WIRRAL CHILDREN'S TRUST BOARD

AGENDA

Tuesday, 20 May 2014 commencing at 9.00 am

Professional Excellence Centre, Acre Lane, Bromborough

1. 09:00 APOLOGIES AND INTRODUCTIONS
2. 09:00 DECLARATIONS OF INTEREST
3. 09:05 MINUTES OF THE LAST MEETING (Pages 1 - 6)
4. 09:10 TRANSFORMING FAMILY SUPPORT (POWERPOINT PRESENTATION)
5. 09.30 CHILD POVERTY UPDATE Q4 (Pages 7 - 8)
6. 09.45 SAFEGUARDING BOARD - UPDATE Q4 (Pages 9 - 12)
7. 10.00 FOUNDATION YEARS TRUST BUSINESS CASE (Pages 13 - 44)

10:15 BREAK

8. 10:30 TEENAGE PREGNANCY STRATEGY GROUP REVIEW (Pages 45 - 50)
9. 10:45 STARTING WELL IN WIRRAL: A JOINT COMMISSIONING STRATEGY (Pages 51 - 98)
10. 11.00 COMMISSIONING STRATEGY UPDATE (Pages 99 - 104)
11. 11.15 CHILDREN'S INTEGRATION WORKSTREAM (VISION 2018) (Pages 105 - 106)
12. 11.30 ANNUAL REVIEW OF CYPP (Pages 107 - 128)
13. 11.45 PERFORMANCE REPORT Q4 (Pages 129 - 132)
14. 11:55 ANY OTHER BUSINESS

Date and time of next meeting:

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WIRRAL CHILDREN'S TRUST BOARD

MINUTES

Minutes of the meeting held on Tuesday, 18 March 2014

Present:
Councillor T Smith (Chair), Councillor W Clements, J Hassall,
P Sheridan, S Dainty, K Podmore, G Price, M Kilcoyne, B Morgan, K Coxhead,
V Harrison, L. Loughran, I. Batman, B. Walker, J. Graham, R. Longster.

In Attendance:
N Clarkson, S. Blevins, C. Druker and Peer Educators, K. Lloyd, T. Woodhouse.

1.0 INTRODUCTIONS and APOLOGIES
Cllr Smith welcomed the members and noted apologies had been received from Cllr C Meaden, J. Webster. D. Gornik, J. Martin, L. Davidson, T. Little.

J. Hassall informed members that due to service reviews currently being undertaken has resulted in members of staff not being able to attend to present reports as originally arranged. These service reviews are a priority across all directorates and will identify savings but the exercise will also need to ensure services are delivered in line with the Corporate Plan and the vision of the future council.

Cllr Smith also took the opportunity to introduce and welcome Bernard Walker, Chair of WSCB.

2.0 DECLARATIONS OF INTEREST
There were no declarations of interest registered.

3.0 MINUTES OF THE LAST MEETING (21 January 2014) and ACTIONS ARISING
The minutes of the last meeting were confirmed as an accurate record of the meeting.

Action no. 5 (21 January 2014 Board meeting)
All members to submit details of OD link person to T. Woodhouse **(outstanding)**

Action no. 8 (21 January 2014)
IFIP update (to include case studies) to be submitted to the July Board)

Action no. 6 (19 November Board meeting).
D. Gornik and K. Coxhead to submit a report on parenting courses (to include funding sources) to the March Board **(on the agenda for this meeting).**

Action no. 11 (19 November Board meeting).
D. Gornik to submit an update on Targeted Services to a future Board meeting **(on the agenda for this meeting).**

All other actions had been completed.

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4.0 CHILDREN'S WORKFORCE DEVELOPMENT STRATEGY

The Board received a presentation and report on the Children's workforce strategy from Sue Blevins which outlined the progress towards delivering the 3-year strategy and the development of a 1-year action plan which focuses on the key deliverables for the groups over the next 12 months and progress to date.

The presentation covered the launch of the learning and development event which is planned for 9 May in Acre Lane. This event would be held in conjunction with members of the Children's Trust, and Wirral Safeguarding Children Board (WSCB) and Safeguarding Adults Partnership Board (SAPB).

S. Blevins went on to outline the aims and objectives of the briefing session being for managers to:

- understand their role in the value of learning and development in improved outcomes for individuals in the community
- realise the full potential of the SAPB/WSCB and CT workforce development strategies.
- embed learning and development outcomes in the workplace
- support staff in their own development
- assess competency of staff and risks associated with staff not being fully equipped to undertake their job role.

Also to:

- launch the competency framework and training needs analysis.

Cllr Smith urged all members to convey this important message to managers and staff as it is in times of change that skills and knowledge can be lost and therefore makes learning and development all the more important.

P. Sheridan enquired who would be the target audience in schools with regard to this event. He was advised that it would be aimed at head teachers/safeguarding leads or whoever was responsible for the children's workforce. Attendance at the event would also contribute to continued professional development.

S. Blevins went on to describe the e-learning tool which would also be made available if it was found that competency was lacking in some areas. This web based tool is widely used and best practice from other authorities can be shared and used as appropriate. It was also advised that this training would enhance the existing designated teacher programme.

Cllr Smith suggested that this topic would be an appropriate yearly agenda item at each school governors' meeting.

It was resolved that:
The Board endorsed the report and approved the recommendations.

5.0 TARGETED SERVICES DEVELOPMENT: Update

J. Hassall took the opportunity to remind the members of the national position and the current position in Wirral with regard to the demands on Children's Services. Nationally the 'pyramid' of services shows the largest number of children accessing universal services, with the next level being access to targeted services and the top layer covers the specialist vulnerable statemented group. However, in Wirral we have a higher number of children in the specialist areas including 20% more statemented children than the national average and high numbers of Looked After Children.

On the appointment of the Head of Targeted Services a review of the service had taken place against a backdrop of budgetary cuts. A multi-agency prevention group has been proposed which reports to the Children's Trust. A multi-agency task and finish event has also been arranged for 1 May. The Chief Executive of Wirral Council will open this event and Cllr Tony Smith and other senior partners will also be in attendance. The aim of the event is for all partners to sign up to a pledge endorsing the approach and for members to work together to manage demand. The outcome for children and their families is for them to lead fulfilling lives, to live in local communities and to have support. This will hopefully enable families to stay together and help to meet the regional strategy which was launched in April last year. It will also be used as the basis for developing and shaping the local strategy which is currently in development. It is also planned to work with the localities following the event in May.

Cllr Smith thanked J. Hassall for the update and encouraged all to engage with the important Early Help event on 1 May 2014.

It was resolved that:
The Board agreed to ensure partner organisations engagement in the event.

6.0 WIRRAL BOROUGH PARENTING REPORT – UPDATE

Kath Lloyd updated the members by advising that in the wake of the review of targeted services a number of areas of work have been brought together in order to develop a more integrated service designed on community need. The key is supporting families and not individual children and to co-ordinate the approach of professionals.

Work is underway to map the parenting service. A multi-agency group has met to refresh the Parenting Strategy and a draft will be submitted to the Board at a future meeting. The Parenting Steering Group is being reviewed to ensure appropriate membership.

A training gap around evidence based programmes has been identified and an offer of help from I. Batman was registered.

Cllr Smith thanked K. Lloyd for the update.

It was resolved that:
A draft report on the new strategy would be submitted to a future board.

.7.0 WHAT HAPPENS NEXT: PEER EDUCATORS TO PRESENT WORK ON SUBSTANCE MISUSE.

Peer Educators from Wirral Youth Theatre performed a short play highlighting the messages given to school children on the dangers of alcohol and substance misuse. This play is part of a programme performed in schools to highlight the dangers. The play is part of a series of workshops and has proved very effective in engaging with and relaying important messages to children and young people.

Gary Price noted the importance of this type of work as a peer approach is very effective with young people. He offered the opportunity for members of the Response project group to contact the staff at A&E with regard to the message in the play about the potential of being admitted to A&E due to excess alcohol consumption.

Cllr Smith on behalf of the Board thanked the performers and hoped that they continued with their excellent work.

8.0 YOUTH PARTICIPATION FRAMEWORK

The Board received the report on Wirral Young People's Engagement and Participation Framework 2014. It outlined the current situation to enable children and young people's engagement and participation and introduces a draft framework for the future facilitation of the agenda.

The development of the framework provides a strategic approach to drive future engagement and participation activities. It will enable Wirral to develop a strong multi-agency leadership and vision and to put children and young people at the heart of services.

The framework proposes that the following structures be established

- Youth Voice Group
- Youth Engagement Reference Group
- Youth Engagement Strategic Champions

Cllr Smith extended his thanks and gratitude for the work being undertaken and of the work with the young people of Wirral and also their involvement in the Youth Zone project.

Cllr Clements asked how the young people of Wirral could engage with the Youth Zone and it was advised that schools/school assemblies will be targeted. L. Loughran also suggested a link with Wirral Multicultural Organisation Youth.

Cllr Smith thanked C. Druker for the update.

It was resolved that: the Board endorse the recommendations.

9.0 WIRRAL CHILDREN'S TRUST STRUCTURE REVIEW

The Board received the report on the operation and structure of the Children's Trust following the recent review.

N. Clarkson advised that the review takes place on an annual basis and in line with the review of the Children & Young People's Plan. She further advised that one of the key drivers for the review has been the significant changes in the structure and function of public sector organisations, the reduction in funding, fewer staff and also to ensure that the Children's Trust remains relevant and fit for purpose. To carry out the review discussions had been held with all key stakeholders via their strategy and sub groups. Discussions had also been held in relation to enhanced joint working between the WSCB and the Children's Trust following the recommendations from the joint event held in 2013.

It was resolved that the Board endorsed the recommendations as set out in the report.

10. BEING HEALTHY ANNUAL REPORT

The Board received the report of the Being Healthy Strategy Group. This report advised that the National Healthy Child Programme sets out the recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing. Key achievements relating to the Being Healthy priorities for 2013/14 were highlighted.

The group's attention was drawn to the key issues for 2014/15, the challenges ahead and the risks to outcome and delivery. The report also highlighted areas requiring further partnership working and areas for reporting focus.

In summary it was reported that across the Being Healthy spectrum good progress had been made in delivering the Being Healthy element of the Children & Young People's Plan and in meeting some of the relevant national indicators relating to this outcome area.

In questions from the floor it was reported that the campaign on safe sleeping was developed in response to the recent data audit which identified Wirral as having a higher than average number of infant deaths. To date, the single most modifiable factor amongst infant deaths is that of co-sleeping. Awareness raising materials have been developed locally, a conference for frontline health and social care professionals was recently held and a series of shared learning events and campaigns are planned for the coming financial year.

Cllr Smith thanked J. Graham for her comprehensive report.

It was resolved that the Board noted the report.

11. PERFORMANCE REPORT QUARTER 3

Nancy Clarkson reviewed the report for Q3 focusing on exception reporting. With regard to Outcome 2 Looked After Children: this is estimated to remain at Amber at year end, despite a considerable amount of ongoing work. It was stated that the percentage figure of 101.6 equated to 688 looked after children. It was also reported that the target for Rate of Child Protection Plans may be achieved at the end of the year. Not in Education, Employment and Training (NEET) quarter 3 figures showed a positive trajectory over the year with the lowest Wirral NEET figures to date.

In further discussion Cllr Clements enquired when missing data would be available. She was advised that this should be available shortly and the quarter 4 report would be on the agenda for the next meeting.

It was resolved that the Board noted the report.

CLOSE:

There being no further business the meeting closed at 11.40 hrs.

DATE AND TIME OF FUTURE MEETINGS

9.00 am 20 May 2014
9.00 am 15 July 2014
9.00 am 23 September 2014
9.00 am 18 November 2014
9.00 am 20 January 2015
9.00 am 17 March 2015
9.00 am 19 May 2015
9.00 am 21 July 2015

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WIRRAL CHILDREN'S TRUST BOARD - 20 May 2014

CHILD POVERTY UPDATE

1.0 Background

1.1 The purpose of this report is to provide an update on actions being taken by the Wirral Child and Family Poverty Working group (herein referred to as the Working Group) and to provide an update on the development of the school community hubs.

2.0 Update

2.1 The Working Group has agreed the following terms of reference:

- Challenge the members of the Working Group and others to take practical action to achieve common goals of reducing poverty and harnessing the talent and ambitions of Wirral's children, families and communities;
- Proactively promote the use of research and best practice in addressing poverty

2.2 The Working Group has committed to focusing their energies on ensuring that Wirral plays a part in delivering the aims and actions identified in the Liverpool City Region Child Poverty and Life Chances Strategy. The current priorities for this strategy are:

- Improve school readiness
- Support families to be prepared for Universal Credit
- Tackle children and young people with unhealthy weight
- Close attainment differences in schools
- Improve transport access
- Increase employment and skills within low income families

2.3 The Working group has established a work programme to deliver topic based presentations to invite comment and challenge from Working Group members with a call to action.

- The focus in December 2013 was support for families to be prepared for Universal Credit. The Working Group put forward a recommendation for funding to be invested in the set-up of a credit union, which could help people on low incomes and facing crisis. Julia Hassall is leading on this recommendation.
- The theme for the March 2014 meeting was working with children and young people with unhealthy weight, the group received a presentation from Gareth Hill, Public Health. The Working Group requested that it be investigated as to whether all staff/volunteers in the voluntary sector could be trained up to deliver HENRY, rather than just council staff.

2.4 The Working Group meeting in June 2014 will focus on improving school readiness. Both school community hub leads have been invited to provide a verbal update and there will be an update provided by Zoe Munby on the Foundations Years Trust project.

3.0 School Community Hub Update

3.1 The school community hubs development and implementation commenced in February 2014.

3.2 Both school Hubs have carried out extensive mapping of local community assets and established steering groups with key partners to progress the work of the Hub. One Hub

has developed a skills map of community volunteers. 'New' money/resources have been attracted as a result of the Hub. One Hub's community connector has attended ethnography training hosted by Wirral Council.

3.3 Partnership work with the other local schools has been established and joint activities for both children and parents developed. Each community Hub is using a model bespoke to its local community needs, using local people as the community connectors. One Hub has hosted an open day for local residents and extended the invite to the working group and local councillors. The purpose of the open day was to raise awareness of the Hub.

3.4 Activities have been developed focusing on the following:

- Family and children wellbeing
- Greater awareness of support available to parents in local area
- Increased desire of parents to move into work
- Increased engagement of parents with existing employment and enterprise
- Improved aspirations of children due to rising parental aspirations

3.5 A number of activities have already been set up and started delivery - these include;

- Easter school which used young local people with experience in child care employed as Easter school staff
- adult education sessions in English and Maths and NVQ 2 child care
- coffee afternoons run by volunteers

3.6 Both Hubs will carry out an early implementation evaluation to consider the challenges of setting up the project and early successes. This evaluation will be completed during June/July 2014

4.0 Recommendations

4.1 It is recommended that the Children's Trust Board:

- Note the updates set out in the report and request further information as required
- Agree to receive the next quarterly update on the 15 July 2014

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WIRRAL CHILDREN'S TRUST BOARD – 20th May 2014

Report to the Children's Trust Board on Safeguarding Arrangements

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1.0 Background and Introduction

1.1 This report forms part of a regular safeguarding update from the WSCB to the Children's Trust Board on key developments locally and nationally. These include regulatory reforms; updates on the progress of local Serious Case Reviews; work being undertaken locally; and key challenges for the partnership and agencies.

2.0 National Reform and Safeguarding Developments

2.1 Child Sexual Exploitation Strategy

The Child Sexual Exploitation (CSE) multi-agency sub committee continues to focus on awareness raising strategies for CSE. Recent progress includes:

- Establishment of monthly operational meetings managed by Merseyside police to establish plans for children identified as at risk of being sexually exploited
- Completion of awareness raising training with police, Response, health and youth workers in schools, foster carers and residential providers
- Commissioning of Catch-22 to deliver 10 multi-agency CSE sessions. First session was delivered on 31st March 2014
- Design of a CSE e-learning module which will be available on the website, following quality assurance
- Develop awareness raising training for multi-agency professionals about the effects of CSE
- Commissioning of Wirral Youth Theatre to develop a CSE drama vignette for schools
- Engagement of the taxi workforce to support a 'see it, report it' strategy including training and advertising material in taxis and taxi offices, and awareness raising training for drivers
- Planned awareness raising training for elected members in June 2014

2.2 Critical Incident Reviews (CIR) and Serious Case Reviews (SCR)

CIR – The findings from the CIR of Child 2 have been presented to the WSCB's Serious Case Review committee. The recommendations from the overview report have been translated into actions for agencies and progress against the actions will be monitored by the Performance Committee of the WSCB. Learning from CIR's and SCR's is embedded in the WSCB's multi-agency training and promoted through materials for agencies such as reports and posters.

A learning from reviews poster has been developed by the WSCB and distributed to agencies and is included in appendix 1.

The WSCB currently has 1 open SCR action plan which is 90% complete. One of the outcomes from the action plan was the practitioner's development day held on the 7th March and detailed below. The WSCB estimate all actions will be completed by the end of Spring 2014.

2.3 WSCB Practitioners Development Day 7th March 2014

In January 2013 the WSCB published the Child G Serious Case Review. Child G was an older teenager who had considerable vulnerabilities. One of the recommendations from the overview report was for the WSCB to improve agencies understanding of the complexity of risks faced by older teenagers. This is reflected in research undertaken by the House of Commons Education Select Committee in 2012 which identified that within the child protection system the two most vulnerable groups of children were babies less than one year old and teenagers aged from 14-19. The review commented that the complexity and range of risk factors facing teenagers including alienation from family, school difficulties, accommodation problems, abuse and neglect, mental health difficulties and others meant that professionals often struggled to develop an effective plan and the corrosive effect of years of neglect and abuse were not understood.

In response the WSCB organised a development day for frontline practitioners who routinely work with teenagers. 11 sessions were delivered throughout the day to 154 practitioners which focused on issues such as mental health, domestic abuse, homelessness, substance misuse, transition into adulthood, youth support and child sexual exploitation. The feedback from the day was extremely positive and a legacy meeting will be held to plan dissemination of the learning and information from the day.

2.4 Neglect Strategy

Neglect is the most common reason for a child to be the subject of a child protection plan or on a child protection register in the UK. 43% of all children subject to a child protection (CP) plan in England in 2012 were under the category of neglect. In Wirral (Sept 2013) the figure is a little higher with 47% of children on a CP plan for neglect.

The challenge for all local children's services in the UK is to develop a coherent, integrated and effective response to neglected children and young people.

The WSCB and partners have developed a Wirral neglect strategy to ensure our children's workforce are able to recognise neglect and provide an effective response which will improve outcomes for children, young people and their families. Integral in the strategy is the identification and engagement of families at the earliest opportunity by preventative services including effective assessment and development of a clear action plan.

Progress on introducing the strategy with commensurate multi-agency training will be reported into the Children's Trust Board

2.5 Development of a Single Assessment

The Munro Review of Child Protection (2011) recommended reducing statutory guidance on safeguarding children in order to promote local autonomy and increase the scope for practitioners to exercise their professional judgement. One of the recommendations later prescribed in Working Together to Safeguard Children 2013 was to introduce a Single Assessment to replace the Initial Assessment and Core Assessment within the Children and Young Person's Assessment Framework.

The Single Assessment in Wirral was introduced in Spring 2014 and it aims to:

- Reduce prescription on timescales to allow Social Workers to specifically respond to that child and family's specific need.

- Allow greater opportunities for the Social Worker to engage with children to explore their wishes and feelings, focussing upon the child's journey and the impact of the concern upon their safety and wellbeing from the child's perspective.
- Create increased opportunity and expectation for the Social Work Practitioner to reflect upon the assessment and the daily lived experiences of the child.
- There is a greater focus on analysis and less expectation of "filling the boxes".
- Reducing the need for families to repeat their story

3.0 Recommendations:
3.1 The Wirral Children's Trust Board notes the report.

4.0 Appendix
4.1 Appendix One – Learning from Wirral SCR Poster

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Learning from Serious Case Reviews

Recent Teenager Case Reviews undertaken in Wirral tell us we must:

- Share information across agencies to ensure services are targeted and co-ordinated
- Be aware of the corrosive effects of long term neglect on young people
- Don't underestimate the vulnerabilities of teenagers, particularly those who have moderate learning difficulties
- Don't assume older teenagers are more resilient than younger children and therefore need less support
- Have a clear understanding of the Wirral thresholds of need and know where and how to access the WSCB multi-agency safeguarding procedures
- Ensure the views of young people are understood and recorded and where appropriate influence service design
- Always balance optimism with objective evidence

Safeguarding is Everyone's Responsibility….

For more information please visit the WSCB website:

http://www.wirral.gov.uk/my-services/childrens-services/local-safeguarding-childrens-board

WIRRAL SAFEGUARDING CHILDREN BOARD

WIRRAL CHILDREN'S TRUST BOARD – 20th May 2014

Birkenhead Foundation Years Project for The Foundation Years Trust up-date

1.0 Background

In September 2012, Wirral Metropolitan Borough Council Cabinet made a number of resolutions in respect of the Birkenhead Foundation Years Trust initiative, including:

"(1) to release an initial sum of £50,000 of the Child Poverty budget allocation to the Foundation Years Trust to develop a comprehensive business case for the 'Springboard' project and that at the same time a pre-pilot phase of work be undertaken which will involve engaging thirty families.

(2) to consider the business case at a future Cabinet meeting, and, subject to being satisfied that the business case is satisfactory, robust, clear about the expected outcomes of the Trust's work, that the activity represents value for money and that the monitoring and performance management arrangements will accurately measure the outcomes, take a further decision as to the release of a further £250,000 to support the "Springboard" project."

A full Business Case was submitted in September 2013. This was subsequently amended to include a summary document, including a statement of purpose and outline of delivery plans, with a revised budget and was considered by Cabinet in March 2014.

The following sections are extracts from the summary document as submitted in January 2014. Please note:

a. The Business Plan is an over-view of the planned approach and so aspects of delivery are anticipated but require further discussion and agreement with other services.

b. In 8 months since September 2013 delivery has been continuously monitored, assessed and modified. The project seeks to develop interventions where there is evidence of successful engagement with poor families and an impact can be identified. As a consequence Sections 3 and 4 below contain activity which has subsequently ended or the time scales have changed; additional activity has been planned which is not recorded here. The budget is a statement of the anticipated spend as it stood in January. A current statement of activity is available.

c. The 'pre-pilot phase' referred to in (1) above had been completed in January, the report was finalised in March, but not included in the documents for Cabinet. This report has been submitted to the Council and is included here in Appendix 2 for information.

2.0 Statement of Purpose/How the project will work

The project's purpose is to reduce child poverty. By supporting children's early development we aim to increase the likelihood that they will do well at school. We seek to reduce the developmental gap that currently emerges between better-off and poorer children at a very early age. We are working to prevent poor children becoming poor adults. We will do this by seeking to influence those factors which impact on early learning and development: the home learning environment, parental warmth and sensitivity, and parental mental health and well-being. These factors are significant for all children and families but poorer families have fewer resources to draw upon, both to avoid difficulties and to do something about them if they arise.

HOW THE BIRKENHEAD FOUNDATION YEARS PROJECT WILL WORK

This plan is designed as a test of a transferable model of family support with the flexibility to complement local strengths and supplement local weaknesses. The plan takes account of the reorganisation of Wirral Children and Families services and the prioritising of support for the Intensive Families Intervention Project (IFIP) and therefore focusses work at the universal level. Local service experts (commissioners, managers and front-line staff) have had a central influence on the thinking behind this business case. We will:

- Work to complement and supplement existing services; deliver services for families at the universal/Level 1 and 2, with resources concentrated on those in most need. Recognise the principle that those families at the higher levels of need are currently engaged with IFIP services; work respectfully and in the spirit of multi-agency collaboration.

- Be guided by local expertise and seek to establish specialist groups to inform the development of Project services.[1]

- Where possible commission Project pilots from partner organisations, to test how easily the service can be introduced to an established local infrastructure. This contributes to value for money.

- Situate pilots so that they are visible and accessible at places where popular universal services are located e.g. alongside the Health Visitor clinics.

- Aim to bring a questioning and reflective voice that champions early learning, child development and family support with the ultimate aim of addressing inter-generational poverty.

- Draw upon the Trust's Advisors to bring fresh ideas and a UK perspective to the Wirral, through their advisory role, seminars or conference opportunities.

[1] For example 6 VCS organisations, recruited by open invitation to the sector, met to scope the nature of the Project's volunteer mentoring pilots.

3.0 How the Birkenhead Project will make a difference

The Birkenhead Foundation Years Project will make a difference to Birkenhead families by influencing factors which impact on early learning and development

Where and how the project makes a difference	Home learning environment	Parental warmth & sensitivity	Parental mental health & well-being
Extending community capacity & strengthening universal services	Parent & child play in public places: (1) Early Explorer groups in Health Visitor clinics or other facilities (Jan 14 onwards, in development) There is the potential to develop further activity in other public places, in the light of the experience with the pilots above. (2) Support for un-funded faith and other community play groups with training and resources.	Antenatal resources: (3) DVD and booklet for all families – a Merseyside-wide development (longer term aspiration)	Giving parents a voice – focus groups, interviews and web-based opportunities; publication and dissemination: (4) Perinatal consultation with 30 mothers (July – October 13) (5) 6 months – 2 years (May – September 14) (6) 3 – 5 years (May – September 15)
	Training and learning opportunities: (7) Multi-agency PEEP Practitioner training for staff and volunteers with optional accreditation (Oct 13) (8) PEEP Practitioner network linking Children's Centre PEEP trained staff with staff and volunteers from the voluntary sector (March 14, and thereafter) (9) Multi-agency PEEP Practitioner training for additional staff and volunteers, subject to evaluation and demand (Oct 14) Influencing parent-centred approaches and multi-agency collaboration in the delivery of services:		

Where and how the project makes a difference	Home learning environment	Parental warmth & sensitivity	Parental mental health & well-being
	(10) Foundation Years Seminars (Feb 14 onwards) (11) Issue-based working groups (in development)		
Open access groups and services available to all	Parent & child play groups: (12) Baby and Toddler Peep Brassey Gardens & St Werburghs Parish Centre (Nov 13 onwards); Rock Ferry (Jan 14 onwards)		Parent volunteer support: (13) St James Centre project (in development)
	Parent and child reading groups: (14) Reader Organisation open group e.g. based with church play group (March 14 onwards)		Parent volunteer support: (15) Bump-Start: Home-Start volunteer-delivered perinatal support up to 1 year of child's life (potential for extension if pilot phase successful, April 14 onwards)
Proactive and targeted support	Parent and child reading groups: (16) Reader Organisation perinatal group (Feb 14 onwards)		Parent volunteer support: (17) Bump-Start: Home-Start single parent perinatal support project (Oct 13 onwards)
	Parent volunteer support: (18) Home-Start volunteer support for disabled children in groups (Oct 13 onwards)	Parent volunteer support: (19) Tranmere Community Project Young Mums project (in development)	
		Parenting programme: (20) Antenatal PEEP (Feb 14 onwards)	
		Parent volunteer support: (21) Volunteer doula/birth partner support (longer-term aspiration)	

4.0 Budget summary

Budget Summary, Years 1 and 2 September 2013 – August 2015					
		Activity	**Cost**	**Committed**	**Projected**
Extending community capacity and strengthening universal services	1.	Early Explorer groups	18,600		√
	2.	Support for community groups	1,500	√	
	3.	*Antenatal resources Y 2*			√
	4.	Giving parents a voice	2,200	√	
	5.	*Giving parents a voice Y 2*[2]	*500*		√
	6.	*Giving parents a voice Y 3*			√
	7.	Multi-agency training	9,000	√	
	8.	PEEP network	400	√	
	9.	*Multi-agency training Y 2*			√
	10.	Foundation Years Seminars	1,600	√	
	11.	Issue-based working groups	250		√
Open access groups and services available to all	12.	Baby and Toddler PEEP	20,000	√	
	13.	St James Centre	4,930		√
	14.	Reader group church	3,000		√
	15.	Bump-Start (open)	25,500		√
Proactive and targeted support	16.	Reader group perinatal	5,100	√	
	17.	Bump-Start single parents	5,000	√	
	18.	Volunteers and disabled children	5,000	√	
	19.	*Young mums Y 2*			√
	20.	Antenatal PEEP	17,420		√
	21.	*Doula support Y 2*			√
Project management		Staff salaries (director, family and volunteer co-ordinator, administrator), office and equipment costs.	133,495	√	
Total			**253,495**	208,795	44,700

5.0 Recommendations

The Children's Trust is asked to note that the following decision was made by Cabinet in March 2014:

Cabinet agrees to allocate the child poverty funding of £250,000 being held in reserve to the Foundation Years Trust on the basis of the business plan.

