisions. The results show that Warwick District have the highest levels of engagement, whilst Nuneaton & Bedworth Borough have the lowest. At a locality level, the proportion of residents in Warwick Rural East who stated that they agree with the statement is double that of the proportion in Weddington & St. Nicolas.

NORTH WARWICKSHIRE		32%
North Warwickshire East	NWE	32%
North Warwickshire North	NWN	35%
North Warwickshire South	NWS	28%
North Warwickshire West	NWW	34%
NUNEATON & BEDWORTH		28%
Abbey & Wembrook	ABB	29%
Arbury & Stockingford	ARB	25%
Bedworth North	BEN	28%
Bedworth South	BES	35%
Camp Hill & Galley Common	CHG	25%
Weddington & St. Nicolas	WED	23%
Whitestone & Bulkington	WHI	30%
RUGBY		34%
Dunchurch	DUN	46%
Earl Craven	EAR	35%
Fosse	FOS	39%
Rugby Town East	RTE	33%
Rugby Town North	RTN	29%
Rugby Town West	RTW	32%
STRATFORD-ON-AVON		34%
Alcester & Bidford	ALC	33%
Shipston	SHI	37%
Southam & Feldon	SOU	39%
Stratford	STR	30%
Studley & Henley	STU	36%
Wellesbourne & Kineton	WEL	30%
WARWICK		37%
Kenilworth	KEN	41%
North Leamington	NLE	36%
South Leamington	SLE	35%
Warwick	WAR	30%
Warwick Rural East	WRE	50%
Warwick Rural West	WRW	43%
Whitnash	WTN	35%

A Residents of Warwick District appear most satisfied that they can influence decisions in their local area

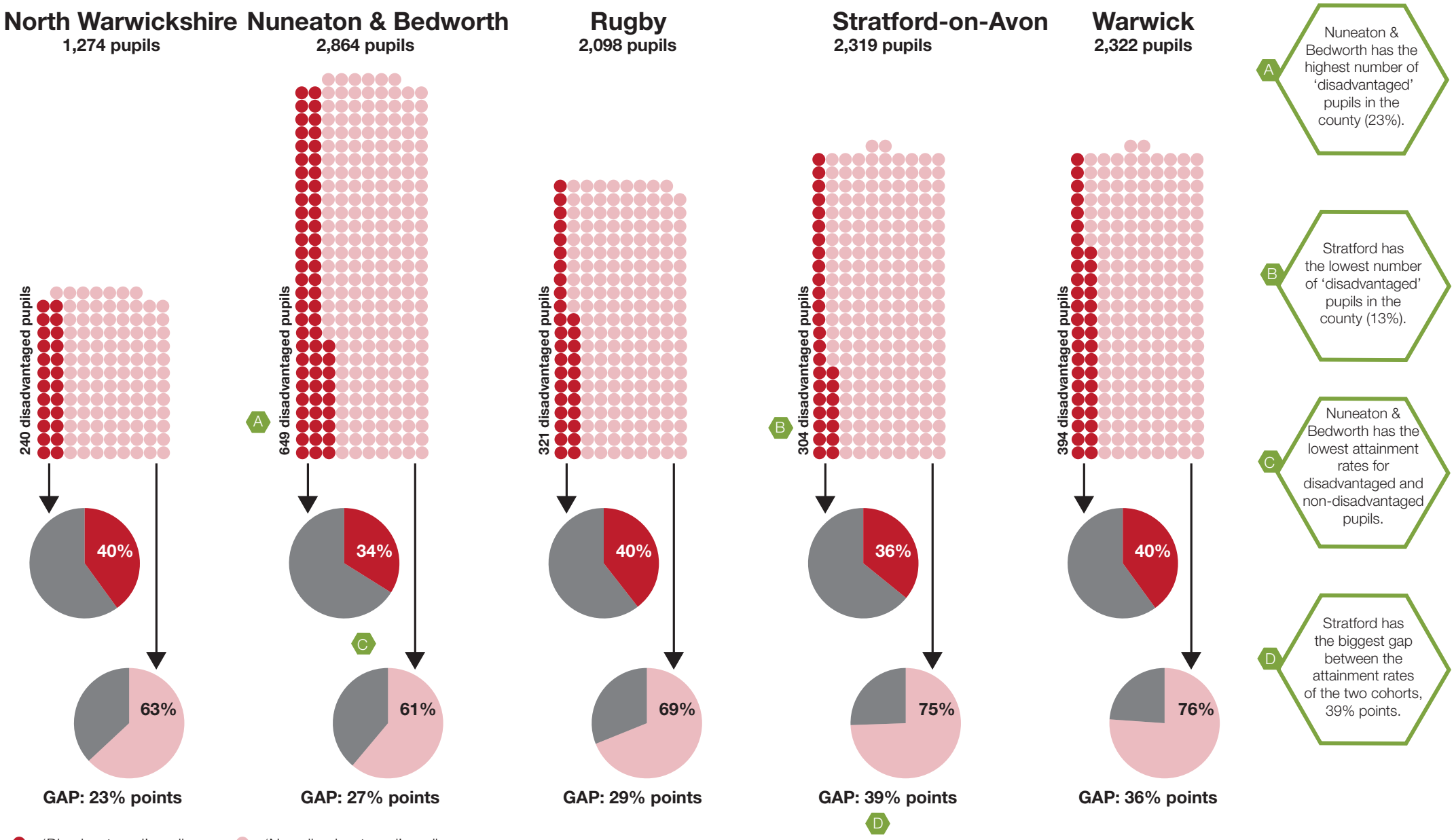
B Half of residents in the Warwick Rural East locality believe they can influence decisions.

