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HEALTH AND WELL BEING BOARD
Agenda

Date Tuesday 26 January 2021

Time 2.00 pm

Venue Virtual Meeting - https://www.oldham.gov.uk/info/200608/meetings/1940/live_council_meetings_online

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, email constitutional.services@oldham.gov.uk

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, 21 January 2021.

4. FILMING – This meeting will be recorded for live and/or subsequent broadcast on the Council's website. The whole of the meeting will be recorded, except where there are confidential or exempt items and the footage will be on our website. This activity promotes democratic engagement in accordance with section 100A(9) of the Local Government Act 1972.

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, Chauhan, Moores, Stretton (Chair) and Sykes, Chris Allsop, Mike Barker, Majid Hussain, David Jago, Dr Keith Jeffery, Gerard Jones, Stuart Lockwood, Dr. John Patterson, Katrina Stephens, Rebekah Sutcliffe, Tamoor Tariq, Mark Warren, Carolyn Wilkins OBE, Liz Windsor-Welsh and Keith Wrate and by invitation Val Hussain, Joanne Sloan, Claire Smith, and Karen Worthington

Item No

1 Apologies for absence

2 Declarations of Interest

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

3 Urgent Business

Urgent business, if any, introduced by the Chair.

4 Public Question Time

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

5 Minutes of Previous Meeting (Pages 1 - 10)

The Minutes of the meeting of the Health and Wellbeing Board held on 10th November 2020 are attached for approval.

6 Bury, Rochdale and Oldham Child Death Overview Panel 2019/2020 Annual Report (Pages 11 - 38)

The Board is asked to receive the Bury, Rochdale and Oldham Child Death Overview Panel Annual Report for 2019/20 and consider the recommendations therein.

7 Greater Manchester Child Death Overview Panels 2019/2020 Annual Report (Pages 39 - 60)

The Board is asked to receive the Greater Manchester Child Death Overview Panels Annual Report for 2019/20 and consider the recommendations therein.

8 National Child Mortality Database Annual Report 2019-2020 (Pages 61 - 94)

9 The Oldham Six-Month Plan for Covid (Pages 95 - 140)

To receive a presentation setting out what Oldham will do to contain Covid-19 over the next six months. Updated presentation, 25th January 2021.

10 Update on NHS developments and impacts on and in Greater Manchester (Pages 141 - 160)

To receive a presentation setting out developments over the coming months and planning for 2021/22.

11 Date of Next Meeting

The next meeting of the Health and Wellbeing Board is scheduled to be held on Tuesday, 23rd March 2020 at 2.00pm.

HEALTH AND WELL BEING BOARD
10/11/2020 at 2.00 pm

Present: Councillor Stretton (Chair)
Councillors Ball, M Bashforth, Chauhan and Moores

Dr John Patterson	Oldham CCG
Majid Hussain	Oldham CCG
Mike Barker	Executive Director Commissioning and Chief Operating Officer (Oldham Council/Oldham CCG)
Mark Warren	Managing Director of Health and Adult Care Services
Gerard Jones	Managing Director of Children and Young People
Rebekha Sutcliffe	Executive Director Communities and Reform
Katrina Stephens	Director of Public Health
David Jago	Pennine Acute NHS Trust
Karen Worthington	Bridgewater NHS Trust
Tamoor Tariq	Oldham Healthwatch
Stuart Lockwood	Oldham Community Leisure
Keith Wrate	First Choice Homes
Liz Windsor-Welsh	Oldham Together

Also in Attendance:

Hayley Eccles	Head of Strategic Safeguarding
Abigail Pemberton	Strategic Safeguarding and Safeguarding Adults Board Manager
Sian Walter-Browne	Constitutional Services
Kaidy McCann	Constitutional Services

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Chadderton, Dr Bal Duper, Dr Keith Jeffrey, Chief Supt. Chris Allsop, Val Hussain, Claire Smith and Joanne Sloan.

2 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

3 **URGENT BUSINESS**

There were no items of urgent business.

4 **MINUTES OF PREVIOUS MEETING**

RESOLVED – that the minutes of the meeting of the Health and Wellbeing Board held on 21st July 2020 be approved as a correct record.

5 **PUBLIC QUESTION TIME**

No public questions had been received.

6 **OLDHAM SAFEGUARDING ADULTS BOARD ANNUAL REPORT**

The Board gave consideration to the Oldham Safeguarding Adults Board (OSAB) 2019/20 Annual Report and priorities for 2020/21, the OSAB being a statutory partnership set up to safeguard adults at risk of experiencing abuse, neglect or exploitation and which had duties to produce a Strategic Plan; to publish an Annual Report; and to undertake a Safeguarding Adult Review (SAR) where it believes someone has experienced harm as a result of abuse, neglect or exploitation.

Over the past year the OSAB had introduced a series of measures designed to remodel adult safeguarding arrangements across Oldham, looking to strengthen and improve multi-agency working through a combination of new safeguarding structures, greater alignment with the Children's Safeguarding Partnership (CSP) and integrating safeguarding structures across Community Health and Social Care. The 2019/20 Annual Report was the first under these new arrangements and reflected the OSAB's ambition to develop a more outward facing role to ensure that there is 'no wrong door' to reporting safeguarding concerns and that the work of the OSAB is publicly accountable.

The Annual Report provided information on the number and type of safeguarding concerns reported during 2019/20, setting out the actions taken to ensure that lessons learnt from the SARs have be used to change front line practice and improve the way services work. The Board's specific attention was drawn to the following matters from the 2019/20 period -

- 1,580 safeguarding referrals were made and, of these, 556 became the subject of a formal safeguarding Enquiry. The number of referrals had almost doubled in the last two years, possibly due to a combination of improvements in data recording and campaigns encouraging people to report safeguarding concerns;
- 1,543 safeguarding referrals and enquiries were dealt with and closed, an increase over the 960 in the previous year. Of the cases closed, 48% were complex cases involving people who lacked capacity to make their own decisions. The breakdown by sex, age and ethnicity suggested that White British women aged between 18 and 64 were more likely to be the subject of a reported safeguarding concern compared to any other group;
- an increase in the number of safeguarding concerns relating to self-neglect, acts of omission and domestic abuse had been seen. Some of the increase in domestic abuse cases coincided with the start of the Covid-19 lockdown where those living with an abusive partner may have experienced an escalation in abuse, coupled with

restricted access to community contacts and professional support; and

- five SARs had been conducted, compared to two in 2018/19. In each case, the OASB adopted the recommendations of the independent reviewer and overseen changes designed to prevent similar cases happening again. These changes had also been informed by 'Making Safeguarding Personal' conversations with local people who had first hand experience of safeguarding issues.

For 2020/21, the ambitions for Oldham's new safeguarding arrangements included an effective 'all age' safeguarding offer and progress had been made over the past year to align the work of the OSAB with the SCP. The ongoing impact of the Covid presented challenges for adult safeguarding with lockdown restrictions and social isolation creating conditions for new safeguarding concerns to emerge, as well as escalating existing safeguarding issues. A trend in SAR referrals for people experiencing neglect or abuse compounded by the first wave of Covid-19 restrictions could already be seen and the OSAB was prioritising the sharing of lessons from these cases as quickly as possible to inform current and future waves of restrictions.

In response to a query, it was confirmed that multi-agency work and communications between organisations had continued over the Covid period, the developing extent of greater partnership working over the period being advised.

The near doubling of safeguarding referrals over two years was noted and the capacity to investigate these referrals and to support those at risk was queried. It was acknowledged that the 'no wrong door' approach would generate increased recorded demand, but the partnership approach meant that issues reported under safeguarding need not necessarily be dealt with by the organisation initially contacted. The operational team would be dealing with safeguarding issues among other work, but Duty Managers kept the overall position under review. With regard to the increase in referrals, it was noted that the proportion of referrals leading to full Investigations had not risen proportionately and assurance sought that this was not due to capacity issues. The Board was assured that all safeguarding referrals raised were considered and addressed, and that those proceeding to full Investigations were considered against Care Act provisions. Where cases did not meet Care Act criteria, the service would look to see trends in reporting and look to develop targeted preventative solutions.

With regard to communications and the reported greater use of websites, the need to ensure that other means of accessing information and services were robust enough was suggested. A Member commented that there was a need to further promote the Helpline service which, it was suggested, was considered by some in the community as being for Covid-related issues only.

Further to a query as to the helpfulness of the Community Hubs in generating safeguarding referrals, it was advised that while there was little evidence at this time, some referrals had come through this route and it was acknowledged that proactive links between the Hubs, community services and safeguarding to provide preventative measures was key.

With specific regard to incidents of domestic violence which were known to have increased during lockdown, the experience of families in need of emergency accommodation was queried in terms of emergency accommodation availability and capacity. It was advised that part of a person's protection plan would include inputs from Children's Services in instances where children were involved, would look at the availability of community support, and would involve other agencies such as housing, the police, and probation as necessary.

RESOLVED that the Oldham Safeguarding Adults Board 2019/20 Annual Report, including the plans for keeping people safe in the future, be noted.

7 **OLDHAM SAFEGUARDING CHILDREN BOARD ANNUAL REPORT**

The Board was reminded that the Local Safeguarding Children Board (LSCB) had been replaced by the Oldham Safeguarding Children Partnership (OSCP), a statutory partnership, on 30th September 2019. The Board was invited to give consideration to the LSCB annual report covering the period 1st April 2018 to 30th September 2019 in order to conclude the work of the LSCB.

LSCBs had been introduced in April 2006 with the primary responsibility of coordinating and ensuring the effectiveness of the work undertaken by partner agencies for the purposes of safeguarding and promoting the welfare of children and young people. The 18-month report demonstrated the activity and impact that the Oldham LSCB had in year one of a three-year strategic plan (2018-2021) across six key priority areas of domestic abuse; complex and contextual safeguarding; children not accessing education; transitions; understanding the impact of trauma; and the child's lived experience.

It was noted that in the 18 month period progress had been evident in all priority areas with key successes including the introduction of Operation Encompass to support information sharing about domestic abuse between police and schools; the introduction of multi-agency training to support trauma informed practice across the Partnership; and dedicated work with children and young people to develop tools to support access to mental health support services. Learning and improvement activity focused on areas of complex safeguarding, and the Greater Manchester peer review of September 2019 highlighted both good practice and areas for improvement, all of which are being used to shape and develop Oldham's Complex Safeguarding offer.

Six serious case reviews and two multi agency concise reviews were held during the period of the report, highlighting key learning themes including -

- the need for evidence-based approaches and interventions relating to children's mental health and trauma;
- a focus on improving the quality of assessments;
- a collective commitment to addressing neglect;
- a focus on collaborative working, decision making and planning;
- early identification of risk specifically in relation to unborn babies, non-mobile children and those at risk of exploitation; and
- supporting professionals to be culturally competent in their practice.

Considering the period following the annual report, the Board was advised that the vision and aims of the OSCP were those stated in the three-year strategic plan (2018-2021), with the local safeguarding partners continuing to be committed to this vision and aims, demonstrating continuity of commitment to the safeguarding partnership, irrespective of change to governance structures. Joint working with the Oldham Safeguarding Adults Board was continuing to develop a joint Safeguarding Oldham brand, social media and website platforms and to engage with adult safeguarding colleagues in a new model of learning and improvement which will ensure that cross cutting themes are identified and responded to quickly and effectively.

RESOLVED that the Oldham Safeguarding Children Partnership Annual Report for 1st April 2018 to 30th September 2019 be noted.

8 **THE OLDHAM RESPONSE TO COVID-19**

The Board received a report providing an update on how the Council and its partners continued to monitor and manage the impact of Covid-19 in Oldham. The report advised of the position in Oldham as at 29th October 2020 with regard to the number of Covid cases, tests carried out and deaths. Within the report, Oldham's response was broken down into four key themes of Test, Trace, Enforcement and Compliance, and Community Engagement and Communications, with a commentary of activities under each theme being provided. Board Members were asked to note that notice of a national lockdown commencing on 5th November 2020 and to run to 3rd December 2020 had been given as the submitted report was being completed.

The Board was advised that the evidence available did not link Covid transmission to any specific setting but did suggest transmission happening in a range of settings where there is social contact between people that is not socially distanced. In order to reduce transmission and bring the R value below 1, it was therefore necessary to substantially reduce the amount of

social contact between people from different households and there had been some recognition that measures which go further than the current tier 3 package of measures may be needed in order to substantially reduce infection rates.

Beyond the current period of national lockdown, it was necessary to consider what package of measures/strategy would be needed for the coming months, as the challenges of controlling transmission will persist throughout the winter and into the spring, periods which would normally see increases in viral infections and pressures on health and social care services. Control measures would need to be supported by effective communications, engagement and enforcement as well as testing and contact tracing and the ongoing work on these remains a vital part of Oldham's ongoing strategy.

In response to a query regarding facilities for homeless people, the Board was advised that a seven day testing service was provided and that should a homeless person be found to have Covid or be required to isolate, partners would be engaged to find appropriate accommodation as set out in Oldham's response plan. Further to a concern as to access to testing provision for those without internet access or a mobile phone, it was advised that this had been raised with the national testing programme which relied on email or text communication: a response to this approach was awaited. It was hoped that newer tests providing more immediate results might offer a solution, and locally a scheme involving a 'trusted contact' was being investigated.

The Board was further advised that Healthwatch Oldham had undertaken a survey of patient experience across Oldham during the Covid period. This survey had concluded at the end of October following particular efforts to ensure the input of disadvantaged groups. It was hoped that an interim report could be shared by late 2020/early 2021, with a full report following.

RESOLVED that the report be noted.

9 **IMPACT ON THE HEALTH AND CARE SYSTEM**

The Board received a briefing, supported by a presentation, regarding the impact of Covid on the health and care system, with a particular focus on the Royal Oldham Hospital and acute services. Board members were advised that data presented had been taken from the date of circulation with the Board agenda, and brief updates were provided at certain points during the presentation. The briefing also considered the overall picture, the changes that had been made in across the health and care system, and the impact on various aspects of acute services across both the North East Sector of Greater Manchester and Oldham specifically.

The Board was reminded that the Oldham response to Covid had been the result of great efforts by many people working across the various partner organisations in Oldham. All parts of

the system had needed to continue to adjust and change ways of working in order to address the Covid pandemic, embracing ways of working that could not have been envisaged earlier in the year. The presentation indicated the changed ways of working in the acute sector, primary care, mental health services and community services, and provided a 'snapshot' listing of those services and arrangements that had been changed.

The presentation provided a series of graphs showing various trends across the North East Sector and on the emergency department at the Royal Oldham Hospital during the pandemic period. It was highlighted that locally, relatively more cases of Covid were being found and were being treated, but that a related increase in excess deaths was not being seen. Looking ahead, each system within Greater Manchester had submitted their plans outlining how they proposed to manage and mitigate the impact of a rise in COVID cases and a number of illustrative scenarios had been modelled. The presentation concluded with a listing of highlights of activities and approaches that had worked well during the Covid response.

The Board was reminded that there remained significant challenges to be faced. It was to be hoped that lockdown would reduce instances of community transmission, and the prospect of mass vaccination was a hopeful sign. It was however noted that delivery of such vaccinations would likely fall on primary care which was already responsible for flu vaccination and some Covid testing.

RESOLVED that the report be noted.

10 **IMPLEMENTING THE PHASE 3 RECOVERY PLAN**

The Board gave consideration to a report which provided an overview of the confirmed 'Phase 3 Recovery' Plan within local health and care services that had been prepared in response to the NHS National activity target expectations and targets for dealing with referrals, elective inpatients, elective outpatients, non-elective inpatients, and emergency department attendances. The Plan has been prepared and submitted as part of the Greater Manchester system and considered the actions required under each of the target strands.

Consideration was given as to the realistic ability to deliver on the national targets, and actions either underway or planned for delivery in respect of cancer services; elective activity; primary care and community services; mental health, learning disability and autism services; winter activities; workforce issues; and in addressing health inequalities and prevention were advised. The core transformation programmes would centre around developing a new model of managing long-term conditions, a new model for urgent care as linked to the Greater Manchester model, and the redesign of local community services.

It was considered that the success of the Phase 3 Recovery Plan would be reliant on robust partnership working; strong

clinical leadership and engagement; effective engagement with communities and patients; clear programmes for service redesign and transformation; and good governance, while noting that changes to Covid-19 infection rates and the need to support the management of any outbreaks, as well as potential changes to the future of commissioning, might affect delivery of the recovery plan.

The Board was advised that there was a big focus on the winter period, and that the position with regard to elective surgery was fluid. There were issues to focus on, such as future provision of mental health services and ensuring that the joint working seen to date in response to Covid was capitalised upon. It was acknowledged that this would not be an easy plan to implement, and some changes in tack had already been seen. There was also a lack of clarity on future financial arrangements to consider. Notwithstanding, the restoration of NHS services and their taking forward on a partnership basis were key tasks.

Looking ahead to Spring 2021, it was stressed that people would need to have had their flu vaccinations by this time as primary care would be required to deliver Covid vaccinations as these came on line: there would not be capacity in the system to deliver both. Further, as new testing came on-line, it would be necessary to deliver this in order to take infective people out of the system.

RESOLVED that the report and the Phase 3 Recovery Plan be noted.

11 **FUTURE DEVELOPMENTS IN THE NHS**

The Board received a presentation intended to introduce a continuing discussion around the setting of a direction of travel for the Oldham health and care system which assumed that the current system evolving into a new, more dynamic place based unified health and care system capable of operating within a Covid-19 environment and that the move forward would erode the current descriptors of commissioning and provision.

The presentation considered the intentions and vision of the NHS Long Term Plan alongside the possible and emerging outcomes of a Greater Manchester strategic review of commissioning arrangements. Arising from these considerations there was an acknowledgment that Oldham's system needed to adapt and evolve, and a new Oldham model and approach to health and social care was presented for consideration. The need to give a balanced consideration, one that focused upon local authority's general duty to promote wellbeing as well as on the NHS, was stressed, and an integrated model of care based firmly on population health management, a reduction in health inequalities and the enabling of people to live well at home that would be delivered through community resources, primary care, integrated community health and social care, and specialist and hospital based care was presented.

This model would be delivered by a core group of partners who would be supported by key partner organisations and, where appropriate, there would be support for developing provider alliances to help with the delivery of holistic pathways. The model would be delivered by integrated teams working through integrated community hubs which would offer opportunities to connect services such as schools, vulnerable tenants etc, and a new Assurance Framework would be developed to ensure standards and quality. The next steps and timescales for what was acknowledged as a challenging activity to develop a system fit for the 21st century were considered.

The submission and consideration of the presentation as a starting point to enable people to focus on the necessary developments needed to develop the local health and social care system was noted.

RESOLVED that the presentation be noted.

12 **DATE OF NEXT MEETING**

It was noted that the next meeting of the Board was scheduled to be held as a Development Session on Tuesday, 15th December 2020 at 2.00pm.

The meeting started at 2.00 pm and ended at 4.00 pm

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BURY, ROCHDALE & OLDHAM

Child Death Overview Panel

Annual Report

April 2019 – March 2020

Data Analysis & Author: Dr Annie Lowe,
Public Health Registrar, Oldham Council

Support: Dr Rebecca Fletcher, PhD,
Consultant in Public Health
Bury, Rochdale and Oldham CDOP Chair

Publication: January 2021

Contents

Executive Summary:

This is an annual review of the Child Death Overview Panel (CDOP) data for Oldham, Rochdale and Bury (ORB), which combine to make one of the four CDOPs in Greater Manchester (GM). The CDOP reviews all child deaths under 18 years, but not including still births, late foetal loss or termination of pregnancy. The panel do not determine the cause of death but instead explores all the factors surrounding the death of the child. This learning enables required actions to be taken to protect the welfare of children and prevent future deaths.

Every year, each CDOP collates information on the cases that have been closed in the last 12 months in order to review for themes. This enables each area to identify any lessons learnt and recognise where population level interventions are required to reduce future child deaths. The report is supported by a GM report which gives an overview of patterns across all four CDOPS. In view of the relatively small numbers, and consequent difficulties with data analysis, this can be helpful when analysing for themes.

Key Findings in Oldham, Bury and Rochdale (ORB)

In 2019/2020 there were 79 notified cases and 29 closed cases. It is pertinent to note that this report looks in detail at the 29 closed cases, however these deaths did not necessarily occur in the last 12 months. Only once a case is closed is there the level of detail required to develop a narrative surrounding the death and therefore draw out themes. The duration of the review process can vary meaning that not all cases are closed in the same year that they are notified. The 79 notified cases in 2019/2020 are children that have died in the last 12 months, however at the time of writing this report these cases have not yet been reviewed. It is important to hold this in mind when interpreting the results of this report. This year closed cases numbers have been low across GM, and nationally, due to the introduction of new guidance and the additional workload associated with this change in practise. In addition, local factors such as a period of vacancy in the CDOP officer role and an organisational restructure of the local acute care provider, have created a backlog of cases which the team are currently working through.

The closed cases for the ORB CDOP equate to 33% of the total closed cases across GM, and ORB has a higher rate of notified cases, 5.09 per 10,000 compared to GM at 3.74 per 10,000. This is a consequence of the high rates of notified cases in Oldham, 7.22 per 10,000. The duration of review of cases was on average 579 days across ORB, this is longer than the average duration across GM which is 391 days. This is due the review duration in Oldham (633 days) and Rochdale (618 days), the highest in Greater Manchester. Many factors can affect the duration of the review process for example if a case requires a serious case review or Coroner's Inquest, the case will be delayed.

66% of the closed cases across ORB were expected deaths and 69% occurred within a hospital setting, with home setting being the second most common location. Males were overrepresented in closed cases at 62%, this is consistent with GM and national findings year on year, the reason for this is unclear.

Children are at the highest risk of death in the first year of life, and this is identified within the ORB data, 34% of cases were in the neonatal period and 58% in the first year of life. In relation to this, perinatal and neonatal events continue to be the most common cause of death, this is consistent with GM and national findings. Across ORB 35% deaths were caused by a perinatal/neonatal event, the leading cause of child death locally and nationally. The second most common cause of death was chromosomal/genetic/congenital abnormalities equating to 18% of the closed cases.

It is important to note that all the closed cases related to chromosomal, genetic and congenital abnormalities were children of BME ethnicity, and overall, there were higher rates of child deaths in BME groups across Bury and Oldham, but not Rochdale. This was consistent across GM and it is important that this inequality is addressed. Consanguinity is a known risk factor for congenital abnormalities and therefore an important risk factor when addressing child deaths. However, in the closed cases in this report where chromosomal, genetic and congenital causes were identified as the cause of death, consanguinity was not found to be a factor associated with the deaths.

Oldham and Rochdale also have higher rates of deprivation when compared to the North West and nationally. In relation to child deaths, there is a clear trend that as levels of deprivation increase, so do the number of child deaths. In ORB 31% of cases were in the most deprived decile and 79% were in the 5 lowest deciles, where decile 1 equate to the 10% most deprived of the population.

Modifiable risk factors are areas which may contribute to an increased risk of child death, and if addressed at a population level can reduce the risk of future child deaths. 31% of closed cases had modifiable risk factors identified. Modifiable factors recognised by GM that were identified in ORB cases included: Maternal obesity, maternal smoking in pregnancy, parental smoking and unsafe sleeping. Other factors identified included drug and alcohol use, hospital and clinical factors and housing issues. Maternal obesity was the most common risk factor identified followed by maternal smoking in pregnancy. In 59% of the child deaths occurring in children under the age of 1, the mother was classified as obese or overweight. Until recent years this factor was not documented by the CDOP. This data highlights the risks associated with maternal obesity, and that this modifiable factor is becoming increasingly common. This is also reflected in the GM data.

Introduction

The aim of this report is to analyse the child deaths within Oldham, Bury and Rochdale (ORB), to make observations on the causes and modifiable factors, in order to identify recurring themes. This helps guide population level interventions to reduce childhood mortality within the area. This annual report is presented to the Health and Wellbeing board to inform on the findings, the current interventions in place and future recommendations.

When a child dies a review process occurs to enable learning and to identify where changes could be made to prevent similar child deaths in the future. The Child Death Overview Panel (CDOP) will review the child deaths of all children under 18-years, but not including still births, late foetal loss or termination of pregnancy. Oldham, Bury and Rochdale combine to make one of the four CDOPS in GM.

The four CDOPs in Greater Manchester are split as follows:

- Manchester North – Oldham, Bury, Rochdale, CDOP
- Manchester South -Tameside, Trafford, Stockport CDOP
- Manchester West -Bolton, Salford, Wigan CDOP
- Manchester City -Manchester CDOP

Every year, each CDOP collates information on the child death in the last 12 months to enable thematic learning to guide decision making on population level interventions. The report is supported by a GM report which gives an overview of patterns across all four CDOPS. In view of the relatively small numbers, and subsequent difficulties with data analysis, this can be helpful when analysing themes.

This report includes information for cases closed between 1st April 2019 and 31st March 2020. During this time there were 129 closed cases and 241 notified cases of child death across GM. Within the ORB CDOP there were 29 closed cases and 79 notified cases. A case is defined as closed at the end of the CDOP review process.

Infant Mortality in the UK and comparisons with ORB

Over recent decades the UKs infant mortality rates has fallen, however the rate of improvement has slowed when compared to other European countries. After three years of slight increases in infant mortality between 2014 and 2017, a small decrease was noted in national data in 2018[1].

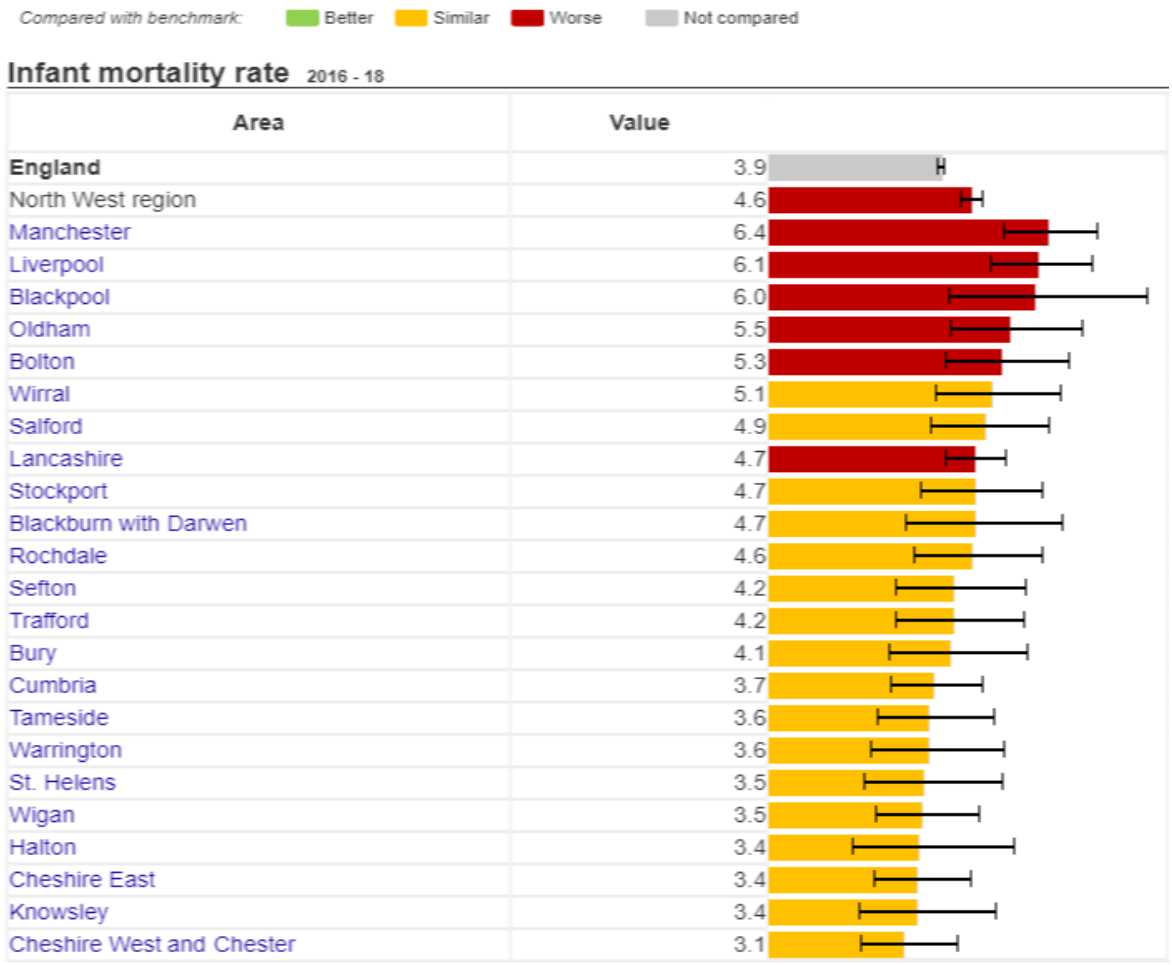
Across the UK, there are inequalities in child deaths and factors such as geography, deprivation and ethnicity affect rates of childhood mortality. For example, infant mortality rates are significantly higher in the 10% most deprived areas compared with the 10% least deprived areas in England. In

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/childhealth/articles/ukdropsineuropeanchildmortalityrankings/2017-10-13

addition, infant mortality rates are highest among babies of Pakistani ethnicity and lowest in babies of white ethnicity[2]. These themes are reflected within this report.

The crude rate Infant mortality (2016-2018) across England is 3.9 per 1000 births, across the North West it is higher than nationally at 4.6 per 1000 births. Whilst Bury and Rochdale have a similar infant mortality rate to the rest of England, Oldham performs worse at 5.5 per 1000, this is demonstrated in figure 1.

Figure 1: Infant Mortality Rate, per 1000 births, by local authority, 2016-2018



Source: Office for National Statistics (ONS).
https://fingertips.phe.org.uk/search/Infant%20mortality#page/3/gid/1/pat/6/par/E12000002/ati/202/are/E08000002/iid/92196/age/2/sex/4/cid/4/tbm/1/page-options/ovw-do-0_cin-ci-4_car-do-1

[2]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018#:~:text=1.-,Main%20points,of%203.6%20recorded%20in%202014

Overview of Oldham, Bury and Rochdale Population aged under 18yrs

Across ORB there are approximately 153,288 children under the age of 18, equating to 24% of the total population of the area. There is minimal difference and when comparing the percentage of the population under 18 years of each local authority to GM and national population data. One thing to note is that Oldham has a slightly higher percentage of under 18 years within its population at 25%, as seen in Table 1.

Table 1: Number of children aged under 18 in Oldham, Bury and Rochdale			
Area	**Under-18 Population size**	**Total Population**	**% population under -18**
Bury	43,289	190,990	23%
Oldham	59,592	237,110	25%
Rochdale	50,407	222,412	23%
Bury, Oldham, Rochdale (ORB)	153,288	650,512	24%
Greater Manchester (GM)	644,540	2,835,686	23%
England	12,642,441	56,286,961	22%

Source: Mid-2019: April 2020 local authority district codes version of this dataset[*https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland*](https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland)

Reviews of child death cases 2019/2020

Closed Cases 2019/2020

In 2019/2020 there were 29 closed cases across the ORB CDOP. As seen in table 2, the closed cases in ORB account for 23% of GM closed cases. Oldham has the highest rate of closed cases, 2.35 per 10,000 of the population.

Table 2: Number and percentage of deaths (cases closed) across ORB 2019/20			
Area	**Total Deaths (Closed Cases)**	**Percentage of overall GM deaths (Closed cases)**	**Rate of Closed cases per 10,000 population**
Bury	7	5%	1.62
Oldham	14	11%	2.35
Rochdale	8	6%	1.59
ORB	29	23%	1.89
GM	129	100%	2.00

Source: GM CDOP Data 2019/2020

It is important to note that whilst these cases were closed during this time, the deaths did not necessarily occur in the same 12-month time frame, due to the variable duration for a case to be closed. Seven of the closed cases were deaths that were notified in the 2019/2020 time period, equating to 24% of the closed cases reviewed in this paper, this compares to 15% average across GM, see table 3. For the purpose of the CDOP annual report, the closed cases are discussed, as these offer the level of detail required to identify themes. It is important that this is kept in mind when interpreting the findings of this report.

Table 3: Notified cases closed in the same year (2019/20)				
Area	**Total Number Notified Cases 2019/20**	**Total Number of Closed Cases 2019/20**	**Number of cases notified and closed in 2019/20**	**% Cases notified and closed in 2019/20**
ORB	79	29	7	24%
GM	255	129	38	15%

Source: GM CDOP Data 2019/2020

This year the number of closed cases has fallen across both ORB and GM, table 4 demonstrates these trends. This is the lowest number of closed cases seen for the last 8 years. This issue has been seen nationally, due to the introduction of new guidance and the increase in workload that this has created. In addition, locally the CDOP Officer role has been vacant, and the local acute care provider has been going through a major organisational restructure. As part of this restructure a new IT data collection system has been introduced, this means that data has been archived which has slowed down the recovery of information requested by CDOP. Previous drops in ORB closed cases in 2013/14 and 2016/17 are also due to the CDOP officer role not being covered.

Table 4: Number of Closed Cases compared by year across each area								
Area	**Number of Closed Cases per year**							
	2012/13	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Bury	20	13	17	17	11	14	12	7
Oldham	27	24	36	29	25	31	14	14
Rochdale	25	20	28	28	15	26	27	8

ORB	72	57	81	74	51	71	53	29
GM	267	216	262	236	231	274	204	129

Source: ORB CDOP report 2017/2018 & GM CDOP data analysis 2019/2020

Notified cases 2019/2020

Between 1st April 2019 and 31st March 2020 there were 79 notified child deaths across ORB, this equates to 33%, an over representation of the child deaths in GM, this is consistent with previous years. Whilst Bury and Rochdale have a similar rate of notified cases compared to GM, Oldham has a higher rate at 7.22 per 10,000 of the population and equates to approximately half of the child deaths in the ORB CDOP, see table 5.

Table 5: Number, percentage and rate per 10,000 of notified deaths across ORB, 2019/20

Area	Number of Notified Deaths	Percentage of overall GM deaths	Population 0-17 yrs	Rate of Notified cases per 10,000 population
Bury	16	7%	43289	3.7
Oldham	43	18%	59592	7.22
Rochdale	20	8%	50,407	3.37
ORB	79	33%	153288	5.15
GM	241	100%	644540	3.74

Source: GM CDOP Data 2019/2020

Duration of Reviews

The duration of review can be described as the number of days from the notification of death to closing the case following the CDOP review. In 2019/20 the range for duration of review of ORB closed cases was 1855 days. The average duration of review across ORB was 597 days, higher than the GM average at 391 days. Oldham and Rochdale had the longest average duration of review compared to all other local authorities across GM at 633 days and 618 days respectively, see table 6. There may be a number of explanations for this range, for example factors such as the cause of death or when additional investigations such as coroner's inquest or serious incident investigations are required, which can delay a case from reaching CDOP. The factors discussed as reasons for a reduction in the number of closed cases, are also likely to have contributed to delays in the review process.

Table 6: Average Duration of Review by Area	
Area	**Duration of Review (Days)**
Bury	425
Oldham	633
Rochdale	618
ORB	579
GM	391

Source: GM CDOP Data 2019/2020

Expected/ unexpected deaths

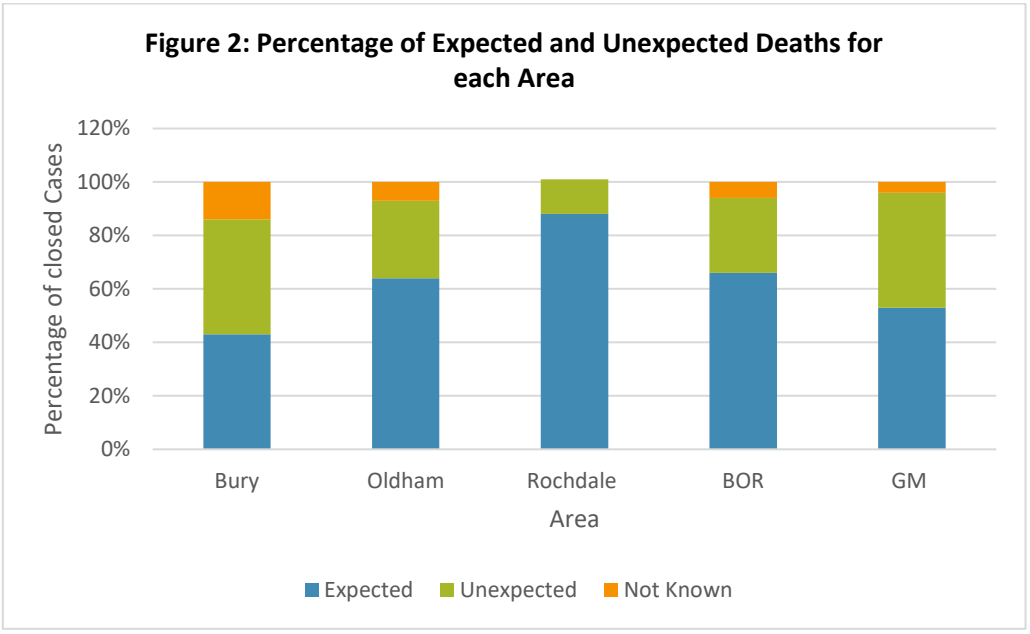
Table 7 shows that 66% of ORB deaths were expected and only 28% were unexpected. This is less unexpected deaths when compared to GM. This may represent a greater burden of childhood chronic disease.