The Children's Trust is asked to note that the maternity report in Appendix 2 is envisaged as the first stage of a discussion on the issues raised by this consultation.

[2] Activity completed in Year 2 but information gathering and some costs incurred in Year 1.

The Foundation Years Trust is seeking responses and intends to publish those in a subsequent report. A format for responses is available on request.

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Appendices:

Appendix 1: Illustrative examples of the approach from the Report

"It takes a village to raise a child"[3]: what does extending community capacity and strengthening universal services mean in practice?

The project's purpose of reducing child poverty means that it has to reach as many families as possible. In particular those families which don't seek help; those which feel unconfident about their own education and unambitious for their children; and those which are suspicious of officialdom. We aim to create as many opportunities as possible for 'accidental engagement' with services.

Example:

Early Explorer PEEP groups
These are play activities for babies and toddlers, run in public places (in the same room as a Health Visitor Clinic, in a GP's surgery, in a shop where queuing happens etc.). The parent and child will be there, waiting to get a baby weighed or to see a doctor, and there is an opportunity to occupy a bored child. Play staff offer free fun and encourage parents to stay as long as they like, sign-post to other services, and build relationships. See (1) below.

Extending community capacity and strengthening universal services can involve a single resource.
Example:

A DVD for all parents at the antenatal stage
A locally produced DVD, showing local parents playing with their babies and demonstrating how very new babies are able to benefit from being talked to and their capacity to respond and enjoy stimulation. This idea is based on a long-standing and widely admired service developed in Tameside. See (3) below.

Services with a wide reach are expensive unless the impact can be multiplied by same messages being delivered by statutory and voluntary sectors, by community and faith groups and crucially, by influencing how everyone from parents to grandparents, neighbours and friends all 'raise the child'. Extending community capacity involves drawing upon awareness, knowledge, skills and enthusiasm for early learning embedded within communities.

Example:

Training and learning opportunities
Parents move on from receiving services, to volunteering, to training and into paid work. See (7-9) below.

[3] A version of an African saying, quoted by Hilary Clinton.

Existing faith/community-based services collaborate and share their skills and are strengthened and benefit from training and resources. See (2) below.

Appendix 2
MATERNITY - Voices of Birkenhead Mothers

Mothers in Birkenhead speak about their experiences of pregnancy, giving birth and the support they received in the first few weeks after the birth

INTRODUCTION

Following the publication of The Foundation Years: preventing poor children becoming poor adults[4], the Foundation Years Trust was established, firstly to pilot the recommendations made in that report, and then to roll out the strategy around the country. The ambition of the Trust is to abolish the intergenerational transfer of poverty, shifting the emphasis of poverty interventions to a focus on improving life chances. Central to the Report's recommendations is the emphasis on the importance of the foundation years, from the antenatal period to the child's 5th birthday. This local review of mothers' experiences was undertaken by the Trust's Birkenhead Project to explore what is important to mothers in a period which has been increasingly identified as crucial not only for longer term maternal and infant physical health, but for children's long term social, emotional and intellectual developmental potential. The significance of these voices is that they provide insights into the experience of maternity services which are not necessarily captured by either routine consultation or evaluation undertaken by the services themselves or by external monitoring. Confident service users, typically also better educated and better-off, are more likely to complete questionnaires, have the skills to express their preferences and articulate what they found unsatisfactory. This group are also more likely to feel able to express dissatisfaction with a service directly to the service through these formal mechanisms. By asking Birkenhead mothers, some of the poorest mothers in the Wirral, to speak, rather than write, about their experiences, in a neutral environment, we are complementing and expanding on the official record of how well services are doing.

The Trust's interest in the period from pregnancy to when a child is five is wide ranging. The particular focus of this report is on one aspect of the Trust's work in relation to this period, from pregnancy until the first few weeks of the new baby's life, and is based upon the analysis of current child development research undertaken for The Foundation Years report. There is increasing understanding of the mechanisms whereby maternal ill-health and distress impact on the foetus and mothers' and babies' ability to form a secure bond and how the baby's very early development is significantly affected by the extent to which mother and child can form a secure attachment.

Mothers' capacity to adjust to and enjoy a new baby is affected by her life before pregnancy. Some of the women we spoke to described lives in which they were managing challenging circumstances. Our sample includes women who had been homeless, those who had experienced periods of mental and physical ill-health, or were pregnant when teenagers and therefore less well equipped in some ways to manage the responsibilities and ties of parenthood. The sample also includes women who had not experienced those difficulties. The project's purpose here is to report on what we were told by this small

[4] Field, F (2010) The Foundation Years: preventing poor children becoming poor adults. HM Government, London.

group of mothers, to illuminate their perspectives and to explore how this could be relevant for service providers and commissioners in considering the implications for children's social, emotional and intellectual development. This work has the potential to enable a dialogue between service users and providers as the second phase of this consultation will be to ask for comment and responses from providers and commissioners. These will be incorporated into the final report.

These accounts place a greater emphasis on what could be improved, rather than what was good. Every mother had something positive to say about aspects of their experience and individual midwives, nurses, health visitors and doctors were singled out for special praise. Hospital ward cleaners were mentioned by more than one person as helpful and sympathetic. The significance of this is explored later. However, it is perhaps inevitable that bad experiences loom larger in the memory than good ones. This point is returned to in section 7 below.

1. SCOPE OF CONSULTATION

We asked voluntary organisations working with women and families in Birkenhead to identify women they knew who had given birth in the last two years[5], or were currently pregnant, and invite them to a focus group. Of the 30 women

- 10 were supported by Home-Start Wirral
- 7 by Tranmere Community Project
- 5 by Tomorrow's Women Wirral
- 4 by Forum Housing
- 4 by Ferries Families Groups[6]

The services the women were accessing ranged from breastfeeding support, through family support and educational groups, to drop-ins, one-to-one peer support and a hostel for young mothers. They were people who sought out support of one type or another. This is not a statistically significant or necessarily representative group. It is a sample of the experiences of mothers from an area with high levels of poverty whose voices are rarely captured.[7]

AGE OF MOTHERS

9 of the women were teenagers when they had, or were about to have, their most recent child; 11 women were in their 20s; 9 were between the ages of 30 and 34; one was 42 years old.

PARENTING EXPERIENCE

Of the 30 women 15 were 1st time mums

- 5 were pregnant when we met them, 3 of whom were pregnant with their 1st child

[5] Despite aiming to find out about current experience of services, some women contributed whose experiences are older: 24 of the women gave birth in 2012-13; 3 in 2010 and one each in the years 2002/4/5. Where significant or exceptional issues were raised by those giving birth prior to 2012, and are used here, we have noted this.

[6] See section 11 Acknowledgements to find out more about these organisations.

[7] The Wirral Teenage Pregnancy Consultation undertaken between April and November 2012 which involved 20 young women covers some common ground to this report – see section 3.e below.

- 8 had two children
- 6 had three children, including one set of twins
- 1 had four children
- Of the 15 mothers who had more than one child, 6 had been teenage parents when they had their first child – so exactly half our sample had experienced being a teen mum.

This consultation consisted of 5 focus groups varying in size from 6 to 2 people and 9 individual interviews undertaken with people who missed a focus group. The groups and interviews followed a semi-structured questionnaire[8] and participants were encouraged to raise those issues which concerned them most. This means that not all topics discussed here were explored with each participant. A version of the questionnaire was produced to use with fathers but none were recruited. Contributions were recorded and a total of 7 hours and 37 minutes of recordings were transcribed and thematically analysed.

2. MIDWIFERY AND HOSPITAL SERVICES

a. Midwifery and hospital services available to Birkenhead families

This section describes the main maternity and related services that are available for women in Birkenhead. This is the information that the mothers interviewed here are trying to make sense of in making choices about the kind of birth they want to have. This context shapes their experiences, before, during and after giving birth. It also shapes the working conditions, reporting regimes and professional support for those working in and providing maternity and related services in the Wirral.

Wirral University Teaching Hospital NHS Foundation Trust, managing **Arrowe Park Hospital** and incorporating the **Wirral Women's and Children's Hospital** is located in Upton, approximately 4 miles from the centre of Birkenhead. It provides -

- A **community midwifery service** which can be accessed at the Arrowe Park Hospital, and St Catherine's Health Centre, Birkenhead (with other contact points in Bebington and Wallasey)
- A **teenage pregnancy service** which supports mothers 18 years or under at conception (and other younger women by exception) via a separate clinic at the 12 week scan and on-going support from a dedicated midwife and the Teenage Pregnancy Advisor (funded by the Local Authority).
- A **midwife shop** at the Pyramids Shopping Centre in central Birkenhead
- A **midwifery-led delivery unit** at Wirral Women's and Children's Hospital

Other maternity hospitals which periodically cater for women resident in the Wirral:

- Liverpool Women's NHS Foundation Trust, managing the **Liverpool Women's Hospital** which is located 5.5 miles from the centre of Birkenhead.
- The **Countess of Chester** NHS Hospital Trust's maternity unit is located 15 miles from the centre of Birkenhead.

[8] See Appendix 1

The **One2One midwifery** service is a private company which delivers an NHS-funded community midwifery service across the Wirral, supplementing the Hospital Trust's community midwifery team. This service is available to Birkenhead mothers (and was originally piloted as a service for Birkenhead families only, with the aim of addressing the need for more support in a community with high levels of deprivation). The service is offered by some GPs or could be requested by mothers themselves. One2One midwives work a 'case loading' system in which a named midwife carries a case load of mothers and provides continuity of care from referral, through labour if a home birth is chosen and postnatally. This is distinctive from the system operated by the community midwives and hospital where care is provided by a named community midwife, one or more hospital midwives (changes of shift may mean a transfer between midwives during labour) and subsequently a midwife who visits the home in the postnatal period.

The **Family Nurse Partnership** (FNP) service is a voluntary home visiting programme for first time young women, aged 18 years or under at conception. A specially trained family nurse with a health visiting, midwifery or school nurse background visits the young woman regularly, from early in pregnancy until the child is two. The Family Nurse Partnership programme aims to enable young mums to:

- Have a healthy pregnancy
- Improve their child's health and development
- Plan their own futures and achieve their aspirations

FNP is a commercial programme, originally developed at the University of Colorado in the US. It has an evidence base with a 30 year track record. It has strong UK government support and has been funded across England by the NHS since 2012. Wirral is an 'early adopter' site having run the programme since 2010.

b. Midwifery and hospital services used by the women in this consultation

The majority of the women (28) gave birth to their babies at Arrowe Park Hospital. Of these women, all but 3 were supported ante- and postnatally by the Hospital Trust's community midwifery service. The 3 who had One2One midwives transferred to Arrowe Park Hospital for delivery. Two women used Liverpool Women's Hospital: 1 was supported by Liverpool community midwifery service and 1 by the One2One midwifery service, offered via Liverpool Women's Hospital. In this sample of 30 recent births none had a home birth: one respondent with the One2One midwives felt there was some pressure to consider this option but wanted a hospital delivery. Another mother, contributing an account of her 2012 experience of hospital child birth and a Caesarean section, also talked about her first baby, born very comfortably at home, with One2One support, at 17 Years, in 2010[9]

Few of the women we talked to seemed aware of or confident in any choice in the maternity services they could use. This may be because of limited access to information or a lack of confidence or understanding about the options. 'Choice' could mean choosing the midwifery service they used or the place of birth, whether at home or in hospital and if hospital, which hospital. Two respondents said that their GPs had offered a choice between the Community and One2One midwifery services and in both cases they had chosen

[9] We did not specifically ask about home births and with this one exception, home births were not mentioned. Many issues were raised spontaneously and this one was not. It might merit further research but within this small sample it did not appear to have been considered.

One2One. It seems possible that choices are being offered to women by health practitioners with little underpinning experience of or commitment to different approaches. This would happen if, for example, midwives with limited experience of or confidence in delivery at home were tasked with discussing this option with women, or if only those GPs who supported NHS-funding for an independent midwifery service chose to offer it to their patients.

The respondents had limited awareness of the One2One maternity service. Two women thought that it was a private service which they would have to pay for and therefore did not consider using it. One respondent knew of 4 friends who had a One2One midwife but of those, only 1 had a home birth, so she felt it was more straightforward to opt for support from the community midwives at the start. Another respondent's friend had given birth alone, unable to reach One2One when she went into labour. From this the friend deduced that the referral system to the hospital service was not properly managed. The 2 women who chose to go to Liverpool Women's Hospital did so because of their own or anecdotal experience at Arrowe Park. One woman had a bad experience of labour management in Arrowe Park Hospital 18 years previously. Another had heard 'good and bad reports' of Arrowe Park and had a poor experience of being a birth partner for a friend at this hospital; she also had a mother-in-law who was a midwife at Liverpool Women's Hospital.

The significance of this anecdotal evidence is that information of this kind influenced all of the women who discussed services in terms of choices. This does not mean that the second hand experiences recorded above are fair or accurate – it means they are they are powerful. The 2 women who chose not to give birth at the local hospital had some personal connection to the Liverpool hospitals.

The midwifery shop, established and run by the hospital community midwifery service, was popular. This shop-front facility, located in the Pyramids Shopping Centre in central Birkenhead, offers a range of services, from routine checks to opportunities for reassurance and a place to ask questions. Of the 30 women, 6 (a fifth) mentioned that they had made use of the Shop and commented favourably.

One teenager arrived in Birkenhead from Wales when 6 months pregnant and used the Shop to arrange her booking with Arrowe Park. For a young person navigating a hospital system on their own this was a convenient option. Another 18 year old experienced several periods of pain and bleeding in early pregnancy and was critical of the perceived inflexibility, lack of sympathy or reassurance she received when she rang the community midwives. She used the Shop for immediate support and reassurance, although she also pointed out that the Shop does not house a toilet so women who are asked to provide a urine sample have to find a public toilet –

> "I had to go to Birkenhead Market toilets or the Pyramid toilets, which is about a 5 minute walk each way…and I couldn't walk standing straight up, I had to lean over because I was in that much pain in my stomach. She could see I was in pain, I was crying when I got there."[10]

The flexibility of the Midwifery Shop service appealed to women in quite different circumstances. There was fulsome praise for the Shop from the respondent in her 40s:

[10] Tranmere Community Project resp.7

> "I've got to say the best thing was that drop in shop down town because I was working full-time, I used to pop in there for my antenatal if I couldn't get to my doctors. I'd go down there with my file and they'd do my tests…I had a couple of sweeps there as well…that is such a good idea."[11]

The Shop was also used by a One2One midwife contracted via the Liverpool Women's Hospital to support a woman in Birkenhead – the respondent said:

> "this nurse wouldn't come into my doctors because she was from Liverpool but she did go to the Shop…She told me on what days she went to the Shop which was nice because then if I felt ill or knew I wanted some questions answered, instead of going all the way to Liverpool or ringing her up, I could go in there….even after the baby was born, I could go into there, although generally she came to my house."[12]

3. ANTENATAL EXPERIENCES

a. Health in pregnancy

Just less than one quarter (7) of this group of pregnant women experienced significant physical or mental health problems in pregnancy. This is probably a higher level of ill-health than found within the general population of pregnant women. It could be accounted for by ill-health associated with poverty or by this being a self-selecting group who had experienced untypically stressful pregnancies and sought additional help from the voluntary sector.

- 3 had a cluster of related conditions: weight gain; suspected gestation diabetes; blood clots; extended sickness; symphysis pubis disorder

These 3 women, a 19 year old and two 18 year olds, had to inject themselves to manage the dangers of the blood clotting. They discussed the varying and conflicting guidance and support they received in injecting – something they found frightening. It is significant that young women were expected to manage their own health condition whilst not recognised as adults in other aspects of the service they received (p.8 below).

The other 4 women experienced serious health problems including:

- Preeclampsia and an extended period of time in hospital
- A pre-existing heart condition
- A kidney problem which had been treated immediately prior to becoming pregnant and which caused problems during pregnancy
- A leaky liver diagnosed during pregnancy which required monitoring and a planned induction to avoid danger to the foetus

Two of the seven women discussed pre-existing depression and mental ill health which affected their experience of pregnancy. These underlying health issues were not visible and were either not picked up or not addressed during their initial midwifery consultation. One of these women also had physical ill-health. The challenges of managing multiple health problems was common to this group, described by one woman in relation to un-coordinated care involving several appointments across a week for scans, physiotherapist, midwifery and consultant appointments.

[11] Home-Start resp. 10
[12] Ferries resp. 4

b. GP care

The GP surgery, the most well-known part of the local health service, was the first place all respondents had visited once they knew or suspected they were pregnant. They saw their GP for a pregnancy test or to confirm one taken privately. These visits were for the most part only referred to in passing and were seen as an insignificant routine event. The exceptions were 2 teenagers who reported a shocked or negative initial response ("are you married?"). Two other women noted that the timing of their pregnancy was commented upon – in one case because it was a pregnancy with a 9 months gap since the last baby's birth and in the second case when two pregnancies occurred at 18 and 21 years old. These GPs clearly had concerns for, or disapproval of, younger women having babies or having babies in quick succession. However the effect on the mothers of these comments, unrelated to advice, suggestions or offers of help, appears to have been simply unhelpful.

A respondent with preeclampsia explained difficulties encountered with the GP altering her medication without coordination with the hospital, suggesting an experience of being powerless between two medical systems.

c. Experience of scans

Seven respondents chose to talk about their experience of scans as significant. Positive experiences included reassurance in relation to a baby's viability or risk of foetal abnormality. Although scans are potentially exciting there were negative experiences associated with fear, physical pain, vomiting and feelings of being rushed and not having sufficient time to ask questions. The routine timing of scans have become a formal marker for mothers that their babies are alive and developing as they should be, especially at 20 weeks, when few if any external signs of pregnancy may exist. The operator conducting the scan needs to focus on undertaking a careful and thorough investigation and their primary tasks are to check the baby's growth, position and check for any abnormalities. However there appears to be a mismatch between the time allocated for this clinical task and the opportunity for the pregnant woman to ask questions and come to terms with the growth of an independent life within her. This may be an opportunity to talk to mothers about the baby, to sow the seeds of sensitive parenting, which from these few cases was being missed.

d. Antenatal classes

Antenatal services include a variety of ways in which parents can learn more about pregnancy, childbirth and the care and feeding of new babies and this preparation and knowledge has the potential to be significant in laying the foundations of a calm or stress free experience. Services available to Birkenhead parents include classes arranged by the community midwifery service to Natural Childbirth Trust private fee-paying classes. Some young women are supported by Family Nurse Partnership nurses with one-to-one tailored educational in-put; historically Children's Centres in Birkenhead have run young mums groups[13] and the Tranmere Community Project's 'Young Mums to be' course has been in existence for 6 years, recruiting from Job Centre Plus referrals of pregnant women across Wirral who are NEET. During the period when this consultation was being conducted the Teenage Pregnancy Service developed a new model of antenatal class exclusively for young

[13] These are run if and when there is demand. None were mentioned by the respondents in this sample. These are typically groups which support young women when they have had their babies.

parents, in response to their 2012 Consultation. The two cohorts of this programme which have subsequently run have been well attended.

Just under one third of respondents had attended some form of antenatal course. However, the take up of antenatal education in this sample is inflated by the numbers of the respondents who were recruited to a focus group via the Tranmere Community Project's course (5). Discounting this group there were only 4 of the 30 respondents who attended any other form of antenatal education. The four respondents who had attended hospital antenatal classes spoke enthusiastically about them. These were all women in their late 20s and early 30s, two being 1st time mothers. One mother referred to her earlier experience of pregnancy –

> "Even though I knew some of the bits from years ago, I had forgotten it."[14]

Although the need to 'catch-up' was expressed by this woman, several others in their 30s gave a number of reasons for not attending classes, from not needing to, because it was their second or subsequent child or because they were having a caesarean section; or because the classes were inconvenient, too far to travel to or clashed with work.

Of the younger respondents 3 had attended the Tranmere 'Young Mums to be' course in the past and 2 others were current students. This group all rejected the hospital classes which they were offered but were not able to clearly explain why they did not attend. One 18 year old with FNP support had rejected the idea of attending any class. She said "I thought that – well, it comes naturally, so I'll wait for that."[15]

e. Attitudes to young mothers

An interlocking pattern of discrimination against young pregnant women and young mothers – whether actual or perceived – and the reaction it creates, was a thread throughout most of the interviews with women under 22 years. Nine of the younger mothers explicitly raised the issue of prejudice against them. This ranged from 'the looks' they got out in public when pregnant or pushing a buggy, and being called 'this little girl' by a nurse on a maternity ward, to more a more subtle sense that they received different treatment.[16]A 19 year old trying to arrange an appointment and worried about missing college ended up in a public argument with a clerk:

> "I went outside and I was crying to my mum…'she's made a holy show out of me in front of everyone. The whole place was packed and she threw the book at me'."[17]

The same mother experienced other conflicts at the hospital and was escorted from a clinic by a security guard on one occasion. Whatever the actual behaviour on both sides involved in this specific situation, this was a young person navigating hospital systems independently for the first time. The complexity of hospital bureaucracy can be stressful for any adult encountering it so it does not seem surprising that younger patients struggle. A younger woman asked to change her community midwife because at her first appointment she believed that she was being unfairly judged. The pregnant women was wearing an electronic tag. Although it was invisible under her clothing she believed that this had been reported to the midwife and she was treated differently as a result.

[14] Home-Start resp. 8
[15] Forum resp. 3
[16] These comments were not made in relation to the Teenage Pregnancy Support Service.
[17] Tranmere Community Project resp. 7

4. CHILDBIRTH EXPERIENCES

The management of childbirth itself was not the focus of dissatisfaction with services[18] with the exception of the period covering the early stages of labour. Several mothers talked graphically about their experiences of giving birth but these were recalled because of the length of labour or the discomfort of induction, rather than for any specific problem that was encountered. Dissatisfaction was focussed upon the limited capacity of the hospital to accommodate women in the early stages of labour. This is made harder because the hospital is located some distance from Birkenhead and has limited car parking. The regime - expressed by one midwife as "you're not technically in labour until you're 3 cm (dilated)" – is not something a pregnant women can assess for herself.[19] Five of the 27 mothers giving birth at Arrowe Park described difficulties when they arrived at the hospital in labour as they were not considered sufficiently advanced to be admitted and were asked to return later.

> "I was in labour for days and every time we went in thought, 'Oh, this is it.' And ended going back home again, had to go all the way home. They always used to say, 'Come in, no matter what.' So you'd have to go all the way in and having all that pain, and be sent all the way home….because I didn't have a car either, so I had to rely on other people to take me."[20]
>
> "They said I could go home, but I couldn't go home because I couldn't walk very far and I kept thinking… you know your instincts didn't feel right, and I said I can't go, I cannot go home. She said well …there's no room on the labour ward if you're not in labour and you're not technically in labour until you're 3cm and I'll see you in a few hours. I think it was like 40 minutes later I gave birth and I only just made it to the labour ward because I couldn't move, once I started it was so fast. They couldn't believe how quick it was, no pain relief, no gas and air because there was nothing there. I was in shock for hours afterwards …it was really quick so it was quite traumatic. I think it took me quite a while to recover, to be honest, I couldn't hold him or anything because I was just shaking."[21]

Other mothers deferred arrival to the hospital, aware that they would be sent home if not well advanced in labour. This did result in several instances of somewhat precipitous birth – 'as soon as I got in the ambulance he was crowning.'

Twelve of the thirty mothers experienced some form of medical intervention in childbirth. These included 5 women who were induced, 2 where forceps were used in delivery and 7 who had caesarean sections. We are unsure if this percentage of women experiencing

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[18] One mother recorded an interview describing her experiences of giving birth to 3 different children, as she wanted to compare and contrast the difficulties and distress she experienced and how lessons from these were and were not learnt by services. She wants this account to be available to services but we are not including the accounts of childbirth here as they took place earlier than the time frame used for this report. Please contact the Birkenhead Foundation Years Trust if you want access to this account.

[19] NHS guidance states that, with advice from the hospital, women should go in when "contractions are:

- regular
- strong
- about five minutes apart
- lasting about 45-60 seconds."

[20] Home-Start resp. 7

[21] TWW resp. 4

interventions typical of deliveries at this hospital. These accounts are the experience of a selected sample. However, an understanding of whether Birkenhead women's and their babies' experience of labour could be made calmer and less stressful would be informed by the analysis and comparison of Wirral-wide, Birkenhead and UK-wide statistics of intervention in childbirth.

Most expressed gratitude to the midwife who had delivered their baby. One, aware that in a long hospital labour consistency of care was unlikely, said her midwife 'was amazing…you were with the same one, right to the end. She stayed late to deliver."

