Lancashire County Council

Children's Services Scrutiny Committee

Tuesday, 24th March, 2020 at 10.30 am in Committee Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Agenda

Part I (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Disclosure of Pecuniary and Non-Pecuniary Interests** Members are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	
3.	**Minutes from the meeting held on 26 February 2020**	(Pages 1 - 4)
4.	**Children's Health - Public Health Update**	(Pages 5 - 64)
5.	**Work Programme 2019/20**	(Pages 65 - 76)
6.	**Urgent Business** An item of urgent business may only be considered under this heading where, by reason of special circumstances to be recorded in the Minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Member's intention to raise a matter under this heading.	
7.	**Date of the Next Meeting** The next meeting of the Children's Services Scrutiny Committee will take place on Thursday 23 April 2020 at 10:30am in Cabinet Room 'C' (The Duke of Lancaster Room) at the County Hall, Preston.	

Lancashire County Council

L Sales
Director of Corporate Services

County Hall
Preston

Lancashire County Council

Children's Services Scrutiny Committee

Minutes of the Meeting held on Wednesday, 26th February, 2020 at 10.30 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Present:

County Councillor Andrea Kay (Chair)

County Councillors

N Hennessy	A Gardiner
L Beavers	P V Greenall
I Brown	J Mein
A Cheetham	D T Smith
B Dawson	P Steen
J Eaton	

Co-opted members

Oliver Moores, Youth Council Representative
Councillor Christine Melia, Children's Partnership Board - Chorley, South Ribble, West Lancs

County Councillor Bernard Dawson replaced County Councillor Matthew Tomlinson for this meeting.

1. Apologies

Apologies were received from Councillor Louise Edge, Children's Partnership Board - Hyndburn, Ribble Valley and Rossendale.

2. Disclosure of Pecuniary and Non-Pecuniary Interests

None were disclosed.

3. Minutes from the meeting held on 15 January 2020

Resolved: That the minutes from the meeting held on the 15 January 2020 be confirmed as an accurate record and signed by the Chair.

4. Child and Adolescent Mental Health Service (CAMHS) Redesign in Lancashire and South Cumbria

The Chair welcomed Sally Nightingale, Steven Tingle and Terry Drake, from the NHS Midlands and Lancashire Commissioning Support Unit, to the meeting.

The report presented sought to provide the Children's Services Scrutiny Committee with information on the CAMHS (Children and Adolescent Mental Health Service) redesign journey in Lancashire and South Cumbria.

Members were provided with a presentation on the redesign including the approach, what has been achieved so far and the timeline going forward.

It was reported that currently CAMHS only has half the spend in comparison to adults mental health. However, the CCG's across Lancashire have committed to a 4 year investment profile of £22.9m in 2021 rising to £26.3m in 2024. When questioned on the funding, members were advised that the funding profile would not meet the entire model at this time, and there would be a potential need to look at elements that could be implemented post 2024 unless more funding could be made available.

In response to the questions around how the county council can further support health partners in implementing the CAMHS proposed model of care, it was highlighted that there continued to be a need to look beyond the NHS funding, with more collaborative working between local authorities, health and the third sector. Members were informed that this redesign provided an opportunity to look at what could be achieved collectively to better support prevention services. In addition, it was suggested that the county council could review the high cost services currently in place to support young people at risk to identify ways that funding could be better invested through working collaboratively with health partners.

It was highlighted that one of the biggest priorities for the LEP (Lancashire Enterprise Partnership) related to adult mental health, so there was an opportunity to also look at work being undertaken within the private sector.

A question was raised in relation to the emerging issues faced in primary schools. Members were advised that although there was very good work being undertaken in some schools, there was a need to have a consistent and robust offer across all schools. It was highlighted that every school would have a link into the primary mental health offer. And to further support the offer to schools, mental health first aid training was being provided.

The committee was informed that early intervention (centring on the Primary Mental Health Work offer) would be one of the main priorities to help stem the flow of young people into CAMHS.

Members questioned the risk support area of the proposed model to further understand the provision of support to those children and young people on the edge of services. In addition, how the proposed model of care would ensure that those children and young people would be identified so they do not fall through the gaps. The committee was reassured that joint approaches between CAMHS and relevant partner agencies would be developed to enable the production of robust safety plans. However it was noted that there remains a need to identify a package of care for those children and young people who do not meet the criteria

for a mental health inpatient bed, who are unable to stay in a paediatric ward, but who are still vulnerable and require 'wrap around' support.

Members of the committee thanked all of the officers in attendance for their comprehensive presentation.

Resolved: That;

i. The proposed model of care be considered and feedback provided.
ii. The timescales for final agreement of the fully costed Clinical Model and Transition & Implementation Plan be noted.
iii. A further review of the Clinical Model and Transition & Implementation Plan be provided at the end of the year.
iv. Consideration be given by the Cabinet Member for Children, Young People and Schools to:
    a. A review of the current county council prevention/early intervention services with a view to supporting more effective, collaborative working with partner agencies.
    b. A review of the support currently provided across county council services to high risk children and young people, to support the identification of a package of care working with partner agencies, with a view to reducing potential duplication of services and ensuring more effective investment of funding.

5. Work Programme 2019/20

The work programme for the Children's Services Scrutiny Committee for the 2019/20 municipal year was presented.

The topics included were identified at the work planning workshop held on 22 July 2019.

Regarding the topic of Child Poverty there was a request at the last meeting for more background information on Holiday Hunger and Food Banks which is currently being produced. Relating to this topic, it was highlighted that at the External Scrutiny Committee meeting on Tuesday 25 February, there was an interesting discussion on Universal Credit which committee members may find useful. A webcast link for this meeting would be circulated to members.

There was also a request for the next meetings item on Children's Health to include information on the recently published Marmot report.

Resolved: That;

i. The report presented be noted.
ii. The webcast link for the External Scrutiny Committee meeting on Universal Credit, held on Tuesday 25 February, be circulated to the Children's Services Scrutiny Committee.

6. Urgent Business

There were no items of Urgent Business.

7. Date of the Next Meeting

The next meeting of the Children's Services Scrutiny Committee will take place on Tuesday 24 March 2020 at 10:30am in Cabinet Room 'C' (The Duke of Lancaster Room) at the County Hall, Preston.

L Sales
Director of Corporate Services

County Hall
Preston

Children's Services Scrutiny Committee
Meeting to be held on Tuesday, 24 March 2020

Electoral Division affected:
(All Divisions);

Children's Health - Public Health Update
(Appendices 'A' to 'C' refer)

Contact for further information:

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Executive Summary

This report provides the Children's Services Scrutiny Committee with an update on key priorities for action to improve health and wellbeing outcomes for children and young people, and identify the work undertaken to address inequalities in health.

Recommendation

The Children's Services Scrutiny Committee is asked to:

i. Acknowledge the work undertaken to improve the health and wellbeing outcomes for children and young people in Lancashire.
ii. Consider and provide feedback on the information provided including the Infant Mortality Action Plan.
iii. Discuss and agree any additional children's health subject areas for inclusion on the committee work programme going forward and reasons for scrutiny.

Background and Advice

Best Start in Life has been identified as one of six key priority areas for action in the recently published update report 'Health Equity in England – The Marmot Review 10 Years On'.

This identifies that life expectancy in England has stalled, and we are still seeing inequalities in health in some of the more deprived areas and in certain minority groups, hence further work is required if we are to reduce this gap. The report also points to some of the key social determinants of health worsening.

The public health team is working with key internal and external partners to tackle inequalities using a number of approaches to ensure a best start in life for our children, young people and families. We are supporting the Early Years Strategy

(attached at Appendix A), to ensure children, young people and their families are safe, healthy and achieve their full potential in Lancashire. This strategy details how we will improve health and wellbeing of children and young people and has a real focus on improving outcomes for early years.

An important aspect is to address infant mortality, as identified in the Lancashire Infant Mortality Report (attached at Appendix B). Similarly, although the overall child mortality rate (age 0-17 years) in Lancashire has been falling, child mortality remains significantly worse than the England rate, with clear links to socio-economic status.

The Infant Mortality Action Plan (attached at Appendix C) details the range of interventions that will make a difference, including a focus on ensuring we increase access and uptake of vaccination and immunisation, as well as promoting breastfeeding and addressing modifiable factors such as smoking in pregnancy.

Consultations

The Early Years Strategy has been shared and signed off by members of the Children and Young People's Partnership Board.

The Lancashire Infant Mortality Report has been presented to both the Health and Wellbeing and the Children and Young People's Partnership Boards.

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985

NA

Reason for inclusion in Part II, if appropriate

NA

Appendix A: Early Years Strategy

The Early Years of Life

A Strategy to ensure children, young people and their families are safe, healthy and achieve their full potential in Lancashire

2020 - 2023

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Lancashire County Council

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Appendices:

FOREWORD

We are delighted to introduce the Lancashire Early Years Strategy 2020-2023. Our vision for the strategy is that all our Children, young people and their families feel safe, healthy and achieve their full potential. Hence we have taken a real partnership approach in identifying the priority areas which we believe will get the best outcomes and reduce inequalities for our children, young people and families across Lancashire.

The Lancashire Early Years Service delivers key statutory functions for Lancashire County Council including management of funded free early education, supporting and monitoring standards and provision across early years settings, provision of early help, SEND services, support for early years provision and the Early Years Foundation Stage statutory assessment.

As a council we are committed to delivering the best possible services and recognise the significant part our service plays in the early intervention and preventative agenda. We are working with Public Health and other services to help achieve the best possible start in life recognising that development begins before birth. As Professor Sir Michael Marmot stated: 'The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years has lifelong effects on many aspects of health and well-being**.** We have therefore focussed our strategy on 4 key priority areas:

To ensure better maternal and child outcomes throughout pregnancy, birth and beyond so children have a **best start in life**	To ensure children are able to learn and develop skills so they are **ready for school** and schools ready for children	To ensure children are **healthy and well** through the delivery of the healthy child framework	To **target inequalities** so children are safe and live in caring and resilient communities

In Lancashire the number of our children achieving a good level of development by the end of reception has been increasing over the last 5 years. A key priority is to ensure we have robust plans in place to ensure children are school ready and our schools are ready for children so we see further increases in the number of children with a good level of development and educational attainment.

We are also keen to improve the areas where we are not doing so well through the commissioning and delivery of the Healthy Child programme and early access to our Early Help offer which we have just reviewed. We hope that by focussing on these priority areas we will see a measurable change in reducing inequalities in areas of greatest need in the longer term.

It has been a privilege to have worked with all our partners across Lancashire and other organisations to develop an Early Years Strategy which will inform the development of local plans based on evidence, need and outcomes which we will measure accordingly.

Councillor Phillippa Williamson
Cabinet Member for Children, Young People and Schools

1. INTRODUCTION

1.1 Purpose of the Early Years Strategy

Every baby and child living and growing up in Lancashire deserves the best possible start in life and the best support that allows them to fulfil their potential. Children develop quickly in their early years and a child's experiences between birth and age five has a major impact on their future life chances. We want all our children to be happy, healthy and grow into confident, capable and resilient young adults.

Our Lancashire children starting school will all have different experiences, as will their families and carers. How good and positive those experiences are by the time they start school will depend on a whole range of factors, like where they grow up, the family they grew up in, the opportunities they have to play and learn and the support they have in their own communities.

A lack of attachment and stressful experiences in the early years can impact negatively on physical and emotional development. There is capacity for healing through changing circumstances, taking nurturing approaches and supporting resilience through family support, childcare providers, schools, communities and services.

Children feeling safe is also critical to supporting them into adulthood. This strategy focuses on vulnerable families and addresses issues of child poverty to empower families to keep themselves and their children safe and well cared for; having the personal resources to cope in difficult situations; knowing where to go for help; and finding help from services that understand and respond to differences in personal circumstances for example for lone parents, parents with a disability, and teenaged and young parents.

Lancashire is committed to working in partnership to achieve the very best start for its youngest children in delivering the Early Years Foundation Stage (EYFS) Statutory Framework for children between birth and age five with fidelity and consistency. The framework is mandatory for all early years providers in England.

Lancashire's key responsibilities are outlined in the *"Early education and childcare statutory guidance for local authorities".* This guidance applies to "the free entitlements for two-, three- and four-year-olds, both the universal entitlement and the extended entitlement which secures sufficient childcare for working parents, provides information advice and assistance to parents and provides information, advice and training to childcare providers."

Lancashire's vision is for all children to be able to take up their funded hours in a high quality setting. Evidence shows that higher quality provision has greater developmental benefits for children, particularly for the most disadvantaged children leading to better outcomes. The EYFS sets the standards that all early years providers must meet to ensure that children learn and develop well and are kept healthy and safe. Lancashire's work with funded education providers is designed to help shape and secure quality provision in accordance with the EYFS and, notably, its guiding principles.

- Every child is a unique child, who is constantly learning and can be resilient, capable, confident and self-assured.
- Children learn to be strong and independent through positive relationships.

- Children learn and develop well in enabling environments, in which their experiences respond to their individual needs and there is a strong partnership between practitioners and parents and/or carers.

Children develop and learn in different ways and at different rates. The framework covers the education and care of all children in early years provision, including children with special educational needs and disabilities.

In all parts of Lancashire, sufficient, high quality early years provision is vital to ensuring all of our children receive the following:-

- Quality and consistency in the provision of all early years services so that every child makes good progress and no child gets left behind
- A secure foundation through learning and development opportunities which are planned around the needs and interests of each individual child and assessed and reviewed regularly
- Good and effective partnership working between practitioners and with parents and/or carers so that information can be shared and additional support identified and provided at the earliest opportunity

1.2 What do we mean by "early years"?

For the purposes of this strategy, early years is from pre-birth to five years old. This broad definition of early years is in recognition of the importance of a healthy pregnancy, good parenting and high quality education and childcare in influencing outcomes. The move into primary school is a critical period in all children's lives and many aspects of this strategy are equally relevant to children beyond the age of five.

1.3 Why have a strategy?

We know however from looking at the information we collect on health, education and other outcome measures, such as income levels and unemployment, that there are differences in how our children are developing. These differences can be seen depending on where families live; between boys and girls; between different cultural and social groups and their experiences of family life; and between those children who are looked after and/or have special educational needs and disabilities.

The overall aim is to ensure children and families have the best start in life through reducing inequalities in health, promoting good health, and readiness to play and learn.

We take an "earliest intervention" approach in child development so that all children can thrive at each age and stage of development. Underpinning this strategy is a focus on progressive universalism, which means a core offer for all families and targeted support for those families according to the level of need.

1.4 What will the strategy do?

The strategy will ensure:

- a preventative and early intervention approach that supports children, young people and families to build resilience and take responsibility for their own health and wellbeing

- Children get the best start in life so they are able to learn and develop resilience, capability, confidence and self-assurance through positive relationships

- building of community capacity to promote health and wellbeing using local assets
- Shared leadership and a joined-up approach to commissioning which is committed to driving real action and change to reduce inequalities and improve education, health and wellbeing outcomes for babies, children and young people living in Lancashire.

2. VISION AND KEY PRIORITIES

2.1 Our vision

Children, young people and their families are safe, healthy and achieve their full potential.