Table 7: Comparing Expected and Unexpected Deaths by Area (2019/2020)							
Area	**Expected**		**Unexpected**		**Not Known**		**Total**
	No	**%**	**No**	**%**	**No**	**%**	**No**
ORB	19	66%	8	28%	<5		29
GM	69	53%	55	43%	5	4%	129

Source: GM CDOP Data 2019/2020

Figure 2 shows the proportion of expected deaths compared to unexpected deaths for each local authority area. Of the three local authorities Bury appears to have the highest percentage of unexpected deaths, however this more likely to be due to the small number of deaths, rather than a significant finding.

Figure 2: Percentage of Expected and Unexpected Deaths for each Area



Source: GM CDOP Data 2019/2020

Location of Death

The majority of deaths occurred in a hospital setting across all three localities. Table 8 shows that ORB had a higher percentage of deaths in hospitals when compared to GM. This year GM had a higher percentage of deaths in other locations compared to previous years, this is not reflected in the ORB data. Deaths in hospital are more likely to do due to a perinatal or medical cause, rather than sudden unexpected death which would be more likely to occur in the home environment.

Table 8: Comparison of Location of Death 2019/2020						
Area	**Hospital**		**Home**		**Other**	
	No	**%**	**No**	**%**	**No**	**%**
ORB	20	69%	7	24%	<5	
GM	60	47%	34	26%	35	27%

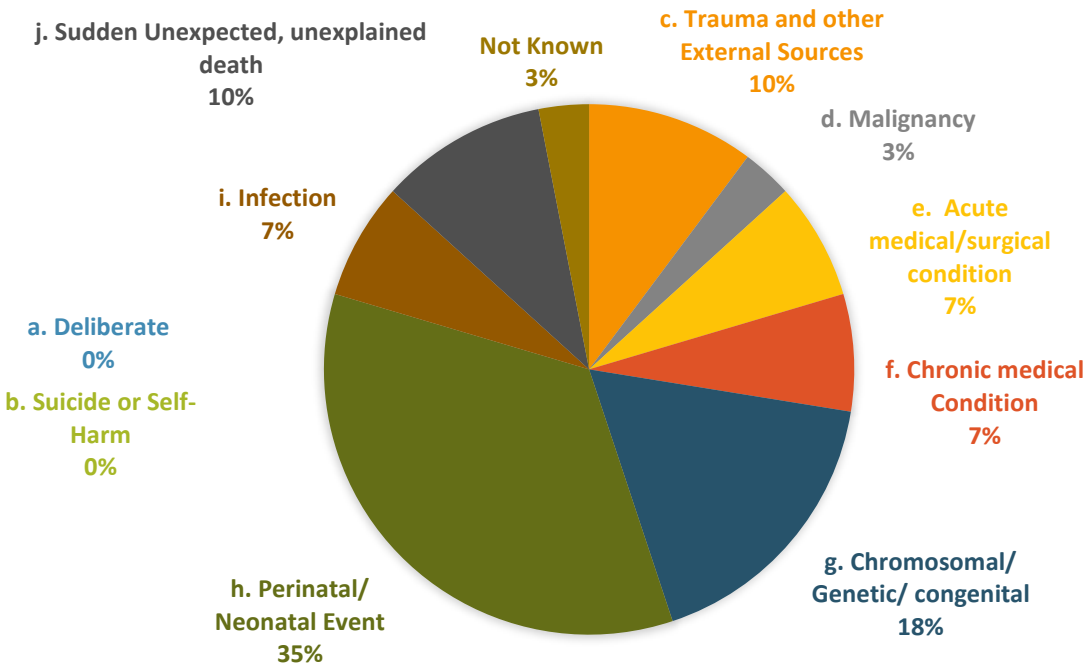
Source: GM CDOP Data 2019/2020

Causes/Category of Death

As part of the CDOP process each case is assigned a category of death from 10 defined options. The classification system is hierarchical therefore the category of death with the most relevance will be recorded as the primary category and cause of death, and others as secondary categories. The nationally defined categories of death as follows:

a. Deliberate inflicted injury, abuse or neglect
b. Suicide or deliberate self-harm
c. Trauma and other external factors
d. Malignancy
e. Acute medical or surgical condition
f. Chronic medical condition
g. Chromosomal genetic and congenital anomalies
h. Perinatal/neonatal event
i. Infection
j. Sudden unexpected, unexplained death

FIGURE 3: PIE CHART TO SHOW CAUSES OF DEATHS ACROSS ORB AS PERCENTAGE OF ALL CLOSED CASES



Source: GM CDOP DATA 2019/2020

Figure 3 clearly demonstrates that perinatal and neonatal events were the most common cause of death, followed by chromosomal, genetic and congenital abnormalities. When combined, these two categories equate to half of the child deaths in ORB. This is consistent across GM, in line with national trends and the same as previous years. There were no deaths classified as deliberate or suicide and self-harm. All other categories equate to a small number of deaths.

Due to the small number of cases it is difficult to compare causes of deaths by local authority. However, perinatal/neonatal events and chromosomal/genetic/congenital causes are the leading category of death across all three local authorities.

Socio-demographics of cases closed in 2019/2020

Gender

When comparing deaths across the local authorities by gender, males appear to be over-represented at 62% when compared to females 38%, as seen in table 9. This is consistent with GM findings and national trends. The reason for this discrepancy is unclear.

Table 9: Number of cases closed by Gender in ORB and GM				
Area	**Female**		**Male**	
	No	**%**	**No**	**%**
ORB	11	38%	18	62%
Greater Manchester	61	47%	68	53%

*Source: GM CDOP DATA 2019/2020 *Note that 1 closed case in GM where Gender was not determined*

Ethnicity

In all three areas, White British is the predominant ethnicity, with 68% of the child population across ORB classified as white and 32% as BME. This is similar to the variance in ethnicity across GM. Of note, Oldham BME child population is 40% compared to 28% GM, see table 2. Both are substantially higher than the UK national figures, which according to 2011 census data, 13% of the UKs population belong to BME groups[3], see table 10.

Table 10: Child Population Ethnicity across Oldham, Bury and Rochdale, using mid 2019 population estimates.					
Area	**Total under 18 population**	**White**		**BME**	
		No	%	No	%
Bury	43289	34631	80%	8658	20%
Oldham	59592	35755	60%	23837	40%
Rochdale	53299	36243	68%	17056	32%
ORB	156180	106629	68%	49551	32%
GM	629278	451275	72%	178003	28%

Source: GM CDOP Data analysis 2019/2020. Based on mid-2019 population estimates

Table 11 shows that ORB and GM figures are similar when comparing child deaths by ethnicity. Both show a higher percentage of child deaths in the white population which is to be expected in view of higher proportion of the population of this ethnicity. However, both have a higher rate of closed cases in the BME population, suggesting that although numbers are small that BME child deaths are over-represented. This is most striking in Oldham where the rate of child deaths is 3.36 per 10,000 in BME children compared to 1.68 per 10,000 in white children, exactly double. Clearly there is a health inequality associated with ethnicity. Rochdale does not show this trend, however this may be due to the small number of total cases.

[3] https://www.ethnicity-facts-figures.service.gov.uk/

Table 11: Cases Closed by Ethnicity for Each Area						
Area	White			BME		
	No	%	Rate/10,000	No	%	Rate/10,000
Bury	<10		1.44	<5		2.31
Oldham	6	43%	1.68	8	57%	3.36
Rochdale	<10		1.93	<5		0.59
ORB	18	62%	1.69	11	38%	2.22
GM	79	61%	1.75	50	39%	2.81

Source: GM CDOP data analysis 2019/2020

When comparing the cause of death and ethnicity, difficulty arises due to the small number of cases. The one clear finding is that all the closed cases with chromosomal, genetic and congenital causes were in children of BME ethnicity. This corresponds with national data that identified that whilst prematurity related conditions were the main cause of infant mortality overall, in Pakistani and Bangladeshi ethnic groups more infant deaths were caused by congenital anomalies[4]. Having consanguineous parents is a known risk factor for congenital abnormalities, and potential explanation for this variation nationally. However, the closed cases in this report where the category of death was chromosomal, genetic and congenital causes were not found to be related to consanguinity.

Inequalities & Index of Multiple Deprivation (IMD)

Deprivation is known to be a contributing factor to many of the risk factors associated with child deaths. The index of multiple deprivation 2019 (IMD) is an overall measure of deprivation taking into account not only income deprivation, but also key resources needed for an individual to meet their basic needs, such as education, employment, health and disability, housing and living environment.

All three local authorities have higher rates of deprivation when compared to both GM and nationally. Oldham and Rochdale in particular, are categorised as being in the 'most deprived' quintile, as demonstrated in table 12. Both have a higher percentage of people living in the 20% most deprived areas in England, when compared to Bury, GM and nationally.

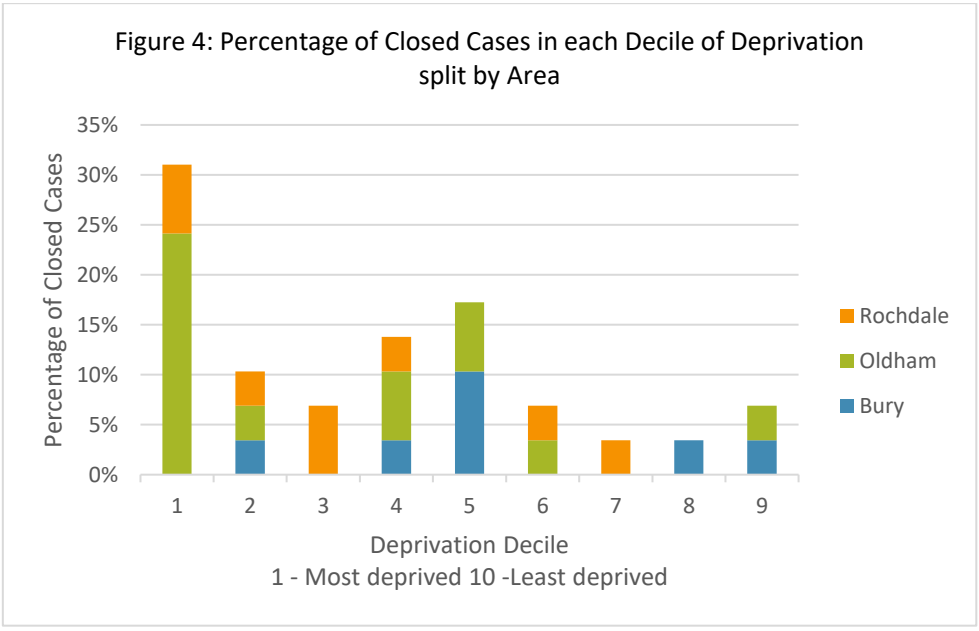
[4] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018#:~:text=1.-,Main%20points,of%203.6%20recorded%20in%202014

Table 12: Comparison of Deprivation, by IMD 2019 and percentage of people living in the 20% most deprived areas in England, for Oldham, Bury and Rochdale.		
Area	**IMD 2019**	**Percentage of people living in the 20% most deprived areas in England**
Bury	23.7	20.5%
Oldham	33.2	43.6%
Rochdale	34.4	44.5%
North West	28.1	31.9%
England	21.7	20.2%

Source:https://fingertips.phe.org.uk/search/deprivation#page/3/gid/1/pat/6/par/E12000002/ati/102/are/E06000008/iid/93553/age/1/sex/4/cid/4/page-options/ovw-do-0_car-do-0

IMD scores can be split into deciles to enable comparisons to be made, where decile 1 equates to the most deprived 10% of the population and decile 10 is the least deprived 10%. Figure 4 shows a clear trend between deprivation and the risk of child deaths, with 31% of closed cases in ORB being in the most deprived decile, and 79% of cases in the lowest 5 deciles. As deprivation falls so does the number of child deaths, this is in keeping with national trends. Oldham appears to have the highest numbers of death in the most deprived decile, despite similar deprivation levels to Rochdale. This may be due to the higher number of closed cases within Oldham.

Figure 4: Percentage of Closed Cases in each Decile of Deprivation split by Area

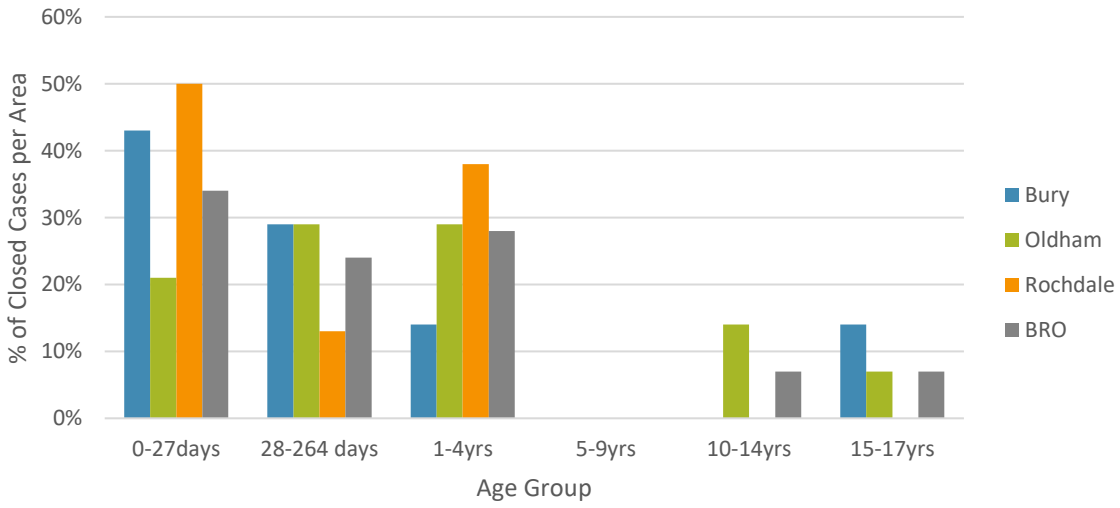


Source: GM CDOP Data 2019/2020

Age at death

Younger children have the highest risk of childhood mortality, and the highest risk of death is during the neonatal period[5]. Figure 5 demonstrates that as age increases the number of deaths falls. In ORB 34% of closed cases were in the neonatal period and 58% within the first year of life. This is consistent with GM and national trends. The percentage of closed cases in the neonatal period is less than previous years, for example in 2016/2017 neonatal deaths accounted for 59% of the deaths. Across all three local authorities most closed cases are before the age of 5 years.

Figure 5: Proportion of Closed Cases by Age Band for each Area



Source: GM CDOP Data 2019/2020

Figure 5 shows that whilst Bury follows the expected trend, both Oldham and Rochdale have a higher proportion of closed cases in the 1-4 years category than previous years. It is important to note that numbers are small, with a total of 8 closed cases in this category, therefore it is difficult to identify a reason for this and may be due to chance. Deaths in this age group appear to fall into three main categories:

- A health condition that subsequently led to the death
- Trauma and external factors
- Sudden unexpected unexplained death

Interestingly, 50% of these cases had modifiable risk factors, higher than average across the CDOP area. Table 13 summaries the number of child deaths and percentages for ORB and GM. Due to the small number of cases, individual areas are not included in this table.

[5] https://www.who.int/maternal_child_adolescent/documents/levels_trends_child_mortality_2019/en/

Table 13: Closed Cases by Age Band for Bury, Oldham, Rochdale and Greater Manchester												
Area	Age Category											
	0-27days		28-264 days		1-4yrs		5-9yrs		10-14yrs		15-17yrs	
	No	%	No	%	No	%	No	%	No	%	No	%
ORB	10	34%	7	24%	8	28%	0	0%	<5		<5	
Greater Manchester	47	36%	36	28%	19	15%	9	7%	13	10%	5	4%

Source: GM CDOP Data 2019/2020

Low birth weight and Prematurity

Preterm delivery is defined as any birth before 37 weeks of pregnancy and can be subdivided depending upon gestational age[6]:

- Extremely preterm -less than 28 weeks
- Very preterm -28-32 weeks
- Moderate to late preterm -32-37 weeks.

Preterm delivery and the associated complications are the leading cause of infant mortality[5]. The earlier the gestation at which a baby is born, the higher the risk of infant death[7]. Preterm delivery is associated with risk factors such as poverty and maternal smoking[8]. 76% of all deaths in children under 1 year were born prematurely across ORB. This was consistent across all three localities ranging from 71% -80%.

Low birth weight, defined as under 2500 grams, is often caused by a premature birth, and whilst some risk factors are unavoidable others include maternal smoking, drug and alcohol use, poor pregnancy health and nutrition, pregnancy related complications and mothers young age[9]. Birth weight for closed cases under the age of 1 have been compared across the localities in table 14. Across ORB 59% of closed cases under 1 year were associated with a low birth weight.

Table 14: Birth weight of closed cases for babies under 1 year only							
Area	<2500g Low Birth Weight		>2500g Healthy Birth weight		Not recorded		Total
ORB	10	59%	<10		<5		17
GM	46	56%	28	34%	8	10%	82

Source: GM CDOP Data 2019/2020

[6] https://www.who.int/news-room/fact-sheets/detail/preterm-birth

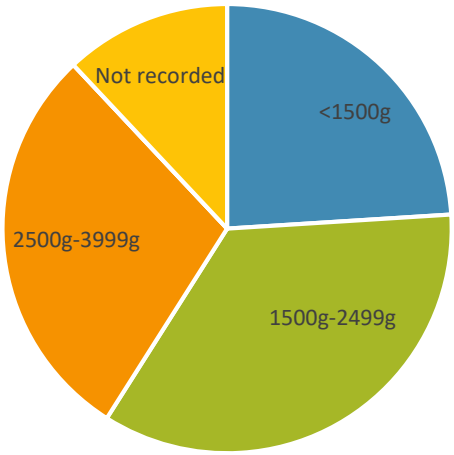
[7] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018#:~:text=1.-,Main%20points,of%203.6%20recorded%20in%202014

[8] https://www.rcpch.ac.uk/sites/default/files/2018-10/child_health_in_2030_in_england_-report_2018-10.pdf

[9] https://www.nuffieldtrust.org.uk/resource/low-birth-weight

Figure 6 demonstrates the further breakdown of birth weights in closed cases under 1 years. 1500g-2499g was the most common weight category, but 24% were less than 1500g, known as 'very low birth weight'. A low birth weight, particularly below 1500g is associated with higher mortality rates[10]. All three localities had closed cases where birth weight was less than 1500g.

Figure 6:Birth Weight for Closed Cases under 1 years across ORB



[10] https://www.who.int/bulletin/volumes/95/8/16-180273/en/#:~:text=Compared%20with%20other%20infants%2C%20low,to%20the%20nearest%20health%20facility.

Modifiable and other risk factors

Factors Identified that may have contributed to vulnerability, ill health or death

Form C, the child death review analysis form, is used by CDOP. All available information, gathered from different agencies, is reviewed in order to develop an understanding of the circumstances of the child's death and whether there were any associated modifiable factors. Through this process lessons can be learnt and shared, and local level action can be taken in order to reduce the risk of child death.

As part of the review, any factors that may have contributed to the child's death are identified.

These are split into four domains:

- Domain A: Factors Intrinsic to the Child
- Domain B: Factors in Social Environment including Family and Parenting Capacity
- Domain C: Factors in the Physical Environment
- Domain D: Factors in Service Provision

The level of influence is then determined, given one of the following:

- 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

Factors identified in closed cases in ORB that may have contributed to vulnerability, ill health or death

Domain A: Factors Intrinsic to the Child
• Acute Sudden onset illness • Other Chronic long- term illness (excluding Asthma, epilepsy and diabetes) • Learning disability • Motor Impairment • Sensory Impairment • Other disability or impairment
Domain B: Factors in Social Environment including family and parenting Capacity
• Emotional/behavioural/mental/physical health condition in a parent or carer
Domain D: Factors in Service Provision
• Prior medical Intervention

89% of the factors identified were in domain A, factors intrinsic to the child, which are unavoidable. The most common was acute sudden onset of illness identified in 23 cases, 79%.

Modifiable Factors

Some factors associated with a child's death are modifiable, these are important as targeted interventions can be used to reduce risk where factors reoccur. A set standard of modifiable factors has been agreed by the GM CDOP Network to ensure consistency when categorising the preventability of child deaths. This is to reduce the subjectivity surrounding these matters.

The agreed definition of Modifiable Factors Identified is:

'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'

The Modifiable Factors are categorised and defined as:

Modifiable Factors in Perinatal / Neonatal Deaths
• Maternal smoking in pregnancy • Maternal Obesity (BMI 30 +) • Mothers who are Underweight (BMI < 18.5) • Unbooked pregnancies • Concealed pregnancies • Necrotizing Enterocolitis (NEC) where the baby was not fed expressed breast milk
Modifiable Factors in Sudden Unexpected, Unexplained Deaths
• Unsafe sleeping arrangements (co-sleeping bed/sofa) • Parental smoking
Modifiable Factors in Consanguineous Related Deaths
• Where there has been an older sibling who has died or is affected by the same genetic autosomal recessive disorder

Across ORB 31% of cases had modifiable factors identified, ORB had a lower proportion of cases with modifiable factors when compared to GM demonstrated in table 15. All cases across ORB had sufficient information to identify modifiable factors.

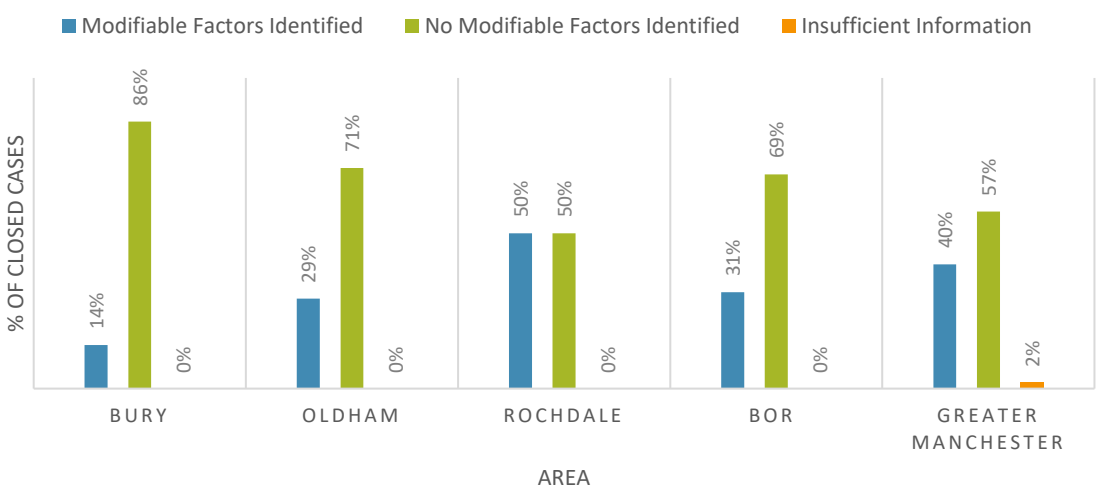
Table 15: Modifiable and Non-Modifiable Factors Contributing Towards Child Deaths in Oldham, Bury and Rochdale

Area	Modifiable Factors Identified		No Modifiable Factors Identified		Insufficient Information		Total
	No	%	No	%	No	%	No
ORB	9	31%	20	69%	0	0%	29
GM	52	40%	74	57%	3	2%	129

Source: GM CDOP Data 2019/2020.

When comparing the three localities, using Figure 7, Rochdale appears to have the highest proportion of modifiable factors, however, the actual number of cases with modifiable factors is equivalent to Oldham. Of the cases where modifiable risk factors were identified 78% had more than one factor, suggesting that modifiable factors are less likely to be found in isolation and in fact multiple factors combined are more likely to put a child's life a risk.

FIGURE 7: PERCENTAGE OF CLOSED CASES WITH MODIFIABLE FACTORS IDENTIFIED



Source: GM CDOP 2019/2020

Modifiable Risk Factors identified by the ORB CDOP in the closed cases of 2019/20 included:

- Maternal Obesity
- Maternal Smoking in Pregnancy
- Parental Smoking
- Unsafe Sleeping arrangements

It is important to note that whilst these factors were identified as modifiable factors, they were not felt to be factors that may have contributed to vulnerability, ill health or death of the child, and therefore not allocated a 2 when scored. Across GM maternal obesity has been recorded for the last three years, however, is not yet assessed to see whether this contributed to the child's death. Data was not recorded for un-booked pregnancy or concealed pregnancy, two of the modifiable risk factors defined by GM.

Other Identified Risk Factors

Other issues raised within the closed cases across ORB that are not defined within the GM CDOP Network:

- Modifiable factors in sudden, unexpected, unexplained deaths such as drug and alcohol use and housing

- Factors in service provision
- Consanguinity
- Window Blind Cord Injury

Understanding Modifiable Risk Factors and Local Initiatives

The following section will explore the modifiable risk factors that have been raised in further detail, and provide examples of what is being done to reduce the risk of child deaths through targeted interventions across the three localities.

Maternal Raised BMI

Preventing perinatal child deaths begins with a healthy pregnancy. Maternal obesity is a risk factor associated with many complications around birth and increased morbidity and mortality for baby. It is also known that social deprivation is associated with maternal obesity[11].

24% of closed cases in children under the age of 1 had maternal obesity identified. In 18% of closed cases in children under the age of 1, maternal obesity was felt to be a modifiable factor. Also, in this group 59% of mothers were overweight or obese, consistent with GM findings. Across GM obesity has overtaken smoking as the largest modifiable risk factor in child deaths, although numbers are small it would appear that a similar trend is emerging across ORB. In 29% of the child deaths under the age of 1, maternal BMI was not recorded. In view of the increasing concerns surrounding this issue, it is important that going forward this is recorded to enable review and understanding of the scale of the issue.

Health visitors across the three boroughs promote healthy eating particularly at times where infant feeding, weaning and child health promotion is carried out.

Oldham

A new Health Improvement and Weight Management service brings two previously separate services together to deliver a jointly commissioned, integrated service to Oldham. The new service will go-live on 1st January 2021.This new model of delivery will be family-centred and aligns with the wider work being undertaken within the Oldham's CCG's long-term conditions portfolio. The objectives for the new service model will contribute to:

- Reducing the proportion of adults who smoke
- Reducing the proportion of adults and children who are overweight or obese
- Reducing the proportion of adults who are physically inactive
- Provide advice regarding drinking alcohol within safe limits
- Reducing the proportion of adults that have a high vascular risk score through post NHS Health Check support
- Reduce the level of health inequalities.

[11] https://www.publichealth.hscni.net/sites/default/files/Maternal%20Obesity%20in%20the%20UK.pdf

Maternal Smoking in Pregnancy

Maternal smoking in pregnancy is known to double the risk of preterm delivery[12]. In 2018/19, nationally 10.6% of mothers were known to smoke at the time of delivery, this was higher in Oldham (13.6%) and Rochdale (16.1%)[13]. In this report maternal smoking during pregnancy was identified in 10% of cases, however maternal smoking was felt to be a modifiable risk factor and related to a perinatal/neonatal event in 3% of cases. In 13% of cases maternal smoking was not documented.

Health visitors make smoking enquiries at the first contact with the family and brief interventions are carried out using health promotion/motivational interviewing techniques. Smoking risks are discussed in relation to pregnancy at antenatal contacts and in relation to safe sleep/ongoing health of children. A smoke free home is promoted to support reduction of risks for pregnant women and/or other children from passive smoking. They also signpost to smoking cessation services, such as Lifestyle Service, and GP services.

Oldham and Rochdale

Since 2018 as part of the Saving Babies Lives requirements, Royal Oldham Hospital has used Babyclear, the GM smoke free pregnancy programme. This is funded up until March 2021. It is a midwifery led model, providing mothers with behavioural support, nicotine replacement therapy (NRT) and risk perception interviews with women who do not engage with services. Mothers from Rochdale will usually access Oldham or North Manchester for delivery, as there is no delivery unit in Rochdale, so would access the services provided within Northern Care Alliance.

Oldham have recently appointed a new midwife who, alongside maternity support workers, will delivery of this service. In order to reduce barriers to accessing NRT, the maternity unit are also piloting a service where NRT can be supplied directly to mums from the hospital. With recent COVID restrictions the team have not been able to use carbon monoxide monitoring, an important part of their service, however it is hoped that it will be reintroduced in the coming months. The team collect and review monthly data to look at trends, they have noted that across both Oldham and Rochdale the number of women smoking at the time of delivery is starting to decline. It is hoped that the recent changes will help to further this decline. The other elements of Saving Babies Lives are explored further in a later section of this report.

Risk factors associated with Sudden, Unexpected, Unexplained Deaths: Parental Smoking & Unsafe Sleeping

Whilst the exact cause for a sudden and unexpected child death is not known, a number of risk factors are likely to contribute, making a child more vulnerable to death. 300 infants die suddenly and unexpectedly in England and Wales each year, these deaths often occur in families where

[12] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

[13]https://fingertips.phe.org.uk/search/smoking#page/3/gid/1/pat/6/par/E12000002/ati/102/are/E08000004/iid/93085/age/1/sex/2/cid/4/page-options/ovw-do-0_car-do-0

circumstances put the child at an increased risk[14]. Safe sleeping advice is known to significantly reduce the risk of child death, and around 60% of sudden infant deaths could be avoided if no baby was exposed to smoke[15].

10% of closed cases were identified as sudden, unexpected and unexplained deaths in ORB. Two thirds of these were felt to have modifiable factors including smoking, safe sleeping, housing, drugs and alcohol. Information regarding prone sleeping, co-sleeping and overheating was not routinely collected, and only mentioned when identified as a modifiable risk factors or issue.

Across ORB safe sleeping guidance is discussed by health visitors at contacts from the antenatal period through the first year of life. Guidance from the Lullaby Trust and Basis is promoted. Risk assessments based on a family's individual circumstances are made where the checklist in a childs Red Book (PCHR) is checked, this has usually been completed by the midwife. Conversations are tailored to the individual family using motivational interviewing techniques, for example if risk factors are present these are discussed to support parental decision making. The health visiting teams receive regular updates from Lullaby Trust and utilise their parent information resources to provide information.

Rochdale

Rochdale Local Safeguarding Partnership have developed an initiative 'Keep Baby Safe', their current focus in on safe sleeping and coping with crying/abusive head trauma. These areas have been informed by local safeguarding reviews. They have developed multiagency sleep guidance and risk assessments which will be launched at a sleep training event in October 2020. These are underpinned by the findings of the national safeguarding panel review of Sudden Unexpected Death in Infancy. The Lullaby trust campaign materials are used during the antenatal and postnatal journey in order to raise awareness with parents, this includes events, information in antenatal packs, discussion with families and briefing professionals across multiple agencies to give the same clear message. The team have Public Health for one year to provide room thermometers which contain the key sleep safe messages.

Parental Alcohol/Substance Misuse

Parental drug and/or alcohol misuse was identified as an issue in 7% of closed cases. Across GM 8% of cases were identified as having drugs and alcohol as a factor which may have contributed to the childs death.

Routine enquiry is made at first contacts with the health visiting service and ongoing support is provided if this becomes or is an ongoing need for the family. Brief interventions are provided in terms of risks and dangers of drug/alcohol misuse around children. A referral to other services is made when a risk of potential significant harm is identified.

[14] https://www.gov.uk/government/publications/safeguarding-children-at-risk-from-sudden-unexpected-infant-death

[15] https://www.lullabytrust.org.uk/safer-sleep-advice/what-is-sids/

Consanguinity

Under the GM definitions of modifiable risk factors consanguinity is only recognised as a modifiable risk factor if the parents have had a previous child who has died from, or is affected by a genetic abnormality. Although consanguinity came up as an issue, no cases had a previous death related to the genetic abnormality and therefore was not formally identified as a modifiable risk factor. However, consanguinity remains a concern in view of the fact that child deaths are overrepresented in ethnic minority groups, particularly in Oldham, and the higher representation of deaths related to chromosomal and genetic disorders.

Health visitors provide supportive discussion around this and signpost families to the appropriate services such as genetics, this referral would likely be done by the GP. Health visitors would promote the importance of accessing national screening programmes to support the family in future pregnancies.

Oldham

In 2016 a Genetic outreach service in Oldham was established. The service works with local communities on genetic literacy and improving access to services. Aims of the service include reducing the prevalence of genetic disorders in the borough, empowering affected families in their decision making and providing support to affected families.

Access to Appropriate Health/Social Care

There were clinical concerns raised in 10% of cases with regards to hospital systems and the approach to care. Themes such as lack of early recognition of warning signs and appropriate escalation, poor record keeping, and the following of procedures were seen in the cases. However, each case occurred in a different departments and teams. When problems with the delivery of healthcare are identified these are managed before the CDOP review. They are discussed during the child death review meeting where professionals who have been directly involved in the child's care meet to discuss how things can be improved. Where patient safety is felt to have been compromised an NHS serious incident investigation will also be carried out. CDOP therefore acts as safety net, or a fresh pair of eyes, at the end of the process to ensure that nothing has been missed. In these cases, the panel sought assurance that the action plans initiated following on from Serious Incidents had been implemented.

Saving Babies Lives

Saving Babies Lives is a national evidence-based care bundle that aims to reduce perinatal mortality. The care bundle has recently been updated to version two and brings together five elements including: reducing smoking in pregnancy, improved detection and management of babies who are

small for gestational age, raising awareness of reduced fetal movements, effective fetal monitoring during labour and reducing preterm births.[16]

At Royal Oldham Hospital the maternity service is fully compliant across all areas apart from fetal monitoring, where a few minor amendments are being made, and preventing premature births, once a premature clinic is set up in November, all requirements will be met. Recent changes have been made to ensure compliance with version 2 of saving babies lives, and to improve the service offered. This has involved many areas of work including improved training packages for midwives, sonographers and clinicians, developing a competency tool around fetal growth, regular auditing of notes, computerised CTGs for reduced fetal movements (particularly for small babies and other at risk pregnancies), and a new prematurity clinic to start in November. Changes to the smoking service are discussed earlier in this report.

Emotional/behavioural/mental/physical health condition in a parent or carer

The emotional, behavioural, mental or physical health condition of a parent or carer may have an effect upon the health of a child and the care they receive. In 10% of cases a parent or carers health was felt to have contributed to vulnerability, ill health or the death of the child, however in two thirds of these cases no modifiable factors were identified. It is important that in situations where parents have their own health difficulties appropriate support is available to ensure that the health and welfare of the child is not compromised.

Accidents and Trauma

Trauma and other external sources accounted for 10% of closed cases, these included accidents such as blind cord injury and road traffic collision. The Royal Society for the Prevention of Accidents works across the UK to help prevent accidents occurring in view of their devastating consequences. As part of this work they have a specific campaign for blind cord injuries. They report that at least 33 young children across the UK have died due to blind cords since 2001. Their work includes working with manufacturers to make products safer and also providing education and campaign materials.