5. POSTNATAL EXPERIENCES

a Baby's nursing care in hospital

Mothers were generally positive about the care and attention their babies received in hospital. The only area of dissatisfaction, for a small number of respondents, was around baby feeding and the perceived pressure to bottle feed poorly or low weight babies (see section 5.d below). None of the babies in this sample had very high levels of support needs: 5 babies had jaundice at birth; 5 were tongue-tied[22]; two babies went to the Special Care Baby Unit (SCBU) with infections for short periods of time. Apart from delays – in one case with identifying jaundice and in the other a tied tongue - there were no complaints with the care received.

b Mothers' postnatal nursing care in hospital

The period immediately after the baby was born, when mother and baby were resting and recovering in the hospital, was not always successfully supported. This was implicitly and explicitly associated with low staffing levels, especially at night. Staff attitudes, willingness or capacity to provide support were criticised. It is possible that these two elements – low staffing levels and staff attitudes - are related. When nursing staff are very busy clinical care is likely to be prioritised above advice and emotional support. Given that the first few hours and days after giving birth are an opportunity to establish secure bonding between mother and baby, this environment is not contributing to the wider objectives of midwifery and health visiting services, in relation to support for mother/baby attachment. Of the 28 women who gave birth at Arrowe Park, 7 described a lack of care and/or a sense of isolation and distress.[23]

> "It seemed more inexperienced people at night-time….nobody really tells you who's who when you go into your little room."[24]

Many mothers could not distinguish between different staff roles, especially with night staff. This uncertainty about who is available to help, and who can help with which problem, is compounded for those having a first baby. An 18 year old, recovering from an epidural and on her own after giving birth for the first time, described her sense of helplessness:

[22] Tongue tie is a problem which occurs in babies who have a tight piece of skin between the underside of the tongue and the floor of their mouth. The medical name for tongue tie is ankyloglossia and the piece of skin joining the tongue to the base of the mouth is called the lingual frenulum. It can sometimes affect the baby's feeding, making it hard for them to attach properly to their mother's breast.

[23] Several who did not make this observation were able to take advantage of early discharge or did not experience care over-night.

[24] Home-Start resp. 7

> "Once I'd had him it was just different women and they were not good at all…I was facing this way and [the baby] was that side and I started crying. I couldn't move and I got really upset. And he was screaming, I couldn't do nothing and they didn't come….she eventually came in, explained and I was dead upset and I was quite narky. I explained I couldn't walk and she said not to be daft and of course I could walk…she said, 'We've all been there'….they just explained to press the buzzer but obviously facing this side, I couldn't move to press the buzzer."[25]

Another 22 year old first time mother, from Eastern Europe, without the support of her own family, described similar disorientation and fear:

> "I was just left in my room and I had to buzz for help. The baby was crying nearly most of the night and I didn't really know what to do. I was exhausted and in pain. Nothing helped him, whether I was feeding him, rocking him, anything like that."[26]

Women who had experience of having babies in Arrowe Park prior to the remodelling in 2011, compared the experience of recovery in a ward with the individual rooms provided in the remodelled hospital. There was recognition that the privacy of an individual room was in some ways more restful, but all commented on the isolation. Only the oldest mother, who remained in Liverpool Women's Hospital for five days after giving birth because her baby was jaundiced, enjoyed the experience – "It was lovely just me and her being together on our own."[27]

Four mothers contrasted the help they had experienced a few years previously with the level of support available now.

> "With my first one I got help in the shower…she stood there while I had a shower…she got me into the shower, she got me out of the shower, I was being sick and everything, she got me buckets…the third time [I had a baby] was not like that at all."[28]

Whatever the reasons for the lack of care, isolation and distress mentioned by seven women, the majority of respondent's accounts commented on or inferred an awareness of staff shortages. Several women who did not mention bad experiences did comment on the pressure nursing staff seemed to be under. A number commented on helpful or sympathetic conversations with ward cleaners. It is possible that if nursing staff are under pressure, cleaners may be the people with time to notice patient distress and the capacity to offer support or understanding. Whether the needs expressed by the mothers were for physical help, guidance or reassurance, the absence of staff compounded the problem.

> "I had quite low blood pressure and they put you in your own room, they said get a shower and get changed, this was about four hours after my caesarean. I remember sitting in the shower crying because I couldn't stand up after, I felt that ill. I got into bed and not one person checked on me that night, not one person came and said do you need help feeding him or anything. They left one bottle on the side and I must have slept, you know the way you do, you're exhausted. They just shouted at me the next day for not waking up to feed the baby."[29]

[25] Forum resp. 3
[26] Tranmere Community Project resp. 6
[27] Home-Start resp. 10
[28] Tomorrow's Women Wirral resp. 2
[29] Tranmere Community Project resp. 3

There were a cluster of complaints about unsympathetic staff at this stage of postnatal care.

> "You could see the different staff. Some are just hard-faced, get on and do, and some give the emotional help. Your hormones are everywhere anyway and you're worried. Like I was worried for stuff going wrong with her, even though nothing was wrong with her, I still had that fear that something's going to happen. And some of the nurses were lovely and some were - open your mouth, temperature, out they go. Two different types of people work there."[30]

c Discharge from hospital

Many women just wanted to leave the hospital as soon as possible, to return to their partner, mother or friend. The minority who stayed in longer so that they or their baby could be cared for and assessed, valued this support. Four women experienced difficulties with discharge from the hospital, having to wait for hours or a day after the discharge had been agreed.

d Support for breastfeeding

A breastfeeding support service is available to mothers provided by Home-Start Wirral, in collaboration with the hospital midwifery service, delivered by a team of volunteer mothers who have breastfeeding experience. Advice and information is available at the hospital antenatally, on the delivery wards and after in the home, for as long as it is wanted.

Experience of breastfeeding	**numbers**	**Any support?**
Breastfeeding for an extended period	15	Liverpool Women's Hospital nurse (1) One2One (1) Home-Start (9)
Breastfeeding initiated but not sustained	5	
Bottle feeding	10	

The percentage of breastfeeding to bottle feeding mothers marks this out as an unrepresentative sample, in part accounted for by the number of respondents contacted via Home-Start and supported by the Home-Start breastfeeding service. This relatively large sample does expose the complexity of establishing what works in this area, as the type of support which was valued varied widely from individual to individual – from satisfaction with a short demonstration of how to position a baby to someone describing as "an onslaught and very intrusive" telephone support they had signed up for when having a baby in 2004[31]. Breastfeeding presents NHS staff with the challenge of supporting and encouraging a behaviour which requires active support from services and commitment and stamina from the mother. The generation of women giving birth today have rarely or never see babies being breastfed around them in everyday life. A generation of midwives and health visitors are supporting a practice they may be personally detached from themselves. Encouragement to breastfeed requires supporting a change in attitudes and feelings not just the passing on of information. NHS staff are skilled at communicating factual health

[30] Ferries resp. 3

[31] This refers to a service offered from Liverpool, not the Home-Start service.

information, possibly less experienced in being agents of cultural change. Despite the high numbers of breastfeeding mums in this sample, there were criticisms of the support available, especially in the first few hours after birth.

Four of the mothers supported by Home-Start's breastfeeding service had the additional difficulty of coping with a baby that was tongue-tied. They described various degrees of delay in identifying and addressing that difficulty and in the meantime, the lack of consistency and knowledgeable support from hospital staff. Help came from unexpected sources, such as the cleaner who suggested nipple shields[32]. Sympathy was not necessarily forthcoming from nurses. There were many, many accounts of feeding a baby whilst crying in the early days and weeks, both from mothers who continued to breastfeed and those who did not. The potential for mothers' ill health or recovery from a caesarean section to create difficulties with milk supply were not explained or discussed. Two mothers who needed rest and recuperation for themselves and made use of an offer from nurses to take the baby at night and feed it in the hospital nursery with expressed milk, believed that in the event the baby had received formula. The two babies who spent time in the Special Care Baby Unit faced additional obstacles to breastfeeding and although Arrowe Park Hospital has access to the Milk Bank[33] the concern of paediatricians and special care nurses for a new baby's weight gain was sometimes at odds with the mechanics of establishing a supply of breast milk for a mother who had never breastfed before.

In this sample very few mothers explicitly said they did not consider breastfeeding. If bottle feeding was not necessarily a matter of preference or expectation, it could result from a lack of opportunity or support to breastfeed. A teenage mum who was distressed and alone in the hospital described this feeling:

> "I wanted to breastfeed him but he wouldn't latch on…there was a lady (to help) there but she went. 'Well he's hungry we're going to have to' – she said you can't just keep trying. I was too upset, I didn't like the environment I was in."[34]

Another respondent, a 3rd time mother, who wanted to breastfeed this child but had not done so with previous children, felt she was rushed home to release a bed when her preference was to stay in and have support with breastfeeding. Another woman who had initiated breastfeeding in hospital but gave up at home described how a telephone offer of help came too late. Time and stamina to feed was lacking because of the pain of early feeding, the demands of school runs for another child and tensions with her partner.

Of those who bottle fed, two were on medication which made breastfeeding unsafe. Others were coping with a mixture of emotions with no one able to support and give them a chance to explore their feelings.

> "I wanted to breastfeed. I found it difficult with my other two children, I wanted to try it with my last one. And they put him skin to skin on me after I gave birth and

[32] Nipple shields are thin silicone covers worn during breastfeeding with holes at the tip which allow milk to flow to the baby and help protect cracked nipples. Painful nipples often occur early on in breastfeeding when milk is not established and the baby is sucking hard on the breast to stimulate the milk supply.

[33] Wirral Mothers' Milk Bank collects donations of breast milk and dispatches pasteurised frozen banked milk to Arrowe Park Hospital, Liverpool Women's Hospital and many other neonatal units in the North West. Babies who benefit from donations are mainly premature and sick babies in neonatal and special care baby units when their own mother's milk is in short supply.

[34] Forum resp. 3

> they left me for an hour with him on my chest. I didn't like it because I'd had a bit of a bad pregnancy with my boyfriend and stuff and I felt I didn't connect with the baby. I couldn't say to the midwife take him away, she'd obviously left the room and I was left with my friend and I just didn't like it."[35]

The message that breastfeeding is the healthy option had an impact not only on those who could not, or did not, breastfeed, but was also reported by breastfeeding mothers when they discontinued or moved to mixed feeding. This caused distress and worry for many of the women at a level out of proportion to the impact on the child's health.

> "The first time they gave me formula [for him] I felt like the worst person in the world. I really thought I was poisoning him, honestly. And I just felt awful for that."[36]

Information on mixed feeding, a pragmatic response to sustaining the health and emotional advantages of breastfeeding whilst reducing the pressure on the mother, was not explained. This had negative effects in one case -

> "I was doing breast[feeding] and I was finding it quite demanding; no one could take her for more than a short while…I wanted to change over to mixed feeding…she was crying so much…and I can't understand why she's not taking the bottle…I just didn't know how to. And I thought, 'Well, it's probably best to just get rid of my milk then she can't smell it'…then cold turkey, which wasn't nice."[37]

Set against these negative comments there were examples of individuals who impressed mothers with their sensitive and supportive approach. The nurse from the Special Care Baby Unit who sat with a mum and made suggestions; the Home-Start volunteer visiting at home who 'just kept popping in – she was lovely'. The mother having her third baby at Liverpool Women's Hospital saw a difference in attitudes from her experience of child birth many years before:

> "The midwives were quite bossy I remember…they've totally changed now…she (recent baby) was under the UVA light and she was upset and I had to do something and I gave her a dummy…and the midwife came in and I went to pull the dummy out of her mouth and she (midwife) went to me – 'Listen, that's your baby, you can do what you want with her.' I thought that hasn't half changed because you were quite scared of midwives when I had my other two."[38]

e Care for mothers affected by postnatal depression

Just under a quarter of the thirty mothers mentioned that they had experienced postnatal depression. They also reported that this problem was not always identified or appropriate support offered. In one case a mother described a midwife running through questions related to depression and answering them herself, leaving no room for the mother to reply. There was understanding from this respondent of the difficulty professionals face in broaching this topic, but frustration that simple listening strategies were not deployed – the woman felt that simple communication would help:

[35] Tomorrow's Women Wirral resp. 2
[36] Home-Start resp. 7
[37] Home-Start resp. 6
[38] Home-Start resp.10

> "Or [she could] look up and just see your face and hesitate and say, 'Oh, are you alright?' Because sometimes you don't want to bother people with it, do you? You think, 'Well I'm alright, I can cope.'"[39]

Another mother described months of tiredness and 'feeling low' before depression was diagnosed. She felt that as the focus was on the baby, her own needs were not visible. She felt it was easier to perform as expected. She describes "putting on a bit of a show…put that kind of face on things…and then when they go you think 'Oh god'." The mother who struggled with breastfeeding on p.14 above was facing the difficult dilemma doing what was best for the baby or for herself, of asking for medication for her depression or breastfeeding. She managed this alone:

> "I think they really need to look into your notes more when you go in, to see what needs you've got. I come across some days that I'm fine, no one knows I've got depression….I wanted to go straight onto medication. I was never offered it at the hospital because I stayed for two nights."[40]

Of all the mothers who experienced postnatal depression one woman's experience stands out as both unique and uniquely insightful. Drawing upon earlier child birth experiences she was able to describe a pattern of staff behaviour:

> "Some of the staff, when you're up on the ward … how can I say? They're there because it's a good job and they're paid to do it and I think they've lost the care, why they went into the work. It's just this regimental way of doing it. If you were sat there crying; some of them would say, 'Are you alright?' and talk to you… one come in and [just] said to me, 'Why are you crying?' "[41]

It may be inevitable that signs of depression are missed as women seek to hide their distress for reasons such as wanting to appear able to cope or because of fear of being judged a failing mother. However, with hindsight at least a minority of these women wished they had received help earlier.

6. POSTNATAL SUPPORT AT HOME

By the time we met these women, when most babies were at least 3 months old, they did not recall much about the weeks immediately after giving birth. Many seemed uncertain about the home visits they had received and there was confusion in relation to which support is ascribed to which service or what help they had received.[42] Mothers had most to say about the support they received from midwives and health visitors at home in this early period immediately after birth on the two topics of baby feeding and depression. These are covered in the two previous sections, as this care started in hospital and continued at home. It seems likely that busy midwifery and health visiting services were arriving at a judgement that individual mothers were managing well and did not require more than the minimum visits but if this was the case, this decision was not explained to or recalled by the women.

[39] Home-Start resp. 7
[40] TWW resp. 2
[41] Ferries resp. 3
[42] All mothers receive visits postnatally from their midwife depending on individual needs but this is anticipated as 3 visits and a postnatal discharge by telephone after 28 weeks. Health visitors similarly provide support dependent on individual need but the universal offer involves 2 visits in the first 8 weeks.

A 24 year old mother living in a hostel with a 13 week old baby looking back to when she had left hospital expressed the sense, if not the reality, of being abandoned:

> "I've not seen anything. I've not seen the midwife since she was about 4 weeks old, 5 weeks old… And the health visitor she's not been around for a month. I don't know where she's gone."[43]

Most mothers were aware that they could ring someone for help or go to clinics but at least one twenty-two year old felt that she shouldn't make this call upon services because she had support from her own mother. She commented that as a first time mum the health visitors were making an assumption that she was doing a good job. Several mothers were articulate about what they would like a health visitor to provide and this was mainly longer-term support and more availability; a mother-like presence.

Of the 9 teenagers, most would have met the criteria to receive enhanced support from a Family Nurse Partnership (FNP) nurse. Not all identified the type of support they were having. Of those who did, a 17 year old mother living in a hostel very much valued her FNP support:

> "The health visitor, she was lovely. [Baby] was born with jaundice and his levels went like, they would go up and then they'd go back down. She was constantly in and out and taking his level readings up to the hospital and making sure everything was okay. She was nice…I think I had about three visits. She still weighs him and stuff now because … well she got involved while I was pregnant as well. She's really helpful. She helps with like when he was 3 or 4 months old, how to wean him on to foods. She was just really, really helpful."[44]

Another found the FNP style and intensity of support challenging:

> "She just goes on about things…she treats me like an idiot to be honest. She treats me like I'm 8 and well, I'm 18…when I was pregnant she'd come out every week with these picture cards and stuff like that and I had to match these picture cards and one week she came with this doll and I was fuming. Because I lived on the bottom floor – hostel, you know, everyone sits on the front. She's got this baby doll and …show me how to feed it…and I said no, it's a doll…So she got the doll…opened the curtain, got the doll in the curtain and she started waving….There's people out the front there…and I thought well, I've got to keep up a rep here."[45]

This mum navigated her relationship with the FNP nurse via encouragement from her housing support worker whose approach was more acceptable - 'She's on it. She's on the ball.' And she had managed to sustain the relationship with the FNP nurse after being prompted to explain how she felt – 'She does treat me a lot better now I've told her. I'll give her that.'

Many more comments were made on health visitor support in relation to issues such as weaning and sleep which went beyond the scope of this report. We will incorporate these in a later report focussing on the period from the baby at 3 months to 2 years.

[43] Forum resp. 1
[44] Forum resp. 3
[45] Forum resp. 4

7. WHAT THIS REPORT DOESN'T TELL US

Many individuals were singled out for special praise by the mothers who talked to us. Moments of sensitive, timely and skilled care were recognised and appreciated. In one instance a young mum who had been through a traumatic, complex birth and remained on the ward for several days, was full of appreciation for her care –'the staff were dead nice…they were really lovely.' These words of appreciation were heartfelt, as were many others, but do not tell us clearly what is valuable to mothers. Respondents were more articulate in their criticisms.

It was notable that mothers did not talk much, if at all, about the support they got from the organisation which had set up their interview/focus group. The result is that the organisations which contribute a specific intervention during this period (Home-Start and Tranmere Community Project) may receive less credit for their work than was deserved. It is likely that the value of that support was assumed. When a transcript of an interview was returned for checking to one woman, she annotated it with a thanks to the support group.

This consultation generated a large volume of detailed description of bad care or treatment, with explanations of how it felt; accounts of clusters of problems and how these affected a woman afterwards. This does not necessarily indicate that the balance of maternity and postnatal care is bad. We don't know if this sample of mothers are typical of all mothers in Birkenhead. Experiences must also be understood as just that – an experience. A statement such as 'no one came for hours' may not be literally true – but it does represent how a mother *felt she had been treated.* Accounts of unhappiness with the availability of care or support, or complaints about staff attitudes, need to be accepted as the experience of that individual. A further stage of investigation may be needed to establish whether a real problem exists, or if expectations of some patients are unrealistic.

In particular younger mothers' sense of being stigmatised can be understood in several ways. It is likely to represent some aspects of their experience accurately and some inaccurately; it can lead to misinterpreting other people's behaviour wrongly; and it can increase the likelihood of challenging behaviour on the part of some young women which itself perpetuates the problem. Awareness of and sensitivity to this issue can help, as it would for all of the issues raised here.

This report is not a balanced account of care as delivered by services supporting women in pregnancy, giving birth and the support they received in the first few weeks after the birth and it does not claim to be. It records the experiences a group of 30 women.

8. SUMMARY

These accounts identify a pattern of dissatisfaction which can be summarised into three broad areas:

a. Lack of equality of experience

- Very few of the mothers were offered informed choice in the maternity services they received. Explanations of the availability of different types of service were not recalled or had not been understood. The minority who were informed had made

choices, others did not. Lack of informed choice impacts disproportionally on poorer people, those who are less well educated and less confident and so leads to inequality

- Younger mothers encountering new procedures or physical challenges as pregnancy progressed were not always accommodated in a way which helped them understand what was happening and the systems with which they would engage

b. Lack of continuity and coherence of care

- Poor transfer arrangements between the One2One midwifery service and the Women and Children's Hospital
- Bad experiences of admission when in labour – the hospital had limited capacity so sent mothers away, resulting in unnecessary tiredness/distress and several examples of rushed admissions
- High levels of dissatisfaction with postnatal care, especially at night – staff shortages, isolation, lack of basic nursing care, information and emotional support.
- Inconsistent discharge arrangements
- Inconsistent and insufficient support for breast feeding, especially in the Women's and Children's Hospital

c. Poor staff attitudes and approaches

- Judgemental attitudes experienced by younger mothers
- More respectful behaviour to 2nd or 3rd time mothers but associated with an assumption that they had less need for information and offers of help
- Lack of sympathetic and empathetic responses to mothers in distress
- Lack of identification of mothers with low levels of prior mental ill-health issues or awareness of the potential for hidden mental health problems
- Inconsistency of advice and didactic advice.

These negative experiences led to a sense of being out of control; feelings of stress, distress, tiredness, fear, loneliness, inadequacy; sometimes challenges and aggression from younger women. These experiences do not support parental mental health and well-being or create a basis for secure attachment between mother and baby. The Foundation Years Trust, concerned with the promotion of calm and happy pregnancies and childbirth, seeks to discover ways in which the problems identified here can be avoided or ameliorated.

9. OTHER PERSPECTIVES

This report offers one perspective on maternity support in the Wirral. Other local reports and consultations touch on some of the same issues. The issue of lack of equality of experience in so far as it affects young women echoes the findings of the Teenage Pregnancy Consultation (Allen, 2012) which had a different focus and a Wirral-wide scope but did find that "all the girls said they felt stereotyped and judged"[46]. It also emphasised

[46] Teenage Pregnancy Consultation, p.17

that the support provided by FNP nurses was valued (5 respondents in this consultation had been supported by FNP), as well as that provided by the Tranmere Project and by the Joseph Paxton Hospital School. These young women also mentioned the positive aspects of being parents when young and made recommendations including "free young mums' health and physical sessions such as pregnancy yoga, aqua natal etc. and more choices of young mums groups… a post baby group."[47]

Poor staff attitudes and approaches are mentioned in relation to parental feedback in The Wirral Way (Sharp, Appleton and Davies, 2011), a service development project focussing on the specific needs of children born prematurely or with a condition associated with developmental delay across the Wirral also has findings in common with this consultation. Although the focus of The Wirral Way is on children with specific needs and their parents and the period of care covered longer, this report mentions isolation in postnatal wards and private rooms and records a low parental score for midwifery communication. This project also records dissatisfaction with breastfeeding support and support for bottle feeding when breastfeeding was not possible.

Other local reports and evaluations provide evidence of good practice and patient satisfaction. The Wirral Women and Children's Hospital has UNICEF Baby Friendly Status[48] at the highest level, as is also the case for Wirral Community NHS Trust and Children's Centres. This status reflects information gathering which includes surveys of parents. This represents systematic work on the part of services to achieve good standards of support for breastfeeding and the recognition of that support by parents.

The Care Quality Commission (CQC)'s most recent report 'National findings from the 2013 survey of women's experiences of maternity care' gives a picture of maternity care across England in which all of the concerns mentioned in this local consultation are repeated. It is heartening that Arrowe Park Hospital's website tells us that Wirral Women and Children's Hospital is named as "one of the top seven Maternity Units in England and the best in the North West" by this survey with scores compared to the 2010 survey of -

- Labour and birth. 8.6/10. 'About the same'
- Staff. 8.7/10. 'About the same'
- Care in hospital after birth. 8.9/10. 'Better'

The national report suggests that 'the same' or 'better' may be relatively modest standards against a backdrop of serious concerns about maternity care. Without access to the local or regional evidence (not published along with the national report)[49] it is unclear how much the CQC local survey provides more extensive or robust evidence than the Foundation Years Trust's survey findings (based on recordings of 30 women's experiences).

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[47] Ibid p. 13

[48] The UNICEF UK Baby Friendly Initiative provides a framework for the implementation of best practice by NHS trusts, other health care facilities and higher education institutions, with the aim of ensuring that all parents make informed decisions about feeding their babies and are supported in their chosen feeding method. Facilities and institutions that meet the required standards can be assessed and accredited as Baby Friendly. The UNICEF website states that both the hospital and the Community Trust have Level 2 accreditation but we believe that they have recently achieved Level 3.

[49] The local review findings are not published so we do not know the mechanism for contributing parental experience, whether on-line only or paper-based responses; the number of local respondents; what their comments were.

Looking at the national or UK-wide context in which these local reports are located it is striking how this pattern of concerns is repeated. This could suggest that wider policy or political trends outweigh the power of local NHS Trusts to develop different approaches. Studies of maternity services in recent years paint a consistent picture of problems created by changes in how services across the country are configured:

> "Despite years of government policy that upholds the importance of autonomous midwifery, midwifery-led care and continuity of care, despite strong evidence of the effectiveness and safety of midwifery-led care, services are being centralised and organised in ways that make the more personal midwifery…more difficult."
> Professor Lesley Page, President of the Royal College of Midwives[50]

The findings of a 2011 survey of 1,400 mothers undertaken jointly by the Royal College of Midwives and Netmums[51] were

- A social divide developing in our maternity services – those on a lower income are getting a poorer deal from maternity services during pregnancy and postnatally
- A feeling of being less well supported and prepared antenatally for birth
- Lack of choice in relation to where they might like to give birth - nearly two thirds had not been offered a home birth.
- Poor postnatal care
- An overstretched maternity service

The extent to which this national picture reflects the situation in the Wirral, and how much the experiences of poorer parents in Birkenhead are in part a result of this situation, is not clear. The existence of a midwifery-led unit at Arrowe Park may be one of the ways in which a more humane and 'personal' service is being delivered, despite external pressures.

The issues raised in this literature include the impact of centralisation of services and the concentration of resources in larger obstetric units; one consequence of this is described as an increase in maternity care being delivered by several specialist midwives rather than a single professional holding a 'case'[52] from pregnancy until the mother is at home and midwife care ends. The Royal College of Midwives (RCM) January 2014 report into maternal mental health argues for local perinatal mental health strategies.[53] Wider than the specifics of midwifery services are the recent findings of the Francis Report into Mid Staffordshire NHS Trust and the NHS England report into the Leeds General Hospital children's heart surgery unit, published in the last week, both identify a lack of compassion in NHS care.

In addition to these longer term trends there is the impact of NHS reorganisation starting in 2013 and continuing; the demise of Primary Care Trusts, the emergence of GP commissioning. Local examples of services change include the movement of the Health Visiting Service from one form of governance to another; Wirral's Child and Adolescent Mental Health Service (CAMHS) which is currently undergoing reorganisation along with the small Parent Infant Mental Health Service (PIMS) provided within that wider service. Local Authority cuts are having an impact on Children's Centres which are one of the community

[50] New Vision for Maternity Care, Association of Radical Midwives, March 2013.
[51] Community Midwives survey http://www.netmums.com/home/netmums-campaigns/community-midwives-the-view-of-mothers
[52] See 2013 Cochrane Review on continuity of care during childbirth www.cochrane.org
[53] Royal College of Midwives, Maternal Mental Health: improving emotional wellbeing in postnatal care, Pressure Points, 2014.

sites for antenatal and postnatal services. Health services and the staff working within them are under immense pressure.

This consultation has been undertaken to explore what is important to Birkenhead mothers at a stage which is associated with children's long term social, emotional and intellectual developmental potential. It will only be useful as part of a dialogue between mothers and providers of maternity services; and if it generates a discussion around which aspects of the report are accurate reflections of the available service, which are less typical, where there may be misinterpretations. This discussion offers the possibility of prompting local changes which will have a real impact and can be shared nationally.

The report is being circulated for consultation widely so that:

- Errors of fact or analysis can be corrected
- The report can be re-publish with responses included
- A dialogue is generated and change can take place, where it is necessary.

We welcome your comments and responses. Please use the attached form so that we can record who has contributed.

