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HEALTH AND WELL BEING BOARD
Agenda

Date	Tuesday 12 November 2019
Time	2.00 pm
Venue	Crompton Suite, Civic Centre, Oldham, West Street, Oldham, OL1 1NL
Notes	1. DECLARATIONS OF INTEREST- If a Member requires any advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Mark Hardman in advance of the meeting.

2. CONTACT OFFICER for this Agenda is Mark Hardman Tel. 0161 770 5151 or email

3. PUBLIC QUESTIONS – Any member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the Contact officer by 12 Noon on Thursday, 7 November 2019.

4. FILMING - The Council, members of the public and the press may record / film / photograph or broadcast this meeting when the public and the press are not lawfully excluded. Any member of the public who attends a meeting and objects to being filmed should advise the Constitutional Services Officer who will instruct that they are not included in the filming.

Please note that anyone using recording equipment both audio and visual will not be permitted to leave the equipment in the room where a private meeting is held.

Recording and reporting the Council's meetings is subject to the law including the law of defamation, the Human Rights Act, the Data Protection Act and the law on public order offences.

MEMBERSHIP OF THE HEALTH AND WELL BEING BOARD IS AS FOLLOWS:
Councillors Ball, M Bashforth, Chadderton, Chauhan, Harrison (Chair) and Sykes
Dr Zuber Ahmed, Mike Barker, Jill Beaumont, Michelle Bradshaw, Julie Daines, Dr Bal Duper, Neil Evans, Julie Farley, Nicola Firth, Majid Hussain, Val Hussain, Dr Keith Jeffery, Merlin Joseph, Stuart Lockwood, Dr. John Patterson, Vince Roche, Katrina Stephens, Mark Warren, Carolyn Wilkins OBE and Liz Windsor-Welsh

Item No

1 Apologies For Absence

2 Appointment of Vice Chair

To consider the appointment of a Vice Chair following the cessation of membership of one of the Board's Vice Chairs as advised at the previous meeting of the Board.

3 Urgent Business

Urgent business, if any, introduced by the Chair

4 Declarations of Interest

To Receive Declarations of Interest in any Contract or matter to be discussed at the meeting.

5 Public Question Time

To receive Questions from the Public, in accordance with the Council's Constitution.

6 Minutes of Previous Meeting (Pages 1 - 8)

The Minutes of the meeting of the Health and Wellbeing Board held on 24th September 2019 are attached for approval.

7 Children's and Adults Local Safeguarding Boards - Business Plans Updates (Pages 9 - 30)

The Chair of the Local Safeguarding Boards will report to the Board providing an update in respect of the Children's and Adults' Safeguarding Boards' Business Plans. A paper relating to the Children's Board is attached; a paper relating to the Adults' Board will follow.

8 Bury, Rochdale and Oldham Child Death Overview Panel – Annual Report (Pages 31 - 66)

The Board is asked to note the Greater Manchester Child Death Overview Panel Annual Report, which includes the work undertaken by the Bury, Oldham and Rochdale Panel, and consider an overview of the implications identified for Oldham.

9 Oldham Health and Care Locality Plan Refresh (Pages 67 - 72)

The Board is asked to note the process for and approach to the refresh of the Oldham Locality Plan for Health & Social Care Transformation (September 2016 - March 2021) and the progress made to date.

10 Update on the Oldham Learning Disability Strategy (Pages 73 - 88)

The Board is asked to receive an update on the Oldham Learning Disability Strategy including a summary of actions and progress to date on each of the strategic priorities and giving context with the Greater Manchester Learning Disability Strategy.

11 Geographical alignment across public services (Pages 89 - 94)

The Board is asked to give its endorsement for partners to progress with geographical alignment across the whole system of public services at populations of 30-55,000 to enable integration to deliver better outcomes for people and communities in Oldham.

12 Date and Time of Next Meeting

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HEALTH AND WELL BEING BOARD
24/09/2019 at 2.00 pm

Present: Councillor Harrison (Chair)
Councillors M Bashforth and Sykes

Dr Bal Duper	IGP Federation
Chief Supt. Neil Evans	Greater Manchester Police
Donna McLaughlin	Alliance Director, Oldham Cares
Dr John Patterson	Clinical Commissioning Group
Katrina Stephens	Director of Public Health
Julie Farley	Healthwatch
Nicola Firth	Royal Oldham Hospital
Sarah Maxwell (substitute)	Oldham Community Leisure
Jayne Ratcliffe (substitute)	Community Services and Adult's Social Care

Also in Attendance:

Andrea Entwistle	Principal Policy Officer - Health and Wellbeing
Mark Hardman	Constitutional Services Officer
Kaidy McCann	Constitutional Services
Julie Winterbottom (item 9)	Oldham Royal Hospital
David Garner (item 12)	Head of Special Projects – Adult's Social Care
Angela Barnes (item 13)	Strategic Partnership Manager - Community Services and Adult Social Care
Andrew Sutherland (item 14)	Director of Education – Skills and Early Years

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Mike Barker, Majid Hussain, Val Hussain, Dr Keith Jeffery, Merlin Joseph, Stuart Lockwood, Vince Roche, Claire Smith, Mark Warren and Liz Windsor-Welsh.

2 **URGENT BUSINESS**

There were no items of urgent business received.

3 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

4 **PUBLIC QUESTION TIME**

There were no public questions received.

5 **MINUTES OF PREVIOUS MEETING**

The minutes of the meeting of the Health and Wellbeing Board held on 25th June 2019 were received.

Further to Minute 7 (Minutes of the Health Scrutiny Sub-Committee), it was commented that while the requested information had been received, this did not indicate a final position or the current status of IVF provision in Oldham. On being advised that the current provision was for one round of treatment, a request was made for details of the decision making on this issue.

Further to Minute 12 (Updates from Sub-Committees), it was commented that reference to the 'Older People's Alliance' should refer to the 'Oldham Cares Alliance'.

RESOLVED that:

1. Subject to the amendment within Minute 12 of the words 'Older People's Alliance' to read 'Oldham Cares Alliance', the minutes of the meeting of the Health and Wellbeing Board held on 25th June 2019 be approved as a correct record.
2. Details of the decision making in respect of IVF provision in Oldham be circulated to Members of the Board.

6 **MINUTES OF THE HEALTH SCRUTINY SUB-COMMITTEE**

RESOLVED that the minutes of the meeting of the Health Scrutiny Committee held on 2nd July 2019 be noted.

7 **RESOLUTION AND ACTION LOG**

RESOLVED that Resolution and Action Log from the meeting held on 25th June 2019 be noted.

8 **MEETING OVERVIEW**

RESOLVED that the Meeting Overview be noted.

9 **ROYAL OLDHAM HOSPITAL SCAPE ACCREDITATION**

The Board received a report presenting the journey the Emergency Department at the Royal Oldham Hospital had undergone in achieving three consecutive green NAAS (Nursing Assessment Accreditation System) assessments and reaching SCAPE (Safe, Clean and Personal Care) status.

Julie Winterbottom, Lead Nurse of the Emergency Department, introduced a presentation to the Board which outlined the NAAS process and the 13 Nursing Core Standards, which were scored against the elements of Environment, Care and Leadership with an overall RAG rating being given based on the outcome of each standard. The SCAPE Accreditation was established at Salford Royal Hospital in 2008 and was introduced at Oldham in 2016, with the first assessment undertaken in March 2017. The decision to award SCAPE status to the Emergency Department was approved by the Trust Board on 29th July 2019.

The Board noted that Oldham was the first Accident and Emergency Department to receive a green rating and

consistently improving results and that the Department, originally built for 230 visits per day, was the busiest in Greater Manchester regularly receiving around 315-415 patients a day. Consequently the accreditation would be set as a benchmark for the rest of Greater Manchester.

Members queried what additional processes had been put in place to help achieve Accreditation. The Board was informed that a Senior Sister was on duty on every shift, a safety checklist was required for each patient which ensured the patients safety, and that all forms and information were now being provided in one clear format creating consistency. Members of the Board commented that the Department was the 'Frontline of the Frontline' and it was queried whether the Police would be able to work like the Department and improve on the services they provided. An invitation was given to the Police to visit the Department. The Board requested that a letter of thanks and praise be sent to the Accident and Emergency Department on behalf of the Board.

RESOLVED that:

1. The update in relation to the Royal Oldham Hospital's Emergency Department achieving SCAPE Accreditation be noted.
2. A letter of thanks and praise be sent to the Accident and Emergency Department on behalf of the Board.

10 **CHILD DEATH OVERVIEW PANEL – STATUTORY RESPONSIBILITIES AND REVISED GOVERNANCE ARRANGEMENTS**

The Board received a report providing an overview of the statutory responsibilities of the Bury, Rochdale and Oldham Child Death Overview Panel (CDOP), including revised governance arrangements and an outline of the Child Death Arrangements Implementation Plan.

The Bury, Rochdale and Oldham CDOP had been set up by Child Death Review Partners, the Bury, Oldham and Heywood, Middleton, Rochdale CCG's and Bury, Oldham and Rochdale Councils, to review the deaths of children under the requirement of the Children Act 2004 and Working Together to Safeguard Children 2018 statutory guidance. The purpose of the CDOP is to undertake a review of all child deaths up to the age of 18 living within the covered areas, irrespective of the place of death.

The Board was informed that the CDOP was accountable to the Health and Wellbeing Boards in Rochdale, Oldham and Bury and that the function was no longer under the Department for Education. The Annual Report of the CDOP was due to be considered at the next meeting of the Health and Wellbeing Board at which further detail could also be considered. It was noted that the Panel was chaired by a Consultant in Public Health with the position rotating between the three Public Health Teams every two years, with Oldham next to Chair the Panel.

Further to a particular issue that Healthwatch were to discuss with Public Health outside the meeting and in response to a query, the Board was informed that all child deaths, including suicides fell under the remit of the CDOP, though babies who were stillborn and lawful planned terminations of pregnancy were excepted.

RESOLVED that the statutory responsibilities of the Child Death Overview Panel, the changes to governance and the transfer of accountability for the Panel to the Health and Wellbeing Boards in Bury, Rochdale and Oldham be noted.

11 **GM COMMON STANDARDS FOR POPULATION HEALTH - UPDATE**

Further to Minute 10 of the meeting held on 25th June 2019, the Board received a report providing an update on the local work being undertaken on the Greater Manchester (GM) Common Standards for Population Health to develop ways to use them locally in line with existing standards and measures and consider how they linked to local outcomes and services.

In addition to the standards for seven population health themes provided in the first publication of GM Common Standards for Population Health, there was an overarching standard covering prescribed and non-prescribed public health functions. It was identified after a review, summarised in an appendix to the submitted report, that Oldham met or partially met all aspects of the standard with the exception of the weight management offer for children and families. The Board was informed that it would be addressed through a new healthy weight strategy and a review of weight management commissioning.

Members queried the overarching role of the standards with regards to the Oldham Locality. It was specified to the Board that the standards were primarily a tool used to assess the aspiration of the Borough and how Oldham compared to peers across the rest of GM. While the standards were not compulsory they could be used to drive outcomes to support localities achieve the best health gain. The standards created a reduced variance and enhanced consistency in the recording of health data and so would improve the measurement of population health across GM.

RESOLVED that the update on the local work on the Greater Manchester Common Standards for Population Health be noted.

12 **BETTER CARE FUND**

The Board received a report seeking agreement for the Oldham Better Care Fund (BCF) Plan 2019-20 from the Health and Wellbeing Board prior to submission to NHS England for approval.

The BCF, administered by NHS England, the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government, provides a mechanism for joint health, housing and social care planning and commissioning whilst bringing together ring-fenced budgets from CCG allocations and funding paid directly to local government. For 2019-20 in Oldham, the total value of the BCF was £30,772,550 which included Disabled Facilities Grant and winter pressures funding.

Access to the Fund was based on four national conditions being satisfied:

- an agreed plan signed off by the relevant Health and Wellbeing Board and the constituent local authorities and CCGs;
- a demonstration that the area will maintain the level of spending on social care services from the CCG minimum contribution in line with the agreed uplift;
- that a specific proportion of the area's allocation is invested in NHS-commissioned out of hospital services, which may include seven-day services and adult social care; and
- a clear plan on managing transfers of care including implementation of the High Impact Change Model for Managing Transfers of Care which includes adoption of the centrally set expectations for reducing Delayed Transfers of Care (DTOC).

There were an additional four national metrics required to be collected and submitted as part of the designated reporting mechanism:

- Non-elective admissions;
- Admissions to residential and care homes;
- Effectiveness of reablement; and
- Delayed Transfer of Care

The Board noted that Oldham continued to perform well on reducing DTOC and ranked the second lowest for DTOC within Greater Manchester. Oldham also ranked third lowest for Social Care attributed to DTOC but performed less well on the number of long-term residential placements.

Looking ahead, it was queried how the BCF would reflect the changing landscape of provision going forward. Members were advised that advance guidance for 2010/21 did reference Primary Care Networks and, for the first time, housing. In light of developments and the guidance it was necessary to review the Locality Plan to ensure it reflected the current and developing landscape.

RESOLVED that the Oldham Better Care Fund Plan be agreed and submitted to NHS England for approval.

13 **GM CARERS CHARTER AND COMMITMENT TO CARERS**

The Board received a report advising on the Greater Manchester (GM) Carers' Charter and Commitment to Carers and sought the formal commitment of the Board to delivering on the ambition of support to Carers locally.

The GM Social Care Partnership had charged the Adult Social Care Transformation Programme in February 2017 with delivery of four transformation priorities, one of which was to re-shape the current offer and support available to unpaid carers across GM. The Commitment to Carers (attached as an appendix to the report) was developed to encourage the commitment of organisations to improve the experience of unpaid carers across GM, the Commitment outlining a vision for carers and setting out how, through collaborative working, the offer to carers would be improved across the region.

The GM Carers Charter (attached as an appendix to the report) was designed by carers, voluntary, community and social enterprise groups, Councils, NHS England and NHS organisations in Greater Manchester, building on the aims of the Care Act 2014 and agreeing to acknowledge, respect and provide support and opportunities for carers. All partners were tasked to bring together best practice from local and national reviews into a comprehensive resource that all localities could use to inform their local delivery models and a GM Exemplar Model for Carer Support had been developed which focused on the following six critical priorities for support -

- early identification of carers;
- improving health and wellbeing;
- carers as real and expert partners;
- getting the right help at the right time;
- young carers and young adult carers; and
- carers in employment

These six priorities had been adopted as the basis for the Oldham Carers Strategy 2018 – 2021 which had been approved by the Board in September 2018. The inclusion of all GM information within the Oldham Strategy was noted, along with the work undertaken by the Oldham Partnership which included the acknowledgement of carers' voices and the reflection of the breadth and diversity of caring roles. In discussion, the Board noted that the Carers Partnership could not operate in isolation as certain outcomes required evaluation or delivery by others such as the Learning Disability or Dementia Partnerships. This was acknowledged and appropriate action plans were to be developed.

A consideration was given to the identification of and support to Carers given by GP surgeries, a matter which had been subject of CQC inspection considerations also. While GPs would hold a Carers' register, the data held could not be shared and so appropriate linkages to the Partnership and the Strategy were under consideration. A safeguarding consideration by Adult

Care had noted an issue concerning carers and bereavement where a vulnerable person might be left alone and even more vulnerable. It was noted that carers were targeted by the unscrupulous, for example when a partner died, and this was something that needed further consideration.

RESOLVED - That the Greater Manchester Carers Charter and the Commitment to Carers be approved and adopted.

14 **SEND STRATEGY**

The Board received a report advising of the development and key highlights of Oldham's new Special Educational Needs and Disability (SEND) Strategy. The Strategy, which among other matters was seeking to address the five issues highlighted within a SEND Inspection undertaken two years previously, was in the final round of consultation. Inspectors were currently attending at the Council and were being presented with the evidence of improvements and the time that had been taken to build the vision and collaborative approach between the partners with an interest and input into SEND matters.

The ambition was for Oldham 'to be a place where children and young people thrive', the mission of the SEND Strategy being that 'We want all our children and young people with special educational needs and disabilities (SEND) to achieve well in their early years, at school and in further education, find employment, lead happy, healthy and fulfilled lives and have choice and control over their support'. The SEND Oldham Partnership believed that all children and young people, including those with SEND, should be:

- able to be educated in the borough where they live;
- able to access opportunities that prepare them to be successful in life, learning and work;
- able to access appropriate high-quality support to build their emotional resilience and improve their health and wellbeing;
- safe and happy when taking part in all experiences; and
- listened to and actively involved in decisions that affect their lives and communities

The key outcomes of the Strategy have shaped and directed a Development Plan which focused on the following key priorities for improvement:

- Every child and young person is a confident communicator;
- Every learning setting is inclusive;
- Every young person is ready for adulthood; and
- Every child and young person is a part of their community

The Board was advised that impacts in the community should become visible if significant improvement could be made in these areas over the coming three to five years. This gave

importance to the final consultations which would ensure that all partners were signed up.

The Board noted the benefits of keeping education, health and social care together as one and, with regard to the objective of inclusivity, the need to ensure the accessibility of schools. Noting issues of the physical accessibility of schools, the Board was advised that the issue was wider than just adaptions and included considerations such as waiting lists and school place planning. With regard to completion of Education, Health and Care Plans, it was confirmed that these were being dealt with in a more timely manner, with 90% now being completed within timescale. Improvements were also being seen in relation to health and social care inputs and to presentation.

RESOLVED – That the mission and outcomes of the Special Educational Needs and Disability (SEND) Strategy be endorsed, and the Board gives its support to the use of the approach undertaken to develop this Strategy being applied to other strategies in Oldham.

15 **CLOSING REMARKS**

The Chair noted that this would be the last meeting of the Board attended by Donna McLaughlin, Alliance Director, Oldham Cares and by Andrea Entwistle, supporting Policy Officer to the Board. Both were thanked for their services to the Board and wished well in their respective new roles.

16 **DATE AND TIME OF NEXT MEETING**

RESOLVED that the meeting of the Board be held on Tuesday 12th November 2019 at 2pm.

The meeting started at 2.00 pm and ended at 3.49 pm

Introduction

Welcome to the year two business plan of our three year strategic plan for 2018-2021. This Business Plan outlines the agreed priorities for Oldham Local Safeguarding Children Board (LSCB) during 2019-20.

The Business Plan 2018-19 saw the achievement of a number of completed actions, all of which will be outlined in the annual report for the 2018-19 period. During the LSCB development day In January 2019 safeguarding partners agreed the carry-over of five actions from the previous action plan and the introduction of sixteen new actions, all of which are designed to support the realisation of the strategic aims by the end of our three-year plan. Acting on findings from recent serious case reviews and audit the LSCB have agreed to introduce Neglect as an additional priority for the remainder of the three-year strategic plan.

Operating amidst a changing strategic context the LSCB will retain its existing statutory function until the implementation of the new safeguarding arrangements in September 2019. As such this year two business plan seeks to support the transition into the new safeguarding partnership whilst maintaining a focus on the key strategic priorities agreed within the 2018-2021 strategic plan.

The LSCB and the new safeguarding partnership will continue to work closely with the Community Safety Partnership, Emotional Wellbeing and Mental Health Partnership and the Health and Wellbeing Board to support the safety and wellbeing of children in Oldham.