Health visitors across ORB address the accidents and trauma reports from the local A&E and Children's hospital departments via the 'Duty' process. A&E/Hospital admissions are reviewed on receipt via the service and documented on the chronology for the child. The review is provided in the context of the child's records and the risk factors present are considered. If the child has a named health visitor they will be informed and appropriate follow up provided. If the child is 'universal' and attends A&E, the incident is reviewed and follow up provided if needed. If the child attends for 3 or more incidents within one year this will also be reviewed and follow up provided. A&E and hospital attendance information will be shared with the Multi-agency Safeguarding Hub

[16] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

(MASH) and safeguarding/child protection multi-agency if required. Health visitors may challenge cases and escalate to the Safeguarding Team if the acute settings have not followed procedures for potential non-accidental injuries in children. Support is also provided for parents in regards to 'coping with crying'. Health visitors can signpost to relevant resources such as the Institute of Health Visiting (iHV) Parent Tips 'Coping with a Crying Baby During the Covid-19 Pandemic[17]'and ICON[18].

Other Risk Factors:

Other Risk factors that can be associated with child deaths, but not identified in the cases discussed in this report:

- Domestic Violence
- Statutory Intervention
- Suicide or self-harm
- Late Booking or concealed pregnancies.

These risk factors were not identified in the closed cases discussed in this report.

[17] https://ihv.org.uk/wp-content/uploads/2020/04/PT-Coping-with-a-crying-baby-during-COVID19-FINAL-VERSION-14.4.20.pdf
[18] https://iconcope.org/parentsadvice/

Recommendations and Actions

The following recommendations and actions are based upon the findings of this report.

Actions

- This year a reduction in closed cases has been seen across GM. ORB CDOP have reflected on potential reasons for this and the reasons for the increase in the length of the review process. The team are working hard to access the information required to work through the backlog of cases.

Recommendations

- Whilst the CDOP process is extremely thorough in its review of potential modifiable risk factors, there are several additional factors that could be considered. CDOPs could consider looking at factors such as a maternal age, as a risk factors, and breastfeeding as protective.[19] These may help to identify other areas where intervention may be required such as young mothers services, or breast feeding education and services.

- Data for unbooked pregnancy and concealed pregnancy was not recorded in the ORB data set, these are modifiable risk factors recognised by GM and therefore there may be benefit from reviewing these. Note that these may not have been included because these factors did not arise in the cases this year.

- Be aware that maternal obesity is of growing concern as a risk factor for neonatal death. It is becoming increasingly common across Greater Manchester, and the ORB CDOP. It is important to record maternal obesity in child deaths under the age of one, where it may be relevant, in order to observe for trends in the data. GM could consider inclusion of obesity as a risk factor to review whether it contributed to the child death using the standardised review system.

- Children living in deprived neighbourhoods or who are BME ethnicity continue to be over-represented in the child deaths, this needs continued acknowledgement and address. This knowledge should be embedded within services, and teams educated, in order to raise awareness for these discrepancies and to ensure that work is done wherever possible to reduce child deaths.

- It is advised that this report is disseminated to the relevant departments, within the health and wellbeing partnership organisations, in order to share learning.

[19] https://www.rcpch.ac.uk/sites/default/files/2018-10/child_health_in_2030_in_england_-report_2018-10.pdf

Greater Manchester Child Death Overview Panels (CDOP)

2019/2020 Annual Report

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CONTENTS

1. EXECUTIVE SUMMARY

1.1 Introduction

This is the 8th annual report reviewing all infant and child deaths reported to the four Greater Manchester (GM) Child Death Overview Panels (CDOP). This report includes data from cases closed between 1st April 2019 and 31st March 2020 (2019/20).

All deaths of children between 0-17 years of age are reported to a CDOP. The CDOP analyses the social and medical circumstances surrounding these deaths, including risk factors which could potentially be avoided to prevent future child deaths. The aim of this report is to inform and guide local organisations on preventing further child deaths.

1.2 Key Findings

During 2019/20, there were 129 child death cases closed and 240 child death notifications. This is a significant reduction in the number of cases closed (204 in 2018/19), mainly a consequence of the significant changes to the child death review process. This reduction in closed cases means it is difficult to draw statistically significant conclusions in comparison to year's previous data. The number of child death notifications during 2019/20 (240) is similar to previous years.

The majority of child deaths occurred within the first year of life (n=83; 64%), with a large proportion occurring in the first month (47; 36%). This is similar to previous report findings. The older age groups: 1-4, 5-9, 10-14 and 15-17, accounted for 15%, 7%, 10% and 4% respectively.

Of all closed cases in 2019/20, 94 cases (72%) were due to medical causes. 'Medical causes' encompasses multiple official categories of causes of death including acute medical or surgical, chronic medical, chromosomal, perinatal/neonatal event, malignancy and infection. Small numbers were attributable to non-medical causes including trauma, deliberate harm/abuse/neglect, suicide/self-harm and sudden unexpected/unexplained death (see Appendix 1).

Of the cases closed, 61 were female (46%) and 68 males (54%). This gender balance is in line with previous regional and national results. This difference is marked in age categories, reflecting that certain causes of death are gender and age specific. For example, trauma is more common in the older children/adolescents and males. However, owing to small numbers in these categories, it is difficult to draw significant conclusions.

GM has a significantly higher Black, Asian, and minority ethnic (BAME) child population (28%) than the UK average (15%). 63% of cases closed were children of White British ethnicity, whilst 37% were children from BAME groups. This clearly shows a higher proportion of child deaths within the BAME communities. These numbers represent 1.75 per 10,000 White British child deaths, compared to 2.81 per 10,000 BAME child deaths. This difference represents a significant health inequality.

Poverty and deprivation correlates closely with the patterns of child deaths in GM. 34% of children in GM fall within the fifth most deprived areas in England and Wales. Of the 129 cases closed, 55% of children lived in the most deprived quintile, compared to 62% in the previous year. A further 20% of deaths occurred in the second most deprived quintile meaning three quarters of all children who died resided in areas of deprivation.

A death is deemed to have potentially modifiable factors, where factors are identified as having contributed to the death of the child and which might, by means of locally or nationally achievable

intervention, be modified to reduce the risk of future child deaths. Specific examples of modifiable factors considered across GM can include unsafe sleeping arrangements where sudden unexpected/unexplained death occurs, maternal obesity in pregnancy in perinatal/neonatal deaths, and consanguinity in chromosomal, genetic and congenital anomaly related deaths. Modifiable factors were identified in 40% of all closed cases. Nationally, 27% of cases are identified to have associated modifiable factors meaning GM is above the national average.

Smoking was identified as a modifiable factor in 10% of all cases closed. Smoking was also identified as a risk factor (relevance score of 2, see Section 3: Modifiable Factors and Relevant Risk Factors) that may have contributed to vulnerability, ill health or death of the child.

Maternal obesity in pregnancy (Body Mass Index (BMI) 30+) was identified as a potentially modifiable factor in 9% of cases closed and considered a risk factor that may have contributed to vulnerability, ill health or death of the child in 11% of all cases. This is broadly in line with previous year's reports.

Though numbers are relatively small, this emphasises smoking and maternal obesity as key contributing factors and modifiable factors to child death. Despite ongoing efforts to reduce both, their influence in the death of children remains steady. The links between smoking and maternal obesity strongly correlate with deprivation, meaning highlighting a significant health inequality.

1.3 The Child Death Review Process

This is the 8th GM CDOPs Annual Report. In line with the publication of Working Together to Safeguard Children (2006), CDOPs became a statutory function from 1st April 2008. Local Safeguarding Children Boards (LSCBs) were tasked with establishing a multi-disciplinary CDOP Subgroup to conduct a review into the death of all children 0-17 years of age, normally resident in their geographical area. Following government recommendations that CDOPs cover a population of at least 500,000, four CDOPs were established across the GM footprint in conjunction with local coronial jurisdictions:

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

In October 2018, HM Government published the revised Child Death Review: Statutory and Operational Guidance (England) for Clinical Commissioning Groups (CCG) and Local Authorities as the Child Death Review Partners (CDR Partners)[1]. The guidance sets out the process that should be followed following the death of a child who is normally resident in England and adds detail to statutory requirements set out in Working Together to Safeguard Children (2018). The aim of the child death review process is to ensure that information is systematically captured for every death to enable learning and prevent future deaths.

2019/20 has been a period of change for CDOPs nationally following the publication of the revised guidance. The new arrangements build on the interface between the hospital/community led mortality reviews, also known as Child Death Review Meetings (CDRM), and the final CDOP review. It was anticipated that nationally CDOPs would see a decrease in the number of cases closed whilst new procedures were being imbedded.

[1] Child death review: statutory and operational guidance (England) https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

The National Child Mortality Database (NCMD) is a repository of data relating to all child deaths in England. The NCMD was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and is delivered by the University of Bristol, in collaboration with the University of Oxford, University College London (UCL) Partners and the software company QES. The NCMD enables more detailed analysis and interpretation of all data arising from the CDOP process, to ensure that lessons are learned following a child's death, that learning is widely shared and that actions are taken locally and nationally, to reduce child mortality.

As of the 1st April 2019, it became a legal requirement that CDOPs across England submit data via the NCMD, from all completed Department of Health and Social Care (DHSC) CDOP templates, forms associated with the child death review process and the analysis of information about the deaths reviewed. This includes, but is not limited to, providing all data and information as collated using the national DHSC CDOP templates such as the Notification Form (Form A), the Reporting Form (Form B), additional Supplementary Reporting Forms and the Analysis Form (Form C). Local CDOP data submitted to the NCMD will support national learning and reviews.

Whilst the GM CDOPs welcomed the introduction of the NCMD, to support and identify local and national learning, this impacted heavily upon CDOP business functions and the time taken to manually input all of the requested NCMD data requirements for cases closed whilst maintaining NCMD live records for every child death notification therefore resulting in fewer cases closed across GM. Following changes to the national CDOP templates the current local GM CDOP Database is no longer fit for purpose and there are hopes to purchase and implement the eCDOP system.

Each of the four GM CDOPs s meet regularly to discuss child deaths for their areas. This process can only occur once coronial investigations have concluded and the final cause of death has been ascertained. Likewise, any death associated with criminal activity can only be discussed once court proceedings or child safeguarding practice reviews and internal agency reviews have concluded.

The review process is based on information gathered about the child, their family environment, their home environment and their access to services. This allows the CDOP to reflect on the presence of risk factors and their contribution to the death of the child. GM CDOPs draw conclusions on what may be influencing child deaths and make recommendations to appropriate authorities and agencies to prevent further deaths. This data is submitted to the Department of Health and Social Care (DHSC) via the NCMD.

1.4 Child Health Profile

Infant, child and adolescent death rates have been decreasing steadily since the 1980s in England and Wales. The lowest ever recorded rate was in 2014 with 3.6 deaths per 1000 live births, rising to 3.9 in 2018. The most recent data from 2019 demonstrates a modest decrease to 3.8. These figures demonstrate that the steady decrease in child deaths has plateaued[2].

Though England often performs more poorly than other comparable European nations on child death statistics, the causes for this are complex[3]. Consequently, the solutions to this appear equally difficult. There are marked social inequalities in child death rates in multiple domains including poverty levels and ethnicity. The majority of deaths occur in the first year of life. After this, death by trauma, injury and suicide/self-harm remain key causes of death in childhood.

[2] PHE Fingertips Tool – Child and maternal health profiles, 2019.

[3] 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.

2. GREATER MANCHESTER CHILD DEATH OVERVIEW PANELS CHILD DEATHS 2019/20

2.1 Child Death Notifications & Cases Closed

Between 1st April 2019 and 31st March 2020 (2019/20) there were 240 child death notifications and 129 cases closed. 30% of the deaths notified during 2019/20 were also closed in the same period. Cases notified data does not provide a full dataset but supports real time information about the frequency of child deaths and their area of residence.

Figure 1.1: Percentage of child death notifications by local authority

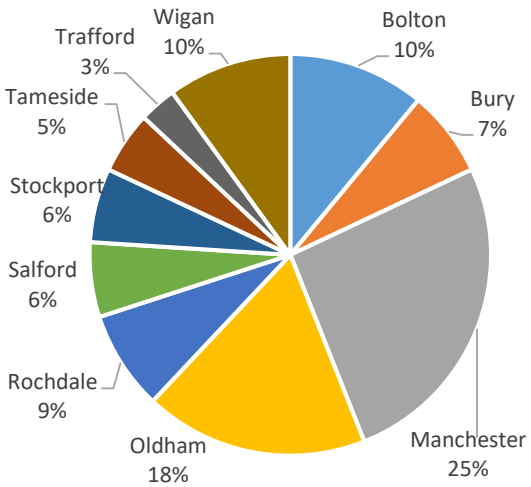
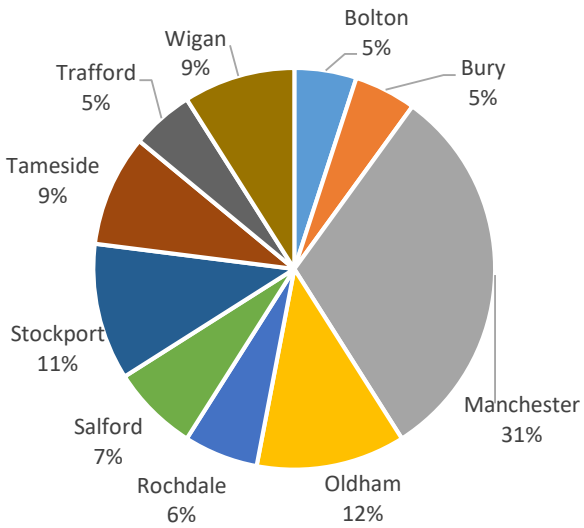
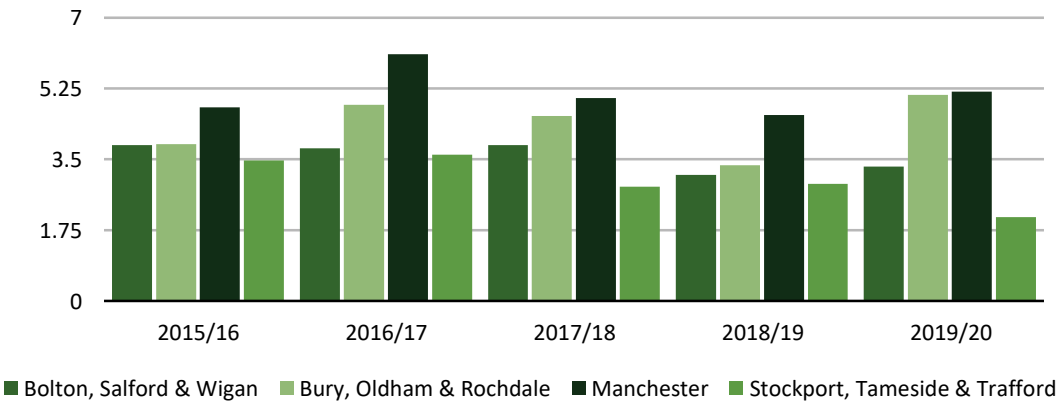


Figure 1.2: Percentage of cases closed by local authority



Owing to changes to the child death review process, there has been a decrease in the number of cases closed compared with previous years. The number of 2019/20 child death notifications has remained stable. Since records on child deaths began in the 1980s, there has been a steady reduction in the rate of child death. This reduction stalled in the last few years, leading to a 'levelling out' of the death rates, with some areas appearing to show a slight increase in the rates of death. The chart below uses rates of notified deaths per 10,000, rather than closed cases, as this provides a more accurate and contemporaneous overview of child death patterns across the four CDOP areas.

Figure 2: Rate of child death notifications per 10,000 by CDOP area 2015/20

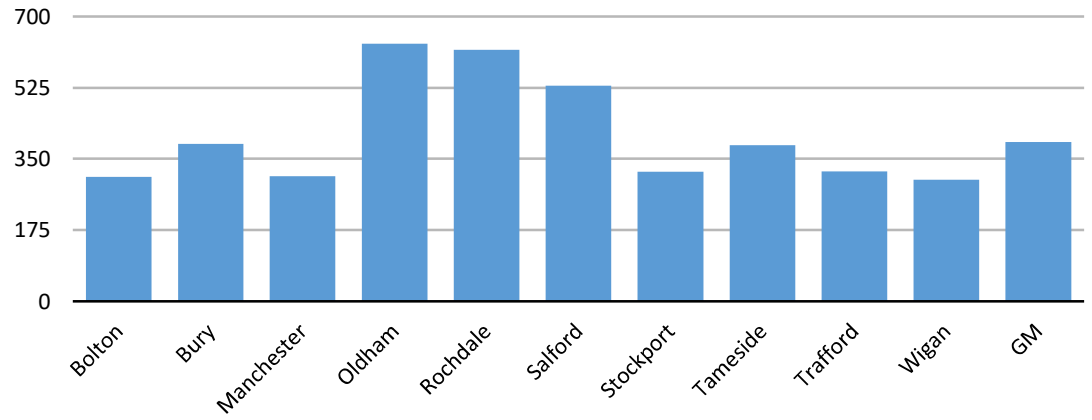


As demonstrated, all areas but Stockport, Tameside, Trafford demonstrated an increase in rate of child death notification compared to the previous year (see Appendix 2).

2.2 Duration of Reviews

The duration of a review refers to the time taken from notification of the death to closing the case at the CDOP. Certain categories of deaths can take longer to close, for example, if a post mortem examination is required or the death is subject to pending investigations. The average time taken to close a case was 391 days. 30% of the 2019/20 child death notifications were closed in the same period so there is limited real time data in the CDOP analysis. Conclusions are drawn over a number of years rather than a single report.

Figure 3: Average duration of reviews (from date of notification to date closed) by local authority



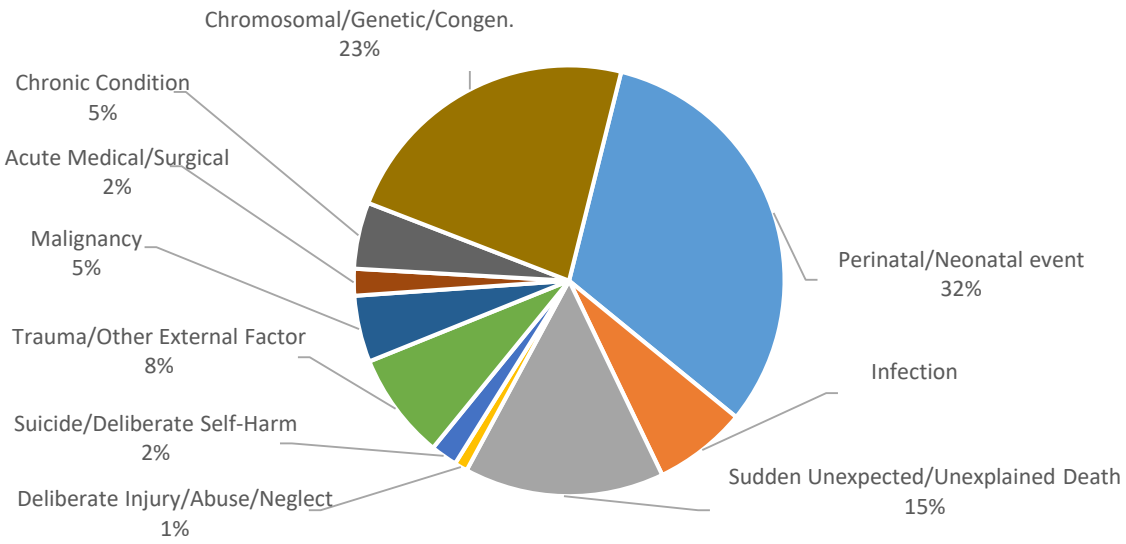
2.3 Categorisation of Death

There are 10 defined categories to which all deaths can be ascribed. It is hierarchical, so should a death fall into more than one category the cause highest on the list is chosen. These nationally defined categorises allow standardisation across the country. These categories are:

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 condition
6. Chronic medical condition
7. Chromosomal, genetic and congenital abnormalities
8. Perinatal/neonatal event
9. Infection
10. Sudden unexpected, unexplained death

There has been a consistent pattern in the categories of death over a number of years. Perinatal/neonatal events remain the single largest category of death, with chromosomal, genetic and congenital causes second. These 2 categories account for over half of all closed cases.

Figure 4: Percentage of cases closed by category of death 2019/20

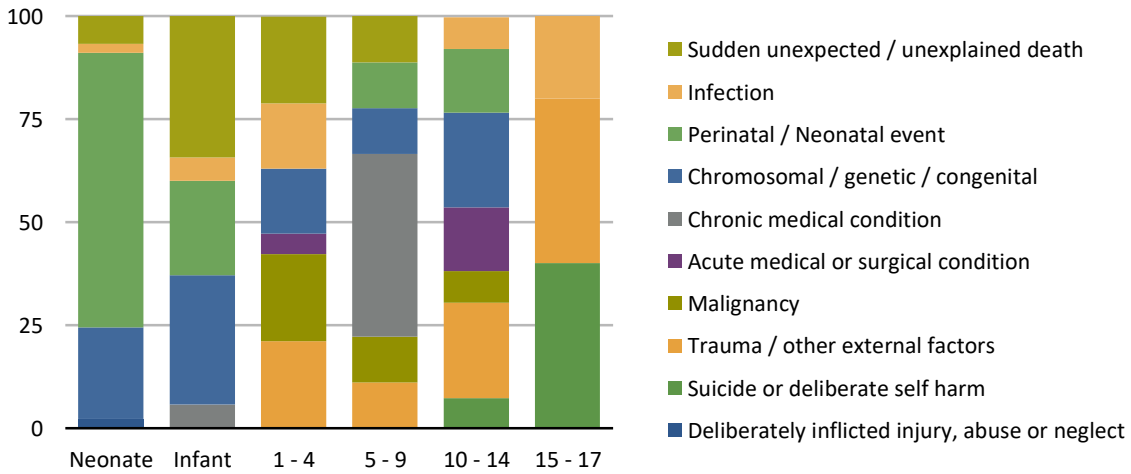


2.4 Age

The correlation between age and death is well established, with the first 28 days of life (neonate) being the most vulnerable period, accounting for 36% of the cases closed. The majority of these deaths were catergorised as a perinatal/neonatal events i.e. problems in the antenatal period, during labour, birth and the first 28 days of life. 64% of all deaths occurred in the first year of life[4].

For 2019/20, there is generally an inverse relationship between increasing age and proportion of deaths. This is different to previous years in which the 15-17 age group showed a spike in deaths due to risk taking behaviour including death by suicide. The numbers for these older groups are small and require caution in their interpretation.

Figure 5: Percentage of cases closed by category for each age group



[4] Zhao, D. et al, 2016, Gender Differences in Infant Mortality and Neonatal Morbidity in Mixed-Gender Twins. Scientific Reports, 7, 8736: 1-6: http://www.nature.com/articles/s41598-017-08951-6

2.5 Sex

Of the 129 closed cases, 68 were males (60%) and 61 females (40%) which is broadly in line with previous GM results. For example, the split in 2017/18 was 58 to 42, and in 2018/19 60 to 40 in males and females respectively. This is also in keeping with national data. Why this should be the case is not well understood[5]. Though there are 1053 males born to every 1000 females in the UK, this discrepancy does not account for differences seen in death rates.

2.6 Location at Time of Death

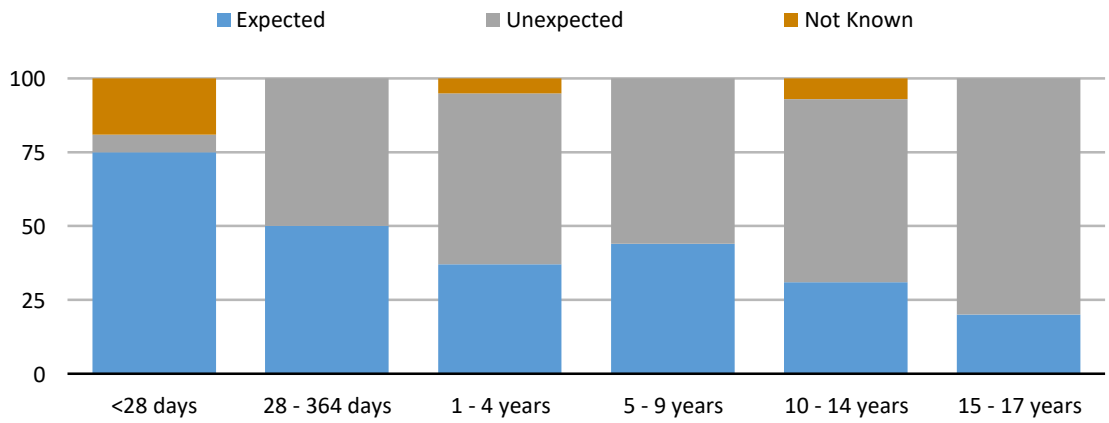
47% of cases closed were children that died in hospital (although the preceding event itself may have occurred in the community), 26% at home and 27% in 'other' settings. This represents a significant decrease in the number of deaths in an acute hospital setting from 2018/19 (71%) and an increase in the percentage of deaths occurring at home (20%). The deaths out of hospital/out of home represent a range of locations from abroad (multiple countries), public spaces, highways and some in a hospice setting.

2.7 Expected & Unexpected Deaths

A unexpected death is defined as 'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death'[6].

Where recorded, 56% of deaths were deemed expected. This is broadly in line with the previous 5 years of annual reports, all of which were between 60-69%. Proportions of expected deaths per age category gives similar results year on year. Broadly, most neonatal/infant deaths are expected, with a large proportion of these associated with prematurity. In line with previous results, there is an increase in the proportion of expected deaths in the age group 5-9 years, relative to other age groups. Deaths in the eldest age category are mainly unexpected with causes of death including suicide and trauma related events accounting for the most.

Figure 6: Percentage of cases closed, expected deaths per age group



[5] Drevenstedt, G., et al., 2008, The rise and fall of excess male infant mortality, Proceedings of the National Academy of Sciences of the United States of America, 105 (13), 5016-5021.
[6] Working Together to Safeguard Children 2015

2.8 Neonatal & Infant Deaths (0-365 Days of Life)

Neonates are defined as babies under 28 days of life and infants as those aged between 28 days and 365 days of life. This group has represented the lion's share of child deaths throughout the history of CDOP reporting. For example, in 2018/19, 42% of all GM deaths occurred in the neonatal period and 61% in the first year of life. Results from 2019/20 demonstrate a similar pattern with 36% of cases closed occurring in the neonatal period and 64% in the first year.

The most common causes of death for this age category are perinatal/neonatal events, followed by chromosomal, genetic and congenital anomalies, and sudden unexpected/unexplained death, making up 32, 15 and 13 cases respectively. The numbers for the other causes of death in this age category are too small to draw any meaningful conclusions.

Chromosomal, genetic and congenital anomalies related deaths account for the second largest share of neonatal and infant deaths both regionally and nationally[7]. Where recorded, 63% of those children catergorised as having chromosomal, genetic and congenital anomalies, resided in the most deprived quintile.

2.9 Gestational Age

Prematurity is categorised as:

- Extreme prematurity (<26 weeks)
- Premature (26 to <37 weeks)
- Term (37+ weeks)

In 2019/20, 49% of all neonatal cases closed were infants born extremely premature and a further 23% premature. This is in line with the results of previous reports with 59% extremely premature and 21% premature in 2018/19.

2.10 Birth Weight

Low birth weight (LBW) is associated with an increased risk of infant and child mortality. It is associated with multiple factors including maternal smoking, maternal age/weight and multiple births. Whilst birth weight correlates with gestational age, babies born on the lowest centiles for their gestational age have the poorest prognosis. Low birth weight is also linked to maternal health which strongly correlates with deprivation and socioeconomic status. Low birth weight is categorised as:

- Low Birth Weight (LBW) <2500g
- Very Low Birth Weight (VLBW) <1500g
- Extremely Low Birth Weight (ELBW) <1000g

Owing to small numbers ELBW and VLBW have been grouped together in this report. Where recorded, 23% were deemed LBW and 33% VLBW. This is an improvement on 2018/19 where these values were 19% and 50% respectively.

2.11 Ethnicity

Ethnicity was recorded in all closed cases in 2019/20. As per the 2011 census data, 14.6% of the UK population is classified as belonging to BAME ethnic groups[8]. Since 2017, subcategories of BAME

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

[8] Source: ONS Census data, 2011 applied to 2019 mid-year population estimates

groups have been established. GM has a significant ethnically diverse population in comparison to the national average, with 28% classified as BAME. Indeed, this is the case for all local authorities aside from Wigan which is lower than the national average (see Appendix 3). 63% of the cases closed were children of White British ethnicity and 37% from BAME groups. This is in line with national data. Closed cases demonstrate 1.75 per 10,000 White British child deaths, compared to 2.81 per 10,000 BAME child deaths in GM.

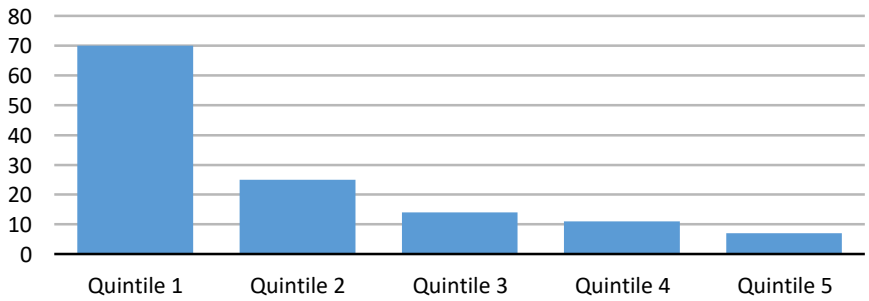
Significant differences exist in rates of death between White and ethnic minority groups across GM. This is especially marked in certain local authorities with Manchester and Oldham being the most prominent. Across GM, this represents a 61% increased risk of death in BAME children compared to children who are White British.

National research has identified certain ethnic groups at an increased risk of death by specific causes, notably in the first year of life. Pakistani children run the highest risk of death by chromosomal, genetic, congenital causes. Black children run the highest risk of death by sudden unexplained/unexpected death. The reasons behind this are complex and thought to represent a combination of deprivation, behavioural and cultural factors[9] [10]. It has been suggested that pregnant women from BAME groups may face barriers in accessing appropriate healthcare, representing another potential health inequality[11].

2.12 Deprivation

Factors for many causes of child death correlate with deprivation or socioeconomic inequality[12]. The Index of Multiple Deprivation is a composite score based on multiple factors including income, employment, education, health, and quality of home and community[13]. These scores allow populations to be categorised into quintiles with a score of 1 representing the most deprived and 5 the least deprived quintile. In GM, 6 out of 10 local authorities have higher scores than the North West average and all but Trafford perform worse than the UK average. By this measure, Manchester is the most deprived area in GM with 41% of its population living in the most deprived quintile. Trafford is the least deprived with 3% living in the most deprived group.

Figure 7: Number of cases closed by deprivation quintile



[9] ONS, Pregnancy and ethnic factors influencing births and infant mortality: 2013. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/pregnancyandethnicfactorsinfluencingbirthsandinfantmortality/2015-10-14#ethnicity

[10] DfE, Ethnicity, deprivation and educational achievement at age 16 in England: trends over time. June 2015.

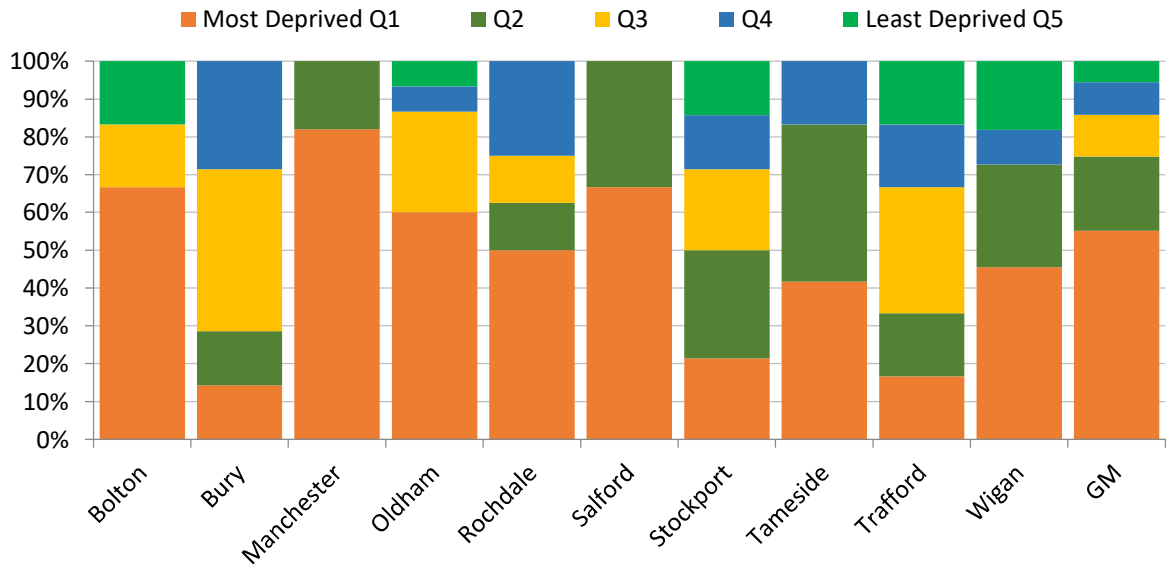
[11] Hollowell. J, Oakley. L, Vigurs. C, Barnett-Page. E, Kavanagh. J & Oliver S. (2012) Increasing the early initiation of antenatal care by Black and Minority Ethnic women in the UK. Oxford: *National Perinatal Epidemiology Unit.*

[12] 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. Marmot, M, Goldblatt, P., Allen, J., 2010, Fair Society Healthy Lives. See: http://www.instituteofhealthequity.org/

[13] CDOPs calculate an IMD score of a child's lower-super-output-area using the national postcode lookup tool (http://imd-by-postcode.opendatacommunities.org/).

Figure 7 demonstrates the link between deprivation and risk of child death, with the risk steadily decreasing as deprivation decreases. Over half of all cases closed in 2019/20 were in the most deprived quintile, and a further 20% in the second most deprived; these two quintiles accounting for three quarters of all deaths. There is significant correlation between local authority levels of deprivation and child deaths.

Figure 8: Percentage of cases closed by deprivation quintile per local authority



3. MODIFIABLE FACTORS & RELEVANT RISK FACTORS

When undertaking a child death review, the CDOP is responsible for identifying potentially modifiable factors. Categorising a death as having modifiable factors does not necessarily mean the CDOP regards the death in question as preventable, but that there may be emerging trends which could reduce the risk of future child deaths:

> Modifiable factors identified: The panel has identified one or more factors across any domain which may have contributed to the death of a child and which might, by means of locally or nationally achievable intervention, be modified to reduce the risk of future child deaths.
>
> No modifiable factors identified: The panel have not identified any potentially modifiable factors in relation to the death.
>
> Inadequate information upon which to make a judgement: the panel was not provided with sufficient information.

The identification of modifiable factors depends heavily upon the circumstances leading to death and the cause of death ascertained. Modifiable factors may include substance/alcohol misuse by the parent/carer, child abuse/neglect, consanguineous relationships and difficulties with access/uptake of healthcare services.

The CDOP is responsible for analysing information to determine relevant risk factors that may have contributed to vulnerability, ill health or death of the child. These factors fall into four domains:

- Factors intrinsic to the child
- Factors in social environment including family and parenting capacity
- Factors in the physical environment
- Factors in service provision

For each of the four domains, the CDOP determines the level of relevance (0-2) for each factor, in relation to the registered cause of death and to inform learning of lessons at a local level. The categories are:

0 - No information available
1 - No factors identified, or factors were identified but are unlikely to have contributed to the death
2 - Factors identified that may have contributed to vulnerability, ill health or death

(There was previously a category 3 in which 'factors identified provided a complete and sufficient explanation of death', though this has been removed by the DHSC)

Modifiable factors were identified in 40% of 2019/20 cases closed, 58% with no modifiable factors and 2% having insufficient information to make a judgment. The most recent national data from 2017 demonstrates modifiable factors were present in 27% of cases, indicating a significantly higher proportion of local cases where modifiable factors may have contributed to the death of the child. Across GM factors such as smoking, maternal substance use and unsafe sleeping arrangements are all identified as modifiable factors, although this is not the case across the whole of England.

The GM CDOPs continue to conduct reviews in line with the agreed GM set standard of modifiable factors, as developed by the GM CDOP Network. The standard ensures consistency across the four GM CDOPs when undertaking review and identifying modifiable factors.