10. REFERENCES

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11. ACKNOWLEDGEMENTS

The Foundation Years Trust thanks the following organisations for their support in undertaking this consultation:

Forum Housing - www.forumhousing.co.uk is a Housing Association specialising in supported accommodation for single young people. Staff provide coaching, information, advice and guidance, as well as offering a range of learning opportunities. Their properties in Birkenhead include one house tailored for parents and babies.

Ferries Family Groups - www.ferriesfamilygroups.org.uk move people from isolation to integration in the local community by providing weekly neighbourhood support groups, The Nurturing Programme, 1-1 crisis work, parenting support, a reading group, an allotment project, training courses and workshops for all the family. Social integration activities such as bingo nights, swim nights, holiday activity clubs and picnic and play activities are also provided throughout the year.

Home-Start Wirral – www.homestartwirral.co.uk provide help and support for families who live in Wirral, to help give children the best possible start in life. Home-Start supports parents as they grow in confidence, strengthen their relationships with their children and widen their links with the local community. The core service is delivered by trained volunteers who are parents themselves who support parents of children under 5 years.

Tomorrow's Women Wirral – www.tomorrowswomenwirral.co.uk is a women only project for all women in the community. One of its principal aims is to help women with any issues they may have in order to prevent offending and divert women from custody. It offers support to women who may have lost their confidence and feel isolated.

Tranmere Community Project – www.tcp.org.uk takes young people who have disengaged from learning and re-defines 'learning' for them in a way that develops confidence, self-worth and a permission to dream and to aspire to better things through learning. Alternative education programmes focus on developing a person's personal and social skills

by developing their emotional literacy and thus providing them with the skills and strategies to re-engage in learning or move into further education, training and employment.

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APPENDIX 1

Questions for interviews/focus discussions: experiences of ante-natal care, childbirth and care in the first few weeks after giving birth, V1 - mums.

Explain: we'd like to hear about your experience of having a baby because we're trying to make things better for mums, dads and children in the future. We're recording interviews and discussions like this with people across Birkenhead. We'll transcribe what you say and give you a copy – so you can tell us if it is correct. We'll give you a voucher to say thanks for helping with this. We are planning to produce a booklet to let people working in health and other organisations how services could be improved.

1. Record name of person speaking

2. Can you tell me/us when you had your **first** baby (year)?

3. Do you mind telling us how old you were then?

[In a group we could record this info at the beginning for everyone]

[Questions are guidelines – use them to prompt if the person speaking dries up or you think there is something they aren't saying; use questions if you think they are helpful – no need to ask all questions]

The main things to ask which will normally fill up a whole interview are:

What were your experiences when you got pregnant – how was it with the doctor, scans and midwife? Which midwife service did you have (Community or One2One)?

What was your experience of giving birth?

What was it like when you brought the baby home? What was the help and advice like?

What was helpful? What was not helpful or unpleasant, a problem?

If people don't seem to just talk, here are some more questions to avoid silence. Don't bother with them if people are talking away!

1. When you first realised you might be pregnant, how did you know what to do (things like going to a doctor etc.?)

2. Who was the first person you saw and what happened? How did you feel?

3. After that first appointment, tell me/us about the people you saw during the rest of your pregnancy: check-ups, scans, visits to the hospital?

4. Were there any problems or issues? Tell us about them?

5. Tell us what happened when you went into labour.

6. In labour: who was with you? What staff were with you and what were they like? What was the most helpful? What was the least helpful?

7. Back home: where were you living when you took your baby home? Was anyone around with you in the first few days/weeks? What was it like?

8. Who visited you? (midwife, health visitor) How did they help? What help would you have liked but didn't get?

9. Looking back now – what didn't you know when you got pregnant that you'd have liked to know?

10. Anything else which you think we should know?

Thanks for helping us!

WIRRAL CHILDREN'S TRUST BOARD – 20TH MAY 2014

RISK AND RESILIENCE STRATEGY PROPOSAL 2014/15

1.0 Background
A review of work to reduce teenage pregnancy on Wirral has been undertaken to identify the most sustainable and effective way of moving forward with this agenda. This paper details the position to date and makes recommendations for the development of a risk and resilience strategy to progress this work.

1.1 National strategy
The National Teenage Pregnancy Strategy came to an end in 2010 and areas were advised to establish their own targets and agree funding priorities. By 2010, Wirral had achieved a 7% overall reduction in rate (against the 1999 baseline) and the Children's Trust Board agreed to continue to prioritise prevention and support for teenage parents locally. A new, local target was established that aimed to achieve a 5% reduction in teenage pregnancies year on year, which has so far been successful (see Appendix 1).

1.2 Data
The most recently published annual statistics for under-18 conceptions are from 2012. These figures show that Wirral recorded an under-18 conception rate of 33.5 per 1000, 15 to 17 year olds for the calendar year 2012, (195 conceptions overall), this was a reduction from the 2011 rate (34.6 per 1000, 15 to 17 year olds - 206 conceptions overall).

1.3 Local action plan and groups
Wirral's current plan around teenage pregnancy addresses the prevention of under-18 conceptions and also looks at the support available for those young people who do become pregnant under the age of 18. Whilst future work will primarily focus on early intervention and prevention, priority should also be given to ensuring adequate pathways and services are in place locally to support teenage parents and improve the life outcomes for those young people and their children.

Since the end of the national strategy, difficulties have been experienced locally sustaining momentum around teenage pregnancy work and this has been further confounded by commissioning restrictions. In recent years, Wirral's Teenage Pregnancy Steering Group (TPSG) has provided the strategic lead and commissioning direction around teenage pregnancy, supported by two sub groups – Better Prevention and Better Support. Recent changes to services and staffing, and a reduction in the national focus on teenage pregnancy, has impacted on the membership of the groups and progress made. Recent local progress and activity has been sustained primarily by the two sub-groups led by Public Health staff.

1.4 Budget
Teenage pregnancy interventions and support for Wirral were historically funded through the Early Intervention Grant and the budget for 2013/14 was £150,000, although due to financial restrictions, much of this remained unspent. The funding for teenage pregnancy work is now met from the Public Health grant. The Public Health

team continue to take responsibility for the strategic direction and co-ordination of work to prevent teenage pregnancy. Ongoing commitments from the budget for 2014/15 include the Connexions Teenage Pregnancy Advisor post and delivery of a workforce development programme until the end of January 2015. The outcomes these initiatives deliver have been incorporated into the Healthy Child Programme 0-19 years (which is currently part of a procurement process).

2.0 Other Local Authority area approaches to reducing teenage pregnancy

Through attendance at regional teenage pregnancy meetings, it is evident that an increasing number of local authority areas have had budgets around teenage pregnancy either removed entirely or significantly reduced. Whilst continuing to address teenage pregnancy as a priority, many areas are now taking the opportunity to review how teenage pregnancy services are delivered.

A collaborative, regional approach is currently being developed by a number of Merseyside authorities. This group are in the process of producing an action plan for teenage pregnancy work based on lessons learned from the national strategy, which can be adapted and used within each authority. The plan continues to view teenage pregnancy as a stand alone priority area, with a focus on prevention, healthy relationships and supporting pregnant teenagers and teenage parents. Wirral has been given the opportunity to take part in this collaborative approach.

In another approach, Halton have opted to develop a risk taking behaviour strategy, of which teenage pregnancy forms a key element. Similarly, but further afield, York have implemented a successful strategy around risk and resilience which incorporates both prevention and support agendas for teenage pregnancy and promotes resilience around risk taking behaviours to young people. Both these approaches have been successful in reducing local under-18 conception rates and integrating teenage pregnancy into wider agendas.

Research shows that in order for a prevention strategy to be effective, it should start early, continue through childhood and adolescence, include both universal and targeted approaches, use cognitive, developmental and behavioural approaches and be delivered within a range of settings (e.g. school, home, community). This evidence needs to inform the most appropriate way to take forward this work plan in 2014/15.

3.0 Overview

Risk taking behaviour is a normal part of growing up and experimental behaviour is common amongst young people. However, some behaviour may escalate to potentially harmful levels, resulting in negative impacts on individual's health and wellbeing. This may include such behaviours as alcohol use, smoking, drug and substance misuse, risky sexual activity, anti-social behaviour, self harm etc. Participation in risk taking behaviour can have a significant impact on individuals, families and communities, with those young people who are exposed to risky behaviour from an early age often continuing to exhibit these behaviours themselves through adulthood.

Given the vast majority of pregnancies to teenagers are unplanned and around 50% lead to a termination, teenage pregnancy could be viewed as a consequence of risk taking behaviour. This proposal therefore focuses on the development of a risk and resilience strategy which would address a range of potentially harmful behaviours,

developing strategies to ensure we build resilience amongst Wirral's young people with the aim of minimising potential harm and improving health and wellbeing.

The need to build resilience amongst Wirral's young people was demonstrated in recent consultation work undertaken by Public Health with young people around the Healthy Child Programme and the strategy will aim to address these issues. New and emerging behaviours around healthy relationships, body image, sexting, self harm etc. would also be addressed to ensure the new strategy is relevant to local need.

To ensure effective links with other local programmes, the strategy could be broken down into universal and targeted service delivery as outlined in Wirral's Healthy Child Programme (HCP) commissioning model which will come into effect from February 2015. Delivery of this work plan would also aim to meet the key components of the HCP through providing prevention and early intervention with regard to risk taking behaviours amongst Wirral's young people.

3.1 Proposal to develop a risk and resilience strategy - rationale

It is proposed that in order to respond to changes to local services and emerging evidence base on risk taking behaviour, teenage pregnancy work within Wirral should be integrated into a wider risk taking behaviour agenda. This option was discussed and supported at the last Being Healthy Steering Group meeting in April. Not only would this acknowledge the increasing financial pressures on services, but it would also address the wide ranging causes and consequences of teenage pregnancy, thus in turn, minimising the potential negative consequences for young people in Wirral. By taking this approach, there is the potential to avoid duplication of work amongst services.

4.0 Next steps

Prior to the development of a strategy, consultation will be undertaken with young people via Wirral's pupil panels to identify what they believe the priority areas should be within a new risk and resilience strategy. Please see work programme timetable in Appendix 2.

Partnership working will be required between the Council, NHS organisations, schools and the voluntary sector, with clear accountability for actions established. It is proposed that the existing Teenage Pregnancy Steering Group is disbanded and a new Risk and Resilience group established with reviewed membership from all relevant services, with appropriate terms of reference.

As with the current TPSG, the newly established group would report into the Being Healthy Strategy Group and subsequently into the Children's Trust Board and deliver actions included in Wirral's Children and Young People Plan.

This proposal would require senior, multi-agency, commitment in order to ensure successful implementation. Coordination and strategic oversight of the plan would be provided through the Public Health team.

5.0 Recommendations

Feedback on the proposed work plan is sought and approval from The Board members to proceed with the following actions:

1. Development of a Risk and Resilience Strategy to include action to reduce teenage pregnancy
2. Establish a new Risk and Resilience Steering Group to develop the strategy and implementation plan
3. Merge the Better Prevention and Better Support teenage pregnancy sub-groups to maintain the local agenda in the interim and disband once new strategy comes into place
4. Disband the current Teenage Pregnancy Steering Group.

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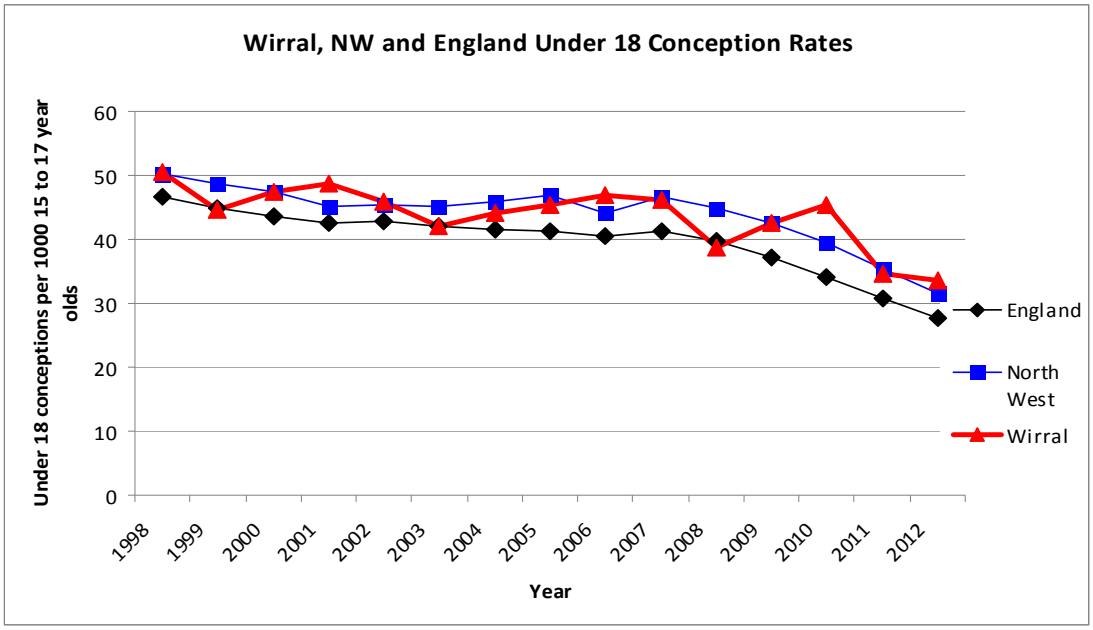
Appendix 1:

Wirral under 18 conception rate (per 1000, 15 to 17 year olds), compared to North West and England



England, North West and Wirral under 18 conception rates per 1000, 15 to 17 year olds, 1998-2012

* Numbers in brackets equate to actual number of conceptions

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
England	46.6	44.8	43.6	42.5	42.8	42.1	41.6	41.4	40.6	41.4	39.7	37.1	34.2	30.7	27.7
North West	50.3	48.8	47.5	45.1	45.4	45.2	46.0	46.9	44.2	46.6	44.8	42.6	39.6	35.3	31.6
Wirral	50.6 (314)	44.5 (284)	47.5 (309)	48.6 (323)	45.8 (303)	42.0 (280)	44.2 (297)	45.3 (302)	46.8 (312)	46.1 (304)	38.6 (249)	42.5 (264)	45.5 (276)	34.6 (206)	33.5 (195)

Appendix 2

Proposed activity timeline:

May 2014	• Set out clear aims and objectives for a Risk and Resilience approach to prevention • Establish Working group to plan the consultation and engagement required to inform strategy development • Disband Teenage Pregnancy Steering Group and inform group of future intentions
June 2014	• Data collation and analysis of need to establish priorities
September 2014	• Key stakeholder event
October 2014	• First meeting of Risk and Resilience group
December 2014	• Strategy drafted
January 2015	• Strategy presented to Children's Trust Board for sign off
Consultation	
June – October 2014	• Consultation with representatives from partner agencies and sub-groups to begin discussions around new strategy and identify membership of Risk and Resilience group • Consultation with young people around priorities for strategy (Youth Hubs, Youth Zone, One Voice Conference and Pupil Panels). Will need to take into account summer holiday period.
Ongoing work	
May 2014 – January 2015	• Continue to implement existing teenage pregnancy plan with sub-groups

WIRRAL CHILDREN'S TRUST BOARD – 20th May 2014

Starting Well in Wirral: A Joint Commissioning Strategy for Children's Public Health Services 0-5years, 2013 - 2015 – update from September 2013 submission.

1.0 Background

An initial paper outlining the proposal to develop this strategy was presented to the Children's Trust Board in September 2013. The paper identified the changes identified below to the NHS to contextualise the rationale for the work.

Following the passing of the 2012 Health and Social Care Act, a number of new organisations were established and commissioning responsibilities for children's services distributed between them:

- NHS England

  Public health services for children 0 – 5 years, specifically the Health Visiting service and Family Nurse Partnership (FNP), in order to deliver the Healthy Child Programme (0 – 5 years)
- Public Health

  Health and wellbeing services to deliver the Healthy Child Programme (5 – 19 years) and health improvement services for 0 - 5 years
- Clinical Commissioning Group

  Midwifery services, elective and non elective health services for 0 – 5 years old.

It is anticipated that responsibility for commissioning of early years public health services will transfer from NHS England to local authorities in October 2015. During this time NHS England is required to work with partners to ensure the effective implementation of the National Health Visiting Development Plan 2011 – 2015 and to develop local Family Nurse Partnership Programmes, specifically to increase capacity, deliver a new model of health visiting and to expand the FNP. This workforce is fundamental to the delivery of the Healthy Child Programme which includes screening and immunisation services and health and development assessment/reviews from pregnancy until the child is 4 years old; with additional support, tailored to individual needs, for those identified as being at risk of poor outcomes.

In recognition of the proposed transfer of overall commissioning responsibilities in 2015 and to ensure commissioning partners optimise health outcomes for children and their families it was previously reported that NHS England Area Team, with local commissioning partners, was required to develop a joint commissioning strategy for early years public health services. This strategy was not proposed to replace existing commissioning plans; rather to align with them and the previous report described the process for the development of a joint commissioning strategy for children's public health services for 0 – 5 years in Wirral.

2.0 Starting Well in Wirral: A Joint Commissioning Strategy for Children's Public Health Services 0 – 5 years, 2013 – 2015

Commissioning partners including NHS England, Wirral Council (CYPD and Public Health) and Wirral CCG, have worked together to identify commissioning priorities for early years public health services in order to develop the joint commissioning strategy up to the proposed transfer of overall commissioning responsibility from NHS England to Wirral Council in 2015. Following a series of meetings, a workshop with representatives from each commissioning organisation was convened in early September at which a number of shared priorities were identified and the strategy's vision and principles agreed based on a collaborative understanding of local needs. The commissioning roles and responsibilities for each commissioning partner were also agreed and are described in the strategy.

Partners agreed that the aim of the strategy is to ensure that all children have the best start in life through the provision of high quality universal services from pregnancy to the age of 5, with additional help for those families who need it through early identification of need and risk. To fulfil this vision, underpin the strategy and to ensure that a coherent commissioning approach is embedded across organisations, the following key principles were jointly established.

Commissioners will ensure:

- the maintenance of investment and quality in early years provision, acknowledging this challenge in a finite fiscal environment
- appropriate and timely access to services
- focus is maintained on improving access for vulnerable groups
- joint workforce planning and training across the early years workforce
- services provide a personalised response, supported by a package of interventions, which is sensitive and responsive to individual needs
- the availability of intelligence on key priorities is enhanced, in order to inform commissioning
- that there is shared learning across the early years system.

A review of needs in relation to health outcomes, benchmarked against national and regional positions, identified a number of agreed areas of priority for improvement across the early years life course (pre conception, antenatal, postnatal and early years). The following priorities aim to maximise health outcomes for children aged 0 – 5 years:

1. Maintenance of quality antenatal preparation (e.g. antenatal education classes)
2. A focus on maternal lifestyle support in pregnancy and early years.
3. Improve maternal mental health
4. Partnership action to increase breastfeeding, refreshing the Wirral strategy
5. Reduce accidents in the early years

Underpinning these priorities is recognition of the necessity for cross cutting, whole system action to address child poverty, domestic violence and to ensure effective safeguarding processes. The strategy is intended to complement and enhance partnership progress to address these complex issues. These priorities resonate with, and contribute to, the outcomes in the Public Health Outcomes Framework, the NHS Operating Framework and the Every Child Matters Outcomes.

3.0 Governance and monitoring of the strategy

The Children's Trust Board recently signed off the proposed structure for the governance of the Children and Young People's Plan. It was identified the Being Healthy Group would monitor the progress of this strategy.

4.0 Recommendations

The Children's Trust Board is asked

- To sign off the strategy and receive regular progress updates.

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Appendix 1

Starting Well in Wirral

A Joint Commissioning Strategy for Children's Public Health Services 0 – 5 years 2013 – 2015

NHS ENGLAND
WIRRAL CLINICAL COMMISSIONING GROUP
WIRRAL COUNCIL

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CONTENTS

INTRODUCTION

The foundations for virtually every aspect of human development; physical, intellectual and emotional, are established in early childhood. These early years, starting in the womb, have a lifelong legacy on many aspects of health and wellbeing from obesity, heart disease and mental health to educational achievement and economic status.

The importance of the years between conception and the age of 5 on longer term outcomes is widely acknowledged. Consequently improving child health outcomes, through a focus on under 5's, is a fundamental commitment for Wirral. This includes continuing to develop key programmes for under 5's and their families, such as Children's Centres, the Health Visiting Service and the Family Nurse Partnership.

This is the first joint commissioning strategy for children's (0 – 5 years) public health services in Wirral and is designed to optimise health outcomes for children and their families. It has been developed by commissioning partners, including NHS England (Cheshire, Warrington and Wirral Area Team), Wirral Clinical Commissioning Group and Wirral Council, and is based on aligned priorities developed in response to local need.

The strategy outlines the multiagency commissioning intentions for 0 – 5 years, up to the proposed transfer of early years public health commissioning to local authorities in 2015. As such it responds to the *National Health Visiting Development Plan 2011 – 2015* to increase capacity and deliver a new model of health visiting. The major challenge is to eliminate disparities in infant health outcomes and ensure that all Wirral children have the best possible start in life.

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CONTEXT

Policy, Evidence and Practice

Having the best start in life is universally acknowledged as critical to establishing the foundation for lifelong health and wellbeing. Later interventions, although important, are considerably less effective where good early foundations are lacking. The period from prenatal development to age 3 is associated with rapid cognitive language, social, emotional and motor development. A child's early experience and environment influence their brain development during these early years, when warm, positive parenting helps create a strong foundation for the future. Parents, carers, families, communities and a number of partnership services all contribute to ensuring the best possible start in life.

Michael Marmot's[1] review of health inequalities established that access to high quality maternity services, parenting programmes, childcare and early years education has the potential to reduce lifelong inequalities. Frank Field's *Independent Review on Poverty and Life Chances*[2] and Graham Allen's *Independent Review on Early Intervention*[3] also highlight the importance of effective, joined-up support for children and families at the start of life. The most recent Chief Medical Officer[4] report is dedicated to improving child health, outlining recommendations which promote early action, proportionate universalism and engaging with children and young people to build resilience. The report shows that child health in England compares poorly with other countries and that there are inequalities within England.

A number of key policy documents aim to maximise outcomes for children and their families describing a strong commitment to children's early years. *Every Child Matters*[5], *Maternity Matters*[6] and more recently the *National Health Visiting Implementation Plan*[7] outline the development of integrated services for all women, children and families providing additional support when it is needed and identified, to enable improved outcomes for children and families. The delivery of evidence based interventions, both universally and through targeting groups at risk of poor outcomes, can significantly improve outcomes and reduce costs to services across a wide range of outcomes in the medium to long term. Intervening early, working with families to build on strengths and improve parenting confidence and, when required, referring early for more specialist help (such as specialist mental health services) is the most effective way of dealing with health, developmental and other problems within the family. Health visitors, working in partnership with GPs, midwives, Children's Centres and other local organisations, have a crucial role in ensuring that this happens. Getting this right can affect the child's physical and mental health and wellbeing, their readiness to learn, and their ability to thrive later in life.

Wirral Children's Trust oversees implementation of national policy and has a strong record of partnership working, providing good services for families. It aims to champion the needs of children and ensure that safeguarding processes are in place across the breadth of the partnership. The vision of the Trust is "*To enable Wirral's children, young people and their families to access services quickly in order to be secure, healthy and have fun and achieve their full potential*". This vision is enacted

through the Children and Young People's Plan (2013-16) which was developed through a collaborative approach involving Wirral's children and young people and all agencies that provide services to support them. The plan is based on the five outcome areas identified in *Every Child Matters*[5]. This document set out the national framework for local change programmes to build services around the needs of children and young people. The areas are:

- being healthy
- staying safe
- enjoying and achieving
- making a positive contribution
- achieving economic well-being.

Healthy Child Programme

The Healthy Child Programme is an early intervention and prevention public health initiative designed to offer an evidence based programme of support, starting in pregnancy, through the early weeks of life and throughout childhood. The Healthy Child Programme offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices.

Universal health and development reviews are a key feature of the Healthy Child Programme. Its universal reach provides an invaluable opportunity to identify families that are in need of additional support and children who are at risk of poor outcomes. The Healthy Child Programme offers 3 levels of care: Universal, Universal Partnership and Universal Partnership Plus. Universal Partnership and Universal Partnership Plus are offered to families with identified additional needs. One of the Healthy Child Programme's key roles is to identify children with additional needs and ensure that these families receive a personalised service.

The Healthy Child Programme requires service integration at all levels. It is delivered through a variety of settings, including General Practice and Children's Centres, and is delivered by a range of practitioners led by the Health Visiting Team supported by the wider children's workforce.

The delivery of the Healthy Child Programme and maternity services is underpinned by a plethora of NICE clinical and public health guidance based on the best and most recent evidence. The relevant guidelines are referenced throughout this document and are detailed in Appendix 1.

Family Nurse Partnership

The Family Nurse Partnership (FNP) is a preventive programme for vulnerable first time young mothers (eligible clients aged 19 years and under (on date of last menstrual period). FNP focuses on those aged <16 years as well as women aged <19 years with risk factors. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until the child is two years old.

Box 1: The Healthy Child Programme- An Overview

Source: Department of Health (2009) Healthy Child Programme: Pregnancy and the first five years of life[8].

Commissioning- Roles and Responsibilities

In recognition of the role of health visitors in the Healthy Child Programme the *National Health Visiting Implementation Plan 2011 – 2015: a call to action*[7] outlines the development of the health visitor service with plans to recruit an additional 4,500 health visitors across the UK by 2015. Following changes to the commissioning of health and public health services the *National Health Visiting Plan: progress to date and implementation 2013 onwards*[9] was published. This plan tasked NHS

England (via Local Area Teams) to led responsibility for commissioning health visiting and early years public health services (including the Health Visiting service and Family Nurse Partnership), delivering workforce growth and service transformation.

Complementary to this are health and wellbeing services commissioned by the local authority (CYPD Early Years and Healthy Child Programme 5 – 19) and Clinical Commissioning Groups (midwifery services, elective and non elective health services for 0 – 5 years). Integrated commissioning of universal and targeted services for children under 5 is crucial to ensure the seamless provision of services delivered by general practice, maternity, health visiting, school nursing and all early years providers.

This strategy has been developed to ensure commissioning partners optimise health outcomes for children and their families and, for the first time, has been developed in collaboration with NHS England, Wirral Clinical Commissioning Group and Wirral Council. It outlines partners agreed commissioning priorities and intentions for early years public health services up to 2015 when it is anticipated that responsibility for commissioning of early years public health services will transfer from NHS England to local authorities. Key priorities and outcomes have been developed in collaboration, based on local need, and within the context of established performance frameworks and national policy. A programme of work to deliver this strategy is included on pages 29 - 40

CHALLENGES

There are 18,933 children aged 0 – 5 years living on Wirral and in 2011 there were 3,802 births[10]. Overall, most of these children will fulfil their aspirations and be healthy, safe and well educated; have easy access to recreation, sport and leisure; be able to make a positive contribution to our society; and be well prepared for their working lives. Most children will live in a decent home and live in a pleasant environment; near a park or open space, with opportunities to explore and have fun.