2.1 Our key priorities

- We will improve outcomes for our babies, children, young people and families.
- We will focus on prevention and evidence-based practice in order to improve the environment, reduce inequalities and build resilience.
- We will provide children and young people with high quality education and learning opportunities so children and young people achieve their full potential in education, learning and future employment.
- We will support children, young people and their parents to make healthy lifestyle choices and to build strong families, friendships and healthy relationships.
- We will prevent the need for children to become looked after through Early Help, so children and young people feel safe from harm through universal and targeted services.
- We will support parents and families to influence decision-making and bring about positive change for themselves and their children.

2.3 How will we do this?

We have identified four priority areas we need to focus on in the next three years if we are to see tangible benefits and improved outcomes.

Key Priority	Objective
1) Best start in life	❖ To reduce inequalities in pregnancy and ensure better maternal and infant outcomes
2) School readiness	❖ To ensure children, families and communities are school ready and schools are ready for children
3) Health and wellbeing	❖ To ensure effective delivery and commissioning of appropriate services for children, young people and families working within the framework of the Healthy Child Programme
4) Inequalities and societal issues	❖ To target inequalities and improve education, health and wellbeing outcomes in areas of greatest priority and need so children feel safe in their communities

2.4 Our outcomes

- We want to reduce infant mortality by ensuring we focus on conception, birth and healthy pregnancies across the social gradient
- We want to increase school readiness at the end of the reception year (with a focus on closing the word gap).

- ❖ We want to reduce inequalities in health through the provision of mandated universal and targeted services.
- ❖ We want to ensure a broader focus on reducing child poverty and inequalities, and their impact across the social gradient.

3 NATIONAL AND LOCAL STRATEGIC CONTEXT

3.1 National drivers

3.1.1 Each day is important in a child's development, especially those first 1,000 days of life, which Unicef calls the "brain's window of opportunity" and says: : *"The time spanning roughly between conception and one's second birthday - is a unique period of opportunity when the foundations of optimum health, growth, and neurodevelopment across the lifespan are established."*

3.1.2 **The Marmot Report** on health inequalities cited evidence that development begins before birth and that the health of a baby is crucially affected by the health and well-being of the mother. Professor Sir Michael Marmot wrote: *"The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being."*

3.1.3 In January 2016 "**Better Births: a five-year forward view for maternity care**" was published, with recommendations for all sectors of health and social care to make to improve maternity outcomes.

3.1.4 A recent Department for Education (DfE) statement clearly illustrates the importance of early education in government strategy: *"The first few years of a child's life are critical to shaping their future development, and our ambition is to provide equality of opportunity for every child, regardless of background or where they live, because we know that good early years education is the cornerstone of social mobility."*

3.1.5 **School Nurseries Capital Fund, September 2018**. Improving social mobility through education - A good early years education is the cornerstone of improving social mobility

3.1.6 **0 to 19 agenda / March 2018 Best start in life and beyond child poverty**. This document is one of four supporting guides to assist local authorities in the commissioning of health visiting and school nursing services to lead and coordinate delivery of public health for children from birth up to the age of 19.

3.1.7 National agencies are increasingly focused on the school readiness of young children. It is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally and is impacted by a whole range of indicators: those related to the family (maternal mental health, homelessness, family income and parental education), the child (low birth weight, health status and immunisation rates) and services (quality and availability of funded early education) among many others. Two key specific indicators are:

- Percentage of children achieving a good level of development at the end of reception year.
- Percentage of children with free school meal status achieving a good level of development at the end of reception year.

3.1.8 In July 2018, the Secretary of State for Education announced his ambition to halve the proportion of children who do not achieve at least expected levels across all goals in the "communication and language "and "literacy" areas of learning in the Early Years Foundation Stage (EYFS) Profile at the end of reception year by 2028.

3.1.9 This ambition builds on **"Unlocking Talent, Fulfilling Potential: a plan for improving social mobility through education"** which set out the government's plans to close the word gap in the early years, which it describes as the "first life ambition".

On 14 December 2017, the Department for Education (DfE) launched Unlocking Talent, Fulfilling Potential: a plan for improving social mobility through education. The plan sets an overarching ambition: no community left behind.

Ambition 1 is to close the word gap in the early years. Children with strong foundations will start school in a position to progress, but too many children still fall behind early, and it is hard to close the gaps that emerge. We need to tackle these development gaps at the earliest opportunity, particularly focussing on the key early language and literacy skills, so that all children can begin school ready to thrive

3.1.10 **Early Years Workforce Strategy 2017.** This document sets out how the DfE plans to support the early year's sector to remove barriers to attracting, retaining and developing the early year's workforce.

3.1.11 **Legislation and statutory duties 2014 Children and Families Act**. This is a key driver for a range of recent reforms and policy development was the 2014 Children and Families Act.

3.1.12 **The Code of Practice 0-25 for children and young people with special educational needs and disabled children and young people** provides statutory guidance on duties, policies and procedures relating to Part 3 of the Children and Families Act 2014 and associated regulations and applies to England.

3.1.13 **Statutory guidance for early years and childcare.** This guidance from the DfE is for English local authorities on their duties pursuant to Section 2 of the Childcare Act 2016 and have regard to this guidance when seeking to discharge their duties.

3.2 Local drivers

3.2.1 **Lancashire Health and Wellbeing Board**. Upper tier and unitary local authorities are required to have a health and wellbeing Board. The board comprises a range of partner agencies and has a duty to decide what the main public health needs of the population are and to determine how to meet them in an integrated way.

The board has a responsibility for child health and wellbeing and key actions such as infant mortality have been identified. An infant mortality strategic action plan is being developed.

3.2.2 The local **Joint Strategic Needs Assessment** (JSNA) is used to assess the current and future healthcare and wellbeing needs of our residents. These needs can only be met by collaborative working across all local authorities, clinical commissioning groups (CCGs), the NHS and a range of other partners including the voluntary, community, faith and social enterprise (VCFSE) sector, and our communities themselves working together in partnership.

3.2.3 The **Lancashire Children and Young People's Partnership Board** provides strategic direction for Lancashire in order to promote integration and to achieve our vision. This will be done through delivering our key local priorities, policies and strategies including the Lancashire Children and Young People's Plan.

3.2.4 In January the **Healthier Lancashire and South Cumbria Integrated Care System** (ICS) published its ICS strategy that sets out how the ICS will work towards its vision that our “communities be healthy and local people will have the best start in life so they can live longer, healthier lives”. There is a key focus on a better start for children and young people.

This strategy, which aims to providing support as soon as a problem emerges, at any point in a child’s life – from pre-birth, the foundation years through to the teenage years.

3.2.5 **Lancashire Safeguarding Children Board** (LSCB). This board is a statutory body established under the Children Act 2004, responsible for ensuring that all agencies who work with children and young people work together to safeguard and promote the welfare of children in the local area. However the structure this is also changing in view of new legislation which has to be implemented from 2019.

3.2.6 This Lancashire Safeguarding Childrens Board also include the findings, learning and recommendations from the Child Death Overview Panel which will support the areas identified as preventable such as modifiable factors and adverse childhood experiences.

3.2.7 **Family experiences**. To help us to inform and implement this strategy, we gathered the experiences, views and ideas of mums, dads, grandparents, carers, childminders and multi-agency front-line practitioners and managers of services.

3.2.8 The Lancashire Special Educational Needs and Disabilities Strategy covers the support and services for children and young people with Special Educational Needs and Disabilities, often known as SEND, and sets out the improvements we want to make as a partnership over the next two years.
https://www.lancashire.gov.uk/media/907090/send-partnership-strategy.pdf

4 LANCASHIRE AT A GLANCE

4.1 Demographics

Information is collected on a wide range of measures throughout our lifetime and is used to help those who make decisions at government level to plan services for families and communities and what health services are needed to look after the local population. This information helps us to build up a picture of an area such as that covered by Lancashire County Council and the people and families who live here.

4.1.1 Children aged 0-5 living in Lancashire

Knowing where our families and very young children live is important in deciding how resources are allocated and how services should be commissioned and delivered across the county. Where we live is important in understanding other challenges linked to social inequalities such as poverty and being able to access services.

- As at the ONS Mid-Year Population Estimate for 2018, there are a total of 1,210,053 people living in Lancashire.
- Of these, there are 81,508 children aged between new-born and five years old.
- This represents 6.7% of the total population.
- There is a slightly higher number of boys at a count of 41,707 (51%) compared to girls at a count of 39,801 or 49%.
- Preston has the highest number with 10,952 boys and girls compared to Ribble Valley with the lowest numbers at 3,157 boys and girls.
- Trend line analysis over the five to six years leading up to 2018 shows the numbers of children born each year has been gradually decreasing.

4.1.2 Social disadvantage and poverty across Lancashire

Where they live is an important factor in shaping outcomes for our Lancashire children. Evidence tells us that very young children and their families who live in communities that are less well-off than others (looking at the Index of Multiple Deprivation) do less well than their peers living in better off areas (see Appendix I).

- One in three (32%) of our children aged up to five years old live in the top fifth of the most deprived areas nationally.
- A third of our very young children are living in our poorest neighbourhoods and communities (Burnley, Hyndburn, Pendle, Preston and West Lancashire).
- If we look at the top 40% most deprived areas nationally, we can see that just over half (51.8%) of our very young children are living in the country's poorest areas.

4.1.3 Special educational needs and disability (SEND)

Where there is disability in a family, whether that is parental or child disability, evidence tells us that disabled people have higher poverty rates than the rest of the population (**Disability and Poverty NPI, 2016**).

Additionally, children with disabilities are less likely to achieve a good level of development (GLD) at the end of the EYFS, more likely to be excluded from school,

achieve on average half a grade lower at GCSE than their peers with similar levels of prior level of attainment, and are less likely to gain employment.

- In 2018 150 children (4.7%) in Lancashire accessing 2 year offer funded early education were identified as having SEND
- In 2018 1570 children (5.8%) in Lancashire accessing 3/4 year offer universal funded education were identified as having SEND, with 270 (3.1%) children with SEND accessing the extended offer.
- Although there has been a slight improvement, fewer children with SEND in Lancashire achieve GLD compared to the national average.

4.2 Inequalities in health

Key issues identified from the **Lancashire Child Health Profile 2019** show that, comparing local indicators with England averages, the health and wellbeing of children in Lancashire is mixed, however there are some areas that are worse than England and therefore a priority for Lancashire (Appendix 2).

5.1 Priority 1 Best start in life

5.1.1 Why have we chosen this as a priority for Lancashire?

There are a number of factors that can increase the risk of harm to the unborn baby and many of these are influenced by factors such as income, having support networks, leading a healthy lifestyle, parenting experience or lack of and access to good quality health care and support services.

The health secretary announced his ambition to reduce stillbirth, neonatal death and maternal death by 50% by 2030. In January 2019, that ambition was accelerated to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.

Low birth weight of term babies can be for a number of reasons, perhaps due to family history. Some risk factors can be associated with an unhealthy pregnancy and the potential harms from smoking, stress and substance misuse.

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions.

Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and new-born, hence a priority area is to improve maternal health as well as the child.

5.1.2 Where are we now?

- In 2017, there were 355 low birth weight babies, representing almost 3% of all babies born that year. The picture in Lancashire remains static, with no significant change in recent trends but the two districts, Burnley and Hyndburn stand out as getting worse.
- The infant mortality rate is worse than England with an average of 62 infants dying before age one each year, although the rate has been consistently reducing over time, there has recently been 33 child deaths (one to17 year olds) each year on average.
- In 2017/18 there were 136 (1%) babies born to teenage mothers in the Lancashire County Council area, or 180 across the larger footprint of the Lancashire and South Cumbria NHS region.
- The areas of Burnley, Hyndburn, Fylde, Preston and parts of West Lancashire stand out as having higher rates of teenage mothers.
- The teenage pregnancy rate is worse than England, with 440 girls becoming pregnant in a year.
- 13.9% of women smoke while pregnant which is worse than the rate for England.
- The rate for Lancashire is 4.7 infant deaths under one year of age per 1,000 live births. This rate is higher than the statistical neighbours' average at 4.3 infant deaths per 1,000 live births, and higher than the England average at 3.9 infant deaths per 1,000 live births.
- Comparing Lancashire trends with England overall shows that Lancashire rates have remained either the same as, or worse than, England over the period between 2001 and 2017.
- We have identified a strong correlation between infant deaths and deprivation.

5.1.3 Where do we want to be?

- We want to reduce inequalities in maternal health and wellbeing.
- We want to target inequalities and reduce infant mortality rates.
- We want to ensure we target vulnerable groups such as teenage pregnancies and children with SEND so they receive the targeted support needed.
- We want to ensure Lancashire has a greater understanding of adverse childhood experiences including a local approach which includes the development of more targeted support within localities through our revised multi agency early help offer where we will be developing integrated teams.

5.1.4 How will we get there?

Priority 1: Best Start in Life	
To **ensure better maternal and child outcomes throughout pregnancy, birth and beyond so children have a best start in life**	1) We will develop an integrated care pathway and an outcomes-based approach for mothers, babies and children which supports the needs and wellbeing of the whole family. 2) We will ensure midwifery services adopt a personalised approach to supporting healthy pregnancies (adopt the Better Births learning into future commissioning). 3) We will develop an infant mortality action plan for Lancashire 4) We will embed learning from child death overview panel reports and serious case reviews into ongoing service review as part of a commissioning process of continuous improvement. 5) We will ensure better information for mothers, parents and carers on where to access support and advice 6) We will ensure practitioners will work to deliver a whole system approach to supporting healthy early attachment and positive relationships in the home and education settings to support children's and mother's emotional health and wellbeing. 7) We will increase the number of parent peer champions so we reinvigorate preparation for parenthood through local parenting plans and development of a parenting Strategy 8) We will develop integrated early help locality based teams that identify and support our most vulnerable families through the implementation of our revised Multi Agency Early Help offer.

5.1.5 How will we know when we get there?

We will ensure we have a baseline in order to measure outcomes in relation to this priority area based on key health outcomes measures where local targets will be established which are ambitious for Lancashire.

- Reduce infant mortality
- Reduce low birth weight of term babies 37 weeks
- Increase breastfeeding rates
- Reduce smoking status at time of delivery
- Reduce under 18s conception rate

5.2 Priority 2 Children are school ready

5.2.1 Why have we chosen this as a priority for Lancashire?

"School readiness" is a term used to describe the development outcomes of children by the time they get to the end of the reception year at school. It is defined by Public Health England as: *"Children defined as having reached a good level of development at the end of the EYFS as a percentage of all eligible children."*

Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy. Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life, as we've already mentioned.

There is increasing concern about the numbers of children starting school with poor speech, language and communication skills with unacceptable differences in outcomes in different areas of the country. Disparities in early language development are recognisable in the second year of life and have an impact by the time children enter school. Around two-fifths of disadvantaged five-year-olds do not meet the expected literacy standard for their age.