A greater proportion of the 2019/20 cases closed were either neonatal deaths where maternal factors in pregnancy are identified, or sudden unexpected deaths, where risk factors in the sleeping environments are identified. Fewer hospital deaths were closed during 2019/2020, and these cases often have fewer modifiable factors identified.

Figure 9: Number and percentage of cases closed with modifiable factors by CDOP area (2012/20)

CDOP Area	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bolton, Salford & Wigan	39% (34)	28% (13)	26% (17)	38% (21)	34% (23)	35% (29)	44% (28)	26% (7)
Bury, Oldham & Rochdale	21% (15)	30% (17)	25% (20)	22% (16)	41% (21)	46% (33)	40% (21)	31% (9)
Manchester	29% (16)	20% (10)	18% (15)	29% (16)	27% (17)	34% (21)	32% (15)	38% (16)
Stockport, Tameside & Trafford	18% (10)	27% (17)	31% (25)	42% (21)	29% (14)	47% (27)	38% (15)	65% (20)

3.1 Smoking

Smoking in pregnancy is associated with multiple poor health outcomes[14]. These include reduced fetal growth, higher risk of miscarriage and still birth, low birth weight and increased risk of sudden unexpected death in infancy. It is estimated that maternal smoking can increase the risk of child mortality by 40%, as well as increasing risk of disease in later life[15].

Public Health England (PHE) uses smoking at time of delivery (SATOD) to measure how many women continue to smoke during pregnancy. The most recent figures show this to be 10.8% nationally and 12.6% in GM[16]. Of the 10 GM local authorities, 7 were deemed to have SATOD rates above the national average, all of which scored above average in the Index of Multiple Deprivation rankings. Indeed, over half of the cases in 2019/20 where smoking was deemed likely to have contributed to the death of a child were in families in the lowest deprivation quintile. For 2019/20, 15% of deaths involved maternal smoking which was considered a modifiable factor. This is an increase from the 11% of cases in which smoking was a modifiable factor in 2018/19.

3.2 Maternal Obesity in Pregnancy

As with smoking, maternal raised body mass index (BMI) scores are associated with worse outcomes for infants including miscarriage and still birth as well as complications with delivery[17] [18]. As a consequence, across GM, a maternal BMI of 30 and over or a BMI less than 18.5 has been considered a potentially modifiable factor in perinatal/neonatal deaths due factors including prematurity delivery and difficulties in labour. The link between obesity and deprivation is well established. BMI can be stratified as follows:

- <18.5: Underweight
- 18.5-24.9: Healthy
- 25-29.9: Overweight
- 30-39.9: Obese
- >40: Morbidly Obese

Maternal obesity was recorded as a modifiable factor in 11% (14) of cases closed. This is an increase from the 8% of cases closed in 2018/19, though broadly in line with the national trend which demonstrates a steady year-on-year increase in levels of maternal obesity as a modifiable factor.

3.3 Genetic Disorders & Consanguinity

Consanguinity is defined as a relationship between two people who share an ancestor, or share blood. There is an increased risk of congenital birth defects and genetic conditions in consanguineous relationships. Unrelated parents have a 2% risk of having a child with a severe abnormality, whilst parents who are first cousins have a 5% risk and second cousins have a 3% risk. However, couples that are more closely related, such as a family with a history of cousin marriages going back generations, will have a higher risk of having a child with autosomal recessive disorders.

As a couple may not be aware that they carry a gene anomaly in their first pregnancy, this is not recorded as a modifiable factor by GM CDOPs. However, if a condition is recognised in a first

[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] Parliamentary Office of Science and Technology, 2016, Infant Mortality and Stillbirth in the UK. Available at: http://researchbriefings.files.parliament.uk/documents/POST-PN-0527/POST-PN-0527.pdf
[18] Maternal obesity in the UK: findings from a national project (2010) UK. Centre for Maternal and Child Enquiries

pregnancy/child and then a second child is born with the same condition, this is deemed potentially modifiable.

Over the past several CDOP reports, the numbers of deaths in which consanguinity was deemed a risk factor has decreased, falling to fewer than 3% of cases (<5 cases in total in 2018/19). For 2019/20 cases closed, there were 11 deaths where consanguinity was considered a contributing factor to a death of the child which represents 9% of all child deaths. Despite this, it was considered a modifiable factor in only 3 cases, owing to the above definition that it is only considered modifiable in the event of a second affected pregnancy/child.

All 11 cases where consanguinity was identified as a factor were children from Asian/Asian British communities, 9 children being of Pakistani heritage. 1.1 per 10,000 BAME children in GM will die of a congenital problem, compared to 0.15 per 10,000 White British children, representing a near 7 fold increased risk in BAME groups[19] [20]. This emphasises that education of congenital disorders will require complex and sensitive societal interventions. The Manchester Foundation Trust Genetics Service is developing strategies to support both practitioners and families to raise awareness of genetic disorders and the support available.

3.4 Alcohol & Substance Use

In 2019/20, 8% of cases closed were identified as having substance or alcohol use as a factor which may have contributed to the death of the child. Over the past 2 reports, this number has been 5%. Though numbers are small, substance and alcohol is recognised in cases categorised as a perinatal/neonatal event or sudden and unexpected death in infancy.

3.5 Unsafe Sleeping Arrangements

Whilst unsafe sleeping practices may not be proven causal in sudden and unexpected deaths of infants, it's recognised as a strong correlation between unsafe sleeping and child deaths. Across GM, when one risk factor is present such as maternal smoking it is usually associated with other risk factors. Educational campaigns to raise awareness of safer sleeping arrangements have shown to be effective and have reduced the number of deaths due to sudden infant death syndrome (SIDS). 5% of the 2019/20 cases closed, compared to the 4% in the previous two GM CDOPs reports, identified co-sleeping as a potentially modifiable factor. Maternal smoking in pregnancy and household smoking is recorded as a contributing factor but these factors overlap significantly.

3.6 Domestic Abuse & Violence

There were 9 cases closed where domestic abuse/violence was present and thought to be a relevant contributing factor which represents 7% of all cases closed. It must be emphasised that these numbers are small and may not represent a statistically significant change.

[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. Inequalities in Infant Mortality Project Briefing Paper 4.

3.7 Access & Uptake of Healthcare Services

Accessing and uptake of appropriate healthcare was noted as a modifiable factor in 7 cases, the majority of which were categorised as a perinatal/neonatal event. There appears to be a link between accessing and uptake of healthcare services in areas of deprivation, with all cases in the two most deprived quintiles. It is also possible that there is a discrepancy in access to health care between ethnicities, though numbers are insufficiently large in this report to draw a meaningful conclusion[21]. Homelessness was referenced in several of these cases. This may draw attention to a possible lack of support and service uptake for mothers and families with no fixed abode.

3.8 Social Environment, Family & Parenting Capacity

Poor parenting was identified as a risk factor in 15 deaths, whilst child abuse/neglect was identified as a risk factor in 10 deaths. There is considerable overlap between these two categories. The factors stated above give an indication of the increased need for multi-agency support for the family.

4. CONCLUSION

Though there has been a reduction in the number of closed cases for the period 2019/20 (129), the number of child death notifications remains steady (240). This means that rates of child death in the GM population have not decreased in the last year. The number of closed cases, is significantly fewer this year than in previous years. This reflects national changes in the operational aspects of the child death review process. Unfortunately, this makes statistical analysis difficult owing to the very small numbers of children in certain categories, and the skew towards the relative increase in the proportion of other categorises.

The majority of deaths continue to occur in the first year of life, with the first 28 days being the most vulnerable. The figures for these age groups remain roughly the same as in previous years. Perinatal/neonatal events account for the majority of these deaths, closely followed by chromosomal, genetic and congenital anomalies. These proportions are in line with previous reports and also correlate with factors such as deprivation levels, consanguinity and maternal health. Improvements to neonatal care have contributed to preventing and in some cases delaying death, especially in the premature infants. certain Modifiable factors such as maternal smoking and maternal obesity in pregnancy continue to be key factors in deaths categorised as a perinatal/neonatal event. Further efforts to reduce the impact of these factors should be a public health priority for all agencies.

The older age groups, 1-4, 5-9, 10-14 and 15-17 years of age, account for 15%, 7%, 10% and 4% of deaths respectively. Though they largely follow the trend from previous years the absolute numbers in the eldest groups are very small, meaning that it is difficult to draw meaningful conclusions in isolation and must be viewed as a trend over several years. The vast majority (72%) of these deaths are due to medical causes (perinatal/neonatal, acute medical, chromosomal, chronic medical, malignancy, infection). This demonstrates that good antenatal, postnatal and ongoing medical care remain integral to reducing both infant and child mortality.

The two eldest age groups (10-14 and 15-17 years of age) remain particularly vulnerable to the non-medical causes of death, including suicide and trauma related death. This is in line with national results and statistics from previous reports, though, it is not possible to state their statistical significance as they represent only a handful of cases closed rather than real-time notification data. Anecdotally, there continues to be an increase in the apparent suicide of adolescents over the last few years. These cases are yet to be closed, and owing to their complexity may not be closed for some time. These

[21] 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.

delays may obscure trauma and apparent suicide related deaths as an ongoing or growing problem. This may be further exacerbated in the coming year(s) due to the effect of the COVID-19 pandemic on social and medical services. Indeed, there are indications that the 'lockdown' period has seen a further increase in apparent suicides. As one child suicide is one too many, this report emphasises the need for GM to continue in its suicide prevention strategy and streamline its reporting process.

There continues to be a link between the rate of child deaths and deprivation, with the majority of closed cases involving children, and their family, residing in the most deprived quintile. Whilst tackling deprivation lies outside the scope of this report, it stands to show that the underlying causes of infant and child mortality rates are complex and long term solutions are required such as tackling the access and uptake of healthcare services in areas of deprivation and BAME communities.

Modifiable factors were present in 40% of cases closed. Much like deprivation, and often inextricably linked, factors such as smoking, substance use and maternal obesity in pregnancy may be deemed contributing factors to death. With regards to the latter, the growing problem of obesity represents a real future challenge for local authorities. Smoking rates remains higher in areas of deprivation than the national and regional rates. Consanguinity associated with congenital abnormalities remains a significant contributing factor in deaths across GM. This report has identified Manchester's Pakistani population at particularly high risk for congenital abnormalities, strongly correlating with consanguineous relationships. As with many cultural/social practices, this is a complex issue requiring sensitive and community inclusive solutions.

5. RECOMMENDATIONS

The following should be considered by the 10 GM Local Safeguarding Partnerships and Health and Wellbeing Boards including distribution to relevant agencies:

1. Health inequalities lie at the heart of child deaths across GM. BAME communities are disproportionately represented with in child deaths, with a strong link to deprivation. This report must be used, in conjunction with other relevant data, to show how reducing inequalities will improve the life chances for children with particular attention and support provided for BAME communities.

2. Smoking remains a key modifiable factor contributing to child deaths. GM has made progress in reducing smoking with mothers who smoke during pregnancy being identified as a priority group. This work must continue to drive down smoking rates in the GM population.

3. Obesity is also a major public health issue and maternal obesity in pregnancy remains a key modifiable factor. GM local authorities need to reduce levels of obesity throughout the population with a focus on maternal obesity to improve the health and wellbeing of the mother and the unborn child, in order to contribute to the reduction in childhood mortality.

4. In light of the small numbers of cases closed in each report, it is often difficult to detect significant patterns in annual trends. By pooling the data gathered over a longer period of time, it may be possible to draw reliable statistical conclusions. The GM CDOPs are to explore any potential capacity and resources available to carry out an additional review such as a 5 year snapshot of cases closed.

5. Though based on anecdotal evidence from child death notifications reported to the GM CDOPs, there appears to have been an increase in the rate of apparent suicide in adolescents. Naturally, these cases will require lengthy reviews due to pending investigations. Owing to the urgency of these deaths and the potential to identify real time emerging themes, this report recommends a streamlining of reporting to CDOPs where suicide is deemed likely cause of death, to provide live data to support appropriate suicide prevention agencies. An appropriate electronic system will need to be implemented to support such requests for live data to highlight real time trends.

6. Following the introduction of the NCMD (1st April 2019), CDOPs have a statutory requirement to submit data relating to all child deaths in England. The CDOP data is used to support the NCMD influence national strategy and improve the child death review process. The NCMD programme team requests real time data to support changes to NHS systems and promote public health messages. Due to the level of data collated and national demand for information, 52 of the 54 CDOPs (outside of GM) have purchased the eCDOP system which automatically populations the NCMD and supports local CDOPs identity live emerging trends. The GM CDOPs have been in discussions with QES, as the eCDOP provider, regarding the functionality of the system and how this will support clinicians, multi-agency representatives, local CDOPs and fulfil national statutory requirements. GM CDOP Chairs are to liaise with local authority budget holders in their area(s) to request and agree funding arrangements to purchase and implement eCDOP.

6. APPENDICES

Appendix 1: Number of 2019/20 GM CDOPs cases closed, duration of reviews (average, minimum and maximum days) by category of death

Category	No. Cases Closed	Average	Min Days	Max Days
1. Deliberately inflicted injury, abuse or neglect	*	963	963	963
2. Suicide or deliberate self-harm	*	406	331	500
3. Trauma and other external factors	10	439	101	1072
4. Malignancy	6	465	171	801
5. Acute medical or surgical condition	*	601	339	1079
6. Chronic medical condition	6	396	104	786
7. Chromosomal, genetic and congenital abnormalities	29	239	100	641
8. Perinatal/ neonatal event	41	392	91	1918
9. Infection	9	400	93	1596
10. Sudden unexpected, unexplained death	20	445	211	1079

Appendix 2: Number of 2019/20 GM CDOPs child death notifications and cases closed by rate per 10,000 population

Local Authority	No. Deaths Notification	Rate of deaths notifications (per 10,000 population)	No. Cases Closed	Rate of Cases closed (per 10,000 population)
Bolton	25	3.69	8	1.02
Bury	16	3.7	7	1.62
Manchester	61	5	41	3.25
Oldham	43	7.23	14	2.52
Rochdale	22	4.18	8	1.5
Salford	15	2.65	9	1.57
Stockport	15	2.37	14	2.2
Tameside	12	2.39	11	2.37
Trafford	8	1.42	6	1.06
Wigan	23	3.36	11	1.6
Greater Manchester CDOPs	240	3.77	129	2
Bolton, Salford & Wigan	63	3.32	28	1.4
Bury, Oldham & Rochdale	81	5.09	29	1.93
Manchester	61	5.17	41	3.28
Stockport, Tameside & Trafford	35	2.07	31	1.89

Appendix 3: Number and percentage of 2019/20 GM CDOPs cases closed by ethnicity per local authority

Local Authority	White		BAME	
	Number	%	Number	%
Bolton	46,502	68	21,883	32
Bury	34,631	80	8,658	20
Manchester	55,311	45	67,603	55
Oldham	35,755	60	23,837	40
Rochdale	36,243	68	17,056	32
Salford	43,664	76	13,788	24
Stockport	52,720	83	10,798	17
Tameside	41,544	82	9,120	18
Trafford	40,123	71	16,388	29
Wigan	64,781	94	4,135	6
Greater Manchester	451,275	72	178,003	28

Appendix 4: Number and percentage of 2012/20 GM CDOPs cases closed by category of death

Category of death	2012/13		2013/14		2014/15		2015/16		2016/17		2017/18		2018/19		2019/20	
Deliberately inflicted injury, abuse of neglect	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Suicide or deliberate self-harm	11	4%	*	*	*	*	7	3%	6	3%	*	*	*	*	3	2%
Trauma and other external factors	*	*	10	5%	14	5%	15	6%	8	7%	15	5%	13	6%	10	8%
Malignancy	12	4%	20	9%	18	7%	15	6%	18	6%	20	7%	16	8%	6	5%
Acute medical or surgical condition	16	6%	20	9%	*	*	12	5%	11	5%	11	4%	14	67%	3	2%
Chronic medical condition	11	4%	12	6%	10	4%	11	5%	7	5%	16	6%	8	4%	6	5%
Chromosomal, genetic and congenital abnormalities	70	26%	50	235	68	26%	56	24%	60	24%	67	24%	41	20%	29	23%
Perinatal or neonatal event	97	37%	81	38%	97	37%	78	33%	93	33%	102	37%	66	32%	41	32%
Infection	18	7%	*	*	12	5%	18	8%	7	8%	12	4%	17	8%	9	8%
Sudden unexpected or unexplained death	20	7%	10	5%	19	7%	24	10%	16	10%	19	7%	20	9%	20	16%

NCMD
National Child Mortality Database
Knowledge, understanding and learning to improve young lives

Child Death Review Data: Year ending 31 March 2020

November 2020

HQIP
Healthcare Quality Improvement Partnership

Contact us

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- Follow us on Twitter: @NCMD_England

Acknowledgements

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Table of contents

1. Introduction

Child death review (CDR) processes are mandatory for Child Death Review Partners (CDR Partners) in England. The CDR process has been in place in England since 1 April 2008 and was previously the responsibility of Local Safeguarding Children Boards (LSCBs). CDR Partners are responsible for reviewing the deaths of all children up to the age of 18. This function is carried out through local Child Death Overview Panels (CDOPs). The overall purpose is to understand why children die and to put in place interventions to protect other children and reduce the risk of future deaths.

In 2018, the Department of Health and Social Care (DHSC) published new and revised statutory and operational guidance related to CDR. The new guidance requires all CDR partners to gather information from every agency that has had contact with the child, during their life and after their death, including health and social care services, law enforcement, and education services. This is done using a set of statutory CDR forms.

The National Child Mortality Database (NCMD) launched on 1 April 2019 and collates data collected by CDOPs in England from reviews of all children, who die at any time after birth before their 18th birthday. There is a statutory requirement for CDOPs to collect this data and to provide it to the NCMD.

The data in this report covers the number of reviews of children whose death was reviewed by a CDOP between 1 April 2019 and 31 March 2020. It should be read in conjunction with the following two data tables:

- Reference Tables – "Child Death Reviews Data (year ending 31 March 2020)"
- Table 1 CSV data

These data have been published for a number of years and are used by CDOPs to inform the production of their local annual reports. Data for 2018/19 and 2017/18 was published by NHS Digital and prior to that it was published by Department for Education. The format has been kept consistent with previous publications, however due to a change in data collection processes there are a few changes which are listed in Section 6. Additionally, it reports the number of notifications of children that died between 1 April 2019 and 31 March 2020.

The second NCMD annual report will follow this publication in Spring 2021 to include detailed analysis along with key messages and recommendations informed by the data and in consultation with the NCMD stakeholder professional and public representation groups.

2. Deaths occurring between 1 April 2019 and 31 March 2020

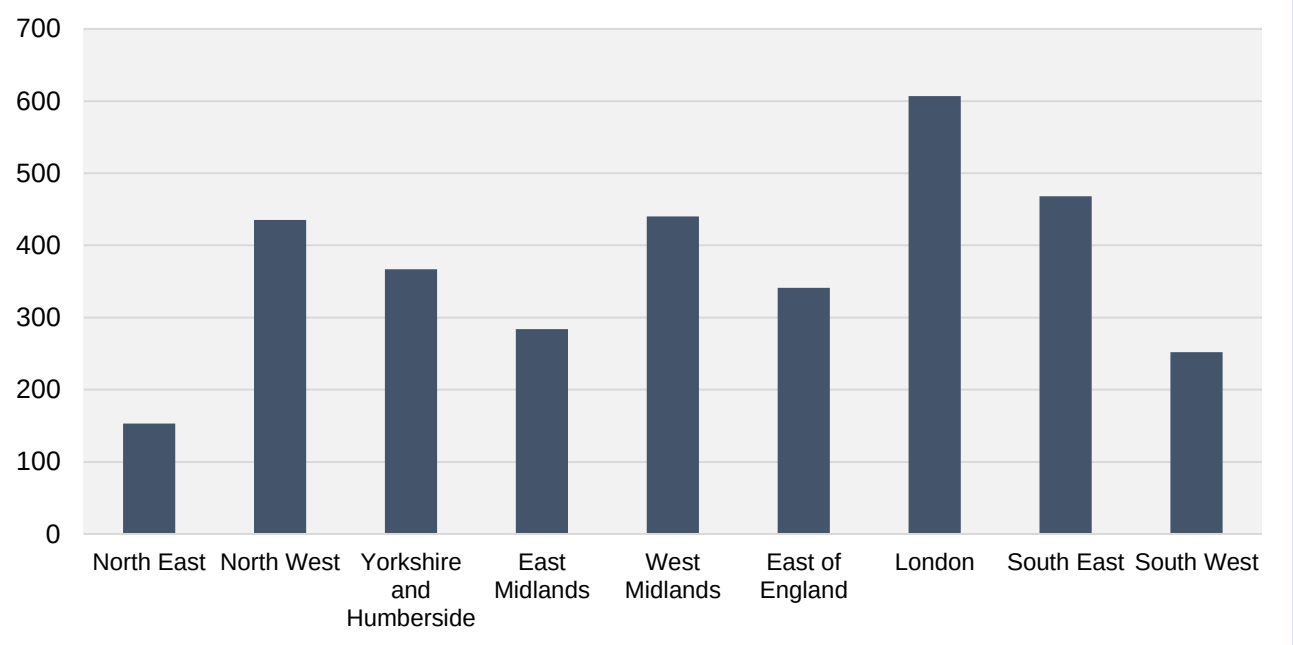
This section of the report focuses on the number of child death notifications received by NCMD where the child died between 1 April 2019 and 31 March 2020.

The number of child death notifications (Reference Table 1)

The NCMD received **3,347** child death notifications from CDOPs in England where the child died between 1 April 2019 and 31 March 2020. CDOPs in the London region submitted the most child death notifications to NCMD (607), where the North East region submitted the least number of notifications (153).

A more detailed breakdown of notification data will be available within the second NCMD Annual Report.

Figure 1: The number of child death notifications received by Child Death Overview Panels by region, Year ending 31 March 2020



3. Deaths reviewed between 1 April 2019 and 31 March 2020

This section of the report presents the number of child death reviews completed by CDOPs between 1 April 2019 and 31 March 2020. It is important to note that the CDOP review of the child death may not be completed in the same year as when the death occurred. Therefore, the population of children reported in Section 2 partially overlap but is distinct from the population of children described in this section of the report.

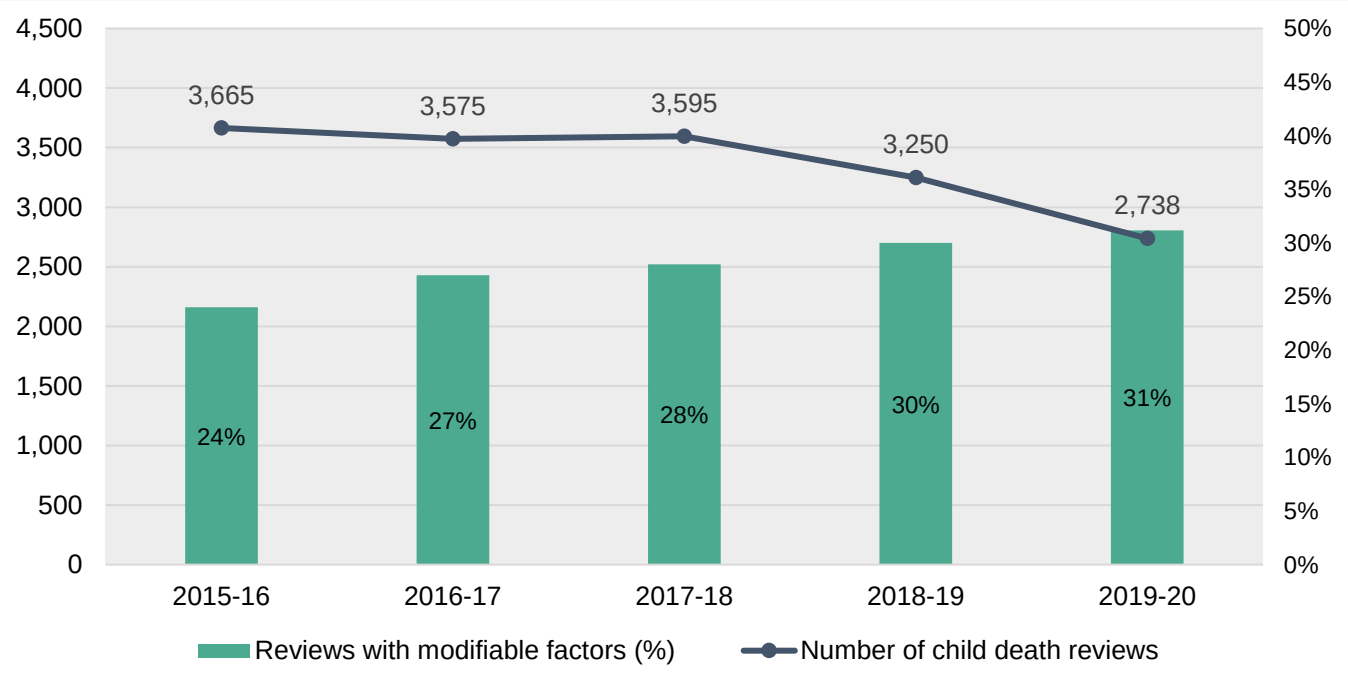
During the child death review the CDOP is responsible for identifying any modifiable factors in relation to the child's death. A modifiable factor is defined as any factor which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

The number of child death reviews (Reference Table 1)

2,738 child deaths were reviewed in England between 1 April 2019 and 31 March 2020, which is a decrease of 512 (16%) in comparison to the previous reporting year. The decrease in the number of reviews for 2019-20 is likely because fewer CDOP meetings took place whilst they were working under transitional arrangements. In addition, many CDOP meetings were cancelled in March 2020 due to the response to the COVID-19 pandemic.

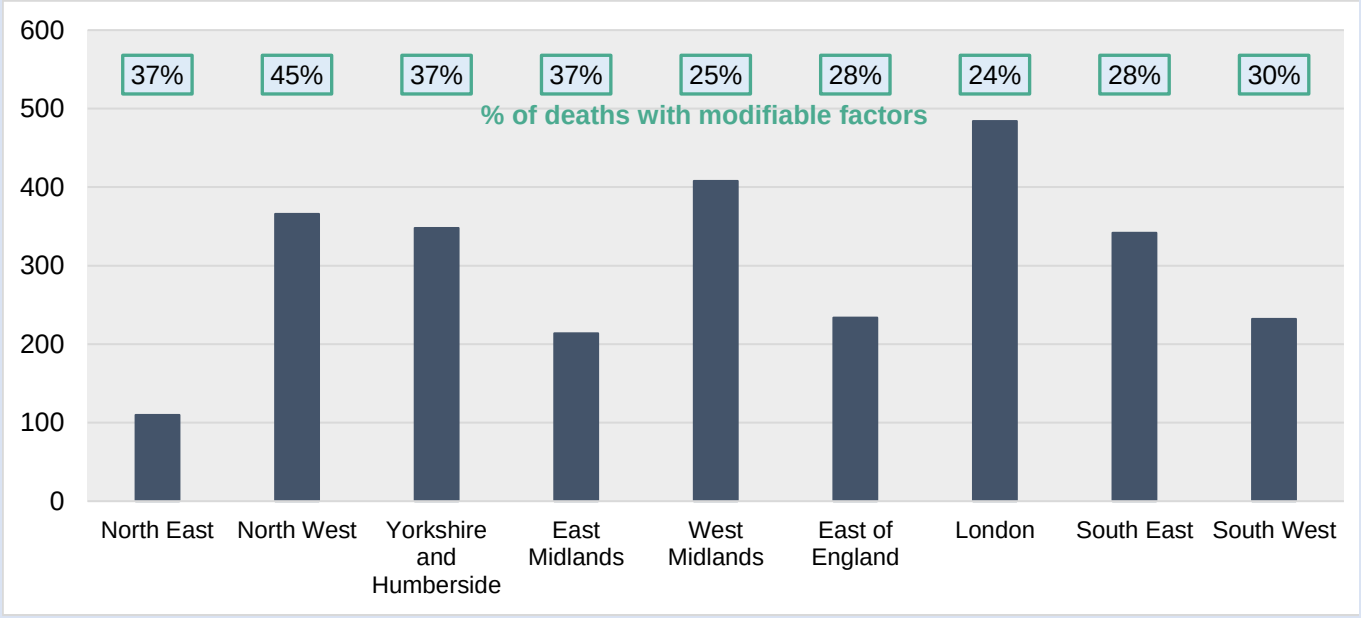
862 (31%) of these reviews identified one or more modifiable factors. This percentage is comparable to the figure reported in 2018-19, but the proportion of cases identified with modifiable factors has increased by 7% since 2015-16.

Figure 2: The number of child death reviews completed by Child Death Overview Panels in England, Year ending 31 March 2020



CDOPs in London reviewed the most child deaths (484), where the North East reviewed the least (110) which is consistent with the number of notifications submitted to NCMD. CDOPs in the North West identified the highest proportion (45%) of modifiable factors in the child death reviews they completed, where London reported the lowest proportion of cases with modifiable factors (24%).

Figure 3: The number of child death reviews completed by Child Death Overview Panels and the proportion of cases with modifiable factors identified by Region, Year ending 31 March 2020



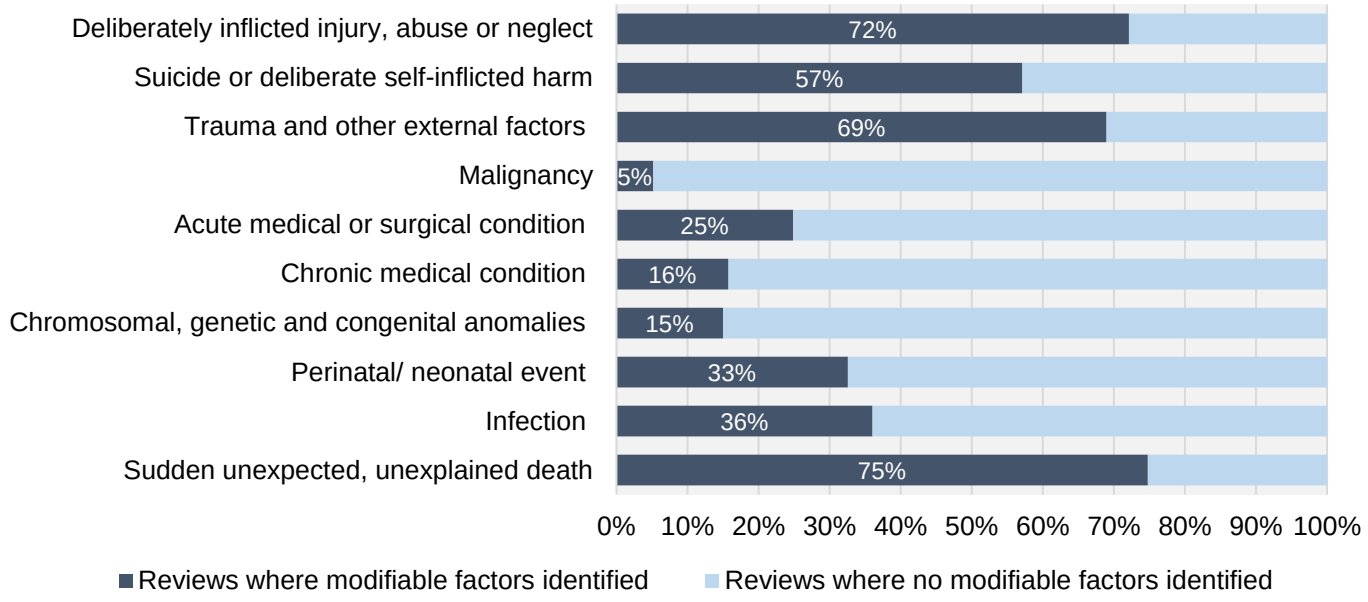
Category of death (Reference Table 4)

CDOPs are required to assign a category of death to each death reviewed within the Analysis Form, the final output of the child death review process. The classification of categories is hierarchical where the uppermost selected category is recorded as the primary category should more than one category be selected.

851 reviews (31%) recorded a primary category of “Perinatal/neonatal event”, and a further 674 reviews (25%) recorded a primary category of “Chromosomal, genetic and congenital anomalies”. These two categories combined represent over half (56%) of reviews completed.

Deaths with a primary category of “Sudden unexpected and unexplained” had the highest proportion (75%) of deaths identified as having modifiable factors, closely followed by deaths with a primary category of “Deliberately inflicted injury, abuse or neglect” (72%). Deaths with a primary category of “Malignancy” had the lowest proportion (5%) of deaths identified as having modifiable factors. This is consistent with previous years’ data.

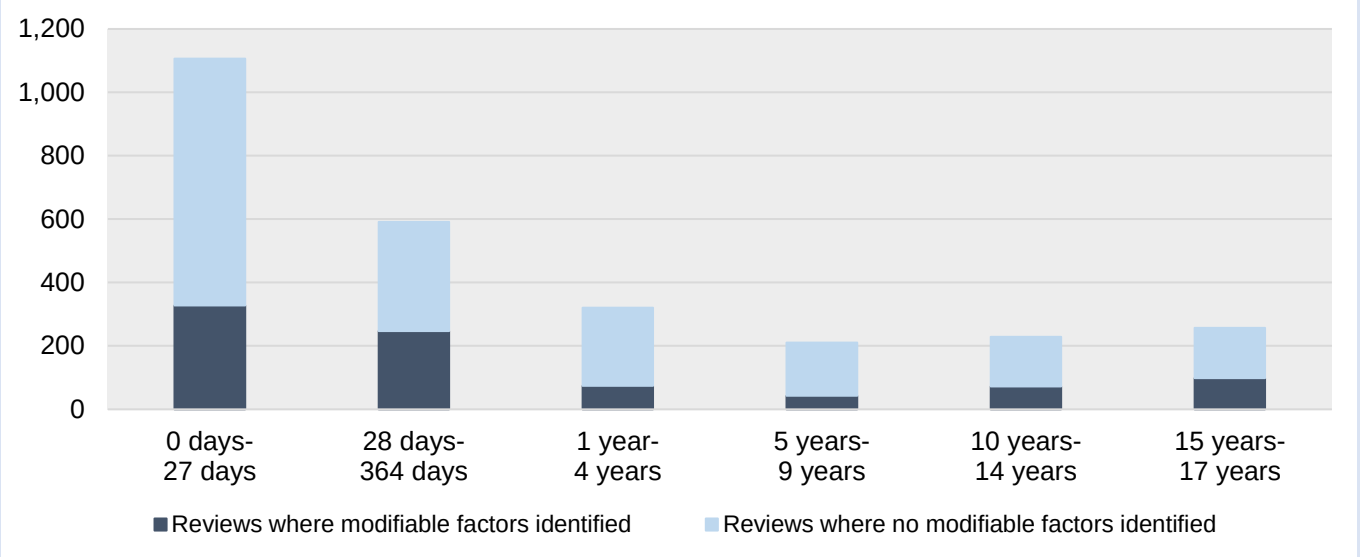
Figure 4: The proportion of child death reviews completed by Child Death Overview Panels with modifiable factors identified by primary category of death, Year ending 31 March 2020



Demographics (Reference Table 9)

Deaths occurring in the neonatal period (0–27 days) represented the largest proportion of deaths reviewed (n=1106, 41%) and a further 591 (22%) deaths were within the 28-364 days age group. Together, deaths where the child was aged under 1 represented 63% of child deaths reviewed during 2019-20. The largest proportion of cases with modifiable factors identified was the 28-364 days age group (42%), where the lowest proportion was in the 5-9 years age group (20%).