Under the new safeguarding partnership model the Safeguarding Partners intend to promote a greater alignment with the work of the Adult Safeguarding Board in order to progress those areas in which we have identified cross cutting issues. The existing LSCB partners agreed to the introduction of three new joint subgroups across both children and adult safeguarding agendas. This is in addition to the four that are already in operation. The joint subgroups will lead on the following areas of work and report into both Safeguarding Partnerships/Boards:

1. Transitions (existing)
2. Communications (existing)
3. Domestic Abuse Partnership (existing)
4. Early Help/MASH (existing)
5. Complex and Contextual Safeguarding (new)
6. Workforce Development and Training (new)
7. Mental Capacity Act & Liberty Protection (new)

The LSCB and, in the future, the new Safeguarding Partnership will also retain five children's specific subgroups to lead on the following areas of business. These will include:

1. Case reviews
2. Learning and Improvement (audit and performance activity)
3. Policy and Procedures
4. Safeguarding and Wellbeing in education

5. Young People's Advisory Group

1. Priority: Development of the new safeguarding arrangements for Oldham **Aim:** To have a new model of accountability for safeguarding children supported by relevant agencies identified with a role in safeguarding and promoting the welfare of children. **Link to strategic aim:** The public feel confident that children are protected					
Objective	Date for completion	Who Responsible	Outcome Measure	What difference will it make for children and young people?	Progress and Evidence RAG
1.1 Submission of proposed arrangements to secretary of state	June 2019	Business Manager	Proposal submitted at time of publication	National scrutiny will ensure that the safeguarding arrangements are sufficient to result in the best outcomes for children and young people.	Completed. New arrangements document was submitted on 29 June 2019 New Safeguarding Arrangements FINAL
1.2 Publication of proposed arrangements	June 2019	Business Manager	Arrangements publicised	This will provide reassurance to children and young people that partners will work together	Completed. New arrangements were published on LSCB website on 29 June 2019

RAG:
Green: if on or better than target
Amber: if worse than target, but within an acceptable tolerance level
Red: if worse than target, and below an acceptable tolerance level
Grey: If complete

				to ensure the best outcomes are achieved and will be subject to independent scrutiny in order to ensure high quality provision.	https://www.oldham.gov.uk/lscb/
1.3 Implementation of proposed arrangements	September 2019	DCS – Local Authority Executive Nurse – CCG Superintendent – GMP	New arrangements implemented		New arrangements have been implemented and first Partnership meeting held on 26 September 2019

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2. Priority: Enhancing the partnership's role in challenge and scrutiny **Aim:** To develop and promote transparent and open culture of respectful challenge across the partnership **Link to strategic aim:** Partners hold one another to account effectively					
Objective	Date for completion	Who Responsible	Outcome Measure	What difference will it make for children and young people?	Progress & Evidence RAG
2.1 Develop a multi-agency learning and improvement activity plan for 2018-19 that explores different methods of evaluating practice across the partnership	April 2019	Learning and Improvement Group	Activity plan has been developed and evidences different approaches to partnership scrutiny of multi-agency practice	This will enhance the level of scrutiny and challenge from the partnership ensuring that we continue to deliver the highest quality practice to children and young people	Completed learning and improvement activity
2.2 Introduce "seriously good case	March 2020	Workforce Development	Two briefing sessions focusing on good	Identification and sharing of good and best practice will	Proposal for the first session to focus on

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reviews" into the LSCB calendar building on the "what good looks like" work undertaken in year 1.		and Training subgroup	practice will be delivered within the 2019-20 training calendar	support improvements in multi-agency practice thus improving the offer for children and young people in Oldham	examples of good multi agency assessment. A proposal is being developed as to how the sessions might be run and date of first session to be booked in New Year.
2.3 Evaluate the impact of professional challenge training via the multi-agency case evaluation process	March 2020	Learning and Improvement Subgroup	Multi Agency Case Evaluations will identify evidence of appropriate professional challenge across the cases. Practitioners will report a positive and respectful culture of challenge acorss the partnership	Effective and confident challenge across the partnership will ensure that practitioners are able to reflect on decisions and seek to continuously improve practice resulting in the best outcomes for children and young people.	Evaluations from training to be presented to Learning and Improvement in November and built into the observations by Safeguarding Partnership leads

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2.4 Work with Children's Social Care to embed the multi-agency supervision model into the new operating model	March 2020	Children's Executive Group	Multi Agency Supervision sessions will be an integral part of the new operating model	Multi Agency Supervision sessions will support practitioners from all disciplines to work together effectively to achieve the best outcomes for children and families in Oldham	Multi agency supervision has been embedded into the model for Oldham Family Connect and will be facilitated by the cluster model of partner agencies. The Practice Improvement Consultant for the Partnership is developing a proposal for the re-instigation of the pilot in the interim.
2.5 Identify opportunities to embed quality assurance at all stages of the child's journey, including direct observations of strategy meetings, Child in Need meetings, core group meetings, Education, Health and Care	March 2020	Learning and Improvement Group	There will be clear multi agency quality assurance processes embedded throughout the child's journey	Children can be assured that multi agency involvement is of the highest quality with a clear focus on improved outcomes	This has been included in the learning and improvement activity plan. Partnership representatives will be undertaking direct observations of key multi agency meetings and will be considering the quality of the multi agency practice at all stages of the journey.

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planning meetings, Child protection conferences					
2.6 Trial "challenge champion" roles across the Partnership	July 2019	Children's Executive Group	Identified senior professionals from key partner organisations will lead on supporting practitoners to provide and receive positive challenge in order to improve the quality of practice	Children and young people will receive the highest quality of service from all agencies	Business manager to work with practice improvement consultant and Head of Independent review to develop draft role description to be presented to Learning and Improvement in November.

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3. Priority: Complex and Contextual Safeguarding

Aim: To have a clear understanding of the scale of complex and contextual safeguarding within Oldham, with a clear multi- agency response to raising awareness with children and young people, assessing their needs and providing appropriate support. Complex and Contextual Safeguarding includes areas such as gang related activity, modern slavery, exploitation and youth violence.

Link to strategic aim: Early identification of safeguarding issues

Objective	Date for completion	Who Responsible / linked plan	Outcome measure	What difference will it make for children and young people?	Progress & Evidence RAG
3.1 Introduce a complex and contextual safeguarding subgroup of the LSCB and LSAB	April 2019	Children's Executive Group	A clearly defined subgroup will be operational and providing regular reports to both children and adult safeguarding boards	By having a clear understanding and plan in relation to complex and contextual safeguarding in Oldham it will support practitioners and commissioners in ensuring the best and most appropriate support is available for young people at risk from these safeguarding concerns.	Small group was established by Head of Safeguarding to identify immediate needs and actions. It has now been agreed that the DCS will chair this wider subgroup meeting and dates/ representatives are being confirmed. Aiming for first meeting in November

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3.2 Using the profile analyses produced in year 1 identify the priority areas of complex and contextual safeguarding that the LSCB will focus on in year 2-3.	June 2019	Complex and Contextual safeguarding subgroup	The priority areas for Oldham are identified and clear multi agency action plans are developed in relation to the top three priority areas.	A clear understanding of the priority concerns relating to complex and contextual safeguarding will support the partnerships in targeting appropriate support and interventions for children and young people	Complete: Priority areas were agreed by small children's group as exploitation, missing from home and education, modern slavery and human trafficking. Data is currently being mapped to these areas
3.3 Develop an all age complex and contextual safeguarding strategy for Oldham	September 2019	Complex and Contextual Safeguarding subgroup	Partner agencies understand and own a multi-agency approach to addressing complex and contextual safeguarding	A clear strategy supports the development of a multi-agency response to new and emerging safeguarding concerns	This will be developed in line with first meeting in November.
3.4 Evaluate the impact of the peer on peer pathway on multi agency decision making in relation to youth violence	December 2019	Policy and Procedure subgroup Partnership practice improvement	The evaluation evidences that the pathway is embedded within the MASH and contributes positively to decision	The use of the pathway by the partnership supports professionals in identifying the most appropriate support and/or intervention for children and young people	This has been added to the workplan for the Partnership practice improvement consultant for completion by December 2019.

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		consultant	making when youth violence is being considered		
3.5 Identify training and referral pathways for schools to support them with the early identification of exploitation in all forms	March 2020	Safeguarding and wellbeing in education partnership	Schools report that they feel confident in identifying exploitation and know where and how to refer to for support	By supporting to schools to identify exploitation earlier children and young people at risk will be able to access appropriate support at the earliest opportunity.	Exisiting input into schools has been mapped and will be considered by safeguarding in education subgroup. Two schools have accessed the two training places offered by Dean Cody regarding Criminal exploitation. Further training will be offered via Designated Safeguarding Lead network meetings.

4. Priority: Domestic Abuse

Aim: To have a competent and confident workforce who are able to recognise and appropriately respond to the needs of children affected by domestic abuse. This will be led by a clear domestic violence and abuse strategy that is fully reflective of children's safeguarding priorities.

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Link to strategic aim: Excellent practice is the norm across all practitioners in Oldham					
Objective	Date for completion	Who Responsible / linked plan	Outcome Measure	What difference will it make for children and young people?	Progress & Evidence RAG
4.1 Undertake a desktop audit of partner agencies' use of the DASH risk assessment for domestic abuse; and the outcomes following the assessment	July 2019	Learning and Improvement Subgroup	A clear evaluation of Agency's use of the DASH risk assessment and the outcomes for the families will be presented to the domestic abuse partnership	Assurance that all agencies are appropriately assessing the risk associated with domestic abuse and referring families appropriately for support	Completed for CSC and presented to CSC performance meeting on 8 July 2019 Themed Audit over view report DASH~r Survey has been sent out to all other agencies and findings are due to be presented to the Learning and Improvement subgroup in November.
4.2 Review participation in multi-agency domestic abuse training and	December 2019	Workforce Development and Training subgroup	A clear evaluation of multi-agency knowledge of domestic abuse and	Increased confidence that practitioners understand the dynamics of domestic abuse and are assessing appropriately to	Participation in MARAC and domesic abuse and the impact on children training has been collated and will be reviewed by

RAG:
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Amber: if worse than target, but within an acceptable tolerance level
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undertake an evaluation of the impact of the training on practice			its impact on children. Clear evidence of domestic abuse being considered in assessments	ensure the safety of children and young people	the Training subgroup. Agency leads will be provided with details and asked to review the impact of the training on their staff's practice.

5. Priority: Children missing from education including elective home education

Aim: All children in Oldham are accessing suitable education and where children are electively home educated that this provision is of a suitable standard.

Link to strategic aim: Information is shared effectively

Objective	Date for completion	Who Responsible / linked plan	Outcome Measure	What difference will it make for children and young people?	Progress & Evidence RAG
5.1 Explore options to establish a threshold and response for "educational neglect" when a child is regularly missing from	March 2020	Safeguarding and Wellbeing in education partnership	Partners recognise the links between safeguarding and children missing from education and an appropriate multi	This supports a more holistic assessment of any potential safeguarding concerns for children who are missing from or not accessing education.	Draft educational neglect policy has been produced based on Knowsley's model. Needs to be signed off by DMT and education

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education and/or there are concerns about safeguarding			agency response is made available		subgroup by 19 November
5.2 Undertake a multi-agency audit into Elective Home Education with a focus on: - understanding the volume and characteristics of children and young people who are known to be home schooled, - the different reasons behind a family's decision to home school, - to understand how the partnership is supporting these families, - how resources are being deployed in this area	March 2020	Learning and Improvement subgroup	An improved understanding across the partnership of the reasons that children are electively home educated and the support offer available to families from the partnership	Support will be available from the partnership to ensure home education is of an appropriate standard to promote achievement and wellbeing in children and young people	This has been planned in the Learning and Improvement activity plan for January 2020.

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6. Priority: Transitions

Aim: To have a clear safeguarding transitions process from children's services to adult services that ensures that that agencies work together to develop a transition plan that begins at an early stage, involves the young person and their family/carers and ensures that appropriate safeguarding information is shared.

Link to strategic aim: Information is shared effectively

Objective	Date for completion	Who Responsible / linked plan	Outcome Measure	What difference will it make for children and young people?	Progress & Evidence RAG
6.1 Review current policies and pathways for identified safeguarding areas relating to transitions	Sept 2019	Transitions subgroup	Each area identified in the strategic plan is reviewed and action plans established where necessary	The review will ensure existing pathways are effective and result in the best outcome for children and young people	Initial scoping work has been undertaken across the five priority areas of transitions. A presentation is currently being developed which will go to the first meeting of the Transitions subgroup in November 2019.
6.2 Involve children and young people, family and carers in	Sept 2019	Transitions subgroup	Policies and pathways are appropriate to meet the needs of the	This will ensure that the response to transitions is reflective of the needs and	This work will begin following the first Transitions meeting and the establishment of the task

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the review of existing policies and pathways			people that they serve	children and young people	and finish groups for each priority area.
6.3 Establish clear policies regarding information sharing about safeguarding concerns when children are moving to adult services	March 2020	Transitions subgroup Policy and Procedures subgroup	Clear policies are established and partners, families and communities are aware of what they are	Clear policies relating to sharing of information will ensure that safeguarding concerns are managed and considered effectively at the point of transition	This will be led primarily by the Transitions group and then ratified by the policy and procedures subgroup

7. Priority: Understanding the impact of trauma on children and young people

Aim: To have professionals appropriately trained to utilise a continuum of tools including the Adverse Childhood Experiences (ACES) toolkit and the Trauma Symptoms Checklist for Children (TSCC) in order to fully assess the impact of trauma on children and young people and to commission appropriate support to meet the needs identified.

Link to strategic aim: Excellent practice is the norm across all practitioners in Oldham

Objective	Date for completion	Who Responsible / linked plan	Outcome Measure	What difference will it make for children and young people?	Progress & Evidence RAG

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7.1 Introduce a task and finish group of the Emotional wellbeing and Mental Health Partnership to map the current offer of support to trauma and ACES in Oldham	April 2019	Emotional wellbeing and mental health partnership	A clear understanding by partners of the range of support available for children and young people experiencing trauma in Oldham	An improved understanding of the current support offer for trauma will enable professionals to refer more appropriately but also to support commissioners in addressing gaps in provision resulting in a more holistic offer for children and young people	Complete. The task and finish group has been estalished and has undertaken mapping of exisiting trauma support offer.
7.2 Ensure there is a clear care pathway for all children in care, those in need of protection and ultimately those in need to have their trauma needs assessed, identified, and a care/action plan in place to support improvement in their emotional resilience.	October 2019	Emotional wellbeing and mental health partnership	A clear and sustainable care pathway is in place	Children and young people have their trauma needs assessed, identified, and a care/action plan in place to support improvement in their emotional resilience.	Learning from the concise practice review into Eve and the MACE on children's mental health will inform the Partnership of the effectiveness of existing pathways. A new governance structure relating to Children's Mental Health has been proposed to JLT.
7.3 Identify additional	September	Emotional	Increased resource	More children will benefit from a	Additional funding has

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funding and resource to support the commissioning of trauma related support services for children and young people in Oldham	2019	wellbeing and mental health partnership	trained to use the TSCC as a tool with children experiencing trauma	trauma assessment leading to more appropriate referrals and support being offered.	been identified by the Virtual Headteacher who has committed to funding a cohort of children looked after staff to be trained in TSCC. Further funding opportunities are being explored in line with the outcomes of 7.3. A spotlight focus on children's mental health took place at the Safeguarding Partnership on 26 September. Recommendation from the Partnership was for governance to be reviewed and clear strategy to be developed.

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					MACE that began on 14 October will focus on the current JTAI theme of Children's mental health.

8. Priority: Child's Lived Experience

Aim: To be confident that all professionals recognise and fully reflect the child's lived experience, including those who are non- verbal and that all children and young people have the opportunity to be involved in the work of the board and its partners.

Link to strategic aim: Learning is promoted and embedded

Objective	Date for completion	Who Responsible / linked plan	Outcome Measure	What difference will it make for children and young people?	Progress & Evidence RAG
8.1 Support the development of a new assessment model for use across the partnership	March 2020	Policy and Procedures subgroup	A holistic model of assessment that is owned and utilise by all partner agencies	A consistent model will ensure holistic assessments are undertaken by all agencies resulting in better outcomes for children.	The roll out of Signs of Safety is the initial element of this action which will be built upon with Oldham Family Connect and reflected in the Continuum of need document.

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8.2 Introduce a young people's advisory panel of the Board	September 2019	Children's Executive Group	Wide range of young people are involved in and are able to influence the work of the Board and its partners.	A wider engagement with children and young people will ensure that we have a better understanding of the needs and wants of children and young people, leading to improved practice across the agencies	Two young people participated in the Safeguarding Partnership workshop on 18 July. Currently working with schools, youth council and children in care council to establish a young person's safeguarding group. Proposal to be presented to the Executive Group on 14 November

9. Priority: Neglect

Aim: Children living with neglect receive the right help and protection because of application of appropriate thresholds, effective information sharing and timely intervention

Link to strategic aim: Excellent practice is the norm across all practitioners in Oldham

Objective	Date for	Who Responsible /	Outcome Measure	What difference will it make for children and	Progress & Evidence

RAG:
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	completion	linked plan		young people?	RAG
9.1 Review and revise the local multi-agency neglect strategy	September 2019	Neglect subgroup	A clear vision and multi agency approach to responding to neglect in Oldham	Children and young people are reassured that professionals understand the experiences of children living with neglect and have a co-ordinated response to reduce risks and meet their needs.	Initial scoping meeting has taken place and data collection is underway. First meeting is planned for November 2019.
9.2 Evaluate the effectiveness of the neglect practice toolkit in supporting practitioner's assessment and planning	March 2020	Learning and Improvement subgroup	A clear understanding of the effectiveness of the neglect practice toolkit on assessment and planning	An evidence-based assessment tool is in place to ensure that the needs of children and young people are effectively assessed, and their needs are planned for.	Completed. Desktop audit completed for 50 social care cases and findings presented to CC performance meeting.  Themed Audit over view report DASH~r Survey has been sent to other agencies and findings are due to be fed back to Learning and Improvement

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					group in November.
9.3 Review the quality of parenting assessments for children experiencing neglect	March 2020	Oldham Practice hub	Professionals have a clear understanding of how the behaviour of parents and carers affects children and can effectively assess strengths and risks in relation to parenting.	Children and young people have positive parenting experiences and are protected from neglect	Socia Care practice improvement consultants will add this to their workplan.
9.4 Map the support provision for children and young people who are experiencing neglect	March 2020	Neglect subgroup	A pathway of support is evident, and practitioners have a clear understanding of how to access it	Children and young people can access a sufficient range of local services, including therapeutic help that improves children's emotional well-being and safety	This wil be undertaken by the neglect subgroup. The first meeting is due to be held on 26 November

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Report to HEALTH AND WELLBEING BOARD

Child Death Overview Panel – GM Annual Report and Oldham Briefing

Portfolio Holder:
Councillor Zahid Chauhan, Cabinet Member for Health and Social Care

Officer Contact: Katrina Stephens, Director of Public Health

Report Author: Rebecca Fletcher, Registrar in Public Health
Ext. 0161 770 3056

25th October 2019

Purpose of the Report

To provide Health and Wellbeing Board with the Greater Manchester (GM) Child Death Overview Panel (CDOP) Annual Report, which includes the work undertaken by the Bury, Oldham & Rochdale panel. The aim of this annual report is take data from the four CDOP panels that cover GM to make observations about causes and modifiable factors in order to inform action to promote child safety and reduce child deaths in GM.
This covering report also provides an overview of the implications for Oldham and the current work happening to address the potentially modifiable factors identified.

