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Oldham Council

# *HEALTH AND WELL BEING BOARD*
## *Agenda*

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| Date | Thursday 7th September 2023 |
| Time | 10.00 am |
| Venue | Lees Suite, Civic Centre, West Street, Oldham, OL1 1NL |
| Notes | 1. DECLARATIONS OF INTEREST- If a Member requires 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 the Constitutional Services team at least 24 hours in advance of the meeting. |

2. CONTACT details for this agenda are available from the Constitutional Services team, telephone 0161 770 5151, or 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 12.00 noon on Monday, 4 September 2023.

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

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Please also note the Public attendance Protocol on the Council's Website

https://www.oldham.gov.uk/homepage/1449/attending_council_meetings

MEMBERSHIP OF THE HEALTH AND WELL BEING BOARD
Councillors Brownridge, J. Harrison (Chair), Mushtaq, Nasheen, Shuttleworth and Sykes

Item No

1 Apologies For Absence

2 Urgent Business

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Urgent business, if any, introduced by the Chair.

3 Declarations of Interest

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

4 Public Question Time

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

5 Minutes (Pages 1 - 14)

The Minutes of the meeting of the Health and Wellbeing Board held on 15th June 2023 are attached for approval.

6 Better Care Fund Plan 2023 - 2025 (Pages 15 - 28)

7 Joint Strategic Needs Assessment - Intelligence update on Tobacco Use in Oldham (Pages 29 - 36)

Presentation by the Data Insight and Intelligence Team Strategy and Performance Service

8 Reducing Tobacco Harms (Pages 37 - 46)

9 Oldham, Rochdale, and Bury Child Death Overview Panel Annual Report 2021/22 (Pages 47 - 70)

A report providing an annual review of the Child Death Overview Panel (CDOP) data for Oldham, Rochdale and Bury (ORB), one of the four CDOP groupings in Greater Manchester

10 Health Protection and Health Improvement Updates

To receive and consider verbal updates on Health Protection and Health Improvement.

**HEALTH AND WELL BEING BOARD**
**15/06/2023 at 10.00 am**

**Present:** Councillor J. Harrison (Chair)
Councillors M Hussain (Deputy Leader, Cabinet Member for Children and Young People), Mushtaq, Nasheen and Sykes
Katrina Stephens - Director of Public Health
Alistair Craig -
Christina Murray – Pennine Care NHS
Claire Hooley – ASC Commissioning
Lorraine Black – First Choice Homes Oldham
Stuart Lockwood – Chief Executive Oldham Community Leisure
Dr. J Patterson – Clinical Commissioning Group
Jon Taylor – Joint Strategic Needs Assessment
Emily Tunney – Research Officer
Rebecca Fletcher – Consultant in Public Health
Charlotte Stevenson – Consultant in Public Health
Paul Rogers – Constitutional Services

1 **APPOINTMENT OF VICE-CHAIRS**

**RESOLVED:** that Majid Hussain and Dr.J Patterson be appointed Vice Chairs of the Health and Wellbeing Board for the 2023/24 Municipal Year

2 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Brownridge, M Barker, H Catterill, G Jones, T Tariq, A Tebay, D Jago.

3 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

4 **URGENT BUSINESS**

There were no items of urgent business received.

5 **MINUTES OF THE PREVIOUS MEETING**

**RESOLVED:** That subject to the following amendments to those present, the Minutes of the meeting of the Health and Wellbeing Board held on 21 March 2023, be approved as a correct record:-

(i) D. Jago – Northern Care Alliance
(ii) Dr.C. Stevenson
(iii) J.Taylor – Public Health Business Intelligence

6 **JOINT STRATEGIC NEEDS ASSESSMENT**

The Health and Wellbeing Board received a presentation by Jon Taylor, Public Health Business Intelligence, regarding Oldham's new Joint Strategic Needs Assessment (JNSA) website.

Jon Taylor informed the Board that the JNSA describes the health, wellbeing and care needs of the Borough and looks to identify and address some of those needs and reduce inequalities in Oldham. It is produced by the Health and Wellbeing Board to inform decisions by the NHS, Oldham Council and other partners about providing services to improve the health and wellbeing of the people living in the Borough. He informed the Board that JSNA for Oldham is not available in printed form. Instead the content is available on the the website https://www.jsnaoldham.co.uk/

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He advised that the website is more visually appealing and accessible and will be updated when additional information is available. He added that JSNA is work in progress and will always be, in that it is continually being updated with new data. It is designed to be a partnership resource for all to use.

He drew members attention to the website data content and examples of data within the content as follows:

(i) **Oldham Profile** – population, derivation, life expectancy and growth.

(ii) **Starting Well** – births, vaccination, early years, A and E attendances. Other information on Children Looked After is under development.

(iii) **Ageing Well** – Life expectancy and health related information for persons of 65 years of Age and above.

(iv) **Health Conditions** – strokes, cancer, dementia as examples.

(v) **People and Places** – ward profiles showing a range of economic, health and social data relating to those areas.

(vi) **Wider Determinants of Health** – income, employment, crime, housing.

(vii) **Deprivation** – levels of deprivation, across the Borough.

Jon Taylor informed the Board that within each profile shown above, there is access to reports and he gave population as an example and the Census report. The site is being developed and will show hyperlinks for easy access to more detailed information. He advised that the site highlighted challenges that needed to be addressed and referred to reports that have been presented to the Board in areas of concern suggesting ways forward to tackle those challenges. He added that even though resources are limited he will continue to update the Board via reports.

Katrina Stevens emphasised that JSNA is a partnership resource and is only as good as the combined contributions from everyone to show life in Oldham.

Resolved: That the presentation be welcomed and noted.

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7 **HEALTH AND WELLBEING STRATEGY**

Consideration was given to a report regarding the Oldham Health and Wellbeing Strategy 2022-2030. Katrina Stevens reminded the Board that the Strategy had been agreed in March 2023. The Strategy details key priorities for improving the health and wellbeing of residents in Oldham for the coming 8 years 2022-2030.

The Board received a presentation from Kathryn Willan, Public Health Registrar, regarding the supporting the residents of Oldham to gain knowledge and skills to confidently make choices and participate in decisions about their own health. Feedback was given from the 'Community Explorers' session on the health literacy theme of the Strategy.

The Board was informed the Board that the Engagement with 'Community Explorers' will help to gain insight into experiences of voluntary, community, faith and social enterprise organisations operating in Oldham

- The Community Explorers network is facilitated by Action Together, and has presence in each of the five districts. A 2015 study found a 'mismatch between the complexity of health materials and the skills of the English adult working-age population', and our residents told us the health and care system can be difficult to understand. Problems with communication have caused stress.

- Limited health literacy is associated with increased risk of morbidity and premature death. People with limited health literacy are also more likely to use emergency services and incur higher healthcare costs.

Improved health literacy has the potential to:

- Increase health knowledge and empower people to effectively manage long-term health conditions.
- Reduce the burden on health and social care services.
- Reduce health inequalities.

Kathryn Willan highlighted the following goals:

- Develop a common framework for engagement which can be used by all organisations and services, and provide the opportunity for residents

to shape the offer to better suit them and their family.

- Adopt a resident-focused approach to communication, ensuring residents feel listened to, language and communication is tailored to need, and steps are taken to ensure messaging has been understood.

- Support established peer and patient support groups to grow and continue to improve their reach.

Kathryn Willan informed the Board that at the session which was held with residents people shared examples of where they, or residents they had worked with, hadn't felt listened to, and the barriers they had faced to accessing healthcare. So the session focused on this goal for most of the session. The sessions were held each month. The following themes were drawn from the discussion:

(a) Flexibility
- Life course approach
- Digital inclusion
- Community languages
- Location and transport

(b) Familiarity

- Informal settings
- Trusted voices
- Shared language

(c) Expectations

- Clear routes to appropriate care
- Follow-up
- Roles and responsibilities

Kathryn Willan emphasised the limitations of a 30 minute session which allowed one goal to be discussed. The limitations were:

- Small number of organisations represented at a single meeting.
- Representation of populations who are engaged with the community.
- Limited time.

Dr. Jon Patterson concurred that health literacy was extremely important. He drew attention to the need for the safeguarding of disclosures which need to be put in place. It was his view that there should be a clear safety mechanism for disclosures.

It was suggested that digital inclusion was important and how this is taken forward within the communities.

Reference was made to various inner groups within communities who are in touch with each person in that community and people communicate through these inner groups. It was suggested that representatives from those groups would be valuable additions in the Community Explorers sessions.

Katrina Stevens, Director of Public Health, made reference to working with communities during Covid and the communities response. The link with Covid is dealing with the impact that Covid has had on the community. The community has been affected by Covid and therefore, the Covid resource fund can be utilised to help resource health literacy via Community Explorers.

Katrina Stevens, Director of Public Health, advised that due to the limited resources of the public health team it would be difficult to achieve the health literacy goals in order to deliver the Strategy objectives. In terms of the collective responsibility of the Board, there was a need for the individual organisations to work together to deliver those the health literacy goals.

Resolved: That

(1) a further report be submitted to the next Board meeting detailing any positive changes and initiatives to achieve improvements to health literacy in the community in line with the Health and Wellbeing Strategy; and

(2) the possibility of utilising Covid funding in relation to health literacy be explored.

8 **OLDHAM HEALTH INEQUALITIES PLAN UPDATE**

Consideration was given to a report which provided information to the Board on progress to date on Oldham's Health Inequalities plan agreed by Health and Wellbeing Board June 2022.

Oldham Life Expectancy for men is 77.2 years, compared to the national average of 79.4 years (PHOF 2018-20). By contrast, Westminster has an average life expectancy of 84.7years. The difference in life expectancy for men, between Alexandra ward (most deprived) and Saddleworth South ward (least deprived) is 12 years.

Oldham Life Expectancy for women is 80.5years compared to the national average of 83.1 years (PHOF 2018-20). By contrast, Kensington and Chelsea has an average life expectancy for women of 87.9 years The difference in life expectancy between Alexandra ward (most deprived) and Saddleworth South ward (least deprived) is 12.9 years.

The inequalities that we observe for life expectancy and for healthy life expectancy in Oldham are not just associated with deprivation but are also present between different ethnicities.

In November 2021, the Health and Wellbeing Board members discussed the development of a Health Inequalities plan for Oldham. This process took key recommendations from the GM Marmot Build Back Fairer and GM Independent Health Inequalities Commission report and mirrored broad six thematic areas

- Income, Poverty, Housing and Debt
- Housing, Transport and Environment
- Work and Unemployment
- Health in all Policies / Communities and Place
- Health and Wellbeing, and Health Services
- Children and young people

Each of the thematic areas was underpinned by a series of actions (a total of 57), and senior sponsor(s) assigned. The board agreed the plan in June 2022.

A tracker tool has been developed, detailing all the actions within the agreed Health Inequalities plan. Action owners have been invited to review and update the progress made towards each of the actions utilising commentary boxes and RAG ratings to provide a visual review of where programmes are on track, stalling or behind. Each of the sponsors has access to the tracker tool for oversight and review of their thematic area.

One of the thematic areas – 'Health and Wellbeing and Health Services' will undergo a review of the actions to align to the Integrated Care Partnership (ICP) priorities outlined within the ICP 5-year strategy and to ensure that the actions are reflective of existing programmes contributing to the reduction of health inequalities. The wording of the actions will be agreed with action owners before being committed.

Of the 40 actions, within the remaining 5 themes, nearly half (19) are RAG rated as green, indicating that they are on track or have been completed. This indicates that broadly speaking the health inequalities plan is on track to deliver the actions within the agreed 2-year time period, completing May 2024.

Those that are amber, are usually so because of short term funding or staffing capacity issues. Amber can also indicate that services are in place as per action, but that demand is exceeding capacity for example healthy weight support from the commissioned service 'Your Health Oldham'

The board is asked to note the addition of new sponsors for the theme 'Housing, Transport and Environment' Paul Clifford, Director of Economy, and Nasir Dad, Director of Environment. Both directors are well placed to oversee progress of work and have already held a forum bringing together all action owners within this theme to monitor progress.

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During the period of September 2022 to March 2023, all six thematic areas had presented focused reviews to the Health and Wellbeing board. This allowed for the sharing of good practice across Oldham organisations, opportunity to accentuate programmes that reduce inequalities and as a system provide a safe place to discuss barriers to delivery.

The table below outlines some of the previously agreed actions or objectives, and a proposed amended version to better align to existing pieces of work or work that will maximise impact in reducing health inequalities.

| **Theme** | **Original objective or action** | **Proposed amended objective or action** |
|---|---|---|
| Children and Young People | Develop systems and pathways that lead to the earlier identification of, and action on, early years and primary school age food insecurity. | To maximise uptake of the Healthy Start scheme for children in early years. |
| Children and Young People | Identify food insecure residents at an earlier age (I.e., before FSM) | Reduce food insecurity at an earlier age i.e., before free school meals |
| Housing Transport and Environment | Developing a pilot funded by GM HSCP to improve minor repair provision, linking in participants into health service offers and measuring the impact of house repairs on resident health. | Explore a housing and health approach so that the warm homes team can signpost individuals with CVD or acute respiratory conditions to 'Your Health Oldham' for targeted support |
| Housing Transport and Environment | Incorporate healthier design principles into all developments (resi and non-resi) in the borough. | Work towards delivery of key ambitions included in the Oldham Transport Strategy. |
| Housing Transport and Environment | Embed active travel and improved air quality within the Oldham transport strategy | Develop and embed a delivery strategy for key ambitions included in the Oldham Transport Strategy with actions and timeframes included. |
| Housing Transport and | Further develop the Healthy Homes | Proactively identify houses with |

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| Environment | element of the housing strategy in the next iteration of the housing strategy action plan, including strengthening links between health services and housing enforcement support. | defects, assessing for category 1 and category 2 hazards.<br><br>Roll out of free universal pest control to Oldham residential properties to understand the scale of the issue and direct action accordingly. |
|---|---|---|
| Health in all Policies/ Communities and Place | Provide workforce development sessions/training on Health Inequalities to improve awareness of the impact in Oldham and action required and make this a core part of the placed based workforce development offer. | To roll out a number of workforce development sessions under one approach that includes trauma informed, strength based and resident first. |

Katrina Stevens, Director of Public Health, emphasised that the Health Equalities Plan is a 2 year plan and in terms of delivering the plan. Referring to the six thematic areas set out in paragraph 1.4 of the report, five of those themes were still in the process of being completed with 40 actions remaining. Half of the total number of actions identified at the beginning of the plan have been concluded with the remainder of those actions on track to be completed with 1 year of the Plan remaining.

Katrina Stevens informed the Board, that she concurred with the suggestion that the wording of the Plan needed to be tightened up to show how the actions are going to be delivered a report to the next meeting will be amended in this regard.

Resolved: That

(i) the proposed amendments to the actions or objectives as outlined in section 2 of the report be agreed;

(ii) to continue an approach whereby each of the six thematic areas brings a focused review or more detailed progress update to the board over the next 12 months; and

(iii) the language in the Plan be tightened up to show how the actions are going to be delivered over the next 12 months.

9 **BETTER CARE FUND PLAN 2023 YEAR END RETURN**

Consideration was given to a report and presentation by Claire Hooley, Head of Commissioning and Market Management – Working Age Adults regarding the Oldham Better Care Fund Plan year end return for 2022-23.

The Better Care Fund (BCF) requires areas to jointly agree to deliver health and social care services supporting improvement in outcomes against the following BCF policy objectives:

- Enable people to stay well, safe and independent for longer
- Provide the right care in the right place at the right time.

In November 2022 the Hospital Discharge Fund was included in the BCF 2022-23allocation.

Oldham's allocation is as follows:

| **Funding source** | |
|---|---|
| NHS Greater Manchester ICB Contribution | £20,755,612 |
| Disabled Facilities Grant | £2,343,87 |
| Improved Better Care Fund (iBCF) | £11,187,623 |
| Hospital Discharge Fund | £2,573,295 |
| **Total** | **£37,525,524*** |

This amount differs from the original amount submitted in the plan (September 2022) due to the inclusion of the Hospital Discharge Fund.

Conditions of the Grant are as follows:

**National Condition 1:** a jointly agreed plan between local health and social care commissioners signed off by the HWB.