5.2.2 Where are we now?

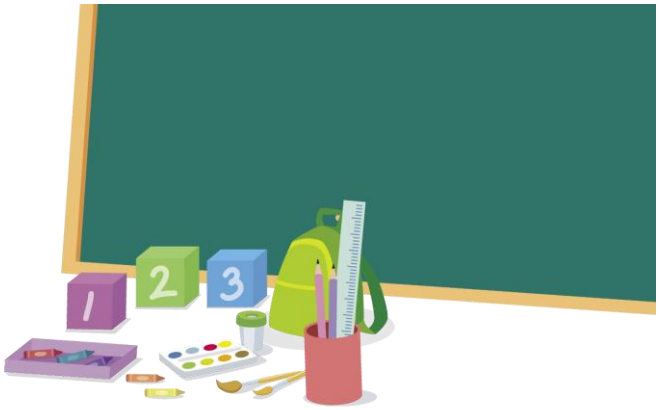
- Nationally, 28% of children leave reception without the literacy skills they require in order to thrive and succeed (**HM Government, 2018**). In Lancashire the number of our children achieving a good level of development by the end of reception has been increasing over the last five years, although it dropped by 0.3% this year and is below national average.
- However, it had not been increasing as quickly as it has for England and had remained relatively static for the last three years, only rising 0.3%.
- For the year 2017/18, 9,796 (69.5%) of children achieved a good level of development and 4,300 (30.5%) children did not achieve a good level of development by the end of reception.
- At 2017/18, 29.2% or 4,116 of Lancashire children did not achieve the expected goals. If we are to halve this figure, then we need to see a development gain in approximately 2,000 more children born over the next decade to 2028 (based on the reception age population as at 17/18).
- In 2018/19 there has been a reduction of 0.3% compared to last year, with 69.2% of children achieving a good level of development.
- In Lancashire, 70.8% of all children achieve the expected level of development for communication and language and literacy (combined) compared to 72.6% of all children nationally.
- In Lancashire, the gap for all children is 2.6% below the national average for all children that achieve at least the expected level of development for communication and language and literacy (combined).
- We can pinpoint gaps between social groups and between boys and girls.
- 12.8% fewer boys, compared to girls achieve the expected standard in communication and language early learning goals.
- Children born pre-term before 37 weeks of gestation are at increased risk of experiencing difficulties with speech, language and communication. Based on data

from the Office for National Statistics in 2017, 8% of live births in Lancashire were pre-term (born before 37 weeks).

- In financial year 2017/18, 99.1% of children who received a development review at two to two-and-a-half years of age in Lancashire had their development reviewed using the Ages and Stages Questionnaire (ASQ-3) compared 90.2% of children nationally.
- There is also disparity across the County in relation to GLD outcomes where for some children on free school meals (FSM), there has been a 3 year trend that is below national.

5.2.3 Where do we want to be?

- We want to target our combined efforts to reach those prospective new mothers and families living in our most deprived communities.
- We want to address the gaps we see in development, with a focus on boys, those in receipt of free school meals and children with additional needs.
- We want to focus on **closing the Word Gap** and improve child communications outcomes. We would do this through children's speech, language and communication in the home learning environment (HLE), early education environment and through early identification and intervention.
- We want to work in partnership to achieve the very best start for our youngest children, in delivering the EYFS statutory framework for children between birth and age five, with fidelity and consistency.
- We want to ensure we deliver on the free entitlements for two, three and four year-olds, both the universal entitlement and the extended entitlement which secures sufficient childcare for working parents, provides information advice and assistance to parents and provides information, advice and training to childcare providers as highlighted in the Early Education and Childcare Statutory Guidance for local authorities (June 2018)
- We want to ensure all children take up their funded hours in a high-quality setting.
- We want to ensure we deliver a range of projects to strengthen workforce development.
- We want to deliver targeted intervention for parents who have concerns about their child's behaviour.



5.2.4 How will we get there?

The following table provides actions to be delivered in this priority area:

PRIORITY 2: Children are ready for school	
To ensure children are able to learn and develop skills so they are ready for school and schools ready for children	1) We will ensure a shared understanding of "school readiness" within early years services, schools and partners across Lancashire 2) We will ensure better information for mothers, parents and carers on where to access support and advice, including a social media and digital communication offer for families and practitioners. 3) We will ensure partners and education settings understand and respond to the development gaps through "warranted variation" so that we target resources to where they are most needed 4) We will ensure the two-year-old funding take-up is improved and benefits disadvantaged children and families* 5) We will ensure the home learning environment is encouraged through every contact, through good information, resources and tools. 6) We will improve pathways to support early detection of, and access to support and therapy for speech delay through the implementation of a Lancashire speech, language and communication strategy and plan. Detection is no good without access to support and therapy. 7) We will ensure affordable and high-quality childcare and early years education for children from disadvantaged communities. 8) We will support the provision of free or low-cost alternative activities and community-based support for families and parent/s of very young children as part of an asset-based community development approach. 9) We will ensure the quality of provision in early years settings and schools will be supported to ensure that children are supported to make maximum progress from their starting points 10) We will ensure we promote children's own wellbeing and resilience 11) We will ensure there is appropriate follow up of children who have been identified with additional needs through the ASQ assessments prior to starting Early Years and school.

**The statutory guidance refers to early years provision free of charge (sections 7 and 7A Childcare Act 2006) and free childcare (section 2 Childcare Act 2016) as the 'free entitlement(s)', a 'free place' or 'free hours'. This reference applies to the 15 hour entitlement for the most disadvantaged two-year-olds*

5.2.5 How will we know when we get there?

We will measure outcomes in relation to impact based on key national outcome areas.

- The proportion of children aged two to two-and-a-half years receiving ASQ-3 as part of the Healthy Child Programme or integrated review and the number of children identified as having additional needs who have been referred for relevant support
- School Readiness: the percentage of children achieving a good level of development at the end of reception (age five)
- School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (age five)
- School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (age six)
- School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (age six)
- To consider the % of children aged two, three and four who have accessed high quality childcare or nursery provision from disadvantaged communities
- The number and percentage of early years schools and settings who achieve a good or outstanding OFSTED inspection outcome

5.3 Priority 3 Improved Health and wellbeing for children

5.3.1 Why have we chosen this as a priority for Lancashire?

In order to support children, young people and their parents to make healthy lifestyle choices we need to ensure that we provide universal prevention, health promotion and early intervention services as early as possible. This is necessary to identify and prevent the need for children to become looked after through signposting to other services through the Early Help offer so children, young people and families feel safe from harm through targeted services. This is important in safeguarding and identifying and signposting families and children early.

The 0-19 public health nursing deliver on the Healthy Child Programme as highlighted in the Best start in life and Beyond Commissioning Guidance, which includes the delivery of Universal Health Reviews and assessments. This includes transition from maternity services, the five mandated health reviews, and maternal mood assessment. In addition, this will include health needs assessments and reviews supporting transition for children and deliver the six high impact areas as follows:

Universal Health Reviews	**0-5 Years High Impact Areas**
1) Antenatal review (women more than 28 weeks pregnant) 2) Birth review (one day to two weeks) 3) Postnatal review (six to eight weeks) 4) 12 months review 5) 24 to 30 months review	1) Transition to parenthood and the early weeks 2) Maternal mental health 3) Breastfeeding (initiation and duration) 4) Healthy weight, healthy nutrition 5) Managing minor illnesses and reducing hospital attendance/admissions 6) Health, wellbeing and development of the child aged two: Two-year-old review and support to be 'ready for school

It is also important we consider the opportunities for non-statutory education assessments when children enter the free entitlement for nursery education at age three, and at age four in addition to the statutory EYFS profile assessment at the end of reception year. This will support early intervention and where necessary early help if the child is not achieving the age related expectation.

The Service will also support and delivery of the National Child Measurement Programme (NCMP) and comply with Public Health England's NCMP operating guidance.

5.3.2 Where are we now?

- We are not achieving 90% take up of the mandated visits within the health visiting service.
- The MMR immunisation level does not meet recommended coverage (95%). By age two, 88.9% of children have had one dose.
- Population vaccination coverage - Dtap / IPV / Hib (2 years old) in 2018/19 was 89.3% in Lancashire compared to 94.2% in England.
- Dental health is worse than England with 34.0% of 5-year olds have one or more decayed, filled or missing teeth compared to 23.3% in England.
- 10% of children in reception are obese compared to 9.7% in England.
- 19.9% of children in Year 6 are obese compared to 20.2%in England which is worse.

5.3.3 Where do we want to be?

- We want to ensure we have developed an integrated care pathway for early years services which will include maternity, health visiting and early years children services.
- We want to agree an integrated workforce development plan for all early years staff.
- We want the 0-19 Healthy Child Programme integrated with the Children and Family Wellbeing Service
- We want to ensure easy access to speech, language and communication services across Lancashire.
- We want to embed a framework for peer-to-peer and cluster working that effectively promotes quality improvement, school readiness and supports children through key transition points, both in and across education settings.
- We want to establish an effective network of communication champions (language leads) in early years settings and other relevant agencies. This will include peer support.

5.3.4 How will we get there?

The following provides key actions to be delivered for this priority area:

Priority 3: Improving Health and wellbeing outcomes for children	
To ensure improved health and wellbeing outcomes for children through the Healthy child programme Framework	1) To develop an integrated care pathway for maternity and integrate the 0-19 Healthy Child Programme with the Children and Family Wellbeing Service 2) To commission, deliver and monitor the 0-5 health visiting service 3) To review the commissioning models for speech, language and communication services across Lancashire. 4) To establish an effective network of communication champions (language leads) in early years settings and other relevant agencies. Include peer support. 5) To review models to support parent interactions – portage and educational psychology – use of video interaction. 6) To ensure all practitioners take appropriate action on families with depression, anxiety and interpersonal violence. 7) To develop agree an integrated Workforce Development Plan for Early Years staff as part of the Early Help offer 8) To align our services with the objectives of the multi-agency Early Help Strategy by bringing together locality based integrated teams.

5.3.5 How will we know when we get there?

We will measure according to key outcome areas as identified in the Outcomes frameworks for Health and social care and public health from a baseline measure in the following areas:

- To ensure all families are offered mandated visits.
- To improve oral health of children from birth to five years old.
- To reduce hospital admissions caused by unintentional and deliberate injuries in children from birth to four years old.
- To reduce the number of children who are obese in reception.
- To increase the number of children, young people and families accessing early intervention and prevention activities and services.
- To identify children with special educational needs and disabilities early.
- To increase the number of staff accessing training and development opportunities.

5.4 Priority 4 Tackling big society Issues so children are safe

5.4.1 Why have we chosen this as a priority for Lancashire?

Tackling big societal issues such as child poverty are crucial if we are going to address inequalities and improve outcomes for our children, young people and families

The early years strategy and the activity associated with this will help to raise awareness and target poverty through effective commissioning and delivery of statutory, voluntary and community services. Partnership and integrated working with a focus on the wider determinants such as economic development, including improving skills, training and employment opportunities is also essential.

There is a clear role for sectors such as housing (housing providers, homelessness teams, addressing fuel poverty and reducing energy bills). Addressing child poverty will not only be the remit of key partners but also the Local Enterprise Partnership, economic development agencies, district councils, business communities, adult learning and education as well as the statutory, voluntary and community sectors.

The level of "resilience" children and young people, and their families have, is often highly relevant in terms of how they are able to deal with poverty related issues, and how their lives are affected. Working with families to increase their 'resilience' is key to sustained improved outcomes.

Helping families to take ownership of any problems and potential solutions, and where possible providing pathways to help lift families out of the poverty cycle. This includes looking at routes to employment and training for both young people, and for parents and carers, supported by accessible and affordable good quality childcare to enable them to work, whilst their children are being given the best possible start to early learning.

There is also a key focus on the areas of inequality identified within the child health profiles such as mental health issues, tooth decay, traffic accidents, substance misuse, abuse, and community safety. Collaboration and local partnership activity are key components in tackling child poverty related issues. Therefore, strategic partnerships must work together in an integrated way to ensure that long term outcomes for children, young people and their families are improved.

5.4.2 Where are we now?

- The level of child poverty (2016) in Lancashire was better than England with 15.1% children aged under 16 years living in poverty compared to 17% in England
- The rate of child hospital admissions for mental health conditions in Lancashire is 98.8 per 100,000 which is worse than England at 84.7.
- In 2017/18 hospital admissions caused by unintentional and deliberate injuries in children aged up to 14) was 137.1 per 10,000 in Lancashire compared to 96.4 in England.
- There are 224 children (34.1 per 100,000) killed or seriously injured on the roads which is worse than the England value of 17.4 (PHE 2016-17)
- There are 79 children in care in Lancashire (per 100,000) compared to 64 in England

5.4.3 Where do we want to be?

- We want to ensure action to address the child poverty agenda is embedded at the highest strategic level.
- We want to ensure ownership and leadership for the child poverty agenda is provided through the Health and Wellbeing Board and the Children's Trust Board.
- We want to ensure the continued development of a coherent early help offer for families will be driven through the Lancashire early help strategy.
- We want a whole-family assessment in place and used effectively across all services and sectors, including information shared effectively between agencies
- We want a workforce that supports working in partnership with parents, to build resilience and enable families to find solutions to issues.
- We want to ensure that we develop place-based strategies.
- We want to ensure we reduce inequalities and develop appropriate pathways and strategies to address poor mental health and self-harm, and reduce the rate of child inpatient admissions for mental health conditions.
- We want to reduce the number of children who are killed or seriously injured on the roads.

5.4.4 How will we get there?

Priority 4: Tackling Big Society Issues	
To target **inequalities** and **improve health and wellbeing outcomes** in priority areas	1) To set clear measurable targets to tackle child poverty and disadvantage 2) To achieve improvements in child health outcomes through a focus on reducing the risk factors associated with each of the priority areas 3) Improvement across all "red" indicators in the Child Health Profile, with priority in deprived areas and the outcomes identified across all the priority areas

5.4.5 How will we know when we get there?

We will ensure we have a baseline of information in order to measure outcomes in relation to the impact on health outcomes where local targets will be established which are ambitious for Lancashire.

- Reduce children in low income families
- Reduce hospital admissions caused by unintentional and deliberate injuries
- To reduce average difficulties, score for all looked after children
- To reduce children who are killed or seriously injured on the roads
- To reduce the rate for self-harm

6. MEASURING PROGRESS

Performance will be measured against the strategic outcomes identified in the early years strategy and the children and young people's plan and against the JSNA.

Early years outcomes across public health, education and all key stakeholders will be captured and reported against within the Early Help shared outcomes framework as part of the implementation of the Multi Agency Early Help Strategy ratified by the Children, Young People and families Board in Dec 2019

Public health outcomes framework (PHOF)

The **PHOF** provides all the indicators and the most recent data that is recorded.

We want to be ambitious in our targets so that we improve health outcomes overall but also target work in areas identified as deprived or achieving below the regional and national average as rated red or amber.

The service will be expected to support improvements from the baseline performance data, so we are ambitious and see an improvement in the longer term in all PHOF areas identified by introducing targets which will be measured quarterly and annually where appropriate.

The strategy will be monitored against the outcomes highlighted for children, young people and families and will submit a quarterly report demonstrating activity against these outcome areas as highlighted in the Appendix 3.

7. GOVERNANCE AND REPORTING PROGRESS

The Health and Wellbeing Board will lead and co-ordinate the oversight of the strategic plan as part of a collaborative and shared leadership approach. Delivering and measuring progress against this strategy will be through the Best Start in Life Strategic Group which will be accountable to the Children and Young People and Families Partnership Board.