Requirement from the Health and Wellbeing Board

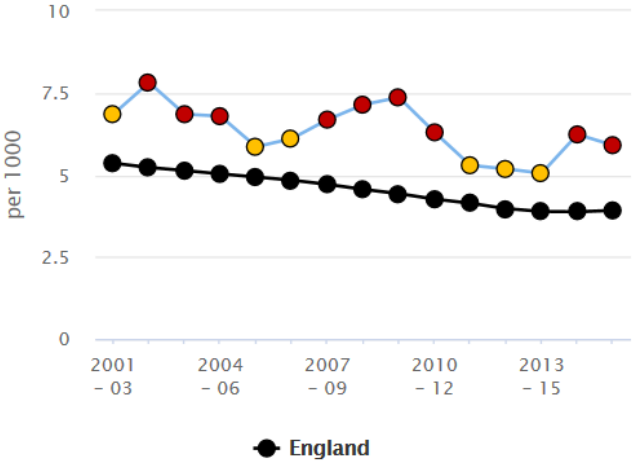
Health and Wellbeing Board are asked to note the Child Death Overview Panel Annual Report for Greater Manchester. The Board are also asked to note this Oldham briefing and agree for further work on infant mortality in Oldham.

Oldham Briefing

Background

In 2018/19 Manchester had both the highest crude number of notified deaths and the highest rate at 4.59 deaths per 10,000 <18 population. The next highest rates were seen in Oldham and Tameside with 3.53 and 3.38 deaths per 10,000 <18 population respectively. It is hard to draw conclusions on the reasons for the variation in child death rates across GM as the absolute numbers are sufficiently small that any variations could be due to chance. These figures correlate with the national infant mortality figures though that show that Oldham has a significantly higher rate of infant mortality than the national average (see table and graph below)

Infant Mortality Crude Rate per 1,000:
Oldham compared to England 2001/03-2015/17



Period		Oldham				CA-Greater Manchester	England
		Count	Value	Lower CI	Upper CI		
2001 - 03		63	6.9	5.3	8.8	6.2*	5.4
2002 - 04		73	7.8	6.1	9.8	6.0*	5.2
2003 - 05		65	6.9	5.3	8.7	5.7*	5.1
2004 - 06		66	6.8	5.3	8.6	5.6*	5.0
2005 - 07		58	5.9	4.4	7.6	5.4*	4.9
2006 - 08		61	6.1	4.7	7.8	5.5*	4.8
2007 - 09		67	6.7	5.2	8.5	5.2*	4.7
2008 - 10		71	7.1	5.6	9.0	5.1*	4.6
2009 - 11		73	7.4	5.8	9.3	5.0*	4.4
2010 - 12		62	6.3	4.8	8.1	4.7*	4.3
2011 - 13		52	5.3	4.0	6.9	4.4*	4.1
2012 - 14		51	5.2	3.9	6.8	4.2*	4.0
2013 - 15		50	5.1	3.8	6.7	4.3*	3.9
2014 - 16		62	6.2	4.8	8.0	4.7	3.9
2015 - 17		59	5.9	4.5	7.6	4.9	3.9

Source: Office for National Statistics (ONS)

The GM CDOP annual report shows that the large majority of child deaths in GM occurred in the first year of life; 42% of closed cases occurred in the first 28 days and 60% in the first 12 months. Oldham has a similar picture with 36% in the first 28 days, and 57% in the first 12 months. This fits with the national picture and the CDOP reports from previous years.

The GM report highlights potentially modifiable factors for reducing deaths in children as well as the existing evidence around reducing deaths in the early weeks of life. There are currently several initiatives in Oldham aimed at addressing these factors. These are outlined below:

Saving Babies Lives

Saving Babies Lives Care Bundle brings together the elements of care that are recognised as evidence based in reducing perinatal mortality (stillbirths and deaths in the first week of life). These include reducing smoking during pregnancy, improving detection of babies who are small for gestational age, raising awareness of reduced fetal movement and reducing preterm labour. Royal Oldham Hospital met all the requirements of the 'saving babies lives care bundle' and a recent GM audit highlighted the trust as performing well

against key indicators. The care bundle has been updated this year to version 2 and plans are in place to address the changes.

PAHT is working hard to detect Small for Gestational Age (SGA) babies early in pregnancy. In Q3 18/19 the Trust detected 58.7% of SGA babies in the antenatal period. This number is increasing each quarter and once detected a management plan is implemented. PAHT were recently highlighted as being in the top 20 trusts in England for detecting SGA.

Maternal smoking during pregnancy: babyClear
Whilst smoking is always hazardous to health, it is associated with worse outcomes in pregnancy for mother and child. These include increased risk of complications in labour, as well as an increased risk of miscarriage, still birth, low birthweight and sudden unexpected death in infancy. Maternal smoking is also estimated to increase the risk of infant mortality by approximately 40%.

The GM smokefree pregnancy programme began implementation in December 2017 with the ambition that every locality will exceed the national target for smoking at delivery by 2021. The programme focuses efforts on smoking cessation in pregnancy through a GM tailored programme which is fully aligned with NICE guidance, offering innovative and evidence-based approaches.

The babyClear model has been rolled out across GM including Oldham. Midwives support pregnant women, and their partners to quit smoking. Over the past five years Oldham has seen reductions in the rates of women smoking when they are pregnant, from 16.8% in 2012/13 to 14.1% in 2017/18. Our rate of improvement has stalled recently, and we have seen some recent increases. This may be due to better recording and improved validation of smoking status.

In addition, the Health Visiting service will be provided with training from GM in order to enhance their smoking cessation support to pregnant women, and new mothers.

Raised Maternal BMI
In 2018/19 there were 19 cases where maternal obesity was identified as a modifiable factor, this is second only to smoking (24) as a leading modifiable factor in GM. Oldham Council is leading the development of an all-age strategy on healthy weight and physical activity which will include addressing raised maternal BMI.

Consanguinity
From 2015/16 it was agreed that consanguinity would be considered as a modifiable factor if a second child is born with genetic anomalies to consanguineous parents to standardise how different CDOPs recorded this data. In 2015/16, following consideration at Oldham Health and Wellbeing Board and the Local Safeguarding Children Board, it was agreed that consanguinity be seen as a priority in Oldham and the Council and CCG cooperate to commission a local specialist response.

A Genetic Outreach Service has been delivered in Oldham since January 2016. Evaluations suggest that the service is having a positive impact in working with local communities to increase genetic literacy and improve access to services. Continuation and development of the service with a focus on targeted approaches within localities will increase the potential for long term impact over the next generation of births. This unique

model is based on a successful well-established service delivered in Blackburn with Darwen and is supported by the only specialist genetics provider in the North West.

Parental alcohol/drug use & specialist midwifery support
A new team of midwives was established in September to focus on providing specialist midwifery support for drugs & alcohol (including the Alcohol Exposed Pregnancy programme), mental health, learning disabilities and safeguarding, with awareness training given to all community midwives. The Alcohol Exposed Pregnancies programme also includes work with alcohol treatment services, as well as addressing social norms regarding drinking in pregnancy.

Co-sleeping
Health visitors raise the issue and risks of co-sleeping with parents during their mandated contacts. This includes the increased risk of sudden infant deaths when co-sleeping on a sofa, following consuming alcohol or drugs, or if you are a smoker. In addition, safe co-sleeping advice from The Lullaby Trust includes ensuring that sheets, pillows and blankets are kept away from the baby.

Conclusions
The findings of the latest Child Death Overview Panel Annual Report highlight key areas where we can work to reduce the higher rates of infant mortality in Oldham. There are several streams of work, and initiatives to address the modifiable factors but currently our rates are still high.

It is recommended that the Board agree for further work to be undertaken to understand the high rates of infant mortality in the borough, and to develop an action plan to address these.

Annual Report of Child Deaths in Greater Manchester, 2018/19

Report updated by Leifa Jennings, based on a report by Louise Harding, with data analysis and editing by Jacqui Dorman (Tameside MBC)

October 2019

Contents

1.0 Executive Summary

This is the seventh annual report which reviews the data taken from all four Child Death Overview Panels (CDOPs) across Greater Manchester (GM). This report includes data from closed cases from 1st April 2018 to 31st March 2019.

All under-18 child deaths are referred to a CDOP, and the findings are recorded and used to inform local strategic planning on preventing child death, safeguarding children and improving outcomes. The CDOP does not determine the cause of death; that is carried out by either the medical team or the coroner depending on the circumstances of the death. The CDOP's responsibility is to consider all the information around the child's death, identify potentially modifiable factors, and lessons that can be learned. The outcome of all cases closed by the CDOPs is collected nationally by the Department for Education to build up a picture of child deaths in the UK.

1.1 Key Findings for Greater Manchester

There were a total of 204 closed cases in 2018/19 with 217 notified deaths. The number of closed cases is less than in 2017/18 (274) as is the number of deaths notified (250). The time taken from notification of death to closure was between 31 and 2,328 days, with an average across GM of 297 days.

The large majority of child deaths in GM occurred in the first year of life; 42% of closed cases occurred in the first 28 days and 60% in the first 12 months. This is a reduction from last year, when deaths in infants aged under 1 year accounted for 65% of closed cases, but the main causes of these deaths remain the same. Most were due to events around the time of birth (perinatal or neonatal events), the next most common issue was genetic or congenital conditions.

The older age groups: 1-4, 5-9, 10-14 and 15-17 accounted for 11%, 8%, 10% and 11% of deaths respectively. This does indicate a slightly wider spread of deaths throughout the age groups than in previous years, but the absolute numbers are too small to draw statistical conclusions. Out of all the closed cases in 2018/19, 162 (79%) were classed as 'medical' causes, i.e. acute medical, chromosomal, chronic medical, malignancy, perinatal / neonatal event or infection. Across GM, 82% of neonatal deaths were expected, falling to 45% of infants aged 28-364 days. The pattern is more mixed across the older age groups, but again this could be due to small numbers. However, in children aged 10-14 years, only around 1 in 5 deaths were expected which reflects a greater number of deaths from unexpected causes, such as health-related causes of death and trauma in this age group. This low percentage also reflects the good health of children in this age group, and that those with serious underlying conditions were likely to have died prior to the age of 10.

The ratio of male to female deaths was similar to previous years (60% male, 40% female). However, in contrast to last year, the gender difference is more evident in some older age brackets, rather than infancy. Whilst deaths due to trauma and other external causes usually have a higher ratio of male to female deaths, in 2018/19 these were roughly equal, but numbers were small in this category (7 males and 6 females).

Modifiable factors were identified in 79 closed cases (39%) across GM, which is similar to the findings from 2017/18 (40%). Smoking was still the most common modifiable factor (24 cases), followed by obesity (19). Access to health care or poor care management was the third largest modifiable factor (11) followed by substance misuse (10).

In 199 of the 204 closed cases in 2018/19 the ethnicity of the child was recorded. Of these, 57% were from a white background, which is below the national rate of 63%. Across GM there was a rate of 4.77 deaths per 10,000 in the 0-17 years BME population compared to 2.50 per 10,000 0-17 years among the white population. This marked difference represents a health inequality between the two groups.

Thirty-seven percent of all children under 18 years old across Greater Manchester are within the most deprived quintile. In 2018/19, 62% of deaths occurred in this group, which is similar to 2017/18 (61%). Eighty-two percent of all GM child deaths occurred within the two most deprived quintiles. This remains a significant health inequality.

2.0 Introduction

This is the 7th Annual Report of Child Deaths in Greater Manchester (GM). The current processes for reviewing child deaths were established in 2008 and have continued to develop year on year. This report focuses on the cases that were closed in GM for the year 2018/19 and will include data on the demographics of the cases, duration of reviews, causes of death, and potentially modifiable risk factors. These may vary across local authorities and CDOP areas reflecting the different make-up of populations across GM.

The aim of this report is take data from the four CDOP panels that cover GM and to make observations about causes of death and potentially modifiable risk factors. This would allow an evidence based discussion about how to promote child safety and reduce child deaths in GM.

3.0 Background

In 2004, the Children Act required each local authority to establish a Local Safeguarding Children Board (LCSB) to safeguard and promote the welfare of children in that area. Since 2008 the LCSBs have the statutory responsibility for the child death review process and in 2015 the government published Working Together to Safeguard Children 2015[1] which built on previous reports detailing how each LSCB must ensure that the CDOP carries out a review of the death of any child normally resident in that area. The purpose of the child death review processes is to gather information on how and why children die, look at potentially modifiable factors and try to put in place interventions to reduce future deaths.

[1] http://www.who.int/mediacentre/factsheets/fs178/en/

In GM there are four CDOPs set up to cover the LSCBs of the ten local authorities:

- Bolton, Salford & Wigan
- Stockport, Tameside & Trafford
- Bury, Rochdale & Oldham
- Manchester

As the number of deaths for each area are small, combining the data from the four CDOPs allows for more detailed analysis as well as comparison between different areas of GM. There is well established co-operation between the local authorities in GM and this report is an opportunity to consider how GM as a whole can improve child health and child safeguarding and work together to reduce avoidable child deaths.

As this is the 7th year of the report, there is some limited trend data available.

4.0 Key findings for the UK

Infant, child and adolescent death rates in the UK have declined substantially since the 1980s with a 64% reduction since 1984 in England and Wales[2]. The infant mortality rate in England and Wales was lowest in 2014 (3.6 deaths per 1,000 live births), but increased to 3.9 per 1,000 live births in 2017[2]. Many of the causes and determinants of childhood deaths are potentially preventable[3]. Some areas of improvement are listed below.[4]

- The overall UK childhood mortality rate is higher than in some other Northern European countries.
- The key areas where the UK rates appear to be relatively high are infant deaths and deaths among children and young people who have chronic conditions.
- Injuries are the most frequent cause of death in children after their first year of life, and although unintentional injuries are the most common, the failure to reduce intentional injury and deaths by suicide among young people recently is also a pressing concern.
- Several reports have shown that health services do not always deliver optimal care for children and young people and lives may be lost as a result.
- There are marked social inequalities in death rates.

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[2] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2017

[3] http://www.who.int/mediacentre/factsheets/fs178/en/

[4] **Wolfe I, MacFarlane A, Donkin A, Marmot M, Viner R.** *Why children die: death in infants, children, and young people in the UK - Part A.* London : RCPCH, NCB, BACAPH, May 2014.

5.0 Overview of Greater Manchester population aged under 18 years

Table 1, below, demonstrates the population of children aged under 18 years in each GM borough.

Table 1: Number of children aged under 18 years in each area of GM and its overseeing CDOP (ONS Data 2018)	
CDOP	**Population Size**
Bolton, Salford & Wigan	**192,624**
Bolton	67,670
Salford	56,566
Wigan	68,388
Stockport, Tameside & Trafford	**169,451**
Stockport	63,141
Tameside	50,223
Trafford	56,087
Bury, Rochdale & Oldham	**155,247**
Bury	43,142
Oldham	59,416
Rochdale	59,416
Manchester	**121,962**
Greater Manchester	**646,011**

Source: ONS 2017

5.1 Ethnicity

We can use ethnicity estimates from the 2011 census and apply these to the 2019 mid-year population estimates for each local authority to tell us the breakdown of the under 18 population by ethnicity. This shows that nine of the local authorities in GM (all except Wigan) have a higher proportion of the population that identify as BME and lower proportion of the population that identify as White British than the North West average. Manchester has the highest percentage BME population and the lowest percentage White British population (see table 2, overleaf).

Table 2: Estimated population by ethnic group for GM local authorities, mid-2018 population data applying 2011 census ethnicity breakdown (source ONS)				
Area	**White British**		**BME**	
Bolton	46,895	69.3%	20,775	30.7%
Bury	34,600	80.2%	8,542	19.8%
Manchester	55,249	45.3%	66,713	54.7%
Oldham	36,125	60.8%	23,291	39.2%
Rochdale	41,056	69.1%	18,360	30.9%
Salford	44,574	78.8%	11,992	21.2%
Stockport	52,975	83.9%	10,166	16.1%
Tameside	41,836	83.3%	8,387	16.7%
Trafford	40,551	72.3%	15,536	27.7%
Wigan	65,447	95.7%	2,941	4.3%
Greater Manchester	459,309	71.1%	186,702	28.9%
North-West	1,309,303	84.3%	243,844	15.7%

Source: ONS 2019

5.2 Index of Multiple Deprivation (IMD)

The Index of Multiple Deprivation (IMD) data has not been updated recently, so the scores from 2015 are still currently used. For GM, 6 out of the 10 local authorities have higher IMD scores than the North West average, i.e. are more deprived than the average. These local authorities also have a higher proportion of their population living in the most deprived areas of the country than the North West average (see table 3). On this measure Manchester ranks as the most deprived local authority in GM with Trafford the least, with 41% and 3% of their respective populations living in the most deprived areas of the country.

Table 3: Average IMD 2015 score and percentage in the most deprived 10% for GM local authorities (source ONS)					
Current Code	**Former Code**	**Area**	**Average IMD 2010 score**	**Average IMD 2015 score**	**% of people in an area in most deprived 10%**
E08000003	00BN	Manchester	41.13	40.51	41%
E08000006	00BR	Salford	34.74	32.95	29%
E08000005	00BQ	Rochdale	33.85	33.68	28%
E08000004	00BP	Oldham	30.41	30.29	23%
E08000001	00BL	Bolton	30.46	28.42	20%
E08000008	00BT	Tameside	29.62	29.38	17%
E08000010	00BW	Wigan	26.01	24.85	14%
E08000002	00BM	Bury	22.23	21.76	10%
E08000007	00BS	Stockport	18.88	19.1	9%
E08000009	00BU	Trafford	17.05	15.38	3%

Source: Local Government and Communities

6.0 2018/19 Reviews by CDOPs

6.1 Closed Cases 2018/19

The four CDOPs in GM completed reviews of 204 child deaths between 1st April 2018 and 31st March 2019. Table 4 below shows the breakdown across GM by local authority and CDOP area.

Bolton, Salford & Wigan CDOP closed the most cases (64) whilst Stockport, Tameside & Trafford CDOP closed the fewest, with 40 closed cases. Looking at individual local authorities (LAs), Manchester closed the most cases (47) with Trafford the fewest (10). The number of closed cases in each area is not the same as the number of deaths that occurred in 2018/19. Of the 2018/19 cases closed, a number of these deaths will have occurred in previous years and it is likely that these were subject to investigation (such as criminal proceedings, or serious case review) which can delay the closure of the case by the CDOP significantly. Some of the deaths notified in 2018/19 will not be closed within that year, therefore the rate of closed cases for 2018/19 has not been calculated as they cannot be interpreted without more information.

Data from Public Health England's (PHE) child health profiles show a small decline in child mortality for GM since 2010. However there is not a clear trend for the whole of GM, with some areas showing a levelling off or an increase. Given the small numbers involved it is impossible to tell whether this is random variation, different data collection methods in different areas or a real effect. Longer term monitoring of the data is needed to establish whether there is an underlying trend.