C Only 23% of residents in Weddington and St. Nicolas locality feel able to influence decisions

Source: Living in Warwickshire Survey, 2013

Education: The drawbacks of being a ‘disadvantaged’ pupil

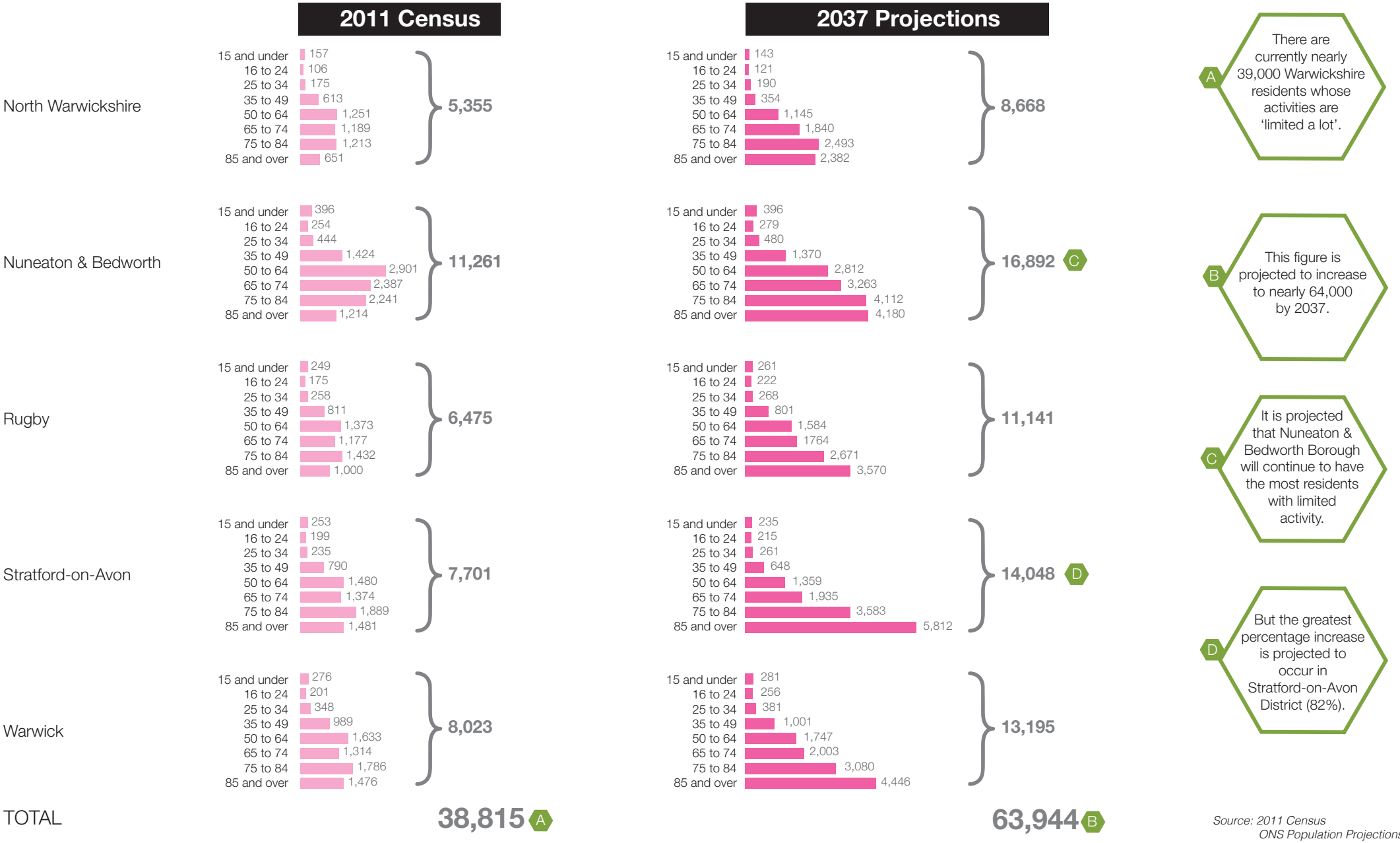
A disadvantaged pupil is defined by the Department for Education as any pupil eligible for free school meals at any time over the last six years, or Children Looked After (CLA). The graphic below looks at the combined Key Stage 4 results for 2011/12 and 2012/13 by district in Warwickshire, and compares the results of the pupils classified as being ‘disadvantaged’, with those who are not. The pie charts show the proportion of each cohort who attain five or more A* to C grade GCSE’s including English and Maths. Across the county, only 37% of ‘disadvantaged’ pupils achieved this standard, compared to 69% of ‘non-disadvantaged’ pupils. This gap between attainment levels is most pronounced in Stratford-on-Avon District, where the results are 36% and 75% respectively.