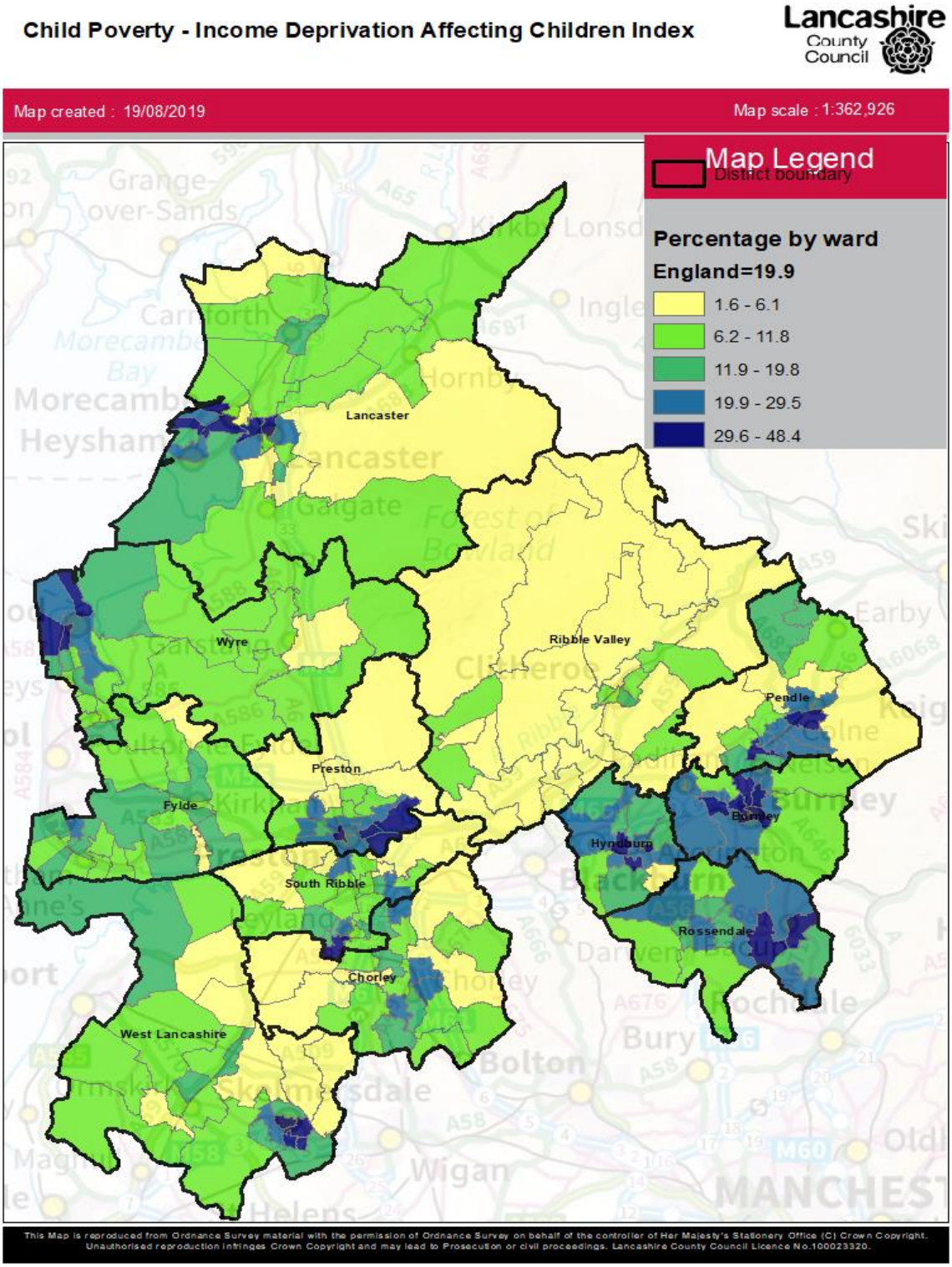
Progress towards achieving the outcomes will be reported through the Children and Young People and Families Partnership Board chaired by the executive director of education and children's services. This strategy will link into as appropriate with other plans to include early help and children with SEND.

Strategic links are therefore key to the delivery of this strategy and plan, with alignment of common actions and themes to the early help strategy; family safeguarding; SEND strategy; managing behaviour strategy and the emotional wellbeing and mental health transformation plan - and to the wider plans for the Lancashire and South Cumbria ICS.

APPENDIX I:

Map 1 –Income deprivation affecting children across Lancashire

The darker shaded areas represent those families and communities especially affected by low income and poverty



Appendix II: Child health profile for Lancashire (March 2019)

This profile shows how Lancashire children are doing against a range of health and education outcome measures, compared to the England average. The “red dots” identify key areas where we must focus our energies, especially for children up to age five.

Indicator	Period	Lancs			Neighbrs average	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Infant mortality rate	2015 - 17	–	185	4.7	4.3*	3.9	8.1		1.7
Child mortality rate (1-17 years)	2015 - 17	–	99	14.0	-	11.2	24.3		7.5
Population vaccination coverage - MMR for one dose (2 years old) <90% 90% to 95% ≥95%	2017/18	↓	10,901	88.9%	92.3%*	91.2%	75.0%		96.9%
Population vaccination coverage - Dtap / IPV / Hib (2 years old) <90% 90% to 95% ≥95%	2017/18	↓	11,164	91.1%	95.2%*	95.1%	83.7%		98.5%
Children in care immunisations	2018	↑	1,245	90.1%	88.0%*	85.3%	5.7%		100%
School Readiness: the percentage of children achieving a good level of development at the end of reception	2017/18	↑	9,796	69.5%	-	71.5%	63.9%		80.5%
Average Attainment 8 score	2017/18	–	-	46.6	-	46.7	39.8		55.8
Average Attainment 8 score of children in care	2017/18	–	-	14.9	-	19.3	0.0		33.9
16-17 year olds not in education, employment or training (NEET) or whose activity is not known	2017	–	2,130	8.3%	-	6.0%	24.4%		1.9%
First time entrants to the youth justice system	2018	↓	205	190.9	-	238.5	554.3		72.3
Children in low income families (under 16s)	2016	↓	32,255	15.1%	-	17.0%	31.8%		6.4%
Family homelessness	2017/18	↓	205	0.4	-	1.7	7.7		0.1
Children in care	2018	↑	1,965	79	-	64	185		23
Children killed and seriously injured (KSI) on England's roads	2015 - 17	–	224	34.1	20.4*	17.4	41.7		2.6
Low birth weight of term babies	2017	→	355	3.07%	2.60%*	2.82%	5.30%		1.57%
Reception: Prevalence of obesity (including severe obesity) New data	2017/18	→	1,235	9.3%	9.3%*	9.5%	14.4%		4.9%
Year 6: Prevalence of obesity (including severe obesity) New data	2017/18	↑	2,388	18.8%	19.0%*	20.1%	29.7%		11.4%
Children with one or more decayed, missing or filled teeth	2016/17	–	-	34.0%	-	23.3%	47.1%		12.9%
Hospital admissions for dental caries (0-5 years)	2015/16 - 17/18	–	1,900	764.7	357.9*	325.1	10.8		1,612.1
Under 18s conception rate / 1,000	2017	↓	436	22.9	18.1*	17.8	43.8		6.1
Teenage mothers	2017/18	↓	123	1.0%	0.8%*	0.7%	2.1%		0.2%
Admission episodes for alcohol-specific conditions - Under 18s	2015/16 - 17/18	–	332	44.9	38.0*	32.9	106.5		7.4
Hospital admissions due to substance misuse (15-24 years)	2015/16 - 17/18	–	499	112.0	-	87.9	329.3		33.1
Smoking status at time of delivery	2017/18	↓	1,619	13.9%	13.9%*	10.8%	26.0%		2.0%
Breastfeeding initiation	2016/17	–	8,673	*	70.4%*	74.5%	37.9%		96.7%
Breastfeeding prevalence at 6-8 weeks after birth - current method	2017/18	–	-	*	40.2%*	42.7%*	-	*Insufficient number of values for a spine chart*	-
A&E attendances (0-4 years)	2017/18	↑	34,587	508.6	568.1*	619.0	2,011.3		321.3
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2017/18	↓	2,857	137.1	99.0*	96.4	203.7		46.5
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2017/18	↓	1,649	113.2	137.6*	132.7	284.4		69.0
Hospital admissions for asthma (under 19 years)	2017/18	↓	701	267.4	195.4*	186.4	511.7		82.5
Hospital admissions for mental health conditions	2017/18	→	245	98.8	85.0*	84.7	187.6		14.5
Hospital admissions as a result of self-harm (10-24 years)	2017/18	–	938	439.3	-	421.2	1,009.6		116.9

Source: PHE Fingertips

Appendix III: Outcomes Framework

Priority 1 – To ensure better maternal and child outcomes throughout pregnancy, birth and beyond		
Objective	**Ref**	**Outcome indicator**
1.1 Reduce infant mortality	E01	Infant mortality
1.2 Reduce low birth weight of term babies 37 weeks	C04	Low birth weight of term babies[2] (see note)
1.3 Increase breastfeeding rates *(New data)	C05a	Breastfeeding initiation All ages
	C05b	Breastfeeding prevalence at 6-8 weeks after birth - current method
1.4 Reduce smoking status at time of delivery	C06	Smoking at time of delivery
1.5 Reduce under 18s conception rate	C02a	Under 18s conception rate / 1,000
	C02b	Under 16s conception rate / 1,000
1.6 Number of antenatal visits by health visitors	KPI	Number of children identified with special needs
1.7 Number of births visits	KPI	Number of birth assessments delivered
1.8 Number of maternal mood assessments	KPI	Number of women identified with maternal mood, anxiety depression
Priority 2 – To ensure Children learn and develop skills for life		
2.1 Increase number of ASQ-3	C08a	Percentage of children at or above expected level of development in all five areas of development at 2-2½ years
	C08b	Percentage of children at or above expected level of development in communication skills at 2-2½ years
	C08c	Percentage of children at or above expected level of development in personal-social skills at 2-2½ years
2.2 To increase the % of children who achieve the expected level of development for communication and language literacy at the end of reception year	B02a	School readiness: the percentage of children achieving a good level of development at the end of reception (5yrs)
	B02a	School readiness: the percentage of children achieving a good level of development at the end of reception (5yrs) with free school meal status
2.3 To increase the number of children who achieve a good level of development (GLD at the end of the reception year. (Baseline: 2017/18:69.5%)v	B02b	School readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (6yrs)
	B02b	School readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (6yrs) with free school meal status
Priority 3 – Children are healthy and well and reach their potential		
3.1 Reduce Children in low income families	B01a	Children in low income families (all dependent children under 20)
	B01b	Children in low income families (under 16s)

3.2 Reduce hospital admissions caused by unintentional and deliberate injuries	C11a	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14)
	C11a	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4)
	C11b	Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)
3.3 To reduce the number of children who are obese	C09a	Reception: Prevalence of overweight (including obesity)
	C09b	Year 6: Prevalence of overweight (including obesity)
Priority 4 – Tackling societal issues so children feel safe and live in caring and resilient communities		
4.1 Reduce the number of Children in low income families	B01a	Children in low income families (all dependent children under 20)
	B01b	Children in low income families (under 16s)
4.2 Reduce hospital admissions caused by unintentional and deliberate injuries	C11a	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14)
	C11a	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4)
4.3 Reduce the % of children where there is a concern	C12	Percentage of children where there is a cause for concern
4.4 To reduce children who are killed or seriously injured on the roads	B10	Killed and seriously injured (KSI) casualties on England's roads

Revised Version
Ruksana Sardar-Akram
14th February 2020

Appendix B: Infant Mortality Report

Lancashire Infant Mortality Report
Director of Public Health

January 2020

www.lancashire.gov.uk

Lancashire County Council

1. Introduction

1.1 This report provides information about infant mortality and outlines our proposed plan to reduce the number of infant deaths in Lancashire.

1.2 Infant mortality is an indicator of the overall health of a population. It reflects the relationship between the causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions.

1.3 Reducing infant mortality is an important part of the Population Health Plan First 1000 Days priority.

1.4 Infant mortality is also a key priority area for the Children, Young People and Families Partnership Board as part of a broader approach in the Early Years Strategy (see Appendix 1).

1.5 Infant mortality has been highlighted as a key part of the Director of Public Health report and is also a major part of the ICS work.

2. Definitions

2.1 Infant mortality is defined as deaths that occur in the first year of a child's life.

2.2 The infant mortality rate is the number of deaths at ages under 1 per 1,000 live births. Stillbirths are not normally counted as infant deaths and are not included in the calculation of the infant mortality rate. Some of the factors that contribute to a stillbirth may also be contributing factors in infant deaths.

2.3 Infant deaths can be divided into three broad stages, each with a different set of risk factors and determinants:

- Deaths under 7 days of life (perinatal mortality)
- Deaths to infants aged under 28 days (neonatal mortality)
- Deaths to infants aged 28 days to 1 year (post-neonatal mortality)

3. Data sources and limitations

3.1 There are three main sources of data and information on infant deaths in the UK:

3.1.1 Vital Statistics i.e. information supplied when infant deaths are certified and registered as part of the civil registration process. This is a legal requirement and the information that is collected is prescribed in the relevant legislation. The data collected through this process is managed by the Office for National Statistics (ONS) and is usually reported based on the local authority within which the deceased was usually resident at the time of death.

3.1.2 Child Death Overview Panels (CDOP) collect and review information about each child death in a local area in order to build a picture of emerging themes and patterns and inform local strategic planning on how to best safeguard and reduce harm and promote better outcomes for children in the future. Each CDOP collects data in a common format and also submits information to the Department for Education on an annual basis to inform the national picture.

3.1.3 Surveillance reporting systems, notably the Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) system. MBRRACE is part of the national Maternal, Newborn and Infant Clinical

Outcome Review Programme, the aim of which is to provide robust national information about the causes of maternal deaths, stillbirths and infant deaths.

3.2 The information collected by each of these sources is different. For example, the restrictions on the data collected as part of the deaths registration process means that the ONS dataset contains limited information on key risk factors, such as ethnic group, mother's country of birth, maternal lifestyles and family circumstances.

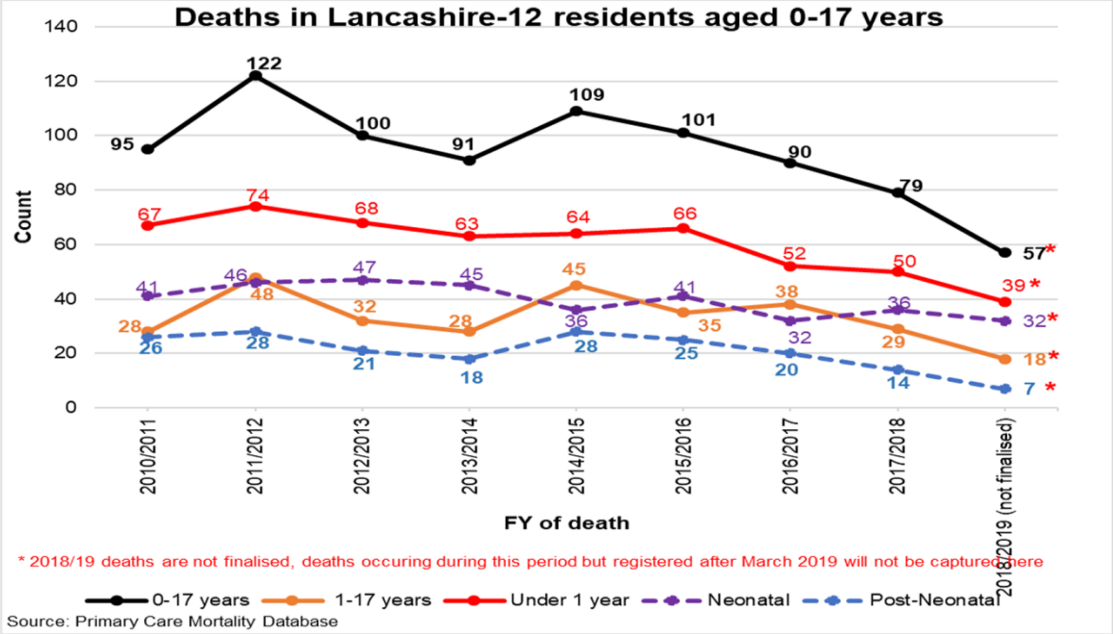
However, data on some of these factors is collected as part of the CDOP process. Used together, the ONS and CDOP data provide a rich and powerful picture of infant deaths in Lancashire.