Table 4: Number and percentage of deaths (cases closed) across GM 2018/19

LA	Total Deaths Closed	Percentage of overall GM deaths (cases closed)	Closed cases per 10,000 populatio
Bolton	33	16%	4.88
Bury	12	6%	2.78
Manchester	47	23%	3.85
Oldham	14	7%	2.36
Rochdale	27	13%	5.12
Salford	16	8%	2.83
Stockport	17	8%	2.69
Tameside	10	5%	1.99
Trafford	13	6%	2.32
Wigan	15	7%	2.19
Greater Manchester	**204**	100%	3.19
Bolton, Salford, Wigan	**64**	31%	3.32
Bury, Oldham & Rochdale	**53**	26%	3.41
Manchester	**47**	23%	3.85
Stockport, Tameside & Trafford	**40**	20%	2.36

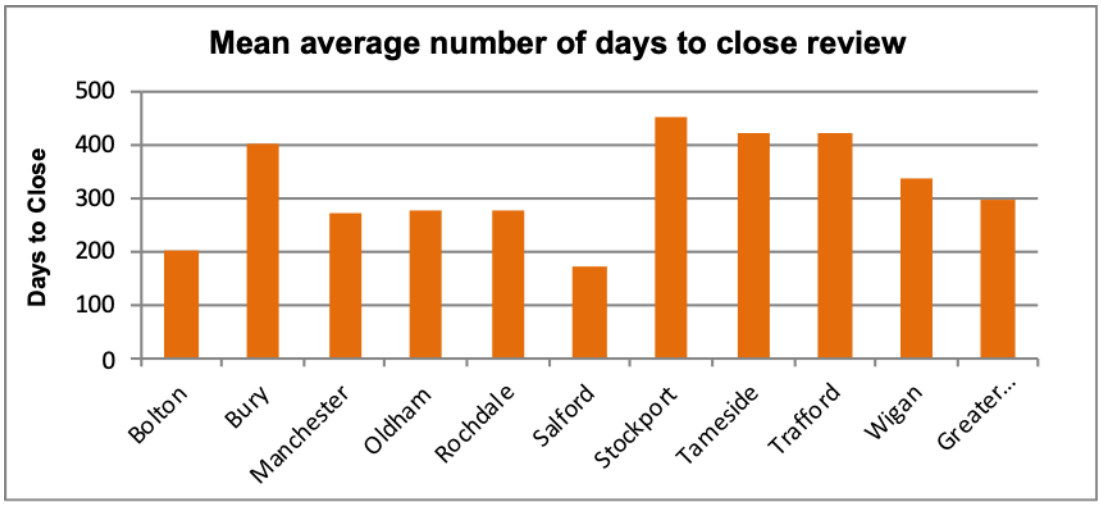
Source: GM CDOPs 2018/19

6.2 Duration of Reviews

The duration of a review is the length of time it takes from the date of notification of death until the review is closed and it is recorded as the number of days. Complex cases that involve agencies such as the Coroner or the Crown Prosecution Service (CPS) will take much longer to close as a CDOP will not review these cases until the relevant authorities have completed their investigations, such as a Serious Case Review (SCR). In these cases it can potentially take years for a case to be closed. There are other factors which can lead to variation in the length of time that different CDOP areas take to review cases; the amount of information that each CDOP requires before opening a review, the speed with which other local agencies notify the CDOP of the death and the time that it takes to gather all the of the relevant information from the external agencies involved.

During 2018/19 Bolton, Salford and Wigan CDOP closed the most cases (64). The longest duration of review was 2,328 days, with the shortest lasting 31 days. The average duration of review for 2018/19 was 297 days across GM.

Chart 1: Mean number of days to close a review (from date of death) by Local Authority (2018/19)



Source: GM CDOPs 2018/19

The different CDOP area is not the only factor that can affect the length of time a review takes. Nationally, it is recognised that cases with potentially modifiable factors, on average, take longer than those without[5] probably because these tend to be more complex cases that can require further investigation.

The cause of death can also effect the duration of the review, so a death involving trauma and other external factors is likely to require more extensive investigation and data collection than a death due to a chronic medical condition which may have been expected.

In 2018/19 the longest average duration of reviews was for Deaths by Suicide or Deliberate Self-harm (248 days), and then Chronic Medical Condition (238 days).

The shortest average duration of review was seen for deaths due to Infections (192 days), and then deaths due to Acute Medical or Surgical Conditions (203 days). This could reflect the fact that deaths in these categories are less likely to involve external agencies, and due to the nature of the deaths,

death certificates may be able to be completed and post-mortem examinations avoided. However, again the absolute numbers are small. All the data on average duration of review by category is summarised in Table 5 below. Categories which include less than 5 cases, and the next smallest category, have been obscured with an asterisk (*).

Table 5: Reviews completed in 2018/19 by duration of review and by category

Category	Closed cases	Average	Minimum days	Maximum days
a. Deliberately inflicted injury, abuse or neglect	*	223	0	2328
b. Suicide or deliberate self-harm	*	248	0	685
c. Trauma and other external factors	13 (6%)	214	0	798
d. Malignancy	16 (8%)	205	0	452
e. Acute medical or surgical condition	14 (7%)	203	0	917
f. Chronic medical condition	8 (4%)	238	0	738
g. Chromosomal, genetic and congenital anomalies	41 (20%)	207	0	562
h. Perinatal / neonatal event	66 (32%)	218	0	1784
i. Infection	17 (8%)	192	0	819
j. Sudden unexpected, unexplained death	20 (9%)	208	0	804

Source: GM CDOPs 2018/19

6.3 Notified Deaths 2018/19

The number of notified deaths across GM decreased in 2018/19 to 217 (from 250 in 2017/18), with Manchester having the highest proportion of these (26%) and Bury having the lowest (6%). Given the wide variation in population size for local authorities across GM it is necessary to adjust these figures to a rate before interpreting them. The rates of child death notifications per 10,000 of the under 18 year old population have been calculated to allow for meaningful comparison across GM.

In 2018/19 Manchester had both the highest crude number of notified deaths and the highest rate at 4.59 deaths per 10,000 <18 population. The next highest rates were seen in Oldham and Tameside with 3.53 and 3.38 deaths per 10,000 under 18 year old population respectively. Trafford had the lowest rate of notified deaths in GM for the second year in a row (2.67 deaths per 10,000 <18 population). It is hard to draw conclusions for the variation in child death rates across GM; it is notable that Manchester is the most deprived local authority in GM and Trafford the least, but the absolute numbers are sufficiently small that any variations could be due to chance.

Table 6: Number, percentage and rate per 10,000 of notified deaths across GM, 2018/19

LA	Total Deaths Notified (number)	Percentage of overall GM deaths	Population 0-17 yrs	Notified cases per 10,000 population
Bolton	22	10%	67,670	3.25
Bury	14	6%	43,142	3.25
Manchester	56	26%	121,962	4.59
Oldham	21	10%	59,416	3.53
Rochdale	17	8%	52,689	3.23
Salford	18	8%	56,566	3.18
Stockport	17	8%	63,141	2.69
Tameside	17	8%	50,223	3.38
Trafford	15	7%	56,087	2.67
Wigan	20	9%	68,388	2.92
Greater Manchester	**217**		639,284	3.39
Bolton, Salford, Wigan	**60**	28%	192,624	3.11
Bury, Oldham & Rochdale	**52**	24%	155,247	3.35
Manchester	**56**	26%	121,962	4.59
Stockport, Tameside & Trafford	**49**	23%	169,451	2.89

Source: GM CDOPs 2018/19

6.4 In-Year Closed Cases (by CDOP)

As previously discussed above, not all cases will be closed in the same year that the death was notified. In GM in 2018/19, 34% of cases were closed in the same year they were notified.

There are also geographical variations between the CDOP areas, in 2018/19 Bolton, Wigan and Salford closed the highest proportion of cases in year (45%) compared to Stockport, Tameside and Trafford which only closed 10% in year.

There is not a clear explanation for these rates of variation, it could be due to the number of cases subject to investigation, differences in how data is recorded in different areas over time, random variation or it might simply reflect how the complexity of the cases reported varies over time and place.

6.5 Causes of death

There are ten nationally defined categories that a CDOP can use when reviewing a death and each case must be assigned to one of these categories. It is a hierarchical list, so if more than one category could reasonably be applied, the highest up on the list should be given.

1. Deliberately inflicted injury, abuse or neglect
2. Suicide or deliberate self-harm
3. Trauma and other external factors
4. Malignancy
5. Acute medical or surgical conditions
6. Chronic medical condition
7. Chromosomal genetic and congenital anomalies
8. Perinatal/neonatal event
9. Infection
10. Sudden unexpected, unexplained death

Having nationally defined categories and standards makes it possible to compare CDOP data from across the country. The chairs and managers of the four GM CDOPs regularly discuss a small number of cases in order to ensure that all of the panels are applying the standards in a consistent way.

The majority of the 204 cases closed in GM in 2018/19, occurred in early life and resulted from events around the time of birth (perinatal/neonatal event) or from conditions which pre-date birth such as genetic and congenital anomalies. This is consistent with the previous year's findings.

6.5.1 Trend Data

In 2018/19, the greatest proportion of deaths occurred due to a perinatal/neonatal event (category 8) followed by chromosomal genetic and congenital anomalies (category 7).

The number of deaths falling into other individual categories are very small, meaning that there is too much variation from year to year to establish clear trends. The table below demonstrates trends in the category of death from 2013/2013 to 208/2019. Categories with small numbers (between 1 and 5) have been obscured with an asterisk (*). Where only one category has a count of between 1 and 5, the next smallest category during that year has also been obscured.

Table 7: Category of death by number and percentage for 2012/13, 2013/14, 2014/15, 2016/17, 2017/18, 2018/19

Form C Category	2012/2013		2013/2014		2014/2015		2015/2016		2016/2017		2017/18		2018/19	
a. Deliberately inflicted injury, abuse or neglect	*	*	*	*	*	*	0	0%	0	0%	*	*	*	*
b. Suicide or deliberate self-harm	11	4%	*	*	*	*	7	29%	6	3%	*	*	*	*
c. Trauma and other external factors	*	*	10	5%	14	5%	15	63%	16	7%	15	5%	13	6%
d. Malignancy	12	4%	20	9%	18	7%	15	63%	15	6%	20	7%	16	8%
e. Acute medical or surgical condition	16	6%	20	9%	*	*	12	50%	12	5%	11	4%	14	7%
f. Chronic medical condition	11	4%	12	6%	10	4%	11	46%	11	5%	16	6%	8	4%
g. Chromosomal, genetic and congenital anomalies	70	26%	50	23%	68	26%	56	24%	56	24%	67	24%	41	20%
h. Perinatal/neonatal event	97	37%	81	38%	97	37%	78	33%	78	33%	102	37%	66	32%
i. Infection	18	7%	*	*	12	5%	18	75%	18	8%	12	4%	17	8%
j. Sudden unexpected, unexplained death	20	7%	10	5%	19	7%	24	100%	24	10%	19	7%	20	9%

6.5.2 Cause of Death by Ethnicity

All closed cases in GM should have data recorded on their ethnicity. This is classed as either White British or Black and Minority Ethnic (BME). In GM as a whole, for the under 18 year old population, 75% identify as White British and 25% as BME[5].

The small numbers demonstrated in most of the categories prevent meaningful analysis, however, BME groups are over represented in both perinatal / neonatal events and chromosomal / genetic / congenital conditions, with 48% and 51% of deaths in these categories despite having only 25% of the population. The BME data is not further subdivided into different populations so it is not possible to tell if particular communities are more affected by these issues. However, consanguineous marriages are known to increase the risk of congenital abnormalities[7], so it may follow that communities where consanguineous relationships are more likely to take place may suffer a disproportionate burden of these cases. The increased risk of perinatal / neonatal events and chromosomal / genetic / congenital conditions does represent a clear health inequality for the BME population in GM.

6.6 Location of death

For the cases closed in 2018/19, 71% (145) occurred in hospital, this in part will reflect the high proportion of deaths from medical causes. The second most common location of death was the home (20% of cases (41)). There is some variation between local authorities across GM in terms of the proportion of deaths occurring in the home) but the absolute numbers are very small. In the case of deaths in the home, these end to represent either sudden deaths or those in children on an end of life pathway where families choose for their child to die at home.

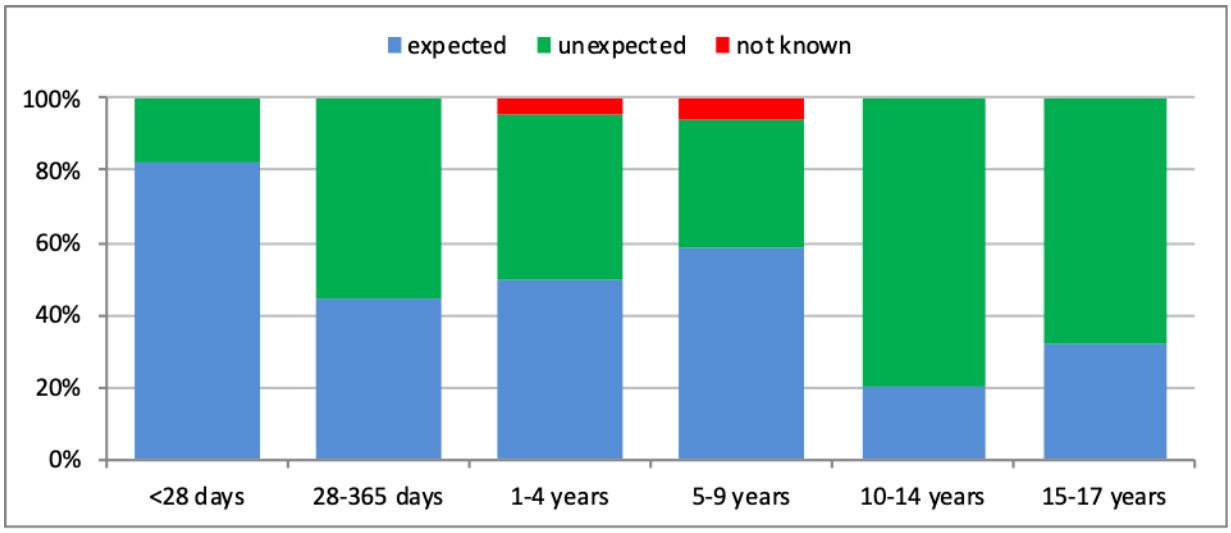
6.7 Expected verses unexpected deaths

Each CDOP will classify cases as either an expected or unexpected death. For 2018/19, 58% of cases were classified as expected, This is in line with the last 5 years, where the overall proportion of deaths categorised as 'expected' has remained stable (60-69%).

The proportion of deaths which are expected or unexpected varies across the age bands, with more expected deaths occurring within the neonatal period. This reflects the fact that deaths in the first year of life are often due to the complications of prematurity or from congenital conditions, whereas older children are more likely to be accidental or trauma related and therefore tend to be unexpected. However, in 2018/19 (similar to the year before), there was also a high proportion of expected deaths in the 1-4 year and 5-9 year age categories. It has been suggested that some improvements have been made in medical and social care of children with known life-limiting conditions, meaning more children may survive infancy and live longer. This may increase the overall population of children with these conditions, meaning numbers of deaths could stay the same but rates of death in that population may reduce. It may also lead to a change in the age breakdown of deaths of children with life limiting conditions.

[5] Source: ONS 2015 mid-year estimate and 2011 Census data

Chart 2: Percentage child deaths expected and unexpected by age group 2018/19



Source: GM CDOPs 2018/19

6.8 Potentially modifiable risk factors

In reviewing the death of each child, the CDOP considers factors which are potentially modifiable in a number of different domains (the child, the family and environment, parenting capacity, and service provision). Once identified, the CDOP can consider what action could be taken locally and what action could be taken at a regional or national level to prevent future deaths. The guidance defines potentially preventable child deaths as those in which modifiable factors may have contributed to the death. In line with the Department for Education, the CDOP categorises each case under one of the following:

1. **Modifiable factors identified**
   The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths

2. **No Modifiable factors identified**
   The panel have not identified any potentially modifiable factors in relation to this death

3. **Inadequate information upon which to make a judgement**
   NB this category should be used very rarely.

Nationally, the percentage of reviews which were closed and identified as having modifiable risk factors was 27%[6] in the year ending March 2017 (the most recently published data), which is an increase from 24% in 2014/15.

[6] 4. **Department of Education.** *Child Death Reviews – Year ending March 2017.* London : s.n., 2017

The CDOP analyses any relevant environmental, external, medical or personal factors that may have contributed to the child's death under the following headings.

0 - Information not available

1 - No factors identified or factors identified but are unlikely to have contributed to the death

2 - Factors identified that may have contributed to vulnerability, ill-health or death

3 - Factors identified that provide a complete and sufficient explanation for the death (This category will no longer exist in the new analysis forms).

Of the 204 cases closed across GM in 2018/19, there were modifiable factors identified in 79 deaths (39%), which is similar to the findings from 2017/18 (40%). There were approximately 89 different issues related to the 79 cases. Smoking was still the largest potentially modifiable factor (24 cases), followed by obesity (19). Access to health care or poor care management was the 3rd largest modifiable factor (11) followed by substance misuse (10).

Table 10, shows the proportion and number of closed cases in each CDOP in which modifiable factors were identified. In all CDOP areas apart from Bolton, Salford and Wigan, the proportion of cases with modifiable factors decreased slightly in 2018/19, which differs to the pattern seen last year where there was a slight increase in all areas. These statistics have to be interpreted with caution due to the small numbers involved.

There is an element of subjectivity in deciding whether modifiable factors are present or not which could explain some of the variation between the four CDOP areas. It is also possible that areas could change their approach over time. The variability seen from year to year in the different areas does not indicate a consistent trend, but the annual data reflects cases closed in that year, this will include deaths occurring over a number of years which could mask any change in approach over time.

Table 8: Percentage and number of child deaths in each CDOP area in which modifiable factors were felt to be present

CDOP Area	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Bolton, Salford and Wigan	39% (34)	28% (13)	26% (17)	38% (21)	34% (23)	35% (29)	44% (28)
Bury, Oldham and Rochdale	21% (15)	30% (17)	25% (20)	22% (16)	41% (21)	46% (33)	40% (21)
Manchester	29% (16)	20% (10)	18% (15)	29% (16)	27% (17)	34% (21)	32% (15)
Stockport, Tameside and Trafford	18% (10)	27% (17)	31% (25)	42% (21)	29% (14)	47% (27)	38% (15)

Source: GM CDOPs 2016/17

Modifiable factors identified by the CDOPs included (in order of frequency):

- Smoking
- Obesity
- Access to appropriate healthcare
- Substance misuse
- Unsafe sleeping
- Safeguarding
- Housing issues / home environment
- Gestational diabetes
- Domestic abuse
- Mental health
- Consanguinity

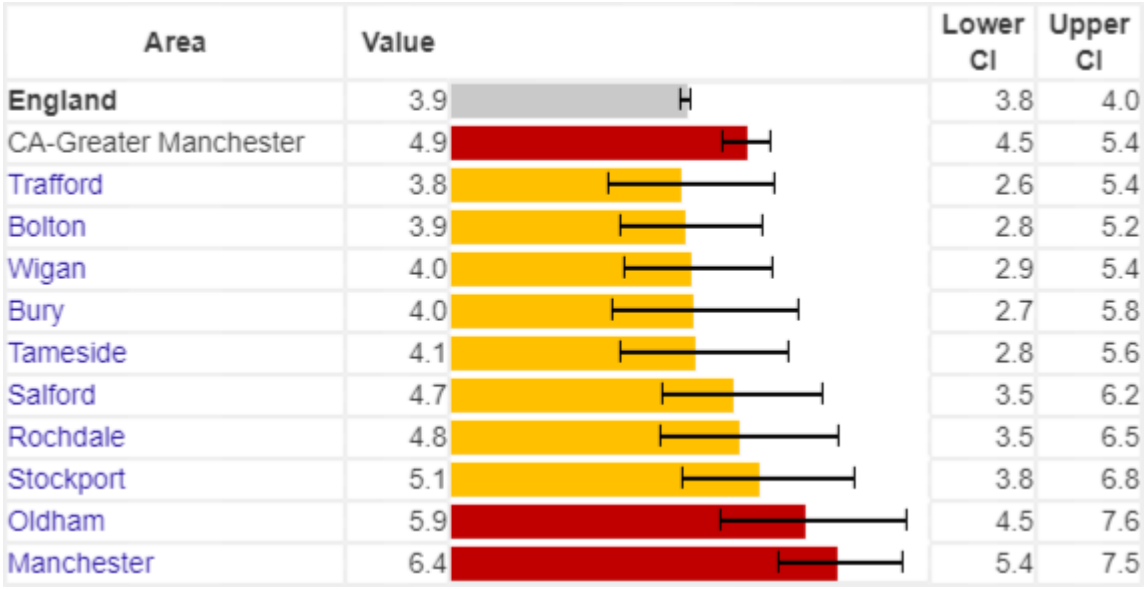
6.9 Neonatal and infant deaths

6.9.1 Infant Mortality Rates

Infant mortality rates are published by the Office for National Statistics, and are available publicly on the Public Health England Fingertips website[7]. These are crude rates, per 1,000 live births, so are likely influenced by population and demographic differences. Due to the small numbers involved, the figures for three years are combined into one. Chart 3 (overleaf) demonstrates the infant mortality rate in each Greater Manchester borough from 2015-2017.