However, whilst overall Wirral is a positive place for children to grow up, some will not fulfil their potential. There are great disparities in Wirral, not least in wealth. Some areas, mostly in the west of the peninsula, are very affluent; whilst on the east of the peninsula there are high levels of poverty and deprivation. Poverty has an adverse affect of all aspects of a child's life which resonate through adulthood, promoting an intergenerational cycle of poverty.

In Wirral 16,665 (23.8%) children live in poverty, higher than the proportion for the North West (22.1%) and England (20.1%)[10]. Rates of teenage pregnancy, whilst having reduced, remain stubbornly high and in Wirral there are more births to women aged under 20 years than the regional and national average. Levels of teenage pregnancy, the number of mothers aged under 20 years, the proportion of lone mothers and the fertility rate are all higher in the least affluent parts of Wirral. This is likely to impact on the provision of health and social care services as deprivation is linked to a number of infant health issues such as low birth weight, higher rates of hospital admission, reduced breastfeeding rates, learning disability and higher than average levels smoking and obesity in pregnancy.

Overall infant health indicators show that Wirral is not significantly different to national and regional averages, however this masks some extreme inequalities reflecting the income disparity that exists within Wirral. This is evident even in spheres where Wirral is performing well for example MMR uptake. There are significantly higher rates of infant mortality, tooth decay, smoking and substance misuse in pregnancy; and lower levels of uptake for breastfeeding and MMR vaccination, in the most deprived section of the Wirral population.

Moreover there are a number of infant health outcomes which, when compared to the North West and England, require attention. These include lower rates of breastfeeding, a higher rate of emergency admissions for unintentional and deliberate injury and a higher number of children killed or seriously injured in road traffic accidents. The number of obese and overweight children at Reception is also higher locally compared to the North West and England and in 2012, Wirral had a higher proportion of children assessed as being in need (4%) than the national average (3.6%). Family dysfunction (38.4%) followed by abuse or neglect (34.4%) was the highest recorded category of need at initial assessment. An overview summary of child health and wellbeing in Wirral is provided in Appendix 2.

Maternal health in pregnancy is an important determinant in infant health. Smoking status, maternal weight and mental health are critically important for the health of both mother and child in both the short and long term. Work is ongoing to reduce levels of smoking in pregnancy which in Wirral is broadly comparable to prevalence for England. The data on maternal weight and mental health is however less clear and enhanced intelligence is required to understand the needs of Wirral women.

Ultimately, these factors culminate to contribute to the proportion of children achieving a good level[*] of development at Early Years Foundation Stage (age 5) which in Wirral is lower than regional and England averages. Longer term, optimising health in the early years is fundamental to increasing healthy life expectancy for Wirral residents. The particular challenge for Wirral is to eliminate disparities in outcomes and ensure that all children have the best possible start in life.

[*] Good is defined as achieving a total score of 6 or more across the seven personal, social and emotional development and communication, language and literacy scales and 78 points or more in total as assessed by the Early Years Foundation Stage Profile at age 5 years.

VISION, PRINCIPLES & PRIORITIES

This strategy aspires to ensure that all children have the best start in life through the provision of high quality universal services from pregnancy to age 5, with additional help for those families who need it through early identification of need and risk.

Early Years Commissioning Principles

To fulfil this vision the following key principles have been jointly established to ensure that a coherent commissioning approach is embedded across organisations. Commissioning partners will therefore ensure:

- Maintenance of investment and quality in early years provision, acknowledging this challenge in a finite fiscal environment.
- Consistency in specifications and quality indicators, jointly funding and commissioning when appropriate.
- Appropriate and timely access to services.
- Maintained focus on improving access for vulnerable groups.
- Joint workforce planning and training across the early years workforce.
- Services that provide a personalised response, supported by a package of interventions, which is sensitive and responsive to individual needs.
- Enhanced intelligence on key priorities to inform commissioning.
- Shared learning across the early years system.
- A strategic plan is in place for 2015 onwards when commissioning responsibilities change.

Early Years Commissioning Priorities

As part of the development of this strategy a review of needs in relation to health outcomes, benchmarked against national and regional positions, identified a number of agreed areas of priority for improvement across the early years life course. The following priorities aim to maximise health outcomes for children aged 0 – 5 years:

1. Maintenance of quality antenatal preparation.
2. A focus on maternal lifestyle support in pregnancy and early years.
3. Improved maternal mental health.
4. Partnership action to increase breastfeeding, including refreshing the Wirral strategy.
5. Reducing unintentional accidents in the early years.

Underpinning these priorities is recognition of the necessity for cross cutting, whole system action to address child poverty, domestic violence and to ensure effective safeguarding processes. This strategy is intended to complement and enhance partnership progress to address these complex issues. These priorities resonate with, and contribute to, the outcomes in the Public Health Outcomes Framework and the NHS Operating Framework.

This strategy adopts a ‘life course’ perspective; the following sections are presented in line with the key 0 – 5 year milestones.

Starting Well in Wirral at a glance: A Joint Commissioning Strategy 2013 - 2015

Vision: **All children have the best start in life through the provision of high quality universal services from pregnancy to age 5, with additional help for those families who need it through early identification of need and risk**

Outcome: **Children are achieving a good level of development at age 5***

CHALLENGES	PRINCIPLES	PRIORITIES	KEY OUTCOMES	
HEALTH & SOCIAL INEQUALITIES • higher rates of infant mortality, tooth decay, smoking and substance misuse in pregnancy and lower levels of uptake for breastfeeding and MMR vaccination in the most deprived section of the Wirral population. • A higher proportion of children assessed as being in need (4%) than the national average (3.6%). • The proportion of children achieving a good level of development at Early Years Foundation Stage (age 5) in Wirral is lower than regional and England averages.	Maintenance of investment and quality in provision. Consistent specifications and quality indicators. Appropriate and timely access to services. Maintained focus on improving access for vulnerable groups. Joint workforce planning and training across the early years workforce. Personalised services; sensitive and responsive to individual needs. Enhanced intelligence on key priorities. Shared learning across the early years system. Work towards a joint strategic commissioning plan for 2015 onwards.	**PRIORITY 1** Maintenance of quality antenatal preparation.	Decreased infant mortality Decreased number of low birth weight babies Increase breastfeeding at initiation Decreased smoking prevalence at delivery	**Children are achieving a good level of development at age 5***
		PRIORITY 2 Focus on maternal lifestyle support in pregnancy and early years.	Decreased infant mortality Decreased smoking prevalence at delivery Decreased maternal obesity at delivery Decreased number of bow birth weight babies	
		PRIORITY 3 Improve maternal mental health.	Increased maternal wellbeing Decreased infant mortality	
		PRIORITY 4 Partnership action to increase breastfeeding, refreshing the Wirral strategy.	Increased breastfeeding at initiation and at 6 – 8 weeks Decreased obesity at 2.5 years and Reception	
		PRIORITY 5 Reduce accidents in the early years.	Reduced hospital admissions caused by unintentional and deliberate injuries in 0 – 4 years	

Multi agency action to address child poverty, domestic violence and effective safeguarding

PRE CONCEPTION

Maternal health, achievement and maintenance of a healthy weight, lifestyle modification (such as smoking and alcohol cessation, adoption of appropriate diet), folic acid supplementation and improvement of diabetic control prior to, and at the time of, conception are all positively associated with maternal and foetal health and pregnancy outcomes. In recognition that pregnancy is a normal physiological process, preconception advice is not specifically contracted but is universally available through GP services. There is no national guidance in relation to universal preconception preparation and advice.

For some women however preconception care and counselling is essential in reducing adverse pregnancy outcomes and preparing antenatal care in some high risk cases. Specialist services are therefore available for genetic screening, counselling and referral commissioned by NHS England.

KEY ACTIONS
Commissioners will:

- Ensure continued provision of health promotion information and availability of lifestyle support services.
- Review preconception needs to ensure that there are no gaps in service provision.
- Ensure the providers explore the needs of women requesting long-acting reversible contraception removal.
- Continue to enable school projects that aim to normalise breastfeeding.

ANTENATAL *(Conception to full term)*

Healthy mothers tend to have healthy babies; a mother who has received high quality maternity care throughout her pregnancy is well placed to provide the best possible start for her baby. Maternity services have a key role to play in identifying women's medical, obstetric and social needs in order to provide holistic support. As women's needs are diverse it is essential that maternity services work in partnership with women and other services and organisations to respond to women's needs in order to ensure the best possible outcomes for mother and child.

Early access to antenatal services is crucial to enable prompt initiation of maternity care to facilitate early identification of risk and management and to support healthy pregnancy. In recognition of this providers are working to a new payment by results (PBR) tariff to ensure women initiate maternity care on or before 12 weeks and 6 days gestation. Following first contact with a health professional and up to delivery there are a number of key antenatal milestones during which time women, in partnership with services, plan their care and are offered information, assessment and access to national screening programmes as specified in the *NICE Antenatal Care Clinical Guideline*[11]

Antenatal Healthy Child Programme Schedule

	Information	**Assessment**	**Screening**
First contact (Referral to maternity services)	Antenatal information provided by the health professional e.g. folic acid supplementation, food hygiene, lifestyle choices and antenatal screening information.		
Booking (Initial antenatal appointment, ideally before 10 weeks up to 12 weeks and 6 days)	Fetal development. Nutrition and diet. Management of common symptoms of pregnancy. Exercise. Place of birth. Pregnancy pathway. Breastfeeding. Lifestyle assessment and advice. Domestic violence. Antenatal classes. Further discussion of antenatal screening. Discussion of mental health issues (NICE guideline 45). Hand held maternity record issued.	Early ultrasound scan to determine gestational age and detection of multiple pregnancy. BMI measurement. Gestational diabetes. Pre eclampsia risk assessment.	Screening for Down's syndrome offered. Screening for infectious disease (e.g. asymptomatic bacteriuria, Hep B, HIV, Rubella and Syphilis). Screening for haemoglobinopathies.
20 weeks gestation		Blood pressure and urinalysis for protein.	Ultrasound screening for fetal anomalies routinely offered.

Before 36 weeks gestation	Breastfeeding information. Preparation for labour and birth. Recognition of active labour. Vitamin K prophaylaxis. Newborn screening tests. Postnatal self care. Awareness of baby blues and postnatal depression.	Blood pressure and urinalysis for protein.	
38 weeks gestation	Options for management of prolonged pregnancy.		

Routine appointments are scheduled after 24 weeks gestation during which symphysis-fundal height is measured and recorded at each appointment in additional to pre eclampsia assessment and antenatal monitoring and information. For nulliparous women 10 appointments are recommended, reducing to 7 for parous women.

Midwife and GP led care, supported by holistic support services (e.g. parenting preparation), is universal for women with uncomplicated pregnancy. All pregnant women will be offered information based on the current available evidence together with support to enable them to make informed decisions about their care. This will include where they will be seen and who will undertake their care. Health visiting contact is initiated at week 36 building on the lead midwife's assessment however targeted antenatal referrals from Midwifery providers to Health Visiting can commence from 20 weeks gestation.

ANTENATAL PARENTING PREPARATION

Wirral has a long established 4 week ante-natal programme delivered in Children's Centres, jointly facilitated by physiotherapists, health visitors, midwives and Children's Centre staff and based on the evidence based pregnancy, birth and beyond model. Parents-to-be are signposted to the programme through their midwives and are able to book onto any one of 15 programmes, 2 of which are in the evenings. If clients are identified as needing additional support, it is made available through the most appropriate professional and 1:1 home visits are arranged.

Wirral Health Visitors achieve a near 100% coverage of mothers receiving a first face to face antenatal contact with them. This represents excellent performance and coverage compared to other areas.

Some women require additional support to address their individual needs. Comprehensive assessment of health and social care needs during universal antenatal care enables identification of women who may have enhanced needs. For

women with mental health needs access to specialist services is available, dependent upon the level of need required, commissioned by NHS England. Wirral has a specialist perinatal mental midwife and a specialist perinatal Health Visitor who provide care and give specialist support to women and their families. There is an integrated specialist perinatal mental health pathway in development for Wirral women to ensure that all the local health services work together and can quickly identify need and give full support to any pregnant women as required.

Tailored parenting programmes for parents with additional needs; including learning difficulties, those for whom English is a second language or young parents who do not access the Family Nurse Partnership service (18 years pus), are provided in small groups or in the home on a one to one basis by qualified parenting facilitators from Children's Centres.

Lifestyle services, commissioned by Wirral Council Public Health Department, are available to all pregnant women who require support to address lifestyle issues such as smoking cessation, obesity, drugs and/or alcohol misuse.

KEY ACTIONS
Commissioners will:

- Maintain access to antenatal parenting support for parents to be.
- Continue to ensure early access to booking, focusing on improving access for vulnerable groups.
- Enhance intelligence on the impact of obesity, smoking, substance misuse (including alcohol), suicide and mental health in pregnancy on delivery outcomes.
- Ensure that pathways and services are available to identify and support women who need additional support in relation to obesity, tobacco, substance misuse including alcohol, suicide and mental health in pregnancy.
- Identify the needs of pregnant women experiencing domestic violence, work with the broader partnership to identify a strategic approach and ensure that providers tailor interventions appropriately.
- Work with providers to review service provision for women with mental health problems in the perinatal period.
- Ensure providers are working towards the minimum criterion of the You're Welcome and UNICEF Baby Friendly Standards.
- Facilitate provider partners working together to provide parenting support.
- Conduct a review of the Family Nurse Partnership across Cheshire, Warrington and Wirral and implement recommendations to ensure allocation of resources reflects need.
- Use emerging evidence base regarding British Family Nurse Partnership to inform Family Nurse Partnership commissioning.
- Ensure providers practice reflects changes in the 'Personal Child Health Record' relating to co-sleeping.

ANTICIPATED OUTCOMES

1. **Increase proportion of women accessing maternity care on or before 12 weeks and 6 days gestation with a focus on vulnerable women.**

2. **Increase breastfeeding at initiation and at 6 – 8 weeks.**

3. **Decreased smoking prevalence at delivery.**

4. **Decreased maternal obesity at delivery.**

5. **Decreased infant mortality.**

6. **Decreased number of low birth weight babies.**

7. **Increased maternal wellbeing.**

8. **Reduced hospital admissions caused by unintentional and deliberate injuries in 0 – 4 years.**

INTRAPARTUM *(Delivery)*

Birth is a life-changing event and the care given to women during labour has the potential to affect them both physically and emotionally in the short and longer term. *Maternity Matters*[6] emphasised the importance of offering choice, access and continuity of care in a safe environment. Following this publication a review of maternity services in Wirral took place in 2007 and again during 2011/12. This has informed the commissioning of providers to offer a range of models of care that are able to meet the needs of the local population reflecting the high levels of inequality in both income and health outcomes.

MIDWIFERY LED CARE
The Midwifery Led Unit provides care during active/established labour and the immediate postpartum period (including for women who have chosen an alternative provider for their antenatal and postnatal care). All care is provided or supervised by registered midwives. All Wirral women who are registered with a Wirral GP who have been identified as low risk at the initial assessment of health and social care needs are eligible for this service.

NICE Clinical Guideline 55[12] describes the recommended care and support which women should receive during labour. This reinforces women centred care in which women are in control and aware of what is happening supported on a one to one basis by a lead midwife. The guideline describes the recommended arrangements for normal labour, planning place of birth, coping with pain, perineal care, delay in the first stage of labour and instrumental birth.

Wirral Clinical Commissioning Group's *Strategic Plan 2013-16*[13] included the redesign of local maternity services to provide a Midwifery Led Unit for women assessed as low risk. This midwifery-led maternity service provides midwifery care which maximises continuity of care, the normalisation of the birthing process and promotion of breastfeeding as the choice for all women. It comprises provision of antenatal and postnatal care at home and also in accessible high quality child and family friendly environments.

KEY ACTIONS
Commissioners will:

- Ensure providers comply with NICE guidelines.
- Ensure providers are working towards the minimum criterion of the You're Welcome and UNICEF Baby Friendly Standards.
- Review and refresh the Wirral Breastfeeding Strategy.
- Ensure providers practice reflects changes in the 'Personal Child Health Record' relating to co-sleeping

ANTICIPATED OUTCOMES

1. **Increase the number of 'low risk' women who choose a midwifery led birth.**

2. **Increased maternal satisfaction with delivery.**

3. **Increased proportion of women who initiate breast feeding.**

4. **Reduced medical interventions during labour e.g. levels of caesarean section and assisted delivery.**

5. **Increased maternal wellbeing.**

POSTNATAL *(Delivery to 6 – 8 weeks after birth)*

Postnatal care is the individualised care provided to meet the needs of a mother and her baby following childbirth. Although the postnatal period is uncomplicated for most women and babies, care during this period needs to address any variation from expected recovery after birth. For the majority of women, babies and families the postnatal period ends 6–8 weeks after the birth. However for some, the postnatal period should be extended in order to meet their needs. This is particularly important where a woman or baby has developed complications and remains vulnerable to adverse outcomes.

During the postnatal phase, like the antenatal period, there are a number of key milestones at which women and their babies are offered information, assessment and access to national screening programmes. This includes the NHS Newborn and Infant Physical Examination Programme, to maximise short and long term health outcomes. NICE *Clinical Guideline 37*[14] outlines the recommended care that every healthy woman and healthy baby should be offered during the first 6 to 8 weeks after birth. During this period, care transfers from midwifery services to health visiting teams who are responsible for delivering individualised postnatal care plans.

Postnatal Healthy Child Programme Schedule

	Information	**Assessment**	**Screening**
Up to 24 hours after birth	Breastfeeding advice and support to encourage initiation. All babies and families registered with Children's Centre's at birth.		
Within 72 hours of birth	Personal Child Health Record issued by Child Health Information Service (CHIS).		Newborn physical examination of the baby as per the screening schedule. A newborn hearing screen should be conducted prior to discharge.
Birth Visit	Discuss signs and symptoms of potentially life threatening conditions following delivery. Discuss family and social support. Information to	Assessment of the mother's mental health by asking appropriate questions for the identification of depression, such as those recommended by the NICE guidelines	Newborn Blood Spot screen offered 5 – 8 days after birth.

	promote their own and baby's health and wellbeing and respond to problems. Promoting sensitive parenting. Promoting development. Reduction of the risk of Sudden Infant Death. Home safety. Discuss immunisation intent.	on antenatal and postnatal mental health.	
10 day visit	Comprehensive review and assessment of need. Offer of: Universal pathway (baby clinics) Universal Plus (HV team meet additional needs of family) Universal Partnership Plus (multiagency response). Share Health Visiting team contact details and information regarding local clinics, groups and Children's Centres. Inform clients of current Healthy Child Programme.	Assessment of the mother's mental health asking appropriate questions for the identification of depression, such as those recommended by the NICE guidelines on antenatal and postnatal mental health.	
6 – 8 weeks after birth	Contact made by Children's Centre and universal, outreach services made available.	Assessment of the mother's mental health asking appropriate questions for the identification of depression, such as	Repeat newborn physical exam in addition to assessment of social smiling and visual fixing and following.

		those recommended by the NICE guidelines on antenatal and postnatal mental health. 6 week check of mother's recovery, health and wellbeing, including contraception, conducted in primary care.	

Initiation of breastfeeding is recommended within the first hour of birth; with breastfeeding advice and support available during the crucial 24 hours after delivery. Breastfeeding contributes to the health of both the mother and child in the short and longer term. Women should be made aware of these benefits and those who choose to breastfeed should be supported by a service that is evidence-based and delivers an externally audited, structured programme with delivery of breastfeeding support coordinated across the different sectors. Breastfeeding uptake at initiation and at 6 weeks in Wirral is significantly below the figure for England. Just 55% of Wirral mothers breastfeed at initiation, dropping to 30% at 6 – 8 weeks. These figures vary across Wirral with 31% of women breastfeeding at initiation in the most deprived parts of the borough and just 8% still breastfeeding at 6 – 8 weeks[10].

ENABLING COMMUNITY & PEER SUPPORT- CHILDREN'S CENTRE REGISTRATION
All Wirral babies are registered with a Children's Centre at birth through the Registry Office. Children's Centre staff attend the Registry office every day to ensure easy access for new parents.

For women and families with additional needs, enhanced provision of postnatal care and support through the early years, is delivered through the Universal Partnership and Universal Partnership Plus health visiting programme. Universal Partnership offers additional support from health visiting in response to identified needs for example; feeding problems, behaviour management, maternal depression, social and communication delay. Children's Centres and the Family Support Service offer further complementary support, including evidence based parenting programmes (some co-delivered with health visitors) and home visits.

The Universal Partnership Plus offers a co-ordinated multiagency response to individually identified needs for example; a mother with on-going mental health problems. This may include referral to Wirral Council's Targeted Service, for a multi-agency 'Team around the Family Assessment' enabling appropriate, targeted support.

A number of specialist services are commissioned for children and families with specific needs. These include specialist treatment health services for children 0 – 5 years (known as tiers 2 and 3) commissioned via the CCG as well as specialist provision for children with disabilities.

There are also additional services (known as tiers three and four) available to families where parenting may be compromised due to substance misuse and domestic violence. There are limited, one to one, services for parents with learning disabilities through Children's Centres however there are recognised gaps in the provision of support for these families.

KEY ACTIONS
Commissioners will:

- Ensure postnatal care from maternity providers, health visiting, Child Health Information Service and primary care complies with NICE guideline and quality standards.
- Maintain quantity and quality of health visiting workforce; with commissioning partners working together to plan the sustainability and transfer of commissioning for health visiting in 2015.
- Enhance and explore intelligence in relation to maternal mental health and suicide.
- Ensure that pathways and services are available to identify, advise and support parents or carers who need additional support in relation to obesity, tobacco, substance misuse including alcohol, suicide and mental health.
- Review the provision of services for families with additional needs at tiers 2, 3 and 4 and commission in response to identified needs.
- Maintain access to universal and appropriately targeted early years services through Wirral Council and commissioned services.
- Conduct a review of the Family Nurse Partnership across Cheshire, Warrington and Wirral and implement recommendations to ensure allocation of resources reflects need.
- Use emerging evidence base regarding British Family Nurse Partnership to inform Family Nurse Partnership commissioning.
- Initiate research to explore why Wirral women are not breastfeeding.
- Ensure providers practice reflects changes in the 'Personal Child Health Record' relating to co-sleeping.

ANTICIPATED OUTCOMES

1. **100% coverage for review of maternal mood.**

2. **100% coverage for newborn physical exam and maternal review at 6 – 8 weeks.**

3. **Increased proportion of mothers initiating breastfeeding and at 6 – 8 weeks.**

4. **100% coverage of recording of breastfeeding status at 6 – 8 weeks.**

5. **Achieve expected immunisation coverage targets.**

6. **Reduced hospital admissions caused by unintentional and deliberate injuries in 0 – 4 years.**

7. **100% coverage for mothers receiving a first face to face antenatal contact with a health visitor.**

8. **100% of health visitor new birth visits conducted face to face within 14 days of birth.**

EARLY YEARS *(8 weeks – 5 years)*

The provision of health and wellbeing services as part of the Healthy Child Programme continues beyond the postnatal period into the early years of life. This includes a number of scheduled assessments, developmental review and immunisations as part of the national vaccination schedule (see Appendix 2). This includes the ongoing provision of universal and enhanced health visiting provision and specialist services commissioned at tiers 2, 3 and 4 as described earlier.

Early Years Healthy Child Programme Schedule

12 - 16 week review	Completed by appropriate member of the Health Visiting Team. The following is covered: • Review of Family Health Needs. • Review of general progress and delivery of key messages about parenting and health promotion. • Offer of support to parents by providing access to parenting and child health information and guidance and Information on Children's Centres and family information services. • Review of immunisations. • Practical guidance on managing crying and healthy sleep practices. • Raise awareness of accident prevention in the home and safety in cars. • Discuss play and development. • Practical advice and guidance on chosen method of feeding and nutrition. • Maternal mental health assessment and identification of post-natal depression and/or other maternal health needs as completed at previous contacts. • If parents wish, or if there has been professional concern about the child's growth, or risk to normal growth (including obesity), an assessment should be carried out. This involves accurate measurement, interpretation and explanation of the child's weight in relation to length, to growth potential and to any earlier growth measurements of the child.
9-12 month review	By the child's first birthday a face to face contact is completed by appropriate member of the Health Visiting Team. This review covers the following: • Growth monitoring. Measurement of length does not have to be done routinely at the Healthy Child Review at 9 -12 months: however, use professional judgement for each individual child. • Observation of the child's posture and movements while the child is awake. • Review of hips. • Asking parents if there are any concerns regarding undescended testicles and offering an information

	leaflet which highlights the importance of identifying that both testicles are in the scrotum by the age of one. • Review of vision. • Completion of the hearing questionnaire. • Review of the speech and language development. • Discussion of social and behavioural development. • Immunisation status. • Public health and community support. • Discussion on healthy lifestyle and dental health. • Childhood safety. • Any additional parental or carer concerns should be discussed and documented with clear action plans/packages of care agreed in partnership. Referrals to other services should be undertaken if any developmental issues or concerns are identified.
2-2 ½ year review	Completed by appropriate member of the Health Visiting Team. The 2-2½ year Healthy Child review includes hearing, speech and language development, vision, public health and community support, healthy lifestyle and safety, height, weight and body mass index (BMI) will also be recorded.
3-5 years review	Aim for a tiered handover to school nursing.

In addition to health and wellbeing services early years social, emotional and educational development are absolutely critical, providing the essential foundations for healthy development. If these foundations are not secure, children can experience long-term problems which often facilitate additional social consequences. Children's attainment, wellbeing, happiness and resilience are profoundly affected by the quality of the guidance, love and care they receive during the first years of their lives. Wirral Council's Family Information Service gives advice on services for families, including childcare options.

While parents and other carers at home are the main source of support, it is also imperative that the support and education provided in pre-school settings is of a high quality. In 2008 the Early Years Foundation Stage (EYFS) was introduced with the intention of providing a framework to deliver consistent and high quality environments for all children in pre-school settings, recognising the importance of this period in a child's life. There are 123 private or voluntary operated preschools and nursery settings in Wirral and a further 257 child minders, providing childcare for children from 0 – 5 years and working under the EYFS Framework.

All children aged 2 years, living in families with a income of less than £16,100 are eligible for 15 hours per week (570 hours per year if taken flexibly over the year) funded childcare. Families are able to apply for funding on-line or through their health worker and are supported to access childcare settings through their local Children's Centre.

HOME SAFETY

Safe and Sound is an accident prevention scheme jointly commissioned by Wirral Council and Wirral Public Health which ensures that families with children under the age of two years receive information, advice and guidance on how to keep their children safe in the home. Families with low incomes are offered a range of safety equipment which is supplied and fitted free of charge to the client by Merseyside Fire Network who also provide advice on fire safety and install a free smoke detector and carbon monoxide monitor, along with a safety check of any outside space.