Figure 5: The number of child death reviews completed by Child Death Overview Panels by age group, Year ending 31 March 2020



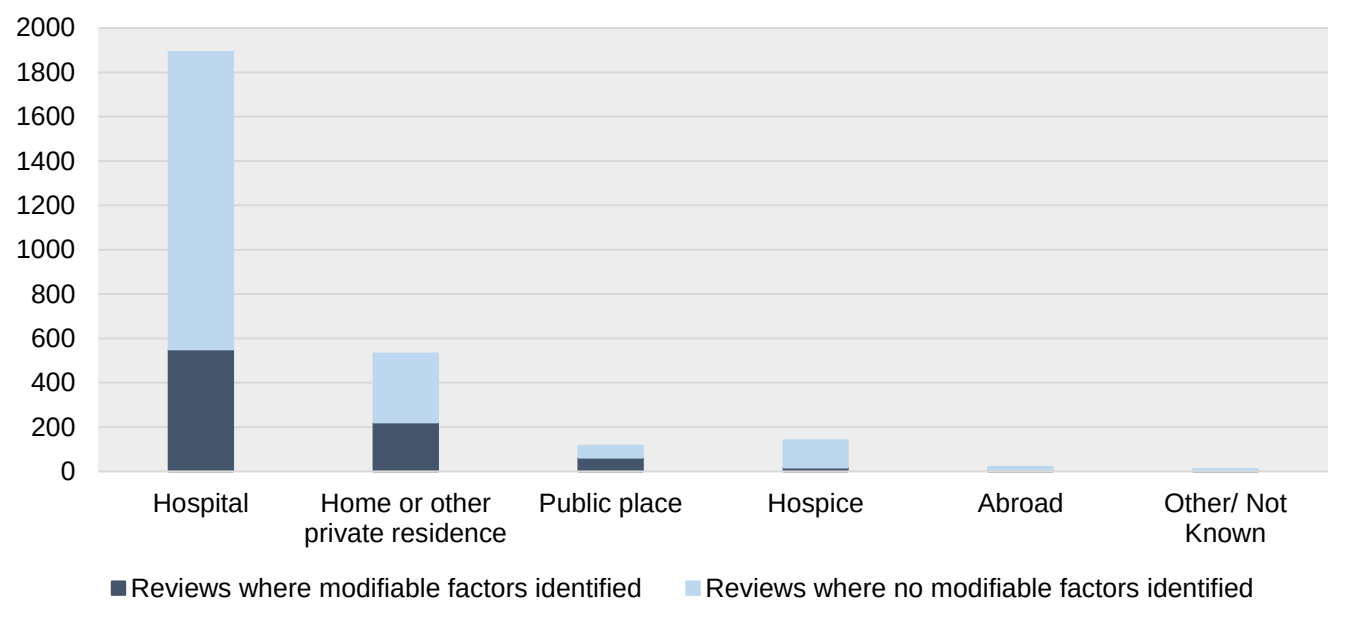
Males represented just over half of child death reviews (56%) and had the same proportion of deaths identified as having modifiable factors to females (32%).

1,570 reviews were completed of deaths of children from a White background, accounting for 65% of reviews completed where the child's ethnicity was recorded. By contrast, 760 (31%) of the deaths reviewed were for children from a Black, Mixed or Asian ethnic background.

Location (Reference Table 6)

1,892 (70%) of the deaths reviewed occurred in a Hospital Trust and 532 (20%) of deaths reviewed had occurred at Home or another private residence. The highest proportion of deaths with modifiable factors could be seen in deaths that occurred in a public place (54%). The lowest proportion of deaths with modifiable factors was seen in deaths that occurred in a Hospice (13%).

Figure 6: The number of child death reviews completed by Child Death Overview Panels by location at the time of event or illness, Year ending 31 March 2020



School not presented in the figure due to low numbers

Child Safeguarding Practice Review (Reference Table 7)

A Child Safeguarding Practice Review (previously Serious Case Review) is conducted when a child is seriously harmed, or dies, as a result of abuse or neglect. The review identifies how local professionals and organisations can improve the way they work together. Out of the number of child death reviews completed throughout the year, the NCMD received information that a Child Safeguarding Practice Review was carried out for at least 48 child deaths. Of these, 79% identified modifiable factors in the review.

Social care (Reference Table 8)

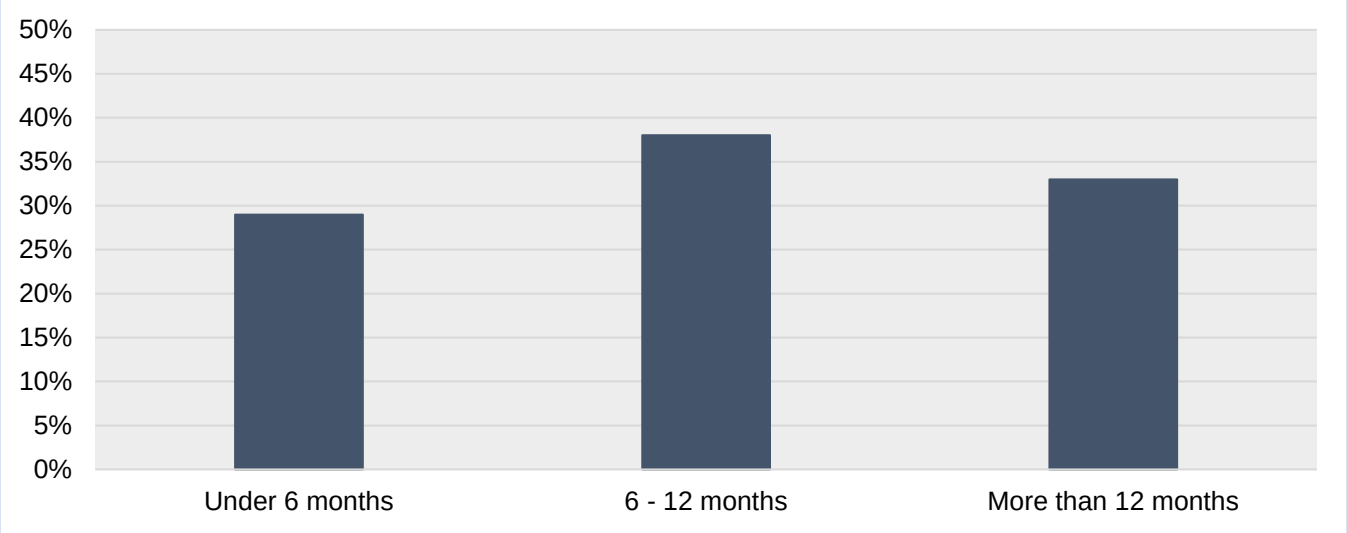
The NCMD received information on 253 children whose death was reviewed during the year were known to social care at the time of their death. Of these, 41% had modifiable factors identified in the review. See Table 8 for a detailed breakdown of how these children were known to social care.

Duration of reviews (Reference Table 2 & Reference Table 3)

740 (27%) reviews completed by CDOPs were of children who died between 1 April 2019 and 31 March 2020, while 1,998 (73%) reviews were of children who died during previous years.

776 (29%) reviews were finalised within 6 months of the child's death, while 1,806 (67%) of the reviews were finalised within 12 months of the child's death. The 909 (33%) reviews that took over 12 months to complete presented the highest proportion of reviews where modifiable factors were identified (44%), compared to 17% for reviews taking under 6 months. There are a number of factors that may contribute to a longer length of time between the death of a child and CDOP review, for example; the return of reporting forms, the receipt of the final post mortem report, undertaking of a criminal investigation or a Child Safeguarding Practice Review, and receipt of the final report from the local child death review meeting. In addition, on occasion when the outcome of a Coroner's inquest is awaited, there may be a longer delay before a case can be reviewed by the CDOP.

Figure 7: The percentage of reviews completed by Child Death Overview Panels by the number of months between the date of death and the date of the Child Death Overview Panel meeting, Year ending 31 March 2020



4. List of Reference Tables

Table 1	Number of child death reviews completed by Child Death Overview Panels by region
Table 2	Number of child death reviews completed by Child Death Overview Panels by the year in which the child death occurred
Table 3	Time between the death of a child and the completion of the CDOP review
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Table 7	Number of reviews completed by Child Death Overview Panels by Child Safeguarding Practice Review (previously Serious Case Review) status
Table 8	Number of reviews completed by Child Death Overview Panels by Social Care status
Table 9	Number of reviews completed by Child Death Overview Panels by age of the child at the time of death, gender and ethnicity
LAA to region mapping	Mapping of local authority areas to regions
Disclosure and methodology	Description of the methodology used in the CSV and Data tables
Data descriptions	Contains information and field definitions about the accompanying CSV file

All Reference Tables can be found here.

5. Further information

Child death reviews: Year ending 31 March	Previous versions of this publication can be found at the following websites: 2018 and 2019: https://digital.nhs.uk/data-and-information/publications/statistical/child-death-reviews/2019 2017 and earlier: https://www.gov.uk/government/collections/statistics-child-death-reviews
Child death review forms	The data collection forms used to gather information on child deaths can be found here: https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths
Child death review statutory and operational guidance	The child death review statutory and operational guidance can be found here: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england
Child death review process	For information on the child death review processes, see Chapter 5 of the 'Working Together to Safeguard Children' document which can be found here: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

6. Technical information

Data in this report represents data that was submitted to the NCMD. As a newly established continuing data collection and with some transitional arrangements still ongoing, more data may be submitted retrospectively, and the figures represented here may change.

All data was checked by the NCMD team prior to data analysis. This includes exclusion of cases that did not meet the criteria for CDOP review and removal of any duplicates.

From May - July 2020 the NCMD team contacted CDOPs to confirm that the data held was correct:

- 52 CDOPs confirmed that the data held was correct
- 3 CDOPs were unable to submit so partial data (i.e. only data which they had submitted) were included for analysis
- For a further 3 CDOPs, the NCMD team was unable to confirm whether the data submitted was correct. These data have been included but are unconfirmed.

Data was downloaded on 30 September 2020.

In a small number of cases (23 reviews in the year ending 31 March 2020), panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. These cases have been included in the number of reviews completed in Tables 1 and 2 but excluded from Tables 3 to 9. This methodology was kept consistent with previous years' publications.

Changes to previous publications

Data on children subject to a statutory order has been withdrawn from the data collection process, and therefore this table is no longer published.

The number of times which CDOPs met and the number of child deaths where the child was not normally resident within the Local Safeguarding Children Board area and are not reported within this publication.

Table 1 now presents data on notifications submitted to the NCMD, rather than death registration data from ONS.

Table 3 has been grouped into smaller timeframes to improve presentation of this data.

Table 5 and 6 now present slightly different categories to represent changes in data collection.

Table 8 has been changed due to a change in the structure of how this question is now asked within the data collection forms.

Table 9 was previously presented as Table 10 in previous publications.

For further information on NCMD data processing please see our Privacy Notice.

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Child Death Reviews Data: year ending 31 March 2020

(previously LSCB1 data collection)

Published: 12th November 2020

Introduction

This analysis focuses on the number of child death reviews completed and the decisions made by Child Death Overview Panels (CDOPs) on behalf of their CDR Partners in England. The tables included show child death reviews completed within the year, including modifiable factors, child characteristics and circumstances of the death. These tables should be read in conjunction with the descriptive report titled "Child Death Reviews Data (year ending 31 March 2020)" which has been published simultaneously on the NCMD website.

Note: Figures prior to year ending March 2018 were published by Department for Education and figures in year ending March 2018 and 2019 were published by NHS Digital.

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Table 1: Number of child death[1] reviews completed by Child Death Overview Panels by region
Years ending 31 March 2016 to 2020
Coverage: England

NCMD
National Child Mortality Database

	Number of child death reviews which were completed in the year ending 31 March[2,3]					Number of child death reviews completed which were assessed as having modifiable factors in the year ending 31 March[2,4]					Proportion of all completed child deaths reviewed which were assessed as having modifiable factors in the year ending 31 March[2,4]					Number of notifications received where the death occurred in the year ending 31 March
	2016	2017	2018	2019	2020	2016	2017	2018	2019	2020	2016	2017	2018	2019	2020	2020
England	3,665	3,575	3,595	3,250	2,738	863	974	1,015	965	862	24%	27%	28%	30%	31%	3,347
Region[5]																
North East	151	157	130	135	110	27	39	45	35	41	18%	25%	33%	25%	37%	153
North West	546	582	565	490	366	161	176	215	200	164	29%	30%	38%	41%	45%	435
Yorkshire and Humberside	407	414	380	315	348	115	126	130	100	128	28%	30%	34%	31%	37%	367
East Midlands	296	280	310	230	214	67	74	95	65	79	23%	26%	31%	27%	37%	284
West Midlands	489	444	595	485	408	96	125	150	140	102	20%	28%	25%	28%	25%	440
East of England	358	303	300	305	234	108	98	85	70	66	30%	32%	29%	22%	28%	341
London	555	600	605	600	484	108	125	125	170	116	19%	21%	21%	28%	24%	607
South East	545	500	455	465	342	91	130	110	115	96	17%	26%	25%	25%	28%	468
South West	318	295	255	225	232	90	81	60	80	70	28%	27%	24%	37%	30%	252

Source: LSCB1, NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. Figures prior to 2018 are shown to the nearest whole number. For 2018, all figures are rounded to nearest 5; therefore, subtotals may not add to totals due to rounding. Percentages are shown rounded to the nearest whole number and have been derived from unsuppressed figures.

3. Please note that not all child deaths which occur each year will have their child death review completed by 31 March. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.

4. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths. The denominator for the percentage is the number of all deaths reviewed. There were 23 deaths in 2020 where it was not known if there were modifiable factors. In 2019, there were 35 deaths (rounded), in 2018, there were 55 deaths (rounded), in 2017, there were 20 such deaths, in 2016, there were 39, and in 2015 there were 31.

5. Region definitions can be found on the tab: 'LAA to Region mapping'

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Table 2: Number of reviews completed by Child Death Overview Panels by the year in which the child death occurred
Years ending 31 March 2016 to 2020
Coverage: England

	Number[2] of child death reviews completed in the year ending 31 March[3]		
	Where the death occurred prior to the start of the year ending 31 March	Where the death occurred during the year ending 31 March	All child death reviews completed in year ending 31 March
2016	2,412	1,253	3,665
2017	2,280	1,295	3,575
2018	2,260	1,335	3,595
2019	2,080	1,170	3,250
2020	1,998	740	2,738
The number of which were assessed as having modifiable factors[4]:			
2016	663	200	863
2017	733	241	974
2018	690	320	1,015
2019	705	260	965
2020	707	155	862
Proportion of completed reviews which were assessed as having modifiable factors[2,4]:			
2016	27%	16%	24%
2017	32%	19%	27%
2018	31%	24%	28%
2019	34%	22%	30%
2020	35%	21%	31%

Source: LSCB1, NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.
2. Figures prior to 2018 are shown to the nearest whole numbers. From 2018, all figures are rounded to nearest 5; therefore, subtotals may not add to totals due to rounding. Percentages are shown rounded to the nearest whole numbers and have been derived from unsuppressed figures.
3. Please note that not all child deaths which occur each year will have their child death review completed by 31 March. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.
4. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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Table 3: Time between the death of a child and the completion of the CDOP review

Year ending 31 March 2020
Coverage: England

Length of time	All child death reviews completed in the year ending 31 March[2]			Percentage[2] of this length of time with:			*Percentage of reviews in each year by duration*
	Modifiable factors identified[3]	No modifiable factors identified[3]	Total	Modifiable factors identified[3]	No modifiable factors identified[3]	Total	
Under 6 months	130	646	776	17%	83%	100%	29%
6-12 months	335	695	1,030	33%	67%	100%	38%
More than 12 months	397	512	909	44%	56%	100%	33%
All	862	1,853	2,715	32%	68%	100%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.
2. Please note that not all child deaths which occur each year will have their child death review completed by 31 March. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.
3. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Table 4: Number of reviews completed by Child Death Overview Panels by category of death
Year ending 31 March 2020
Coverage: England

	Category of death[2]										
	Deliberately inflicted injury, abuse or neglect	Suicide or deliberate self-inflicted harm	Trauma and other external factors	Malignancy	Acute medical or surgical condition	Chronic medical condition	Chromosomal, genetic and congenital anomalies	Perinatal/ neonatal event	Infection	Sudden unexpected, unexplained death	All child death reviews completed in year ending 31 March 2020
All child death reviews completed in the year ending 31 March 2020[3]											
Number of which had:											
Modifiable factors identified[3]	43	60	80	11	43	21	101	277	62	164	862
No modifiable factors identified[3]	17	45	36	201	130	112	573	574	110	55	1,853
TOTAL	60	105	116	212	173	133	674	851	172	219	2,715
Percentage of this category of death which had:											
Modifiable factors identified[4]	72%	57%	69%	5%	25%	16%	15%	33%	36%	75%	32%
No modifiable factors identified[4]	28%	43%	31%	95%	75%	84%	85%	67%	64%	25%	68%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of each category of death under this assessment:											
Modifiable factors identified[4]	5%	7%	9%	1%	5%	2%	12%	32%	7%	19%	100%
No modifiable factors identified[4]	1%	2%	2%	11%	7%	6%	31%	31%	6%	3%	100%
Of all deaths	2%	4%	4%	8%	6%	5%	25%	31%	6%	8%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. Category of death and event are recorded at different times in the review process and there may be deaths where it was not possible to determine the intent and so classifications may differ. The number of deaths recorded as "suicide or deliberate self-inflicted harm" may be different to the number of deaths recorded as "apparent suicide" in Table 5. Similarly, the number of deaths recorded as "perinatal/neonatal event" may be different to the number recorded as "neonatal death" in Table 5.

3. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

4. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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Table 5: Number of reviews completed by Child Death Overview Panels by event which caused the child's death
Year ending 31 March 2020
Coverage: England

NCMD
National Child Mortality Database

	Event which caused the child's death[7]																			
	Neonatal death[8]	Known life limiting condition[6]	Sudden unexpected death in infancy	Vehicle collision	Drowning	Fire, burns or electrocution	Poisoning	Other non-intentional injury/ accident/ trauma	Apparent violent related death[2]	Apparent suicide[3] or self harm	Acute epilepsy	Acute asthma or anaphylaxis	Acute metabolic diabetic ketoacidosis	Cardiac congenital or acquired	Other chromosomal, genetic, or congenital anomaly	Infection	Oncology condition	Other	Unknown	All child death reviews completed in year ending 31 March 2020
All child death reviews completed in the year ending 31 March 2020[4]																				
Number of which had:																				
Modifiable factors identified[5]	290	18	151	35	7	6	*	21	42	61	5	11	*	33	90	54	11	10	11	862
No modifiable factors identified[5]	589	52	48	20	6	*	*	8	23	47	28	5	*	243	439	91	211	31	10	1,853
Total	879	70	199	55	13	6	*	29	65	108	33	16	5	276	529	145	222	41	21	2,715
Percentage of this event which had:																				
Modifiable factors identified[5]	33%	26%	76%	64%	54%	100%	100%	72%	65%	56%	15%	69%	60%	12%	17%	37%	5%	24%	52%	32%
No modifiable factors identified[5]	67%	74%	24%	36%	46%	0%	0%	28%	35%	44%	85%	31%	40%	88%	83%	63%	95%	76%	48%	68%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of each event under this assessment:																				
Modifiable factors identified[5]	34%	2%	18%	4%	1%	1%	-	2%	5%	7%	1%	1%	-	4%	10%	6%	1%	1%	1%	100%
No modifiable factors identified[5]	32%	3%	3%	1%	-	-	-	-	1%	3%	2%	-	-	13%	24%	5%	11%	2%	1%	100%
Of all deaths	32%	3%	7%	2%	-	-	-	1%	2%	4%	1%	1%	-	10%	19%	5%	8%	2%	1%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. A violent related death may be assessed as having no modifiable factors if the panel determines that the homicide was unforeseen, for example a random act where there were no previous concerns about the suspect.

3. Category of death and event are recorded at different times in the review process and there may be deaths where it was not possible to determine the intent and so classifications may differ. The number of deaths recorded as "apparent suicide" may be different to the number of deaths recorded as "suicide or deliberate self-inflicted harm" in Table 4. Similarly, the number of deaths recorded as "neonatal death" may be different to the number recorded as "perinatal/neonatal event" in Table 4.

4. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

5. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

6. Due to a change in data collection and more granular categories reported in the year ending 31 March 2020, Known life limiting condition presents less data than in previous years.

7. Due to a change in data collection, NCMD validated this data to improve data quality.

8. A neonatal death is related to neonatal or perinatal events.

Table 6: Number of reviews completed by Child Death Overview Panels by location at time of the event or illness which led to the death

Year ending 31 March 2020

Coverage: England

	Location at time of the event or illness							
	Hospital	Home or other private residence	Public place	School	Hospice	Abroad	Other/ Not Known	All child death reviews completed in year ending 31 March 2020
All child death reviews completed in the year ending 31 March 2020[2]								
Number of which had:								
Modifiable factors identified[3]	550	222	63	*	18	6	*	862
No modifiable factors identified[3]	1,342	310	53	*	123	14	9	1,853
Total	1,892	532	116	*	141	20	11	2,715
Percentage of deaths in this location which had:								
Modifiable factors identified[3]	29%	42%	54%	33%	13%	30%	18%	32%
No modifiable factors identified[3]	71%	58%	46%	67%	87%	70%	82%	68%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of each location under this assessment:								
Modifiable factors identified[3]	64%	26%	7%	-	2%	1%	-	100%
No modifiable factors identified[3]	72%	17%	3%	-	7%	1%	-	100%
Of all deaths	70%	20%	4%	-	5%	1%	-	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. In the year ending 31 March 2020, there were 23 deaths where panels has insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

3. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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Table 7: Number of reviews completed by Child Death Overview Panels by Child Safeguarding Practice Review (previously Serious Case Review) status[2,3,4]

Years ending 31 March 2016 to 2020

Coverage: England

Child Safeguarding Practice Review status		All child death reviews completed in the year ending 31 March			Percentage of this Child Safeguarding Practice Review status with:			*Percentage of reviews in each year by Serious Case Review status*
		Modifiable factors identified[5]	No modifiable factors identified[5]	Total	Modifiable factors identified[5]	No modifiable factors identified[5]	Total	
A Child Safeguarding Practice Review did not take place	2016	784	2,677	3,461	23%	77%	100%	95%
	2017	914	2,545	3,459	26%	74%	100%	97%
	2018	865	2,345	3,215	27%	73%	100%	91%
	2019	870	2,115	2,980	29%	71%	100%	93%
	2020	776	1,648	2,424	32%	68%	100%	89%
A Child Safeguarding Practice Review took place	2016	62	54	116	53%	47%	100%	3%
	2017	59	35	94	63%	37%	100%	3%
	2018	65	25	90	74%	26%	100%	3%
	2019	60	10	75	85%	15%	100%	2%
	2020	38	10	48	79%	21%	100%	2%
Unknown[6,7]	2016	17	32	49	35%	65%	100%	1%
	2017	1	1	2	50%	50%	100%	-
	2018	80	155	235	34%	66%	100%	7%
	2019	35	125	160	22%	78%	100%	5%
	2020	48	195	243	20%	80%	100%	9%
All	2016	863	2,763	3,626	24%	76%	100%	100%
	2017	974	2,581	3,555	27%	73%	100%	100%
	2018	1,015	2,525	3,540	29%	71%	100%	100%
	2019	965	2,250	3,215	30%	70%	100%	100%
	2020	862	1,853	2,715	32%	68%	100%	100%

Source: LSCB1, NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. Figures prior to 2018 are shown to the nearest whole numbers. For 2018, all figures are rounded to nearest 5; therefore, subtotals may not add to totals due to rounding. Percentages are shown rounded to the nearest whole numbers and have been derived from unsuppressed figures.

3. "-" represents percentages less than 0.5% but greater than 0%.

4. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

5. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

6. It was unknown if the death resulted in serious case review. This may because this information is not collected by the panel or the information collected is not in the required format.

7. Due to submission issues in 2018 and 2019, there were more 'Unknowns' for SCR status

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Table 8: Number of reviews completed by Child Death Overview Panels by Social Care status[2,4]
Year ending 31 March 2020
Coverage: England

Known to Social Care		All child death reviews completed in the year ending 31 March			Percentage of this status with			*Percentage of reviews in each year by status*
		Modifiable factors identified[3]	No modifiable factors identified[3]	Total	Modifiable factors identified[3]	No modifiable factors identified[3]	Total	
Yes		**104**	**149**	**253**	**41%**	**59%**	**100%**	**9%**
	Child protection plan[5]	32	9	41	78%	22%	100%	-
	Looked after child[5]	12	13	25	48%	52%	100%	-
	Child in need[5]	31	74	105	30%	70%	100%	-
	Other[5]	47	70	117	40%	60%	100%	-
Previously, but not at time of death		**78**	**96**	**174**	**45%**	**55%**	**100%**	**6%**
Not at all		**407**	**1,022**	**1,429**	**28%**	**72%**	**100%**	**53%**
Unknown[6]		**273**	**586**	**859**	**32%**	**68%**	**100%**	**32%**
All		**862**	**1,853**	**2,715**	**32%**	**68%**	**100%**	**100%**

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

3. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

4. Due to a change in the way in which this question is answered following a change in CDR processes in the year ending 31 March 2020, it is not possible to compare this table to previous years. The deaths reviewed in the year ending 31 March 2020 will have used both the old and new data collection process, depending on when the child died. For children who died before 1 April 2019, CDOPs collected 'Was the child on a child protection plan?' with the following options: At the time of death; Previously, but not at time of death; Not at all; Unknown. From 1 April 2019, the question changed to 'Was the child known to children's social care prior to their death/the event leading to their death?' with the following options where more than one could be selected: Yes on a child protection plan; Yes, as a looked after child; Yes, as a child in need; Yes, as an asylum seeker; Yes, other; Previously known, but not an open case; No; Unknown

5. Each child death review included under 'Yes' can be known to social care in multiple ways and therefore these totals will not sum to the total of child death reviews reported under 'Yes'.

6. Due to a change in data collection and CDR processes in the year ending 31 March 2020, there were more 'Unknowns' for social care status.

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Table 9: Number of reviews completed by Child Death Overview Panels by age of the child at the time of death, gender and ethnicity

Year ending 31 March 2020

Coverage: England

	Age of the child at the time of death						Gender			Ethnicity						All child death reviews completed in year ending 31 March 2020
	0 days-27 days	28 days-364 days	1 year-4 years	5 years-9 years	10 years-14 years	15 years-17 years	Male	Female	Unknown/ Indeterminate	White	Mixed	Asian	Black	Other	Unknown/ not stated	
All child death reviews completed in the year ending 31 March 2020[2]																
Number of which had:																
Modifiable factors identified[3]	328	247	74	43	72	98	482	379	*	562	47	97	43	21	92	862
No modifiable factors identified[3]	778	344	247	168	157	159	1,039	797	17	1,008	89	336	148	66	206	1,853
Total	1,106	591	321	211	229	257	1,521	1,176	18	1,570	136	433	191	87	298	2,715
Percentage of this age group/gender/ethnicity which had:																
Modifiable factors identified[3]	30%	42%	23%	20%	31%	38%	32%	32%	6%	36%	35%	22%	23%	24%	31%	32%
No modifiable factors identified[3]	70%	58%	77%	80%	69%	62%	68%	68%	94%	64%	65%	78%	77%	76%	69%	68%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of each age group/gender/ethnicity under this assessment:																
Modifiable factors identified[3]	38%	29%	9%	5%	8%	11%	56%	44%	-	65%	5%	11%	5%	2%	11%	100%
No modifiable factors identified[3]	42%	19%	13%	9%	8%	9%	56%	43%	1%	54%	5%	18%	8%	4%	11%	100%
Of all deaths	41%	22%	12%	8%	8%	9%	56%	43%	1%	58%	5%	16%	7%	3%	11%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.
2. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.
3. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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Local Authority Area to Region mapping

Region	Child Death Overview Panel	Local Authority Area
East Midlands	Derby and Derbyshire	Derby
		Derbyshire
	Leicester, Leicestershire and Rutland	Leicester
		Leicestershire
		Rutland
	Lincolnshire	Lincolnshire
	Northamptonshire	Northamptonshire
	Nottinghamshire and Nottingham City	Nottingham
		Nottinghamshire
East of England	Bedfordshire	Bedford Borough
		Central Bedfordshire
		Luton
	Cambridge and Peterborough	Cambridgeshire
		Peterborough
	Hertfordshire	Hertfordshire
	Norfolk	Norfolk
	Southend, Essex and Thurrock	Essex
		Southend
		Thurrock
	Suffolk	Suffolk
London	North Central London	Barnet
		Camden
		Enfield
		Haringey
		Islington
	North East London	Barking and Dagenham
		Havering
		Redbridge
	North East London (WELC)	Hackney and City
		Newham
		Tower Hamlets
		Waltham Forest
	North West London	Brent
		Ealing
		Hammersmith and Fulham
		Harrow

London	North West London	Hillingdon
		Hounslow
		Kensington and Chelsea
		Westminster
	South East London BGL	Bexley
		Greenwich
		Lewisham
	South East London	Bromley
		Lambeth
		Southwark
	South West London	Croydon
		Kingston upon Thames
		Merton
		Richmond upon Thames
		Sutton
		Wandsworth
North East	Durham and Darlington	Darlington
		Durham
	North and South of Tyne	Gateshead
		Newcastle upon Tyne
		North Tyneside
		Northumberland
		South Tyneside
		Sunderland
	Tees	Hartlepool
		Middlesbrough
		Redcar and Cleveland
		Stockton on Tees
North West	Blackpool, Blackburn and Lancashire	Blackburn with Darwen
		Blackpool
		Lancashire
	Bolton, Salford and Wigan	Bolton
		Salford
		Wigan
	Bury, Rochdale and Oldham	Bury
		Oldham
		Rochdale
	Cumbria	Cumbria
	Manchester	Manchester
	Merseyside	Knowsley
		Liverpool
		Sefton
		St Helens
		Wirral
		Isle Of Man
	Pan Cheshire	Cheshire East
		Chester and Cheshire West

	Pan Cheshire	Halton
		Warrington
	Stockport, Tameside and Trafford	Stockport
		Tameside
		Trafford
South East	Hampshire and Isle of Wight	Hampshire
		Isle of Wight
		Portsmouth
		Southampton
	Kent and Medway	Kent
		Medway Towns
	Milton Keynes	Milton Keynes
	Oxfordshire and Buckinghamshire	Buckinghamshire
		Oxfordshire
	Pan Berkshire	Bracknell Forest
		Reading
		Slough
		West Berkshire
		Windsor and Maidenhead
		Wokingham
	Pan Sussex	Brighton and Hove
		East Sussex
		West Sussex
	Surrey	Surrey
South West	Gloucestershire	Gloucestershire
	Pan Dorset and Somerset	Bournemouth, Christchurch and Poole
		Dorset
		Somerset
	South West Peninsula	Cornwall
		Devon
		Isles of Scilly
		Plymouth
		Torbay
	Swindon and Wiltshire	Swindon
		Wiltshire
	West of England	Bath and North East Somerset
		City of Bristol
		North Somerset
		South Gloucestershire
West Midlands	Birmingham	Birmingham
	Black Country	Dudley
		Sandwell
		Walsall
		Wolverhampton
	Coventry, Warwickshire and Solihull	Coventry
		Solihull
		Warwickshire

	Herefordshire and Worcestershire	Herefordshire
		Worcestershire
	Shropshire, Telford and Wrekin	Shropshire
		Telford and Wrekin
	Stoke on Trent and Staffordshire	Staffordshire
		Stoke on Trent
Yorkshire and Humberside	Barnsley	Barnsley
	Bradford	Bradford
	Doncaster	Doncaster
	East Riding of Yorkshire	East Riding of Yorkshire
	Kingston upon Hull	Kingston upon Hull
	Leeds	Leeds
	Northern Lincolnshire	North East Lincolnshire
		North Lincolnshire
	Rotherham	Rotherham
	Sheffield	Sheffield
	Wakefield, Calderdale and Kirklees	Calderdale
		Kirklees
		Wakefield
	York City and North Yorkshire	North Yorkshire
		York City

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Disclosure control:

In order to minimise the disclosure risk associated with small numbers, we have applied the following controls to these tables:

- "*" denotes that a figure has been suppressed due to small numbers (less than 5, including zero)
- "-" denotes less than 0.5% but greater than 0%

Methodology

Data in this report represents data that was submitted to the NCMD. As a newly established continuing data collection and with some transitional arrangements still ongoing, more data may be submitted retrospectively and the figures represented here may change.

Figures reported are following data being checked by the NCMD team. This includes exclusion of cases that did not meet the criteria for CDOP review and removal of any duplicates.

From May - July 2020 the NCMD team contacted CDOPs to confirm that the data held was correct:
- 52 CDOPs confirmed that the data held was correct
- 3 CDOPs were unable to submit so partial data (i.e. only data which they had submitted) were included for analysis
- For a further 3 CDOPs, the NCMD team was unable to confirm whether the data submitted was correct. These data have been included but are unconfirmed.

Data was downloaded on 30th September 2020.

In a small number of cases (23 reviews in the year ending 31 March 2020), panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. These cases have been included in the number of reviews completed in Tables 1 and 2 but excluded from Tables 3 to 9. This methodology was kept to be consistent with previous years publications.

Changes to previous publications

Data on children subject to a statutory order has been withdrawn from the data collection process, and therefore this table is no longer published.

The number of times which CDOPs met and the number of child deaths where the child was not normally resident within the Local Safeguarding Children Board area are not reported within this publication.

Table 1 now presents data on notifications submitted to the NCMD, rather than death registration data from ONS.
Table 3 has been grouped into smaller timeframes to improve presentation of this data.
Table 5 and 6 now present slightly different categories to represent changes in data collection.
Table 8 has been changed due to a change in the structure of how this question is now asked within the data collection forms.
Table 9 was previously presented as Table 10 in previous publications.

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Data descriptions

The table below contains information and field definitions about the accompanying CSV file.