Source: National Consortium of Examination Results, NCER

Health: Projecting numbers of residents with limited activity

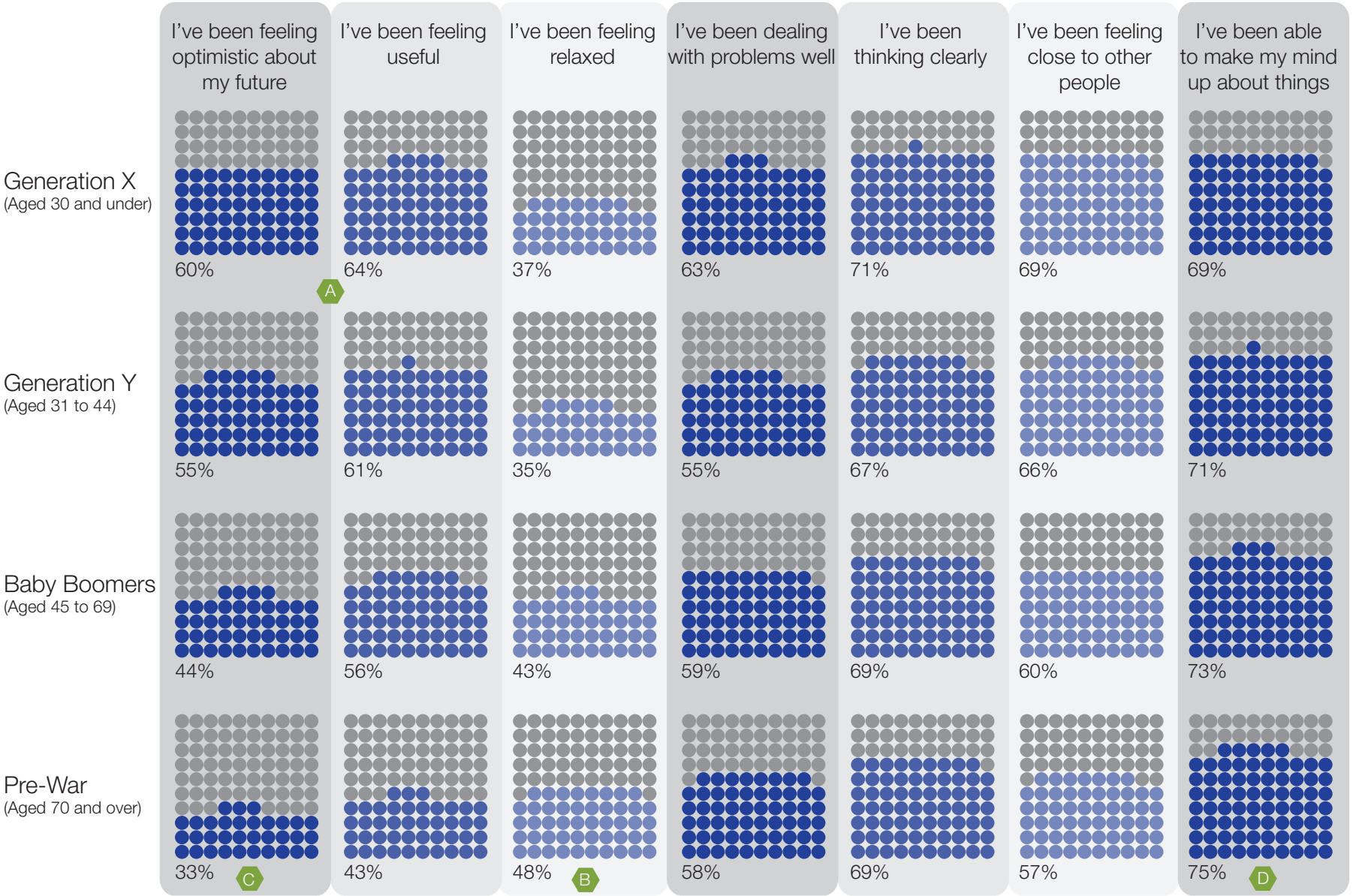
The graphic below presents the number of residents in Warwickshire who stated that they had a long-term limiting illness that 'limited their activities a lot'. The results are taken from the 2011 Census, and show that the activities of over 38,000 residents are limited a lot, including over 11,000 in Nuneaton & Bedworth Borough. Using Office for National Statistics population projections, and assuming that similar proportions of residents will have limited activity, the diagram below projects the numbers of residents who will have limited activity in the future. The number whose activities will be limited a lot is projected to increase by 65% to nearly 64,000 in 2037, with the oldest age groups projected to increase the greatest.



Source: 2011 Census
ONS Population Projections

Life Satisfaction: Feelings and thoughts by Generation

The Living in Warwickshire Survey asked respondents how often they experienced a number of thoughts and feelings over the last two weeks. The diagram below shows the proportion feeling each emotion 'often' or 'all of the time', by generation.



A: Younger respondents generally feel more optimistic and useful compared to older respondents.