**National Condition 2:** NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution.

**National Condition 3:** invest in NHS commissioned out of hospital services

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**National condition 4:** implementing the BCF policy objectives. Beyond the 4 national conditions and the funding criteria, localities have flexibility in how the fund is spent but need to agree how the spending will improve performance against the following metrics:

- Avoidable admissions to hospital
- Admissions to residential provision
- Effectiveness of reablement
- Hospital discharges that are to the person's usual place of residence

The funding of schemes was utilised across HSC to fund a wide range of provision for residents including the following:

- Residential enablement at Butler Green and Medlock Court
- A range of dementia services across the borough
- Community equipment and wheelchair provision
- Minor adaptations
- A range of Falls Services
- Warm Homes
- Alcohol liaison
- Carers' support
- Healthwatch
- Respite Care
- Stroke support services
- A range of services to support hospital discharge

The year end return requires the inclusion of two successes and two challenges, and to be aligned to at least one of the logic model enablers, those reported were:

| (i) **Successes** | **Response Detail** |
|---|---|
| Joint working on the delivery of the integrated contract for residential and nursing homes. | The focus of the work was to refresh the commissioning and contracting arrangements in place for residential and nursing homes supporting Oldham residents, made possible by HSC partners coming together with clear priorities. Whilst predominantly the arrangements are for in-borough provision, they also cover out of area placements supporting Oldham residents. The approach has provided clarity to internal staff and also external partners such as providers of care. |

Carers — The Carers team is jointly HSC funded through the BCF and has seen a significant increase in the identification of hidden carers, including individuals who do not identify themselves as carers. As such more information, advice and support has been offered.
2022/23 saw a coproduction refresh on the Carers Strategy with a number of focus groups being held encouraging wide participation from a variety of stakeholders.

| (ii) **Challenges** | **Response Detail** |
|---|---|
| Care Home market | During 2022-23 the care home market has become increasingly fragile nationally, with Oldham not exempt from this. A number of providers have approached commissioners advising about considering to deregister from nursing provision or moving away from general nursing to moving towards specialist provision such as Mental Health. We are seeking to address this by reviewing our care home rates, and in particular nursing fee rates, which will have longer term implications for us from a funding perspective enabling us to meet the needs of the Oldham population. |
| Discharge to Assess | The 'Discharge to Assess' process places additional pressures on an already stretched social care resource. This can result in reviews not taking place as quickly as the system would wish. It can also place pressures on community health services such as GPs and Therapy teams where people are placed in short term placements away from where they are normally registered. The Oldham health and social care system is currently exploring opportunities for block booking 'Discharge to Assess' beds in one or two locations which may streamline the review and therapy inputs but more resource/support is required in this area. |

The BCF Plan required four key metrics to be measured and reported on, summarised in the table below

| Metric | Planned | Actual | Commentary |
|---|---|---|---|
| Avoidable admissions - Unplanned hospitalisation for chronic ambulatory care sensitive conditions | 1,160 | Local estimate is 1,113 | Oldham are on track to achieve this due to the number of avoidable admissions services in place. The Urgent Care Hub managed over 70,000 patients with a 96% success rate of keeping them out of hospital. Community HSC services have also significantly contributed to the achievement with existing and newly developed pathways for patients, including reablement, 2 hour rapid response service, and district nursing care. Extensive work across health and social care has taken place with care homes in order to better manage patients and enable them to stay in their own place of residence. |
| Discharge to normal place of residence (from acute setting) | 92.3% | 90.8% for 12 months to Feb-23 | We have seen a decrease in patients returning to their normal place of residence due to two main factors:<br>1. the emphasis on D2A has resulted in patients being discharged earlier to a D2A setting in order to best establish their needs without being in an acute hospital bed. These patients often do return to their usual place of residence, but the extra move within their journey has an impact on this metric.<br>2. the acuity of patients presenting and subsequently being |

| | | | |
|---|---|---|---|
| | | | discharged from hospital. Oldham are seeing an increased number of patients who are sicker or more advanced in their illness than in previous years and so their destination once treatment has taken place is often needed to be long-term care and/or hospice care. |
| Residential admissions – (Rate of permanent admissions to residential care per 100,000 population (65+)) | 681 | 590 | Actual rate is better than planned, and this equates to 229 permanent admissions to residential care of people aged 65+ |
| Reablement – (Proportion of older people who were still at home 91 days after discharge from hospital into reablement services) | 93.3% | 88% - of 108 people 13 didn't stay at home. | To meet target an additional 8 people would have needed to stay at home for 91 days. The acuity of people at the point of discharge is significant and this is having an impact on this measure. |

In response to a query regarding the planned and actual expenditure, and the number of packages in paragraph 2.5 of the report, Claire Hooley informed the Board that more detailed information to clarify and update the figures relating to each scheme would be circulated to the Board.

The Board noted that funds would be vired between schemes to cover overspends.

Resolved: That the Better Care Fund return for 2022-23 be signed off in line with national conditions subject to the amendments to clarify and update the figures to the extract from the year end return as shown in paragraph 2.5 of the report.

10 **PUBLIC HEALTH UPDATES**

Consideration was given to a Health Improvement Highlight report presented by Dr.Rebecca Fletcher, Consultant in Public Health, for the period March-June 2023. Dr.Charlotte Stevenson, Consultant in Public Health, presented a Health Protection Highlight report for the period April-June 2023.

In referring to Tobacco Alliance section, Dr. Rebecca Fletcher informed the Board of two areas of focus. Where vapes are being used with other drugs which is a growing problem. The

Board was also informed that North West Trading Standards had seized £4000 of illicit vapes which also is of concern.

The Board was also informed that Trading Standards had seized a large quantity of illicit vapes locally which means that potentially unsafe products have been removed from our shelves.

Resolved: That the Health and Wellbeing Board notes the presentations and agrees that future updates of both reports be presented to future Board meetings.

The meeting started at 10.00 am and ended at 11.39 am

Report to HEALTH AND WELLBEING BOARD

# Better Care Fund Plan 2023-25

**Portfolio Holder:**
Councillor Barbara Brownridge, Cabinet Member Health & Social Care

**Officer Contact:** Jayne Ratcliffe, Director of Adult Social Care (DASS)

**Report Author:** Claire Hooley, Head of Commissioning and Market Management – Working Age Adults

**Contact:** 4292 / Claire.Hooley@Oldham.gov.uk

**Date:** 7th September 2023

**Purpose of the Report**

To provide Adult Social Care Management Team and Oldham's Integrated Care Partnership Board with details of the Oldham Better Care Fund (BCF) Plan for 2023-25 and to obtain sign off in line with the requirements of the national conditions of the BCF.

**Requirement from ASC DMT and Oldham's Integrated Care Partnership Board**

1. That the Boards considers the content of the Oldham BCF Plan 2023-25 and provide any suggested amendments.

2. Subject to any agreed amendments the Boards agree to sign off the plan in line with the requirements of the national conditions of the BCF.

**Better Care Fund Plan 2023-25**

## 1. Background

1.1 The details of the operation of the BCF are set out in two documents: *Better Care Fund policy framework 2023 to 2025* and *Better Care Fund planning requirements 2023-25*. These documents form the basis of the Oldham BCF plan for 2023-25.

1.2 The timeline provided by the Better Care Fund national team is presented in the table below. From this we understand that the plan has been agreed both regionally and will be agreed nationally once we confirm that the plan has been agreed by the Health & Wellbeing Board as required under National Condition 1.

| BCF Planning requirements published | 5 April |
|---|---|
| Optional draft BCF planning submission (including intermediate care capacity and demand plan) submitted to BCM and copied to the BCF team | 19 May |
| BCF planning submission (including intermediate care and short-term care capacity and demand plan; and discharge spending plan) from local HWB areas (agreed by ICBs and local government). All submissions need to be sent to the local BCM, and copied to england.bettercarefundteam@nhs.net | 28 June |
| Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation | 28 June – 28 July |
| Cross-regional calibration | 3 August |
| Approval letters issued giving formal permission to spend (NHS minimum) | 3 September |
| All section 75 agreements to be signed and in place | 31 October |

1.3 In line with the national requirements the Oldham BCF Plan was due to be submitted by the deadline of 28th June 2023. The process allows for submission of the plan prior to approval of the Health and Wellbeing Board. Subsequently, Oldham's plan has been approved by the regional Better Care Fund Panel and was provided to the central team for sign-off. On 31st July the NHSE Regional Assurance Team that Oldham's BCF plan has been recommended for approval.

1.4 For 2023-25 the BCF plan is in three parts: an overall template that provides information on income, expenditure, type of schemes funded, metrics and how the plan meets national conditions; a narrative plan outlining the key areas of focus in Oldham and a Capacity and Demand template.

1.5 The Better Care Fund's vision has been to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. The BCF Policy Framework centres of these objectives and now sets separate National Condition for each:

- enable people to stay well, safe and independent at home for longer
- provide people with the right care, at the right place at the right time.

1.6 As well as supporting delivery of the *Next Steps to put People at the Heart of Care*, the BCF programme underpins key priorities in the NHS Long Term Plan by joining up services in the community and the government's plan for recovering urgent and emergency care (UEC) services.

1.7 Differing from previous years, this year's BCF plan spans two years for the period 2023-25, with the delivery of the BCF supporting two key priorities for the health and care system that align with the two existing BCF objectives of:

- improving overall quality of life for people, and reducing pressure on UEC, acute and social care services through investing in preventative services
- tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow.

1.8 Additional funding has been allocated to the BCF allocations which include:

- a 5.66% increase to the NHS minimum contribution into the BCF each year
- an extra £1.6 billion nationally to support hospital discharge – Oldham's allocation to this funding is presented in the table below at paragraph 2.2

Additionally, as announced in the *Next Steps to put People at the Heart of Care* a further £102 million nationally to support adaptations is likely to be dispersed as an additional tranche of the DFG funding, with the position to be confirmed later in the year.

## 2. Current Position

2.1 The BCF continues to consist of three main funding contributions: NHS Greater Manchester Integrated Care Board (NHS GM ICB) contribution to the BCF; the Disabled Facilities Grant (DFG); and the Improved Better Care Fund (iBCF).

2.2 The total value of the BCF in Oldham for 2023-25 period is £80,369,133. This is broken down as follows for 2023-25:

| **Funding Sources** | **Income Year 1 (2023/24)** | **Income Year 2 (2024/25)** |
|---|---|---|
| DFG | £2,343,287 | £2,343,287 |
| Minimum NHS Contribution | £21,951,512 | £23,193,968 |
| iBCF | £11,187,623 | £11,187,623 |
| Additional LA Contribution | £0 | £0 |
| Additional ICB Contribution | £822,739 | £570,713 |
| Local Authority Discharge Funding | £1,568,487 | £1,594,524 |
| ICB Discharge Funding | £1,420,360 | £2,185,010 |
| **Total** | **£39,294,008** | **£41,075,125** |

2.3 Funding is dependent on meeting the following four national conditions:

**National Condition 1: Plans to be jointly agreed**
Plans must be agreed by the ICB and the local council chief executive prior to being signed off by the Health and Wellbeing Board.

**National Condition 2: Enabling people to stay well, safe and independent at home for longer**
Localities agree on how the services they commission will support people to remain independent for longer, and where possible support them to remining their own home.

**National Condition 3: Provider the right care in the right place at the right time**
Localities agree on how the services they commission will support people to receive the right care in the right place at the right time.

**National Condition 4: NHS minimum contribution to adult social care and investment in NHS commissioned out of hospital services**
The NHS minimum contributions for social care and NHS commissioned out of hospital spend for all HWB areas in both 2023-24 and 2024-25 has been uplifted by 5.66%. ICBs and Councils may agree a higher level of spend, where this will deliver value to the system and is affordable.

2.4 The BCF funding received may only be used for the purposes of:

- meeting adult social care needs
- reducing pressures on the NHS, including seasonal winter pressures
- supporting more people to be discharged from hospital when they are ready
- ensuring that the social care provider market is supported.

2.5 The funding is utilised across health and social care to fund a wide range of provision for residents including the following:

- Residential enablement at Butler Green and Medlock Court
- Falls prevention
- A range of dementia services across the borough
- Community equipment and wheelchair provision
- Minor adaptations
- A range of Falls Services
- Warm Homes
- Alcohol liaison
- Carers' support
- Healthwatch
- Respite Care
- Dementia support services
- Stroke support services
- A range of services to support hospital discharge

2.6 During 2022-23 a review of the funding arrangements was carried out which resulted in an updated group of services supported by the various components of

the Better Care Fund. These are set out in the overall plan template and include funding being made available for the new Adult Referral Contact Centre (ARCC).

2.7 The Narrative Report of the Oldham BCF Plan for 2023-25 is required to include details on how we will continue to deliver significant improvements in the health and wellbeing outcomes of our residents as we move towards place-based, person-centred provision of care and services. Each section has been updated to reflect changes and progress that has occurred during 2022-23 and how the capacity and demand activity has impacted on what services are required through this funding for the next two years. As required, reference is made to the High Impact Change Model[1] and Core20PLUS5[2].

2.8 Work is taking place reviewing the section 75 agreement for it to be in place by 31 October as per the national BCF deadline (please see table at paragraph 1.2).

## 3. Key Issues for the Boards to Discuss

3.1 For the Boards to consider the contents of the BCF Plan for 2023-25 and make any suggested amendments.

3.2 To agree whether the Boards are prepared to sign off the plan, subject to any amendments it proposes, in order for the locality to meet National Condition 1.

## 4. Recommendation

4.1 It is recommended that the Boards agree to sign off the Better Care Fund Plan for 2023-25.

## 5. Appendices

1. Planning template

230619 Oldham HWB BCF 2023-25 Pl

2. Narrative report

BCF 2023-25 Narrative Plan_FINAl

[1] The high impact change model offers a practical approach to manage transfers of care. It can be used to self-assess how local care and health systems are working now, and reflect on, and plan for, action they can take to reduce delays throughout the year. (LGA)

[2] Core20PLUS5 is a national NHS England approach to reducing health inequalities for adults. It defines a target population – the 'Core20PLUS – and identifies '5' focus clinical areas requiring accelerated improvement. (NHS England)

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# Better Care Fund Plan 2023-25



7 September 2023

Claire Hooley: Head of Commissioning and Market Management – Working Age Adults

NHS
Greater Manchester
Integrated Care

Oldham
Council

# Purpose

The Better Care Fund (BCF) requires areas to jointly agree to deliver health and social care services supporting improvement in outcomes against the following BCF policy objectives:

- Enable people to stay well, safe and independent for longer
- Provide the right care in the right place at the right time.

The Hospital Discharge Fund, Disabled Facilities Grant and the Improved Better Care Fund (iBCF) are elements of the Better Care Fund 2023-25

# Reporting and timelines

For 2023-25, the BCF plan is in three parts;

1. Planning template including information on income, expenditure, schemes funded
2. Narrative plan
3. Capacity and Demand metrics

| Item/update | date |
| --- | --- |
| BCF Planning requirements published | 5 April |
| Optional draft BCF planning submission (including intermediate care capacity and demand plan) submitted to BCM and copied to the BCF team | 19 May |
| BCF planning submission (including intermediate care and short-term care capacity and demand plan; and discharge spending plan) from local HWB areas (agreed by ICBs and local government). All submissions need to be sent to the local BCM, and copied to england.bettercarefundteam@nhs.net | 28 June |
| Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation | 28 June – 28 July |
| Cross-regional calibration | 3 August |
| Approval letters issued giving formal permission to spend (NHS minimum) | 3 September |
| All section 75 agreements to be signed and in place | 31 October |

# National Conditions of the grant

| | |
|---|---|
| Locally agreed | • A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board. |
| Policy objective one | • Plans to set out how the services the area commissions will support people to remain independent for longer and, where possible, support them to remain in their own home. |
| Policy objective two | • Plans to set out how services the area commissions will support people to receive the right care in the right place at the right time. |
| Maintaining NHS contributions | • NHS contributions to adult social care and NHS commissioned out of hospital services to be maintained in line with the uplift to NHS minimum contribution to the BCF. |

Beyond the 4 national conditions and the funding criteria, localities have flexibility in how the fund is spent but need to agree how the spending will improve performance against the following metrics:

- Avoidable admissions to hospital
- Admissions to residential provision
- Effectiveness of reablement
- Hospital discharges that are to the person's usual place of residence

# Main points of the Better Care Fund 2023-25

## Duration

- 2 year plans for meeting the national conditions and objectives
- 2 year spending plans with second year provisional for some aspects
- 1 year plans for metrics and capacity and demand

## Funding sources

- NHS minimum funding allocations published, ICB discharge funding allocations published
- Additional discharge funding included in the BCF, second year conditions and allocations still to be confirmed
- iBCF allocations for second year not yet published
- DFG allocations not yet published for either year

## Collection of outputs and capacity

- Capacity and demand planning retained and should be a core element of BCF plans
- Departmental and NHS focus on whether there is sufficient capacity in the system – particularly to support discharge
- Reintroduction of estimated outputs for BCF spend
- Inclusion of an estimate of the BCF spend on services as a proportion of overall system spend.