[7] https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/3/gid/1938133228/pat/126/par/E47000001/ati/102/are/E08000008/iid/92196/age/2/sex/4

Chart 3: Infant mortality rate, per 1000 live births, by local authority, 2015-2017 (Source: Fingertips)



Area	Value	Lower CI	Upper CI
England	3.9	3.8	4.0
CA-Greater Manchester	4.9	4.5	5.4
Trafford	3.8	2.6	5.4
Bolton	3.9	2.8	5.2
Wigan	4.0	2.9	5.4
Bury	4.0	2.7	5.8
Tameside	4.1	2.8	5.6
Salford	4.7	3.5	6.2
Rochdale	4.8	3.5	6.5
Stockport	5.1	3.8	6.8
Oldham	5.9	4.5	7.6
Manchester	6.4	5.4	7.5

6.9.2 Overview of CDOP deaths by age

Across GM in 2018/19, 42% of all closed cases were neonates (under 28 days old) and 61% of all closed cases were infants (under 12 months old). This is similar to 2017/18 when the figures were 36% and 62% respectively. In previous years there has only been a small amount of variation in figures reported in the different age groups. The number of deaths is generally expected to reduce as age increases, and in GM the large majority of deaths were seen in the neonatal and infant categories with small numbers for all other ages.

6.9.3 Neonatal and Infant Categorisation of Death (0 – 364 days of life)

There were a total of 123 cases in this age category with around three quarters occurring in the first 28 days of life. The most common causes of death in the neonatal age group were Perinatal/neonatal event followed by Chromosomal, genetic and congenital anomalies and then Infection with 60, 14 and 6 cases respectively. There is however a different pattern of deaths between the two age bands. Unsurprisingly, perinatal/neonatal events was a far more common cause of death in neonates than older infants, with only 5 cases recorded over the age of 28 days. Sudden unexpected, unexplained deaths on the other hand were rare in neonates (<5 cases) but the most common cause of death in babies aged 28-364 days (15 cases).

Overall, congenital anomalies are the second most common cause of death for infants under 1 year old across GM, this reflects the situation for England as a whole. Nationally, congenital anomalies contribute approximately one third of the extra infant deaths experienced by lower socio-economic groups compared with the population as a whole, which is a clear health inequality[8].

[8] **National Perinatal Epidemiology Unit.** The contribution of congenital anomalies to infant mortality . Oxford : University of Oxford, 2010. Inequaliites in Infant Mortality Project Briefing Paper 4.

6.9.3 Gestation

Rates of infant mortality are higher in babies born prematurely compared to those born at term. In the majority of cases the excess deaths occur in the neonatal period, however, improvements in medical care mean that more premature babies are surviving the neonatal period. This has the effect of increasing the number of cases where prematurity is the cause of death recorded in infants up to 1 year old.

The categories of premature birth are:

- Extremely Premature (<26 weeks)
- Premature (26 weeks to <37 weeks)
- Full Term (37+ weeks)

Of the 85 neonatal deaths across GM, 59% (50) were in the extremely premature category with 21% (18) premature and 20% (17) at full term. This is unsurprising as gestational age has a significant effect on a neonate's chance of survival outside the womb and a foetus is not considered viable until after 24 weeks. (Please note, the numbers are not reported at local authority level as they are sufficiently low to be potentially identifiable.)

6.9.4 Low birth weight

Please note that this section refers only to cases closed that occurred when the child was less than 1 year old

Low birth weight (LBW) is recognised risk factor for infant mortality[9]. There are a number of risk factors for LBW including multiple births, smoking and maternal age, as well as gestation at delivery.

Of the infant deaths closed across GM in 2018/19 50% had a birth weight of less than 1500 grams, which is a slightly higher proportion than 2017/18 (47%). However, the data for this year is less complete than last year with no birth weight recorded in 2% of cases.

For the 161 deaths in the under 1 year age group, 69% had a birth weight of less than 2500 grams, which is higher than 2017/18 (63%).

Table 9: Birth weight categories (%)

	<1500g	1500g-2499g	2500g-3999g	4000g+	Not Stated
Greater Manchester	50%	19%	26%	3%	2%

Source: GM CDOPs 2018/19

[9] ONS (2015) Statistical bulletin: Childhood mortality in England and Wales: 2015.

6.10 Socio Demographic Characteristics

6.10.1 Age and Gender

The distribution of male and female child deaths is in line with recent years, with 60% of closed case deaths occurring in males (122) and 40% in females (82).

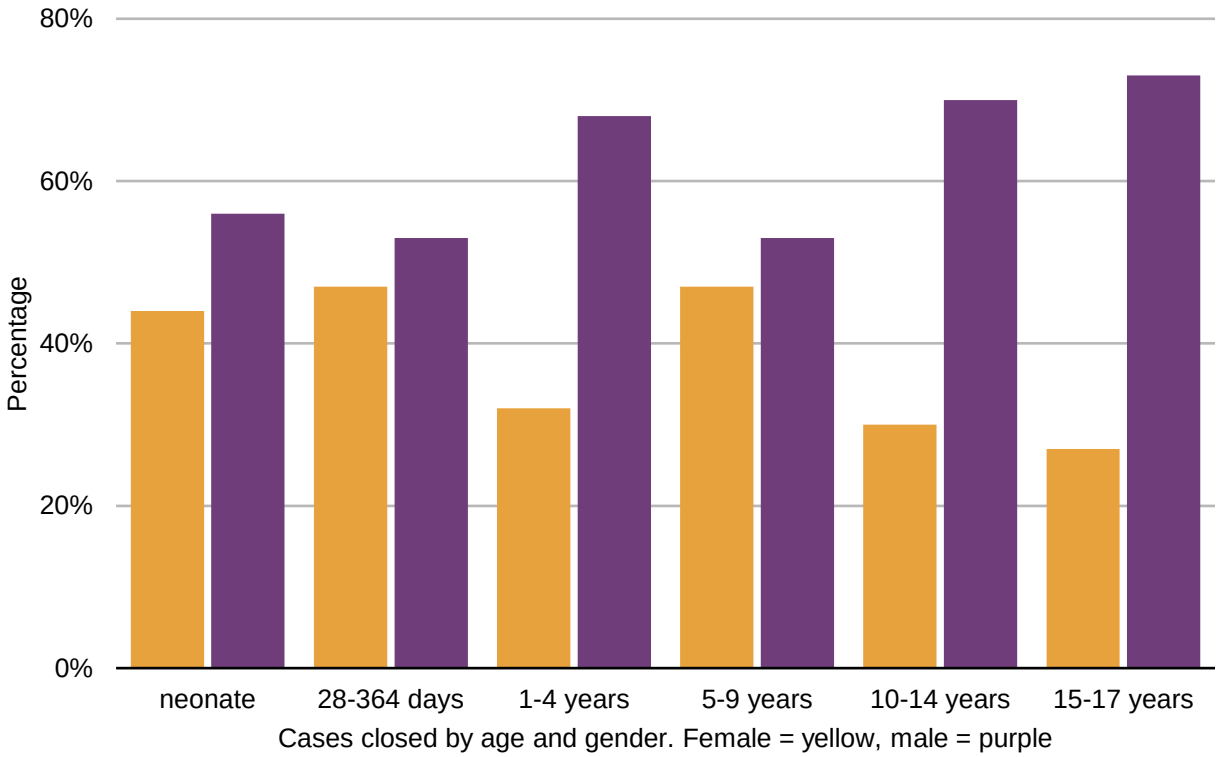
The difference in proportion of male and female deaths is most apparent in the 1-4, 10-14 and 15-17 age groups (see Chart 7). This differs to last year's data, when the gender difference was more pronounced in those aged under 1. Given the small numbers involved, it is possible that this change is due to random variation rather than a changing trend. Continuing to monitor the gender data going forward will be the only way to establish if this year is an anomaly in the longer term trend.

In the 15-17 age group in 2018/19, 38% of deaths in males were categorised as due to suicide or deliberate self-harm, compared to 17% for females in this age group. This is in line with national gender differences in suicide in the UK[10].

Looking at the gender data across local authorities, this pattern continues, as nine areas have more male deaths than female. However, the numbers involved are small.

Chart 4: Cases Closed by Age and Gender

Source: GM CDOPs 2018/19



[10] https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/

Table 10: Number of cases closed by gender by Local Authority 2018/19		
LA	**Males**	**Females**
Bolton	19	14
Bury	*	*
Manchester	26	21
Oldham	8	6
Rochdale	18	9
Salford	10	6
Stockport	10	7
Tameside	*	*
Trafford	6	7
Wigan	*	*
Greater Manchester	**122**	**82**

6.10.2 Ethnicity

Large inequalities in infant mortality rates exist between White and ethnic minority groups in England and Wales[11].

- Caribbean and Pakistani babies are more than twice as likely to die before the age of one as white British or Bangladeshi babies, in part due to a higher prevalence of preterm birth and congenital anomalies, respectively, in these particular groups.
- There is considerable heterogeneity between different ethnic groups in both the causes and the risk factors for infant mortality.
- Explanations for variations in infant mortality between ethnic groups are complex, involving the interplay of deprivation, physiological, behavioural and cultural factors.
- More research is needed in order to identify the pathways that lead to higher risks of infant death among black and other ethnic minority groups.

Nationally, reviews of deaths of children from a white background account for around two thirds of cases[12], which is higher than the proportion across GM in 2018/19, with 57% of in-year closed cases being from a white background. Ethnicity estimates have been calculated by applying total ONS mid-year population estimates for the <18 year old population to the ethnicity rate at the 2011 census for each area. As the estimate is specific to a particular year, the best measure of rates by ethnicity is looking at closed cases where notification was in the same year. This data is displayed in table 11

[11] Gray, R., Headley, J., Oakley, L., Kurinczuk, J. J., Brocklehurst, P. & Hollowell, J. (2009) **Inequalities in infant mortality project briefing paper 3.** Towards an understanding of variations in infant mortality rates between different ethnic groups. Oxford: *National Perinatal Epidemiology Unit.*

[12] **Department of Education.** *Child Death Reviews – Year ending March 2017.* London : s.n., 2017

below, along with the rates per 10,000 to account for varying population sizes. Please note, any potentially small numbers in a local authority area of between 1 and 5 have been labelled with an asterisk (*), to reduce any risk of identification.

This data indicates that 57% of in-year closed cases in 2018/19 were white (similar to previous years) and 43% were from BME populations. The data was reasonably complete, with five cases having no recorded ethnicity data. The proportion of BME cases is slightly higher than the national picture and indicates a substantial over-representation of BME populations in GM as BME groups make up only 25% of the under 18 year old population. Whilst differences in deprivation could account for some of this effect it is also possible that there are separate inequalities related to race such as additional barriers for BME women accessing antenatal care[13].

The inequality varies from area to area, so in Oldham, Trafford, Bolton and Rochdale, the child death rate was much higher amongst populations other than white British for 2018/19. However, this is not consistent year on year. Due to the small numbers involved, even small variations due to chance can make the figures look very different from one year to the next.

Table 11 : Cases closed by Ethnicity where date of notification occurred in year 2018/19

Local Authority	White		BME	
	Number	rate/10,000	Number	rate/10,000
Bolton	11	2.35	21	1.37
Bury	*	*	*	*
Manchester	23	4.19	24	3.34
Oldham	*	*	*	*
Rochdale	10	2.78	15	9.24
Salford	16	3.65	0	0.00
Stockport	*	*	*	*
Tameside	*	*	*	*
Trafford	*	*	*	*
Wigan	15	2.30	0	0.00
Greater Manchester	113	2.50	86	4.77

*Please note there were 5 cases where ethnicity was not recorded

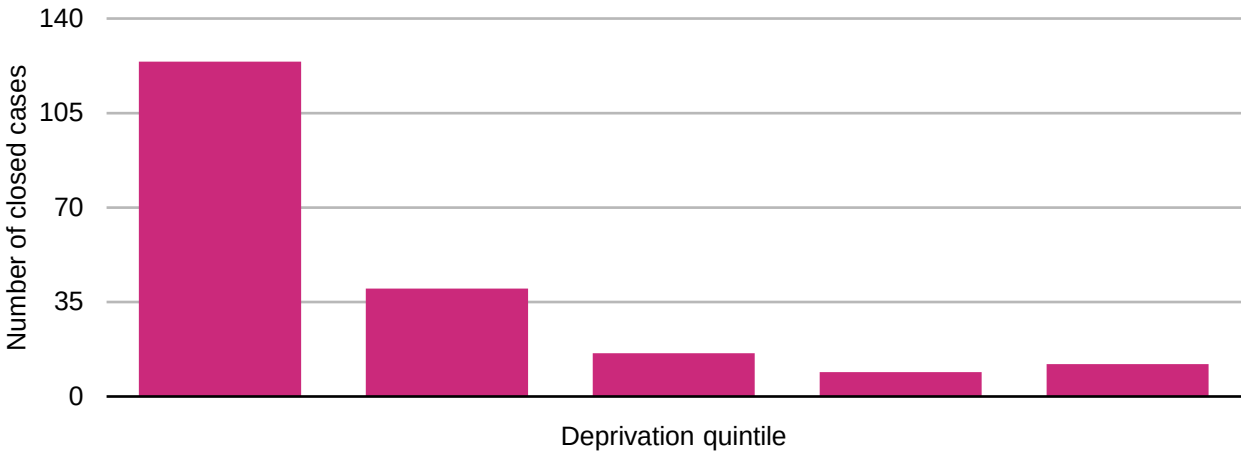
** The total number of deaths used in this table for GM was 199, excluding the 5 not recorded

[13] Hollowell. J, Oakley. L, Vigurs. C, Barnett-Page. E, Kavanagh. J & Oliver S. (2012) Increasing the early initiation of antenatal care by Black and Minority Ethnic women in the UK. Oxford: *National Perinatal Epidemiology Unit.*

6.10.3 Deprivation

The Index of Multiple Deprivation (IMD) is a widely used, area-based score that combines a number of markers to give an overall measure of deprivation. IMD across GM has been previously discussed in section 5.2. In Greater Manchester, 37% of the 0 to 18 population live in the most deprived quintile (quintile 1); in 2018/19, 63% of the child deaths in GM were from this quintile. This is similar to 2017/18, where 61% of child deaths were from this quintile. There is a consistent trend over recent years of higher rates of child deaths in the most deprived groups. Chart 5 shows the number of closed cases by deprivation quintile, demonstrating a much higher risk for those in the most deprived two quintiles.

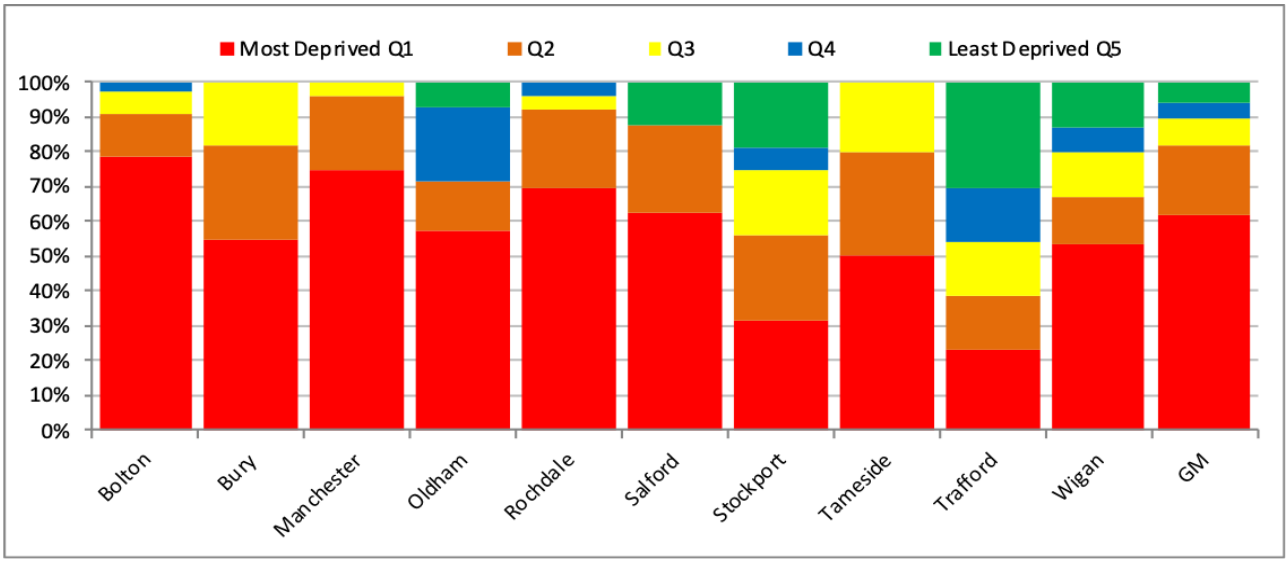
Chart 5: Number of cases closed by deprivation quintile 2018/19



Source: GM CDOPs 2018/19 & IMD 2015

Chart 6 below shows the average IMD score for each local authority and the number of closed cases. There is some variation but, generally, local authorities with higher (more deprived) IMD scores have higher numbers of closed cases. As this data is not adjusted for the different population sizes of these areas it can only show a potential correlation between deprivation and child mortality.

Chart 6: Proportion of closed cases 2018/19 and deprivation quintile by Local Authority



Source: GM CDOPs 2018/19 and IMD 2015

6.11 Smoking status of the mother

Whilst smoking is always hazardous to health, it is associated with worse outcomes in pregnancy for mother and child. These were described by the Royal College of Physicians[14] as an increased risk of complications in labour, as well as an increased risk of miscarriage, still birth, low birth-weight and sudden unexpected death in infancy. Maternal smoking is also estimated to increase infant mortality by approximately 40%[15].

Public Health England (PHE) uses smoking at time of delivery (SATOD) as a national measure to record rates of smoking in pregnancy. The most up to date figures available for this measure are from 2017/18[16] and show an average SATOD for England of 10.8% and 12.6% for Greater Manchester. The figures for GM show that 7 out of 10 local authorities are above the England average. This shows that smoking in pregnancy is a considerable problem for GM. Two of the areas in GM under the national average were the least deprived local authorities, Trafford and Stockport, which recorded rates of 6.7% and 10% respectively. This reflects that tobacco use is strongly linked to deprivation and constitutes another health inequality. However Manchester also had a rate of 10.7, which was just under the England average.

For 2018/19 smoking was deemed to be relevant in 23 closed cases for infants under the age of one year. This appears to be a decrease from 38 in 2017/18. The proportion of cases in which smoking was a factor ranges from 0-50% across the ten local authorities, demonstrating huge inter-borough variation, but the absolute numbers are small only ranging from 0-6.