3.3 The CDOP Annual Report for Lancashire is also produced on an annual basis and supports the context for this report and the action plan.

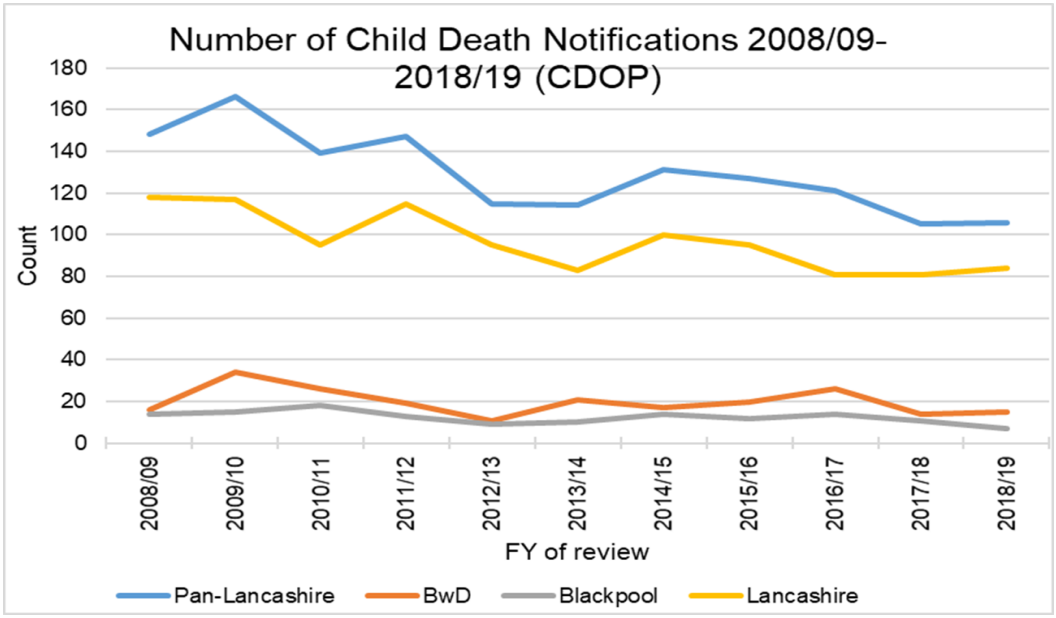
4. Trends and patterns of infant deaths in Lancashire

4.1 Infant Mortality rates

- The overall child mortality rate (age 0-17) in Lancashire has been falling as can be seen below. However child mortality remains significantly worse than the England rate (coverage over the period 2010-12 to 2015-17).
- According to recent published figures (2015-17) infant mortality and post-neonatal mortality remain worse than the England rate (2010-12 to 2015-17).
- Neonatal mortality has been similar to the England rate (coverage between 2012-2014 and 2015-2017).



4.2 According to Child death notifications from 2008/9 to 2018/19, there are inequalities between geographical areas where Lancashire has the highest number of deaths compared to Blackburn and Darwen and Blackpool.



4.3 The infant mortality rate for Lancashire is 4.7 per 1,000 compared to 3.9 per 1,000 England 2015-17. Lancashire after Staffordshire is ranked worst compared to its neighbours.

4.01 - Infant mortality New data 2015 - 17 Crude rate - per 1000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	7,734	3.9	3.8	4.0
Neighbours average	–	-	1,623	3.7*	-	-
Staffordshire	–	2	141	5.5	4.6	6.5
Lancashire	–	-	185	4.7	4.1	5.5
Northamptonshire	–	6	122	4.5	3.7	5.4
Warwickshire	–	7	75	4.2	3.3	5.2
Worcestershire	–	9	74	4.1	3.2	5.2
Nottinghamshire	–	1	104	4.0	3.3	4.8
Kent	–	8	199	3.8	3.3	4.4
Derbyshire	–	5	86	3.7	3.0	4.6
Leicestershire	–	15	77	3.7	2.9	4.6
Lincolnshire	–	10	75	3.3	2.6	4.1
Cumbria	–	12	46	3.3	2.4	4.3
Gloucestershire	–	4	65	3.3	2.5	4.1
Norfolk	–	13	86	3.2	2.6	4.0
Essex	–	3	153	3.1	2.6	3.6
West Sussex	–	14	72	2.7	2.1	3.4
Suffolk	–	11	63	2.7	2.1	3.4

Source: Office for National Statistics (ONS)

4.4 There are also local variations and inequalities in infant deaths within areas of residence in Lancashire. As can be seen in the period 2015-2017 Burnley stands out as having the highest number of deaths, followed by Pendle, Wyre, Fylde, Chorley and Hyndburn. Ribble Valley and Lancaster have lowest number of deaths.

Infant mortality (2015 - 17), crude rate per 1,000 live births

Area	Count	Rate per 1,000	95% Lower CI	95% Upper CI
England	**7,734**	**3.9**	**3.8**	**4**
Lancashire	**185**	**4.7**	**4.1**	**5.5**
Burnley	28	7.8	5.2	11.2
Chorley	19	5.1	3.1	8
Fylde	10	5.3	2.6	9.8
Hyndburn	16	5	2.9	8.1
Lancaster	11	2.6	1.3	4.6
Pendle	21	5.7	3.5	8.7
Preston	26	4.7	3	6.8
Ribble Valley	3	2.2	0.4	6.3
Rossendale	8	3.4	1.5	6.7
South Ribble	14	3.9	2.2	6.6
West Lancashire	13	4.2	2.2	7.1
Wyre	16	5.5	3.2	9

4.5 There are clear links between socioeconomically deprived areas and infant mortality. When broken down into deprivation using IMD, the infant mortality rate is highest in most deprived areas compared to least deprived areas.

IMD Decile	Count of infant deaths	IMR	
1	218	6.7	-0.90
2	91	5.5	
3	63	4.2	
4	51	4.1	
5	33	3.9	
6	45	4.1	
7	37	3.1	
8	39	3.3	
9	27	2.7	
10	19	2.9	

4.6 As can be seen from the table below the majority of the births occur in the most deprived quintile includes Hyndburn, Burnley and Pendle.

Births in 2017						
District	**IMD 2015 Quintile (1=20% most deprived, nationally) - % of total births**					
	1	**2**	**3**	**4**	**5**	**Total**
Burnley	**58.8%**	**24.8%**	5.6%	7.5%	3.3%	100.0%
Chorley	13.5%	25.7%	16.3%	26.6%	17.9%	100.0%
Fylde	4.4%	10.2%	30.6%	34.1%	20.7%	100.0%
Hyndburn	**62.6%**	**16.8%**	6.7%	12.0%	1.9%	100.0%
Lancaster	30.0%	19.6%	19.7%	21.5%	9.1%	100.0%
Pendle	**50.1%**	**22.0%**	14.7%	10.7%	2.5%	100.0%
Preston	44.2%	24.4%	10.6%	9.7%	11.0%	100.0%
Ribble Valley	0.0%	3.1%	28.9%	30.0%	38.0%	100.0%
Rossendale	15.4%	43.3%	17.6%	15.5%	8.2%	100.0%

South Ribble	5.1%	10.6%	35.4%	23.6%	25.4%	100.0%
West Lancashire	31.8%	13.9%	20.9%	14.8%	18.7%	100.0%
Wyre	22.6%	10.1%	28.1%	24.6%	14.6%	100.0%
Lancashire	32.1%	19.7%	18.0%	17.6%	12.6%	100.0%

4.7 There are also links with low birth weight and areas of deprivation. The following table shows the areas with highest IMD scores also have the highest rates of low birth weight babies. Burnley, Hyndburn, Pendle and Preston are worse when compared to England Average.

Low birth weight of term babies, five year aggregate, 2011-2015 (same period as ward data)

District	%	Lower CI 95.0 limit	Upper CI 95.0 limit	Count	Denominator	Compared to England value
Burnley	3.8	3.3	4.3	204	5412	Worse
Chorley	2.4	2.0	2.8	137	5677	Similar
Fylde	2.0	1.6	2.6	59	2944	Better
Hyndburn	3.4	2.9	3.9	174	5108	Worse
Lancaster	2.6	2.2	3.0	181	6999	Similar
Pendle	3.3	2.9	3.8	193	5882	Worse
Preston	3.6	3.3	4.1	314	8615	Worse
Ribble Valley	2.5	1.9	3.3	51	2043	Similar
Rossendale	2.8	2.3	3.4	104	3741	Similar
South Ribble	2.1	1.8	2.6	120	5593	Better
West Lancashire	2.4	2.0	2.8	121	5061	Similar
Wyre	1.9	1.5	2.4	83	4342	Better

5. Causes and underlying factors of infant deaths

5.1 National data shows a correlation between deaths and deprivation, and as can be seen from the table analysis of local data highlights an obvious correlation locally between IMD and the infant mortality rate.

5.2 National data shows that of babies with known gestational age, babies born in the White Other ethnic group (White Irish and any other White background) had the lowest infant mortality rate. In contrast, Pakistani and Black African babies had the highest infant mortality rates. Further analysis is required on ethnicity locally.

5.3 There are a range of factors that contribute to infant mortality. These are low birth weight, Under 18 conceptions, smoking in pregnancy and breast feeding initiation.

5.4 In Lancashire various modifiable factors have been identified which contribute to the infant mortality rate. This can increase the risk of prematurity, meaning the infant will not be born in the best possible condition, or make sudden infant death more likely.

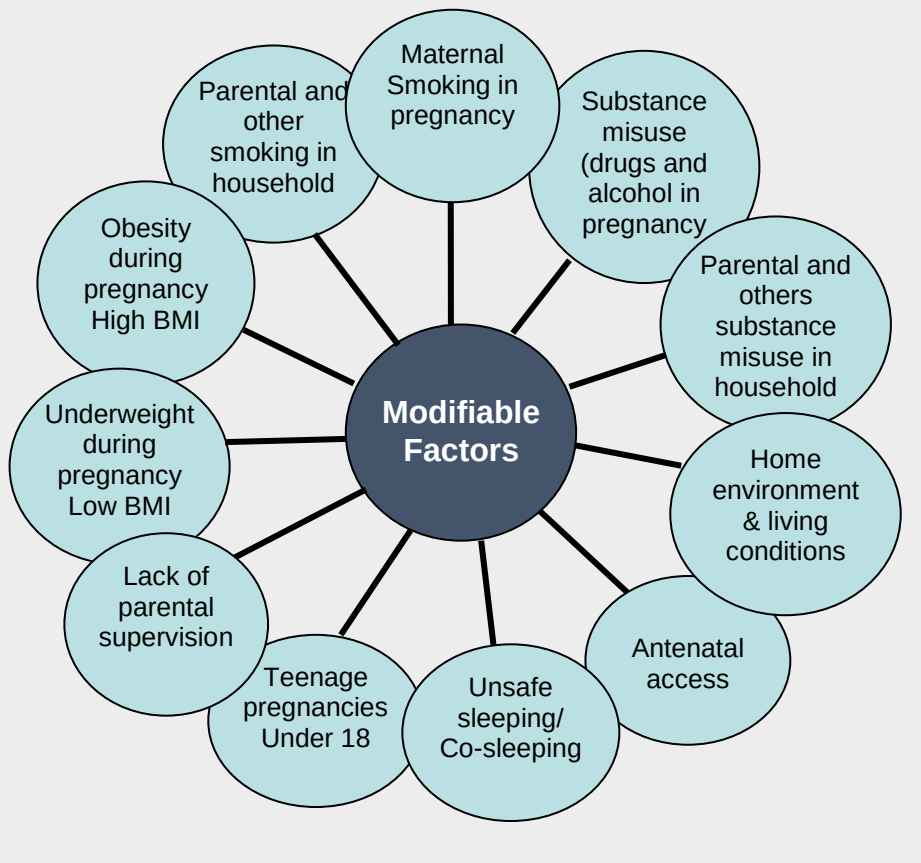
5.5 Modifiable factors act as a multiplier effect. Where there are two or more factors present, the vulnerability of the child increases. The modifiable factors that occur most frequently, and therefore where most impact can be made, include maternal smoking in pregnancy, maternal obesity in pregnancy and Parental/household smoking and substance misuse.

5.6 In part, this can be linked to the fact that the prevalence of some lifestyle factors known to increase the risk of infant mortality are higher in certain ethnic groups. For example, the prevalence of obesity is known to be higher among some South Asian communities.

5.7 Maternal obesity during pregnancy can lead to increased health risks for mother and baby.

5.8 Smoking in pregnancy is the single biggest risk factor for infant mortality.

5.9 Those modifiable factors identified in the CDOP for Lancashire are highlighted in the diagram below.



5.10 As well as these modifiable factors there are a number of protective factors against infant deaths. These include vaccinations including flu vaccination for pregnant women, breastfeeding and safe sleeping practices.

6. What is the data telling us about these factors and the associated risks in Lancashire?

6.1 The following table highlights the risk factors and the associated risk, with data on numbers in Lancashire.

Risk Factor	Local data for Lancashire (2016)	%/Number
How maternal age is associated with increased risk	The risks of birth complications, congenital anomalies and stillbirth increase with age. Multiple births are also more common in older women, particularly as the result of assisted conception. However, the exact age at which these risks increase is uncertain and co-existence of additional risk factors such as smoking will increase the chance of adverse birth outcomes.	In this area, **17.4%** of women giving birth in 2016/17 were aged 35 years or above: **2,227 women**
How teenage pregnancy is associated with higher risk	In 2016 babies born to mothers under 20 years had a **24% higher rate of stillbirth** and a **56% higher rate of infant mortality.** Teenage pregnancy is associated with a higher risk of smoking, of late booking antenatally, lower birth weight babies, stillbirth and infant mortality	In this area, **1.0%** of women giving birth in 2016/17 were aged under 18 years: **132 women**
Low birth weight of <u>all</u> babies	Babies born with a low birth weight are almost **9 times more likely to die in infancy**. Smoking is linked to low birth weight. Evidence suggests reducing and quitting smoking is associated with increased birth weight. Babies which are part of a multiple birth are also more likely to have a low birth weight	In this area, **7.9%** of babies (including pre-term) were born with a low birth weight in 2016: **1,038 babies**
Low birth weight of <u>term</u> babies	This indicator is included in the Public Health Outcomes Framework and looks at the number of babies born live with a low birth weight at full term (37 weeks or more) as a percentage of all babies born at full term. At a population level, a higher percentage for this indicator might suggest that women's lifestyles during pregnancy could be improved	In this area, **2.8%** of term babies were born with a low birth weight in 2016: **338 babies**

6.2 What is the data telling us about Lancashire locally and what do we need to do to make a difference?

The following summary provides information on where we are currently in relation to the areas identified and provides a benchmark against England and Regional data. This will help to prioritise areas of need and inform action planning in order to make a difference in reducing infant mortality from baseline data so we either improve compared to a regional or national benchmark. The data is taken from a toolkit by PHE.