# Oldham's allocation

| Funding source | 2023/24 | 2024/25 |
|---|---|---|
| Disabled Facilities Grant | £2,343,287 | £2,343,287 |
| Minimum NHS contribution | £21,951,512 | £23,193,968 |
| Improved Better Care Fund (iBCF) | £11,187,623 | £11,187,623 |
| Additional LA contribution | £0 | £0 |
| Additional ICB contribution | £822,739 | £570,713 |
| LA Hospital Discharge Fund | £1,568,487 | £1,594,524 |
| ICB Hospital Discharge Fun | £1,420,360 | £2,185,010 |
| **Total** | £39,294,008 | £41,075,125 |

# Funded schemes

The funding was utilised across HSC to fund a wide range of provision for residents including the following:

- Residential enablement at Butler Green and Medlock Court
- A range of dementia services across the borough
- Community equipment and wheelchair provision
- Minor adaptations
- A range of Falls Services
- Warm Homes
- Alcohol liaison
- Carers' support
- Healthwatch
- Respite Care
- Stroke support services
- A range of services to support hospital discharge

# Key Issues and Recommendations

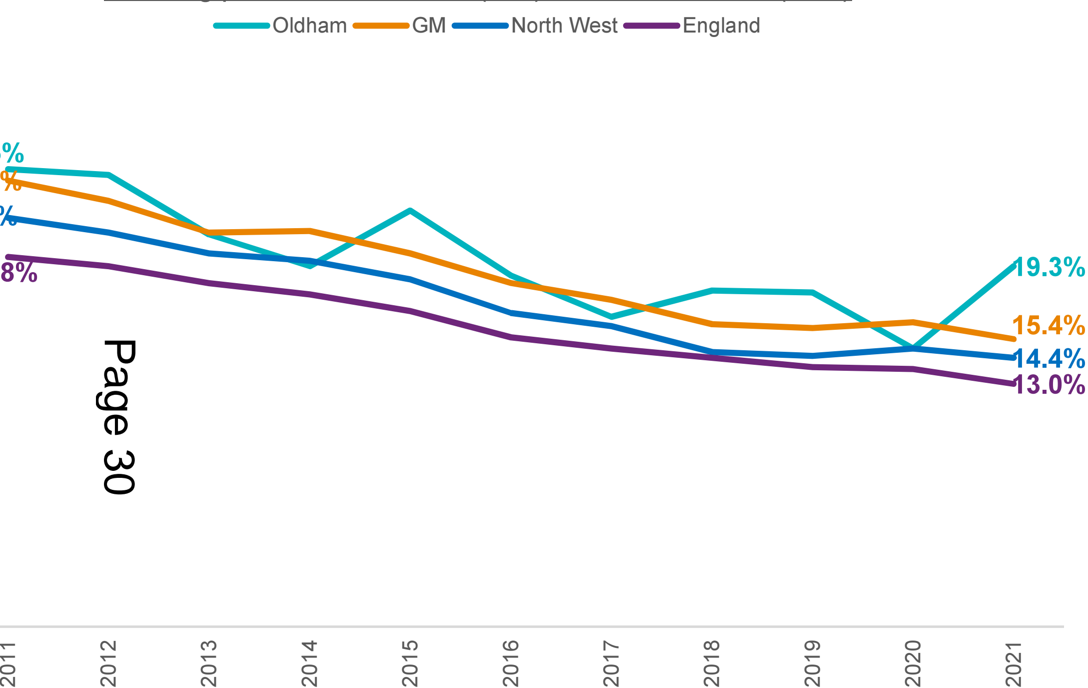
- For the Board to consider the contents of the BCF Plan for 2023-25
- To agree to ratify the BCF plan for 2023-25 (in line with national conditions)
- It is **recommended** that the Board agree to sign off the BCF plan 2023-25 in order for Oldham to comply with the national conditions of the fund

# JSNA - Tobacco use in Oldham
## Health & Wellbeing Board
## Thursday 7th September 2023



Insight & Intelligence Team
egy & Performance Service

# bacco use in Oldham - Prevalence

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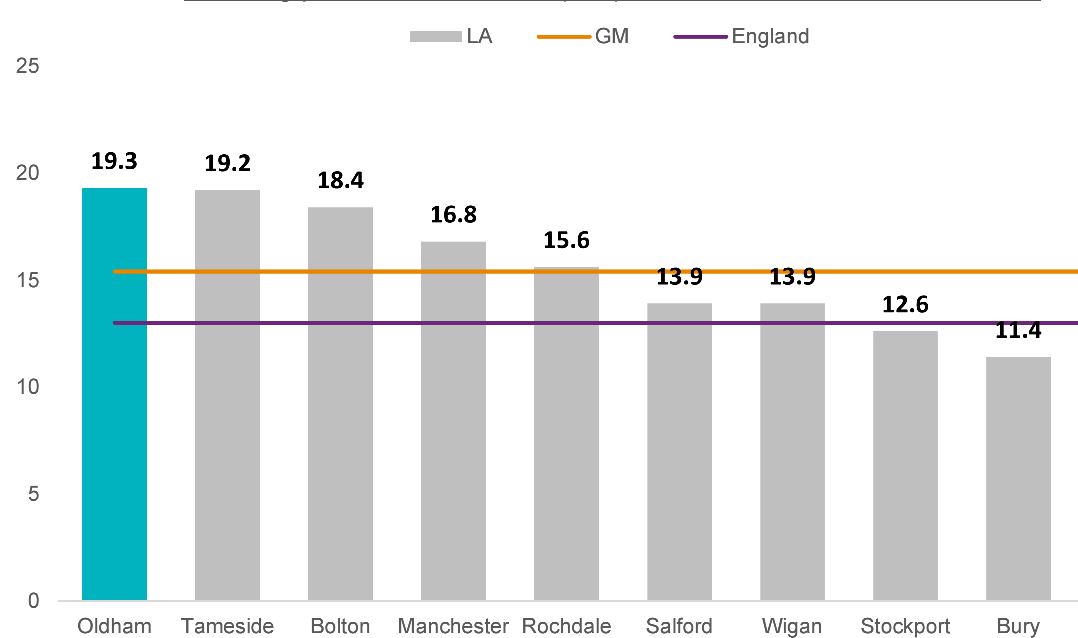
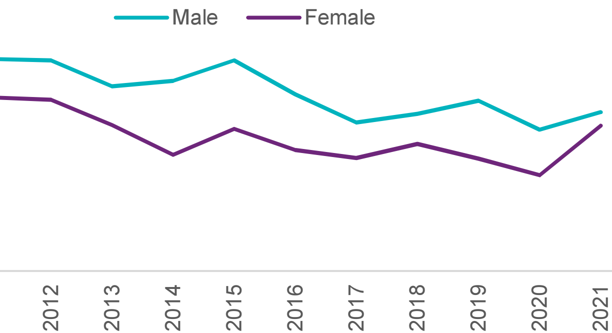


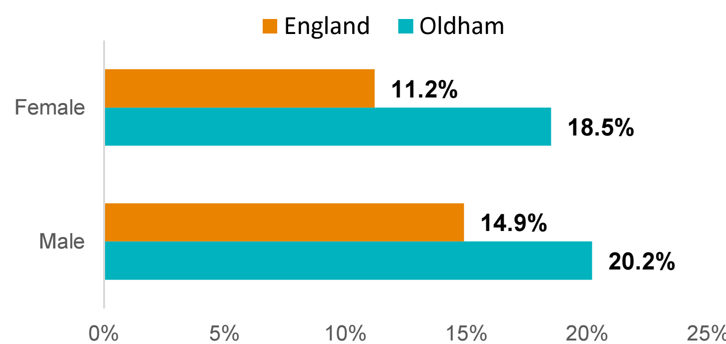

Oldham's smoking prevalence has taken a substantial increase compared with the last few years of data, rising by 30% between 2020 and 2021. Oldham's 2021 rate is highest across GM and 4th highest nationally.

The decrease in the proportion of current smokers over time may be partly attributed to the increase in vaping and e-cigarette use. Data from the Opinions and Lifestyle Survey (OPN) have shown regular use of a vaping device has increased in 2021 and the highest usage was among those aged 16 to 24 years"[1]. Policies associated with the Tobacco Control Plan for England, such as increased public awareness campaigns and smokefree places, may have also contributed to decreased smoking prevalence [2].

onal Statistics. Adult smoking habits in the UK
obacco Control Profiles

# bacco use in Oldham - Prevalence

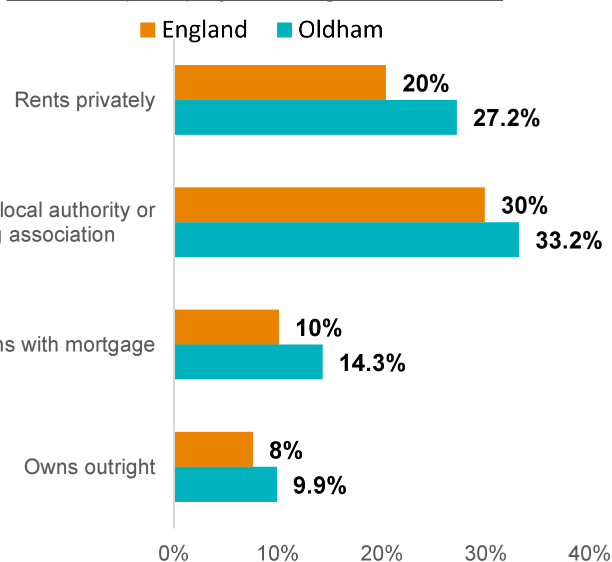


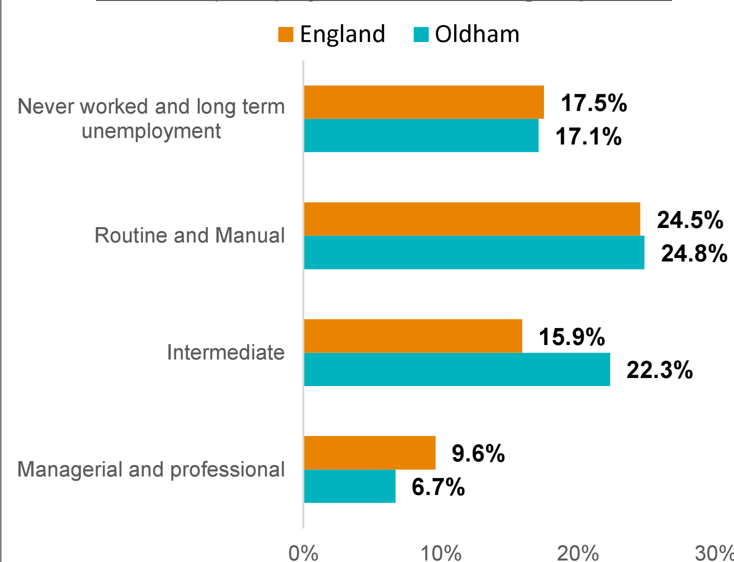




Both males and females have seen a gradual decline in smoking rates over the last 10 years within Oldham.

Historically within Oldham, rates for female smokers have remained consistently below rates for male smokers by a similar amount. However, the latest data (2021) reveals a much smaller gap in rates, with a 3.7 percentage point gap for England and a 1.7 percentage point gap for Oldham.





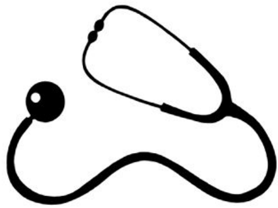




Smoking is the single largest driver of health inequaliti in England. Smoking is more common among people that experience higher levels of deprivation and lower incomes.

Rates vary vastly between different housing tenure ac Oldham, with those in rented accommodation more th twice as likely to smoke as home owners.

Routine and manual workers and unemployed residen have higher smoking than those in Intermediate and Managerial & Professional occupations nationally. In Oldham however, we see a high smoking rate amongs Intermediate level roles.

# bacco use in Oldham – Hospital Admissions



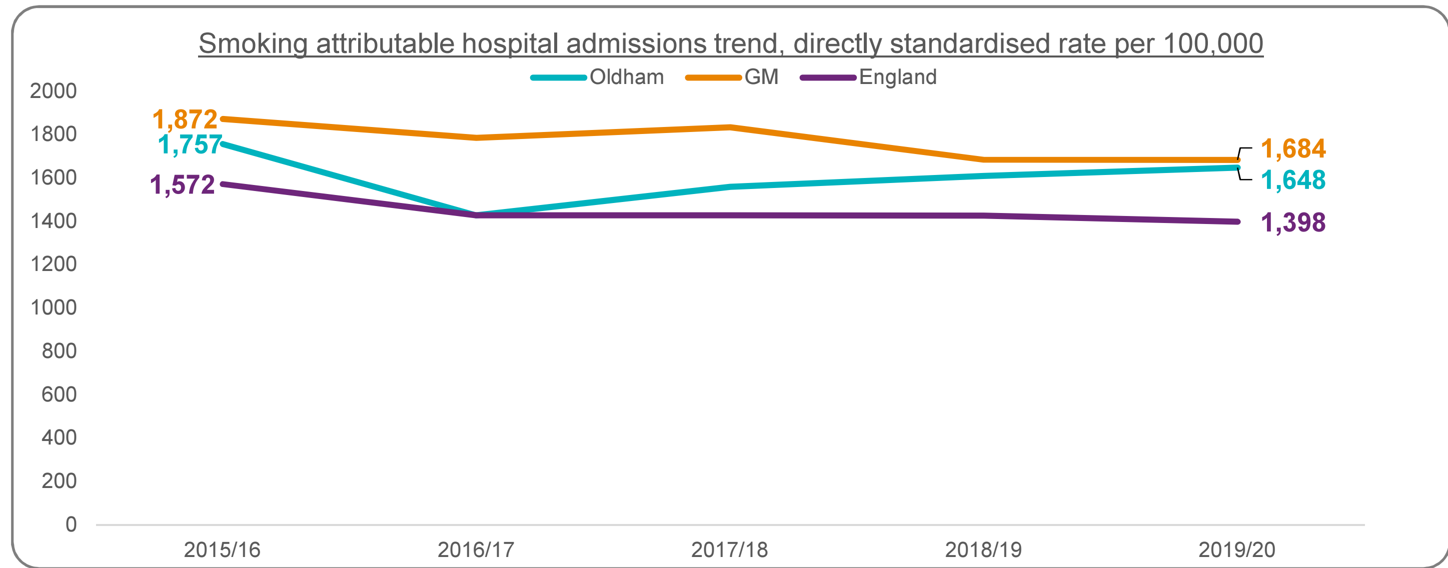
ng accounts for approximately 5.5% of
HS budget. Admissions to hospital due
oking related conditions represent a
demand on NHS resources.

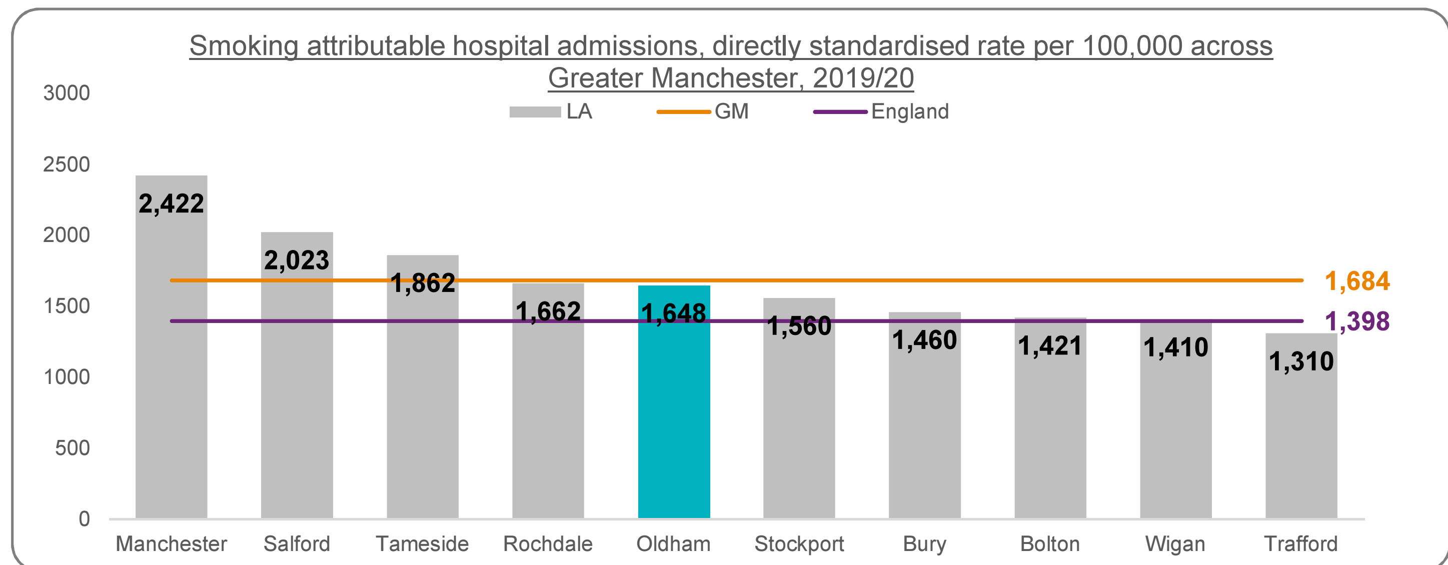
Page 32

9/20 there were 2,002 smoking
table hospital admissions to Oldham
nts.

m's smoking attributable hospital
sions are similar to 2015/16 figures, with
ble dip in 2016/17 and an increase year
r since. Greater Manchester and
nd have seen slight reductions in their
over the same period.

m's latest rate is similar to the GM
ge and 42nd highest across England.