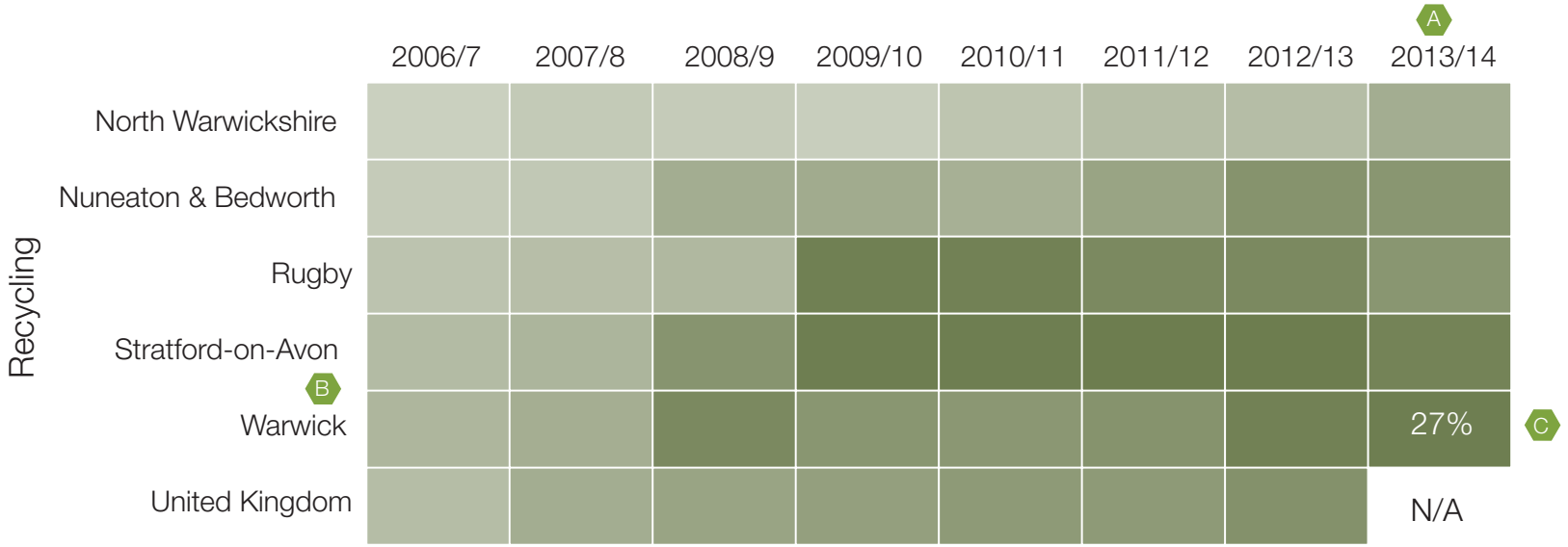
B: Older respondents generally feel more relaxed.