All 3 and 4 year olds living in England are eligible for 15 hours per week (570 hours per year if taken flexibly over the year) funded childcare. Funding is accessed through the childcare provider and information about the funding is available through the Wirral Family Information Service. Children under the age of 5 years with identified additional needs are supported through the Special Educational Support Service with a range of services provided by the School Readiness Team. Access to this service is through Wirral Council's Targeted Service Gateway Referral Point.

KEY ACTIONS

Commissioners will:

- Ensure that there is joint workforce planning and training across the early years workforce.
- Maintain access to early education for identified 2 year olds and universal childcare for 3 to 4 year old for 15 hours per week.
- Ensure that pathways and services are available to identify, advise and support parents or carers who need additional support in relation to obesity, tobacco, substance misuse including alcohol, suicide and mental health.
- Ensure that all providers promote the Merseyside Fire Network free home safety check.
- Ensure providers are working towards the NICE *social and emotional wellbeing in early years public health guidance.*
- Implement finding of Home Safety Health Needs Assessment.
- Enhance and explore intelligence on the incidence of road traffic accidents, burns and scalds based on A & E attendance for 0 – 5 year olds.
- Review the strategic partnership approach to prevention of child accidents.
- Ensure providers utilise 24 month review to identify and address any weight issues.
- Ensure providers practice reflects changes in the 'Personal Child Health Record' relating to co-sleeping
- Develop a commissioning plan to ensure positive parenting support is established in the early years complemented by a plan for children 5 – 19 years.

ANTICIPATED OUTCOMES

1. **More than 90% of children to receive a 12 month health visitor review by the age of 12 months.**

2. **100% of children to receive a 12 month health visitor review by the age of 15 months.**

3. **More than 90% of children to receive a 2 - 2½ year review by age of 2½ years.**

4. **100% of sure start advisory boards with a health visitor presence.**

5. **Children are achieving a good level of development at age 5*.**

6. **Decreased obesity at 2.5 years and Reception.**

7. **Reduced hospital admissions caused by unintentional and deliberate injuries in 0 – 4 years.**

STARTING WELL IN WIRRAL: IMPLEMENTATION PLAN

PRE CONCEPTION			
ACTION	**HOW**	**WHO**	**WHEN**
Ensure continued provision of health promotion information and availability of lifestyle support services.	Map current provision of information and support services. Ensure information is up to date and user friendly.	All – led by Wirral Council – Public Health	End of April 2014 Ongoing
Review preconception needs to ensure that there are no gaps in service provision.	Review evidence around good practice and map current system. Consult with expectant and new mums in relation to their experience and needs preconception.	Wirral Council – Public Health	September 2014 September 2014
Ensure that providers explore the needs of women requesting long-acting reversible contraception removal.	Review during contract monitoring process.	Wirral Council – Public Health	Ongoing
Continue to enable school projects that aim to normalise breastfeeding.	Continue to commission school based projects (evaluating throughout) through the 0 – 19 years pathway.	Wirral Council – Public Health	Ongoing

ANTENATAL			
ACTION	**HOW**	**WHO**	**WHEN**
Maintain access to antenatal parenting support for parents-to-be.	Ensure health visiting service maintain 100% coverage of antenatal face to face visits.	Wirral CCG/NHS England/Wirral Council (CYP & PH)	Ongoing
Continue to ensure early access to booking, focusing on improving access for vulnerable groups.	Scrutinise through commissioning contract monitoring process. Implement Maternity PBR tariff for early booking (e.g. before 12 weeks and 6 days). Monitor FNP baseline to ensure vulnerable groups are achieving improved engagement with services through early booking.	Wirral CCG	Ongoing Ongoing Ongoing
Enhance intelligence on the impact of obesity, smoking, substance misuse (including alcohol), suicide and mental health in pregnancy on delivery outcomes.	Using maternity dashboard, establish prevalence of smoking, obesity, drugs and alcohol, mental health issues amongst pregnant women. Investigate delivery outcomes amongst a population of mothers with known lifestyle factors during pregnancy.	Wirral Council - Public Health	By end of September 2014 By end of September 2014

Ensure that pathways and services are available to identify and support women who need additional support in relation to obesity, tobacco, substance misuse including alcohol, suicide and mental health in pregnancy.	Review existing pathways for pregnant women, establishing gaps and commission evidence based solutions. Determine the training needs of: • health visitors • midwives. Develop an annual joint training package around lifestyle for health visitors and midwives. Ensure that midwives, health visitor and Family Nurse Partnership teams are signposting appropriately to pathways and services through contract monitoring process. Monitor referrals to lifestyle services from antenatal providers.	Wirral Council - Public Health/Wirral CCG/NHS England	Ongoing March 2014 Sept 2014 Delivery from April 2015 Ongoing Ongoing
Identify the needs of pregnant women experiencing domestic violence, work with the broader partnership to identify a strategic approach and ensure that providers tailor interventions appropriately.	Initiate research with pregnant women to understand the key issues and needs. Map out what support and services are currently available for pregnant women. Present findings from research and mapping to Children's Trust, Safeguarding Group, Health & Wellbeing Board and Public Service Board.	Wirral Council - Public Health	September 2014 September 2014 October 2014 onwards

Work with providers to review service provision for women with mental health problems in the perinatal period.	Improve pathway based on findings from a service review currently underway.	Wirral CCG	June 2014
Ensure providers are working towards the minimum criterion of the You're Welcome and UNICEF Baby Friendly Standards.	Monitor compliance through contract monitoring process.	All	Ongoing
Facilitate provider partners working together to provide parenting support.	Determine local need and work towards joint funding and commissioning of a parenting support programme as appropriate. Share the learning from the multiagency antenatal parenting programme and replicate approach, where appropriate, to other parts of the 0 – 5 life course system.	Wirral Council-Public Health/Wirral CCG	By March 2015 By March 2015
Conduct a review of the Family Nurse Partnership across Cheshire, Warrington and Wirral and implement recommendations to ensure allocation of resources reflects need.	Complete review. Draw up action plan to implement recommendations.	NHS England	By end of November 2013 January 2014 onwards
Use emerging evidence base regarding British Family Nurse Partnership to inform Family Nurse Partnership commissioning.	Evidence base published. Apply evidence to form commissioning intentions for local Family Nurse Partnership provision.	NHS England	End of March 2014 End of June 2014

Ensure providers practice reflects changes in the 'Personal Child Health Record' relating to co-sleeping	Implement the Safe Sleep Guidance. Monitor providers to ensure that they implement the new Safe Sleep Guidance policy. Provide training for Midwives and Health Visitors.	NHS England/ Wirral CCG/ Wirral Council - Public Health	January 2014 Ongoing Ongoing

INTRAPARTUM			
ACTION	**HOW**	**WHO**	**WHEN**
Ensure providers comply with NICE guidelines.	Monitor compliance through contract monitoring process.	Wirral CCG	Ongoing
Ensure providers are working towards the minimum criterion of the You're Welcome and UNICEF Baby Friendly Standards.	Monitor compliance through contract monitoring process.	Wirral CCG	Ongoing
Review and refresh the Wirral Breastfeeding Strategy.	Work to develop a new Breastfeeding Strategy currently underway**.**	Wirral Council – Public Health	Complete September 2014
Ensure providers practice reflects changes in the 'Personal Child Health Record' relating to co-sleeping	Implement the Safe Sleep Guidance. Monitor providers to ensure that they implement the new Safe Sleep Guidance policy through contract monitoring process. Provide training for Midwives and Health Visitors**.**	NHS England/ Wirral CCG/ Wirral Council- Public Health	January 2014 Ongoing Ongoing

POSTNATAL			
ACTION	**HOW**	**WHO**	**WHEN**
Ensure postnatal care from maternity providers, health visiting, Child Health Information Service and primary care complies with NICE guideline and quality standards.	Ensure compliance through contract monitoring process.	NHS England/Wirral CCG	Ongoing
Maintain quantity and quality of health visiting workforce; with commissioning partners working together to plan the sustainability and transfer of commissioning for health visiting in 2015.	Recommission services for robust service specifications to achieve quality and coverage indicators. Ensure health visitors and Family Nurse Partnership services are commissioned on robust contracts from April 2015 onwards.	NHS England/Wirral Council – Public Health	By October 2014 January 2015
Enhance and explore intelligence in relation to maternal mental health and suicide.	Develop system to determine needs in relation to postnatal maternal health. Ensure maintenance of 100% coverage of maternal mood review by health visitor teams.	Wirral Council - Public Health/NHS England	By end of June 2014 Ongoing
Ensure that pathways and services are available to identify, advise and support parents or carers who need additional support in relation to obesity, tobacco, substance misuse including alcohol, suicide and mental health.	Review existing pathways for new parents and carers, establishing gaps and commission evidence based solutions. Determine the training needs of health visitors.	Wirral Council - Public Health/NHS England	Ongoing End of March 2014

	Develop an annual joint training package around lifestyle for health visitors and Children's Centre staff. Ensure that health visitors, Family Nurse Partnership teams and Children Centre staff are signposting appropriately to pathways and services through contract monitoring process. Monitor referrals to lifestyle services from early years providers.		Delivery from April 2015. Ongoing Ongoing
Review the provision of services for families with additional needs at tiers 2, 3, and 4, and commission in response to identified needs.	Review and present findings as appropriate	Wirral CCG/ Wirral Council - Public Health	September 2014
Maintain access to universal and appropriately targeted early years services.	Ensure that appropriate and timely information is available to parents/carers through the Family Information Service. Ensure that appropriate information, signposting and referral routes are in place to enable multi-agency support for families.	Wirral Council/NHS England	September 2014 onwards
Conduct a review of the Family Nurse Partnership across Cheshire, Warrington and Wirral and implement recommendations to ensure allocation of resources reflects need.	Complete review. Draw up action plan to implement recommendations.	NHS England	By end of November 2013 January 2014 onwards

Use emerging evidence base regarding British Family Nurse Partnership to inform Family Nurse Partnership commissioning.	Evidence base published. Apply evidence to form commissioning intentions for local Family Nurse Partnership provision.	NHS England	End of March 2014 End of June 2014
Initiate research to explore why Wirral women are not breastfeeding.	Complete research with Wirral women.	Wirral Council – Public Health	September 2014
Ensure providers revise practice to reflect changes in the 'Personal Child Health Record' relating to co-sleeping.	Implement the Safe Sleep Guidance. Monitor providers to ensure that they implement the new Safe Sleep Guidance policy through contract monitoring process. Provide training for Midwives and Health Visitors.	NHS England/ Wirral CCG/ Wirral Council - Public Health	January 2014 Ongoing Ongoing

EARLY YEARS			
ACTION	**HOW**	**WHO**	**WHEN**
Ensure that there is joint workforce planning and training across the early years workforce.	Work with commissioning partners to identify areas of overlap/ duplication in client pathways. Agree action to streamline provision. Support providers to share learning with other provider organisations.	NHS England/ Wirral Council-PH & CYP/Wirral CCG	September 2014 By March 2015 Ongoing
Maintain access to early education for identified 2 year olds and universal childcare for 3 to 4 year old for 15 hours per week.	Implement refreshed marketing and awareness raising strategy to ensure full take up of funded early education places by local families. Ensure sufficiency of childcare & early education for all families.	Wirral Council	Ongoing
Ensure that pathways and services are available to identify, advise and support parents or carers who need additional support in relation to obesity, tobacco, substance misuse including alcohol, suicide and mental health.	Review existing pathways for new parents and carers, establishing gaps and commission evidence based solutions. Determine the training needs of health visitors. Develop an annual joint training package around lifestyle for health visitors and Children's Centre staff.	NHS England/ Wirral Council - Public Health	Ongoing End of March 2014. Delivery from April 2015.

	Ensure that health visitors, Family Nurse Partnership teams and Children Centre staff are signposting appropriately to pathways and services through contract monitoring process. Monitor referrals to lifestyle services from early years providers.		Ongoing Ongoing
Ensure that all providers facilitate uptake of the Merseyside Fire Network free home safety check.	Monitor uptake of the free home fire safety check.	Wirral Council - Public Health	Ongoing
Ensure providers are working towards the NICE *social and emotional wellbeing in early years public health guidance*.	Monitor through contract management process.	NHS England	Ongoing
Implement finding of Home Safety Health Needs Assessment.	Complete Health Needs Assessment. Develop implementation plan.	All – led by Wirral Council- Public Health	September 2014 From October 2014 onwards
Enhance and explore intelligence on the incidence of road traffic accidents, burns and scalds based on A & E attendance for 0 – 5 year olds.	Review data availability, interrogate data and develop recommendations in relation to findings**.**	Wirral Council – Public Health	September 2014
Review the strategic partnership approach to prevention of child accidents.	Host Wirral 'Child Accident' Conference.	'Be Healthy' Steering Group/	January 2015

		Wirral Council – Public Health	
Ensure providers utilise 24 month review to identify and address any weight issues.	Ensure health visitors provide a quality 2 - 2½ year review which includes weight/height check, identifying any issues and addressing appropriately including signposting to services as appropriate. Commission and implement 0 – 5 weight management service.	NHS England Wirral Council – Public Health	Ongoing February 2015
Ensure providers revise practice to reflect changes in the 'Personal Child Health Record' relating to co-sleeping	Implement the Safe Sleep Guidance. Monitor providers to ensure that they implement the new Safe Sleep Guidance policy through contract monitoring process. Provide training for Midwives and Health Visitors**.**	NHS England/ Wirral CCG/ Wirral Council - Public Health	January 2014 Ongoing Ongoing
Develop a commissioning plan to ensure positive parenting support is established in the early years complemented by a plan for children 5 – 19 years, including support for parents of children with additional needs.	Review Wirral Parenting Strategy. Refresh and implement changes to the Wirral Parenting Strategy.	Wirral Council/Wirral CCG/ Wirral Council – Public Health	December 2014 From April 2015

GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

The agreed remit of partners commissioning responsibilities for this strategy is outlined below.

NHS England	Wirral CCG	Wirral Council
0 – 5 Healthy Child Programme including Health Visiting and Family Nurse Partnership services	Midwifery Services	Healthy Child Programme 5 – 19 years
Immunisation and screening services for 0 – 5 year olds	Elective and non elective health services	Lifestyle support services including: • Drugs • Alcohol • Smoking • Obesity
Specialist health services for 0 – 5 year olds Specialist women's services		
Breastfeeding		

The implementation and performance of this strategy will be overseen by the 'Be Healthy' Steering Group, with representatives from each partner organisation. This group will report into the established Children's Trust Board governance structures, which provide a framework to ensure accountability and effective monitoring of the delivery of outcomes.

APPENDIX 1

Early Years NICE Guidance: Clinical Guidance, Public Health Guidelines and Quality Standards

Antenatal care. NICE clinical guideline 62 (2010).

Diabetes in pregnancy: management of diabetes and its complications from pre-conception to the postnatal period. NICE clinical guideline 63 (2008).

Intrapartum care: care of healthy women and their babies during childbirth. NICE clinical guideline 55 (2007).

Antenatal and postnatal mental health: clinical management and service guidance. NICE clinical guideline 45 (2007).

Postnatal care: routine postnatal care of women and their babies. NICE clinical guideline 37 (2006).

Caesarean section. NICE clinical guideline 13 (2004) [replaced by NICE clinical guideline 132]

Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households. NICE public health guidance 11 (2008).

Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities. NICE public health guidance 10 (2008).

Brief interventions and referral for smoking cessation in primary care and other settings. NICE public health intervention guidance 1 (2006).

Induction of labour. NICE clinical guideline 70 (2008).

Routine antenatal anti-D prophylaxis for women who are rhesus D negative. NICE technology appraisal 156 (2008).

Maternal and child nutrition. NICE public health guidance 11 (2008).

Weight management, before, during and after pregnancy. NICE public health guidance 27 (2010).

Social and emotional wellbeing in early years. NICE public health guidance 40 (2012).

Postnatal care. NICE Quality Standards QS37 (2013)

Hypertension in Pregnancy. NICE Quality Standards 35 (2013).
Caesarean Section. NICE Quality Standards.

Antenatal Care. NICE Quality Standard 22 (2012)

APPENDIX 2: Wirral Child Health Profile Summary

Wirral Child Health Profile — March 2013

Summary of child health and well-being in Wirral

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

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

England average: 25th percentile – 75th percentile
range of values that differ significantly from the average

	Indicator	Local no. per year	Local value	Eng. ave.	Eng. worst	Eng. best
Preventable mortality	**1** Infant mortality rate	18	4.7	4.4	8.0	2.2
	2 Child mortality rate (age 1-17 years)	9	14.1	13.7	23.7	7.5
Health protection	**3** MMR immunisation (by age 2 years)	3,513	93.4	91.2	78.7	97.2
	4 Diphtheria, tetanus, polio, pertussis, Hib immunisations (by age 2 years)	3,672	97.6	96.1	85.7	98.8
	5 Children in care immunisations	440	84.6	83.1	0.0	100.0
	6 Acute sexually transmitted infections (including Chlamydia)	1,412	37.2	35.6	75.2	19.9
Wider determinants of ill health	**7** Children achieving a good level of development at age 5	2,261	60.8	63.5	51.5	76.5
	8 GCSE achieved (5A*-C inc. Eng and maths)	2,477	65.4	59.4	40.9	79.6
	9 GCSE achieved (5A*-C inc. Eng and maths) for children in care	-	-	14.6	0.0	40.0
	10 Not in education, employment or training (age 16-18 years)	1,090	8.9	6.1	11.8	1.6
	11 First time entrants to the Youth Justice System	198	648.2	876.4	2,436.3	342.9
	12 Children living in poverty (aged under 16 years)	14,875	25.3	21.1	45.9	7.4
	13 Family homelessness	74	0.5	1.7	7.4	0.1
	14 Children in care	675	100.0	59.0	150.0	19.0
	15 Children killed or seriously injured in road traffic accidents	18	31.1	22.1	47.9	4.4
Health improvement	**16** Low birthweight	254	6.6	7.4	11.0	5.0
	17 Obese children (age 4-5 years)	347	9.7	9.5	14.5	5.8
	18 Obese children (age 10-11 years)	627	19.8	19.2	27.8	12.3
	19 Participation in at least 3 hours of sport/PE	24,163	55.6	55.1	40.9	79.5
	20 Children's tooth decay (at age 12)	-	0.8	0.7	1.5	0.2
	21 Teenage conception rate (age under 18 years)	276	47.3	35.4	64.7	6.2
	22 Teenage mothers (age under 18 years)	81	2.2	1.3	2.8	0.3
	23 Hospital admissions due to alcohol specific conditions	79	117.9	55.8	138.3	16.9
	24 Hospital admissions due to substance misuse (age 15-24 years)	57	148.9	69.4	186.3	25.7
Prevention of ill health	**25** Smoking in pregnancy	482	13.2	13.2	29.7	2.9
	26 Breastfeeding initiation	2,029	55.6	74.0	41.8	94.3
	27 Breastfeeding at 6-8 weeks	1,119	30.2	47.2	19.7	82.8
	28 A&E attendances (age 0-4 years)	8,365	448.6	483.9	1,187.4	136.3
	29 Hospital admissions due to injury (age under 18 years)	943	139.2	122.6	211.1	72.4
	30 Hospital admissions for asthma (age under 19 years)	155	216.6	193.9	484.4	73.4
	31 Hospital admissions for mental health conditions	57	84.2	91.3	479.7	22.6
	32 Hospital admissions as a result of self-harm	112	165.4	115.5	311.9	26.0

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

1 Mortality rate per 1,000 live births (age under 1 year), 2009-2011
2 Directly standardised rate per 100,000 children age 1-17 years, 2009-2011
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2011/12
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2011/12
5 % children in care with up-to-date immunisations, 2012
6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2011
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2011/12
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2011/12 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local Connexions services, 2011
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2010/11
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2010
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2011/12
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2012
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2009-2011
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2011
17 % school children in Reception year classified as obese, 2011/12
18 % school children in Year 6 classified as obese, 2011/12
19 % children participating in at least 3 hours per week of high quality PE and sport at school age (5-18 years), 2009/10
20 Weighted mean number of decayed, missing or filled teeth in 12 year olds, 2008/09
21 Under 18 conception rate per 1,000 females age 15-17 years, 2010
22 % of delivery episodes where the mother is aged less than 18 years, 2011/12
23 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2008-11
24 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2009-12
25 % of mothers smoking at time of delivery, 2011/12
26 % of mothers initiating breastfeeding, 2011/12
27 % of mothers breastfeeding at 6-8 weeks, 2011/12
28 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2010/11
29 Crude rate per 10,000 (age 0-17 years) for emergency hospital admissions following injury, 2011/12
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2011/12
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2011/12
32 Crude rate per 100,000 (age 0-17 years) for hospital admissions for self-harm, 2011/12

APPENDIX 3

EARLY YEARS NATIONAL VACCINATION SCHEDULE

Age	Vaccine
2 months	5-in-1 (D(DTaP/IPV/Hib) vaccine Pneumoccocal (PCV) vaccine Rotavirus vaccine
3 months	5-in-1 (DTaP/IPV/Hib) vaccine, second dose Meningitis C Rotavirus vaccine, second dose
4 months	5-in-1 (DTaP/IPV/Hib) vaccine, third dose Pneumococcal (PCV) vaccine, second dose
Between 12 and 13 months	Hib/Men C booster, given as a single jab containing meningitis C (second dose) and Hib (fourth dose) Measles, mumps and rubella (MMR) vaccine, given as a single jab Pneumococcal (PCV) vaccine, third dose
2 and 3 years	Flu vaccine (annual)
3 years and 4 months, or soon after	Measles, mumps and rubella (MMR) vaccine, second dose 4-in-1 (DTaP/IPV) pre-school booster, given as a single jab containing vaccines against diphtheria, tetanus, whooping cough (pertussis) and polio

erences

[1] The Marmot Review (2010) Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010. http://www.ucl.ac.uk/marmotreview.

[2] HM Government (2010) The Foundation Years: preventing poor children becoming poor adults. The report of the Independent Review on Poverty and Life Chances.

[3] HM Government (2011) Early Intervention: The Next Steps. An Independent Report to Her Majesty's Government.

[4] Annual Report of the Chief Medical Officer 2012: Our Children Deserve Better: Prevention Pays. October 2013.

[5] Department of Education and skills (2004) *Every Child Matters: Change for Children*.

[6] Department of health (2007) *Maternity Matters: Choice, access and continuity of care in a safe service.*

[7] Department of Health (2011) Health Visitor Implementation Plan 2011 – 2015. A call to action.

[8] Department of Health and Department for Children, School and Families (2009) Healthy Child Programme. Pregnancy and the first five years of life.

[9] Department of Health, NHS England, Public Health England, NHS Health Education England (2013) The National Health Visitor Plan: Progress to date and implementation 2013 onwards.

[10] Wirral Council and Wirral Clinical Commissioning Group (2013) Joint Strategic Needs Assessment.

[11] National Institute for Health and Clinical Excellence (2010) Antenatal Care. NICE clinical guideline 62.

[12] National Institute for Health and Clinical Excellence (2007) Intrapartum care: care of healthy women and their babies during childbirth. NICE clinical guideline 55 (2007).

[13] Wirral Clinical Commissioning Group (2013) Strategic Plan 2013 – 2016.

[14] National Institute for Health and Clinical Excellence (2006) Routine Postnatal care of women and their babies. NICE clinical guideline 37.

WIRRAL CHILDREN'S TRUST BOARD – 20 May 2014

Children's Services Commissioning

1.0 Background

This report covers the Children's Services Commissioning. Also attached is the RAG report for year end March 2014. This RAG report is for 11 months as the contracts began on 1st May 2013. This will bring the reporting into the financial year and April's figures will be included in the following year's report.

2.0 Introduction

This information is an update to inform the Board about the performance of the Children's Commissioning. The contracts, with the exception of one which has been decommissioned as it had been duplicated, have been rolled over for a further 11 months as part of the budget saving options. Also each contract has had a reduction in their funding for the coming year. This will be monitored and the impact reported on at a later date.

The Priority areas for which services were commissioned are:

PA1 – Parenting
PA2 – Short Breaks for Disabled Children
PA3 – Youth Challenge
PA4 – Statutory Services
PA5 - IFIP

Delivery against the performance measures have been RAG rated Red, Amber or Green. A Red rating denotes underperformance; Amber reflects work in progress broadly in line with expectations and Green is meeting or exceeding expectations. Red and Amber ratings are followed up by commissioners in one to one discussions at which corrective actions are identified to improve performance.

Each organisation is contracted to supply a completed monitoring form every quarter as well as having a monitoring visit. 100% of the organisations have had a contract compliance visit. There are two organisations which present as a concern and the commissioner is in discussion with them about their performance.

3.0 Current Position

The current position for each of the areas is as follows

PA1 Parenting

There are four organisations currently commissioned in this area and each of the organisations has met their outputs and outcomes for this year

PA2 Short Breaks

There are twelve different organisations commissioned in this area and although in the RAG report there are two organisations which are not meeting their outputs, this will be rectified as they were planned for Easter which is in April.

PA3 Youth Challenge

In this area of Youth Challenge there were three services commissioned and they are all meeting their outputs and outcomes.

PA4 Statutory Services
There are four different organisations delivering these commissioned services and only one which is not currently meeting their outputs and outcomes. An alternative plan has been put in place and they have now increased their outputs and outcomes since the last quarter. In discussion with this organisation, they reported that the difficulty was with the monitoring return as this did not fully show the work they had undertaken and this has now been rectified.

PA5 IFIP
In this area there are two services which have been commissioned and there is concern with one contract not meeting its outputs and outcomes. The commissioner has had a series of meetings with this organisation and a plan has been put into place to rectify this.

4.0 Additional Commissioning
There have been two new areas of commissioning which is the Adoption Reform Grant which C4EO have been commissioned to work with both District Social Workers and Adoption Social Workers to ensure that permanency for children is planned from the outset when a child comes into care. The other area is the local offer for the new SEND reforms. The Family Forum has been commissioned to co-produce this with the LA and partners and there will also be a new commissioning opportunity on The Chest for the development of a website.