CSV data file column name	Description of field
Period	The reporting period
Geog_level	Geographical level breakdown (National, regional or local authority)
Geog_name	Geographical name breakdown
Review_total	Total number of child death reviews completed in the year ending 31 March 2020
Mod_total	Total number of child death reviews completed in the year ending 31 March 2020 where modifiable factors were identified in the review

Period	Geog_Level	Geog_name	Review_total		Mod_total	
2019-20	National	England		2738		862
2019-20	Region	North East		110		41
2019-20	Region	North West		366		164
2019-20	Region	Yorkshire and Humberside		348		128
2019-20	Region	East Midlands		214		79
2019-20	Region	West Midlands		408		102
2019-20	Region	East of England		234		66
2019-20	Region	London		484		116
2019-20	Region	South East		342		96
2019-20	Region	South West		232		70
2019-20	Local Authority Area	Barking and Dagenham		14	*	
2019-20	Local Authority Area	Barnet		20	*	
2019-20	Local Authority Area	Barnsley		17		7
2019-20	Local Authority Area	Bath and North East Somerset	*		*	
2019-20	Local Authority Area	Bedford Borough	*		*	
2019-20	Local Authority Area	Bexley		17	*	
2019-20	Local Authority Area	Birmingham		176		24
2019-20	Local Authority Area	Blackburn with Darwen	*		*	
2019-20	Local Authority Area	Blackpool	*		*	
2019-20	Local Authority Area	Bolton		8	*	
2019-20	Local Authority Area	Bournemouth, Christchurch and Poole		13	*	
2019-20	Local Authority Area	Bracknell Forest	*		*	
2019-20	Local Authority Area	Bradford		41		7
2019-20	Local Authority Area	Brent		19		5
2019-20	Local Authority Area	Brighton and Hove		7	*	
2019-20	Local Authority Area	Bromley		17		10
2019-20	Local Authority Area	Buckinghamshire		25		6
2019-20	Local Authority Area	Bury		7	*	
2019-20	Local Authority Area	Calderdale		8	*	
2019-20	Local Authority Area	Cambridgeshire		24		5
2019-20	Local Authority Area	Camden	*		*	
2019-20	Local Authority Area	Central Bedfordshire	*		*	
2019-20	Local Authority Area	Cheshire East		16		7
2019-20	Local Authority Area	Chester and Cheshire West		12	*	
2019-20	Local Authority Area	City of Bristol		19		5
2019-20	Local Authority Area	Cornwall		29		6
2019-20	Local Authority Area	Coventry		21	*	
2019-20	Local Authority Area	Croydon		32		9
2019-20	Local Authority Area	Cumbria		21		5
2019-20	Local Authority Area	Darlington	*		*	
2019-20	Local Authority Area	Derby	*		*	
2019-20	Local Authority Area	Derbyshire		50	*	
2019-20	Local Authority Area	Devon		31		6
2019-20	Local Authority Area	Doncaster		14		7
2019-20	Local Authority Area	Dorset		16		9
2019-20	Local Authority Area	Dudley		16		8
2019-20	Local Authority Area	Durham		17	*	
2019-20	Local Authority Area	Ealing		9		5
2019-20	Local Authority Area	East Riding of Yorkshire	*		*	
2019-20	Local Authority Area	East Sussex		12	*	
2019-20	Local Authority Area	Enfield		16	*	
2019-20	Local Authority Area	Essex		65		20
2019-20	Local Authority Area	Gateshead		5	*	
2019-20	Local Authority Area	Gloucestershire		23		7
2019-20	Local Authority Area	Greenwich		24		10
2019-20	Local Authority Area	Hackney and City		14	*	
2019-20	Local Authority Area	Halton	*		*	

2019-20	Local Authority Area	Hammersmith and Fulham		9	*		
2019-20	Local Authority Area	Hampshire		33		10	
2019-20	Local Authority Area	Haringey		18		6	
2019-20	Local Authority Area	Harrow		24	*		
2019-20	Local Authority Area	Hartlepool	*		*		
2019-20	Local Authority Area	Havering		8	*		
2019-20	Local Authority Area	Herefordshire		11	*		
2019-20	Local Authority Area	Hertfordshire		57		10	
2019-20	Local Authority Area	Hillingdon		22		10	
2019-20	Local Authority Area	Hounslow		25	*		
2019-20	Local Authority Area	Isle Of Man	*		*		
2019-20	Local Authority Area	Isle of Wight	*		*		
2019-20	Local Authority Area	Isles of Scilly	*		*		
2019-20	Local Authority Area	Islington	*		*		
2019-20	Local Authority Area	Kensington and Chelsea		10	*		
2019-20	Local Authority Area	Kent		74		19	
2019-20	Local Authority Area	Kingston upon Hull		10		5	
2019-20	Local Authority Area	Kingston upon Thames		7	*		
2019-20	Local Authority Area	Kirklees		34		21	
2019-20	Local Authority Area	Knowsley		12		9	
2019-20	Local Authority Area	Lambeth		10	*		
2019-20	Local Authority Area	Lancashire		86		38	
2019-20	Local Authority Area	Leeds		75		24	
2019-20	Local Authority Area	Leicester		17		11	
2019-20	Local Authority Area	Leicestershire		14		8	
2019-20	Local Authority Area	Lewisham		20		8	
2019-20	Local Authority Area	Lincolnshire		29		13	
2019-20	Local Authority Area	Liverpool		28		13	
2019-20	Local Authority Area	Luton	*		*		
2019-20	Local Authority Area	Manchester		41		15	
2019-20	Local Authority Area	Medway Towns		9	*		
2019-20	Local Authority Area	Merton	*		*		
2019-20	Local Authority Area	Middlesbrough		5	*		
2019-20	Local Authority Area	Milton Keynes		19	*		
2019-20	Local Authority Area	Newcastle upon Tyne		25		10	
2019-20	Local Authority Area	Newham		31		13	
2019-20	Local Authority Area	Norfolk		35		12	
2019-20	Local Authority Area	North East Lincolnshire		7	*		
2019-20	Local Authority Area	North Lincolnshire		5	*		
2019-20	Local Authority Area	North Somerset		8	*		
2019-20	Local Authority Area	North Tyneside		11		6	
2019-20	Local Authority Area	North Yorkshire		41		14	
2019-20	Local Authority Area	Northamptonshire		20	*		
2019-20	Local Authority Area	Northumberland		9	*		
2019-20	Local Authority Area	Nottingham		28		15	
2019-20	Local Authority Area	Nottinghamshire		56		26	
2019-20	Local Authority Area	Oldham		16		9	
2019-20	Local Authority Area	Oxfordshire		27		8	
2019-20	Local Authority Area	Peterborough		7	*		
2019-20	Local Authority Area	Plymouth		18		5	
2019-20	Local Authority Area	Portsmouth		10	*		
2019-20	Local Authority Area	Reading		5	*		
2019-20	Local Authority Area	Redbridge		22	*		
2019-20	Local Authority Area	Redcar and Cleveland	*		*		
2019-20	Local Authority Area	Richmond upon Thames		10	*		
2019-20	Local Authority Area	Rochdale		6		6	
2019-20	Local Authority Area	Rotherham		35		15	
2019-20	Local Authority Area	Rutland	*		*		

2019-20	Local Authority Area	Salford		9	*	
2019-20	Local Authority Area	Sandwell		28		6
2019-20	Local Authority Area	Sefton		9		6
2019-20	Local Authority Area	Sheffield		39		14
2019-20	Local Authority Area	Shropshire		12		8
2019-20	Local Authority Area	Slough		6	*	
2019-20	Local Authority Area	Solihull		8	*	
2019-20	Local Authority Area	Somerset		25		8
2019-20	Local Authority Area	South Gloucestershire		14	*	
2019-20	Local Authority Area	South Tyneside		9		5
2019-20	Local Authority Area	Southampton		12	*	
2019-20	Local Authority Area	Southend		7	*	
2019-20	Local Authority Area	Southwark		11	*	
2019-20	Local Authority Area	St Helens		9		6
2019-20	Local Authority Area	Staffordshire		24		8
2019-20	Local Authority Area	Stockport		16		9
2019-20	Local Authority Area	Stockton on Tees		9	*	
2019-20	Local Authority Area	Stoke on Trent		17	*	
2019-20	Local Authority Area	Suffolk		18		9
2019-20	Local Authority Area	Sunderland		11	*	
2019-20	Local Authority Area	Surrey		54		13
2019-20	Local Authority Area	Sutton		20	*	
2019-20	Local Authority Area	Swindon		10	*	
2019-20	Local Authority Area	Tameside		12		7
2019-20	Local Authority Area	Telford and Wrekin		7	*	
2019-20	Local Authority Area	Thurrock		16	*	
2019-20	Local Authority Area	Torbay		6	*	
2019-20	Local Authority Area	Tower Hamlets		9	*	
2019-20	Local Authority Area	Trafford		9		5
2019-20	Local Authority Area	Wakefield		14		7
2019-20	Local Authority Area	Walsall		30		9
2019-20	Local Authority Area	Waltham Forest		11		7
2019-20	Local Authority Area	Wandsworth		13	*	
2019-20	Local Authority Area	Warrington		13	*	
2019-20	Local Authority Area	Warwickshire		46		16
2019-20	Local Authority Area	West Berkshire	*		*	
2019-20	Local Authority Area	West Sussex		37		20
2019-20	Local Authority Area	Westminster		19	*	
2019-20	Local Authority Area	Wigan		11	*	
2019-20	Local Authority Area	Wiltshire		16		6
2019-20	Local Authority Area	Windsor and Maidenhead	*		*	
2019-20	Local Authority Area	Wirral		14		5
2019-20	Local Authority Area	Wokingham		5	*	
2019-20	Local Authority Area	Wolverhampton		10		5
2019-20	Local Authority Area	Worcestershire	*		*	
2019-20	Local Authority Area	York City	*		*	

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Oldham's Covid-19 Six-Month Plan

January 2021

Contents

1

Introduction

Introduction

Since the start of the Covid-19 pandemic we have seen an incredible effort, from across Team Oldham and our communities, to respond to the unprecedented challenge to our way of life posed by the virus. Oldham has suffered some of the highest rates of infections and deaths in the country, and our communities have made significant sacrifices to contain the spread of the virus and save lives.

By working together across Oldham and Greater Manchester we have achieved a number of successes as part of our Covid-19 response - including implementing localised contain measures that have reduced the rate of increase, improving Covid-safe practices in our educational settings, retail, hospitality and businesses, and supporting the most vulnerable.

While our collective efforts meant we successfully reduced the rate of growth of the virus, the reproduction rate rose significantly above one across the country and led to a rapid resurgence of infections. On the 4th January 2021 a further national lockdown was announced, instructing people to stay at home to control the virus, protect the NHS and save lives. This drastic jump in cases has been attributed to the new variant of COVID-19, which is more transmissible than the previously predominant variants.

The impact of Covid-19 and the measures to contain it in Oldham have already had far reaching impacts, and have exacerbated the health, social and economic inequalities both within Oldham and between Oldham and the rest of the UK. While we suffer the cost of higher mortality, our businesses have also been under more severe restrictions and for a longer period of time than many places in the UK.

We also need to look ahead to the next six months. We have a number of challenges to overcome but also hope that our collective actions and scientific developments will enable us to soon reach a phase where the virus no longer poses a significant risk.

Over the next six months Covid-19 continues to pose a very serious threat, compounded by the additional challenges our society faces over winter. We need to learn from the lessons of this last year in how to safely reopen our society and economy and continue to suppress the virus. The contain measures we put in place will be crucial to doing this.

This plan sets out what we will do to contain Covid-19 over the next six months. It is based on the Greater Manchester's Covid-19 Six-Month Plan, but contains specific detail about Oldham's response. It sets out how we will take an evidence-based approach through the assessment framework we have developed, and how we will work within the Government tiered approach to contain Covid. Recognising the impacts that contain measures have, we also set out the mitigations we will put in place over the next six months to support health, reduce social harms and protect the economy.

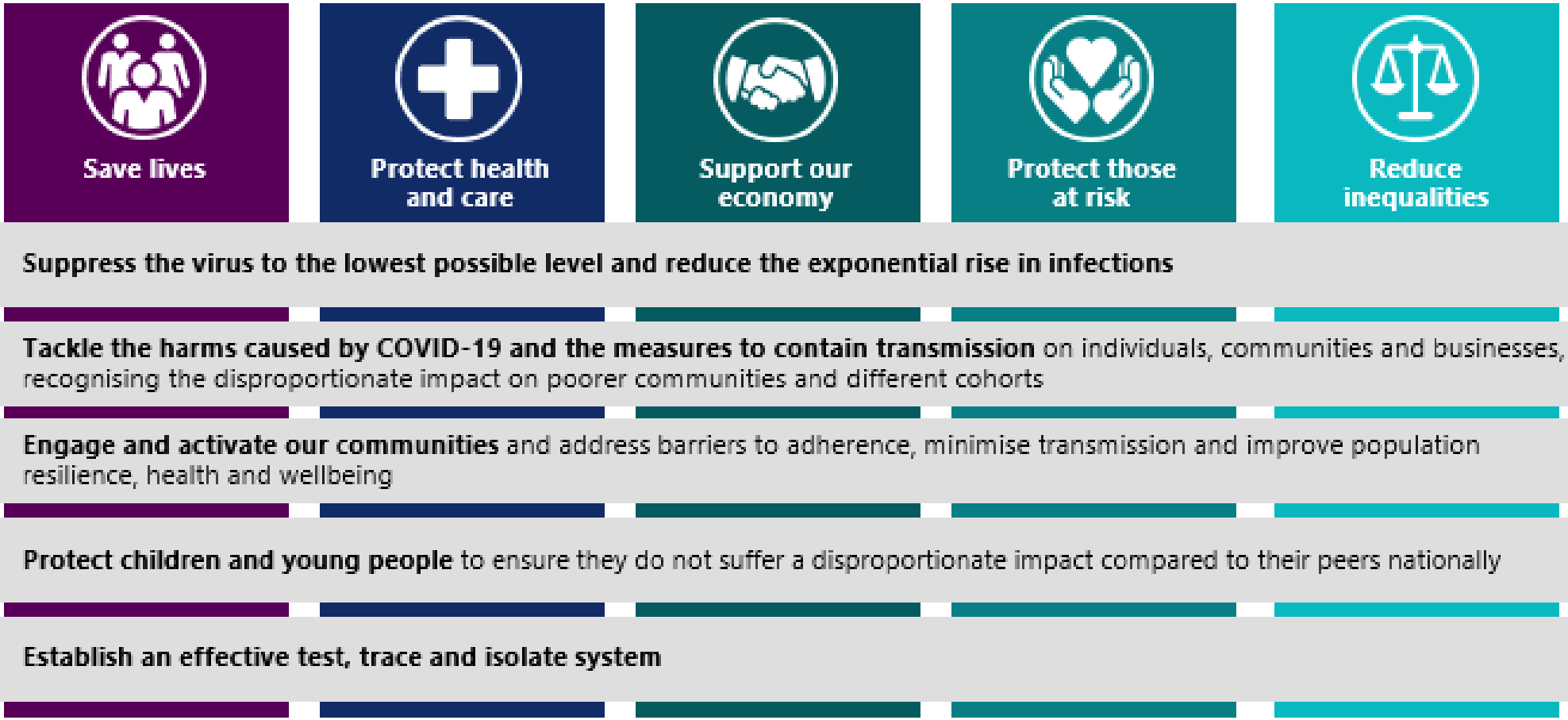
Scientific developments over the next six months give us hope that we will soon reach a phase where the virus no longer poses a significant risk to public health. This plan sets out what we will do in terms of rollout of a vaccine and testing to enable us to live with Covid-19 in the longer term.

Oldham's Covid-19 Six Month plan sets out the following, aligning to the GM plan:

The impact of Covid-19	Containing Covid-19	Engaging our communities	Mitigating the harms	Living with Covid
What we understand about the impact of Covid-19 in Oldham.	The measures we will put in place to contain Covid-19 and the assessment framework we will use to inform our position.	How we will communicate with, engage and activate our communities alongside implementing these contain measures.	The mitigations we will put in place to counter the harms to health, society and the economy of these contain measures	The actions we need to take over the next six months to to reach a position where the virus no longer poses a very severe threat.

Our strategic intent for the next six months

To develop this plan, we agreed that our intent would be to:



Our Six Month Plan is guided by the following principles

The actions we plan to take are also guided by both national, and agreed Greater Manchester containment principles.

National principles

- The primary responsibility is to make the public safe
- Build consensus between decision-makers to secure trust, confidence and consent
- Build on public health expertise and use a systems approach
- Be open with data and insight so everyone can protect themselves and others
- Consider equality, economic, social and health-related impacts of decisions
- Follow well-established emergency management principles

Greater Manchester containment framework principles:

1. Informed by epidemiology and key metrics
2. Fluid to allow for professional judgement
3. Responses are proportionate
4. Moderated by an understanding of local context and soft intelligence
5. Specific, evidence-based responses to the issues identified
6. Responses are transparent for communities
7. Informed by solid community engagement and behavioural insights
8. Responses are appropriate and timely
9. Responses are non-stigmatising

2

The Impact of Covid-19 in Oldham

Oldham has been disproportionately impacted by both Covid-19 and the measures to contain it

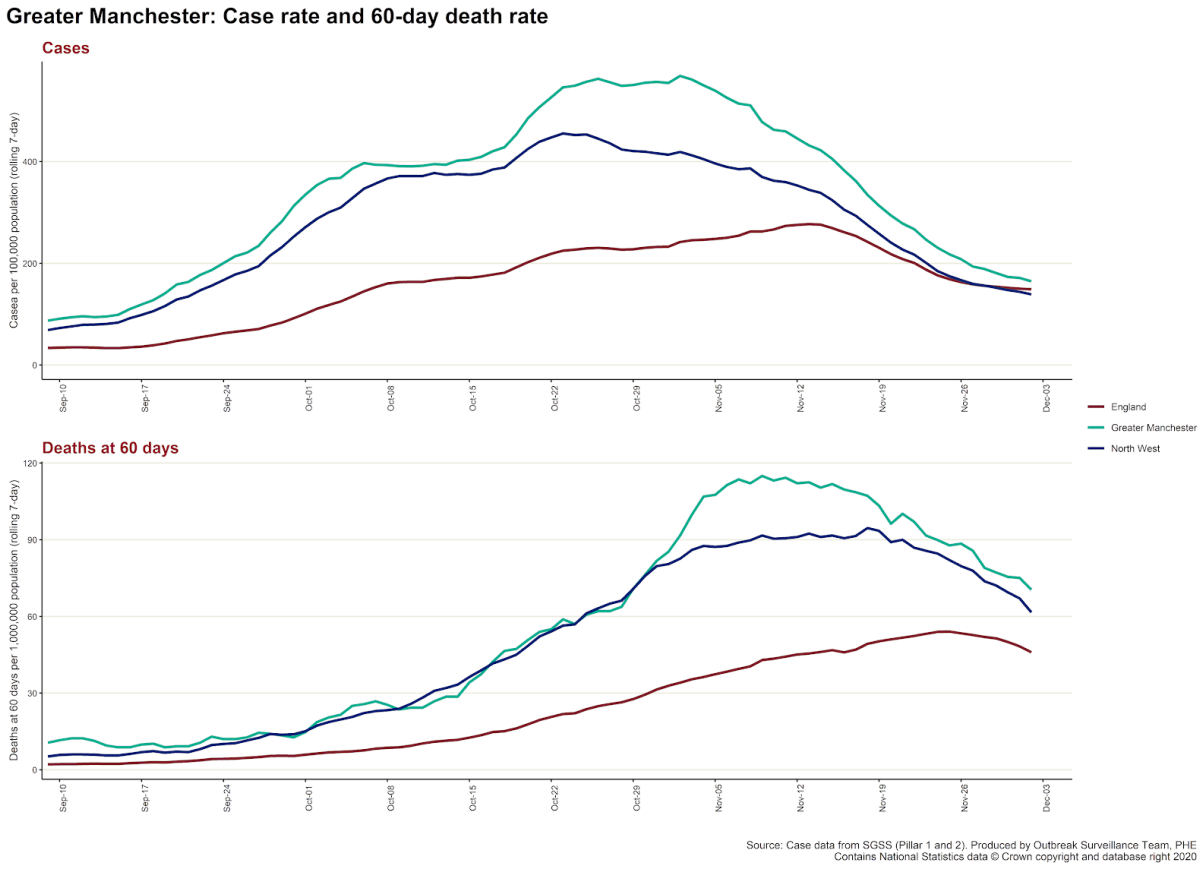
As of 4 January 2021 Oldham has had a total of 17,570 Covid-19 cases, with the tragic loss of 532 lives.

Oldham, like its GM counterparts, has been disproportionately impacted in comparison to the rest of the UK: and is ranked 2nd highest (6377 per 100k) nationally, across local authorities in the UK by all-time case rate.

Both Covid-19 and the measures to control it have exacerbated the fundamental inequality in death rates between Oldham, GM and the wider North, and the rest of the UK.

The Northern Health Science Alliance has found that 12.4 more people per 100,000 population have died with Covid-19 in the North from March to July than elsewhere in the country, with 57.7 more people per 100,000 dying of all causes

This gap has only widened during the second wave of the pandemic where Oldham has suffered from extremely high case rates and deaths (3rd nationally, as of 28th November) and the most severe restrictions for the longest period of time. Many businesses will not be able to withstand more restrictions without additional support. The impact of the virus and the restrictions on individuals and our communities is significant - and is most keenly felt by the most vulnerable.



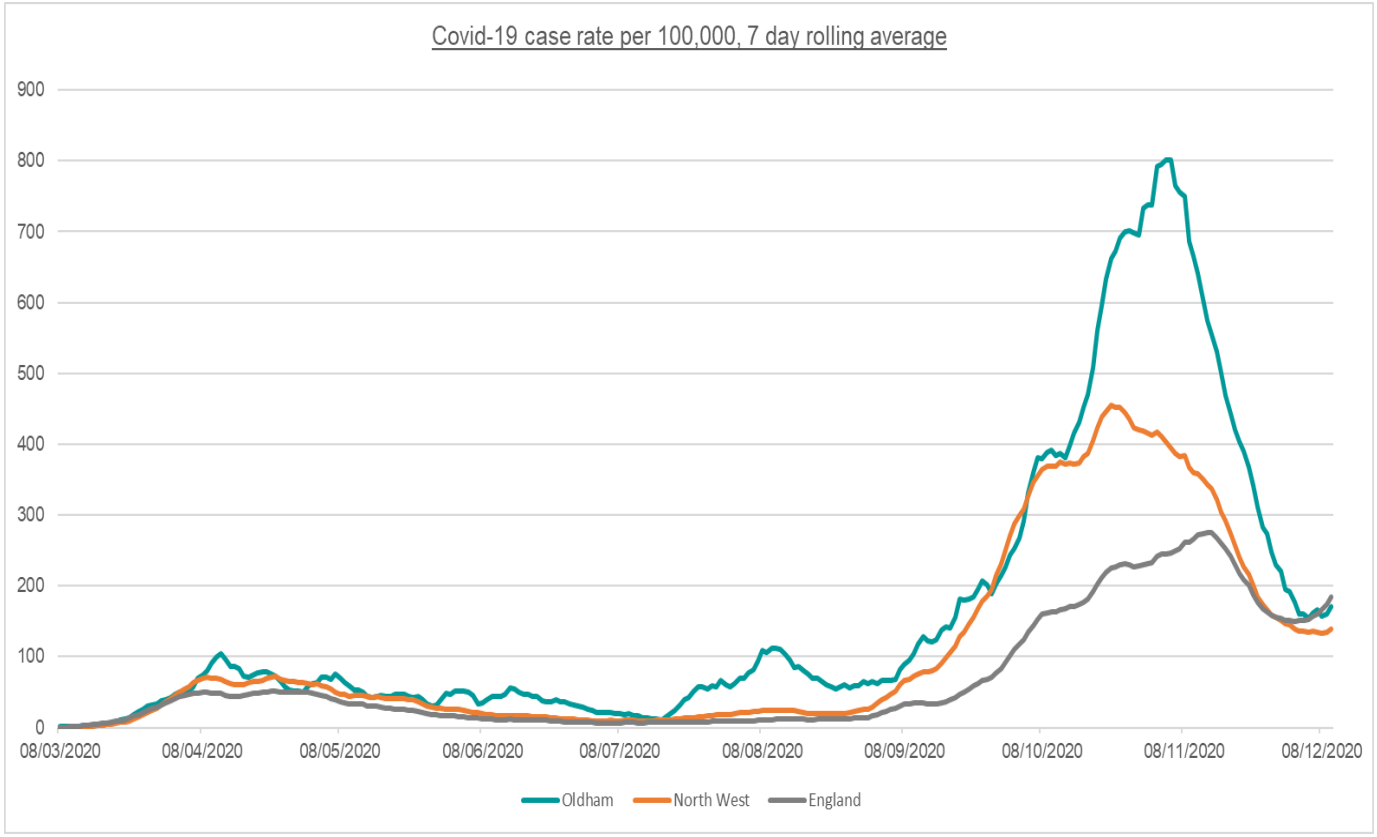
We have taken unprecedented action to contain transmission of Covid-19 in Oldham

Since the pandemic began we have taken unprecedented action to contain transmission of Covid-19. This started with the first national lockdown which was effective in bringing Covid-19 under greater control in Oldham.

However the last nine months has shown that easing measures too fast can lead to a rapid resurgence in cases, as we saw after the first lockdown was eased. We also know if the package of measures put in place is not comprehensive enough we risk putting restrictions on our businesses without the benefits of a substantial reduction in transmission, as we saw with the Tier 3 restrictions in GM before the second lockdown.

As we look forward over the next six months we must continue to learn from our experience of how to effectively contain Covid-19 and bring R to as low as possible and keep it there.

We must also recognise and mitigate as far as possible against the significant impacts on individuals, businesses, and communities that these measures have. We have taken action to mitigate the harms caused by these measures - for example improving the way we manage Covid-19 in schools to reduce the number of days of learning lost by our children and young people, and working with businesses to help them operate in Covid- secure ways - but more needs to be done over the next six months to mitigate these harms.



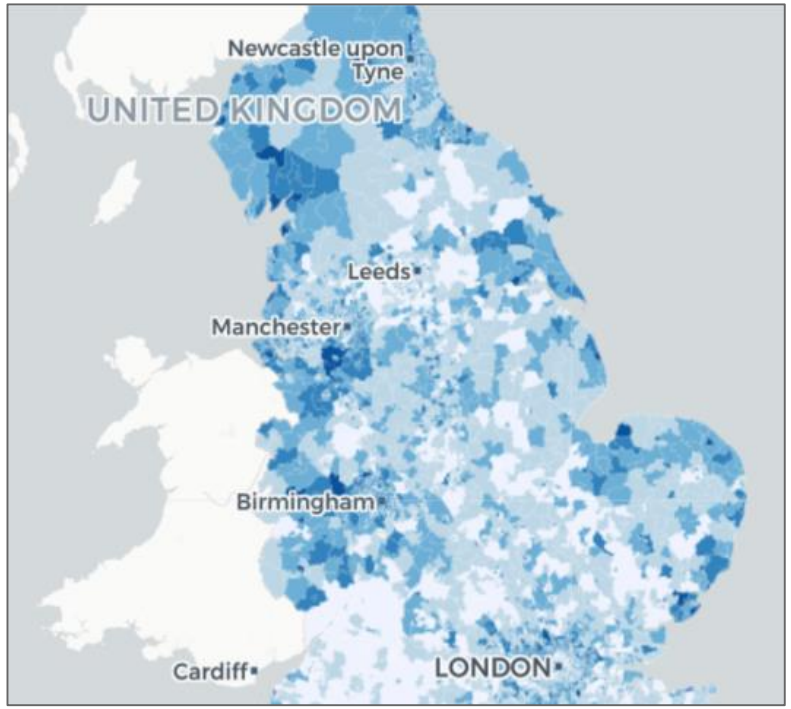
Both Covid-19 and the measures to contain it have severe socioeconomic impacts and have exacerbated inequalities within Oldham

Both Covid-19 and measures to contain it have affected every person and every business in every part of our Borough. To some it has been inconvenient, to some challenging, and to many, devastating. The impact has been unequal and unfair, starkly highlighting and deepening existing inequalities and social harms. The impacts are ongoing and we do not yet know their full extent. As we seek to set out how to contain Covid-19 in Oldham we must continue to do all we can to tackle harms and inequalities, recognising that the scale of the issue requires a comprehensive national response as well as regional and local action.

Covid-19 has exacerbated inequalities within Oldham

- As with other diseases, Covid-19 has had a more severe impact on vulnerable groups, including older people, people with disabilities, ethnic minorities and those living in deprived areas
- In Oldham we have a particularly high concentration of deprivation, with some of the most intense deprivation in places. Many of our areas of deprivation overlap with BAME communities and Covid-19 vulnerabilities [Figure 1] such as overcrowded housing, and low-paid insecure work.
- There is now a substantive body of evidence proving that more deprived areas have experienced higher mortality rates from Covid-19 than more affluent areas.
- Our most vulnerable communities are not only at higher risk of Covid-19 mortality but are also most adversely affected by the measures put in place to contain Covid-19.

Fig 1: Population map showing overlapping Covid vulnerabilities in the UK (% of population on shield list; average resident age; BAME population; index of multiple deprivation; ONS deaths; population density.



We are seeing significant impacts on vulnerable groups including the homeless, those living in poverty and on our children and young people

Impact on vulnerable groups including the homeless and those living in poverty

Our system set up to provide humanitarian aid has experienced significant demand through the pandemic. While initially set up to provide support to the clinically vulnerable, we have had to respond to calls for support to those facing the socioeconomic impacts of the pandemic.

The distribution of food parcels and medication has been compounded by requests for support relating to welfare advice, mental health and wellbeing and we continue to identify unmet needs and vulnerabilities across many of our communities.

The Covid-19 response has also been inextricably linked to the challenges of people having safe, affordable accommodation. The numbers of people living in temporary accommodation is higher than it has ever been in GM and the requirement for truly affordable housing, homelessness prevention, and access to appropriate and timely support remains critical.

Impact on our children and young people

- **We anticipate a direct impact on child development** as a result of reduced activity in the Early Years Foundation Stage during Lockdown. Anecdotal evidence is emerging that Yr1 cohort has below expected skills due to them experiencing a sustained period of absence during Lockdown.
- **School children in Oldham have been disproportionately impacted compared to their peers nationally** by number of days of learning lost. Between 12 October and 20 November 15.7% of children were unable to attend school due to Covid, compared to 11.5% across GM and 6% nationally. Along with the impact on each individual child, this risks widening the pre-existing attainment gap between Oldham and the UK average.
- **The educational impact is greatest on our most vulnerable children.** Whilst overall attendance figures demonstrate an average of 77.6% since 2nd November 2020; those pupils with and EHCP show and average of 70.7% and those with a social worker 74.4%.
- **The wider socioeconomic impact of Covid-19** will also see many more children and young people living in families experiencing unemployment, debt and bereavement with the potentially greater exposure to issues such as domestic abuse. Many more will be experiencing anxiety and depression. Evidence suggests they are also at increased risk of exploitation both online and in the community particularly for those not in school - a situation exasperated by limited capacity and closures of youth venues during lockdowns.
- **Young people are also suffering economically** with people in Oldham aged 18-24 experiencing 132% increase in unemployment since March compared with 101% of people of working age.

The severity and length of restrictions has caused significant stress for businesses and the scale of the economic problem will likely only grow

Businesses have reported significant stress as a result of the pandemic and contain measures, including decreased sales, cashflow issues and less than six months sustainability. Many are increasingly reliant on Government support.

Even before additional Covid-19 restrictions were in place, in Oldham we saw:

- Unemployment claimants almost double from **6,545** in March to a total of **14,015** at peak in September.
- Oldham's monthly Claimant Count increase by **101%**, a similar rate to GM (**102%**) but lower than English levels (**118%**).
- Oldham's monthly youth Claimant Count increase by **132%,** significantly more than GM (**122%**) and roughly in line with England (**135%**).
- Increases have hit more traditional deprived areas to a greater extent, rather than being spread proportionally across the borough.

The impacts across our economy have not been uniform. Sectors dependent on social mixing such as hospitality, culture and leisure have been hit the hardest and most immediately - but the impact extends across the foundational economy, through supply chains, or from lower overall confidence and demand. Other businesses have been able to find growth opportunities, including those in digital and cyber industries, and in the life sciences sector.

Nevertheless, the scale of the economic problem will likely only grow.

Whilst low numbers of business failures have been registered to date, national survey data shows 15% have ceased trading permanently or temporarily, including manufacturing, ICT and constructions companies as well as the more immediately affected sectors [2].

This suggests many business failures may be in the pipeline in the coming months. The end of Government support schemes including furlough and the start of interest payments on business loans may be the triggers. This requires proactive and preventative action, as well as significant planning for GM's economic recovery as the vaccine takes effect.

The pandemic has also exacerbated health inequalities and disrupted our wider health and social care system

The impact of Covid-19 on the health and social care system goes beyond the impact of Covid-19 mortality and morbidity. It has exacerbated health inequalities and caused disruption to the wider health and social care system that will worsen health outcomes in Oldham. The impacts in Oldham risk worsening the health inequalities that already exist between Oldham and the rest of the UK and within Oldham itself, with the associated socioeconomic damage that health inequality is inextricably linked to.

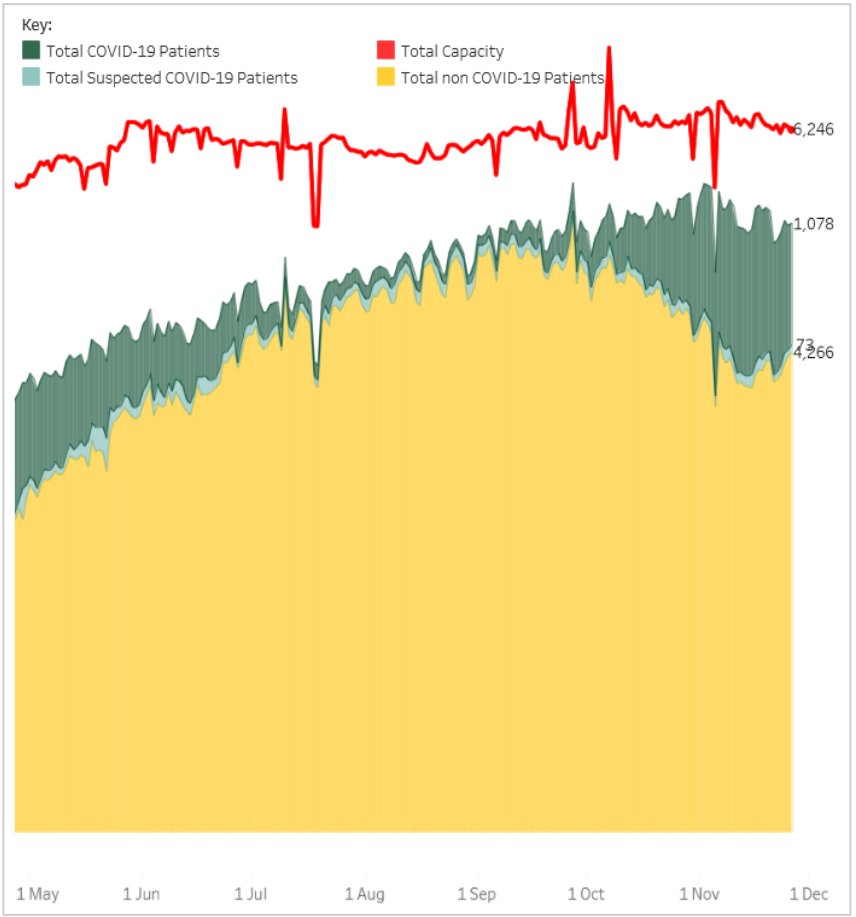
Mental health: The impact of the pandemic and restrictions on mental health on our residents is significant - with consequences of lockdown such as food insecurity, income loss, isolation and anxiety all worsening mental health outcomes. We have seen increases in mental health referrals from A&E and the community, and increases in mental health admissions for 34 hours and 3-5 days which are indicators of crisis.

Physical health: The physical health of our residents has also been impacted both by high Covid-19 mortality and morbidity and by the disruption to the wider health and social care system caused by the pandemic. The NHS has worked at times to capacity to manage increasing Covid-19 hospital and ICU admissions. This has had knock on impacts on the health and social care system including the disruption to non-Covid acute care across Oldham and a backlog of care across acute and primary care.

Significant drops in A&E use, admissions for urgent conditions, and attendance rates for primary care also indicate that many residents have not been seeking the help they need. This is particularly the case for our most vulnerable residents and risks increasing the health inequalities that already exist within Oldham and causing more non-Covid deaths.

Workforce resilience: Additionally there are also longer-term impacts on NHS and social care capacity and resilience, including the impact on a workforce that has tirelessly worked through many months of a pandemic.

GM Hospital total and ICU patients and total capacity



Looking forward over the next six months we have a series of challenges that we need to work together to overcome

1. **A large resurgence of COVID-19**, with widespread community transmission coinciding with a period of peak demand on the NHS and increased household mixing over the holiday period

2. **Ongoing restrictions** with major concern from the business community that ongoing restrictions will lead to business closures if they are not given the support they need.

3. **Disruption of health and social care and a backlog of non-Covid-19 care**, with increased non-Covid morbidity and mortality and a surge in long-Covid worsening health outcomes and increasing the gap between GM and the UK.

4. **Multiple pressures on public services**, including staff sickness through Covid-19 and flu, seasonal risks such as cold weather and flooding, and the potential impact of Brexit.

5. **A disproportionate impact on children and young people** from Covid-19 compared to their peers nationally, both in educational attainment and wellbeing.