Factor	Outcome of risk factor	England	Region
Stillbirths	In 2014-2016, there were on average 58 stillbirths per year, with a rate of 4.4 stillbirths for every 1,000 live births and stillbirths		
Infant Mortality	In 2014-2016, there were on average 59 infant deaths per year, with a rate of 4.5 infant deaths for every 1,000 live births.		

Smoking	In 2017/18, 13.9% of women in this area smoked when pregnant: **1,619 women**. Approximately **130** fewer women smoking during pregnancy in this area could reduce infant mortality rate to match the North West average. ❖ Reducing smoking during pregnancy alone to 0% would not be enough to reduce the stillbirth rate to be among the 25% best performing local authorities ❖ Any reduction in smoking during pregnancy will have a positive impact on health and help to reduce stillbirth rates. You should consider taking action on other factors as well.		
Obesity	**51.0%** of women in this area in 2017 were obese in early pregnancy: 6,190 women. Approximately **181 fewer women obese in pregnancy** in this area could reduce your infant mortality rate to match the North West average. ❖ Approximately 2,593 fewer women obese in pregnancy in this area could reduce your stillbirth rate to be among the 25% best performing local authorities ❖ Achieving these reductions in the short term may be challenging but at an individual level having a normal weight during pregnancy is beneficial for mother and baby. ❖ Over time year-on-year reductions in maternal obesity should be reflected in reduced stillbirth and infant mortality rates		
Immunisations	In 2017/18, **86.1%** of children in this area were vaccinated against diphtheria, pertussis (whooping cough), tetanus, Haemophilus influenzae type b (an important cause of childhood meningitis and pneumonia) and polio at age 1.		
Low birth weight	In 2016, 7.9% of babies (including pre-term) were born in this area with a low birth weight: 1,038 babies		
	In 2016, 2.8% of term babies were born in this area with a low birth weight: 338 babies		
Mothers aged under 18	In 2016/17, 1.0% of women giving birth in this area were aged under 18 years: 132 women		
Mothers aged 35+	In 2016/17, 17.4% of women giving birth in this area were aged 35 years or above: 2,227 women.		

7. What are the key priority areas for action in Lancashire?

7.1 Given the inequalities mentioned above, the public health intelligence data, CDOP findings and serious case reviews, to make a difference in reducing infant mortality we need to take action on the following priority areas:

Key Priority Area	Objective
1. Wider determinants	❖ To address the wider determinants such as poverty, poor housing, overcrowding knowing there is a link between infant mortality and socioeconomic status and a factor on affecting sleeping habits in the home, as well as other risks such as low birth weight.
2. Sudden infant deaths	❖ To reduce the number of sudden infant deaths caused by co-sleeping in unsafe situations
3. Access to services	❖ To ensure equal access to all aspects of pre-conception, maternal and infant health care
4. Social and emotional support	❖ To improve social and emotional support for vulnerable parents, especially those living in areas of social disadvantage, including maternal mental health and wellbeing and attachment
5. Smoking in pregnancy	❖ To reduce the numbers of women (and partners/families) smoking during pregnancy
6. Substance misuse	❖ To reduce the numbers of women with high levels of use of alcohol and/or non-prescribed drugs in pregnancy
7. Women, infant nutrition and breastfeeding	❖ To improve the health and nutrition of pregnant women, babies and infants by promoting a healthy food culture, and tackling obesity
8. Performance, data and intelligence	❖ To ensure appropriate performance and data intelligence to monitor infant mortality
9. Communications	❖ To ensure effective communication so these plans are implemented and shared widely with individuals, communities and professionals

A proposed draft of the action plan can be found in Appendix 2.

8. About the Infant Mortality Plan

8.1 Implementation and delivery

8.1.1 It is proposed the Reducing Infant Mortality Action plan will be over three years from 2020 to 2023 to allow time for outcomes to be realised.

8.1.2 A Strategic Partnership Group will be developed with key internal and external partners who will have a key role in the monitoring and implementation of the plan.

8.1.3 There is already a strong network of organisations and programmes in Lancashire that are supporting healthy pregnancy and the first years of a baby's life.

8.1.4 The approach therefore will be to map and embed priorities in the provision of existing services so they target areas of inequality and develop work programmes and new approaches to improve the health and wellbeing of mothers and infants based on areas of greatest need.

Key thematic groups will be established to oversee the delivery of these priority areas.

8.2 Performance and outcomes

8.2.1 Performance will be measured against the strategic outcomes identified in the Early Years Strategy and the Children and Young Peoples Plan (Appendix 1)

8.2.2 This will be benchmarked against the Public Health outcomes framework (PHOF) which will provide all the indicators and the most recent data that is recorded (https://fingertips.phe.org.uk/profile/public-health-outcomes-framework)

8.2.3 We will be ambitious in setting our targets so that we improve health outcomes overall but using public health intelligence to target areas identified as deprived or achieving below the regional and national average outcomes.

8.2.4 The service will be monitored against the outcomes highlighted for children, young people and families and will be submitted quarterly demonstrating activity against these outcome areas as highlighted in Appendix 3.

8.3 Governance and Reporting

8.3.1 Delivering and measuring progress against this plan will be through the establishment of a Best Start Strategic Group who will monitor progress as part of the wider Early Years Strategy highlighted in Appendix 1.

8.3.2 The Health and Wellbeing Board will have oversight of the Strategic Plan as part of a collaborative and shared leadership approach.

8.3.3 Progress towards achieving the outcomes will be reported through the Children and Young People's and Families Partnership Board, chaired by the Executive Director of Education and Children's Services.

8.3.4 This strategy will link and support as appropriate other wider plans such as the Early Help Strategy; Safeguarding; SEND Strategy; Managing Behaviour Strategy and Emotional Wellbeing and Mental Health Transformation Plan.

8.3.5 The plans will deliver and support key national and local plans in relation to the priority areas identified within the NHS Plan and the Integrated Care Partnership.

9. Next steps

9.1 To establish a Strategic Partnership Group comprising of key partners to oversee the implementation of the Plan.

9.2 To consult, engage and agree with key partners so a robust action plan and performance framework is developed under the key priority areas proposed.

9.3 A detailed Infant Mortality Action plan to be launched in March with regular updates to the Children, Young people and Families Partnership Board and Health and Wellbeing Board.

10. Conclusion and recommendations

- To acknowledge the report
- To approve the Key Priority areas being proposed

APPENDIX 1: Early Years Strategy Plan on a page

Integrated Care System (ICS) | **Health & Wellbeing Board**

CHILDREN, YOUNG PEOPLE & FAMILIES PARTNERSHIP BOARD

Strategic Best Start in Life Partnership Group

VISION:
Children, young people and their families are safe, healthy and achieve their full potential.

INTEGRATED EARLY YEARS STRATEGY - KEY PRIORITY AREAS

Best start in life	School readiness	Improve health and wellbeing	Reduce health inequalities
OBJECTIVES			
To ensure better **maternal and child outcomes** throughout **pregnancy, birth and beyond**	To ensure children families and communities are **school ready** and schools ready for children	To ensure improved health and wellbeing outcomes through the **Healthy child programme** framework	To target **inequalities** and **improve health and wellbeing outcomes** in priority areas
OUTCOMES AND PERFORMANCE			
• Reduce Infant Mortality • Reduce Low birth weight of term babies 37 weeks • Reduce smoking status at time of delivery • Reduce under 18s conception rate	▪ Increase % of reception children achieving CLL and a GLD to national norms ▪ Increase the % of disadvantaged reception children achieving CLL and a GLD to national norms	• Improve oral health • Reduce hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4) • Reduce childhood obesity in reception • Early identification of children with	▪ To achieve a measurable improvement in areas of greatest need ▪ Ensure a targeted approach to reducing inequalities in areas highlighted as priority
KEY ACTIONS			
▪ Develop Infant Mortality Action Plan ▪ Deliver Better births Action Plan ▪ Deliver 1001 critical days action plan	▪ Develop pathways to support early detection of speech delay ▪ Implementation of a Lancashire speech, language and communication plan ▪ Promote Home Learning Environment ▪ Develop parenting Strategy	▪ Develop an Integrated care pathway ▪ Delivery of high impact areas ▪ An integrated workforce development plan ▪ Ensure all families receive mandated developmental reviews	▪ Ensure a clear reporting and governance structure ▪ Develop a Lancashire outcomes framework for CYP ▪ Develop a performance dashboard

Safeguarding, Leadership, Evidence Base-Practice, Accountability

APPENDIX 2: Draft Infant Mortality Reduction Plan

Key Priority Area	Objectives	Actions
1. Addressing the wider determinants to health	1.1 To support efforts to reduce poverty in families	• To ensure we raise awareness of the links between child poverty and infant mortality targeting services in areas of greatest need based on deprivation and infant mortality data
	1.2 To tackle child poverty as a priority	• To consider the development of a child poverty strategy and action plan/embed the importance of this as a priority across everything we do
	1.3 To improve the availability of good quality and affordable housing	• To work with housing services to ensure the needs of pregnant mothers, babies and children are prioritised so we address inequality in housing through improved living conditions and assessment of need and risk of overcrowding
	1.4 Take ensure take up of benefits in most deprived areas	• To support and advise individuals and communities at risk who are eligible for welfare benefits and support with their family and child's needs
	1.5 To establish links with Health and Social care so we target vulnerable Families	• To work with early help, safeguarding and Health and Social care services so we target vulnerable communities at risk
	1.6 To target anti-social behaviour, violence and domestic abuse in pregnant women and families with babies and infants	• To ensure safeguarding of vulnerable women, babies and families by using a partnership approach to address some of these wider determinants linking with youth services, anti-social behaviour and safeguarding teams
2. To reduce the number of deaths caused by co-sleeping in unsafe situations (see case Review Recs)	2.1 To improve professional advice about co-sleeping in unsafe situations and reduce SIDs	• To develop and implement an individualised safer sleep assessment tool as part of the 6 safer sleep steps programme.
		• To strengthen and clarify the safer sleep messages for parents as well as the criminal consequence should they ignore professionals' advice.
		• To continue with the Train the Trainer Sessions so members of the health/ social care/ education professions receive training.
	2.2 To improve public awareness of infant death	• Public campaign on the risks of co-sleeping in line with the Pan-Lancashire safer sleep guidance including a broader approach to reducing SIDS using social media, marketing and a communications plan as well as the development of a workforce development plan.
		• Training carers and parents in rescue and resuscitation techniques to minimise the severity of outcomes from.

	2.3 To raise awareness of deaths and life limiting injuries sustained through shaking an infant and causing Abusive Head Trauma (AHT)	• To implement the ICON (Abusive head Trauma) Campaign as set out in Hampshire's ICON Campaign with additions from UNICEF BFI and signed off by CDOP: • To consider Phase 2 of the ICON campaign • Links with schools/GPs/Digital Screens and the use of the full length film.
	2.4 To ensure adequate support to affected parents and families	• To support families who have been bereaved and ensure appropriate care of next infant (CONI)
3 To ensure equal access to all aspects of pre-conception, maternal and infant health care	3.1 To ensure engagement with antenatal services and promote the benefits of preconception, antenatal care	• To ensure equal access to midwifery services so that every woman receives the appropriate level of antenatal care, assessment and targeted support where needed
		• To develop an integrated care pathway from birth to ensure consistency and evidence based approach across Lancashire so maternity services are engaged and there are clear pathways and a streamlined approach to maternity and other services such as health visiting and early year's services.
		• To align public health and early years services with the Better Births Programme Action Plan
	3.2 To deliver core offer of Health Visiting mandated services	• To ensure all women are offered the mandated visits as part of the core health visiting offer and an assessment of need is carried out at all visits especially the antenatal and birth visit
	3.3 To focus prevention programmes on families most at risk	• To prioritise the needs of those with social circumstances that expose infants to more risk and promote parental behaviour change, including more vulnerable and at risk women and families such as for teenage mothers
		• Communications and raising awareness with so called hard to reach groups - Consider targeted health promotion messages (e.g. ESOL classes, family and neighbourhood centres, nurseries, schools)
	3.4 To ensure timely and complete immunisations and vaccinations	• To increase access to immunisations and vaccinations for pregnant mothers (pertussis, flu) and babies and children (DTaP/IPV/Hib/ HepB, Pneumococcal conjugate vaccination (PCV), MenB, gastroenteritis Rotavirus
		• To ensure screening tests during pregnancy including for infectious diseases, Sickle cell and thalassaemia, Down's syndrome, Edwards' syndrome and Patau's syndrome, 20-week scan and Newborn screening
	3.4 To provide genetic counselling/genetic literacy for	• To ensure clear pathways for genetic counselling when family history is identified or where families have been affected by genetically inherited conditions

	individuals and communities with a need	• To provide training for midwives and obstetricians to improve knowledge of genetics and consanguinity • To raise community awareness of genetics
4 Improve social and emotional support for vulnerable parents	4.1 To improve social and emotional support for vulnerable parents, especially those living in areas of social disadvantage	• Early identification of women and appropriate pathways in place for vulnerable women including younger (teenage mothers) and vulnerable mothers addressing issues such as domestic violence, antisocial behaviour or abuse in families
		• To ensure fathers/partners are provided with appropriate support where social and emotional support is required
		• To provide an enhanced Health Visiting service to vulnerable women with additional visits as well as the core offer which will identify and support women at risk who need more targeted support
	4.1 To ensure early identification of women with perinatal and post-natal depression through universal mood assessment	• To ensure maternal mood and emotional health and wellbeing issues are assessed through antenatal access and maternal mood assessments by Health visitors, including monitoring of referrals and follow up
5 To reduce the numbers of women (and families) smoking during pregnancy (and after	5.1 To ensure commissioning and delivery of Public Health Harm reduction services include a focus on smoking in pregnancy	• To ensure commissioning and delivery of Public Health Harm reduction and other services recognise the importance of the impact smoking on pregnancy has on infant mortality and stillbirths and to include this as part of specifications
	5.2 To ensure all women are offered CO monitoring at their antenatal appointments	• To ensure all midwives have accessed training to use CO monitors and that all women are CO monitored at booking appointments with support to identify and refer women as necessary
		• To ensure smoking cessation clinics for women attending ante-natal ‘high risk’ obstetric clinics and ongoing improvements to CO monitor use, referral system and CO levels recorded
	5.3 To ensure reducing smoking in pregnancy is a core part of the Children and family centres	• To ensure reducing smoking in pregnancy is part of the core offer for Children/family/neighbourhood centres and have trained advisers and brief intervention training on-going with early year's staff with targeted interventions where there is highest need
	5.4 To use public health intelligence data to identify trends and hot spots	• Need to consider the hot spots for smoking using public health data and intelligence as well as linking into key partnerships such as the ICP
	5.5 To reduce smoking in pregnancy and parents and	• Promote smoke free homes and support staff with the training and skills to have conversations about smoke-free homes, with clear, constructive and supportive