6.12 Raised Body Mass Index

Maternal obesity is known to be associated with worse pregnancy outcomes and higher rates of stillbirth[17]. Maternal obesity is also strongly associated with socioeconomic deprivation, so mothers in more deprived groups are more at risk of these negative outcomes. Since 2015/16 data on maternal BMI has been collected for all cases where the child was aged less than 1 year old, and it was agreed that a BMI of over 30 should be considered as a modifiable factor in cases categorised as perinatal / neonatal deaths.

In 2018/19 there were 19 cases where maternal obesity was identified as a modifiable factor, this was second only to smoking (24) as a leading modifiable factor in GM. This is a decrease from 2017/18 where obesity was identified as a modifiable factor in 39 cases, but similar to the data in 2016/17. Given that there are rising rates of obesity nationally and across GM, it is important that this data continues to be gathered in future years so that the trend can be monitored. As with maternal smoking data, CDOPs should promote data collection requirements among front line professionals to try and capture as much health-related data as possible.

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[14] J R Coll Physicians Lond. **1992** Oct;26(4):352-6. **Smoking and the young**

[15] NICE Guidance PH26 (2010) Smoking: stopping in pregnancy and after childbirth. https://www.nice.org.uk/guidance/ph26/chapter/2-public-health-need-and-practice

[16] http://fingertips.phe.org.uk/search/smoking

[17] Maternal obesity in the UK: findings from a national project (2010) UK. Centre for Maternal and Child Enquiries

6.13 Other factors

6.13.1 Consanguinity

From 2015/16 it was agreed that to standardize recording between different CDOPs, consanguinity would be considered as a modifiable factor if a second child was born with genetic anomalies to consanguineous parents. In 2018/19, consanguinity was recorded as a modifiable factor in a small number of cases (<5), which was a decrease from last year (3%) and a decrease from 2017/18 (4%).

This is a sensitive and complex topic because some cultures have higher rates of marriage amongst relatives than others. It can be argued that different cultural attitudes to screening and termination of pregnancy may affect the rates of congenital anomalies[18,19], however given that not all of the conditions that the NHS screens for are fatal conditions (e.g. Down syndrome) this is unlikely to provide a full explanation of the difference. Some groups, such as women who are born outside of the UK, may experience additional barriers to accessing antenatal care and education and so may miss out on measures such as folic acid supplementation which can reduce the risk of some defects.

Parents from all social groups require genetic counselling services to be widely available for couples with a family history or past history of pregnancy affected by congenital anomalies[20] so that they have the information and support they need to plan their families.

6.13.2 Parental Alcohol/Drug Use

Alcohol and/or drug use by parents was identified as a potentially modifiable factor in just under 5% of cases (10) which is the same as last year (13). Although not always a direct risk factor, parental drug or alcohol use is associated (although not proven to be causal) with higher rates of sudden unexplained deaths in childhood and co-sleeping.

6.13.3 Co-sleeping

Co-sleeping was identified as a potentially modifiable factor in just under 4% of closed cases (8) across GM in 2018/19. This is a similar proportion of cases to last year (4%) however, co-sleeping persistently appears as a key modifiable factor in the years since this report began even if the numbers are small. This suggests that more parental education around safe sleeping for babies would be helpful to ensure that the key messages are understood and acted upon.

6.13.4 Domestic Violence

In GM, domestic violence and abuse was deemed a relevant modifiable risk factor in a small number of closed cases (<5) for 2018/19. This is similar to previous years. However, it is difficult to draw conclusions around trends with such small numbers.

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[18] Hawkins, A., Stenzel, A., Taylor, J., Chock, V. & Hudgins, L. (2012) Variables Influencing Pregnancy Termination Following Prenatal Diagnosis of Fetal Chromosome Abnormalities. *Journal of Genetic Counselling.* 22(2) pp. 238-248

[19] Gil, M., Giunta, G., Macalli, E., Poon, L. & Nicolaides, K. (2015) UK NHS pilot study on cell-free DNA testing in screening for fetal trisomies: factors affecting uptake. *Ultrasound in Obstetrics and Gynecology.* 45(1) pp. 67-73. DOI: 10.1002/uog.14683

[20] **National Perinatal Epidemiology Unit.** The contribution of congenital anomalies to infant mortality . Oxford : University of Oxford, 2010. Inequaliites in Infant Mortality Project Briefing Paper 4.

6.13.5 Access to Appropriate Healthcare

Access to appropriate healthcare includes a wide range of factors relating to the mother or child receiving appropriate medical and maternity care. This can include factors such as parents being unable or unwilling to seek medical help when advised, as well as failings within the system such as medical errors or factors around service provision. Access to appropriate healthcare was identified as a modifiable factor in 5% of cases (11) for 2018/19, which was similar to the numbers in 2017/18 (14).

7.0 Discussion and Conclusions

This report focuses on the cases reviewed and closed by CDOPs during 2018/19. The number of cases notified in 2018/19 is referred to but full details are only available to analyse for cases that have been closed. As the overall number of child deaths for GM is small compared to the size of population (204 closed cases for the whole of GM), all of the analysis has to be treated with some caution as variation between areas or over time may be due to chance.

Whilst the absolute numbers are small, each child's death represents many years of potential life lost and a huge loss to the family and community involved. There is a need to ensure that all those affected have access to timely and appropriate support services, including specific provision for bereaved children.

Both the number of closed cases and the number of notified cases have decreased slightly in 2018/19 compared to those from the year before. There is not a clear trend in the number of child deaths across GM over the last few years as the small variations seen from year to year can be explained by chance.

The large majority of child deaths in GM occurred in the first year of life; 42% of closed cases occurred in the first 28 days and 60% in the first 12 months. This is a decrease on last year, when deaths in infants aged under 1 year accounted for 65% of closed cases, but the main causes of these deaths remain the same. Most were due to events around the time of birth, perinatal or neonatal events, with the next most common issue being genetic or congenital conditions, which would have been present from before birth.

The older age groups: 1-4, 5-9, 10-14 and 15-17 account for 11%, 8%, 10% and 11% of deaths respectively, which does indicate a slightly wider spread of deaths throughout the age groups than in previous years, but the absolute numbers are too small to draw conclusions. From all the closed cases in 2018/19, most deaths (79%) were classed as 'medical' causes, i.e. acute medical, chromosomal, chronic medical, malignancy, perinatal / neonatal event or infection. Across GM 82% of neonatal deaths were expected, falling to 45% of infants aged 28-364 days. However, in children aged 10-14 years, only a small number of deaths were expected which reflects a greater number of deaths from unexpected causes, such as health-related causes of death and trauma in this age group. Overall, 79% of closed cases were attributed to medical causes. The high proportion of deaths relating to the child's health mean that the provision of high quality maternity and paediatric care across all the local authorities is essential and work needs to ensure services work together. Access to appropriate healthcare was listed as a modifiable factor in 11 of the closed cases from 2018/19 but this figure was higher in 2017/18 and should be considered, as deprived or vulnerable groups are likely to face greater barriers to accessing care.

The proportion of cases where potentially modifiable factors were identified has continued to remain above the national average, at 39% in Greater Manchester. Whilst potentially modifiable factors are not often directly causal, they reflect factors in the child's situation that make poorer health outcomes more likely and reducing potentially modifiable factors, such as parental smoking, for the population as a whole would be likely to reduce child mortality. This is why it is important to identify the factors associated with higher rates of childhood deaths, to try and reduce their prevalence in the population.

8.0 Recommendations

The following should be considered by each CDOP panel and the Public Health lead for children's health. A coordinated GM response is recommended:

1. This report means that there are now seven sets of data and analysis which are available to review and combine into an aggregate report. This should help to identify trends, and having larger numbers to work with should reduce the impact of random error in the data. This will be a large piece of work and will need greater resources than for the stand alone annual report, but it should be possible to identify a group of public health registrars to carry out this work.

2. Health inequalities in the distribution of child deaths remain a concern. The BME population remains at increased risk of childhood mortality and the proportion of deaths in the most deprived groups is consistently high. Although data is now being collected for more BME subgroups by CDOP panels, meaningful analysis may take several years as the small numbers involved would mean that aggregate will be required. However, further analysis on these subgroups should be conducted as it may help to identify further patterns and areas for intervention.

3. A higher proportion of deaths occurred in males (60%) compared to females (40%). Although the age at which this disparity was most apparent has changed since 2017/18, possibly due to the small numbers of cases involved, this may require further investigation. Suicide prevention, especially in males age 15-17, should be a public health and CDOP priority.

4. As in previous years, smoking remains a key modifiable factor for child deaths across GM, with the proportion of cases where smoking is identified as a relevant factor higher than the rate of smoking in pregnancy. This has been recognised in the Greater Manchester Population Health Plan which is putting in place a GM evidence-based approach to reducing smoking, particularly in pregnancy. CDOP data and action plans should be linked to this and allow an opportunity to review the impact of smoking on deaths through the in depth CDOP review process. Work to reduce smoking prevalence across Greater Manchester should continue.

5. GM CDOPs should consider any emerging evidence from other areas and from international research to identify any risk factors which have not received the focus that others have, including areas for future data collection and analysis. In particular, it may be worthwhile recording the relevance (1,2,3) for factors which are not (yet) on the national data analysis proforma but which CDOPs currently record, such as physical health or learning disability.

The above recommendations should be followed up at the next GM CDOP panel meeting and CDOP panels and public health leads should continue to conduct reviews and monitor the number of child death notifications.

Appendix 1: Summary of Gender, Ethnicity and Deprivation Data for 2018/19

Characteristic	Number of child deaths for Greater Manchester 2018/19	Greater Manchester <18 year old Population (%)
Sex		
Male	122 (60%)	51%
Female	82 (40%)	49%
Undetermined	0 (0%)	
Ethnicity		
Asian/Asian British	52 (25%)	White (72%)
Black/Black British	17 (8%)	BME (29%)
White British	109 (53%)	
Other/mixed	22 (10%)	
No data	<5 (<5%)	
Deprivation		Approximately 20% of the GM population live in the most deprived 10% quintiles
1 (most deprived)	124 (62%)	
2	40 (20%)	
3	16 (8%)	
4	9 (4%)	
5 (least deprived)	12 (6%)	
No data	<5 (<5%)	

Appendix 2: Population and number of cases closed by CDOP panel (2012/2013 - 2018/19)

Area	0-17 population 2016	Number of cases closed in 2012/13	Number of cases closed in 2013/14	Number of cases closed in 2014/15	Number of cases closed in 2015/16	Number of cases closed in 2016/17	Number of cases closed in 2017/18	Number of cases closed in 2018/19
Manchester CDOP	**119,825**	**56**	**49**	**61**	**56**	**64**	**62**	**47**
Bury, Oldham & Rochdale CDOP	**153,144**	**72**	**57**	**81**	**74**	**48**	**71**	**53**
Bury	42,879	20	13	17	17	11	14	12
Oldham	58,802	25	20	28	28	24	31	14
Rochdale	51,463	27	24	36	29	13	26	27
Bolton, Salford & Wigan CDOP	**189,634**	**88**	**48**	**66**	**56**	**68**	**83**	**64**
Bolton	66,918	43	17	20	12	23	23	33
Salford	54,881	27	12	19	23	21	27	16
Wigan	67,835	18	19	27	21	24	33	15
Stockport, Tameside & Trafford	**166,675**	**52**	**62**	**54**	**50**	**48**	**58**	**40**
Stockport	62,372	18	18	14	20	21	24	17
Tameside	49,349	16	15	25	14	16	16	10
Trafford	54,954	18	29	15	16	11	18	13
Greater Manchester	**629,278**	**268**	**216**	**262**	**236**	**228**	**274**	**204**

Report to HEALTH AND WELLBEING BOARD

Oldham Health and Care Locality Plan Refresh

Portfolio Holder:
Cllr Zahid Chauhan, Cabinet Member for Health and Social Care

Officer Contact : Katrina Stephens, Director of Public Health

Report Author: Richard Cohen, Consultant, Transforming Care
Mobile: 07833161711

31st October 2019

Purpose of the Report
To provide visibility to the Health and Wellbeing Board of the process for the refresh of The Oldham Locality Plan for Health & Social Care Transformation (September 2016 - March 2021), prior to submission of a draft to Greater Manchester on the 30th November 2019.

Executive Summary
In 2016 a Locality Plan for Health & Social Care Transformation was drafted. The Plan covers the period dated September 2016 to March 2021. It outlines the key transformational programmes that will enable Oldham to deliver significant improvements in the health & wellbeing of our residents. The strategic context has moved on since 2016 and Oldham is now in a much better position than in 2016 to describe a whole public service approach to transformation at place level. There has also been a recent ask, at the end of July, made by Greater Manchester (GM) to refresh the Plan to support the development of its implementation plan for GM Health and Social Care prospectus plan and as a response to the NHS Long Term Plan Commitments. Combined with Oldham's desire to continually review direction and progress we have the opportunity to refresh the Plan to reflect our own unique journey to developing a local population health system and reformed public services at place level. A structured approach is being adopted to develop the Plan. Good progress is being made and Oldham is on track for the Plan to be submitted for approval to the Joint Commissioning Partnership Board in November. Following this it will be submitted in 'Draft' to GM. The Plan will be an item for discussion at the next Health and Wellbeing Board Development Session.

Recommendations/Requirement from the Health and Wellbeing Board

To note the note the drivers for the refresh of the Health and Social Care Locality Plan, the structured approach being adopted and the good progress made to date.

The Refresh of the Oldham Locality Plan for Health & Social Care Transformation

1. Background

1.1 In 2016 a Locality Plan for Health & Social Care Transformation was drafted. The Plan covers the period dated September 2016 to March 2021. It outlines the key transformational programmes that will enable Oldham to deliver significant improvements in the health & wellbeing of our residents. It focuses in particular on how we aim to transform prevention services and primary and social care.

1.2 The Plan describes four main transformation programmes:

- Establishing an Integrated Care Organisation
- Mental health is central to good health
- Starting Well: Early Years, children & young people
- Living Well: Action to build thriving communities and provide early help

1.3 The strategic context has moved on since 2016, with considerable changes to the health and social care landscape over the last 12 months. For example the North East Sector community services transaction and Phase 1 of the integration of health and social care.

1.4 Oldham is now in a much better position than in 2016 to describe a whole public service approach to transformation at place level – both in respect of commissioning and provision with a focus on neighbourhood level delivery (30,000 to 50,000 populations).

1.5 There has also been a recent ask, at the end of July, made by Greater Manchester (GM) to refresh the Plan to support the development of its implementation plan for GM Health and Social Care prospectus plan and as a response to the NHS Long Term Plan commitments. This will be integrated with the GM Combined Authority in respect of the implementation of the Unified Model of Public Services.

1.6 Combined with Oldham's desire to continually review direction and progress we have the opportunity to refresh the Plan to reflect our own unique journey to developing a local population health system and reformed public services at place level. It is also an opportunity to reaffirm the outcomes that we are seeking to influence.

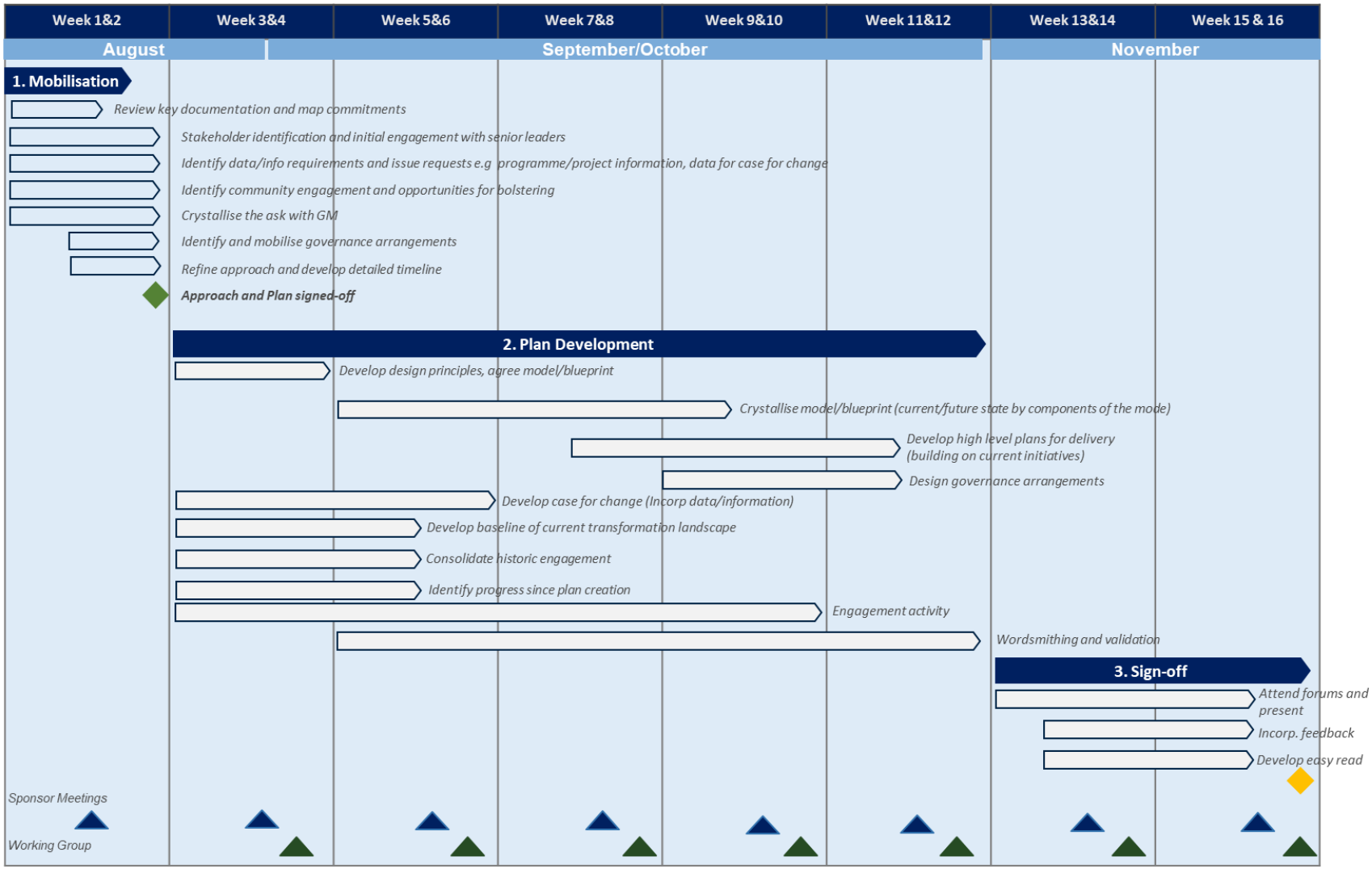
1.7 We recognise that Oldham has been engaging residents on the implementation of its Locality Plan for the last three years. As part of this refresh, we will capture and incorporate this activity, where relevant.

1.8 In order that the refreshed Locality Plan can influence the planning for the first year of delivery under the Long Term Plan (2020-21), the Plan will need to be complete by the end of November 2019 and submitted in 'Draft' to GM.

1.9 The purpose of this report is to provide visibility to the Health and Wellbeing Board of the process for the refresh and progress to date, prior to submission of a draft to Greater Manchester on the 30th November 2019.

2. Approach

2.1. A structured approach and timeline has been developed to undertake the refresh of the Plan. This is illustrated below. Senior Officers have been providing oversight of the its development, receiving weekly highlight reports. In addition a task and finish group that meets weekly has been mobilised to coordinate and contribute to the drafting of the Plan.