6. **Lost economic output, investment and human and firm-specific capital due to loss of businesses and jobs that risks 'levelling down' the region** compared to the rest of the country

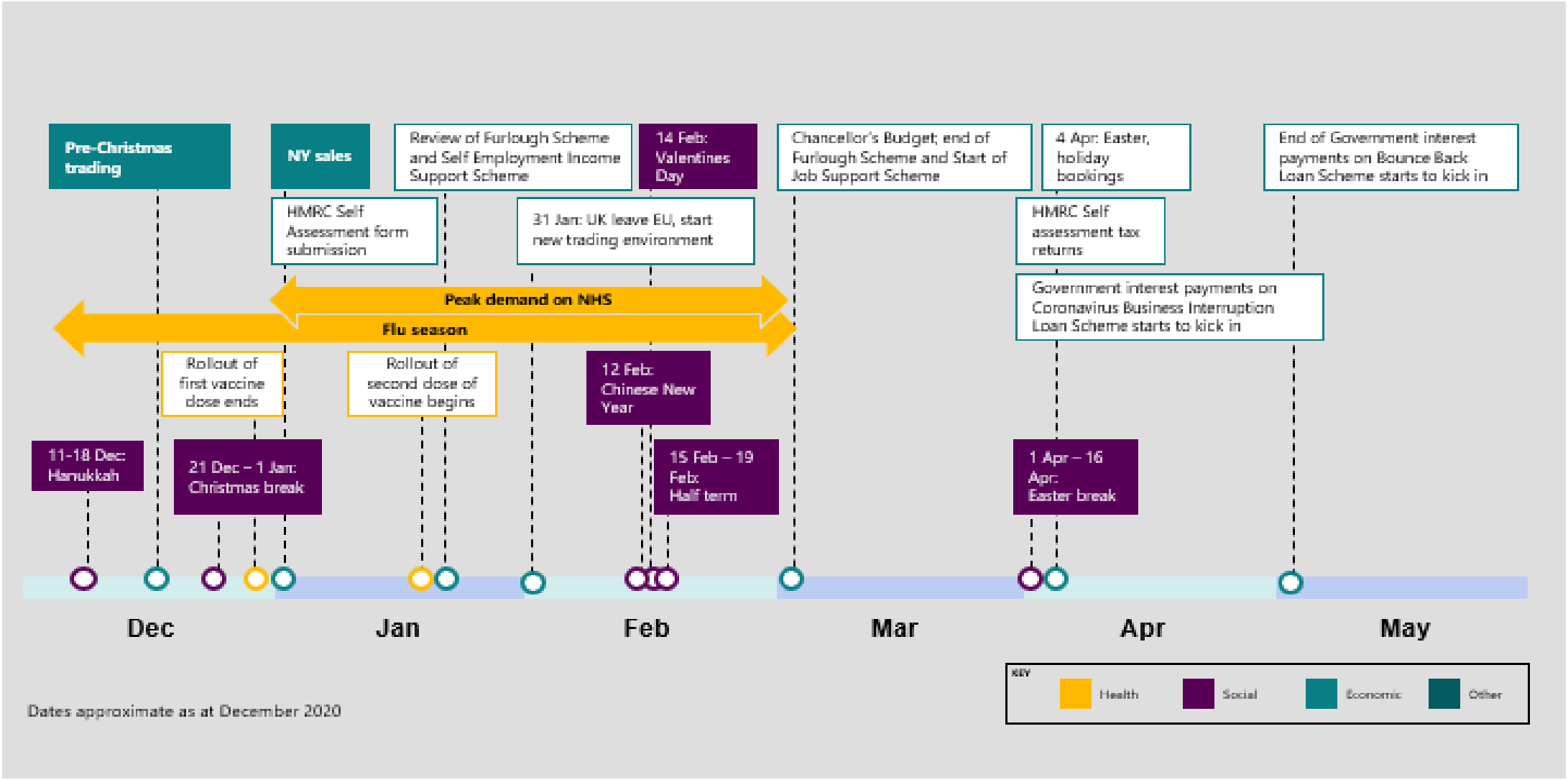
7. **Wider societal impacts** of Covid-19 and of measures to contain the virus, including on **mental health and wellbeing**, loneliness and exacerbated inequalities

8. **Operational issues in the Covid response**, including inconsistent national rules and messaging, testing and tracing systems not effectively reaching the numbers they need to, and inadequate financial support to enable people to comply.

9. **Fatigue with contain measures** and the challenge of how to continue to engage and activate our communities to comply with measures to contain Covid-19 over the next six months

Despite these challenges our six month plan can look ahead with a degree of optimism. Scientific developments in treatment of Covid-19, testing and vaccinations give us hope that we will soon reach a phase where the virus no longer poses a significant threat to public health. This plan will set out a framework for how we will tackle these challenges to a point where we reach a more sustainable solution and can live with Covid-19 in the longer term.

Key events over the next six months



3

Containing Covid-19

This chapter sets out how we will contain Covid-19 over the next six months ensuring that our plan is agile and evidence-based

The prevalence of the virus is still high in Oldham, and we will need to take action to suppress it over the next six months until a vaccine is widely available. Throughout the pandemic Oldham has had high rates of Covid-19 compared with the rest of the country, and there is evidence that the virus may be endemic in central parts of the borough where there are high levels of deprivation, as well as other risk factors for Covid-19 such as overcrowded housing. We cannot predict exactly how the virus will affect us over the next six months but can set out two high level projections that we may face to prepare for likely best and worst case scenarios. Although we hope that current measures will sufficiently reduce R and a vaccine will soon be available, our plan for containing Covid-19 must be able to respond to all situations, and must be agile to respond to our situation as it develops. It must also be evidence-based and rooted in local context and understanding of the impact both of Covid-19 and of the measures we use to contain it.

Dec

Jan

Feb

Mar

Apr

May

Optimistic projection for the next six months

Good adherence to lockdown in the New Year. Limited household mixing over holiday period. Good adherence to case isolation and quarantine and good access to effective and timely tests. Initial roll out of vaccine sees effective uptake of most vulnerable elderly and staffing groups

Outcome: good reduction in R to below 1 and case rates continue to fall in all parts of the borough.

Contain measures and mitigations put in place as appropriate. Spring leads to more outdoor activities and fewer infectious diseases. Cases continue to fall in all parts of the borough and reach a low rate by May. Successful vaccine developed which starts to be available in increasing amounts to reduce mortality. Further successful vaccine developments enable increasing roll out to priority cohorts with effective uptake and impact on mortality

Outcome: R remains below 1 with gradual easing of restrictions and positive socioeconomic impacts of fewer infections and restrictions.

Pessimistic projection for the next six months

Lockdown insufficient or poor adherence to lockdown measures. Easing of household restrictions over holiday period or lack of adherence leads to a spike in cases mid-January, with continuing high and increasing case rates. Limited vaccine uptake due to uncertainty of vaccine stability and public perception of safety.

Outcome: rates increasing, with major impact on hospitals and lives lost by end of January.

More severe restrictions needed and for a longer period of time in GM, with Tier 3 continued throughout March and April. Vaccines not effective or not delivered before June. **Outcome: ongoing high R and ongoing need for continued restrictions in GM and mitigations to be put in place.**

Our contain plan is informed by learning from our experiences to date and emerging evidence

Since the pandemic began we have sought to rapidly learn from local, national and international experiences and from emerging evidence on the efficacy and wider impacts of contain interventions.

These key lessons have informed our contain plan and the mitigations we will put in place.

1. **It is difficult to assess the impact and efficacy of interventions.** This is easier for interventions that are implemented across the whole population (e.g. lockdown) than it is for targeted control measures. There is an incubation period between when interventions are implemented and when results may be seen in the data.

2. **A package of measures is required to reduce transmission when it is widespread in the community,** with each measure having a relatively small effect but acting simultaneously to slow rate of growth. 'Whole population' control measures are more likely to be effective than targeted ones and individual case management measures such as test and trace.

3. **The earlier and stronger we intervene the less time interventions need to be in place.** The longer they are delayed the more stringent measures may need to be and for a longer period of time, and may cause more economic damage. Countries that instituted hard, early restrictions lost the fewest lives and have been more economically resilient.

4. **Easing contain measures too fast can lead to a resurgence in cases** if incidence and prevalence is still high, regardless of the trend for infection rates. The first lockdown is likely to have ended when prevalence was still high, and this endemic picture is likely to have led to an accelerated increase in rates and the early second wave.

5. **Individual case management measures** such as test and trace and self-isolation is likely to have an impact on transmission when transmission is localised with a small number of cases. It is less likely to be effective when there is widespread transmission in the community.

6. **COVID-19 and all measures to contain it have negative short and long term socioeconomic impacts.** Restrictions impact businesses required to close but also affect others indirectly. GM has the most stringent restrictions and for the longest period of time in the UK. Many businesses will not be able to withstand further restrictions without support.

7. **Maintaining detailed understanding of local epidemiology is crucial** and decisions on contain measures must be focused on a range of indicators, including current metrics, trends and future projections. Decisions must also take into account wider indicators on the impacts of contain measures.

8. **Acting across a broad geography has greater impact.** Social geography is more important than administrative boundaries when implementing measures – within GM and across the NW. Multiple varying and regularly changing approaches is not effective in controlling transmission and may have a perverse effect due to public confusion.

Our position on which contain measures and mitigations are required in Oldham is informed by data, intelligence and local judgement

Decisions on contain measures need to be evidence-based and informed by local context and understanding. They also need to take into account the socioeconomic and health impacts of both Covid-19 and the measures to contain it, to ensure appropriate decisions are made and mitigations put in place.

Within GM a process has been developed to proactively understand the GM situation and to ensure that data, intelligence and local judgement informs the policy position. The best time for assessing our local position and making decisions on contain measures and mitigations will not necessarily align to the frequency set by Government and although we will feed into this, we will continue with our local battle rhythm over the next six months.

The GM approach is designed to aid decision making at a locality level, support discussions about policy options and mitigations in GM, and enable proactive engagement with Government and our local population.

Within Oldham, locality data is formally assessed twice per week to understand the current position and identify where further action is needed to reduce transmission or mitigate the impact of both Covid-19 and control measures.

Data and intelligence	Frequency	Purpose
Interactive Data Warehouse	Ongoing	To provide ongoing access to as near as possible real time evidence for decision makers in localities on Covid-19 and the socioeconomic harms, enabling them to access data and intelligence for GM and their localities.
Dashboard	Weekly	To provide weekly updates to decision makers on the latest data through a comprehensive dashboard of key indicators providing as near as possible real time evidence and data
Assessment Framework	Fortnightly	To provide a fortnightly expert assessment of our current Covid-19 situation and wider impact to: • Provide expert advice and analysis informed by data, intelligence and local judgement • Inform, as far as is helpful, a united position across GM about Covid-19 and its impacts and a shared narrative to share with Government • Guide our own decisions and actions within GM including on mitigations required to put in place for contain measures • Influence government policy on mitigation of harms.
Oldham data and intelligence report	Twice per week	To provide local leaders with an assessment of the current position in relation to Covid-19, health and care system resilience, and the impact of Covid-19 and control measures on local residents, services and businesses.

We have established effective Governance arrangements to support a whole system response to managing the pandemic and delivering this plan

- It is clear that it will take a whole Oldham system approach to continue to effectively manage the pandemic. We will need to reply upon the leadership of every sector in Oldham and have put governance arrangements in place to enable this.
- We have established a single Oldham System Response & Recovery Board to oversee the overall strategic response covering the breadth and depth of those issues needed to respond as a whole borough to the pandemic, including transition, recovery and transformation. This group is chaired by the Deputy Leader of the Council and Portfolio Lead for Covid 19.
- The System Response and Recovery Board is supported by:
  - The Strategic Coordination Group which meets twice weekly to coordinate the delivery of this plan and the local response to the pandemic, and fulfils the role (set out in national guidance) of the Health Protection Board
  - Local Community Bronze Sub-Group responsible for coordinating emergency crisis support, including food, medicine and other essential items.
  - The Health & Care System Coordination Group to coordinate the response of the health and care system, and support the resilience of the local system.
  - The Health Protection & Air Quality Sub group which fulfils the role of the member-led local outbreak control board for public engagement and community leadership.
- In addition the Oldham Equalities Advisory Group will continue to provide advice and challenge to all of the Oldham system on the effectiveness of its response and therefore acts in support of all of the groups described above.

Actions we will take to contain Covid-19 over the next six months

Actions we will take over the next six months:

1

Ensure decision making is informed by data, intelligence and local judgement

- Utilise the interactive data warehouse and local data and intelligence to provide real-time data accessible to locality decision makers
- Continue to provide twice weekly intelligence reports to SCG and weekly reports to the System Response & Recovery Board
- Continue to review indicators and respond to changes in national framework and policy

2

Continue to review the evidence base on the effectiveness of contain measures and mitigations

- Continue to review evidence within Oldham, GM, nationally and internationally on the effectiveness of contain measures and mitigations to inform the response over the next six months

3

Maintain links across the Oldham system with range of partners

- Continue to use the Contain and Data and Intelligence cells as a forum for maintaining links across the GM system and incorporating expertise from a range of partners including VCSE and academia
- Continue to work as part of the GM system, maximising the benefits of City Region collaboration whilst ensuring that decisions meet the needs of, and benefit, Oldham residents.

National action required:

- Collaborate with GM and Oldham in the development of additional contain approaches and mitigations
- Communicate early and effectively around any changes to the current tiered framework or the implementation of the framework
- Engage in regular discussion about the current position of Oldham and GM and the measures, mitigations and support required

What are the indicators we use to measure containment?

- Testing rates per 100,000
- Positivity rate in Oldham, compared to North West and England
- Contact tracing performance data – proportion of people contacted

Our contain approach will be supported by efforts to increase compliance and enforce where needed

In April 2020 the GM Covid-19 Compliance Group was stood up to establish a consistent approach to compliance across GM. Oldham representatives (Council and Police partnership) attend the GM Group and report to the local TCG with a focus on:

- communicating and engaging with the community and local businesses to educate them on the restrictions in place, and undertaking compliance visits to premises.
- Regularly meeting with partners, educational settings and local businesses to ensure the wider population is aware of, and engaged in, complying with restrictions
- Working closely with communications and engagement teams to secure insights from across our population are in place to inspire and change behaviours
- Carrying out multi-agency enforcement across the Borough using the Engage, Explain, Encourage and Enforce approach

Additional funding has been allocated to spend on compliance and enforcement of regulations which are tier dependent. In Oldham we are continuing to focus on:

- Checking COVID-19 secure arrangements are in place in premises and engaging businesses about what more they can do, or ensuring premises are closed.
- Providing bespoke advice to businesses each time the tiers/restrictions are changed.
- Working closely with the police to communicate and engaging with the community and local businesses to educate them on the restrictions in place, and undertaking compliance visits to premises.
- Regularly meeting with partners, educational settings and local businesses to ensure the wider population is aware of, and engaged in, complying with restrictions.
- Working closely with communications and engagement teams to secure insights from across our population are in place to inspire and change behaviours.
- Carrying out multi-agency enforcement across the Borough using the Engage, Explain, Encourage and Enforce approach.

What are the indicators we use to measure compliance and enforcement?

Private properties:

- Number of warning letters sent
- Number of visits made
- Number of enforcement actions

Businesses:

- Number of directions to close
- Number of other enforcement powers used
- Number of licenced and unlicensed businesses engaged with/provided evidence to on managing the risks of COVID-19
- Number of Health and Safety Improvement notices served to licenced and unlicensed businesses in relation to safe workplace requirements
- Number of Health and Safety Prohibition notices served to licenced and unlicensed businesses in relation to safe workplace requirements
- Number of Health & Safety Prosecutions initiated for licenced and unlicensed businesses in relation to safe workplace requirements

Face coverings:

- Number of complaints received related to face coverings

Plans / projects which this work links to:

- GM Compliance and enforcement terms of reference and compliance and enforcement approach.

4

Communicating, engaging and activating our communities

Communicating, engaging and activating our communities

Our communities have already made significant sacrifices during the pandemic and are central to our continued efforts to suppress the virus over the next six months.

However our ability to effectively communicate with our residents has been held back by a number of challenges, including frequently changing restrictions, blanket messaging, disinformation, increasing public frustration, and a lack of insight.

Over the next six months we will continue to work with our partners to engage our communities, focusing on key public health messaging, including updated messaging on the revised guidelines in Oldham which we continue to communicate through a wide range of engagement channels.

We will continue to build confidence and trust across Oldham's diverse communities, promoting our We Are Oldham Campaign aimed at showing how the borough is coming together to help tackle Coronavirus, as well as continuing to promote the support available for vulnerable residents, people financially impacted by the pandemic, and local businesses.

Over the next six months we will continue to use our partnerships and networks to tailor our messaging to reach as many communities as possible, helping contain the spread of Covid-19 and minimise its harmful impacts.

Supporting our enforcement approach. These activities will also form an essential part of our enforcement approach which is rooted in 'The Four Es' - Engage, Explain, Encourage and then Enforce. Increasing our engagement, clearly communicating contain measures, and activating our communities to encourage them to comply will mean we only need to use enforcement when it is genuinely required. We recognise that there are often good reasons why people do not or cannot comply, and we will seek to address these through our communications, engagement and support.

What are the wider indicators we are using to measure impact in this areas?

- Individual feelings (life satisfaction / wellbeing; confidence in key areas such as work, transport and visiting town / city centres; changes that could be made to improve lives) through our Covid-19 Survey.
- Advice / instructions / regulations (levels of awareness and understanding; willingness and ability to comply, including current behaviours, barriers and motivations; perceptions of other people's compliance.)
- Impacts (how coronavirus is affecting individuals, friends, family and community; worries / anxieties for future; perceptions of ability of NHS / public services to cope)
- Access to information (where people obtain COVID information; levels of trust in these different sources)
- Community sentiment through our networks, including the Equality Advisory Group

So far we have:

- Utilized a variety of communication platforms to ensure that key messaging around government policy is communicated in a meaningful and helpful way for our communities. This includes an information hub on the council website, extensive social media activity, newsletters to businesses, direct mail to our most vulnerable groups along with regular engagement with local media channels.
- Established Oldham's Equality Advisory Group to help develop culturally appropriate messaging.
- Launching the We Are Oldham Campaign to show how the borough is coming together to help tackle Coronavirus.
- Promoted self-isolation payments to support people self-isolating.
- Through our website, communication channels and partners we have been promoting a wide range of mental health support that's available.

1

Increase insight

- Secure ongoing insight on key trends and emerging issues through monthly surveys with residents from all boroughs , in-depth qualitative interviews and rapid 'pulse checks'
- Working with PHE Behavioural Insights Team and the Independent Scientific Pandemic Insights Group on Behaviours to create genuine behavioural insight across GM
- Undertake a Covid-19 Impacts survey of Oldham residents in January 2021

2

Develop deeper, targeted insight for equalities-focused approaches (not yet funded)

- Through the Equality Advisory Group, facilitate targeted community conversations with key audiences to inform culturally competent comms and engagement approaches
- Collaborate with partners and networks for deeper investigation into issues holding back communities' ability to live with and recover from Covid-19

3

Increase comms and campaigns

- Draw on the outcomes of insight activities, co-design and deliver evolved approaches to informing, educating and engaging our residents, with more accessible, targeted and sophisticated social marketing approaches.

4

Continue to build trust across Oldham's communitie

- Share good news stories about community groups / individuals through the We Are Oldham Campaign.
- Co-design our approach with the public, including our targeted approaches to address inequalities through the Equality Advisory Group and Equality Strategy.
- Draw on expertise from across the system to tailor our messaging, ensuring we reach all of Oldham's diverse communities.
- Continue to work across Team Oldham to coordinate key messaging.

5

Mitigating Harms

Resetting the health and care system

Following the implementation of phase 2 recovery as part of the Covid-19 response, Oldham's health and care phase 3 recovery assessment and route to implementation has been established.

The overarching aim of this recovery work is to ensure that more, if not all, services are stepped back up safely, whilst operating within the context of enhanced infection, prevention and control (IPC) measures, which as well as impacting on care delivery, impacts on estate capacity also.

The data used for our planning is based on assumptions using existing and current capacity and demand modelling, and is aligned (for Oldham borough patients) with the Northern Care Alliance (incorporating Pennine Acute Hospitals – Royal Oldham) and Pennine Care.

National activity target expectations

Referrals:
- The national expectation is that this returns to **100%** of the previous year's activity – Oldham is realistically planning for this to be back to **80%**

Elective inpatients:
- That national ask is that this activity incrementally returns to **70%** of the previous year **rising to 90%** by March 2021 – Oldham is realistically planning for this to be back up to **73%**

Elective outpatients:
- The national ask is that this activity incrementally returns to **90%** of the previous year **rising to 100%** by March 2021 – Oldham is realistically planning for this to be back up to **91%**

Non-elective inpatients:
- Oldham is planning for this to be back up to **83%** of the previous year's activity

Emergency department attendances:
- The regional ask is that this activity returns to not less than **75%** of the previous year – Oldham is realistically planning for this to be back up to **89%**

Assessing the gap

The data that has been compiled and submitted provides us with the ability to assess the gap between the national ask around phase 3 recovery and current local capacity and delivery - we also know there is a gap in relation to some of the expected timescales for implementation and completion, and the ability for some of the services to be able be meet these specified deadlines.

Work is, therefore, now underway to establish how we can get local health and care services to the required levels for phase 3 recovery implementation – this builds on what was already taking place in Oldham prior to the Covid-19 response, due to many services not meeting the required national NHS Constitutional standards.

Additional bed capacity was put in place across the North West, but more work is needed to establish what the acute and complex parts of the pathway need to look like in Oldham – the aim will be for independent sector providers to support lower acuity care, and builds on brokerage between organisations to help develop relationships across providers to enable them to work together effectively across the locality.

Activity context

The CCG is required to plan for its population, which is anyone registered at an Oldham member GP practice, irrelevant of where they receive their care. Many Oldham patients receive care outside of Oldham, either due to circumstance or choice. Whilst the CGG commissioned a large amount of healthcare, it does not commission everything. Some services provided by hospital are commissioned by other agencies and are therefore not included the CCG's plans.

Hospitals are required to plan for the utilisation of their facilities. They are location based and have to plan for anyone attending their services, irrelevant of where those patients live or are registered. Many people from out of the Oldham borough access Royal Oldham Hospital, and in the last 12 months, only 62% of the activity for people who used Royal Oldham were Oldham-registered patients.

For these reasons the CCG activity plan and the local hospital provider plan will never fully align. The CCG has submitted a plan that is broadly in-line, but slightly less than national and regional recovery expectations, with the exception of referrals, which are significantly less than required.

Over the next six months we will:

1

Cancer

- Improve cancer referral data
- Work with NCA on a diagnostic hub business case to provide additional capacity
- Work with NCA to ensure that its cancer recovery plan is reviewed and approved
- Implement additional PET-CT scan machine
- Continue to promote the bowel, cervical and breast proactive screening programmes in primary care under 'Primary Care Plus'
- Implement local and national cancer campaigns: "We are here for you"
- Utilise existing Covid-19 community engagement to provide information on cancer symptoms and services

2

Elective care

- Work with providers to enact key demand management tools, such as 'advice and guidance' to support the reduction in outpatient need
- Work with NCA on the broader 'System Wide Outpatient Programme' to continue to implement different ways of delivering outpatient care, as well as implementing new initiatives to support reduction in volumes such as PIFU
- Work with providers to consider and consult on a more permanent arrangement to the use of medication for early medical abortions (up to 10 weeks) in conjunction with over the phone or virtual appointments
- Roll out of new referral template to improve quality of referral information and support improved triage with advice and guidance responses back where appropriate

What we are already doing

Cancer

- Northern Care Alliance (NCA) has recently launched the Rapid Diagnostic Centre at its Oldham and Salford sites, which has seen an increase in referrals and is running at an 8-10% cancer conversion rate
- Two week wait (2WW) cancer referrals now only 8% down on pre-lockdown levels
- Contracting of routine endoscopy diagnostics were transferred to the hospital trust to provide support for cancer work – supported by a GM-wide programme to increase mobile endoscopy capacity
- GM-wide surgical hubs for cancer in place at Rochdale Infirmary and The Christie as 'green' Covid-secure sites
- CCG-chaired Board in place to transform outpatients system-wide (SWOP), focusing on diagnostics and service recovery

What we are already doing

Elective care

- GM-level management of independent sector hospital capacity in place across the system
- Independent sector community elective providers being engaged in relation to capacity availability, and will be supported by the CCG regarding estates needs due to IPC measures
- Virtual solutions are being used to increase outpatient activity (including assessments and reviews) to the required levels
- Pregnancy terminations continued to be provided throughout lockdown, with medications sent via post
- Supply of all community elective providers to NCA to look at potential for additional capacity that can be offered on an provider-to-provider basis
- Implementation of tele-dermatology to reduce face-to-face contacts required and increase the numbers of patients managed outside of specialist services

Mental health and learning disabilities

- IAPT services activity is returning to pre-Covid levels – the service has continued to be in place throughout
- It is expected that the children and young people access target will be met
- Health checks for people with learning disabilities (LD) have continued throughout as part of the Direct Enhanced Service and Primary Care plus
- We are expecting the Transforming Care trajectories to be met for both secure and non-secure patient discharges by 31 March 2021
- The ‘eliminating mixed sex accommodation’ programme is now underway again following a pause in March 2020

Health inequalities

- Health inequalities are being addressed via Primary Care Plus in relation to key indicators such as by increasing prevalence and reducing exception reporting – those with severe and enduring mental health conditions are targeted, as well as those vulnerable to frailty
- Work is underway to address the issues that driver poor health outcomes, such as the recruitment of social prescribers who are deployed into PCNs
- GPs and the acute trust are reviewing all children and young people on the ‘shielded’ patient list and removing those from the list that are no longer deemed clinically ‘extremely vulnerable’ – all children and young people on the list are seen by services
- Increased testing is in place for all vulnerable people
- Regular ‘sit-reps’ are in place for care homes

Over the next six months we will:

3

Workforce
- Work across the Oldham Cares system to agree a collaborative approach and response to the NHS People Plan
- Produce a specific primary care response to the NHS People Plan, as a collaborative approach between the commissioners and Greater Manchester and Health Education England workforce leads
- implement the new primary care workforce programme to support the delivery of recruitment, retention and training objectives

4

Mental health and learning disabilities
- Increase investment in mental health services in line with the 'MHIS' plan
- Oversee the implementation of the IAPT 24/7 helpline to include full crisis resolution and home treatment services, and work with Pennine Care FT to ensure that the appropriate recruitment is in place and delivered to support the workforce action plan for the service
- Work with providers to ensure that access to these services is clearly promoted and advertised – this will include continued borough-wide campaigns to support mental health and wellbeing for all
- Following a review of LD prescribing of anti-psychotics, develop an action plan for this area to support practices and provide them with implementation plans
- Develop an action plan to support LeDeR reviews and lack of capacity

5

Health inequalities
- Examine the potential to utilise medicines optimisation pharmacists working within PCNs to identify and support at risk patients as part of structured medicines reviews and health checks
- Extend the teams to support the 'continuity of carer' agenda, with specific teams to be put in place for vulnerable patients, including those with learning disabilities
- Phase in a new 'visiting plan' for maternity units to ensure the necessary family support is in place, as safety measures allow

Workforce actions already underway

- Enhanced mental health initiatives, platforms and support for all staff across the Oldham system are in place
- Regular 'pulse' surveying is in place to track how staff in the Oldham Cares system are feeling
- New equality strategy for Oldham is being produced by all partners and the community, voluntary and faith sector
- Oldham CCG 'equity' plan for recruitment, retention and progression is in development

We are ensuring community health and care services are enabled to support the most vulnerable through:
- Prioritising the safeguarding needs of adults at risk
- Working to enable flow at the hospital so as to ensure Oldham residents can receive lifesaving acute care and beds are not taken by people who have acute needs
- Supporting care homes and care providers to continue providing care and support the most vulnerable seven days per week
- Supporting informal carers (23,000 in Oldham) through these challenges times

Over the next six months we will:

Primary care

- Ensure clinical pathways and standard operating procedure are signed off for the paediatric virtual ward
- As part of processes to deal with childhood immunisation issues, oversee (in collaboration with CHIS) the redesign of processes to improve the system going forward
- Assess the effectiveness and quality of the weekly pastoral care calls between primary care and care homes, as well as individual care plans and structured medicines reviews
- Development of a revised outcome-based district nursing offer to bridge the period up to March 2021, which will ensure caseload prioritisation and also areas of current commissioned activity that can be ceased/provided differently in the wider system
- Confirm next steps for STICH enhanced nursing support for care homes and end of life pathways
- Develop robust links between medicines optimisation team and the PCNs
- Commission the GM ‘minor ailments’ scheme as support to the ‘self-care’ policy work
- Work with secondary care to increase the amount of medicines provided at discharge to reduce pressure on primary care prescribing
- Ensure that clinical vulnerable children are prioritised in community service recovery plans
- Ensure oversight of children with complex health needs and who have been shielding who may not be able to return to school so that their care and educational needs are met
- Maximise and lock in the benefits and changes that have been realised during COVID-19
- The system deficit will need to be managed in the context of the impact of the pandemic and will focus on: Managing the backlog of patients; Safely resuming clinical activity; Preparing for winter; Surge planning; Supporting our existing workforce and securing a sustainable workforce; and Exacerbation of existing health inequalities.

What we are already doing

- Locality-wide post-Covid rehab pathway implemented across acute, community and primary care and is working well, and additional capacity has provided for the lung service
- Community service recovery plans in place
- A community optometry service was commissioned in May 2020 to support the national ask for local urgent eye care services, which has continued and will be expanded to include routine care to help reduce the demand on acute trusts
- Care home ‘STICH’ enhanced community nursing support in place for care homes and end of life
- Work underway for PCNs to take a greater lead role in proactively reaching out to vulnerable patients as part of the MDT approach
- All 6-8 week checks for babies have been maintained throughout
- Paediatric ‘virtual’ ward due to go live, with an additional 20 beds to support early discharge
- Paediatric ‘rapid access clinics’ due to commence for primary care community care services to refer into specialisms, with the aim of avoiding hospital admissions
- The children’s community nursing team has maintained face-to-face contract throughout Covid-19 with children who have complex health needs and also children on the end-of-life pathway

Over the next six months we will:

7

Winter

- Consider the establishment of a ‘cold diagnostic site to reduce DNAs due to Covid-19 fears
- Consider a more joined-up approach with community pharmacy so that there is reduced competition for vaccine supply
- Work with community pharmacies to improve the signposting of key services and the best ways to access them during the winter, as well as promotion of the flu immunisation programme to encourage take-up
- Increase the number of paediatric multi-disciplinary teams across the neighbourhoods in the borough

What we are already doing

Winter

- A robust flu immunisation programme plan is now in place for Oldham, with specific interventions for target and at-risk groups, integrated with the national and local communications and engagement flu and winter campaign
- A multi-agency flu programme group is in place to ensure the delivery of the immunisation plan – this includes a dedicated individual from the CCG’s primary care team to coordinate work as needed with practices
- Community and primary care nurses are trained to administer flu vaccines
- Paediatric rapid access clinics are increasing in number, offering up to 30 appointments per week - GP ‘advice and guidance’ service in place, which will also coordinate with the rapid access clinic
- StartWell specialist nurses are back in the emergency department

Conclusion

The success of the next six month recovery plan will be reliant on:

- Robust partnership working
- Strong clinical leadership and engagement
- Effective engagement with our communities and with patients
- Clear programmes for service redesign and transformation
- Good governance

The core transformation programmes will centre around:

- A new model for managing long term conditions, utilising a ‘hub’ that includes non-elective, elective and primary / community care
- A new model for urgent care, as linked to the Greater Manchester model
- Redesign of local community services

Mitigating social harms and inequalities

Tackling the inequalities exacerbated by Covid-19

Oldham has a rich history of people from different backgrounds and cultures living and working together. However, we know that there are groups of people that are marginalised, who are more likely to face inequality and discrimination than others. As we recover from the impact of Covid-19 it is critical that we tackle inequality and discrimination head on.

We know Oldham is a place where deep social and economic disadvantage still exists and life can be a struggle for many. COVID-19 has exacerbated these pre-existing inequalities. Nationally, we know that some people may be more at risk of transmission of COVID-19, at risk of poorer outcomes from infection, and at risk of greater impact from control measures. Public Health England (PHE) have found older people, males, those living in deprived areas, and those from Black, Asian and Minority Ethnicities (BAME) are at increased risk of poor outcomes. However, it is equally important to note that inequalities are also experienced in how people are treated – in the assumptions that are made; the language that is used; the way we communicate; and how services are designed and accessed.

In Oldham equality and diversity has been at the heart of our Covid-19 response. We have formed the Equality Advisory Group, made up of key community representatives, to help us positively respond to any disproportionate impact Covid-19 has had on our communities. We have completed a comprehensive Equality Impact Assessment to help us identify and mitigate any equality impacts caused by the pandemic, shaping both our response and subsequent recovery planning, ensuring our offer is responsive and equitable to all.

We are also developing an Equality and Diversity Strategy for Oldham, which will aim to:

1. Identify and mitigate the potential equality impacts caused by Covid-19, informing our response through research, best practice and lived experience.

2. Provide services that put the citizens' voice at the heart of decision-making, advancing equality of opportunity and celebrating diversity and inclusion for all.

3. We will lead the way in championing inclusivity across the borough, working with our partners and communities to design out inequality, making Oldham a fairer place for everyone.

4. Encourage and enable a skilled and diverse workforce to build a culture of equality and inclusion in everything we do.

Tackling poverty in Oldham

Poverty in Oldham

The exacerbation of existing inequalities as a consequence of COVID19 has also resulted in a further deepening and widening of poverty in the borough. Unemployment rates have doubled since March and rates are highest in our most disadvantaged communities. We are especially concerned about the rise in youth unemployment; now approaching 16% borough wide in some hotspots, within our poorer wards, as high as 37%.

Calls to our Emergency Helpline set up in response to the pandemic remain high (from March to the beginning of December we'd received 11,000 calls). Whilst the number of calls in relation to COVID19 and shielding have decreased, calls in relation to poverty remain high as people are now seeking help with accessing benefits; managing debt and paying essential bills. Callers are increasingly presenting with more complex needs and requiring support across multiple services. We are currently working with colleagues across the system to maintain the helpline as a first port of call for support; ensure it is sustainable longer term and that referral routes across the system operate effectively to get people the help they need early and quickly.

The end of the furlough scheme in March of next year, the removal of mortgage payment holidays and protection from eviction for rent arrears, will continue to challenge us and place increasing demands on increasingly constrained crisis services. Our commitment to tackling poverty is unwavering and we are working hard with our partners to ensure we are doing all we can both to support people experiencing poverty now; enabling them to take steps out of poverty and working longer term to tackle the underlying causes.

In the short term, for those struggling with poverty now, we are ensuring no child in Oldham goes hungry over Christmas through the roll-out of the DWP COVID-19 Winter Grant. We are again working with our partners e.g. VCFSE sector, Credit Union and Registered Providers to ensure vulnerable families and individuals can get help with essential bills; boiler repairs and essential goods. In the longer term our approach will focus on how we enable people to move out of poverty and tackle the root causes. To help us with this we have established a senior level Poverty Steering Group to oversee and provide ownership of the development of a system-wide Poverty Strategy and Action Plan .

In addition we are:

- Ensuring our understanding of poverty informs our proposals for place-based integration and links to both our Thriving Communities and Community Wealth Building programmes

- Supporting the development of and engagement in a Poverty Truth Commission to ensure we are engaging, listening and working with people experiencing poverty to tackle it

- Working with Action Together to strengthen our existing Poverty Agenda Group – so that it becomes more focused on delivery of our key poverty priorities

Supporting Oldham's Children and Young People

We are supporting our children and young people by prioritising safe education provision and addressing the mental, physical, social and developmental harm that has been caused by Covid-19. The actions that do this are:

- Maintaining opening of schools through contact tracing, advice to schools and guidance for parents
- Multi agency work on risk management of vulnerable children
- Attendance focus for agencies working with CYP with EHCPs and / or social workers
- Flexible and responsive approach to FSM provision and a holiday hunger strategy
- Increased SEND transport provision and other work to support the most vulnerable children to attend school
- Safeguarding the CME and EHE pupils and supporting schools to minimise exclusion
- Sharing high quality research, practice and resources for online/blended learning, including a digital learning commission
- Support the sustainability of the local childcare market and take account of changing parental needs and preferences
- Face to face visits and virtual consultations for SEND pupils and families, as required.

Children's Social Care

Within Children's Social Care and Early Help we will continue to maintain a focus on our children and young people and their well-being and safety remains paramount. We will continue to adhere to our key service principles and ways of working which have been established in response to the pandemic in relation to ensuring children and families continue to receive the care, help and protection needed. Staff safety will remain our priority and we will continue to ensure that guidance is regularly updated, staff can readily access testing and PPE, and there is regular communication through a weekly update and management oversight and supervision is maintained.

We will continue to maintain our Children's Social Care Service "Bubble Rota" which means that each service area will have a Duty Team in the office for the week they are on the rota and all other staff are working from home and maintain contact with all children and families on their caseload, with team regular check in with their team managers in via Microsoft Teams. A 'hybrid' approach is being taken to Child Protection Conferences and Looked After Reviews with partners being invited via MS Teams for the foreseeable future.

We have developed a flexible approach to service delivery and continue to ensure that where there are co-working arrangements in place with other services there are clear cross-service communications in place to reduce duplication.