	exposure to tobacco smoke in the home and cars	messages and communications.
6. To reduce the numbers of women with high levels of use of alcohol and/or non-prescribed drugs in pregnancy	6.1 To raise awareness of the risks associated with substance misuse in pregnancy	• To ensure that available alcohol and substance-misuse services are communicated more effectively to health professionals and other relevant agencies
		• To ensure that health professionals are aware of the safeguarding risks associated with drug and alcohol use
		• To raise awareness of Foetal alcohol syndrome and the impact of alcohol on the developing foetus, and how children are affected at different ages
	6.2 To ensure referral pathways are up to date and effective	• To ensure existing pathways target pregnant women who have issues with substance misuse and poor mental health as a result
	6.3 To identify substance misuse in pregnancy	• To ensure all women receive the Audit C screening to identify women and signpost to appropriate services and treatment.
		• To consider specialist Substance Misuse Midwife and champions in centres
		• To ensure social workers understand the vital role in their daily practice - effective working with and parenting affected children
	6.3 To ensure appropriate training and resources	• To ensure basic Awareness through Alcohol and Drug courses and consider on-line e-learning Basic Awareness Course
		• To promote this through Every Contact Count so that we embed alcohol screening, smoking cessation and sexual health awareness
7. To improve the health and nutrition of pregnant women, babies and infants	7.1 To reduce maternal obesity and improve nutrition in pregnancy and before	• To raise awareness of the importance of healthy weight for a healthy pregnancy and work with partners to consider maternal obesity that focuses on prevention and earlier intervention
		• To train more health professionals to confidently identify, provide consistent advice, and refer where required.
	7.2 To ensure obesity pathways in place	• To revisit what pathways we have for obesity and faltering growth and ensure that maternal obesity is treated as a priority and that referrals to appropriate services take place as early as possible (family-planning and booking stages).
		• To ensure links are established between Women and Infants Nutrition and Child Poverty so priority areas are targeted as appropriate
	7.3 To develop and policies and guidelines for maternal and early years nutrition	• To ensure we have a strategy on maternal and Early Years nutrition which is developed with key partners
		• To develop guidelines and training on nutrition for maternal and infant health

		including weaning
		• To consider the development of a model food policy for children's centres to use to quality check their provision of food activity including a Food and nutrition toolkit for early year's settings.
	7.4 Community awareness and training	• Consider nutrition training programme for 2020
		• Healthy Start Programme – increase community awareness and uptake of vitamin D supplements • Development and production of a guide to weaning in appropriately culturally sensitive languages
	7.5 To encourage and support breastfeeding	• To take a collaborative approach to breastfeeding and nutrition, ensuring the benefits of breastfeeding and maternal Body Mass Index (BMI) are understood • To ensure consistent advice provided by all health professionals to ensure women are able to make an informed choice • To explore options for increasing the provision of peer support delivering evidence based care • To increase in the number of GPs accessing breastfeeding training • To consider Breastfeeding Champions being in Children/community Centres • UNICEF Baby Friendly Initiative adopting across the area and increase in the number of Organisations working towards Baby Friendly initiative standards
8. Performance, Data and Intelligence	8.1 To ensure appropriate performance and data intelligence is used to monitor infant mortality.	• To ensure work is systematically being undertaken and monitored to reduce local area infant mortality rates. • To improve the focus and understanding of infant mortality rates in the local area • To measure inequalities and progress in areas of greatest need • To ensure relevant performance data is available in the areas identified so we can monitor progress
		• To work closely with CDOP to inform planning and monitoring of infant mortality • To ensure this clear governance and accountability through the CYP and families partnership board, health and wellbeing board and ICS where appropriate
	8.2 To develop a dashboard for infant mortality	• To develop a dashboard as part of the Early Years strategy with a key focus on infant mortality so this can be monitored and benchmarked according to national and regional targets.

9	**Communication plan**	To ensure these plans are shared widely and understood by communities, professionals across Lancashire	▪ To ensure communities are better informed ▪ To develop a website (review what we have) ▪ To ensure Infant mortality is embedded within midwifery, health visiting and early years through development and dissemination of an integrated care pathway. ▪ To ensure consultation and engagement with communities via CCG maternity service user groups ▪ To use social media to raise awareness of modifiable factors mentioned above

APPENDIX 3: OUTCOMES AND PERFROMANCE FRAMEWORK (Example – to be agreed)		
Priority 1: Best Start in Life		
Objective	**Performance Measure**	**Indicator ref**
1.1 Reduce Infant mortality	1.1.1 Rate of infant mortality	
1.2 Reduce Low birth weight of term babies 37 weeks	1.2.1 Low birth weight of term babies 37 weeks gestational age at birth	2.01
1.2 Increase breastfeeding rates	1.2.1. Breastfeeding initiation All ages	2.02i
	1.2.2 Breastfeeding prevalence at 6-8 weeks after birth - current method	2.02ii
1.3 Reduce smoking status at time of delivery	1.3.1 Smoking status at time of delivery All ages	2.03
1.5 Reduce under 18s conception rate	1.5.1 Under 18s conception rate / 1,000 <18 yrs.	2.04
	1.5.2 Under 16s conception rate / 1,000 <16 yrs.	2.04

Ruksana Sardar-Akram
9th January 2020

Appendix C: Infant Mortality Action Plan

Infant Mortality Action Plan v3 (5 February 2020)

Priority 1: Addressing the wider determinants to health			
Objective	**Action Plan**	**Lead**	**Partners**
1.1 To support efforts to reduce poverty in families	• To ensure we raise awareness of the links between child poverty and infant mortality targeting services in areas of greatest need based on Public Health intelligence data on deprivation and infant mortality	Public Health Specialist, Wider Determinants Team	Public Health Housing services Benefits Employment Service Police Domestic abuse service Children and Families Wellbeing Service (CFWS)
1.2 To tackle child poverty as a priority	• To consider the development of a child poverty strategy and action plan/embed the importance of this as a priority across everything we do so we see a difference in areas of greatest need.		
1.3 To improve the availability of good quality and affordable housing	• To ensure the needs of pregnant mothers, babies and children are prioritised so we address inequality in housing through improved living conditions and assessment of need and risk of overcrowding		
1.4 Take ensure take up of benefits in most deprived areas	• To support and advise individuals and communities at risk who are eligible for welfare benefits and support with their family and child's needs		
1.5 To establish links with Health and Social care so we target vulnerable Families	• To explore how Housing Associations could partner with health improvement initiatives, Early help, Health and Social and Children and family wellbeing service (CFW) to target vulnerable tenants and offer appropriate support and referrals.		
1.6 To reduce anti-social behaviour, violence and domestic abuse in pregnant women and families with babies and infants	• To ensure safeguarding of vulnerable women, babies and families by using a partnership approach to address some of these wider determinants linking with youth services, anti-social behaviour and safeguarding teams		
1.7 To support economic development and establish links between housing and vulnerable children and young people	• To link in with the economic development and LEP team, including school improvement and supported accommodation for Children and young people • To consider how current commissioning capacity in the education and children's team which is on care leavers and the homelessness protocol can take forward this wider housing agenda. • Consider how some Districts might support embedding Housing Officers within Family Safeguarding Teams in order to improve support for most vulnerable families with children	HoS Policy, Information, and Commissioning, Start Well	

Priority 2: To reduce the number of deaths caused by co-sleeping in unsafe situations (see Serious Case Review recommendations)			
2.1 To improve professional advice about co-sleeping in unsafe situations and reduce infant deaths	• To develop and implement an individualised safer sleep assessment tool as part of the 6 safer sleep steps programme.	Sudden Unexplained Death in Childhood (SUDC) Prevention Group	CDOP Public Health Health Visiting Early years Children Family Service (CFW)
	• To strengthen and clarify the safer sleep messages for parents as well as the criminal consequence should they ignore professionals' advice.		
	• To continue with the Train the Trainer Sessions so members of the health/ social care/ education professions receive training.		
	• To audit the extent to which safer sleep messages are being advocated by health professionals and others		
2.2 To improve public awareness of infant death	• Public campaign on the risks of co-sleeping in line with the Pan-Lancashire safer sleep guidance including a broader approach to reducing infant deaths using social media, marketing and a communications plan as well as the development of a workforce development plan.		
	• Training carers and parents in rescue and resuscitation techniques to minimise the severity of outcomes from.		
2.3 To raise awareness of deaths and life limiting injuries sustained through shaking an infant and causing Abusive Head Trauma (AHT)	• To implement the ICON (Abusive head Trauma) Campaign as set out in Hampshire's ICON Campaign with additions from UNICEF BFI and signed off by CDOP: o To consider Phase 2 of the ICON campaign o Links with schools/GPs/Digital Screens and the use of the full length film. o Integrate Safer sleep messages into the programme		
2.4 To ensure adequate support to affected parents and families	• To support families who have been bereaved and ensure appropriate care of next infant (CONI)		
2.5 To reduce the number of deaths and life limiting injuries sustained through shaking an infant and causing AHT.	• Following the Terms of Reference as set out in Hampshire's ICON Campaign with additions from UNICEF BFI and signed off by CDOP: o Awareness to be raised re negative impact of shaking a baby following an SCR recommendation o Continuation of the Train the Trainer Sessions so that members of the health/ social care/ education professions receive training. o Agreed use of materials and tools. • Phase 2 of the ICON campaign to be considered. Links with schools/GPs/Digital Screens and the use of the full length film.	SUDC Prevention Group	CDOP Public Health Health Visiting Early years Midwifery

Priority 3: To ensure equal access to all aspects of pre-conception, maternal and infant health care			
3.1 To ensure engagement with **antenatal services** and promote the benefits of **preconception, antenatal** care	• To ensure equal access to midwifery services so that every woman receives the appropriate level of antenatal care, assessment and targeted support where needed	Better Births Workstream ICS	
	• To develop an integrated care pathway from birth to ensure consistency and evidence based approach across Lancashire so maternity services are engaged and there are clear pathways and a streamlined approach to maternity and other services such as health visiting and early year's services.		
	• To align public health and early years services with the Better Births Programme Action Plan		
3.2 To deliver core offer of Health Visiting **mandated services**	• To ensure all women are offered the mandated visits as part of the core health visiting offer and an assessment of need is carried out at all visits especially the antenatal and birth visit	Senior Public Health Practitioner, Health Services, Health Visiting	Health Visiting CFWS
3.3 To focus prevention programmes on families most at risk	• To prioritise the needs of those with social circumstances that expose infants to more risk and promote parental behaviour change, including more vulnerable and at risk women and families such as for teenage mothers	TBC	
	• Communications and raising awareness with so called hard to reach groups - Consider targeted health promotion messages (e.g. ESOL classes, family and neighbourhood centres, nurseries, schools)	TBC	
3.4 To ensure timely and complete **immunisations and vaccinations**	• To increase access to immunisations and vaccinations for pregnant mothers (pertussis, flu) and babies and children (DTaP/IPV/Hib/ HepB, Pneumococcal conjugate vaccination (PCV), MenB, gastroenteritis Rotavirus	NHS England Senior Public Health Practitioner, Assurance	NHS England Health Visiting CCGs Midwifery
	• To ensure screening tests during pregnancy including for infectious diseases, Sickle cell and thalassaemia, Down's syndrome, Edwards' syndrome and Patau's syndrome, 20-week scan and Newborn screening		
3.5 To provide **genetic counselling/genetic literacy** for individuals and communities with a need	• To ensure clear pathways for genetic counselling when family history is identified or where families have been affected by genetically inherited conditions	Genetics Service TBC	CDOP Health Visiting Midwifery
	• To provide training for midwives and obstetricians to improve knowledge of genetics and consanguinity		
	• To raise awareness of genetics and pathways available in community and neighbourhood centres.		

Priority 4: Improve social and emotional support for parents and families			
4.1 To improve social and emotional support for vulnerable parents, especially those living in areas of social disadvantage	• Early identification of women and appropriate pathways in place for vulnerable women including younger (teenage mothers) and vulnerable mothers addressing issues such as domestic violence, antisocial behaviour or abuse in families • To establish links with family safeguarding as Adult mental health practitioners will be embedded in the family safeguarding teams		Better Births CCGs Early Help HV Service Public Health Social care Midwifery
	• To ensure fathers and partners are provided with appropriate support where social and emotional support is required, including group and one to one family support via the Children Family Worker (CFW)		
	• To provide an enhanced Health Visiting service to vulnerable families with additional visits as well as the core offer which will identify and support families at risk who need more targeted support	Senior Public Health Practitioner, Health Services, Health Visiting	
4.2 To ensure early identification of women with perinatal and post-natal depression through universal mood assessment	• To ensure **maternal mood** and emotional health and wellbeing issues are assessed as soon as possible and as appropriate through antenatal/perinatal/postnatal access and maternal mood assessments	Midwifery Health Visiting	
Priority 5: To reduce the numbers of women (and families) smoking during pregnancy and after			
5.1 To ensure commissioning and delivery of Public Health Harm reduction services include a focus on smoking in pregnancy	• To ensure commissioning and delivery of Public Health Harm reduction and other services recognise the importance of the impact smoking in pregnancy has on infant mortality and stillbirths and to include this as part of service specifications	Public Health Specialist, Behaviour Change	Better Births Prevention Group CCGs Early Help HV Service Public Health Social Care
5.2 To ensure all women are offered CO monitoring at their antenatal appointments	• To ensure all midwives have accessed training to use CO monitors and that all pregnant women are CO monitored at booking appointments with support to identify and refer women as necessary	Better Births / Prevention work-streams, ICS	
	• To ensure smoking cessation clinics for pregnant women attending ante-natal 'high risk' obstetric clinics according to NICE guidance and saving babies Lives (including ongoing improvements to CO monitor use, referral system and CO levels recorded)		
5.3 To ensure reducing smoking in pregnancy is a core part of the Children and family centres	• To ensure reducing smoking in pregnancy is part of the core offer for Children/family/neighbourhood centres and have trained advisers and brief intervention training on-going with early year's staff with targeted interventions where there is highest need		

5.4 To use public health intelligence data to identify trends and hot spots	• To consider the hot spots for smoking using public health data and intelligence as well as linking into key partnerships such as the ICP and CCG Networks		
5.5 To reduce smoking in pregnancy and parents and exposure to tobacco smoke in the home and cars	• To promote smoke free homes and support staff with the training and skills to have conversations about smoke-free homes, with clear, constructive and supportive messages and communications		
5.6 To increase the quit rate at time of delivery	• To increase the quit smoking rate to decrease the smoking at time of delivery rate, with emphasis on areas identified with highest rates		
Priority 6: To reduce the numbers of women with high levels of use of alcohol and/or non-prescribed drugs in pregnancy			
6.1 To raise awareness of the risks associated with substance misuse in pregnancy for all pregnant women	• To ensure that available alcohol and substance-misuse services are communicated more effectively to health professionals and other relevant agencies	Better Births Workstream ICS, including Health Visiting	Better Births Prevention CCGs Early Help HV Service Public Health Social Care Midwifery Services CFW Service
	• To ensure that health professionals are aware of the safeguarding risks associated with drug and alcohol use		
	• To raise awareness of Foetal alcohol syndrome and the impact alcohol has on the developing foetus, and how children are affected at different ages		
6.2 To ensure referral pathways are up to date and effective	• To ensure existing pathways target pregnant women who have issues with substance misuse and poor mental health as a result	CCGs Midwifery CFWS	
6.3 To identify substance misuse in pregnancy	• To ensure all pregnant women receive the Audit C screening to identify women and signpost to appropriate services and treatment.		
	• To consider specialist Substance Misuse Midwife and champions in centres		
	• To ensure social workers understand the vital role in their daily practice - effective working with and parenting affected children		
6.4 To ensure appropriate training and resources for professionals and families	• To ensure basic Awareness through Alcohol and Drug courses and consider on-line e-learning Basic Awareness Courses		
	• To promote this through Every Contact Count so that we embed alcohol screening, smoking cessation and sexual health awareness		
Priority 7: To improve the health and nutrition of pregnant women, babies and infants			
7.1 To reduce maternal obesity and improve nutrition in pregnancy and before	• To raise awareness of the importance of healthy weight for a healthy pregnancy and work with partners to consider maternal obesity that focuses on prevention and earlier intervention	Better Births workstream, ICS	
	• To train more health professionals to confidently identify, provide consistent advice, and refer where required.		