3. Progress Update

3.1. The development of the Plan is progressing well and Oldham is on track for a draft to be submitted to the Joint Commissioning Partnership Board in November for approval. Following this it will be submitted in 'Draft' to GM. The Plan will be an item for discussion at the next Health and Wellbeing Board Development Session.

3.2. There continues to be extensive engagement across partners to crystallise the content and to ensure that it accurately reflects the current and proposed transformation activity.

3.3. In line with the structured approach to developing the Plan, work is in the final stages - wordsmithing of the content of the Plan and validation with key stakeholders. Activity continues to be driven through a task and finish group on a weekly basis.

3.4. For early visibility, the structure and content of the Plan, model of care and design principles have been included in this report.

3.5. The Locality Plan structure is as follows:

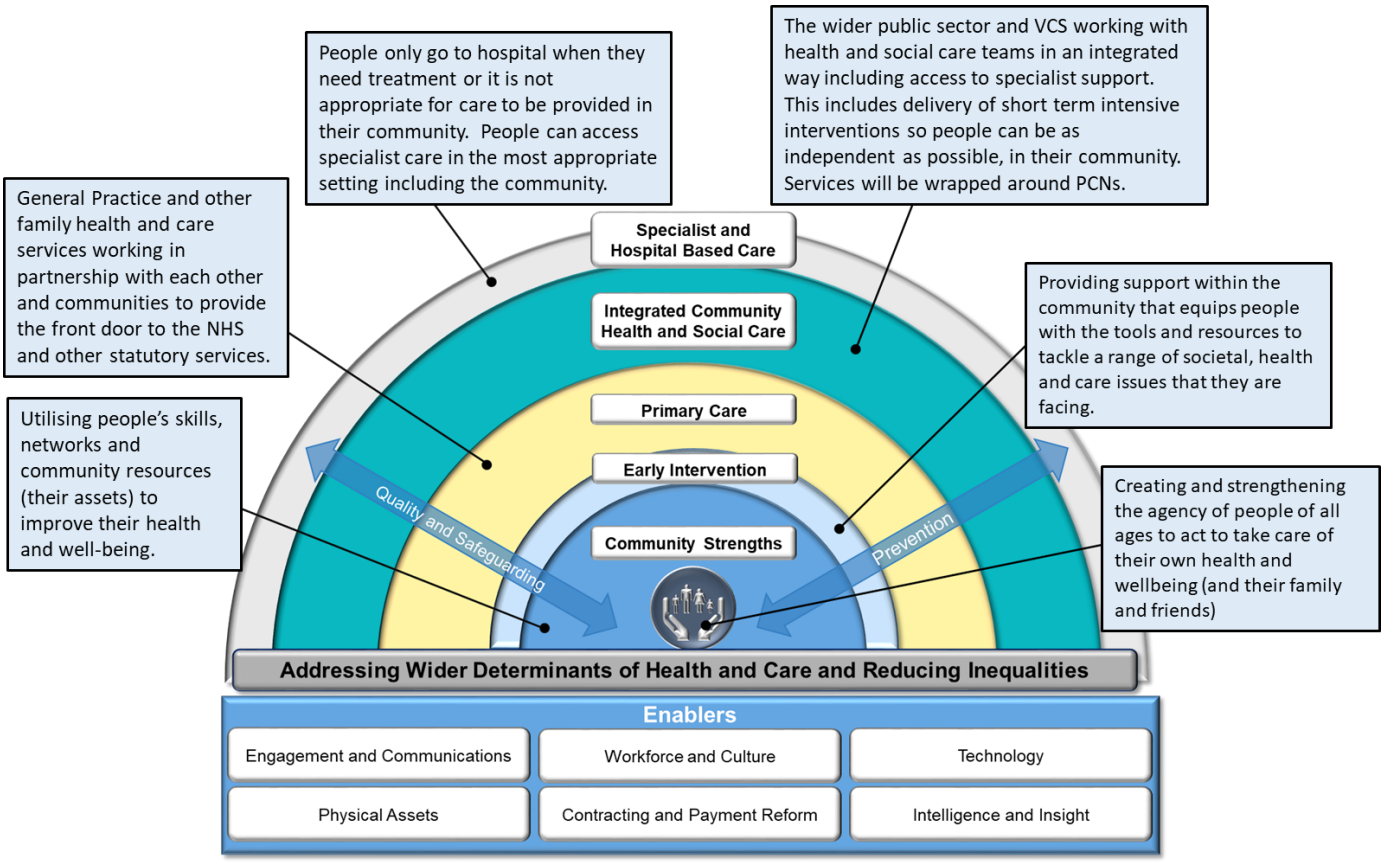
3.6. To support the evolution of an Integrated Care System for Oldham a model of health and care has been developed. A model of care broadly describes the how different health and care services and partner organisations should work together in the future for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, in the right place at the right time, by the right team.

3.7. Significant work has been undertaken to design the model of care based on the feedback of clinicians, patients and the public, as well as the wider workforce. By considering all of the feedback, a model and set of design principles have been developed.

3.8. The model serves a high level visual that can be shared internally with staff to explain where services sit in the context of the wider health and care system. A model from which more detailed service models can be designed and delivered.

3.9. The **design logic** behind the model is that it:

- is an 'All Age' model;
- places the person and their community at the centre;
- builds on the requirements for all services to help address the wider determinants of health and address inequalities;
- flows outwards recognising that people need to access different and more specialist care as their needs increase and become more complex;
- is not linear, recognising that people can access services and support at all levels at a time;
- provides an indication of the number of people accessing services through the width of the arcs; and
- ensures that the core themes of Prevention, Safeguarding and Quality permeate all levels.



3.10. Design Principles

- Provided in the most appropriate setting, starting with neighbourhood and place
- As a minimum services are of a 'good' quality and are safe
- Evidence based and driven by feedback, data and intelligence
- Co-designed with local communities and the people who use them
- Emphasise prevention and early intervention

- Promote the strengthening of social value
- Make best use of collective resources to maximise the health and wellbeing outcomes (economies of outcome)
- Ensure value for money for the Oldham Pound
- Adopt an asset, strength based, life course approach to care, working with and not doing to people
- Are personalised and holistic, giving an equal focus on physical, mental health and emotional wellbeing
- Easy and seamless to access, use and transition between services
- Maximise opportunities to improve the health literacy of people and communities
- Create the right environment for all staff to contribute to the best of their skills and abilities
- Reduce inequalities, giving increased focus to those who face the greatest disadvantage or experience the worst outcomes
- Reduce variation and standardised where that is the right thing to do

4. Recommendation

4.1. The Health and Wellbeing Board is asked to note the drivers for refresh of the Locality Plan for Health & Social Care Transformation, the structured approach being adopted and the good progress made to date.

Report to Health and Wellbeing Board

Update on the Oldham Learning Disability Strategy

Portfolio Holder: Cllr. Zahid Chauhan – Cabinet Member for Health and Social Care

Officer Contact: Mark Warren – DASS

Report Author:
Gary Flanagan – Senior Commissioning Business Partner
Jo Charlan – Planning and Commissioning Manager
Charlotte Walker – Head of Service Adults LD and Autism

Ext. 0161 622 6605

Date: 12th November 2019

Reason for Decision
This report is to provide and update and does not require a decision from the Health and Wellbeing Board.

Executive Summary
This report provides an update on the Oldham Learning Disability Strategy. It provides context on the GM LD strategy and a summary of the actions and progress to date on each of the 10 strategic priorities that form the strategy.

Recommendations
The recommendation for Health and Wellbeing Board members is to note the progress to date with the Oldham LD strategy.

Update on the Oldham Learning Disability Strategy

1 Background

1.1 In Greater Manchester the LD strategy has been in place from last year, and the work to support implementation was launched at the GM Health and Care Board in the summer of 2018. The GM strategy has been written by people with a learning disability for people with a learning disability, and there are 10 priorities identified within the strategy, many of which are already being worked on through the GM Adult Social Care Transformation Programme or the Transforming Care programme, but recognising that in each area there are improvements that can and should be made.

1.2 Oldham has signed up to the GM LD Strategy and made a commitment to make improvements in the 10 key areas that have been identified. The 10 key areas are as follows:

- Strategic leadership
- Advocacy
- Bespoke commissioning
- Belonging
- Good health
- Homes for people
- Employment
- Workforce
- Early support for children and young people
- Justice system

1.3 To accelerate implementation specific to the strategy a collective '100 Day Challenge' was initiated looking at where localities could make positive changes aligned to the priorities above, over an initial period. Localities and the GM Partnership committed and worked towards a broad range of actions dependent on their local position. In Oldham it was agreed by the LD Partnership Board that the priority areas for the 100 Day Challenge would be Good Health and Employment.

1.4 Taking the learning from the 100 Day Challenge, localities in GM are developing longer term plans, that need to be co-produced with local self-advocates, for the delivery of *all* of the strategy priorities from 2019 onwards. The longer term implementation plans will ensure effective delivery of the strategy and hold localities to account when it comes to ensuring that the outcomes of these plans are making a difference to people's lives.

1.5 Oldham is in the process of developing a local LD strategy for the borough, now that the context and strategic priorities have been set by GM. This report provides an outline of the Oldham strategy work that has taken place to date and a summary of the actions to be delivered on over the coming 12 months, across all 10 priority areas.

2 Current Position

2.1 The Oldham LD strategy aligns to the GM priorities, with 10 work streams each with a named responsible lead. The named leads for each programme of work are in the table below:

Priority Area	Responsible Lead

Strategic Leadership	Mark Warren – Oldham DASS/Managing Director Health & Adult Social Care Community Services
Advocacy	Camilla Guereca – Chief Executive, Oldham Personal Advocacy Limited
Bespoke Commissioning	Jo Charlan – Planning and Commissioning Manager, Oldham Cares
Belonging	Camilla Guereca – Chief Executive, Oldham Personal Advocacy Limited
Good Health	Gary Flanagan – Senior Commissioning Business Partner for Mental Health and LD, Oldham Cares John King – Clinical Team Manager LD Directorate, PCFT
Homes for People	Diane Taylor – Associate Director, MioCare Group
Employment	Charlotte Walker – Head of Service: Adults LD and Autism Service and Integrated Discharge Team
Workforce	Emma Gilmartin – HR Business Partner, OMBC
Early Support for Children and Young People	Cllr. Marie Bashforth – Deputy Cabinet Member for Health and Social Care
Justice System	John King – Clinical Team Manager LD Directorate, PCFT

2.2 The sections below outline the key actions for each work stream, with timescales for delivery (where known at this stage).

2.3 Strategic Leadership

This priority is focused on ensuring that there is the right strategic leadership to support a reduction in inequality across Greater Manchester. The Oldham actions are as follows:

Actions for Oldham
Action 1: Implement the GM LD strategy locally and embed the principles in what we do

Progress to date:

- The LD strategy forms a key part of the LD Partnership Board (LDPB) agenda with work stream leads presenting their priority areas.
- Head of Service for LD has been appointed to provide strategic leadership and oversee integration of community team. An LD away day was held on 10th October to review and improve the accommodation process.
- Work stream leads attend the GM LD Delivery Group and have presented on Oldham's strategy

- At the request of LDPB, a formal audit of the integrated team and commissioning arrangements has been undertaken and is forming an overarching work plan for the Head of Service.

2.4 Advocacy

The aim of this work stream is primarily to support more children, young people, and adults with a learning disability, as well as their family and friends, to have to confidence and skills to speak up for themselves and their peers.

Actions for Oldham
Action 1: Skill development for self-advocates- through accessible training opportunity delivered at a t time, place and pace identified by them
Action 2: Identify opportunities for people to have a meaningful voice in matters which affect them e.g. LDPB sub groups, consultations Identify good practice in other localities and see if this model could be replicated/adapted for Oldham self-advocates
Action 3: Identify good practice for the development and sustainability for citizen advocate partnerships and see how this mode might work in Oldham.
Action 4: Work with partners to identify ways in which existing groups of self-advocates can contribute to decision making processes – e.g. MioCare and Keyring groups
Action 5: Review accessible information about the different types of advocacy available in Oldham and agree how to make sure people know about it. Liaise with other localities to see what they are using

Progress to date:

- It has been identified that there is a need for a skills delivery programme for self-advocates, that is delivered through accessible training opportunities delivered at a time, place and pace identified by them. The first skills session lead by OPAL was delivered on the 26th September. The meeting in October has a focus on employment, listening to the views of the group on what should be included in a supported employment service and the barriers that people face trying to enter the job market

- Meeting held with Stockport Advocacy as an area of good practice, with a view to understand ways to develop and sustain strong citizen advocate partnerships. During Q3 and Q4 of this year this work stream will explore potential for developing or adopting elements of this model in Oldham.

- 'Speakeasy' sessions are planned for October to March. Each session will focus on one theme from the strategy and feedback from the session will be presented to the LDPB. Challenge will be made to LDPB on the basis of 'we said, what did you do?' The speak easy sessions are aligned to the work streams with invites extended to the relevant people involved.

2.5 Bespoke Commissioning

This priority is about bespoke support being provided for people with a learning disability where possible – i.e. support designed 'with me and for me'. This work stream recognises

the importance of ensuring high quality, value for money support for people. The self advocates involved at the start emphasized that areas should 'always expect and plan for the unexpected so there are fewer crisis situations'.

Actions for Oldham
Action 1: Fully embed the Greater Manchester Flexible Purchasing System (FPS) in LD commissioning
Action 2: Develop an Oldham FPS to enable a more dynamic commissioning process for commissioning services within the Borough
Action 3: Continue to review complex cases jointly between health and social care at Complex Case Forum (CCF) to ensure joint working to achieve the best outcomes for people with learning disabilities
Action 4: Working with care and housing providers collectively, to ensure that there are the best care and accommodation offer is available for people with LD (links with housing theme)
Action 5: Implement better embedding of personalisation based on strength based conversations with individuals to commission differently

Progress to date:

- FPS is being used to support procurement of placements for people, although it is recognized that there are still challenges in utilizing the new system. This has been addressed at the LD accommodation workshop held in October and will be built into the revised accommodation pathway.

- Bespoke commissioning arrangements are discussed at the monthly Complex Case Forum (CCF) and some good examples of very person-centred approaches implemented for people who have been discharged from hospital placements (e.g. extensive adaptations at home). Further work has been undertaken to join up the work of CCF and the monthly accommodation panel to identify areas of joint working.

- Reviewed and revised the pen picture template to enable practitioners to enhance the information they provide to potential care organisations.

- First steps to explore new housing opportunities have been taken, with meetings held with care providers and potential landlords for supported living. There is a planned survey of providers regarding fees and numbers of customers.

- Linked in to the assistive technology strategy in development to understand how we can use technology to help increase independence for people

- Work has begun on exploring the new options for supported living (links with the housing theme) and how this would provide opportunities to use the FPS in a localised way.

2.6 Belonging

The focus of this work stream is on reducing inequalities in the individual right to have a great life – 'belonging not isolation'.

Actions for Oldham
Action 1: Promote the Learning Disability Friend project 'Bridge that Gap' to recruit members in existing community groups who will welcome people with learning disabilities increasing the opportunities for people to take part in activities within their community. We will use our extensive range of partners to help us promote this piece of work and to gain access to groups in Oldham.
Action 2: Recruit co presenters (self-advocates) to deliver awareness sessions for learning disability friends
Action 3: Publicise information about groups with 'learning disability friend' on our website in a format which is easy to access and understand.
Action 4: Promote and publicise opportunities for people to make friends in Oldham (including Meet and Match)

Progress to date:

- Information on the LD and autism friends scheme has been launched. The website has been launched by OPAL and 25 groups in Oldham are now 'LD/Autism friends'.

- The LD/autism friend scheme will be further promoted at the planned 'speakeasy' events during Q3

2.7 Good Health

This priority was identified as one of the key areas in the '100 Day Challenge' and as a result there are several actions. The overarching aim of this priority is to reduce health inequalities for people with a learning disability. The actions include improving annual health check uptake, learning from the Learning Disability Mortality review (LeDeR), improving access to mainstream services, reducing the use of medication, and improving experiences for people with a learning disability.

Actions for Oldham
Action 1: Work with self-advocates, families and providers to ensure people are on GP register
Action 2: Increase the number of people with LD getting an Annual Health Check
Action 3: Review how health and social care services coordinate to ensure good health for people with a learning disability
Action 4: Work with our care providers to assess their practice for people with a learning disability using the NHSI LD Assessment Toolkit
Action 5:Assess policies in GP practices in relation to people with a learning disability to ensure reasonable measures are made where necessary

Action 6: Promote the triangle of care model in services to ensure carers views are heard
Action 7: Ensure carers needs are taken into account
Action 8: Ensure health care staff are trained and understand the MCA and used appropriately including best interest assessments
Action 9: Identify and address any health inequalities in health services in Oldham
Action 10: Ensure hospital passports are up to date and are used appropriately by health care staff.
Action 11: Implement changes to service provision from the findings of the LeDer review
Action 12: Ensure patient's views are central to care provision
Action 13: Review communication between health and social care services
Action 14: Staff, families and carers are aware of Safeguarding, their role and how to report.
Action 15: Focus on prevention
Action 16: Develop strategies to encourage people with a learning disability from BAME groups engage with health services
Action 17: Promote STOMP (stop over medicating people with a learning disability or autism)
Action18: Promote awareness of the complications that can be caused by constipation
Action 19: Promote the Red Flag Project
Action 20: Review cancer screening promotion for people with a learning disability
Action 21: Promote self-directed care to people with a learning disability so that they are aware of Personal Health Budgets and Direct Payments.

Progress to date:

- Facilitated work between CLDT and BI team at the CCG to agree how information from various systems (Paris, Mosaic and EMIS) can be brought into one register to ensure accurate representation of people in Oldham who have an LD

- Standards for GPs on completion of health checks have been completed and are ready for circulation to Oldham practices

- Pennine Care have commenced a relaunch of the ‘triangle of care’ model

- Meeting held with Oldham Carer’s Service and primary care leads to improve the carer’s register, with a plan to develop a checklist for surgeries to proactively identify and support carers

- Added a KPI for social care services to ensure all service users have an up to date hospital passport

- Approved national funding for continuation of LeDeR reviews in Oldham, but importantly to support implementation of the recommendations. Event to be planned for during Q3.

- Dedicated pharmacist working with four GP practices to reduce level of prescribing of anti-psychotic medication

2.8 Homes for People

This priority is about supporting people with a learning disability to gain confidence and understand what housing options are available, and help people plan for the future, and live in a place they can call home.

Actions for Oldham
Action 1: Develop local accommodation strategy for people with LD: Analysis need of adults with LD; Analysis of needs of children in transition; Analysis of current supply accommodation by type, tenure, landlord; Identify gaps in supply
Action 2: Develop new housing options framework for bespoke accommodation
Action 3: Develop support service framework for care to support living arrangements
Action 4: Develop local protocol for new accommodation in Oldham to ensure best provision at reasonable cost
Action 5: Implement GM protocol for moves between boroughs
Action 6: Develop processes around accessing new provision and advice and support for individual to understand their housing options
Action 7: Improve working with Children's services around transition

Progress to date:

- Development of purpose built, 20 apartment site 'Holly Bank':
    - LD service and MioCare collaborating to support the first group of people to move in, and this is expected to be in Q4. Assessments have been completed, and there is close involvement with individuals and families, housing, client finance and others to enable smooth transitions and positive outcomes
    - Second group of potential residents to be determined for next phase – this is in draft and MioCare are commencing the assessment process over the next month
    - Reflection on process and levels of collaboration to commence from November and will include feedback from the first group of residents.