5.0 Recommendations:
- That Wirral Children's Trust Board note the report.

Appendices:

Appendix 1 – RAG Report for Quarter 1 through to 4

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Children's Services Commissioning Rag Report Quarter Four January - March 2014

Service/Provider		Actual Outputs QTR 1	Actual Outputs QTR 2	Actual Outputs QTR 3	Actual Outputs QTR 4	R/A/G QTR 1	R/A/G QTR 2	R/A/G QTR 3	R/A/G QTR 4	Comments
Priority area 1 Parenting and family support										
Out of care - Homestart	100	0	9	14	63					Since the referral route/criteria opened up to levels 2 and 3 the service has become much more productive. Some of the outcomes are still being measured as it is too early to quantify. 100% increased awareness of community support services reported.
Domestic Violence - Zero Centre	80	16	28	23	31					100% of participants rated this service as successful. This organisation also has met its outcomes for this quarter and has met its outputs
BME - WMO	180	41	65	35	54					44 families were regularly supported including 61children.This service has met its outcomes for the past four quarters and has also exceeded their target of 90% of people satisfied with their service and has met its outputs
Young Carers - Barnardos	140	42	55	56	62					115 Young Carers have been supported to date and the organisation might fall slightly short of its outputs by the end of the contract. However all the outcomes have been met. Recently referrals have been relatively low which the organisation believes is due to the reorganisations within the LA across adults, children and adult mental health services. Barnardos are working with Social Care and other teams across the services to raise awareness of the service and to clarify the referral process
Priority Area 2 - Short Breaks										
Service/Provider	**Predicted Outputs per year**									
PA2.1a Activate Training	48 sessions 10 yp per session	6 sessions 11 per session	9 sessions 11 per session	10 sessions Av of 10 per	14 sessions Av of >10 per session					No issues. Additional sessions will take place as holiday sessions in April so that target is reached.
PA2.1b.Wirral Youth and Play	96 sessions 15 yp per session	14 sessions 10 per session	20 sessions 10 per session	18 sessions 12 per session	22 sessions 12 per session					Additional sessions for performances and additional rehearsals were not recorded on spreadsheets. Wednesday sessions also split into 2 separate sessions for different service user groups and these were not recorded as separate sessions. Total actual sessions delivered 117 which exceeds target. Additional work also took place with individual service users outside of sessions which was not recorded.
PA2.2 Wiral Toy Library	156 sessions, numbers attending vary	27 sessions	35 sessions	37 sessions	34 sessions					No issues. Target number of sessions will be reached with April sessions.
PA2.3 Wirral Sport Development	84 sessions 15 yp per session	21 sessions 11 per session	18 sessions 9 per session	25 sessions 13 per session	31 sessions 16 per session					No issues. Target reached

PA2.4 Crossroads- Pensby Wood	4x4hr sessions per wk for 48wks per year. 48 unique yp per week	36 sessions 44 unique yp per week	48 sessions, 42yp per week	25 sessions 13 per session	46 sessions, 41yp per week					No issues. Overall attendance for year 49 unique young people
PA2.5 Wirral Play Council	235 sessions	37 sessions	56 sessions	59 sessions	59 sessions					No issues. Target number of sessions will be reached with April sessions.
PA2.6 Crossroads after school clubs	78 sessions, 7 yp per session	14 sessions 8 yp attending	9 sessions av of 7 yp attending each week	18 sessions 6yp av of 5 yp attending each week	16 sessions av of 4 yp attending each week					Numbers slightly lower than anticipated and number of sessions lower; took longer than expected to start up the sessions at Elleray Park. Some additional sessions will be run in April.
PA2.7 Wirral Autistic Society Activity Clubs	3x2hr sessions per week for 48 weeks	24 sessions	38 sessions	36 sessions	36 sessions					No issues. Target number of sessions will be reached with April sessions.
PA2.8 Crossroads residential weekends	8 weekends per year; 6 for level 2/3 yp with app 12 yp per weekend, 2 for	2 weekends each with 10 yp attending	2 weekends. 23yp & 7yp	2 weekends. 16yp & 14yp	1 weekends. 14yp					No issues. Target number of sessions will be reached with April sessions.
PA2.9 Wirral Autistic Society Take 2 Short Breaks	1800 session 50 unique yp per year	146 sessions 23 yp year to date	140 sessions 28 yp year to date	315 sessions 72 yp to date	482 sessions 90 yp to date					Unique number of service users exceeded. Sessions slightly lower than expected due to initial staffing issues which have now been addressed. Sessions where staff were available and families cancelled at short notice were not recorded but will be recorded in future.
PA2.10 Family Support	1935 session 30 unique yp per year	330 sessions 21 yp year to date	424 sessions 22 yp year to date	345 sessions 27 yp year to date	12 sessions 26 yp year to date					The EIG funded young people currently being supported have high level of need and need staffing levels of 2, 3 or 4 to one. The team are working intensively with two of these young people to prevent them being placed out of borough. Where young people have very high support needs the team also put in a number of hours supporting the family and without this additional work the short breaks would not take place. One of these young persons has now been placed out of borough and this should be reflected in future stats.
PA2.11 Wirral Autistic Society Friendship Support	2x2hr sessions per wk 96 sessions per year 60 unique yp per year	19 sessions 10 yp year to date	17 sessions 14 yp year to date	11 sessions 20 yp year to date	12 sessions 26 yp year to date					At the request of service users some sessions are 3,4 or 5 hours long rather than 2 and some session are split into two separate gender groups, staffed separately. Total hours overall delivered is 201 which exceeded the target of 192 hours. Unique number of young people is lower than expected and the service is working with families to address the time taken for young people to be ready to move on
PA2.12 Action for Children Contract Carer scheme	242 nights per year: 218 nights contract care, 6 yp per year 24 nights SB care	22 nights total, 16 contract care, 6 SB care. 4 yp contract care, 1 yp SB	56 nights total, 49 contract care, 7 SB care. 7 yp contract care, 1 yp SB Year to date	92 nights total, 88 contract care, 4 SB care. 12 yp contract care, 1 yp SB Year to date	78 nights total 72 contract care, 6 SB care. 13yp contract care, 1 yp SB year to date					No issues

Priority Area 3 - Youth Challenge										
Universal Support - Youth Service	9 courses - 100 young people in each course	100	227	215 new this quarter	179 yp new this quarter 409 regularly supported					A total of 1000 yp have participated from January to March and 179 represents new young people this quarter Target level of 71% from target localities . 302 will have received an OC accreditation this year.409 are regularly worked with and 399 of these will have an accredited outcome Positive feedback from all young people who wish to participated. Activities include 13-19 INTEGRATED DANCE, ADVANCED URBAN & BREAKDANCE, NEW ELEMENTS 2 VISUAL ARTS PROJECT, LIVE 'N' LOUD MUSIC SESSIONS, 13-19 INCLUSIVE DRAMA WYT has also set up locality based Children Services Commissioning projects in a range of settings.
Targeted Support - Youth Fed	18 courses - 10 young people in each course	0	3 courses - 34 young people	114yp this quarter 6 courses	76 regulary supported this quarter					This service has over the year had many challenges getting referrals but have overcome them and have ended supportingf 185 yp 100% of the young people who took part rated the service as being successful. An average of 90% was recorded for three of the outcomes which related to an improvement in school attendance and improved behaviour and a reduction of ASB. This service has been decommissioned as they have left a learning legacy by training young people and workers.
Targeted Support - YOS	5 courses - 10 young people in each course	57	17	14 new this quarter 36 regularly supported	14 new this quarter and 48 regulary supported					100% of young people who took part rated the service as being succesful . Referral agencies reported that they were pleased with the success and progress made by the young people. Also 100% of the young people taking part showed an increase in their school attendance and improved attendance. No young people who were at risk of exclusion or NEET became excluded or NEET
Priority Area 4 - statutory services										
Advocacy and IV - Barnardos	400	47	16	19 this quarter (82 to date)	35 this quarter (117 to date)					This organisation has not fully acheived the outputs. The reason for this is that this service is dependent on referrals being made from Social Workers. Discussion has taken place with the relevant people and an alternative plan has been put into place to achieve the outputs. Of the young people supported the outcomes achieved were all over 90%. Referrals are not as high as we require for advocacy, newly looked after and foster care reviews
Parent Pship - WIRED	400 parents/carers	45	97	88	210					This organisation has achieved its outputs. They also achieved 100% in their four outcomes from the evaluations returned
Missing from home - Catch 22		55	112	80	86					Three of the four outputs this organisation achieved 100% as well as achieving 85% in three of their outcomes. Catch 22 provide police with regular feedback from return assessments which is beneficial for future missing reports and assists with risk assessments.
Post Adoption - After Adoption	40	11	9	7	11					This organisation has acheived its outputs and have supported 86 service users to date They also achieved 100% in their four outcomes

Priority 5 - IFIP										
Family Role Model - Homestart	180	0	12	14	7 new families this quarter. 28 regularly supported this quarter					Of the evaluations from the regularly supported families 100% rated the service as successful.Most significant problem with this project is that the organisation can only accept referrals from IFIP Key Workers and they have not received the amount that they expected. Working to support level 2 and 3
FIP- Catch 22	75	73	83	92	54					This organisation over-achieved in majority of their outputs and eight outcomes. They are making referrals to Homestart but reported that a number of families have been opposed to a referral

WIRRAL CHILDREN'S TRUST BOARD – 20 May 2014

Health & Social Care in Wirral – Developing Vision 2018
Children's Integration Workstream - Update

1.0 Background

National Context
There is a real and significant financial challenge facing the NHS, Local Government and our partners in the coming years.

Local Challenges
Consistent with the national trend, the Wirral health and social care system is under increasing financial pressure, and if we continue to deliver services the way we do now, the demand for services will outweigh the available funding. The traditional efficiencies will not be enough to ensure high quality and affordable health and care services continue in the future.

Over the coming years all health and social care organisations in Wirral will need to continue to respond to escalating demand and continued financial constraint to meet the health and social care needs of the population.

Locally, leaders of health and social care have agreed to work in partnership to develop a health and social care strategy called "Vision 2018." The aim is for quality of care and outcomes to be protected and enhanced, despite increased costs and a potential reduction in funding. The Vision 2018 Group consists of health and social care leaders, working in partnership to address these challenges together, with the following agreed vision:

To ensure the residents of Wirral enjoy the best quality of life possible, being supported to make informed choices about their own care, and being assured of the highest quality services.

A Programme Board has been established, overseeing 8 workstreams one of which is the Children's Integration Workstream. Over the next 3-4 months mechanisms will be put in place to engage with the public and staff across the NHS and Local Authority to develop our vision for the future.

2.0 Children's Integration Workstream
The Inaugural meeting of the group was held on 02 May 2014. Julia Hassall, Director of Children's Services, Wirral Council and Dr Adrian Hughes, Wirral University Teaching Hospital Consultant Paediatrician/Clinical Service Lead Community Paediatrics,
will act as Chair and Vice Chair respectfully. The Terms of Reference for the group were considered and will be finalised at the next meeting. The group will meet on a monthly basis with the next meeting being held on 3 June.

The themes that emerged from the first meeting were:

- The Right Service First Time
- Transition
- Opportunities for integration with Child Development Centre/Service
- Resilience and mental health
- Emotional Health and Wellbeing
- Breastfeeding

The next step will be to draw up a list of priorities and programme of work for the group to take forward.

3.0 Recommendation:

- **The Board is asked to note the work of the Children's Integration Workstream and updates on the progress of the work of the group will be provided.**

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WIRRAL CHILDREN'S TRUST BOARD – 20TH MAY 2014

THE CHILDREN AND YOUNG PEOPLE'S PLAN 2013-2016 – REVIEW 2013-14 AND REFRESH 2014-16

1.0 Background

1.1 The Children and Young People's Plan (CYPP) is a overarching strategic plan developed by Wirral Children's Trust for all organisations providing services for the children and young people of Wirral. It is developed and reviewed by multi-agency groups ensuring all partner organisations and children and young people are fully involved. The CYPP is reviewed annually.

1.2 In May 2013 Wirral Children's Trust (CT) Board approved the new three CYPP 2013-16. The CT made a commitment to review and refresh the CYPP on an annual basis to evidence the positive difference being made and ensure that the CYPP remains relevant and fit for purpose. The review and refresh does not replace the 2013-16 CYPP but is a concise tool for review, assessing progress and refreshing areas of work as required.

1.3 Progress against the first year of the new plan has been reviewed with a focus on reporting on outcomes achieved. Exceptions are provided where activities have been delayed. The plan has been refreshed ensuring it remains fit for purpose reflecting the organisational changes currently occurring. The review and refresh document is provided for endorsement.

2.0 Recommendation

That the Board approve the Children and Young People's Plan 2013-16 Review 2013-14 and Refresh 2014-16.

3.0 Appendices

Appendix 1: Children and Young People's Plan 2013/16- Review 2013-14 and Refresh 2014-16

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WIRRAL CHILDREN AND YOUNG PEOPLE'S PLAN 2013-16

REVIEW 2013-14 AND REFRESH 2014-16

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INTRODUCTION

In 2013 Wirral Children's Trust published our 2013-16 Children and Young People's Plan (CYPP). This plan outlines how all partners working together will continue to make a positive difference to the lives of children, young people and their families.

In our CYPP we outlined the constraints Wirral Children's Trust operates under in light of significant public sector change and austerity, and this position continues. This was reflected in the CYPP through ensuring a small number of highly focused priorities to ensure cost-effective activity is targeted in the right areas. We also made a commitment to ensure that through review and refresh the CYPP would evolve and remain fit for purpose in these times of significant change.

Central to the delivery of the CYPP is the effective operation of the Children's Trust. The Trust operation is annually reviewed and all partner organisations have refreshed their commitment to focus on continually improving services for children and their families. The structure of the trust has also been reviewed in order to ensure that vibrant and effective partnership groups remain in place to deliver the agreed priorities and activities. The voices of children and young people are integral to ensuring services are fit for purpose and a refreshed framework of engagement and participation has also been developed by young people. The revised structure is shown in Appendix 1 and the refreshed Framework for Young People's Engagement and Participation is shown in Appendix 2.

The plan is a live document and we monitor progress on a quarterly basis through the Children's Trust Board. In addition we have made a commitment to review and refresh the CYPP on an annual basis to evidence the positive difference being made and ensure that the CYPP remains relevant and fit for purpose. This document does not replace the 2013-16 CYPP but is a concise tool for review, assessing progress and refreshing areas of work as required.

OUTCOMES DELIVERED IN 2013-14

The focus of the plan is the delivery of outcomes for children and families. The framework below shows the progress made in 2013-14 to deliver outcomes related to each priority area.

At the time of publication of the 39 outcome measures data is available for 15, not available 22 and 2 are awaiting development of a national definition. Of those with data available in 2013-14 figures have improved or stayed the same in 80% of indicators which suggests a positive direction of travel in the first year of our three year plan.

Comparison with England and Statistical Neighbour authorities indicates that the attainment gap between those children who are eligible for free school meals and those that are not is wider in Wirral than that seen nationally. Children in Wirral who are eligible for Free School Meals have historically performed much better than national and benchmark groups but in 2013 their level of performance fell in line with benchmark groups, contributing the widening gap.

Whilst Children in Need are higher than statistical neighbours, through great effort they have reduced to lowest number since 2009. This provides evidence of a positive direction of travel with plans in place to continue to improve this with targeted activities.

However there are key areas where performance is not as good as expected, these include the rate of children in care compared to other authorities, the breastfeeding rate and infant mortality. These key areas are continuing to be addressed in the refreshed CYPP.

Outcome Area 1: We will support you to have the best possible start to life and to develop healthy lifestyle choices.

Impact Indicator	2011/12	2012/13	2013/14	OfSTED Statistical Neighbours	All England	North West Region	Direction of Travel
PHOF 4.1 Infant Mortality	4.5 (2010)	4.9 (2011)	6.0 (2012)	4.2 (2012)	4.1 (2012)	4.5 (2012)	⇧
PHOF 2.2 Breastfeeding at 6-8 weeks	29.9 (2010)	29.8 (2011)	29.8 (2012)	32.4 (2012)	32.3 (2012)	46.6 (2012)	N/A
PHOF 4.2 Tooth decay in children under 5	-	1.05 (2007/08)		1.46	1.11	1.52	N/A
PHOF 1.2 School readiness	Placeholder awaiting national definition						
PHOF 2.6 Excess weight in reception year	24.5	24.7	22.2	23.0 (2013)	22.2 (2013)	23.2 (2013)	⇩
PHOF 2.6 Excess weight in Year 6	33.8	35.6	33.3	34.4 (2013)	33.2 (2013)	34.2 (2013)	⇩
PHOF 2.4 Under 18 conception rate per 1,000 females (aged 15 – 17)	47.3 (2010)	34.6 (2011)	33.5 (2012)	35.3 (2012)	27.7 (2012)	31.6 (2012)	⇩

Outcome Area 2: We will keep you safe from harm, in a family environment and where necessary support you at the earliest opportunity.

Impact Indicator	2011/12	2012/13	2013/14	OfSTED Statistical Neighbours	All England	North West Region	Direction of Travel
Looked after children rate per 10,000	99.0	99.0	100.0 (P)	81.5 (2013)	60.0 (2013)	79.0 (2013)	
Children in need rate per 10,000	429.7	417.7	401.6 (P)	370.1	332.2	343.1	
Child Protection Plan rate per 10,000	55.0	39.8	41.2 (P)	42.1	37.9	41.4	
Child Protection Plans lasting 2 years or more	3.5	4.2	3.8 (P)	4.2	5.2	4.2	
Child Protection Plan second or subsequent time	18.6	17.1	16.5 (P)	16.5	14.9	14.9	
Stability of foster placements – Number of moves	10.5	7.2 (2013)	6.8 (P)	10.8 (2012)	11.0 (2012)	9.3 (2011)	
Stability of foster placement – Length of placement	70.0	73.7 (2013)	67.9 (P)	69.1 (2012)	68.0 (2012)	68.2 (2011)	
Timeliness of adoptions	69.9	64.7	75.0 (P)	69.6 (2011)	74.0 (2011)	65.3 (2011)	
PHOF 1.11 Domestic Abuse	Placeholder awaiting national definition						

(P) = Provisional data

Outcome Area 3: We will raise your aspiration and achievement, so that you are equipped to enter adulthood and working life.

Impact Indicator	2011/12	2012/13	2013/14	OfSTED Statistical Neighbours	All England	North West Region	Direction of Travel
% Pupils achieving a Good Level of Development - EYFS	-	-	47.0 (2013)	48.3 (2013)	52.0 (2013)	50.0 (2013)	NA
% Pupils reaching expected level in Phonics decoding - KS1	-	54.0 (2012)	68.0 (2013)	68.7	69.0	69.0	NA
% Pupils achieving level 4+ (Reading, Writing and Maths) – KS2	-	74.0 (2012)	76.0 (2013)	76.6 (2013)	76.0 (2013)	77.0 (2013)	NA
Uncapped Average Point Score - KS4	468.7	476.1	462.5 (2013)	472.9 (2013)	455.3 (2013)	457.1 (2013)	NA
Percentage of Schools in Education Quality	-	94% (2012)	94% (2013)	-	-	-	NA
% Pupils achieving 5 + A* to C GCSEs including English and maths – KS4	64.1 (2011)	65.4 (2012)	65.9 (2013)	59.6 (2013)	58.6 (2013)	59.7 (2013)	NA
Total absence in Primary Schools	5.1	4.5 (2012)	5.2 (2013)	4.5 (2013)	4.7 (2013)	4.5 (2013)	⇧
% of offers of education or training to 16 and 17 year olds (September Guarantee)	91.6	94.3 (2012)	95.9 (2013)	92.5 (2013)	92.1 (2013)	92.5 (2013)	⇧
% of 16 – 18 year olds NEET	8.9	7.5 (2013)	5.9 (2014)	8.5 (2014)	6.1 (2014)	7.1 (2012)	⇩

Outcome Area 4: We will support those of you who need extra help to achieve you potential and do well.

Impact Indicator	2011/12	2012/13	2013/14	OfSTED Statistical Neighbours	All England	North West Region	Direction of Travel
% Pupils reaching expected level in Phonics decoding (FSM)	-	41.0 (2012)	58.0 (2013)	55.1 (2013)	56.0 (2013)	55.0 (2013)	NA
Attainment Gap – Early Learning Goals (New 2013)	-	-	39.5 (2013)	38.0 (2013)	36.6 (2013)	38.7 (2013)	NA
Attainment gap - % Pupils achieving KS2 level 4+ (Reading, Writing and Maths) – (New 2013)	-	-	20.9 (2013)	-	-	-	NA
% Pupils achieving 5 + A* to C GCSE grade including English and maths (FSM gap)	34.2 (2011)	30.0 (2012)	34.8 (2013)	31.8 (2012)	26.4 (2012)	30.0 (2012)	NA
% Pupils achieving 5 + A* to C GCSE grade including English and maths (SEN Statement)	9.0 (2011)	12.0 (2012)	11.5 (2013)	10.5 (2013)	9.5 (2013)	9.7 (2013)	NA
% LAC Pupils achieving KS2 level 4+ (Reading, Writing and Maths) – (New 2013)	-	-	42.9 (2013)	-	-	-	NA
% LAC Pupils achieving 5 + A* to C GCSE grade including English and maths	10.9 (2011)	12.0 (2012)	11.8 (2013)	15.2 (2012)	14.6 (2012)	15.9 (2012)	NA
Attainment at Level 2 by aged 19 (FSM gap)	20.0 (2011)	21.0 (2012)	17.0 (2013)	17.7 (2013)	16.0 (2013)	18.0 (2013)	NA

Impact Indicator	2011/12	2012/13	2013/14	OfSTED Statistical Neighbours	All England	North West Region	Direction of Travel
Attainment at Level 3 by aged 19 (FSM gap)	36.0 (2011)	34.0 (2012)	36.0 (2013)	27.2 (2013)	24.0 (2013)	28.0 (2013)	NA
% Care Leavers that are EET	39.0 (2011)	48.0 (2012)	58.1 (2013)	62.8 (2012)	58.0 (2012)	58.0 (2012)	NA

Outcome Area 5: We will listen to your views to inform decision that affect you.

Impact Indicator	2011/12	2012/13	2013/14	OfSTED Statistical Neighbours	All England	North West Region	Direction of Travel
% LAC participating in their reviews	93.8	94.2 (2012)	95.7 (2013)	tbc	tbc	tbc	NA
Number of Schools in Youth Parliament	-	12	16	-	-	-	NA
Percentage of pupils who have shared their ideas about their school- Primary (HELP survey 2013)	-	-	54.5% Baseline	-	-	-	NA
Percentage of pupils who have shared their ideas about their school- Secondary (HELP survey 2013)	-	-	65.7% Baseline	-	-	-	NA

REVIEW OF 2013-14

In the development of our strategic CYPP the majority of the activity outlined will be delivered over the three years of the plan. The outcomes delivered in the first year have been highlighted in the previous section and work will continue to improve these outcomes over the remaining two years of our plan.

In our review we have identified areas where difficulties have arisen in delivery and an exception is provided relating to these areas outlining where planned work has been reviewed. In addition in other areas due to changes in circumstances the activity requires amendment and a refreshed delivery item will be added to the plan.

Priority	What we will deliver 2013-16	Exception
Priority 1: From conception to age five Wirral Children have the best possible physical, social, emotional and psychological start in life.	• Breastfeeding will be embedded in the nursery, primary and secondary school curriculum through the use of resources that show women breastfeeding instead of feeding formula milk so that children grow up experiencing breastfeeding as the norm.	*Breastfeeding rates are lower than expected and the target is not being achieved. There are considerable resources currently allocated to provide support in the community following discharge from hospital to sustain breastfeeding. Rates need to be increased in order to enable the 6-8 week target to be reached. A workshop for key stakeholders will be held in June 2014 to map out existing provision and identify opportunities to increase rates. A breastfeeding needs assessment is being completed which will be used to inform the breastfeeding strategy going forward.*
Priority 2: From 5 - 19 years, Wirral children and young people's health and well-being will continue to develop.	• The Teenage Pregnancy Strategy will be reviewed to focus on 16 and 17 years olds living in wards with under 18s conception rates higher than the Wirral average and priority will be given to appointing a 1-1 support worker for those young people assessed as 'at risk' of early parenthood.	*The most recently published annual statistics for under-18 conceptions are from 2012. These figures show that Wirral recorded an under - 18 conception rate of 33.5 per 1000, 15 to 17 year olds for the calendar year 2012, (195 conceptions overall), this was a reduction from the 2011 rate of 34.6 per 1000, 15 to 17 year olds (206 conceptions overall). The strategic approach to teenage pregnancy is currently under review and an options paper is to be presented to the Children's Trust Board in May.*

Priority	What we will deliver 2013-16	Exception
Priorities 6: To ensure that there is appropriate support and challenge to educational settings.	• Review, redesign and market traded services for schools. • Manage school traded services cost effectively and efficiently.	*The benchmark at the end of EYFS has changed to the % of pupils achieving a good level of development. 47.2% of Wirral pupils a good level of development which is below the national average of 52%.* *The Early Years team have identified schools below the national average and are working closely to improve provision. An Early Years Continual Professional Development programme is in place delivered by expert practitioner.*
Priority 7: To ensure children and young people across Wirral will have improved attainment levels and skills, to enable then to fulfil their aspirations.	• Schools below floor standards, schools causing concern and/or schools in an OFSTED category will be supported to make good or better progress; those in Schools Causing Concern or an OFSTED category should be removed from that category in the shortest possible time.	*The performance measure has changed to L4+ in reading, writing and mathematics which has resulted in many schools FSM gap widening because of lower attainment in reading. The FSM gap is 22% compared to national gap of 17%.* *The School Improvement Team have identified schools with the largest free school meals gap. Pupil attainment is tracked and teachers are held account for pupil progress. A School Causing Concern process is implemented with schools that have the largest gap.*
Priority 9: Improve the educational outcomes for vulnerable children and young people.	• Expansion of the project targeting primary schools with the largest attainment gaps. • The Raising Attainment for Disadvantaged Youngsters (RADY) project for secondary schools will continue to develop and outcomes and learning will be transferred to all secondary and primary schools. • Advise and challenge schools and settings to utilise the additional funding for children in care to improve outcomes.	*The free school meal gap has increased to 35% compared to the national average of 25%. Attainment of non-free school meals is significantly better than the national average with attainment increasing at a higher rate than free school meal pupils. Free school meals pupils attained higher than the national average. Analysis of pupil premium spend was carried out by the School Improvement Team and fed back to the Schools Forum and head teachers. Schools Causing Concern process used to hold head teachers account in narrowing the gap.* *Children in Care: The time between the end of Year 10 and the final examinations in year 11 can be a difficult time for CiC with several changes including exams, finishing school*

Priority	What we will deliver 2013-16	Exception
	• Monitor and report on the compliance of and quality of Person Education Plans (PEPs) as a central support document.	*and moving to the leaving Care team. For the target to be achieved the 9 schools that have targeted CiC to achieve %+A*-C EM must achieve 100% success.* *The Virtual Headteacher discussed the individual pupils with the 8 Schools resulting in the 16 CiC targeted at the beginning of the year being reduced to the current 10 due to a variety of individual reasons. All Head teachers have expressed the concern that "providing nothing goes wrong" the young people should meet their individual targets* *Auditing checks are in place to assess if PEPs are in place and up to date. The results indicate that continuing work is required for PEPs to be in place as a support document. 42% PEPs are in place for Primary age CiC and 43% for secondary age CiC.*
Priority 11: Enhance the involvement of children and young people in the decision making process.	• Children's Takeover Day 2013 involving 50 young people in care.	*The takeover day was scheduled in 2013 but was postponed due to staff capacity and limited take up. The day is being reset for 2014 ensuring joint planning and resourcing.*

CHILDREN AND YOUNG PEOPLE'S PLAN 2014-16 REFRESH

The review of the first year of the CYPP indicates the initial progress made to deliver our planned three year activities. It also highlights the areas where targeted progress continues to be required. No changes have been made to the eleven plan priorities however two new activities have been introduced which are highlighted below.