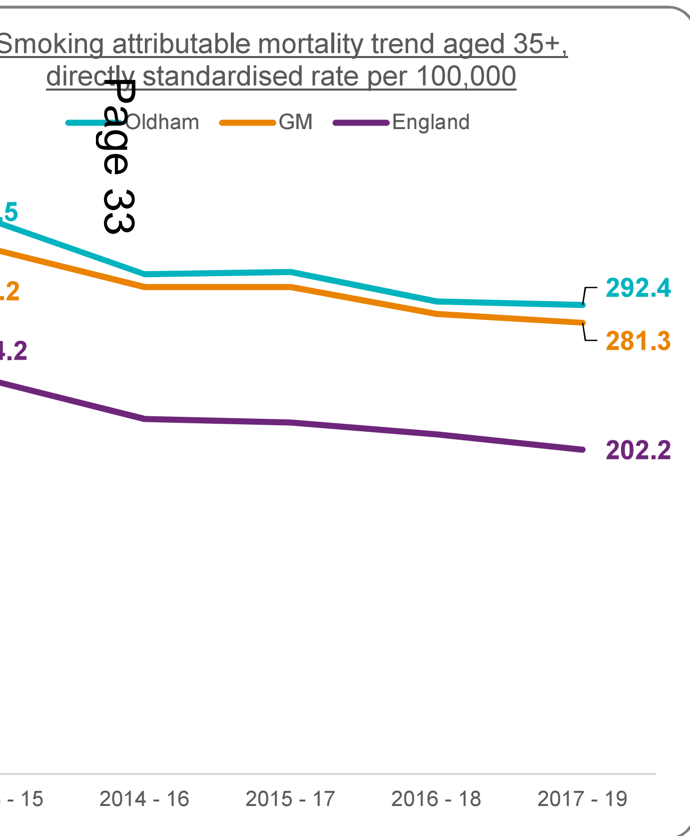



# bacco use in Oldham – Mortality

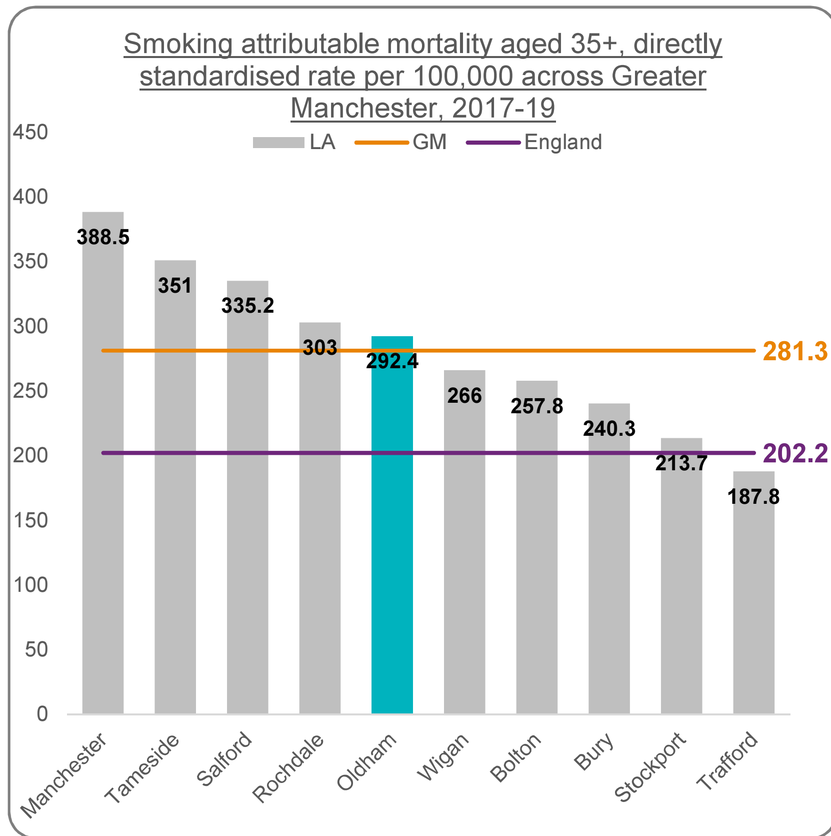
smoking attributable mortality rate is comparable to the Greater Manchester average (ranks 5th highest) but is significantly higher than the national average. Alt
s in line with the Greater Manchester average, it is important to note the rate is still extremely high and ranks 16th highest nationally.

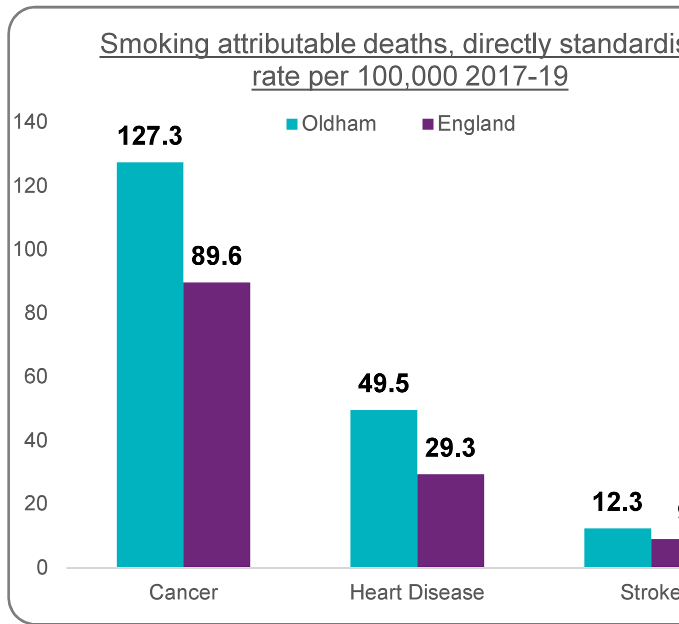
as a higher smoking related mortality rate across Cancer, Heart Disease and Stroke. The rates below for Oldham represent 447 Cancer deaths, 174 deaths fror
nd 42 deaths from Stroke. Oldham's rate is ranked 18th highest nationally for Cancer, 7th highest for Heart Disease and 16th highest for Stroke.

disadvantaged someone is, the more likely they are to smoke and to suffer from smoking-related disease and premature death. Nationally, smoking related dea
rived decile are more than double that in the least deprived.

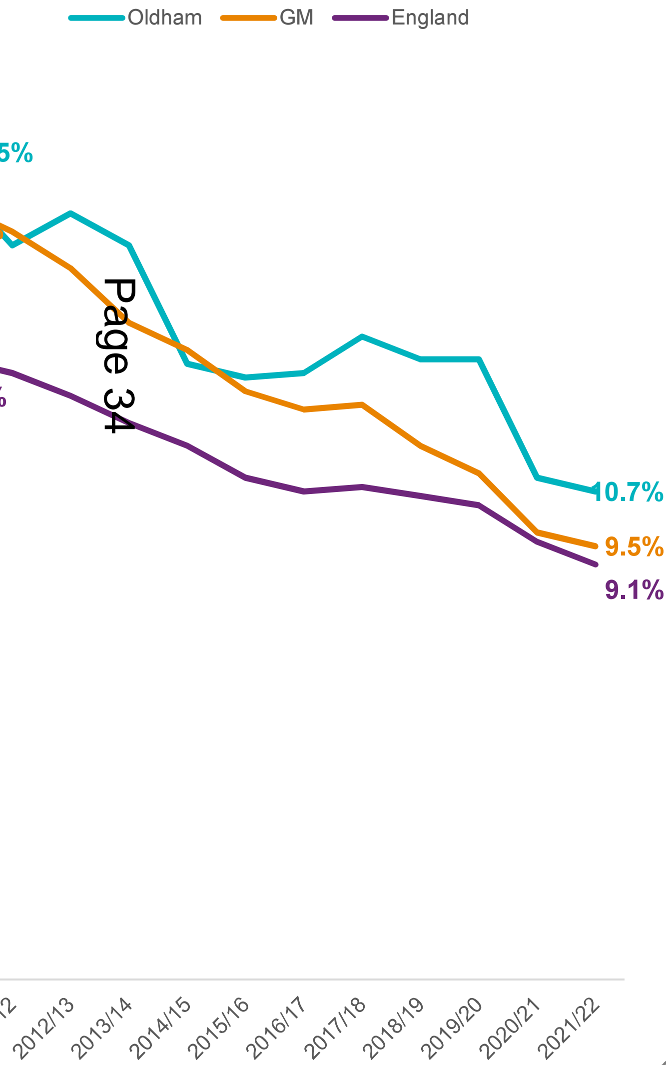




# bacco use in Oldham – Smoking in Pregnancy

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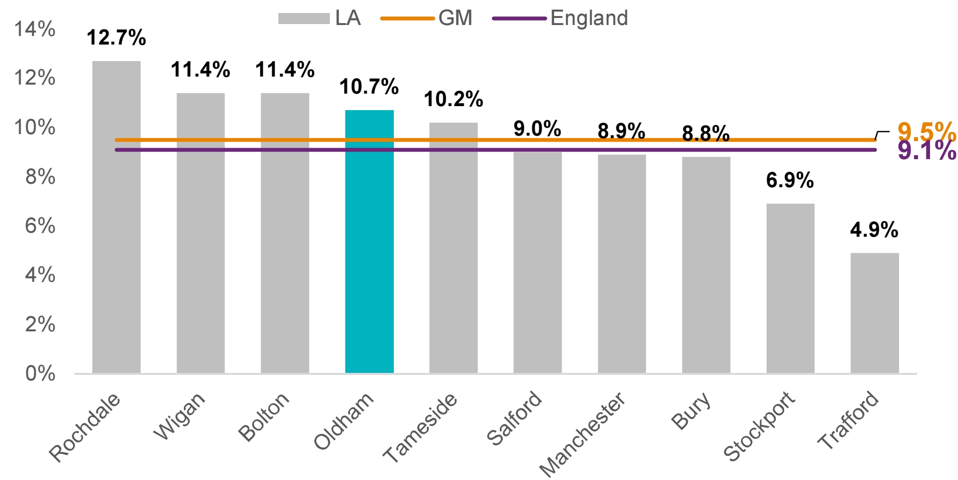
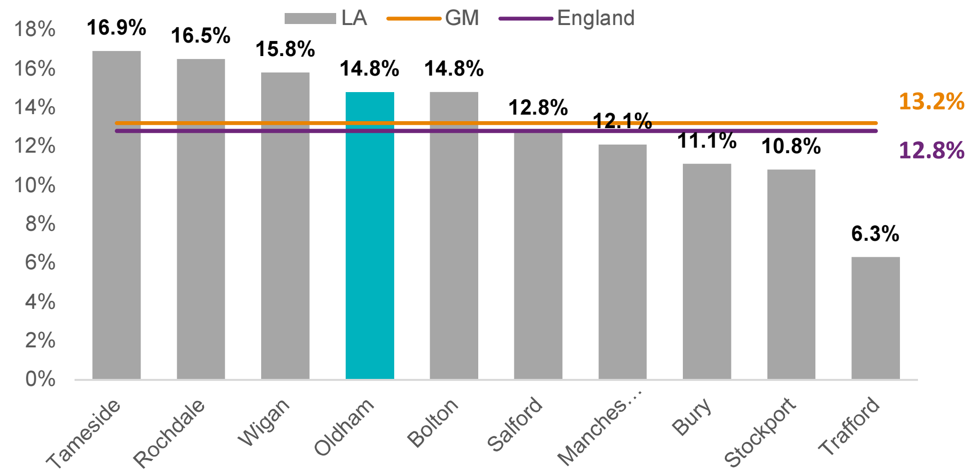


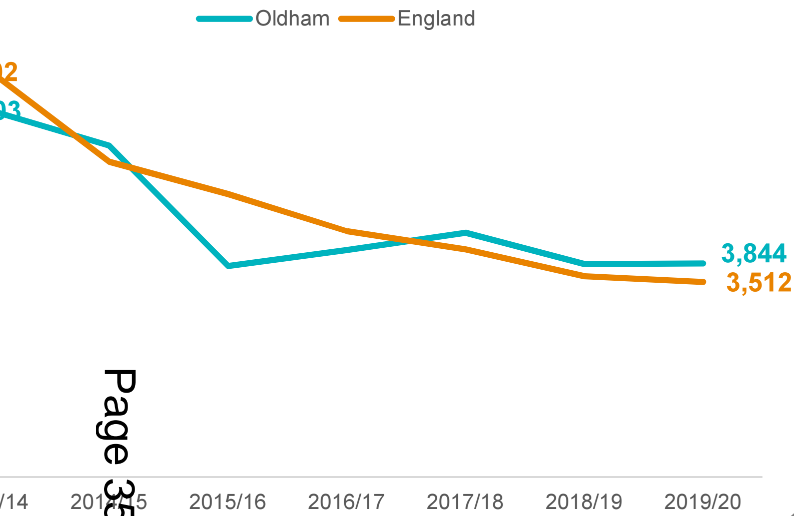

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health o the mother. On average, smokers hav more complications during pregnancy and labour.

The number of women smoking at tim of delivery has been on a steadily decreasing trend for both Oldham and England over the last decade. Oldham rate has been consistently well above England averages for this time, although has seen a slightly better improvement in rate than nationally ar so the gap is closing gradually.

Oldham has the 4th highest rate of smoking at time of delivery across Greater Manchester. Rates vary considerably across England, from 3.1% in Ealing to 21.1% in Blackpool. Oldham is 54th highest across Englanc

There is a similar pattern for smoking during early pregnancy, Oldham ranks 4th highest across GM and 54th highes across England.

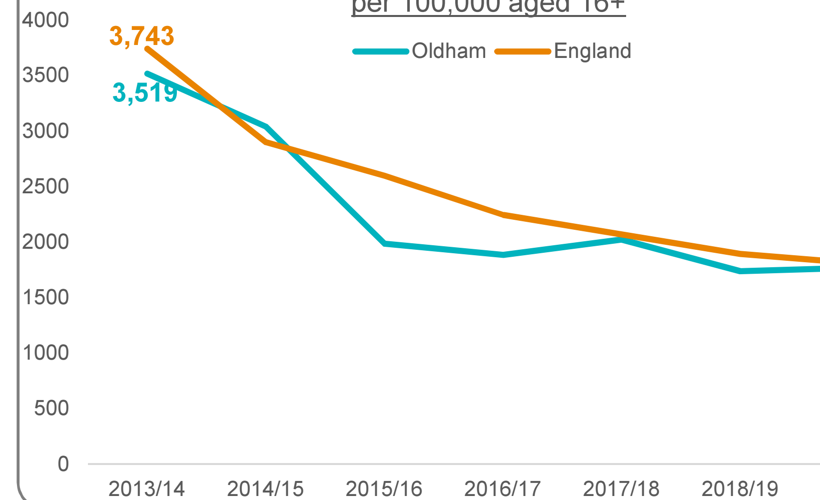
# bacco use in Oldham – Quitting

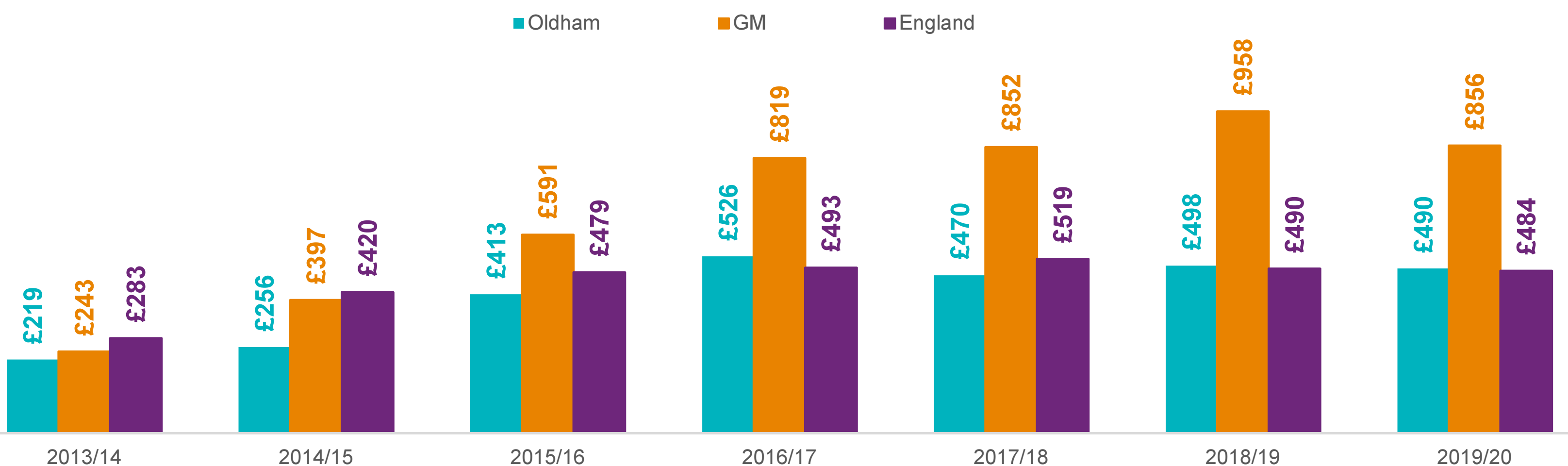



Oldham has a similar rate of smokers setting a quit date and successful quitters compared to England, although both have been on a downward trend year on year.

In 2019/20, 1,264 people set a quit date in Oldham and 582 had successfully quit at 4 weeks.

Oldham has the highest rate of smokers setting a quit date across Greater Manchester and 3rd highest rate of successful quitters.