- Development of Shared Lives scheme for Oldham with additional investment to support. Over the next 12 months there will be a greater emphasis placed on future recruitment drives for Shared Lives carers, and the MioCare team are in the process of advertising a 12 month secondment for a Transition Care Coordinator to

work specifically with this cohort of service users and foster carers who have a working knowledge and experience of transitional working.

- In addition to the recruitment/approval of potential foster carers identified through the transition work the scheme will continue to actively recruit, approve and train carers who have expressed an interest in working with vulnerable adults with varying needs.

- Work shop held with relevant stakeholders on accommodation process, including links to Complex Case Forum, and utilization of the FPS. MioCare are in agreement with the suggested pathway and will have a greater involvement including invite to Complex Case Forum.

- There is an Oldham Cares accommodation strategy in development and expected in Q3. Commissioning options for supported living are to be agreed in Q4 this year. Integration of specialist allocations/support within housing is to be agreed and developed.

- Work has begun on the process to retender supported living for people with learning disabilities. A consultation exercise has been undertaken to gain the options of people currently in supported living.

2.9 Employment

The focus of the employment work stream is to increase the number of people with a learning disability and autism in employment, traineeship or apprenticeship.

Actions for Oldham
Action 1: Map the resources currently working to support people with a Learning Disability into employment
Action 2: Meet with all partners across Oldham Cares to launch the working health programme to support people with a Learning Disability into employment
Action 3: To increase awareness of the access to work programme across all partners , operational teams, service users and carers
Action 4: Review exiting contracts to ensure there is an employer lead approach in terms of social value, which is audited and monitored
Action 5: Review the employment engagement strategy for Oldham, with an emphasis on targeting small to medium employers to engage in supporting people with a Learning Disability into employment.
Action 6: Devise a business disability tool kit, to engage local businesses in working in accordance with employment engagement strategy.
Action 7: Oldham to work with GM in the development of the service with the aim of providing a specialist employment service by the end of 2019.
Action 8: Engagement with schools to ensure schools are aware of the local strategy
Action 9: One story across all partners, ensuring performance is measured accordingly and consistently

Action 10: Communication of success stories with the implementation of one local comms strategy

Progress to date:

- Commenced mapping exercise to understand the number of adults with learning disabilities in Oldham who are in work
- Get Oldham Working have focused on targeted employment with 5 traineeships for people with LD
- Royal Oldham Hospital have agreed to recruit 10 people with a LD
- 32 people have been identified within the caseload of adults know to the specialist LD team who could be supported to access employment
- Initial discussions on the approach to transitions have started with a view to establishing joint working principles specific to the CHC framework application and processes. The intention is to mirror such principles within social care and education.
- Work is underway with the DWP and wider local working group on the intention to hold a focused jobs fair for adults with LD. There is work underway with POINT and SEND colleagues on the training of employers for adults with autism.
- In the next 12 months, this work stream will:
    - Map the resources currently working to support people with a LD into employment
    - Meet all partners across Oldham Cares to relaunch the Working Well programmes to support people with a LD into employment
    - Increase awareness of the access to welfare to work programme across all partners, operational teams, service users and carers
    - Review existing contracts to ensure there is an employer led approach in terms of social value, which is audited and monitored
    - Review the employment engagement strategy for Oldham, with an emphasis on targeting small to medium employers to engage in supporting people with an LD into employment
    - Devise a business disability tool kit, to engage local businesses in working in accordance with the employment engagement strategy
    - Work with GM in the development of the Working Well Specialist Employment Service
    - Communicate success stories with the implementation of one local comms strategy.

2.10 Workforce

The driving principle for this priority is to remember that 'it's everyone's job' – it is important that we work with mainstream universal health services to ensure that people with a learning disability are able to access services – there needs to be a skilled workforce and good quality providers.

Actions for Oldham

Action 1: Undertake a workforce audit in order to asset us in expediting integration
Action 2: Make use of the information received through the audit to identify any practice issues/development requirements and expectations which will form part of an action plan for delivery

Progress to date:

- Completed the service audit as part of the joint LD review. This sets out the findings, recommendations, actions and responsibilities across a range of areas including:
  - Transitioning the GM LD strategy into local plans and reporting to stakeholders
  - Governance and decision making
  - Commissioning arrangements
  - Workforce strategy and development
  - Systems, policies and procedures

- Secured funding for specific training on Mental Capacity Assessments and Court of Prevention Deprivation of Liberty (COP DoL) processes.

2.11 Early Support for Children and Young People

It is important that this work stream strengthens and delivers on joint working between SEND, CAMHS and children's social care leads to improve services for children and young people and their families. Ultimately this priority is about people getting the right help as early as possible, and adopting a whole family approach where possible.

Actions for Oldham
Action 1: Support the implementation of the local action learning set action plan as part of the SEND review
Action 2: Engaging with the published written statement of action in relation to SEND for children and young people following the recent Ofsted/CQC inspection, and subsequent action and implementation plans.
Action 3: Support the implementation of the Oldham Joint Autism Strategy 2016 - 2019.
Action 4: Development of a joint commissioning strategy children and adults through CAMHS
Action 5: Increase take up of health checks - now offered age 14+ joint approach with adults
Action 6: Transforming care - complex case forum convened

Progress to date:

- Complex Case Forum is now all-age with the relevant representatives from children's services.

- Transitions sub group of the Safeguarding Board has been established, following a recognition of a need for a more inclusive way of supporting young people and families up to 25

- Head of Service for LD is working closely with SEND colleagues on reviewing Educational Health and Care (EHC) cases and joint approaches to case work and culture change.

2.12 Justice System

There is currently an inequality in how people with learning disabilities are represented and treated fairly when navigating the justice system.

Actions for Oldham
Action 1: we will strengthen links with Mentally Vulnerable Offenders Panel to ensure that people with LD who are offending are identified & redirected to therapeutic services, where appropriate.
Action 2: Identify and organise appropriate training within the Team around understanding CJS, risk, formulation and promoting positive risk taking.
Action 3: Ensuring that people with LD who are at risk of offending receive early intervention for health & social care and we focus on preventative work
Action 4: Develop better links with other stakeholders, Probation CJMHT, GMP etc

Progress to date:

- CLDT leads have met with GMP and agreed to provide Learning Disability Awareness Training to existing officers and new officers completing training. This is being scheduled for early 2020.
- There is now consistent CLDT representation at the Mentally Vulnerable Offenders Panel – ensuring that people with LD are identified and redirected to therapeutic services where appropriate. The team is ensuring that there is a social work lead for justice.

2.13 The Oldham strategy will align to several wider strategies, policies or guidance documents at a GM or national level. Some examples of this are provided below (not comprehensive):

- The NHS Long Term Plan has a section for Learning Disability and Autism that makes the following promises:
    - Action will be taken to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people
    - The whole NHS will improve its understanding of the needs of people with learning disability and autism, and work together to improve their health and wellbeing
    - There will be tests to implement the more effective ways to reduce waiting times for specialist services
    - Where possible, people with a learning disability, autism or both will be enabled to have a personal health budget (PHB)
    - Increased investment in intensive, crisis and forensic community support
    - Focus on improving the quality of inpatient care across the NHS and independent sector

- *Improving identification of people with a learning disability: guidance for general practice* (NHS England and Improvement)[1] will support the **Good Health** work stream with options to improve reasonable adjustments in primary care and support increased uptake in annual health checks

- *A vision and priorities for people with learning disability and autism: A joint plan between LGA Care and Health Improvement Programme and ADASS* – a strategy from the LGA that sets out the shared priorities for improvement, proposing outcomes to be achieved and how these would be measured and how we will involve experts by experience and the wider partnership

- Greater Manchester Integrated Health and Justice Strategy that is in development to inform and enhance the way in which we understand and address the health, care and criminal justice factors that can lead to life-long poor physical and emotional health, and reduced life-expectancy, for people who are seen in the criminal justice system, as offender or victim. This will support our local **Justice System** work stream.

- *Making Greater Manchester Autism Friendly 2019-2022* (Greater Manchester Health and Social Care Partnership)[2] – Ensuring that where there is crossover between LD and autism strategies that there is no duplication and best practice can be shared where applicable.

- *Learning Disability Mortality Review (LeDeR) Programme: Action from Learning* (NHS England) [3] provides guidance on service improvements across acute hospitals, community teams, primary care and for family and paid carers. Oldham is ensuring that all local findings are embedded in the strategy action plans and are clearly identified.

3 Options/Alternatives

3.1 Not applicable

4 Preferred Option

4.1 Not applicable

5 Consultation

5.1 Not applicable

6 Financial Implications

6.1 At this stage of the Oldham LD strategy, any financial implications of the actions summarized in this report have not yet been determined. It is expected that the majority of actions will be 'cost neutral' and are focused more on changes in practice and process, behaviours etc. Any financial implications that come out of the LD strategy work will be taken through the relevant Oldham Cares governance and decision-making processes.

7 Legal Services Comments

[1] https://www.england.nhs.uk/wp-content/uploads/2019/10/improving-identification-of-people-with-a-learning-disability-guidance-for-general-practice.pdf
[2] http://www.gmhsc.org.uk/wp-content/uploads/2019/03/GMHSCP-Autism-Doc-FINAL.pdf
[3] https://www.england.nhs.uk/wp-content/uploads/2019/05/action-from-learning.pdf

7.1 Not applicable

8. **Co-operative Agenda**

8.1 Advocacy services have a positive impact on the environment and the health and safety of both people receiving the services and the wider community. The service helps to ensure that people who are at risk of social exclusion are able to remain safe and independent in their community.

8.2 The approach to redesigning Supported Living service provision has been one that supports people to become more independent, and aims to reduce the amount of formal health and social care required, thus improving longer-term health and wellbeing outcomes for individuals.

9 **Human Resources Comments**

9.1 The workforce work stream is led by the HR Business Partner for OMBC and will ensure HR consideration is given to all elements of the strategy.

10 **Risk Assessments**

10.1 There will need to be a full risk management process for the LD strategy. At the time of writing this report, this is not developed enough to share.

11 **IT Implications**

11.1 Any IT implications for the implementation of the LD strategy will need to be fully determined. The strategy has identified that there are IT implications in some areas such as coordinating data across various systems to understand LD registers in GP practices.

12 **Property Implications**

12.1 At this stage of the strategy, any property implications are not yet determined.

13 **Procurement Implications**

13.1 At this stage of the strategy, any procurement implications are not yet determined.

14 **Environmental and Health & Safety Implications**

14.1 At this stage of the strategy, any environmental and health and safety implications are not yet determined.

15 **Equality, community cohesion and crime implications**

15.1 All elements of the LD strategy are based on delivering equality for people with LD. This is summarized for some of the work stream areas below:

Priority Area	Equality Ambition
Advocacy	Reducing inequalities in being heard
Bespoke Commissioning	Reducing inequalities in control – support designed with me and for me

Good Health	Reducing health inequalities
Belonging	Reducing inequalities in my right to have a great life
Homes for People	Reducing inequalities in getting a good home
Employment	Reducing inequalities in getting a paid job

16 **Equality Impact Assessment Completed?**

16.1 No

17 **Key Decision**

17.1 No

18 **Key Decision Reference**

18.1 Not applicable

19 **Background Papers**

19.1 Not applicable

20 **Appendices**

20.1 Not applicable

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Report to HEALTH AND WELLBEING BOARD

Geographical alignment across public services at populations of 30-55,000

Portfolio Holder: Cllr Sean Fielding, Leader of the Council

Officer Contact: Rebekah Sutcliffe, Strategic Director of Communities and Reform, Oldham Council

Report Author: Vicky Sugars, Head of Reform, Oldham Council
Ext. 3303

Date: 4 November 2019

Purpose of the Report

Oldham has championed health and social care and place-based integration and reform for some-time now, leading the way regionally and nationally in developing a model for public service that puts the needs of people and communities before that of organisations.

Our experience and learning from health and social care and other forms of integrated working, have led to agreement in Oldham and Greater Manchester to scale up place-based integration across the whole system of public services, at populations of 30-55,000, so that we can better direct our resources to people and communities. This has the support of Oldham partners through the Joint Leadership Team and the Oldham Leadership Board and at GM through the Wider Leadership Team and the GM Health and Social Care Partnership.

In Oldham we do not have coterminous boundaries across all public services and this makes it difficult to achieve the full integration and reform of public services as our staff, resources and capacity do not align. Therefore, an important step towards the full integration of services in communities is geographical alignment.

This report seeks endorsement from the Health and Wellbeing Board for partners to progress with geographical alignment across the whole system including health and social care and wider public services at populations of 30-55,000. This will enable us to integrate delivery across the whole system to deliver better outcomes for people and communities in Oldham.

Recommendations/Requirement from the Health and Wellbeing Board

1. To endorse developing coterminous public service footprints at populations of 30-55,000 across the borough

2. To endorse that geographical alignment should be sought on 5 footprints but using wards as the building blocks for alignment
3. To endorse the criteria and principles by which a decision on geographical alignment will be reached
4. To note the next steps and decision-making process

Geographical alignment of public services at populations of 30-55,000

1 Background: Place based integration and reform

1.1 Place based, multi-agency integration is key to the transformation and reform of public services and communities both here in Oldham and across GM. Only by developing a single approach to building resilience that is informed by insight into what drives demand and shapes behaviour in communities will we shift the stubborn inequalities that exist within our borough.

1.2 Place based integration is not new to Oldham and it is not a "project" unrelated to the way mainstream services are delivered. Rather it is the way mainstream services should be delivered across the whole system and in partnership with residents.

1.3 In the past few years we have seen forms of multi-agency integration taking shape including:

- Health and Adult Social Care Community Provider, working to PCN footprint for adults – this has been rolled out across the borough. These teams are using their combined skills to support people to stay in their house/near to where they live for as long as possible, promote self-care and connect people in to what is happening in their neighbourhood. The co-location of staff is now complete (phase 1) but transformational work is still underway to scale up and embed new models of care (phase 2).
- Focused place-based teams in Holts and Lees, Westwood and North Chadderton and Limehurst and Hollinwood, who operate on a ward level or below but across all ages. They have proved that multi-agency place based integration really does improve lives and communities and is a good long-term investment for public services.
- A long-established District working model out and within communities with strong partnership elements
- An early help service with place-based elements and outreach
- A Focussed Care model in Fitton Hill and Hollinwood that works with GPs to provide social and clinical outreach to patients in the community
- An emerging children's operating model 'Oldham Family Connect' that incorporates a placed based approach strengthening the coordination and integration of service delivery with schools, partnerships and community assets.

1.4 One example from the above is the evaluation work in the Holts and Lees focused team. This has shown how we can move 70-80% of cases from 'not coping' (and in high cost services) to coping well (in universal services). The teams have really high levels of trust which is shown in the engagement levels (97%). They work in an asset-based way to improve the community. They focus on the things that matter to local people and the area and without needing to 'refer on'. The team has a 3:1 return on investment for public services as we move people out of crisis into and into more mainstream services.

1.5 However, despite the case for place-based integration we do not have this at the scale required. However, our experience of integration, aligned with the commitment locally and from GM, provides us with an opportunity to do this at scale and across the whole system.

1.6 We are currently developing our model for place-based integration across the whole system that articulates how we will fundamentally reshape the mainstream delivery of services by bringing staff together in a common geographic footprint, operating to a shared purpose and working in a holistic way with people and communities. This would include the full range of Social Care, Mental Health, Community Care, Primary Care, Policing, Housing

and Homelessness Support, Environmental health, Employment and Skills Support, VSCE provision, Community Safety Advisors, Substance Misuse and Early Years etc. They would interact frequently and consistently with GPs, Schools, the wider Community, Voluntary and Faith sector and other Universal Providers. However, to achieve this ambition we firstly need to have coterminous geographical delivery footprints so that we can align our capacity and resources.

2 Why we need geographical alignment across public services at populations of 30-55,000

2.1 Without geographical alignment we are unlikely to progress with the full integration and reform of public services as staff, resources and capacity would not align. The building block for Locality Care Organisations and public health management, police beats and district working is a 30-55,000 footprint. This is the optimum size for services to organise themselves because it is big enough to create economies of scale but small enough to be locally sensitive. Any footprint below this would make it difficult for services to align their capacity and resources to a place-based model. However, that is not to say that more localised and focused approaches are not needed below this footprint or that natural communities will be defined at this population size.

2.2 Discussions have already taken place across the system on how we might achieve geographical alignment. This includes the Joint Leadership Team, Cluster Cabinet, Council Leadership and the Oldham Leadership Board. Five geographical footprints are operationally and financially the most feasible for whole system public service integration. This is the current number of health and social care clusters and to increase the number to more than 5 would have both financial, resource and logistical implications as we already have staff and assets co-located on this footprint. However, whilst 5 footprints are the most operationally sound there is an acceptance that the current PCN boundaries are not sustainable and that any new arrangements should use ward boundaries as the legitimate building blocks for service footprints. Although GM indicate a 30-50,000 footprint, Oldham do not need to be totally constrained by this and this may stretch to 55,000 in places.

2.3 Via the Oldham Leadership Board, Greater Manchester Police and First Choice Homes, along with other key Oldham partner agencies have also indicated a willingness to change and amend existing boundaries to achieve alignment.

3 Key Principles for geographical alignment

3.1 To enable us to reach a decision on geographical alignment we have followed a clear set of criteria and guiding principles. These are listed below.

Criteria	Guiding principles	Feasibility
Population levels between 30-50,000	This is a guide only and we should not be restrained by this. Likely that this will be up to 55,000 for Oldham.	May need to exceed 50,000 populations in some cases.
Operationally sound	To not exceed 5 or 6 footprints	5 footprints is preferred. More than 7 would be operationally unfeasible and have large resource implications.
	To address existing anomalies within current arrangements where	To consider anomalies such as Mossley sitting within current cluster boundaries if possible.

	possible	
	That the geography is coterminous with Primary Care Networks	Guidance from NHS England encourages Primary networks to be geographically based but acknowledges that some might be built on relationships which makes the negotiation of this key.
Reflects natural communities	Footprints should reflect natural communities where possible and should not seek to split natural boundaries.	District boundaries more closely align to natural communities. Likelihood that more localised and focused approaches within any footprint will be required regardless.
Enables political leadership	Ward boundaries to be retained	Non-negotiable as the democratic foundation and any split will not be politically acceptable

4 Next steps and decision making

4.1 Options for developing geographical alignment at 30-55,000 have been developed and a preferred option, which is close to PCN boundaries, but using wards as building blocks, has been developed. This option has broad support across the system. Following endorsement from the Health and Wellbeing Board we will progress with further consultation on the preferred option.

4.2 Once agreement has been reached, we will then go through a formal decision-making process of both the CCG and Oldham Council along with any other respective partner decision making bodies. This decision-making process will be twin tracked with all organisations involved. The Council this decision will be taken at Full Council and the CCG this will be a decision for the Governing Body. Likewise, partners via the Oldham Leadership Board will also be consulted so that policing, housing and other operational boundaries can be amended. We hope that a decision will be made by January 2020.

5 Links to Oldham Model and Oldham Cares

5.1 The ambition for whole system place-based integration and reform is absolutely part of the vision for both Oldham Cares and underpins our Oldham Model to develop co-operative services that go hand in hand with thriving communities and an inclusive economy by developing a whole system approach to the mainstream delivery of services. Likewise, geographical alignment is also a key feature of the GM white paper on 'unified public services' and is aligned to the GM Health and Social Care Prospectus.

6 Recommendations for Health and Wellbeing Board

1. To endorse work to develop coterminous public service footprints at populations of 30-55,000 across the borough
2. To endorse that geographical alignment should be sought on 5 footprints but using wards as the building blocks for alignment
3. To endorse the criteria and principles by which a decision on geographical alignment will be reached
4. To note the next steps and decision-making process

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