7.2 To ensure obesity pathways in place	• To revisit what pathways we have for obesity and faltering growth and ensure that maternal obesity is treated as a priority and that referrals to appropriate services take place as early as possible (family-planning and booking stages). • Planning a pregnancy will be a focus work-stream from April 2020 as will data collection. • To create a central website for Better Births for all of the ICS by April 2020. The website will contain sections for all stages of the pregnancy journey and will provide information for breastfeeding, bottle feeding and starting solids as well as signposting to appropriate resources. Maternal nutrition and eating well in preparation for pregnancy will be included, but at a later date.		
	• To ensure links are established between Women and Infants Nutrition and use a family approach and share messages of how mum's eating habits can influence babies/children's) and use of person centred approach to incorporate poverty (where applicable) so priority areas are targeted as appropriate.		
7.3 To develop and policies and guidelines for maternal and early years nutrition	• To ensure we have a strategy on maternal and Early Years nutrition which is developed with key partners. Sub-group will be identified by February 2020 and arrange a first meeting.	Better Births workstream ICS, Public Health Practitioner, Health Services, Infant Feeding Network (LSC IFN)	Better Births Prevention CCGs Early Help HV Service Public Health Social Care Midwifery Services CFWS
	• To develop guidelines and training on nutrition for maternal and infant health including weaning including provision of 2 day infant feeding and relationship training course which adheres to BFI standards offered to all health professionals and community workers in contact with families including maternity, HV, CFWB and peer support infant feeding service. It is continually reviewed as they widen the scope of it to be inclusive for dieticians, school nurses and others		
	• To consider the development of a model food policy for children's centres to use to quality check their provision of food activity including a Food and nutrition toolkit for early year's settings.		
7.4 Community awareness and training	• Consider nutrition training programme for 2020 – such as Institute of Health Visiting who have already done quite a significant piece of work around training – train the trainer packages		
	• To deliver on evidence based programmes such as Healthy Start Programme, Start for Life, First Steps in order to increase community awareness and uptake of vitamin D supplements		

	• Development and production of a guide to weaning in appropriately culturally sensitive languages	Senior Public Health specialist, Health Services Public Health Specialist, Health Services CFWS Better Births workstream, ICS	
	• Healthy Start Programme – increase community awareness and uptake of vitamin D supplements and vitamins/supplements while pregnant (folic acid and vitamin D).		
	• Review provision of antenatal courses as part of early years strategy for example Bump Birth and Beyond antenatal courses		
7.5 To encourage and support breastfeeding	• To ensure infant feeding for the first year of life including a unified infant feeding policy and supporting guidelines have been created for use across the ICS footprint for all acute and community services • To ensure all women and their families receive standardised care and a seamless transfer of care across services across the footprint.		
	• To take a collaborative approach to breastfeeding and nutrition, ensuring the benefits of breastfeeding and maternal Body Mass Index (BMI) are understood		
	• To ensure consistent advice provided by all health professionals to ensure women are able to make an informed choice		
	• To explore options for increasing the provision of peer support delivering evidence based care		
	• To increase in the number of GPs accessing breastfeeding training		
	• To consider Breastfeeding Champions being in Community and neighbourhood centres via the CFWs • Peer support services delivering evidence based care and adhering to baby friendly standards. • Increase in the number of GPs accessing breastfeeding training • Breastfeeding Champions being developed in Neighbourhood Centres		
	• To consider the UNICEF Baby Friendly Initiative across the area and increase in the number of Organisations working towards Baby Friendly initiative standards • Every pregnant woman, new mother, infant and their family in Lancashire and South Cumbria is cared for by maternity, health visiting, neonatal and neighbourhood centre services are BFI accredited by 2023. • Lancashire community services are due their GOLD BF assessment end March 2020.		
7.6 To consider physical activity as part of tackling obesity	• Consider physical activity as an appropriate way to help with maternity outcomes and the input from PHE, and the appointment of a midwife to help with this agenda		

Priority 8: Performance, Data and Intelligence			
8.1 To ensure appropriate performance and data intelligence is used to monitor infant mortality.	• To ensure work is systematically being undertaken and monitored to reduce local area infant mortality rates.	Public Health with support from Public Health Intelligence Team	
	• To measure inequalities and progress in areas of greatest need		
	• To ensure relevant performance data is available in the areas identified so we can monitor progress		
	• To work closely with CDOP to inform planning and monitoring of infant mortality		
8.2 To ensure appropriate reporting on infant mortality in areas identified with highest rates	• To ensure clear governance and accountability through the CYP and Families Partnership board, health and wellbeing board and ICS where appropriate for monitoring outcomes and performance	Performance Team	
8.2 To develop a dashboard for infant mortality	• To develop a dashboard as part of the Early Years strategy with a key focus on infant mortality so this can be monitored and benchmarked according to national and regional targets.	Public Health Specialist, Assurance	
Priority 9: Communication and Workforce Development			
9 To ensure these plans are shared widely and understood by communities, professionals across Lancashire	▪ To review current website and update with areas identified within the infant mortality plan	LCC Comms Team And Teams from all service areas	All NHS/LCC Communications Teams
	▪ To use social media to raise awareness of modifiable factors mentioned above and produce appropriate community resources		
	▪ To ensure consultation and engagement with communities via CCG maternity service user groups		
	▪ To ensure communities are better informed		
Priority 10: Workforce development			
10.1 To ensure that the wider workforce is knowledgeable and confident to provide and promote reduction in infant mortality and disseminate information.	• To ensure infant mortality is included in all CYP service workforce development plans • To ensure we have a skilled and trained wide CYP workforce • That infant mortality is a mandated training expectation of midwifery, health visiting, social care, GP, obstetrician, paediatric, smoking cessation, mental health services, substance misuse and CYP early help services • CDOP development of e-learning package • Learning, evaluation and improvements from serious case reviews, CDOP and serious case reviews embedded within provider and commissioning functions.		

	• Risk assessment tool, identification of modifiable factors and checking the sleeping environment to be universally undertaken by midwifery and HV services, trained as necessary.		

Ruksana Sardar-Akram
5th February 2020
Version 3

Children's Services Scrutiny Committee
Meeting to be held on Tuesday, 24 March 2020

Electoral Division affected:
(All Divisions);

Work Programme 2019/20
(Appendix 'A' refers)

Contact for further information:
Samantha Parker, Tel: (01772) 538221, Senior Democratic Services Officer,
sam.parker@lancashire.gov.uk

Executive Summary

The work programme for the Children's Services Scrutiny Committee is attached at Appendix 'A'.

The topics included were identified at the work planning workshop held on 25 July 2019.

Recommendation

The Children's Services Scrutiny Committee is asked to:

i. Note and comment on the report and work programme;
ii. Discuss and confirm topics for the next meeting and reasons for scrutiny.

Background and Advice

A statement of the work to be undertaken and considered by the Children's Services Scrutiny Committee for the 2019/20 municipal year is set out at Appendix 'A'.

The work programme will be presented to each meeting for consideration and includes topics to be discussed at committee meetings, events, task groups, rapporteur work, briefing notes and training for members.

Members are requested to note and comment on the report and to discuss and confirm topics for the next meeting and reasons for scrutiny.

Consultations

NA

Lancashire County Council

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel

NA

Reason for inclusion in Part II, if appropriate

NA

Children's Services Scrutiny Committee Work Programme 2019/20

The Children's Services Scrutiny Committee Work Programme details the planned activity to be undertaken over the forthcoming municipal year through scheduled Committee meetings, task group, events and through use of the 'rapporteur' model.

The items on the work programme are determined by the Committee following the work programming session at the start of the municipal year in line with the Overview and Scrutiny Committees terms of reference detailed in the County Councils Constitution. This includes provision for the rights of County Councillors to ask for any matter to be considered by the Committee or to call-in decisions.

Coordination of the work programme activity is undertaken by the Chair and Deputy Chair of all of the Scrutiny Committees to avoid potential duplication.

In addition to the terms of reference outlined in the Constitution (Part 2 Article 5) for all Overview and Scrutiny Committees, the Children's Services Scrutiny Committee will:

- Scrutinise matters relating to services for Children and Young People delivered by the authority and other relevant partners
- Review and scrutinise any matter relating to the planning, provision and operation of the health service in the area and make reports and recommendations to NHS bodies as appropriate
- Invite interested parties when reviewing any matter relating to the planning, provision and operation of the health service in the area, to comment on the matter and take account of relevant information available, particularly that provided by the Local Healthwatch
- Review and scrutinise any local services planned or provided by other agencies which contribute towards the health improvement and the reduction of health inequalities in Lancashire and to make recommendations to those agencies, as appropriate
- Take steps to reach agreement with NHS body, in the case of contested NHS proposals for substantial service changes
- Refer a matter to the relevant Secretary of State in the case of contested NHS proposals for substantial service changes where agreement cannot be reached with the NHS
- Refer to the relevant Secretary of State any NHS proposal which the Committee feels has been the subject of inadequate consultation

Lancashire County Council

- Scrutinise the social care services provided or commissioned by NHS bodies exercising local authority functions under Section 31 of the Health Act 1999
- Draw up a forward programme of health scrutiny in consultation with other local authorities, NHS partners, the Local Healthwatch and other key stakeholders
- Acknowledge within 20 working days to referrals on relevant matters from the Local Healthwatch or Local Healthwatch contractor, and to keep the referrer informed of any action taken in relation to the matter
- Require the Chief Executives of local NHS bodies to attend before the Committee to answer questions, and to invite the chairs and non-executive directors of local NHS bodies to appear before the Committee to give evidence
- Invite any officer of any NHS body to attend before the Committee to answer questions or give evidence

The Work Programme will be submitted to and agreed by the Scrutiny Committees at each meeting and will be published with each agenda.

The dates are indicative of when the Children's Services Scrutiny Committee will review the item, however they may need to be rescheduled and new items added as required.

Topic	Purpose	Lead Officers/ Organisation	Proposed Date(s)	Recommendations	Progress
Committee Meetings					
Lancashire SEND Partnership Improvement Plan	Progress update on the Improvement Programme and Plan as requested at the meeting of the committee on 13 May 2019	Sally Richardson Samantha Jones (LPCF) Hilary Fordham (Health) Ajay Sethi	3 July 2019	An update to be provided on the speech and language services, the progress of actions delayed and progress of the 12 areas set out in the WSoA	To be reported to Education Scrutiny Committee at 29 Oct 2019 meeting
Children and Families Partnership Arrangements	Progress update on the review of current partnership arrangements	Dave Carr Rob Dobson (Burnley BC)	3 July 2019	Noted	NA
Youth Offending Team (YOT)	Inspection outcomes and action plan	Head of Fostering, Adoption, Residential and YOT	9 Oct 2019	A briefing note be provided to committee members in March 2020 on the post inspection action plan progress.	Added to work programme

Participation Strategy	Enhancing participation practice – new draft strategic framework	Strategy Lead for Participation Youth Council representative Head of Policy, Information and Commissioning (Start Well)	9 Oct 2019	Details of the network of participation champions when identified be circulated to all councillors to assist with supporting a 'culture of participation'. A progress report be provided to a future meeting of the committee. Information on the questionnaire to schools be circulated to committee members to support generating responses.	Awaiting details Added to WP Circulated to members 6/3/2020
Child Poverty	Holiday hunger and food banks Poverty and knife crime Impact of Universal Credit Housing and housing conditions	Director of Children's Social Care Partners TBC Business Intelligence	15 Jan 2020	A briefing note on Holiday Hunger and Food Banks be circulated to the Children's Services Scrutiny Committee.	Circulated to members 17/3/19
Permanence	Overview of Permanence and the new Permanence plan	Director of Children's Social Care Head of Children's Social Care	15 Jan 2020	The evidence of improvements included in the 'Getting to Good Plan' be presented to the committee in six months' time	To be added to new WP

Neglect Strategy	Update on implementation of strategy and partnership working	Director of Children's Social Care	15 Jan 2020	A request be made to Education Scrutiny Committee to include the Neglect Strategy as part of any discussions around Elective Home Education.	Included on ESC work programme

CAMHS	Update on progress of service redesign programme for Lancashire and South Cumbria	Sally Nightingale Head of Policy, Information and Commissioning (Start Well)	26 Feb 2020	A further review of the Clinical Model and Transition & Implementation Plan be provided at the end of the year. Consideration be given by the Cabinet Member for Children, Young People and Schools to: A review of the current county council prevention/early intervention services with a view to supporting more effective, collaborative working with partner agencies. A review of the support currently provided across county council services to high risk children and young people, to support the identification of a package of care working with partner agencies, with a view to reducing potential duplication of services and ensuring more effective investment of funding.	To be added to new WP Request sent for a response from the Cabinet Member

Children's Health	Update on current data/trends on children's health	Head of Health, Equity, Welfare and Partnerships Interim Public Health Consultant	24 March 2020		
Area Safeguarding Arrangements	Future focus and plans	Director of Children's Social Care	23 Apr 2020		
Adoption Service	Review of new Regional Adoption Agency – update on implementation plan for new Pan Lancashire arrangements	Head of Fostering, Adoption, Residential and YOT	23 Apr 2020		
Looked After Children	Update on Independent Reviewing Officer (IRO) service annual report priority to improve the quality of IRO challenge in respect of quality of care plans and drift and delay with a focus on improving outcomes for the child. Ensuring that challenge is evident and effective	Head of Safeguarding, Inspection and Audit	23 Apr 2020		
Participation Strategy	Update on progress of the strategy implementation	Strategy Lead for Participation Head of Policy, Information and Commissioning (Start Well)	TBC		
0-19 Healthy Child Programme	Virgin Care contract review of service provision	Health	TBC		

Briefing Notes					
Road Safety	Update on Lancashire road safety data following release of national data	TBC			
Domestic Abuse	Update following conclusion of the cabinet working group	TBC			
Suicide Prevention	Data update at district level and bereavement support work undertaken. Links to child poverty, safeguarding and social media for school age children	Head of Health, Equity, Welfare and Partnerships			
Independent Visitors	Update on recruitment and strategy to increase diversity	TBC			
YOT	Action plan progress post inspection	Barbara Bath	April 2020		
Child Poverty	Information on holiday hunger and food banks – where is provision – what are districts doing?	Scrutiny Officer	March 2020		
Proposed Information Sessions (BSB's)					
Inspection outcomes	Inspection outcomes across children's services	Director of Children's Social Care	TBC		
Reports for Review					
LSCB Annual Report					

IRO Annual Report					
LGO Annual Complaints Review					
Lancashire Getting to Good Plan					

Potential topics:

- Road safety
- Independent children's homes
- Peer review outcomes
- Family Safeguarding Model – end 2020/early 2021
- Child poverty – money management and support from agencies
- Getting to Good plan update – Sept 2020
- CAMHS Implementation Plan – end 2020

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