Oldham has a similar cost per quitter to the England average. GM's cost per quitter is substantially higher.

# bacco use in Oldham – Sources

Local Tobacco Control Profiles
ngertips.phe.org.uk/profile/tobacco-control

nual Population Survey (APS)
ww.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/methodologies/annualpopulationsurveyapsqmi

y Services Dataset (MSDS) v1.5
igital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set

Episode Statistics (HES)
ons data

ollege of Physicians – 'Hiding in Plain Sight' (relative risks)
ww.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs

igital Stop Smoking Services Data
igital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england

**Report to HEALTH AND WELLBEING BOARD**

# Tobacco Control

**Portfolio Holder:**
Councillor Barbara Brownridge, Cabinet Member for Health and Adult Social Care

**Officer Contact:** Dr Rebecca Fletcher, Director of Public Health (Interim)

**Report Author:** Andrea Entwistle, Senior Business and Commissioning Manager, Public Health
**Ext.** 3386

**7 September 2023**

## Purpose of the Report

This report provides an overview of the tobacco control work in Oldham, in the context of regional and national policy and approaches. It focuses on the role of the Oldham Tobacco Alliance, made up of partners and services from across the borough, in progressing this agenda and working together to tackle tobacco-related harm and improve the health and wellbeing of people living in Oldham.

## Executive Summary

One in seven adults still smoke in England and tobacco remains the single biggest cause of preventable illness and death. Up to two out of three lifelong smokers will die from smoking, and smoking substantially increases the risk of heart disease, heart attack and stroke and causes the vast majority of cases of lung cancer. Tackling smoking is one of the most evidence based and effective interventions that we can take to prevent ill health and reduce health inequalities. Reducing smoking rates not only improves health outcomes and reduces the burden on the NHS, it also boosts productivity and economic growth.

Smoking prevalence in Oldham is considerably higher than GM and England rates and tobacco-related harm disproportionality impacts a number of our communities, including

those who are already impacted by high levels of deprivation and other socio-economic determinants of health. Reducing smoking rates in the borough is a priority in the Oldham Health and Wellbeing Strategy and Oldham Integrated Care Partnership's Locality Plan.

The vision of the Oldham Tobacco Alliance is to improve the health and wellbeing of Oldham's population by reducing smoking rates, minimising tobacco related harm and contributing to a reduction in the health inequalities experienced by some of our communities due to smoking and tobacco.

Significantly reducing smoking prevalence at a far faster rate than at present will:

- improve health outcomes,
- support poverty reduction,
- deliver higher productivity,
- give babies and children a better start in life,
- reduce health and social care costs and
- cut crime by dealing with the illegal tobacco trade.

Therefore, the Oldham Tobacco Alliance is taking a strategic and comprehensive approach to tobacco control (aligned to national and regional policy and evidence base) to make smoking less accessible, acceptable and desirable, empower successful quitting and stop young people starting to smoke in the first place.

**Recommendations/Requirement from the Health and Wellbeing Board**

Health and Wellbeing Board is asked to consider Oldham's approach to tobacco control, the work to date of the Oldham Tobacco Alliance and the wider health and care system in tackling smoking and the effectiveness of the locality tobacco control plan in reducing smoking prevalence and tobacco related harm.

Health and Wellbeing Board is asked to consider what more can be done to address smoking locally and to reduce the risk and impact of tobacco related harm and how we can work together as a system to contribute to reducing the health inequalities caused by tobacco and smoking and improve the health and wellbeing of our residents.

**Tobacco Control in Oldham**

## 1. Background

1.1. The UK has made considerable progress in reducing the harms related to tobacco. Smoking rates have fallen, both nationally and locally, over the last few decades but smoking remains the single greatest cause of preventable death, disability, ill-health and social inequality for local people.

1.2. Smoking is a modifiable risk factor, with strong connections to wider socio-economic determinant of health, that affects three of the major killers in Oldham, which are circulatory disease, cancer, and respiratory disease. Four in five cancers are caused by tobacco use, and 90% of lung cancer is directly attributable to smoking. Up to two out of three lifelong smokers will die from smoking and smoking accounts for 1 in 6 deaths in England, with huge inequalities existing across areas and populations. In Oldham, 600 deaths and over 3,700 hospital admissions each year are attributable to smoking. On average, for every smoker who dies another thirty are suffering serious smoking-related diseases. Non-smokers are also at risk of harm through second-hand smoke exposure, especially vulnerable adults, children, and babies.

1.3. For the NHS and wider public services, the lifetime value of a person stopping smoking is considerable. Smoking accounts for approximately 5.5% of the NHS budget. Admissions to hospital due to smoking related conditions represent a large demand on NHS resources. There is also an impact on demand for social care and other support services. On average, smokers have difficulty carrying out everyday tasks like dressing, eating and walking across a room, seven years earlier than never smokers and need care support ten years earlier than never smokers. Action on Smoking and Health (ASH) estimate that the total additional spending on social care in Oldham as a result of smoking for adults aged 50 and over in 2021 was £5,960,600. This includes the costs of care for 425 individuals receiving home based care, and 87 individuals receiving state-funded residential care.

1.4. Not only does tobacco impact on health and care, but smoking is also detrimental to the economy, with smokers more likely to become ill while of working age, contributing to the 30% productivity gap due to ill health in Greater Manchester. Those who smoke are burdened with a costly addiction, each spending on average £2,451 a year on tobacco. Whilst smoking is not a root cause of poverty, the addiction, associated ill-health and loss of income it causes can significantly exacerbate and lock people and families into an intergenerational cycle of poverty and disadvantage, resulting in the widening of health inequalities. The pandemic, and now the cost-of-living crisis, has not only shone a light on these health inequalities but exacerbated them. In Oldham, the cost per quitter for the local authority commissioned specialist stop smoking service was £490 in 2019/20, which was less than the regional average and similar to the England value (£484).

1.5. Smoking is the single biggest preventable cause of health inequalities. The Marmot Review reported that smoking remains responsible for around half the difference in life expectancy we see between our poorest and most affluent communities.

Smoking is far more common among routine and manual workers and people with lower incomes and is transmitted across generations due to social-norms and addiction. The more disadvantaged someone is, the more likely they are to smoke and suffer from smoking-related disease and premature death. Smoking rates are also higher among people with mental health conditions, those living in social housing, prisoners, looked-after children and care leavers, and LGBTQ+ people.

1.6. Oldham's smoking prevalence in adults is currently 19.3% (2021) – this has reduced significantly from 2012 when smoking prevalence was at 24.2% but is still higher than the England average of 13% and much higher than the trajectory needed to achieve the national and Greater Manchester ambition to be smoke free (which is to reduce overall adult smoking prevalence to less than 5%) by 2030. We also know there is considerable variation in smoking prevalence across the borough and that in some wards, particularly those with high levels of deprivation, rates are considerably higher. The proportion of the Oldham population who have never smoked is also smaller than the national average and, whilst considerable progress has been made to reduce the proportion of women who smoke in pregnancy, numbers are still higher in Oldham than they are nationally (10.7% - Oldham, 9.1% - England, 2021/22).

1.7. Tackling smoking is one of the most evidence based and effective interventions that we can take to prevent ill health. Reducing smoking prevalence would have a significant impact on improving population health, reducing demand on health and social care services and tackling health inequalities. However, smoking is an addiction most smokers were trapped into as children and young people. Two thirds of those who try smoking go on to become regular smokers, only a third of whom succeed in quitting during their lifetime. Most smokers want to quit and many more regret ever having started. Therefore, whole system action is needed to support those who want to quit and prevent people from starting smoking in the first place.

1.8. Comprehensive tobacco control is a coordinated, multiagency approach to reducing smoking prevalence and the harm from tobacco. A coordinated and comprehensive approach to tobacco control across Oldham will make smoking less accessible, acceptable and desirable, empower successful quitting and stop young people starting to smoke.

## 2. Current Position

National Position

2.1. In 2019, the Tobacco Control Plan for England, *Towards a Smokefree Generation*, set out the Government's ambition for England to be Smokefree by 2030 (achieving smoking prevalence of less than 5%). The initial objectives of the tobacco control plan were to:

- reduce the number of 15 year olds who regularly smoke from 8% to 3% or less
- reduce smoking among adults in England from 15.5% to 12% or less
- reduce the inequality gap in smoking prevalence, between those in routine and manual occupations and the general population
- reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less

2.2. Achieving the Smokefree 2030 ambition is identified as an essential step towards increasing healthy life expectancy by five years by 2035, reducing health inequalities and levelling up the nation as set out in the statement made in January 2023 regarding the Major Conditions Strategy, the Government's plan to tackle preventable ill-health and mortality in England. Smokefree 2030 is also expected to contribute to achieving one of the Prime Minister's key priorities: to cut NHS waiting lists.

2.3. In June 2021, the All Party Parliamentary Group (APPG) on Smoking and Health released a report that set out recommendations for the forthcoming refreshed Tobacco Control Plan to deliver a Smokefree 2030. The recommendations in the report included global leadership to end smoking; 'Polluter pays' fund for tobacco control; comprehensive strategy approaches including targeted investment to reduce inequalities, plus tougher regulations to further denormalise smoking; improved data collection and analysis to inform progress; and interim targets for 2025 with further action to be taken if not on track by then.

2.4. In June 2022, the independent review by Dr Javed Khan into the government's ambition to make England smokefree by 2030 was published. The review provided independent, evidence-based advice to inform the government's approach to reduce the number of people taking up smoking and helping smokers to quit. The review made 15 recommendations for government to achieve a smokefree society. This included 4 critical recommendations:

- Urgently invest £125 million per year in a comprehensive smokefree 2030 programme. Options to fund this include a 'polluter pays' levy.
- Increase the age of sale by one year, every year.
- Offer vaping as a substitute for smoking, alongside accurate information on the benefits of switching, including to healthcare professionals.
- For the NHS to prioritise further action to stop people from smoking, by providing support and treatment across all of its services, including primary care.

2.5. In April 2023, the Government outlined 'The Next Eight Steps' towards Smokefree 2030. These included:

- stopping the growth of vaping among children,
- introducing new help for a million smokers to quit via a 'swap to stop' programme, offering vaping as a quit aid,
- increasing enforcement of illicit sales,
- expanding access to new treatments, including unblocking supplies to licensed medicines,
- backing joined-up, integrated approaches with a particular focus on stop smoking support in Mental Health services,
- rolling out a national incentive scheme to help pregnant women quit,
- consulting on new pack inserts using modern technology,
- ensuring Smokefree is at the core of the Major Conditions Strategy.

Greater Manchester Position

2.6. Greater Manchester (GM) is committed to becoming the first global city region to be smokefree and since 2017 has been delivering its unprecedented and evidence-

based Making Smoking History (MSH) strategy through a partnership of city region, local authority borough and community-based programmes. Built on the evidence-based World Health Organisation (WHO) MPOWER model, the programme has delivered system-wide transformation at scale, influenced national policy, including the Khan Review and NHS Long Term Plan, and delivered ongoing reductions to smoking prevalence across GM.

2.7. The GM Joint Forward Plan includes an action section around 'Making Smoking History' as part of the 'Helping people stay well and detecting illness earlier' mission. The delivery of Making Smoking History actions is the responsibility of both Locality Boards and the Population Health Board. This work has 'points of delivery' through Primary Care, Local Authorities, the VCFSE and multiple other public sector partners such as Housing providers, Police and Fire and Rescue. A GM Make Smoking History Alliance has been established with locality membership from across all ten boroughs and diverse partner engagement.

2.8. Reducing smoking prevalence is integral to GM's approach to tackling inequalities and ensuring fair health for all. Becoming a smokefree city region by 2030 creates a unique opportunity to reduce health inequality, with the Office of National Statistics estimating that healthy life expectancy would increase by just over 6 years for men and 7 years for women if GM becomes smokefree by 2030. Smoking cessation also contributes to all five of the key clinical areas identified as priorities in NHS England's Core20plus5 approach to reducing health care inequalities:

- CORE20: Smoking accounts for half the difference in life expectancy between richest and poorest.
- PLUS: Smoking tobacco is linked to >100 conditions.
- 5:
    - Respiratory disease – >80% of COPD, a leading cause of mortality, caused by smoking,
    - Maternity – women who smoke have 47% increased risk of stillbirth,
    - Mental Health – up to 50% of all deaths in people with Serious Mental Illness (SMI) are attributable to smoking,
    - Cancer – smoking is a leading cause of lung cancer, largest killing cancer in UK,
    - Hypertension – smokers are twice as likely to suffer acute coronary events and twice as likely to die from them.

2.9. The Greater Manchester Making Smoking History GMPOWER Model features seven key components which ensure delivery of a comprehensive and system-wide approach to tobacco control, from neighbourhood to city region level based on improving and increasing quits and preventing relapse and uptake.

| GMPOWER | Improve Quit Success | Increase Quit Attempts | Prevent Relapse | Prevent Uptake |
|---|---|---|---|---|
| **G**row a social movement | ✓ | ✓ | ✓ | ✓ |
| **M**onitor tobacco and prevention policies | ✓ | ✓ | ✓ | ✓ |
| **P**rotect people from tobacco smoke | ✓ | ✓ | ✓ | ✓ |

| | | | | |
|---|---|---|---|---|
| **O**ffer to Stop Smoking Support | ✓ | ✓ | ✓ | |
| **W**arn about the dangers of tobacco | ✓ | ✓ | ✓ | ✓ |
| **E**nforce tobacco regulation | ✓ | ✓ | ✓ | ✓ |
| **R**aise the price of tobacco | ✓ | ✓ | ✓ | ✓ |

2.10. Five years since the launch of the GM Making Smoking History programme, a summary report has been produced and comprehensive review and refresh has been underway to reflect upon the progress made to date and renew the commitment to the ambition for a smokefree city region to deliver a healthier, fairer future. An updated Making Smoking History (MSH) five-year framework will be published in Autumn 2023. The refreshed framework will further strengthen GM's reputation as national leaders in tobacco control through a strong commitment to innovation and research and delivering behaviour change. The framework will outline the actions needed at a national, regional and local level to achieve Smokefree 2030.

Oldham Position

2.11. Reducing smoking is one of the key priorities of Oldham's Health and Wellbeing Strategy and it is our ambition to work towards a smoke-free Oldham. Smoking is identified as a key challenge facing the system in the Oldham Integrated Care Partnership's Locality Plan and highlighted as one of the 18 core areas we need to improve and transform. High smoking rates and the need for improved support for self-management around smoking cessation were identified as key factors in the recent report by Carnall Farrar which identified priorities for addressing health and care demand and drivers of demand in Oldham.

2.12. The Oldham Tobacco Alliance, which reports into the Health Improvement Sub-group of the Health and Wellbeing Board, is a collective partnership of stakeholders and local representatives. The Tobacco Alliance provides strategic leadership and drive for the tobacco control agenda in Oldham, in line with national, regional and local priorities. Its primary role is to provide strategic leadership to improve the health and wellbeing of Oldham's population and to reduce the inequalities in health experienced by some communities, through tobacco control. The Alliance collaboratively supports the strategic vision of making Greater Manchester Smokefree by 2030. This includes facilitating the local delivery of evidence-based tobacco control work across Oldham to reduce smoking rates, minimise tobacco-related harm and contribute to reductions in health inequalities.

2.13. The Oldham Tobacco Alliance has developed a Locality Tobacco Control Action Plan which uses the GMPOWER model and is informed by the national Smokefree 2030 Tobacco Control Plan and incorporates the APPG and Khan Review recommendations, as well as taking learning from ASH and Cancer Research UK around effective tobacco control policy approaches.

2.14. In order to appropriately prioritise work, areas of focus have been identified from the Locality Tobacco Control Action Plan by the Alliance and task and finish groups established to take the workstreams forward. These include:

- Children and young people
- Alternative forms of tobacco and nicotine (including vaping)
- Smokefree homes and places
- Illicit tobacco and enforcement
- Communications and engagement

Each task and finish group has its own operational action plan to progress the relevant workstream and provides regular updates on progress to the Alliance.

2.15. The Oldham Tobacco Alliance has been meeting regularly since it was launched in September 2021, and has made considerable progress to date. Some of the key actions undertaken by the Alliance, and its sub-groups, have included:

- Inclusion of Tobacco Control as a key priority in our refreshed Health and Wellbeing Strategy.
- Development of a local vaping position statement (superseded by GM Vaping Position Statement that is awaiting sign off via GM Public Health Leaders).
- Successful coordination of communication campaigns, including collaborative Stoptober events jointly delivered by all of our different stop smoking services and joint approaches around national No Smoking Day
- Enhanced training and workforce development offer including Very Brief Advice on smoking cessation for wider workforce and targeted and bespoke training for services that work with vulnerable and at-risk groups.
- Surveys undertaken with communities (with high levels of uptake) to better understand prevalence and use of alternative forms of tobacco and nicotine in order to inform myth-busting and targeted messaging and engagement.
- Comprehensive review of all smoke-free policies for partner organisations to identify gaps, opportunities for learning and explore options for shared protocols and an alliance wide approach.
- Involvement in the development and coordination of the GM Social Housing Stop Smoking Consultation – findings of the evaluation are due to be shared in October 2023
- Development of a Youth Vaping Support Pack for Education Settings – due to launch in Autumn Term 2023, with an enhanced support offer from School Nursing and community stop smoking service
- Continued focus on enforcement of tobacco legislation (including underage sales) and a persistent approach to tackling illicit tobacco and unregulated vapes.