Twice-weekly strategic partnership meetings are held to ensure an integrated approach to Oldham's response to children and families and develop our recovery planning including the management of increased demand for services, including Domestic Abuse.

We are considering how, moving forward we may use the learning from the Covid-19 crisis to develop our future operating model and deliver more flexible and responsive services for vulnerable children and families in Oldham

Tackling and Preventing Homelessness

We are working with our key stakeholders to prevent homelessness. Our registered social landlords have signed a pledge that they will not evict tenants who are experiencing hardship due to Covid 19.

Oldham has continued to operate the ‘everyone in’ initiative which the Government launched at the start of the pandemic. Oldham has a localised offer for rough sleepers and this is delivered through an extension of our A Bed Every Night ‘ABEN’ scheme. Anyone who is a rough sleeper or who is at risk of rough sleeping will be accommodated through this scheme. All our temporary accommodation has been risk assessed as Covid safe and complies with the relevant guidance.

Through our strategic housing partnership we are working on refreshing our homelessness pledges to ensure fairness and consistency throughout the housing sector and to ensure everyone receives their entitlement to a warm, safe, secure place to live which they can call home.

In addition we are:

- Working closely with Oldham Street Angels, the 7-day homelessness service enables individuals to provide an address for test results, ensuring that homeless people can access testing facilities in Oldham.
- Providing £974,689 of Winter Grant funding to support residents with food, fuel and other essential costs during winter (from December 2020 to March 2021).
- Work across services to ensure the mechanisms are in place to support the timely distribution of the vouchers and to match this with other sources of funding for example the DEFRA Emergency Assistance Fund; vouchers from the GM Mayor’s No Child Should Go Hungry Campaign; Local Welfare Provision and resources available within the VCFSE sector. This will enable us to ensure that support reaches the maximum number of vulnerable families and individuals - giving them peace of mind in the run up to Christmas, and over the winter months, that they will be able to access help with food and essential bills.

Providing Humanitarian Assistance

Through a multi-agency Community Bronze Structure, will be provided to those who are most in need, using the local authority-led Helpline and Community Hubs that we set in each district in our initial response. These will continue providing humanitarian aid and our strategy to implement a whole system model for public services (including the voluntary, community, faith sector (VCFSE) to work as 'one response' and with 'one voice' in communities, based on five public service neighbourhoods, underpinning our current approach to outreach in communities and individuals disproportionately impacted by Covid-19. This will include:

- Maintaining preparedness for increases in demand for humanitarian and acute welfare support.
- Strengthen the connection with the VCSE and mutual aid groups and work in partnership with them to ensure they have the resources they need to meet the increasing demands.
- Provide ongoing humanitarian support to those shielding and self-isolating
- Prepare for additional humanitarian support that will be required when the current Universal Credit cap 'grace period' ends in January and the £20 Universal Credit increase ends in March

In addition to support our humanitarian assistance, we will continue community engagement work through Action Together (our CVS) and Council district teams working closely with community leaders, champions and anchor organisations. Also through an outreach team do targeted door to door engagement.

Humanitarian assistance measures:

No of people contacting the helpline for assistance
No of people referred for support into the Hubs
No and type of support requested
No and reason for request
No. of 'CEVs' contacted by the Councils and no. that the Council was unable to contact
Number of 'CEVs' directly supported to access food
Number of 'CEVs' who did not need support with access to food after follow-up

The indicators we will use to measure progress over the next six months

Inequalities

- Self referrals to IAPT services
- Education (e.g. number of new COVID-19 cases, children self-isolating, staff self-isolating) – from GM and DFE data
- Domestic Abuse Incidents
- Prevalence and severity of impact for BAME residents
- Volume of residents in council tax arrears.
- Number of new claimants for Universal Credit, new-style JSA and new-style ESA.

Education

- Attendance in school, and of vulnerable children in school
- No. of children affected by COVID and unable to attend school
- Average Days of Education Lost to COVID per FTE
- The number of +VE cases affecting schools (staff and pupils)
- The number of contacts identified per positive case
- GM provider survey on Early Years and Out of School Provision

Homelessness

- Number of people:
  a) Rough sleeping
  b) In emergency temporary accommodation
  c) In statutory temporary accommodation
- Progress through move on programmes (Housing First, Next Steps etc.)

Older People

- Falls and fractures related admissions to hospital for 65+ age group (TBC)
- Mental health referrals for 65+ age group (TBC)
- Waiting times for specific health services (TBC)
- Self-reported nutrition and hydration status (TBC)
- Older people volunteering (TBC)
- Access to cultural / community activities (TBC)
- Pension Credit take up (TBC)
- Use of the concessionary bus pass (through Transport for Greater Manchester)
- Attendance at leisure service physical activity provision (through GM Active)
- Attendance at exercise referral schemes (through GM Active)
- Attendance figures from GM Culture Fund recipients
- Utilisation of the Dementia United Greater Moments App

Humanitarian assistance

- No. of households contacting local authority Community Hubs for:
  a) food support
  b) medication support
  c) other non-essentials support
  d) welfare support and advice
  e) well-being support
- No. of individuals seeking support from local authority Community Hubs because they are:
  a) Shielding (CEV and non-CEV)
  b) Experiencing poverty/hardship
  c) Self-isolating
- No. of Self-isolation grants requested and received
- Volume of individuals and families supported through the COVID Winter Grant Scheme
- Demand on VCSE services, its workforce resilience and financial sustainability.

Supporting Oldham's economy

As per the GM Economic response, over the next six months it will be essential to protect the economy and ensure it receives the support it needs to lead to a strong recovery. There is massive uncertainty both from Covid-19 and the end of the Brexit transition period, but until a lasting solution to the Covid-19 crisis is found businesses are going to find it harder to survive and unemployment will rise.

The widespread impacts on the UK economy will continue to require large scale resources and programmes from central Government support such as the Job Support Scheme and Local Discretionary Business Grants.

Oldham will need to work with publicly funded agencies to maximise the value of the core existing and emerging employment support programmes, including: Working Well, JE:TS and recently announced £2.9bn "Restart" programme. The aim is to launch the new Social Enterprise Incubator Hub within the next 6 months.

GMCA aims to use resource and expertise to fill the gaps left by Government support, react quickly, support groups missed by national provision and deliver more effectively where an integrated response is required. We will also focus on growing new businesses and good jobs beyond the immediate restrictions.

So far GMCA have implemented targeted support on the newly unemployed and those facing long-term entrenched inequalities, however, the referrals from onto these programmes are not geographically equal.

What are the wider indicators we are using to measure impact on Oldham's economy?

- Claimant count (JSA and UC)
- Number of businesses requesting pause in business rates
- Numbers of people on furlough scheme/SEISS
- Number of redundancy notifications (not available at LA level)
- Business Start ups Supported by GC

Over the next six months to support our economy we will:

1

Support businesses

- Ensure that local businesses access maximum support to ensure that they are able to survive and recover from the difficulties caused by the pandemic including:
- Keeping them informed of latest support programmes via a weekly CV19 business newsletter and social media campaigns.
- Deliver a number of business grant programmes including the Local Restrictions Grant Scheme, National Lockdown Programme and the Additional Restrictions Grant (ARG) in Oldham. The ARG will be used to maximise support for those businesses that have been badly affected and cannot access mainstream Government funding.
- Continue to work with the Business Growth Hub and other partners through Team Oldham to ensure that businesses are aware of and can access the support they need to recover and grow following the pandemic.

2

Support unemployment

- Support to furloughed or newly unemployed, including fully-funded skills programme, Employ GM and Working Well Early Help
- Retraining and reskilling, including Safe Return to Work Programme and £7m Skills for Growth Programme, and Fast track Digital Workforce Fund
- Support for young people, £150k GM Tech Fund and Young Person Guarantee launched
- £300k funding for new apprenticeships, Levy Matchmaking Service, annd free bikes for key worker apprentices
- Tackling inequalities including £2.5m local authority grant scheme, supporting 50+ people into employment

6

Living with Covid-19

Living with Covid-19

Looking ahead to the next twelve months we also have a degree of optimism that society to return to some form of normality, though there will likely be ongoing restrictions in place to combat the spread of the virus and limit the impact of virus mutations which could impact on the effectiveness of vaccines. Effective, test, trace and isolate (TTI) infrastructure can exert strong downward pressure on R, and can handle the occasional spike before we need to resort to stronger contain measures. Technological developments in testing and in vaccinations, and developing the infrastructure in Oldham and GM to roll these out rapidly and ensure they are widely available, are critical in helping us to reach this phase where the virus no longer poses a significant risk.

- Test for the disease through the roll out of targeted testing at scale
- Contact trace and ensure infected residents and their contacts isolate
- Vaccinate the population, starting with those most at risk

What are the wider indicators we are using to measure the effectiveness of our Living with Covid-19 Plan

Testing:

- Prevalence rate (rate per 100,000)
- Testing rate
- Turnaround time for test results
- Public insight surveys as well as soft intelligence and feedback on testing where indicators are yet to exist

Contact trace and isolate:

- % of index cases and contacts reached (already exists)
- Number of contacts per case

Vaccination:

- Analysis of data by cohort to ensure early recognition of most vulnerable
- Prevalence rate of vaccine uptake (once the roll out begins)
- Correlation of vaccine uptake against % cases per cohort to understand the impact (measure over time however impact of immunity will be some way into the future)
- Utilise GM & National Public Insight Surveys in support of our local communications to enable appropriate feedback and outreach to vulnerable groups, health inclusion groups and to address inequalities on a locality basis

Over the next six months we will:

		National action required:
1	**Test** • Continue to test symptomatic patients via our three local testing sites • Review take up of testing and location of testing sites to assess future need for sites • Begin to test asymptomatic residents in targeted cohorts e.g. health and social care staff • Scale up testing in Oldham using new and existing technologies and increasing capacity • Continue to make improvements to existing testing arrangements	Proposal provided to the government for GM to have more autonomy and control of testing in GM, including finance and discretion in use of tests. GM also continues to meet with DHSC to determine the requirements and approaches for lateral flow and saliva testing in GM.
2	**Trace and isolate** • Continue to operate the locality Single Point of Contact for contact tracing for schools and other settings escalated by the national system • Continue to deliver locally supported contact tracing (Level 2) for index cases not reached by the national team within 24 hours. • Lobby for a fundamental redesign of the national test and trace system • Support the redesign of the GM contact tracing system to be locally led, GM supported and nationally enabled. • Strengthen our Level 1 response to complex settings and vulnerable people, with an emphasis on implementing a “local first” model • Increase our focus on proactive and preventative engagement • Engage, empower and mobilise settings, citizens, communities and VCSE sector	Fundamental redesign of the national test and trace system with an emphasis on co-design, system architecture, resources, and strategic intent. In the absence of this, improve the approach to households and families, and to improve timeliness, reduce “handoffs” and streamline processes. Continued investment in locality-led approaches to CT and the redeployment of national staffing assets to local levels.
3	**Vaccinate** • Deliver the vaccination program at at operational level across Oldham, in line with JCVI Priorities, starting with the most vulnerable segments of our population • The high priority categories including over 80’s, care home residents and staff and health and care frontline workforce will be completed by mid February 2021 • Focus on vulnerable groups and particularly our homeless population to ensure equity of access to vaccination • Vaccinate JCVI Priorities 1-4 by 15th February 2021 and priorities 5-9 by end of June 2021. The national aim is for all population by Autumn 2021. • Utilise GM Mass Vaccination site at Etihad Tennis Complex to support local delivery	Investment in locality led delivery of the vaccination programme with redeployment of national staffing resource. Streamlined data aligned with JCVI cohorts to enable local targeted delivery. Clarity on national booking and recording processes to align with GM Mass Vaccination site. Move as quickly as possible to a ‘pull’ model of vaccine supply.

7

Conclusion

Asks of Government

Action is required from national Government to support Oldham and GM in our response.

- The scale of disruption and challenge to our way of life caused by the virus is unprecedented. It requires more than the action we will take at a local and GM-level.

- A concerted response from UK Government is required, both to control the spread of the virus but also to provide the support our individuals, communities and businesses desperately need to survive the next six months. We ask that Government continues to engage with us over the next six months and responds to the national action required we have set out in each section of the plan.

- As we look over the next six months we have hope that we will reach a position where the virus no longer poses a significant threat to public health. However we also know that at this point the socioeconomic implications of Covid-19 may only just be starting to be seen. Packages of further support will be required to ensure GM is able to recover from the virus and continue to tackle the inequalities within Oldham, and between Oldham and the rest of the UK.

Health & Wellbeing Board

January 2021

Mike Barker, Chief Operating Officer

Oldham Council

NHS Oldham Clinical Commissioning Group

Jan-Mar 2021

Managing the remainder of 2020/21

Given the second wave and the new more transmissible variant of the virus, it is clear that this winter will be another challenging time for the NHS

Our task is now five-fold:

1. Responding to Covid-19 demand
2. Pulling out all the stops to implement the Covid-19 vaccination programme
3. Maximising capacity in all settings to treat non-Covid-19 patients
4. Responding to other emergency demand and managing winter pressures
5. Supporting the health and wellbeing of our workforce

- In addition, we are now following a single operational response model for winter pressures, including Covid-19 and the end of the EU transition period. Our SRO to lead the EU/UK transition work is the Chief Operating Officer

What this means…

Responding to emergency demand and managing winter pressures

Lead: Nicola Hepburn, Director of Commissioning Operations

We are asking systems to take the following steps to support the management of urgent care:

- Ensure those who do not meet the 'reasons to reside' criteria are discharged promptly. We are asking all systems to improve performance on timely and safe discharge, as well as taking further steps that will improve the position on 14+ and 21+ day length of stay, aided by 100% completion of discharge and reasons to reside data
- Complete the flu vaccination programme, including vaccinating our staff against flu and submitting vaccination uptake data to the National Immunisation and Vaccination system (NIVS)
- Minimise the effects of emergency department crowding, continue to develop NHS 111 as the first point of triage for urgent care services, with the ability to book patients into the full range of local urgent care services, including urgent treatment centres, same day emergency care and speciality clinics as well as urgent community and mental health services.
- Maximise community pathways of care for ambulance services referral, as a safe alternative to conveyance to emergency departments. Systems should also ensure sufficient arrangements are in place to avoid unnecessary conveyance to hospital, such as the provision of specialist advice, including from emergency departments, to paramedics as they are on scene.

Responding to ongoing Covid-19 demand

Lead/s: Mike Barker, Nicola Hepburn & Claire Smith

- With Covid-19 inpatient numbers rising in almost all parts of the country, and the new risk presented by the variant strain of the virus, you should continue to plan on the basis that we will remain in a level 4 incident for at least the rest of this financial year and NHS trusts should continue to safely mobilise all of their available surge capacity over the coming weeks. This should include maximising use of the independent sector, providing mutual aid, making use of specialist hospitals and hubs to protect urgent cancer and elective activity and planning for use of funded additional facilities such as the Nightingale hospitals, Seacole services and other community capacity. Timely and safe discharge should be prioritised, including making full use of hospices. Support for staff over this period will need to remain at the heart of our response, particularly as flexible redeployment may again be required.
- Maintaining rigorous infection prevention and control procedures continues to be essential. This includes separation of blue/green patient pathways, asymptomatic testing for all patient-facing NHS staff and implementing the ten key actions on infection prevention and control, which includes testing inpatients on day three of their admission.
- All systems are now expected to provide timely and equitable access to post-Covid assessment services, in line with the commissioning guidance.

Implementing the Covid-19 vaccination programme

Lead: Mike Barker, Chief Operating Officer

- The Joint Committee for Vaccination and Immunisation (JCVI) priorities for roll out of the vaccine have been accepted by Government, which is why the priority for the first phase of the vaccination is for individuals 80 years of age and over, and care home workers, with roll out to care home residents now underway. It is critical that vaccinations take place in line with JCVI guidance to ensure those with the highest mortality risk receive the vaccine first. To minimise wastage, vaccination sites have been ensuring unfilled appointments are used to vaccinate healthcare workers who have been identified at highest risk of serious illness from Covid-19. Healthcare providers have been undertaking staff risk assessments throughout the pandemic to identify these individuals and it remains important that this is organised across the local healthcare system to ensure equitable access.
- If further vaccines are approved by the independent regulator, the NHS needs to be prepared and ready to mobilise additional vaccination sites as quickly as possible. In particular, Covid-19 vaccination is the highest priority task for primary care networks including offering the vaccination to all care home residents and workers. All NHS trusts should be ready to vaccinate their local health and social care workforce very early in the new year, as soon as we get authorisation and delivery of further vaccine

What this means…

Maximising capacity in all settings to treat non-Covid-19 patients

Lead: Nicola Hepburn, Director of Commissioning Operations and Claire Smith, Chief Nurse

- Systems should continue to maximise their capacity in all settings. This includes making full use of the £150m funding for general practice capacity expansion and supporting PCNs to make maximum use of the Additional Roles Reimbursement Scheme, in order to help GP practices maintain pre-pandemic appointment levels. NHS trusts should continue to treat as many elective patients as possible, restoring services to as close to previous levels as possible and prioritising those who have been waiting the longest, whilst maintaining cancer and urgent treatments.
- To support you to maximise acute capacity, as set out in Julian Kelly and Pauline Phillip's letter of 17 December, we have also extended the national arrangement with the independent sector through to the end of March, to guarantee significant access to 14 of the major IS providers. NHS trusts have already been notified of the need for a Q4 activity plan for their local IS site by Christmas; this should be coordinated at system level. If you need it, we can also access further IS capacity within those providers subject to the agreement of the national team. However, we will need to return to local commissioning from the beginning of April and local systems, in partnership with their regional colleagues, will need to prepare for that.
- The publication of the Ockenden Review of maternity services is a critical reminder of the importance of safeguarding clinical quality and safety. As set out in our letter of 14 December there are twelve urgent clinical priorities that need to be implemented. All Trust Boards must consider the review at their next public meeting along with an assessment of their maternity services against all the review's immediate and essential actions. The assessment needs to be reported to and assured by local systems, who should refresh their local programmes to make maternity care safer, more personalised and more equitable.

Supporting the health and wellbeing of our workforce

Lead: Julia Veall, Joint Director of HR & OD

National direction: Our NHS people continue to be of the utmost importance, and systems should continue to deliver the actions in their local People Plans. Please remind all staff that wellbeing hubs have been funded and will mobilise in the new year in each system

Plan for 2021/22

National planning priorities

The Spending Review announced further funding for the NHS for 2021/22 but in the new year, once we know more about the progress of the pandemic and the impact of the vaccination programme, the Government will consider what additional funding will be required to reflect Covid-19 cost pressures.

1. Recover non-covid services

in a way that reduces variation in access and outcomes between different parts of the country. To maximise this recovery, we will set an aspiration that all systems aim for top quartile performance in productivity on those high-volume clinical pathways systems tell us have the greatest opportunity for improvements: ophthalmology, cardiac services and MSK/orthopaedics.

The Government has provided an additional £1bn of funding for elective recovery in 2021/22. In the new year we will set out more details of how we will target this funding, through the development of system-based recovery plans that focus on addressing treatment backlogs and long waits and delivering goals for productivity and outpatient transformation. In the meantime we are asking you to begin preparatory work for this important task now, through the appointment of a board-level executive lead per trust and per system for elective recovery.

2. Primary and community care

Prioritise investment in primary and community care, to deal with the backlog and likely increase in care required for people with ongoing health conditions, as well as support prevention through vaccinations and immunisations. Systems should continue to focus on improving patient experience of access to general practice, increasing use of online consultations, and supporting the expansion of capacity that will enable GP appointments to increase by 50 million by 2023/24.

3. Health Inequalities

Address the health inequalities that covid has exposed. This will continue to be a priority into 2021/22, and systems will be expected to make and audit progress against the eight urgent actions set out on 31 July as well as reduce variation in outcomes across the major clinical specialties and make progress on reducing inequalities for people with learning disabilities or serious mental illness, including ensuring access to high-quality health checks

4. People and workforce

Strengthen delivery of local People Plans, and make ongoing improvements on: equality, diversity and inclusion of the workforce; growing the workforce; designing new ways of working and delivering care; and ensuring staff are safe and can access support for their health and wellbeing.

5. Mental Health

Accelerate the planned expansion in mental health services through delivery of the Mental Health Investment Standard together with the additional funding provided in the SR for tackling the surge in mental health cases. This should include enhanced crisis response and continuing work to minimise out of area placements.

6. Integrating Care: Build on the development of effective partnership working at place and system level. Plans are set out in our Integrating Care document.

Overall aim is to reset the health and care system through eight priorities

Following the implementation of phase 2 recovery as part of the Covid-19 response, Oldham's health and care phase 3 recovery assessment and route to implementation has been established.

The overarching aim of this recovery work is to ensure that more, if not all, services are stepped back up safely, whilst operating within the context of enhanced infection, prevention and control (IPC) measures, which as well as impacting on care delivery, impacts on estate capacity also.

The data used for our planning is based on assumptions using existing and current capacity and demand modelling, and is aligned (for Oldham borough patients) with the Northern Care Alliance (incorporating Pennine Acute Hospitals – Royal Oldham) and Pennine Care.

We have devised a six month plan with 8 priorities:

1. Cancer
2. Elective
3. Workforce
4. Mental health and learning disabilities
5. Health inequalities
6. Primary care
7. Winter
8. Integrate care

National activity target expectations

Referrals:
- The national expectation is that this returns to **100%** of the previous year's activity – Oldham is realistically planning for this to be back to **80%**

Elective inpatients:
- That national ask is that this activity incrementally returns to **70%** of the previous year **rising to 90%** by March 2021 – Oldham is realistically planning for this to be back up to **73%**

Elective outpatients:
- The national ask is that this activity incrementally returns to **90%** of the previous year **rising to 100%** by March 2021 – Oldham is realistically planning for this to be back up to **91%**

Non-elective inpatients:
- Oldham is planning for this to be back up to **83%** of the previous year's activity

Emergency department attendances:
- The regional ask is that this activity returns to not less than **75%** of the previous year – Oldham is realistically planning for this to be back up to **89%**

Over the next six months we will…

1

Cancer

- Improve cancer referral data
- Work with NCA on a diagnostic hub business case to provide additional capacity
- Work with NCA to ensure that its cancer recovery plan is reviewed and approved
- Implement additional PET-CT scan machine
- Continue to promote the bowel, cervical and breast proactive screening programmes in primary care under 'Primary Care Plus'
- Implement local and national cancer campaigns: "We are here for you"
- Utilise existing Covid-19 community engagement to provide information on cancer symptoms and services

2

Elective care

- Work with providers to enact key demand management tools, such as 'advice and guidance' to support the reduction in outpatient need
- Work with NCA on the broader 'System Wide Outpatient Programme' to continue to implement different ways of delivering outpatient care, as well as implementing new initiatives to support reduction in volumes such as PIFU
- Work with providers to consider and consult on a more permanent arrangement to the use of medication for early medical abortions (up to 10 weeks) in conjunction with over the phone or virtual appointments
- Roll out of new referral template to improve quality of referral information and support improved triage with advice and guidance responses back where appropriate

What we are already doing

Cancer

- Northern Care Alliance (NCA) has recently launched the Rapid Diagnostic Centre at its Oldham and Salford sites, which has seen an increase in referrals and is running at an 8-10% cancer conversion rate
- Two week wait (2WW) cancer referrals now only 8% down on pre-lockdown levels
- Contracting of routine endoscopy diagnostics were transferred to the hospital trust to provide support for cancer work – supported by a GM-wide programme to increase mobile endoscopy capacity
- GM-wide surgical hubs for cancer in place at Rochdale Infirmary and The Christie as 'green' Covid-secure sites
- CCG-chaired Board in place to transform outpatients system-wide (SWOP), focusing on diagnostics and service recovery

What we are already doing…

Elective care

- GM-level management of independent sector hospital capacity in place across the system
- Independent sector community elective providers being engaged in relation to capacity availability, and will be supported by the CCG regarding estates needs due to IPC measures
- Virtual solutions are being used to increase outpatient activity (including assessments and reviews) to the required levels
- Pregnancy terminations continued to be provided throughout lockdown, with medications sent via post
- Supply of all community elective providers to NCA to look at potential for additional capacity that can be offered on an provider-to-provider basis
- Implementation of tele-dermatology to reduce face-to-face contacts required and increase the numbers of patients managed outside of specialist services

Mental health and learning disabilities

- IAPT services activity is returning to pre-Covid levels – the service has continued to be in place throughout
  It is expected that the children and young people access target will be met
- Health checks for people with learning disabilities (LD) have continued throughout as part of the Direct Enhanced Service and Primary Care plus
- We are expecting the Transforming Care trajectories to be met for both secure and non-secure patient discharges by 31 March 2021
- The 'eliminating mixed sex accommodation' programme is now underway again following a pause in March 2020

Health inequalities

- Health inequalities are being addressed via Primary Care Plus in relation to key indicators such as by increasing prevalence and reducing exception reporting – those with severe and enduring mental health conditions are targeted, as well as those vulnerable to frailty
- Work is underway to address the issues that driver poor health outcomes, such as the recruitment of social prescribers who are deployed into PCNs
- GPs and the acute trust are reviewing all children and young people on the 'shielded' patient list and removing those from the list that are no longer deemed clinically 'extremely vulnerable' – all children and young people on the list are seen by services
- Increased testing is in place for all vulnerable people
- Regular 'sit-reps' are in place for care homes

Over the next six months we will…

3

Workforce

- Work across the Oldham Cares system to agree a collaborative approach and response to the NHS People Plan
- Produce a specific primary care response to the NHS People Plan, as a collaborative approach between the commissioners and Greater Manchester and Health Education England workforce leads
- implement the new primary care workforce programme to support the delivery of recruitment, retention and training objectives

4

Mental health and learning disabilities

- Increase investment in mental health services in line with the 'MHIS' plan
- Oversee the implementation of the IAPT 24/7 helpline to include full crisis resolution and home treatment services, and work with Pennine Care FT to ensure that the appropriate recruitment is in place and delivered to support the workforce action plan for the service
- Work with providers to ensure that access to these services is clearly promoted and advertised – this will include continued borough-wide campaigns to support mental health and wellbeing for all
- Following a review of LD prescribing of anti-psychotics, develop an action plan for this area to support practices and provide them with implementation plans
- Develop an action plan to support LeDeR reviews and lack of capacity

5

Health inequalities

- Examine the potential to utilise medicines optimisation pharmacists working within PCNs to identify and support at risk patients as part of structured medicines reviews and health checks
- Extend the teams to support the 'continuity of carer' agenda, with specific teams to be put in place for vulnerable patients, including those with learning disabilities
- Phase in a new 'visiting plan' for maternity units to ensure the necessary family support is in place, as safety measures allow

Workforce actions already underway

- Enhanced mental health initiatives, platforms and support for all staff across the Oldham system are in place
- Regular 'pulse' surveying is in place to track how staff in the Oldham Cares system are feeling
- New equality strategy for Oldham is being produced by all partners and the community, voluntary and faith sector
- Oldham CCG 'equity' plan for recruitment, retention and progression is in development

Over the next six months we will…

Primary care

- Ensure clinical pathways and standard operating procedure are signed off for the paediatric virtual ward
- As part of processes to deal with childhood immunisation issues, oversee (in collaboration with CHIS) the redesign of processes to improve the system going forward
- Assess the effectiveness and quality of the weekly pastoral care calls between primary care and care homes, as well as individual care plans and structured medicines reviews
- Development of a revised outcome-based district nursing offer to bridge the period up to March 2021, which will ensure caseload prioritisation and also areas of current commissioned activity that can be ceased/provided differently in the wider system
- Confirm next steps for STICH enhanced nursing support for care homes and end of life pathways
- Develop robust links between medicines optimisation team and the PCNs
- Commission the GM ‘minor ailments’ scheme as support to the ‘self-care’ policy work
- Work with secondary care to increase the amount of medicines provided at discharge to reduce pressure on primary care prescribing
- Ensure that clinical vulnerable children are prioritised in community service recovery plans
- Ensure oversight of children with complex health needs and who have been shielding who may not be able to return to school so that their care and educational needs are met
- Maximise and lock in the benefits and changes that have been realised during COVID-19
- The system deficit will need to be managed in the context of the impact of the pandemic and will focus on: Managing the backlog of patients; Safely resuming clinical activity; Preparing for winter; Surge planning; Supporting our existing workforce and securing a sustainable workforce; and Exacerbation of existing health inequalities.

What we are already doing

- Locality-wide post-Covid rehab pathway implemented across acute, community and primary care and is working well, and additional capacity has provided for the lung service
- Community service recovery plans in place
- A community optometry service was commissioned in May 2020 to support the national ask for local urgent eye care services, which has continued and will be expanded to include routine care to help reduce the demand on acute trusts
- Care home ‘STICH’ enhanced community nursing support in place for care homes and end of life
- Work underway for PCNs to take a greater lead role in proactively reaching out to vulnerable patients as part of the MDT approach
- All 6-8 week checks for babies have been maintained throughout
- Paediatric ‘virtual’ ward due to go live, with an additional 20 beds to support early discharge
- Paediatric ‘rapid access clinics’ due to commence for primary care community care services to refer into specialisms, with the aim of avoiding hospital admissions
- The children’s community nursing team has maintained face-to-face contract throughout Covid-19 with children who have complex health needs and also children on the end-of-life pathway

Over the next six months we will…

7

Winter

- Consider the establishment of a ‘cold diagnostic site to reduce DNAs due to Covid-19 fears
- Consider a more joined-up approach with community pharmacy so that there is reduced competition for vaccine supply
- Work with community pharmacies to improve the signposting of key services and the best ways to access them during the winter, as well as promotion of the flu immunisation programme to encourage take-up
- Increase the number of paediatric multi-disciplinary teams across the neighbourhoods in the borough

What we are already doing

- A robust flu immunisation programme plan is now in place for Oldham, with specific interventions for target and at-risk groups, integrated with the national and local communications and engagement flu and winter campaign
- A multi-agency flu programme group is in place to ensure the delivery of the immunisation plan – this includes a dedicated individual from the CCG’s primary care team to coordinate work as needed with practices
- Community and primary care nurses are trained to administer flu vaccines
- Paediatric rapid access clinics are increasing in number, offering up to 30 appointments per week - GP ‘advice and guidance’ service in place, which will also coordinate with the rapid access clinic
- StartWell specialist nurses are back in the emergency department

Conclusion

The success of the next six month recovery plan will be reliant on:

- Robust partnership working
- Strong clinical leadership and engagement
- Effective engagement with our communities and with patients
- Clear programmes for service redesign and transformation
- Good governance

The core transformation programmes will centre around:

- A new model for managing long term conditions, utilising a ‘hub’ that includes non-elective, elective and primary / community care
- A new model for urgent care, as linked to the Greater Manchester model
- Redesign of local community services

Transition to an integrated system model

High level timeline

Jan – Mar '21 Planning Phase

Do as much work now to prepare for the future

April – Sept '21 Transitional Phase

Move into new arrangements where feasible

Sept – Mar '22 Shadow Running

Be ready to operate new systsem

Vision and principles

Vision

- Significantly raise healthy life expectancy through a place-based approach to better prosperity, health and wellbeing
- To enable place based approaches to tackling the social determinants of health, reduce inequalities, and provide high quality, proactive care within a population health approach
- Focus on the people we serve, the place where we live and work and the partnerships we create

Principles

- To be organised and act as accountable to the local population and to each other
- To provide strategic leadership for place- political, clinical and executive/ managerial focused on the needs of our population rather than organisations
- Priorities and objectives will be framed according to our service and offer to residents - advice on staying well; preventative services; simple and joined up services for care and treatment when they need it; simple, active support to those who are vulnerable and at risk to keep as well as possible
- The sector as a local economic contributor, delivering social value - through its employment, training, procurement and volunteering activities, to play a full part in social and economic development
- Deliver the best health and care services for the place based budget
- Continue to redress the balance of care to move it closer to home
- Make decisions about funding for the totality of the place based budget, criteria and design of services through co-production and co-design with service users
- Working with communities to empower change
- Removing (through integration) and disregarding (through governance) the commissioner/provider separation
- Decides upon and drives the changes we pursue collectively at the GM level

Functions and responsibilities

Governance and the role of the Local System Board/Partnership Board

- Setting strategic direction
- Aligning political, clinical and managerial leadership or the place including accountable public health leadership
- High level resource allocation including incorporation of the NHS allocation for the locality into the place based budget
- Agreeing transformation plans and overseeing system delivery and health & care transformation
- Agree Locality's strategic connection to GM, NW etc. according to agreed functional alignment and responsibility
- Responsible for relevant 'health' outcomes within the Single Outcomes Framework
- Overseeing the development of the new system (neighbourhood model and PCN support, integration of delivery and alignment of resources)

Delivery arrangement

- Confirmed scope of service and operating model for the 'next generation LCO' (this will confirm a common, minimum core – primary care, social care, community services, local acute care (eg acute medicine, elements of outpatients etc), community Mental Health & wellbeing) alongside the means to connect to Out Of Hours, VCSE, housing, education, criminal justice etc partners) and will be all age. It is understood that some will be organisationally integrated, some contractually and some aligned through partnership agreement and that this may change over time.
- Responsibility for driving the change -Tactical commissioning; risk stratification & case finding; lived experience and co-production; strengths based/asset based working; workforce development and blended roles
- Actionable connections to true prevention services (housing, employment, VCSE etc)
- Confirming what is out of scope and proposed to be enacted at the GM level (suggestions include - certain aspects of specialised commissioning, cancer, elective care, EPPR, Business Intelligence and Analytics, Clinical pathway development, market management of the Independent Sector, aspects of Urgent and Emergency Care?)

Developing the local model

Local system Board

- Aligned intentions around local System Board/Population Health Board (often collapsing 2-3 existing boards into the new construct)
- To establish and operate the Place Based Budget together. The budget may include resources pooled, aligned and 'in view'
- Mechanism or clinical leadership will need specific attention and support
- Intention in some places for equivalent neighbourhood governance and deployment/delegation of budgets to neighbourhoods (localised subsidiarity)
- Creation of expanded Place Budget with system budget process and shared responsibility for financial sustainability
- system based quality and assurance approach

Evolution of commissioning

- Commissioning will be brought together into a single function, with a single leadership structure, significantly expanded pooled budget and the back office between the CCG, Council & LCO will be consolidated into a single support function with the efficiency benefits realised.
- Arrangement to ensure also the deployment of resources organised at community level and all core teams coming together to form a geographically-focused resource to provide core support to local population health needs
- New financial framework to accelerate LCO maturity and development – eg progress to a single, whole population health contract

Developing the local model

Integrating Provision

- Clarify options for the next stage of the locally integrated model - Primary Care, Social Care, Mental health and FT working together through a legally binding integrated contractual agreement; OR a lead provider model; OR intended development of an expanded care trust. Potential for provider side s75
- Need to understand implications for the development of the FT model
- It is understood that some will be organisationally integrated, some contractually and some aligned through partnership agreement and that this may change over time. Each locality will have their own route map guiding these changes – NB we have recognised the need to identify a balance between flexibility & consistency
- A means to enable the neighbourhood model, supporting the development of the integrated teams and confirming contracting, accountability and leadership arrangements with PCNs (PCN Maturity and Development)
- Expanding neighbourhood ambitions – mental health, housing, schools, drugs and alcohol, people with no recourse to public funds etc
- There will be an erosion of the commissioner /provider split and the local system will identify how it describes and organises those functions in future
- New quality assurance, quality monitoring, and improvement models spanning the scope of the LCO/Local Care Trust/Local Partnership
- Alignment of staff into the LCO/Local Care Trust/Local Partnership to create single place based functions eg's include: IT, BI, Finance, Communications, Contracting, IG, Choose and Book and CHC.
- Demonstrating readiness to undertake the relevant commissioner and provider functions- possibly through an authorisation process

Key areas of focus for Jan - Mar

1. Governance options (functions, membership & establishment of local system board; delegation framework)
2. Financial framework (funding flows, accountability, mechanisms for pooling)
3. Clinical/professional leadership model and framework
4. Determination of appropriate geographies for specific services/commissioning responsibilities
5. Detailed CCG functional analysis
6. People/HR implications

- Overseen by MET with updates to Governing Body as appropriate
- Models implied need to be signed off by Governing Body as well as other parts of the system

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