In continuing to develop the planning for children and their families the Children's Trust aims to ensure the priorities and activities are coordinated and aligned to improve the outcomes for children and families in Wirral. As a result of this review and refresh process four key transformational outcomes have been identified to help drive and focus the work of all partners; these are:

- Children are ready for school;
- Young People are ready for work and adulthood;
- Young People have their needs met as early as possible;
- Young People feel safe and are safe.

These four areas will be delivered by the identified plan priorities and activities outlined in this plan.

The CYPP quarterly review and challenge by the Children's Trust Board will ensure that progress continues to be made in improving outcomes. In addition this will allow any further significant organisational changes to be monitored and activity reviewed and refreshed as required.

Two years of this plan remain and there is continued commitment from all partner organisations to work together to deliver our priorities and our vision:

"*To enable Wirral's children, young people and families to access services quickly in order to be secure, healthy, have fun and achieve their full potential."*

Priority	What we will deliver in 2014-16 - Refreshed
Priority 1: From conception to age five Wirral Children have the best possible physical, social, emotional and psychological start in life.	• A pathway will be developed to ensure that all relevant agencies understand the signs of post natal depression and offer early help/referral to appropriate services – to include nursery and school based staff and practitioners working in the IFIP. • Brief intervention training is to be offered to nursery and Early Years Practitioners to assist in supporting families who may be on the edge of services. • A stop-smoking service to work specifically with pregnant women and targeting younger women will be commissioned. The potential for this service to offer holistic brief interventions or referral to other relevant services will be explored e.g. weight management, emotional health and wellbeing, perinatal mental health, sexual health services. • An audit of infant deaths will be conducted to gather intelligence to inform targeted health improvement campaign. • Breastfeeding will be embedded in the nursery, primary and secondary school curriculum through the use of resources that show women breastfeeding instead of feeding formula milk so that children grow up experiencing breastfeeding as the norm. • The benefits of Vitamin D across maternity, health visiting, GP and pharmacy services will be promoted in order to increase uptake among pregnant women and under 5's. • Good oral hygiene to be promoted as part of the Personal Health and Social Education (PHSE) curriculum. • Explore the potential to increase access to fluoride through options including, extending the fluoride milk programme to early years settings and the development of a toothpaste distribution scheme. • Midwifery and health visiting services to identify women who are obese at their 12 week ante natal assessment. • Examine local data to determine current levels of maternal obesity in Wirral and identify appropriate solutions to tackle these. • Develop an early year's programme to include focus on healthy eating and being active. • Develop a Wirral obesity strategy within the wider Health and Wellbeing Strategy with an emphasis on prevention and physical activity. • Explore the potential to deliver healthy cookery classes in schools.

Priority	What we will deliver in 2014-16 - Refreshed
Priority 2: From 5 - 19 years, Wirral children and young people's health and well-being will continue to develop.	• A Schools Substance Misuse Advisor will be recruited to support the promotion, adoption and implementation of the following: • Schools Substance Misuse guidance and policy documents; • Alcohol Alright brief intervention toolkit; • Provision of interventions for young people admitted to the Accident and Emergency department, addressing the presenting issues and reducing the likelihood of future presentations; • Involvement of the young person's parents or carers; • Ensure that specialist substance misuse agencies engage with the IFIP to provide education, treatment and other support for families where parents or children are misusing substances; • Develop a range of bespoke programmes of activities and interventions to target vulnerable young women misusing alcohol; • Deliver specialist treatment/interventions via CAMHS, Response and Youth Offending Services to reduce substance misuse, improve school attendance and improve family relationships. • The Sexually Transmitted Infections (STI) screening programme will be commissioned to monitor and address the increase in Gonorrhoea cases amongst the 16-25 year old heterosexual population in Wirral. • The Teenage Pregnancy Strategy will be reviewed to focus on 16 and 17 years olds living in wards with under 18s conception rates higher than the Wirral average and priority will be given to appointing a 1-1 support worker for those young people assessed as 'at risk' of early parenthood. • The brief intervention toolkit will be embedded into services to engage and advise young people on risks associated to alcohol. • We will raise awareness of, and unpick myths about contraception. • Contraception provision in Wirral secondary schools will be further developed. • A stop-smoking service to work specifically with pregnant women and targeting younger women will be commissioned. • The potential for this service to offer holistic brief interventions or referral to other relevant services e.g. weight management, emotional health and wellbeing, sexual health and housing support. • An emotional health, psychological wellbeing and mental health pathway will be established to ensure schools have direct access to informal generic advice from CAMHS. • Pilot the proposed new 'health and happiness' indicator (once confirmed) with low level school based emotional health and wellbeing intervention service as well as other Health Services in Schools (HSIS) providers.

Priority	What we will deliver in 2014-16 - Refreshed
Priority 3: To support those children and young people who require extra help at the earliest opportunity.	• The Preventative Services Review will be completed and implemented. • *The review will confirm a commitment from all partners to co-develop and deliver a preventative approach which targets services to those who need them the most.* • A quality assurance framework will be developed to measure the effectiveness of targeted services.

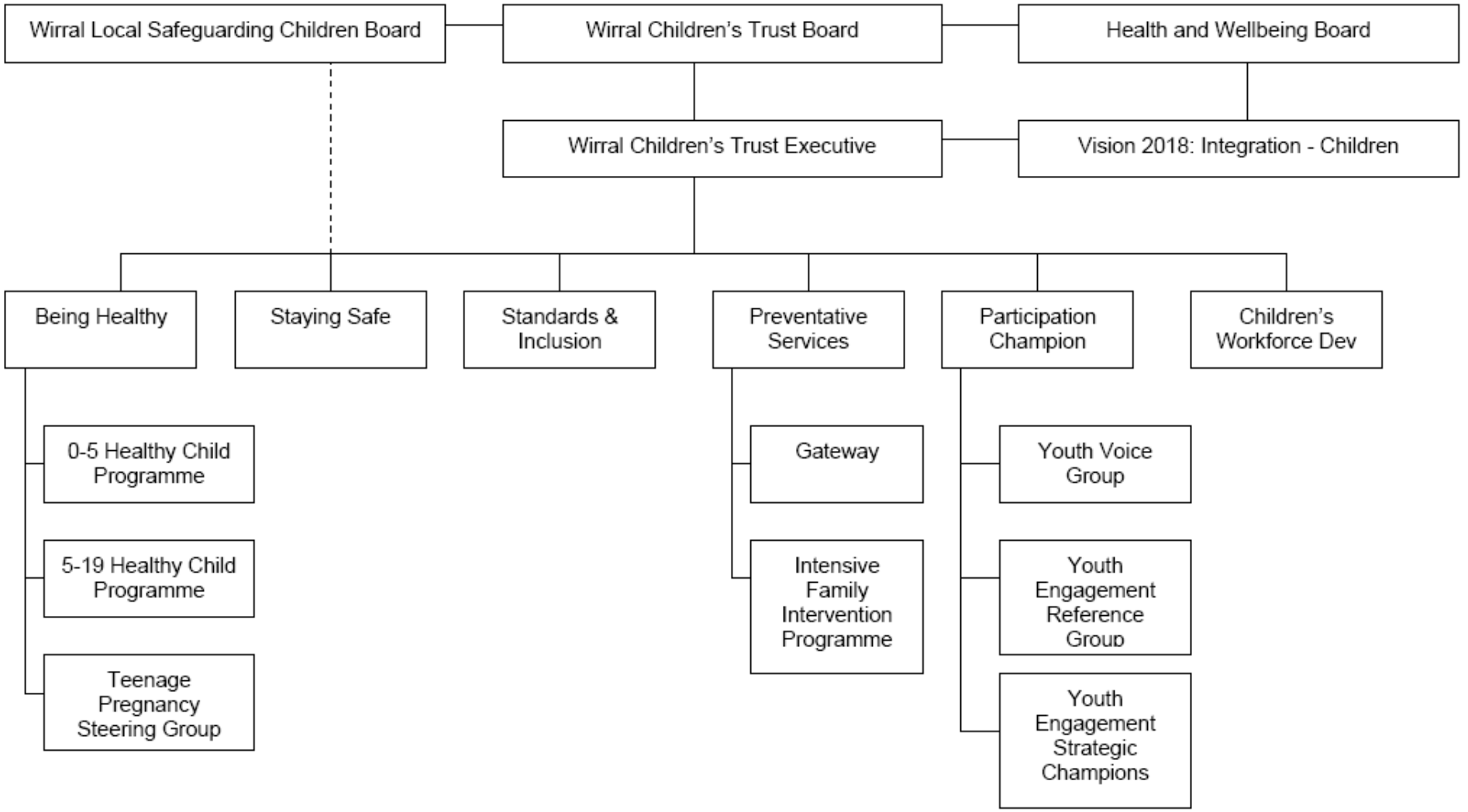
Priority 4: To improve outcomes for children and young people in need of protection.	• Implement revision of Working Together 2013 including reviewing thresholds.
	• Develop a joint agency approach to a Multi-Agency Safeguarding Hub (MASH).
	• Ensure the Wirral Safeguarding Children Board (WSCB) Business Plan includes action related to runaways and sexual exploitation.
	• Ensuring all agencies have clear processes for listening to the voice of the child.
	• Ensure that lessons learnt nationally and locally from Serious Case Reviews (SCR) and Critical Incident Reviews inform practice.
	• Review the effectiveness of single gateway for homelessness 16-17 year olds to ensure suitable accommodation is provided.
	• Ensure promotional programmes are in place and effectively reviewed for:
	  ○ Road safety
	  ○ Anti bullying
	  ○ Teenage Pregnancy
	  ○ Sexual Health
	  ○ E Safety
	  ○ Safety in the home

Priority 5: To improve outcomes for Children in Care and Care Leavers.	• The Corporate Parenting Strategy and the refreshed Looked After Children's Strategy. • The Adoption Improvement Plan will be developed and implemented. • Social Work practice to comply with the Pre-Proceedings Protocol. • We will develop our readiness for the new Inspection Framework for children in care and care leavers, targeting key areas that require additional focus.

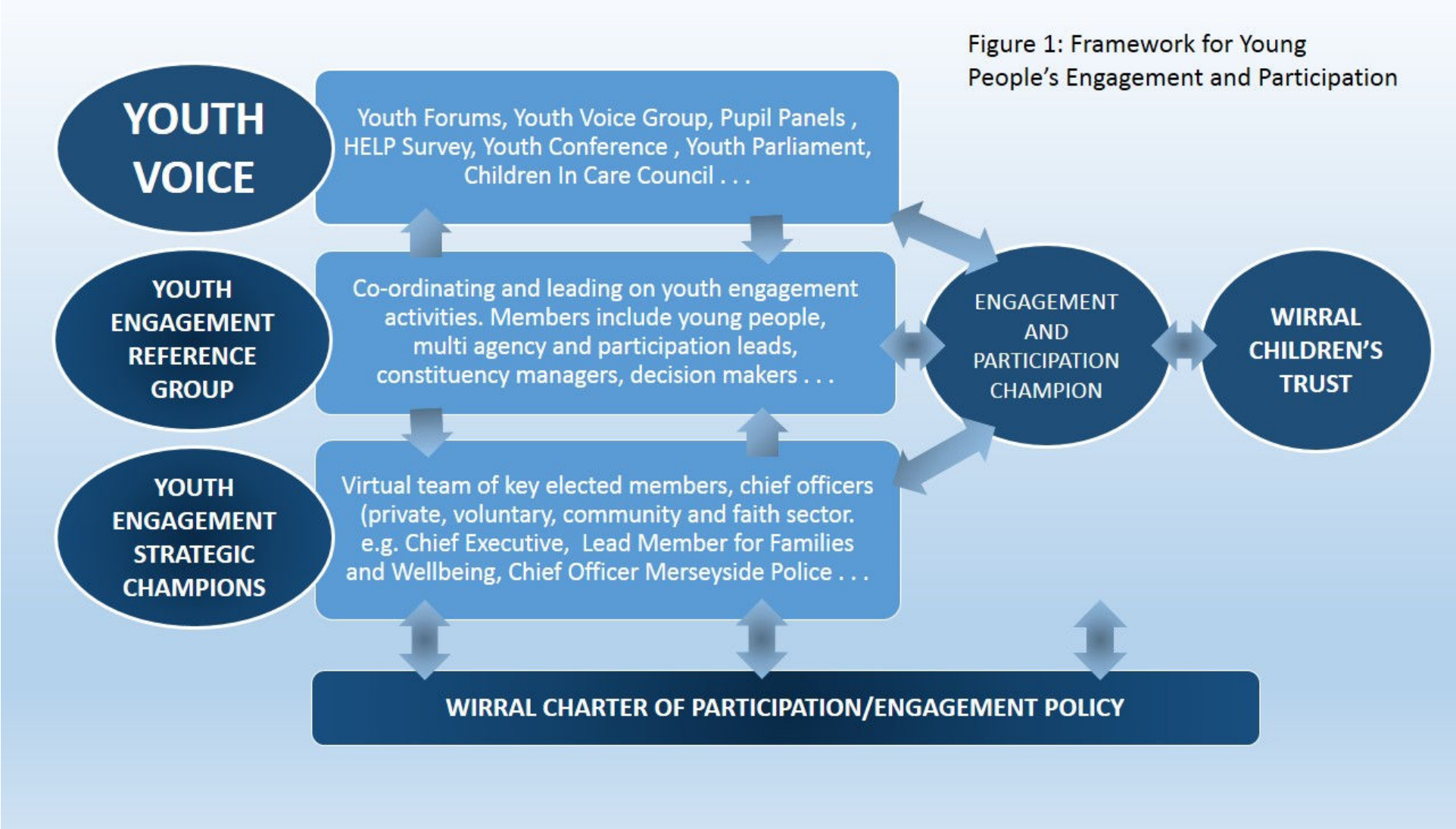
Priority	What we will deliver in 2014-16 - Refreshed
Priorities 6: To ensure that there is appropriate support and challenge to educational settings.	• Review, redesign and market traded services for schools. • Manage school traded services cost effectively and efficiently.
Priority 7: To ensure children and young people across Wirral will have improved attainment levels and skills, to enable then to fulfil their aspirations.	• Schools below floor standards, schools causing concern and/or schools in an OFSTED category will be supported to make good or better progress; those in Schools Causing Concern or an OFSTED category should be removed from that category in the shortest possible time. • Persistent Absence will be reduced and attendance in primary schools improved.
Priority 8: Effectively promote and enable participation and progression for all young people.	• Young people will have access to, and be equipped to take advantage of, a range of training, employment or entrepreneurship opportunities. • To provide young people with the best possible preparation for work we will maintain and further develop strong partnerships which connect the educational sector, training providers and the business sector. • Lifelong and family learning provision will be focused to engage and motivate disadvantaged families, encourage achievement and progression and strengthen communities. • The Council joint protocol for homeless 16 and 17 year olds will be delivered and embedded. • A targeted careers information, advice and guidance service for vulnerable young people aged 16-18 (up to the age of 24 if subject to a learning difficulty assessment) will be delivered. • A web based careers information and advice interactive tool – Mersey Interactive (www.merseyinteractive.com) will be provided for use by all Wirral young people, parents, carers and teaching professionals. • Contribute to the Liverpool City Region Apprenticeship 'Hub' and ensure Wirral supports the headline regional delivery target of 10,000 apprenticeships starts in 2013-14.

Priority	What we will deliver in 2014-16 - Refreshed
Priority 9: Improve the educational outcomes for vulnerable children and young people.	• Ensure that there are sufficient childcare places to meet local needs. • Provide information, advice and guidance to parents through the Family Information Service (FIS). • *Improve access to early intervention and preventative services through Children's Centres particularly for the most vulnerable.* • Expansion of the project targeting primary schools with the largest attainment gaps. • The Raising Attainment for Disadvantaged Youngsters (RADY) project for secondary schools will continue to develop and outcomes and learning will be transferred to all secondary and primary schools. • Narrowing the post 16 education attainment gap projects will continue with schools and further education providers; specifically at level 3. • Review, monitor and report on the attainment, progress, attendance and exclusions. • Advise and challenge schools and settings to utilise the additional funding for children in care to improve outcomes. • Monitor and report on the compliance of and quality of Person Education Plans (PEPs) as a central support document. • Provide a programme of academic mentoring for young people in year 9 onwards. • Deliver an internship programme for care leavers. • Develop a Housing Strategy Plan for young people at risk and care leavers.
Priority 10: Improve provision, choice and outcomes for children and young people with Special Educational Needs and/or Disabilities.	• A continuum of specialist education provision for SEND that meets the local needs of children and young people. • A local offer that publishes in one place information about educational, health and social care provision for children and young people aged 0- 25 with SEND and their parents and carers. Coupled with clear assessment arrangements. • A full review of the specialist service area. • Develop a Council all age disability service to ensure lifelong planning and needs led support for children, young people, adults and their carers.
Priority 11: Enhance the involvement of children and young people in the decision making process.	• Key participation events - The Youth Voice Conference, Youth Parliament and Participation Action Group. • Development of Junior Children in Care Council (CICC). • Train and support young people in care to formally recruit and select Wirral social care staff. • CICC peer mentoring for young people in care. • Children's Takeover Day 2014 involving 50 young people in care. • The implementation of the Wirral Peer Education Programme (WPEP).

APPENDIX 1: The revised structure of Wirral Children's Trust



APPENDIX 2: The revised Framework for Young People's Engagement and Participation.



WIRRAL CHILDREN'S TRUST BOARD – 20 May 2014

Children and Young People's Plan Performance Report Quarter 4 2013/14

1.0 Executive Summary

1.1 The Children and Young People's Plan 2013/16 has been produced by partners to address identified needs of children in key priority areas. The plan is delivered by partners working through the Strategy Groups. Performance monitoring of the delivery of the plan is conducted via the Children's Trust Executive Board, chaired by the Director of Children's Services and the Wirral Children's Trust Board chaired by the Lead Member for Children's Services and Lifelong Learning.

The delivery of key projects is monitored by reporting on the key performance measures identified at the planning process. This report provides an overview of progress made against Children's and Young People's Plan indicators for quarter four including corrective action for performance issues.

1.2 At Q4 there are 26 indicators that can be measured of these 21 are performing well against targets, 5 have no targets as there are in the baseline year. Note that not all Q4 figures are available for reporting, a final year end position will be published alongside Q1 for 2014/15.

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Appendices: Children and Young People's Plan Scorecard Q4

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Children and Young People's Plan Performance 2013/14

Target RAG Within 5% | 5% - 10% | Over 10%

Outcome 1: We will support you to have the best possible start to life and to develop healthy lifestyle choices.

Measure	Historically			Latest Benchmark			Q1			Q2			Q3			Q4		
	2010/11	2011/12	2012/13	NW	Eng	SN	Target	Actual	RAG	Target	Actual	RAG	Target	Actual	RAG	Target	Actual	RAG
PHOF 4.1 Infant Mortality	5.0	4.5	4.9	4.7	4.3	4.5	*Benchmarking 2011 data. Three year averages latest available 2009 - 12*											
PHOF 2.2 Prevalance of Breastfeeding at 6-8 weeks	31.2	29.9	30.2	-	46.9	31.5	35.4	33.6		35.4	32.3							
PHOF 4.2 Tooth Decay in Children under 5			32.1				*Four Yearly study next due 2016*										32.1	
PHOF 1.2 School Readiness (Placeholder)																		
PHOF 2.6 Excess Weight in Reception Year	25.0	24.5	24.7	23.2	22.6	23.4	*Benchmark 2012 data*									24.7	22.2	
PHOF 2.6 Excess Weight in Year 6	35.5	33.8	35.6	34.7	33.9	33.9	*Benchmark 2012 data*									35.6	33.5	
PHOF 2.4 Under 18 Conception Rate per 1,000 females (15 - 17)*	47.3	34.6	-	35.3	30.7	38.1	32.9	35.7										

**Conception data related to year 2012/13 due to reporting delay*

Outcome 2: We will keep you safe from harm, in a family environment and where necessary support you at the earliest opportunity.

Measure	Historically			Latest Benchmark			Q1			Q2			Q3			Q4		
	2010/11	2011/12	2012/13	NW	Eng	SN	Target	Actual	RAG	Target	Actual	RAG	Target	Actual	RAG	Target	Actual	RAG
Looked After Children Rate per 10,000 aged 0 - 17	102.0	100.0	99.2	79.0	60.0	81.5	99.2	98.8		97.9	100.6		96.6	101.6		95.2	100 (P)	
Children in Need Rate per 10,000 aged 0 - 17	445.1	429.7	417.7	343.1	332.2	370.1	419.7	418.6		417.9	413.5		410.4	429.4		396.8	401.6(P)	
Rate of Child Protection Plans per 10,000	43.4	55.0	39.8	41.4	37.9	42.1	45.1	46.8		45.1	49.0		45.1	47.5		45.1	41.2(P)	
Children Plans lasting 2 or more years	1.8	3.5	4.2	4.5	5.2	4.2	5.0	0.0		5.0	2.0		5.0	2.8		5.0	3.8 (P)	
Children subject to a CP a second or subsequent time	17.6	18.6	17.1	14.9	14.9	16.5	10.0	9.0		10.0	9.0		10.0	10.3		10.0	11.9 (P)	
Stability of Foster Placements - Number of Placements	9.0	10.5	9.4	9.3 (2011)	11.0 (2012)	10.8 (2012)	9.0	7.9		9.0	6.6		9.0	7.0		9.0	6.8 (P)	
Stability of Foster Placements - Length of Placement	59.8	70.0	71.5	68.2 (2012)	68.0 (2012)	69.1 (2012)	70.0	71.5		70.0	69.8		70.0	71.1		70.0	67.9 (P)	
Timeliness of Adoptions	72.2	69.9	64.7	65.3 (2011)	73.4 (2011)	69.6 (2011)	76.0	100.0		76.0	94.4		76.0	91.7		76.0	75 (P)	
PHOF 1.11 - Domestic Violence (Placeholder)																		

Outcome 3: We will raise your aspirations and achievement, so that you are equipped to enter adulthood and working life.

Measure	Historically			Latest Benchmark			Q1			Q2			Q3			Q4		
	2010/11	2011/12	2012/13	NW	Eng	SN	Target	Actual	RAG	Target	Actual	RAG	Target	Actual	RAG	Target	Actual	RAG
Percentage of Children achieving a Good Level of Development -EYFS				50.0	52.0	48.3	*Benchmark 2013 data*										47.0	
Percentage of Pupils reaching expected level in Phonics Decoding - KS1	-	-	54.0	69.0	69.0	68.7	*Benchmark 2013 data*										68.0	
Percentage of Children Achieving Level 4 + (Reading, Writing and Maths) - KS2	-	-	74.0	77.0	76.0	76.6	*New from 2013*										76.0	
Percentage of Children Achieving 5 or more GCSE's (Including English and maths)	58.7	64.1	65.4	59.6	58.6	59.7					65.9						65.9	
Uncapped Average Point Score Key Stage 4	445.2	468.7	476.1	457.1	455.3	472.9					462.5						462.5	
Percentage of Schools in Education Quality	-	-	94.0	-	-	-											94.0	
Percentage of Total Absence in Primary Schools	5.3	5.1	4.5	4.2	4.4	4.2	*Data available June 2014*											
Percentage of Offers of Education or Training to 16 and 17 year olds (September Guarantee)	93.0	91.6	94.3	93.8	92.4	93.1											94.4 (P)	
Percentage of Young People aged 16 - 18 who are Not in Education, Employment or Training (NEET)	-	8.9	7.5	7.1	6.1	8.5	7.0	7.3		7.0	5.7		7.0	5.9		7.0	5.9	

Outcome 4: We will support those of you who need extra support to reach your potential and do well.

Measure	Historically			Latest Benchmark			Q1			Q2			Q3			Q4		
	2010/11	2011/12	2012/13	NW	Eng	SN	Target	Actual	RAG	Target	Actual	RAG	Target	Actual	RAG	Target	Actual	RAG
Attainment Gap across Early Learning Goals - 2013 onwards	-	-	-	38.7	36.6	38.0	*New data baseline year*										39.50	
Percentage of FSM Pupils reaching expected level in Phonics Decoding, KS1	-	-	41.0	55.0	56.0	55.1											58.00	
FSM Attainment Gap - Percentage of Children Achieving Level 4+ KS2 (Reading, Writing and Maths)	0.0	0.0	0.0	-	-	-	*National data due March 2014*										20.9 (P)	
FSM Attainment Gap - Percentage of Children Achieving 5 or more GCSE's (Including English and maths)	36.1	34.2	30.0	30.0	26.4	26.4	*Benchmark 2012 data. National data due March 2014*										34.8 (P)	
Percentage of Children with a SEN Statement Achieving 5 or more GCSE's (Including English and maths)	6.0	9.0	10.5	7.7	8.4	6.8	*Benchmark 2012 data. Data available December 2013*											
Looked After Children - Percentage of Children Achieving Level 4 and above at Key Stage 2 (Reading, Writin	0.0	0.0	0.0	-	-	-	*National data due March 2014*										42.9 (P)	
Looked After Children - Percentage of Children Achieving 5 or more GCSE's (Including English and maths)	7.8	10.9	12.0	15.9	14.6	15.2											11.8 (P)	
Attainment Gap - Level 2 at Aged 19	25.0	20.0	21.0	19.0	17.0	20.5	*Data available March 2014*											
Attainment Gap - Level 3 at Aged 19	36.0	36.0	34.0	28.0	24.0	27.1	*Data available March 2014*											
Percentage of Care Leavers who are in Education, Employment or Training (EET)	39.0	48.0	58.1	58.0	58.0	62.8	*Benchmark 2012 data. National data due March 2014*											

Outcome 5: We will listen to your views to inform decisions that affect you.

Measure	Historically			Latest Benchmark			Q1			Q2			Q3			Q4		
	2010/11	2011/12	2012/13	NW	Eng	SN	Target	Actual	RAG	Target	Actual	RAG	Target	Actual	RAG	Target	Actual	RAG
Percentage of Children particpating in Reviews	93.8	94.2	95.7	-	-	-	*Data Available September 2014*											
Number of Schools in Youth Parliament	-	12	16	-	-	-	*Data Available September 2014*											
Percentage of pupils who have shared their ideas about their school- Primary (HELP survey 2013)	-	-	54.5	-	-	-	*Benchmark 2012 data.*											
Percentage of pupils who have shared their ideas about their school- Secondary (HELP survey 2013)	-	-	65.7	-	-	-	*Benchmark 2012 data.*											

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