2.16. Some of the ongoing challenges and areas of focus for the Tobacco Alliance going forward include:

- Ensuring that there is high quality, evidence-based specialist stop-smoking services available to everyone who smokes (including access to alternative products to support people to quit smoking successfully) whilst ensuring that there is appropriately targeted support for those most at risk of tobacco-related harm and any emerging vulnerable groups (such as the digitally excluded, asylum seekers)

- Building robust pathways between local authority commissioned stop smoking services and healthcare stop smoking provision (and the wider health and care system) and navigating the complicated commissioning landscape.
- Alternative forms of tobacco, including shisha, and use of tobacco with illicit substances (such as cannabis) and the development of targeted training for professionals alongside resources and engagement materials for residents
- Illicit tobacco and the impact of the Cost of Living Crisis
- Vaping including tackling myths about harms, unregulated vapes and those containing illicit substances and balancing messaging around the benefits of vapes as an effective quit aid together with preventing the uptake of vaping by young people and never smokers.
- Further work around Smokefree Places (including exploring feasibility options around Smokefree Pavement Licences and pedestrianised areas) and Smokefree Homes (including more work with Social Housing providers).

2.17. The Oldham Locality Tobacco Control Action Plan will be reviewed and updated in line with the release of the anticipated refreshed national Tobacco Control Plan for England and the revised GM Making Smoking History delivery framework.

**3. Data and Intelligence**

3.1. Officers from Oldham Council Data Insight and Intelligence Team will attend the Health and Wellbeing Board to present comprehensive data from the Joint Strategic Needs Assessment in relation to tobacco use in Oldham.

**4. Key Issues for Health and Wellbeing Board to Discuss**

4.1. Health and Wellbeing Board is asked to consider Oldham's approach to tobacco control, the work to date of the Oldham Tobacco Alliance and the wider health and care system in tackling smoking and the effectiveness of the locality tobacco control plan in reducing smoking prevalence and tobacco related harm.

**5. Key Questions for Health and Wellbeing Board to Consider**

5.1. Health and Wellbeing Board is asked to consider what more can be done to address smoking locally and to reduce the risk and impact of tobacco related harm and how we can work together as a system to contribute to reducing the health inequalities caused by tobacco and smoking to improve the health and wellbeing of our residents.

5.2. Health and Wellbeing Board may wish to consider specific roles and approaches for system-level leadership that may support and strengthen local tobacco control work, which could include:

- bringing together the resources and expertise held across the NHS, local government, voluntary sector and other partners
- enabling partner organisations to take co-ordinated, mutually-reinforcing action and reducing duplication
- supporting consistency of approach and reducing variation in access to services

- aggregating skills and creating a central hub of expertise to help drive up effectiveness
- accessing new or different funding streams and using these to increase total investment in prevention
- enabling partners to speak with a stronger collective voice to amplify their impact on wider policy.

There may also be opportunities to take a more integrated approach to prevention, supporting approaches which tackle multiple risk factors simultaneously.

## 6. Additional Supporting Information

6.1 Partners from across the health and care system will attend Health and Wellbeing Board and present further information regarding the work that has been ongoing in the borough to reduce tobacco related harm, including the support that is available for help people to stop smoking, the work that has been done to protect people from tobacco smoke, how we enforce restrictions and legislation locally, and work that is being undertaken to address youth vaping.

**Report to HEALTH AND WELLBEING BOARD**

# Child Death Overview Panel – Oldham, Rochdale and Bury Annual Report 2021/2022

**Portfolio Holders:**
Councillor B Brownridge, Cabinet Member for Adult Social Care and Public Health

**Officer Contact:** Rebecca Fletcher, Interim Director of Public Health

**Report Author:** Katie Bretherton, Public Health Specialty Registrar, Bury Council

**Date: 7th September 2023**

**Purpose of the Report**

To provide the Health and Wellbeing Board with the Oldham, Rochdale and Bury Child Death Overview Panel Report. This is an annual review of the Child Death Overview Panel (CDOP) data for Oldham, Rochdale and Bury (ORB), one of the four CDOP groupings in Greater Manchester (GM). CDOPs review all child deaths under 18 years, apart from still births, late foetal loss, or termination of pregnancy. CDOPs are not responsible for establishing the cause of death, they explore all factors relating the death of the child.

The findings of the report should be used to inform future action to prevent child deaths. CDOPs collate information annually on closed cases, this is used to establish themes in the data enabling each area to identify lessons learnt and recognise where service or population level interventions are needed.

**Requirement from the Health and Wellbeing Board**

The Health and Wellbeing Board members are asked to note the Child Death Overview Panel Annual Report. The Board members are also asked to take the key findings of the report back to their organisations if appropriate and to consider if there are any issues that need addressing within the borough.

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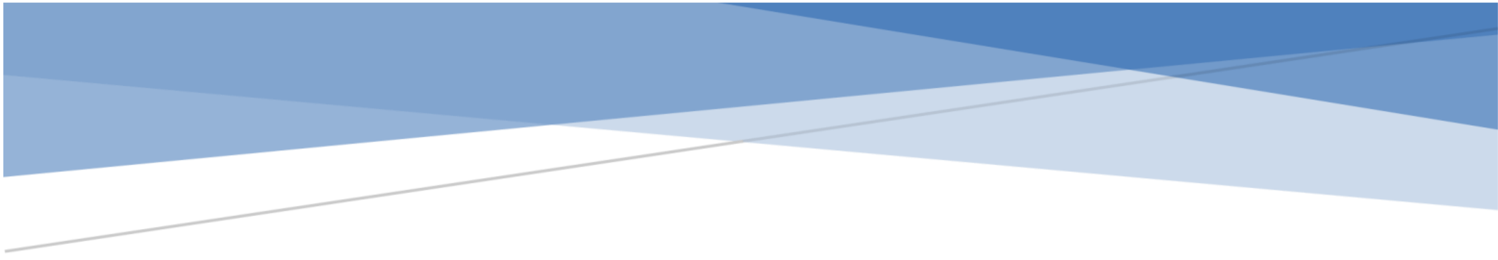

# OLDHAM, ROCHDALE AND BURY CHILD DEATH OVERVIEW PANEL ANNUAL REPORT 2021-2022

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Publication date: June 2023

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**Oldham, Rochdale and Bury Child Death Overview Panel Annual Report 2021-2022**

## 1 Executive Summary

This is an annual review of the Child Death Overview Panel (CDOP) data for Oldham, Rochdale and Bury (ORB), one of the four CDOP groupings in Greater Manchester (GM). CDOPs review all child deaths under 18 years, apart from still births, late foetal loss, or termination of pregnancy. CDOPs are not responsible for establishing the cause of death, they explore all factors relating the death of the child. The findings of the report will be used to inform future action and to generate recommendations on behalf of ORB CDOP.

CDOPs collate information annually on closed cases, this is used to establish themes in the data enabling each area to identify lessons learnt and recognise where service or population level interventions are needed. 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 the data.

### 1.1 Key Findings in Bury, Oldham and Rochdale

Between April 2021 to March 2022 there were 64 notified deaths and 44 CDOP case reviews that were closed in the ORB area. Deaths are not necessarily notified in the same year that CDOP case review is completed and none of the cases closed in the period covered by this report are deaths that were also notified during this time. A CDOP review must be completed and the case considered closed before there is enough information to perform analysis which may contribute to the development of themes from the data. This process means that CDOP reviews do not contain a substantial amount of information for the deaths that have occurred in the year the analysis takes place.

In the period covered in this report the number of cases being closed has started to rise compared to previous years after a decrease caused by several factors including process and IT changes, staffing constraints, and other organisational changes. It is hoped that this increase in closed cases will continue and reach the point where it is back to pre-pandemic levels. The ORB area took around 172 days longer than the GM average to close cases for this period.

For registered deaths most children died in hospital for both the ORB and GM areas with a similar proportion dying at home in both areas.

The largest proportion of deaths for both the ORB and GM area were due to perinatal/neonatal events. In the ORB area this proportion was 59%, which was statistically similar to GM (56% of deaths). In Both ORB and GM there was a higher proportion of male deaths in closed cases and in the ORB area there was a disproportionate number of deaths in ethnic minorities (38.6%) when considering the proportion of ethnic minorities in the ORB population as a whole (17.1% to 31.9% depending on ORB area). In the ORB area 55% of deaths in closed cases were in children under 27 days old and 55% of all child deaths were considered to include modifiable factors.

### 1.2 Summary of Recommendations

I. To mitigate for limitations in analysis due to a small dataset for notifications and closed cases, future report should include an overview and headline analysis for the year with in depth investigation of the data over a three-year period. This would increase the ability to identify any patterns and themes which are occurring and allow

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for more meaningful comparisons with the North West data which is predominantly reported in this way.

II. A number of data fields for both death notifications and closed cases did not meet the completeness threshold and were identified as requiring improvement. Of those identified the fields which allow for learning points to be shared and advise of action to be taken had particularly poor completion rates at 27%, suggesting immediate improvement is needed in the collection of this type of data.

III. There is currently a backlog of CDOP reviews which is increasing each year due to the occurrence of more deaths each year than reviews being completed. Some of this has been due to external factors such as the impact of the COVID-19 pandemic in services and the implementation of a new nationwide database, however, a review of available resources is needed to ensure that this issue can be resolved to prevent the backlog increasing each year.

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## 2 Introduction

The following report will provide an analysis of child deaths in Oldham, Bury and Rochdale (ORB) for the period April 2021-March 2022. The report is intended to guide population and service level interventions with an aim to reduce childhood mortality in the area. It will conclude with recommendations which will be presented to the relevant health and wellbeing boards across the three boroughs.

For each child death that occurs a review takes place to explore the circumstances surrounding the death to identify potentially modifiable factors that contributed to the death. The reviews allow the system to learn from these tragic incidents and work together to prevent children from dying from the same modifiable causes in future.

Child Death Overview Panels (CDOP) review the deaths of those under 18, excluding 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 (GM) are:

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

Each year CDOPs collate information from the previous twelve months to inform decision making and future action.

The following report includes information for cases closed between 1st April 2021 and 31st March 2022. During this period there were 229 notifications of deaths of under 18s in GM, with 64 of those occurring in the ORB area. In GM, 143 reviews were closed in this period with 44 of those from the ORB area. A case is defined as closed at the end of the CDOP review process, this does not always occur in the same year as notification of death.

### 2.1 Infant Mortality in the UK and comparisons with Bury, Oldham and Rochdale

Over recent decades the UKs infant mortality rates has fallen, however, the rate of improvement has slowed when compared to other European countries.

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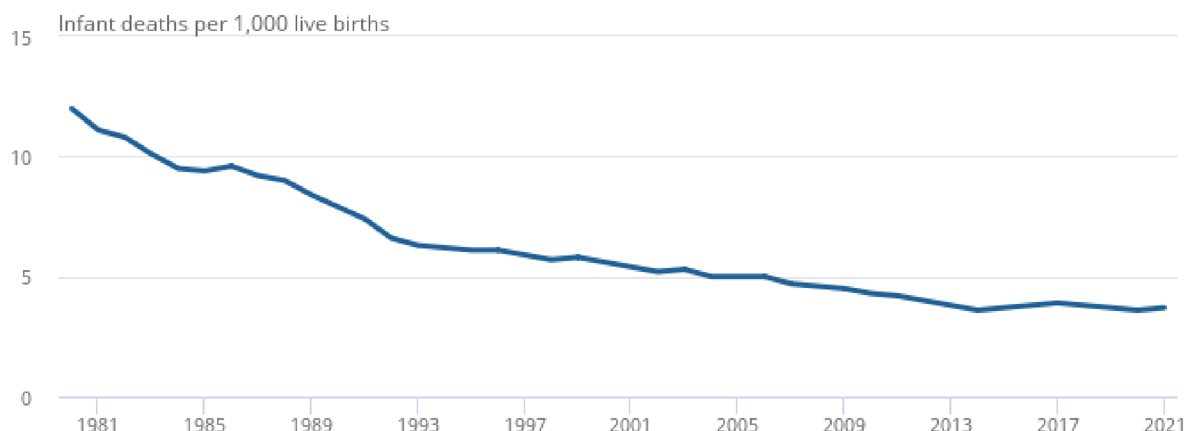
*Figure 1- Overall decline in infant mortality in England and Wales 1980-2021 (ONS)*




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. Infant mortality rates are highest among babies of Pakistani ethnicity and lowest in babies of white ethnicity.

The crude rate infant mortality (2018-20) was 3.9 per 1000 births in England with a slightly higher rate of 4.3 across the North West. Bury has a similar level of infant mortality rate to the rest of England and the North West at 4.1 per 1000 births. Rochdale and Oldham have higher rates at 5.0 and 6.2 per 1000 births respectively.[1]

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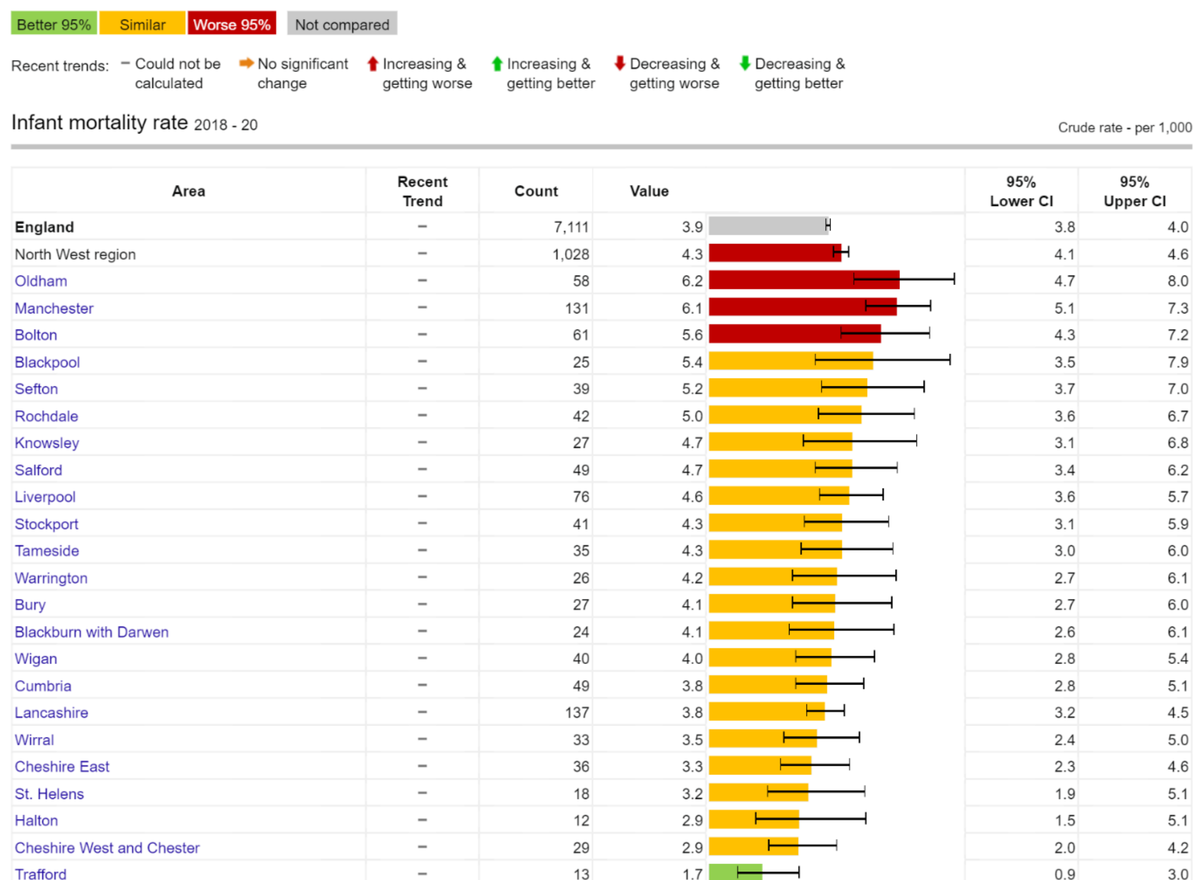
[1] Although the difference between the infant mortality rate in Rochdale and England is not statistically significant, this is likely due to small numbers of deaths in each rolling three year period. Rochdale's rate has been higher than England since the 2015-17 period and if aggregated over a longer time period, the difference is statistically significant.