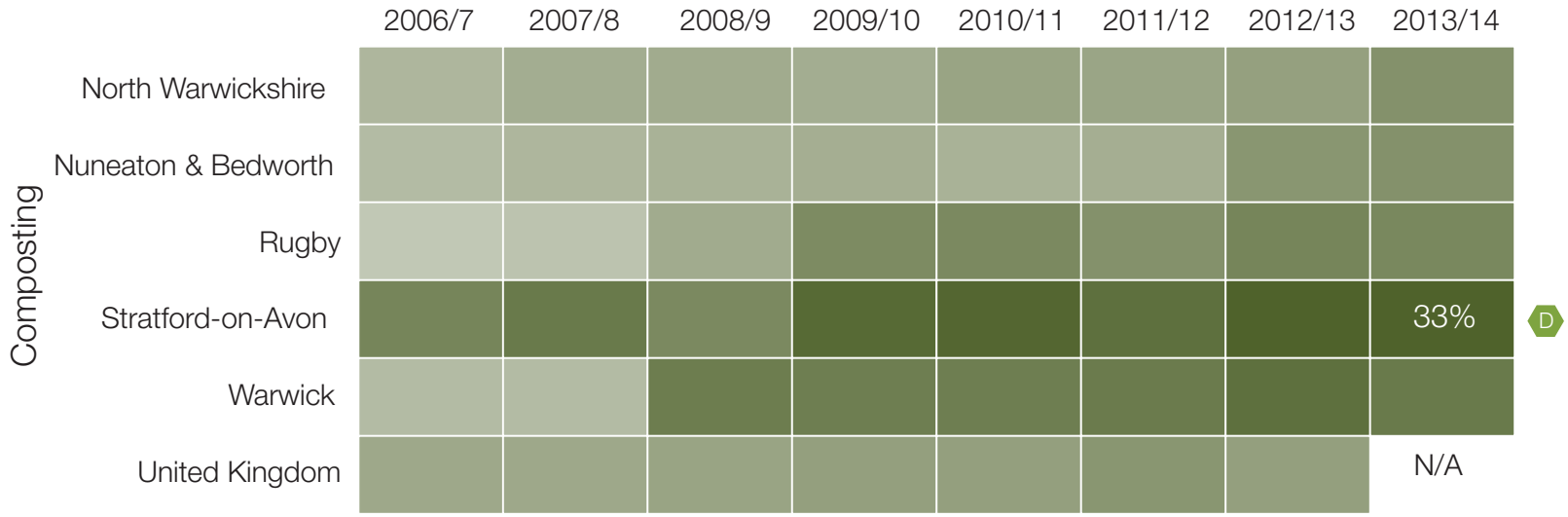
C: Respondents in the Pre-War generation appear to find it most difficult to be optimistic, compared to the other emotions.

D: Being able to make their mind up is the emotion felt by the highest proportion of respondents in the oldest three age groups.

Environment: Recycling and composting in Warwickshire

The heat maps show the recycling rate and composting rate levels in each of the districts and boroughs alongside a national rate. The 2012/13 national recycling rate was 23% which can be compared to Warwick District which had the highest recycling rate in Warwickshire at 27%. The 2012/13 national composting rate was 20% and can be compared to a much higher 33% recorded in Stratford-on-Avon District.





A — The recycling and composting rate in all districts have increased over the last eight years.

B — Generally, the south of the county sees the highest rates of recycling and composting.

C — The highest recycling rate in the county is in Warwick District.

D — The highest composting rate in the county is in Stratford-on-Avon District.

Source: Warwickshire Waste Partnership

QUALITY OF LIFE IN WARWICKSHIRE

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Warwickshire County Council

Working for Warwickshire

Item 7

Warwickshire Health & Wellbeing Board

21 January 2015

Health and Wellbeing Strategy Updates from Districts & Boroughs

Recommendations

That the Warwickshire Health and Wellbeing Board (HWBB):

1. **Note and endorse the updates provided by District and Borough Board Members.**

1.0 Background

1.1 At the November HWBB, the Warwickshire Health and Wellbeing Strategy (HWBS) 2014- 2018 was agreed.

1.2 The HWBS is the culmination of a thorough period of consultation with the public and all HWBB partners. It replaces the previous interim HWBS.

2.0 Purpose

2.1 The HWBS provides Warwickshire residents and organisations with a picture of what the Health and Wellbeing Board, through its members and partners, will need to deliver over the next 5 years and how we will work together to achieve this.

2.2 The updates from boroughs and districts, provide the HWBS with an overview of the work being undertaken locally to address the priorities within the HWBS.

3.0 Next Steps

3.1 The action plans and updates provided by district and boroughs will be added to the HWBB website to enable the public to understand how the HWBS is being implemented locally.

3.2 Action plans will be brought to the HWBB on a regular basis to identify improvements and developments over the lifetime of the HWBS.

4.1 Background Papers

4.2 None

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