*Figure 2- Infant mortality rates for the North West of England (PHOF)*




| Area | Recent Trend | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|
| **England** | – | 7,111 | 3.9 | 3.8 | 4.0 |
| North West region | – | 1,028 | 4.3 | 4.1 | 4.6 |
| Oldham | – | 58 | 6.2 | 4.7 | 8.0 |
| Manchester | – | 131 | 6.1 | 5.1 | 7.3 |
| Bolton | – | 61 | 5.6 | 4.3 | 7.2 |
| Blackpool | – | 25 | 5.4 | 3.5 | 7.9 |
| Sefton | – | 39 | 5.2 | 3.7 | 7.0 |
| Rochdale | – | 42 | 5.0 | 3.6 | 6.7 |
| Knowsley | – | 27 | 4.7 | 3.1 | 6.8 |
| Salford | – | 49 | 4.7 | 3.4 | 6.2 |
| Liverpool | – | 76 | 4.6 | 3.6 | 5.7 |
| Stockport | – | 41 | 4.3 | 3.1 | 5.9 |
| Tameside | – | 35 | 4.3 | 3.0 | 6.0 |
| Warrington | – | 26 | 4.2 | 2.7 | 6.1 |
| Bury | – | 27 | 4.1 | 2.7 | 6.0 |
| Blackburn with Darwen | – | 24 | 4.1 | 2.6 | 6.1 |
| Wigan | – | 40 | 4.0 | 2.8 | 5.4 |
| Cumbria | – | 49 | 3.8 | 2.8 | 5.1 |
| Lancashire | – | 137 | 3.8 | 3.2 | 4.5 |
| Wirral | – | 33 | 3.5 | 2.4 | 5.0 |
| Cheshire East | – | 36 | 3.3 | 2.3 | 4.6 |
| St. Helens | – | 18 | 3.2 | 1.9 | 5.1 |
| Halton | – | 12 | 2.9 | 1.5 | 5.1 |
| Cheshire West and Chester | – | 29 | 2.9 | 2.0 | 4.2 |
| Trafford | – | 13 | 1.7 | 0.9 | 3.0 |

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

Across ORB there are approximately 160,171 children under the age of 18, equating to 23% of the total population of the area. This is similar to the percentage in both GM and England. Rochdale and Oldham have a higher percentage of under 18s than the North West average, with Bury having a lower percentage than Rochdale, Oldham, Greater Manchester and England (table 1).

| Table 1: Number of children aged under 18 in Oldham, Bury and Rochdale[2] | | | |
|---|---|---|---|
| **Area** | Under-18 Population size | Total Population | Percentage of population <18 |
| **Bury** | 43,754 | 224,087 | 20% |
| **Oldham** | 61,748 | 242,072 | 26% |
| **Rochdale** | 54,669 | 224,087 | 24% |
| **Bury, Oldham, Rochdale (ORB)** | 160,171 | 690,246 | 23% |
| **Greater Manchester (GM)** | 653,244 | 2,868,387 | 23% |
| **North West** | 1,561,965 | 7,422,295 | 21% |
| **England** | 13,838,088 | 56,536,419 | 24% |

## 3 Notification of deaths and closed cases

The number of notified deaths and closed cases are reported each year within each CDOP area, when reviewing this data some important distinctions in terminology are important.

**Notified case**: A death that have been legally notified during the period of this report.

**Closed case:** A CDOP case which has reached its conclusion during the period of this report, this death did not necessarily take place in the period which the report covers and may have occurred in any of the years before the case being closed.

Most of the analysis in this report (and unless stated otherwise) will refer to closed cases as these are the cases for which the information needed for analysis is available. Due to the number of closed cases for this period some analysis that has been performed in previous years will not be possible. It is also worth noting that any inferences must be made with caution due to the small numbers being dealt with throughout, as statistical significance cannot be assessed with any confidence.

### 3.1 Notified cases 2021/2022

There were 64 notified deaths across ORB, almost one third of the GM total. This suggests a disproportionate amount of deaths in the ORB areas as ORB is home to around 25% of GM's children. The main contributor to this is Oldham with death at a rate of 4.86 per 10,000 people equating to just under half of the child deaths in the ORB area (table 2).

2 https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

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| Table 2: Number, percentage and rate per 10,000 of notified deaths across ORB, 2021/22 | | | | |
|---|---|---|---|---|
| **Area** | **Number of Notified Deaths** | **Percentage of overall GM deaths** | **Population 0-17 years** | **Rate of Notified cases per 10,000 population aged 0-17** |
| **Bury** | 18 | 8% | 43,754 | 4.11 |
| **Oldham** | 30 | 13% | 61,748 | 4.86 |
| **Rochdale** | 16 | 7% | 54,669 | 2.93 |
| **ORB** | 64 | 28% | 160,171 | 4.00 |
| **GM** | 229 | 100% | 653,244 | 3.51 |

Data is collected on the completeness of data entry of death notifications, any section which is shown to have been completed less than 90% of the time is considered as need improvement. For the period 2021-2022 the joint agency response field fell below this threshold with 88% completeness indicating improvement is needed in this area.

3.2 Closed Cases 2021/2022

In 2021- 22 there were 44 closed cases across the ORB CDOP. As seen in table 3, the closed cases in ORB account for 31% of GM's closed cases. Oldham has the highest rate of closed cases, 3.4 per 10,000 of the population. As previously mentioned, this information is only in relation to the reviews which were closed in this period and does not indicate what year the deaths took place in, this is because many factors may impact the length of time it takes to review a child's death.

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| Table 3: Number and percentage of deaths reviewed (cases closed) across ORB 2021/22 | | | |
|---|---|---|---|
| **Area** | **Total Deaths (Closed cases)** | **Percentage of overall GM deaths (Closed cases)** | **Rate of Closed cases per 10,000 population** |
| **Bury** | 9 | 6% | 2.06 |
| **Oldham** | 21 | 15% | 3.40 |
| **Rochdale** | 14 | 10% | 2.56 |
| **ORB** | 44 | 31% | 2.75 |
| **GM** | 143 | 100% | 2.19 |

For the period 2021-2022 none of the case which were closed in the ORB area were deaths that were notified in that year, with fewer than five cases closed from this period across GM. This backlog that has been experienced in recent years is due to the ongoing impacts of workforce challenges and the aftereffects of the COVID-19 pandemic.

| Table 4: Notified cases closed in the same year (2021/22) | | | | |
|---|---|---|---|---|
| **Area** | Total Number Notified Cases 2021/22 | Total Number of Closed Cases 2021/22 | Number of cases notified and closed in 2021/22 | % Cases notified and closed in 2021/22 |
| **ORB** | 65 | 44 | 0 | 0% |
| **GM** | 229 | 143 | <5 | <11% |

This year the number of closed cases has started to rise across both ORB and GM (table 5) after closed cases declined in 2019-2020 due to the introduction of new guidance and the subsequent increase in workload. This was exacerbated locally due to staffing issues, major organisational changes at the acute care provider, and a new data collection system which slowed down data retrieval. These issues have been mostly resolved which is expected to resolve the issue and ORBs closed cases can begin to reach previous levels.

**Table 5: Number of Closed Cases compared by year across each area**

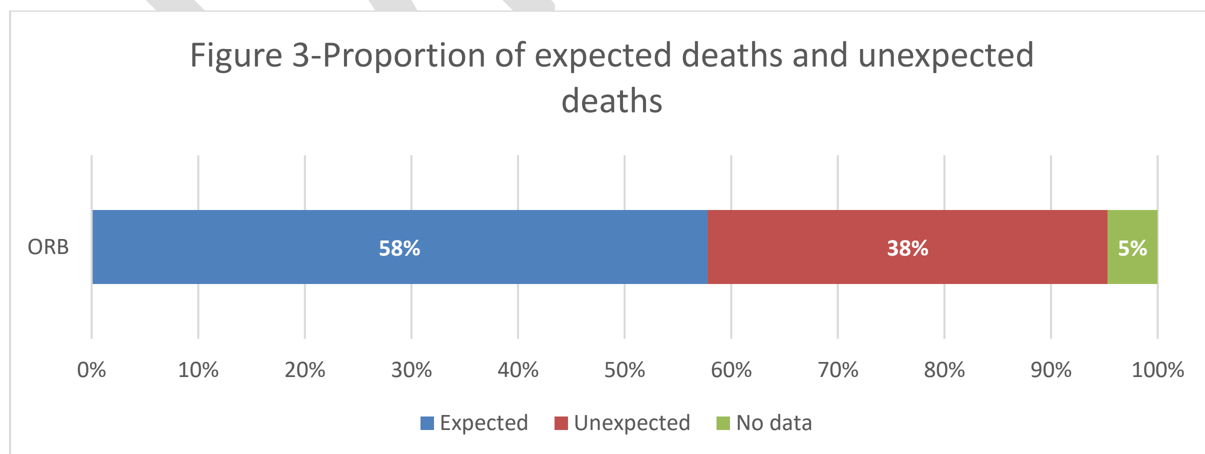
| Area | Number of Closed Cases per year | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2012/ 13 | 2013/ 14 | 2014/ 15 | 2015/ 16 | 2016/ 17 | 2017/ 18 | 2018/ 19 | 2019/ 20 | 2020/ 21 | 2021/ 22 |
| Bury | 20 | 13 | 17 | 17 | 11 | 14 | 12 | 7 | 9 | 9 |
| Oldham | 27 | 24 | 36 | 29 | 25 | 31 | 14 | 14 | 8 | 21 |
| Rochdale | 25 | 20 | 28 | 28 | 15 | 26 | 27 | 8 | 12 | 14 |
| ORB | 72 | 57 | 81 | 74 | 51 | 71 | 53 | 29 | 29 | 44 |
| GM | 267 | 216 | 262 | 236 | 231 | 274 | 204 | 129 | 132 | 143 |

Data is collected on the completeness of data entry of closed CDOP reviews, any section which is shown to have been completed less than 90% is considered as needing improvement. For the period 2020-2021 the field collecting information on joint agency response, ethnicity, mode of death, learning points, and actions all fell below this threshold indicating a need for improvement with learning point and actions both being completed less than 30% of the time.

## 4 Analysis of Notified deaths

### 4.1 Expected and unexpected deaths

Figure three below shows that there was a larger proportion of expected deaths than unexpected deaths in the ORB areas in the period 2021-22. This data cannot be broken down into the individual ORB areas due to the size of the data available.

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4.2 Inequalities & Index of Multiple Deprivation (IMD)

Deprivation is linked to various health outcomes and too many of the modifiable risk factors associated with child deaths. The index of multiple deprivation 2019 (IMD) is an overall measure of deprivation including resources needed for an individual to meet their basic needs, such as education, employment, health and disability, housing and living environment alongside income deprivation.

All three local authorities have higher rates of deprivation when compared to both GM and nationally, however, Bury has a lower rate than the North West region. Oldham and Rochdale have a considerably higher percentage of people living in the 20% most deprived areas in England compared to Bury, GM, the North West and England. Oldham and Rochdale also a higher percentage of child poverty than Bury and England.

**Table 6: 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 score | Percentage of people living in the 20% most deprived areas in England | Child poverty (proportion using IDACI[3] index) |
|---|---|---|---|
| Bury | 23.7 | 20.50% | 16.90% |
| Oldham | 33.2 | 43.60% | 23.30% |
| Rochdale | 34.4 | 44.50% | 23.50% |
| GM | 21.7 | 20.20% | Not available |
| North West | 28.1 | 31.90% | Not available |
| England | 21.7 | 20.20% | 17.10% |

IMD scores can be split into deciles to enable comparisons to be made relating to deprivation, decile 1 represents the most deprived 10% of the population and decile 10 represents the least deprived. Figure 4 below indicates a relationship between the first three IMD deciles (i.e. the most deprived) and child deaths. This data may be influenced by differences in the spread of deprivation across the three ORB boroughs and it may also be influenced by a tendency for there to be more children in the more deprived deciles. This can be explored further through calculating rates per 10,000 for each IMD decile, this allows us to look at the proportion of deaths in relation to the number of children living in each decile.

[3] Income Deprivation Affecting Children Indicator, a measure of the proportion of children experiencing poverty included in the Indices of Multiple Deprivation.



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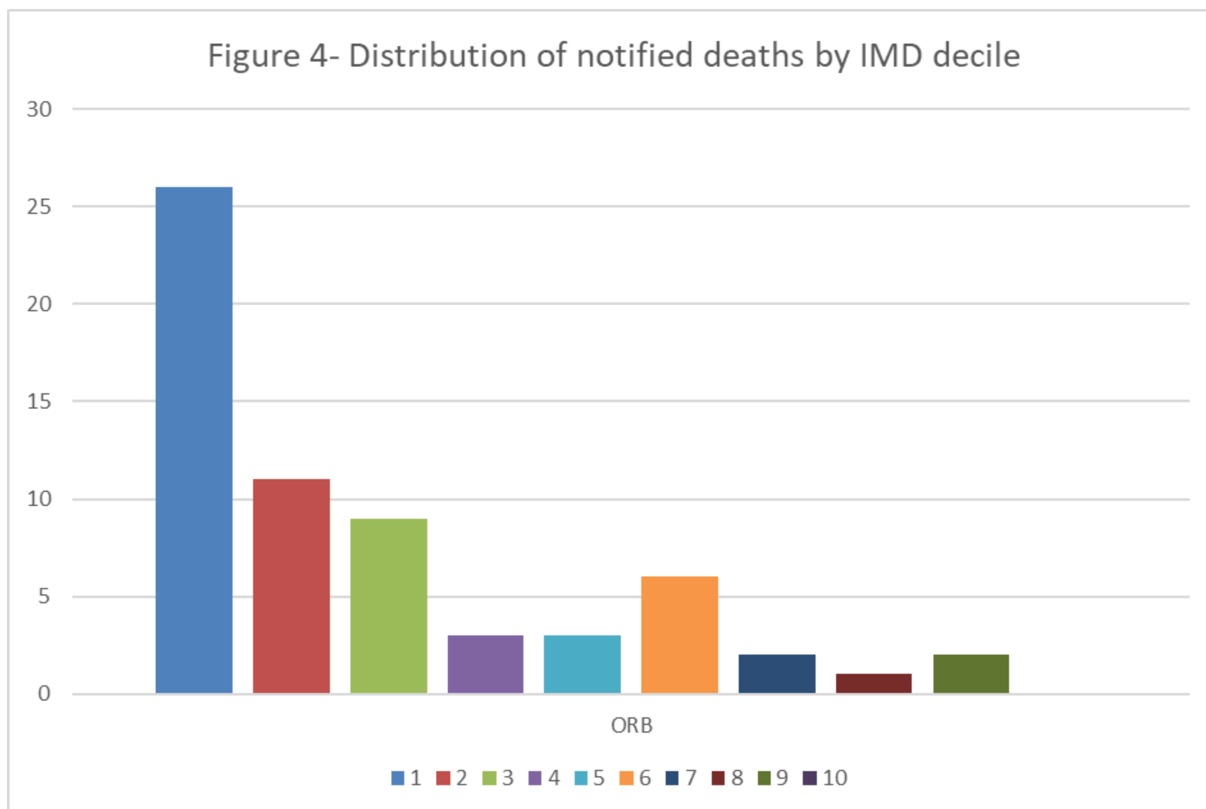

Figure 4- Distribution of notified deaths by IMD decile

Table 7 explores the relationship between deprivation and notified deaths across the three boroughs further. The calculations performed to generate this data utilises 2021 census and IMD 2019 data and it must be noted that there were no child deaths in IMD decile 10 in Rochdale and Oldham as the boroughs have no decile 10 areas. From the data we can see that the decile six peak in figure 4 is due to deaths occurring in Bury and Rochdale as Oldham had no deaths in this decile. The variation in rates of notified deaths in individual boroughs does not establish as clear a pattern as when combined across the three areas, which demonstrates the need for cautions when dealing with small datasets such as this one. There is an evidenced link between deprivation and child deaths, to identify any local statistically significant variations the dataset would need to be increased by exploring the issue over a number of years.

| Table 7- Proportion of notified deaths across Index of Multiple Deprivation deciles across ORB (rates per 10,000) | | | | |
|---|---|---|---|---|
| **IMD decile** | Bury | Oldham | Rochdale | ORB |
| **1** | 7.42 | 5.89 | 4.02 | 5.30 |
| **2** | 3.29 | 8.22 | 1.13 | 4.46 |
| **3** | 5.80 | 4.35 | 3.36 | 4.41 |
| **4** | 2.77 | 2.83 | 2.89 | 2.83 |
| **5** | 5.42 | 0.00 | 3.27 | 3.16 |
| **6** | 8.39 | 6.95 | 0.00 | 6.62 |
| **7** | 0.00 | 3.63 | 3.82 | 2.34 |
| **8** | 0.00 | 2.50 | 0.00 | 0.80 |
| **9** | 7.19 | 0.00 | 0.00 | 2.78 |
| **10** | 0 | 0* | 0* | 0.00 |
| **No data** | 0 | 0 | 1 | 1 |

## 5 Reviews of child death cases 2021/22

### 5.1 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 2021-22 the average duration of review across ORB was 823 days, higher than the GM average of 652 days (table 6). Many contributing factors, for example cause of death, the need for additional investigations such as coroner's inquest, and serious incident investigations can delay a case from reaching CDOP and delay its closure date. The backlog of cases from previous years will also be having an impact and contributing to the rise in the average duration.

| Table 8: Average Duration of Review by Area (Median) | |
|---|---|
| **Area** | **Duration of Review (Days)** |
| **ORB** | 823 |
| **GM** | 651 |
| **NW** | 486 |

### 5.2 Location of Death

Most deaths of children occurred in a hospital setting across the ORB area. ORB's proportions of child deaths that happen in hospital are similar to GM's.

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| Table 9: Comparison of Location of Death for death registered 2021/22 | | | | | | |
|---|---|---|---|---|---|---|
| **Area** | **Hospital** | | **Home** | | **Other** | |
| | **No** | **%** | **No** | **%** | **No** | **%** |
| **ORB** | 50 | 78% | 10 | 16% | 4 | 6.25% |
| **GM** | 174 | 76% | 40 | 17% | 15 | 7% |

5.3 Causes/Category of Death

Each case is assigned a category of death from 10 defined classifications. The category of which is deemed the most relevant is recorded as the primary category and cause of death, others as recorded as secondary categories. The nationally defined categories of death are 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

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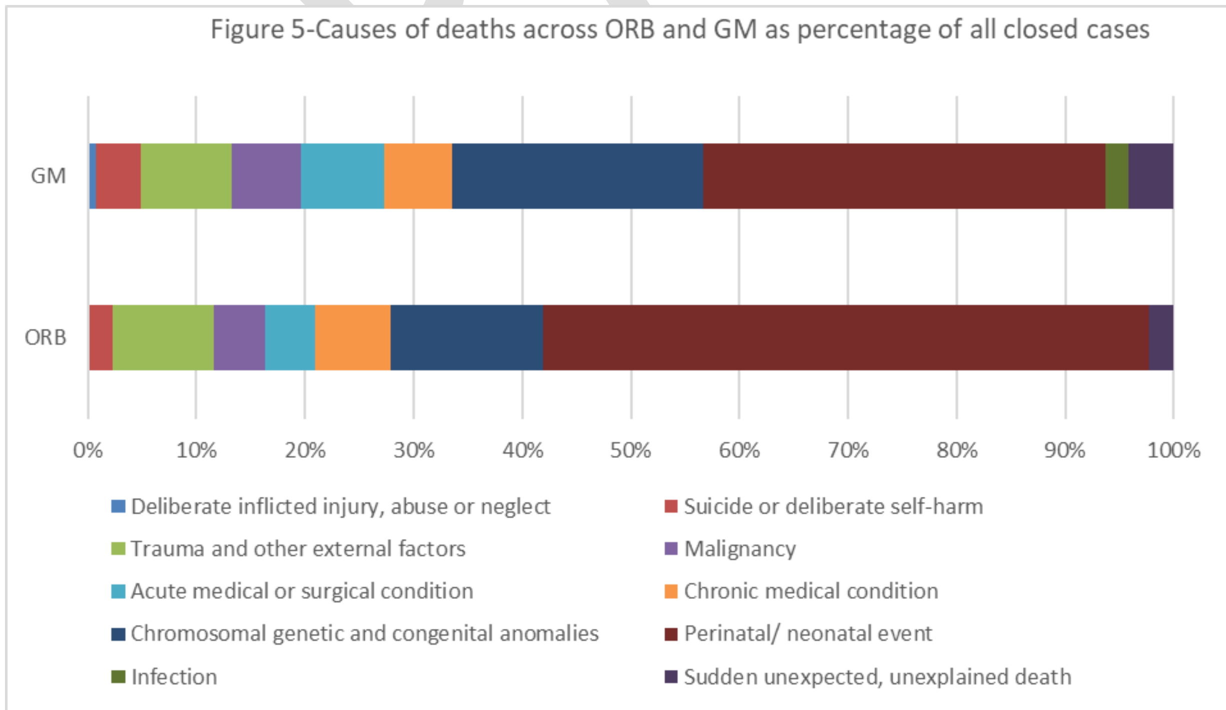

The figure above refers to the cause of death/primary category. In the ORB area cases closed for the period 2021-22 is perinatal/neonatal events are the main cause of death, this is also the case for GM. Due to the small numbers involved, and the deaths occurring across various years, it is not possible to comment on any patterns or trends in this data and it is not appropriate to break this data down by individual Local Authority areas.
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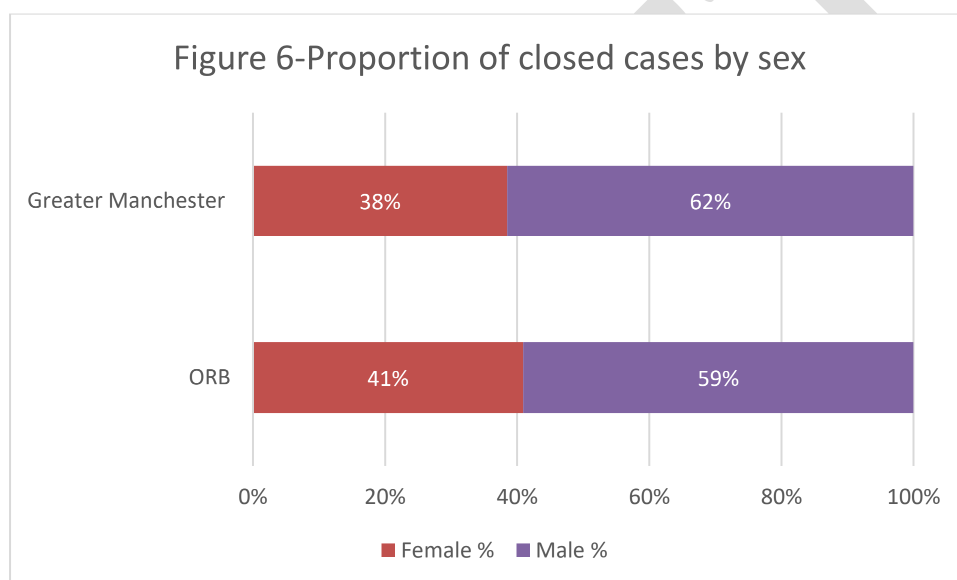
## 6 Socio-demographics of cases closed in 2021/2022

### 6.1 Sex

In both the ORB and the wider GM area males represent a higher proportion of deaths than females, this difference is consistent with previous years. This is an established phenomenon, accounted for by higher rates of death from a number of causes, notably neonatal abnormalities, neoplasms, and external causes.




### 6.2 Ethnicity

The 2021 census is the most up to date and accurate proportions of ethnicities in the UK and has released data on the proportions of ethnicities in Local Authority areas, this data has been used to estimate the percentage of children from white and ethnic minorities in the ORB, regional and national areas. Ethnic diversity varies across ORB with Bury having a higher proportion of residents from White ethnic groups than the other ORB areas, regionally and nationally. Whilst Bury has a larger White population than others there is cultural diversity, with a larger than average Jewish population, this not be captured using data on ethnicity and consideration is needed into how the needs of this population is met and how any potential patterns in CDOP data could be observed for this community. Both Rochdale and Oldham have higher proportions of ethnic minorities than the regional and national averages (table 10).

| Table 10: Child Population Ethnicity across Oldham, Bury and Rochdale, using mid 2019 population estimates. | | | | | |
|---|---|---|---|---|---|
| Area | <18 population | White | | Ethnic minorities | |
| | | No | % | No | % |
| Bury | 43,754 | 36,272 | 82.9% | 7,482 | 17.1% |
| Oldham | 61,748 | 42,050 | 68.1% | 19,698 | 31.9% |
| Rochdale | 54,669 | 40,455 | 74.0% | 14,214 | 26.0% |
| NW | 653,244 | 559,177 | 85.6% | 94,067 | 14.4% |
| England and Wales | 12,378,116 | 10,112,921 | 81.7% | 2,265,195 | 18.3% |

The proportion of deaths categorised as ethnic minorities in ORB is similar to that of GM although around 20% of ORB cases and around 9% of GM closed case's ethnicity were unknown. Due to the small number of closed cases in this period the data cannot be meaningfully analysed at a locality level, multiple years data or a wider geography would need to be utilised to assess whether any patterns linked to ethnicity exist.

| Table 11: Cases Closed by Ethnicity for Each Area | | | | |
|---|---|---|---|---|
| Area | White | | Ethnic minorities | |
| | No | % | No | % |
| ORB | 18 | 40.9% | 17 | 38.6% |
| GM | 75 | 52.4% | 56 | 39.2% |

6.3 Age at death

Risk of mortality is higher the younger the child is, with the highest risk of death occurring in the neonatal period. In the ORB area over half of deaths were in this aged group for cases closed in this period. This is a much higher proportion than the GM figure, as a result GM has a higher proportion of deaths in all other age categories However, due to the small number of cases closed in this period it is not possible to conclude whether this difference is statistically meaningful.

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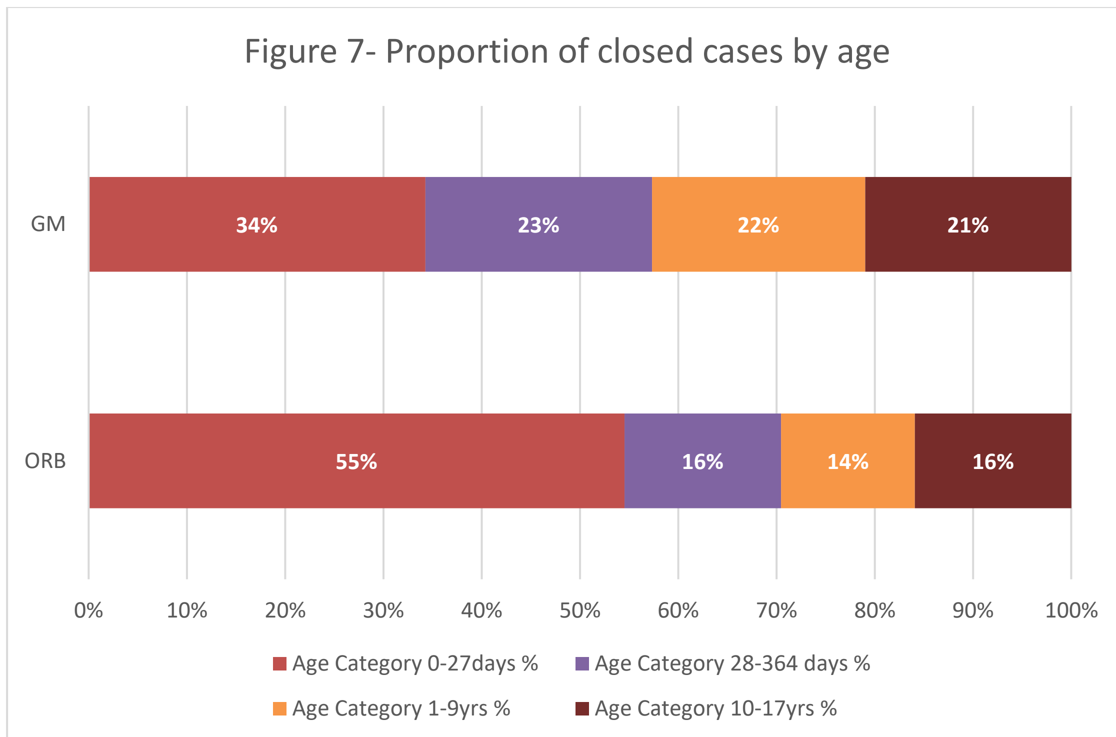


## 7 Modifiable and other risk factors

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

At CDOP review meetings all available information about the circumstances surrounding a child's death is collated from the people and agencies involved in the child's care. The information gathered is used to complete 'Form C', the child death analysis form which is used to inform the child death review meeting. This process is used to determine whether there were any modifiable factors involved which facilitates learning than can be used to prevent future child deaths.

The factors which can contribute to a child death are separated into four domains:

a. Factors Intrinsic to the Child
b. Factors in Social Environment including Family and Parenting Capacity
c. Factors in the Physical Environment
d. Factors in Service Provision

Each domain is then allocated a level of influence from 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
- 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
- Intra and inter service communication
- Resourcing issues

## 7.2 Modifiable Factors

Identifying modifiable factors in child deaths is an important element of CDOP reviews, it allows learning to be used to explore ways in which to reduce further risk where modifiable factors are present. 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'*

Modifiable Factors are categorised and defined as:

*Modifiable Factors in Perinatal / Neonatal Deaths*

- Smoking in pregnancy
- Obesity during pregnancy (BMI 30 +)
- Underweight during pregnancy (BMI < 18.5)
- Unbooked pregnancies (someone who has not attended any antenatal clinic session with a trained personnel before presentation in labour)
- 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*

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- Where there has been an older sibling who has died or is affected by the same genetic autosomal recessive disorder

Across ORB 55% of cases had modifiable factors identified, ORB had a higher proportion of cases with modifiable factors when compared to GM (table 15). All cases across ORB had sufficient information to identify modifiable factors.

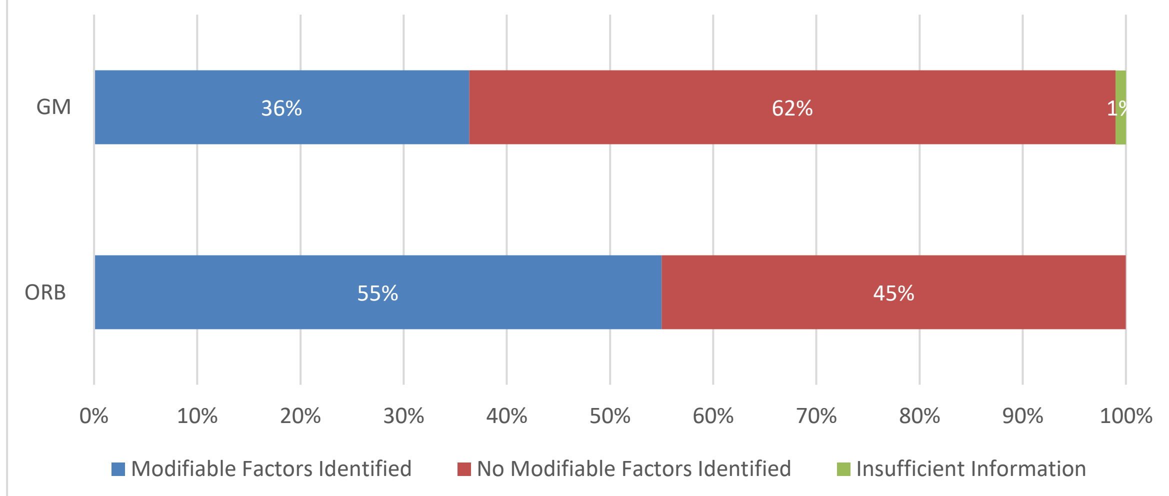
**Table 12: Modifiable and Non-Modifiable Factors Contributing Towards Child Deaths in Oldham, Bury and Rochdale**

| Area | Modifiable Factors Identified | | No Modifiable Factors Identified | | Insufficient Information | | Total |
|---|---|---|---|---|---|---|---|
| | No | % | No | % | No | % | No |
| ORB | 24 | 55% | 20 | 45% | 0 | 0% | 44 |
| GM | 52 | 36% | 89 | 62% | 2 | 1% | 143 |

It was not possible to explore the difference in modifiable factors between the ORB areas due to data limitations, however, it was possible identify which primary causes of death were most likely to have modifiable risk factors involved, these were:

- Acute medical or surgical condition
- Suicide or deliberate self-inflicted harm
- Sudden unexpected, unexplained death
- Trauma and other external factors, including medical/surgical complications/error
- Chronic medical condition

Again this data must be viewed with caution due to the number of deaths which are included in this analysis, along with the acknowledgment that these are the types of deaths that more likely to be influenced by modifiable factors.

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**Modifiable Risk Factors identified by the ORB CDOP in the closed cases of 2021/22 included:**

- Smoking in pregnancy
- Obesity during pregnancy
- Unbooked pregnancies
- Parental smoking
- Unsafe sleeping arrangements

## 8 Recommendations

I. The ORB area should continue to work towards reducing the key factors which are identified as contributing to child deaths, this will also have wider benefit for child health in general

II. To mitigate for limitations in analysis due to a small dataset for notifications and closed cases, future report should include an overview and headline analysis for the year with in depth investigation of the data over a three year period. This would increase the ability to identify any patterns and themes which are occurring and allow for more meaningful comparisons with the North West data which is predominantly reported in this way.

III. A number of data fields for both death notifications and closed cases did not meet the completeness threshold and were identified as requiring improvement. Of those identified the fields which allow for learning points to be shared and advise of action to be taken had particularly poor completion rates at 27%, suggesting immediate improvement is needed in the collection of this type of data.

IV. There is currently a backlog of CDOP reviews which is increasing each year due to the occurrence of more deaths each year than reviews being completed. Some of this has been due to external factors such as the impact of the COVID-19 pandemic in services and the implementation of a new nationwide database, however, a review of available resources is needed to ensure that this issue can be resolved to prevent the backlog increasing each year.

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## 9 Glossary

CDOP- Child Death Overview Panel

Closed case- A case is defined as closed at the end of the CDOP review process and cases are not necessarily closed in the same year as notification of death
GM—Greater Manchester

IMD- Index of Multiple Deprivation

Infant Mortality- When a person dies before their first birthday

Neonatal-The period between the first seven days and the first 28 days of a person's life

Notified case- when a death has occurred and legally registered

ORB- Oldham, Rochdale and Bury

Perinatal- The first seven days of a person's life

SID- Sudden Infant Death

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