TRAFFORD COUNCIL

UPDATE AGENDA INCLUDING ALL PAPERS MARKED 'TO FOLLOW' FOR

HEALTH AND WELLBEING BOARD

Date: Friday, 15 September 2023

Time: 10.00 a.m.

Place: Committee Room 2 and 3, Trafford Town Hall, Talbot Road, Stretford M32 0TH

A G E N D A **PART I** **Pages**

1. **ATTENDANCES**

To note attendances, including officers, and any apologies for absence.

2. **DECLARATIONS OF INTEREST**

Members to give notice of any interest and the nature of that interest relating to any item on the agenda in accordance with the adopted Code of Conduct.

3. **MINUTES** 1 - 8

To receive and if so determined, to approve as a correct record the Minutes of the meeting held on 21st July 2023.

4. **QUESTIONS FROM THE PUBLIC**

A maximum of 15 minutes will be allocated to public questions submitted in writing to Democratic Services (democratic.services@trafford.gov.uk) by 4 p.m. on the working day prior to the meeting. Questions must be within the remit of the Committee or be relevant to items appearing on the agenda and will be submitted in the order in which they were received.

5. **APPOINTMENT VICE CHAIR**

To appoint a Vice Chair of the Committee for the 2023/24 Municipal year.

6. **HOUSING STRATEGY** 9 - 24

To receive a presentation from the Housing and Growth Manager.

7. **LOCALITY PERFORMANCE ASSURANCE FRAMEWORK** 25 - 30

To receive a report from Deputy Place Lead for Health and Care Integration for the Trafford Locality and the Programme Director Health and Care, NHS GM (Trafford) and Trafford Council.

8. **SYSTEM WORKING TO ADDRESS HEALTH INEQUALITIES** 31 - 48

To receive a report from the Director of Public Health.

9. **CHILD DEATH OVERVIEW PANEL (CDOP) ANNUAL REPORT** 49 - 80

To receive a report from a Public Health Consultant.

10. **BETTER CARE FUND (BCF)** 81 - 130

To consider a report from the Deputy Place Lead for Health and Care Integration for the Trafford Locality and the Corporate Director of Adults and Wellbeing.

11. **OPERATIONAL OUTBREAK PLAN** 131 - 164

To receive a report from the Deputy Place Lead for Health and Care Integration for the Trafford Locality and the Director of Public Health.

12. **URGENT BUSINESS (IF ANY)**

Any other item or items which by reason of special circumstances (to be specified) the Chairman of the meeting is of the opinion should be considered at this meeting as a matter of urgency.

13. **EXCLUSION RESOLUTION (REMAINING ITEMS)**

Motion (Which may be amended as Members think fit):

That the public be excluded from this meeting during consideration of the remaining items on the agenda, because of the likelihood of disclosure of "exempt information" which falls within one or more descriptive category or categories of the Local Government Act 1972, Schedule 12A, as amended by The Local Government (Access to Information) (Variation) Order 2006 and specified on the agenda item or report relating to each such item respectively.

SARA TODD
Chief Executive

Membership of the Committee

L. Murphy, J. Wareing, Councillor J. Slater (Chair), Councillor K.G. Carter, Councillor R. Thompson, Councillor P. Eckersley, Councillor J. Brophy, H. Fairfield, H. Gollins, R. Spearing, P. Duggan, D. Evans, M. Hill, J. McGregor, E. Calder, G. James, C. Rose, S. Todd, J. Cherrett, M. Prasad, C. Davidson, Roe, C. Siddall, and N. Atkinson.

Further Information
For help, advice and information about this meeting please contact:

Alexander Murray, Governance Officer,
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HEALTH AND WELLBEING BOARD

21 JULY 2023

PRESENT

Councillors J. Slater (in the Chair), and R. Thompson.

In attendance

Nathan Atkinson	Corporate Director Adults & Wellbeing
Richard Roe	Corporate Director, Place
Heather Fairfield	Chair of Healthwatch Trafford
Gareth James	Deputy Place Lead for Health & Care Integration
Caroline Siddall	Housing Strategy & Growth Manager
Jane Wareing	GP Board Representative
Dr. Manish Prasad	Associate Medical Director
Alicia Smith	Detective Superintendent, Stretford Police Station
George Devlin	Trafford Community Collective Representative
Caroline Davidson	Director of Strategy at MFT
Jo Bryan	Public Health Programme Manager
Aimee Hodgkinson	Public Health Commissioning Manager
Kate McAllister	Public Health Intelligence Lead
Kate Shethwood	Public Health Consultant
Berni Tomlinson	Neighbourhood Engagement Coordinator
Nat McGregor	Work Experience
Harry Callaghan	Governance Officer
Alexander Murray	Governance Officer

APOLOGIES

Apologies for absence were received from Councillor K.G. Carter, Councillor P. Eckersley, Councillor J. Brophy, C. Rose, and S. Todd.

1. MINUTES

RESOLVED: That the minutes of the meeting 18 May 2023 be agreed as an accurate record and signed by the Chair.

2. DECLARATIONS OF INTEREST

No declarations were made.

3. QUESTIONS FROM THE PUBLIC

No questions were received.

4. GM JOINT FORWARD PLAN

The Deputy Place Lead for Health and Care Integration gave an outline of the plan, highlighting the six key ‘missions’. Integrated Care Boards (ICB) had a duty to produce a five-year delivery plan in place stating how the ICB would use its

powers. With the establishment of the six 'missions', clear areas of focus were in place and the plan contained details around delivery for each area. The Deputy Place Lead for Health and Care Integration asked Board Members to consider how the Board could align and work with the ICB to help to deliver the Plan.

The Chair noted that the plan highlighted communications with the public and the importance of having the right communications in place. The Chair then opened the floor for discussions.

The Corporate Director for Adults and Wellbeing highlighted the importance of aligning the plan with the Council's neighbourhood model and to ensure measures for success were identified within the plan. The Trafford Community Collective Representative agreed with this and added that discussions at the locality Board highlighted the importance of collaboration between all of the Boards to avoid duplication and ensure they worked together effectively.

The Public Health Consultant informed the Board of an important mapping exercise which would show where Trafford was collaborating with partners to implement the forward plan and how the borough was progressing with the plan. This would enable the Board to spot any gaps and overlaps that existed. The Health and Social Care Programme Director responded that within the plan there are plenty of tangible examples which show the work which is going on within the locality.

The Associate Medical Director Gave an overview of the hospital at home programme and informed the Board that it was a way of caring for people in their home to ensure that hospital was the last resort for End-of-Life care. Work on the programme was already ongoing and were looking to deliver this over the next few years.

The Deputy Place Lead for Health and Care Integration agreed that the ICB's priorities needed to be aligned with partners. He recognised that there were gaps within the plan, but it was a good piece of work to build upon.

The Chair of Healthwatch Trafford felt that there was not enough focus within the report upon children's mental health and she hoped that it was something the Board would pick up as a priority. The Chair agreed that Children's Mental Health was a priority for the Board and something that they would focus upon going forward.

RESOLVED: That the report be noted and recommendations approved.

5. CENSUS UPDATE - WHAT THIS MEANS FOR TRAFFORD

The Public Health Intelligence Lead delivered the presentation to the Board. The presentation covered the aims of the census from 2021 and how data can be used to shape questions around public health in Trafford. The Public Health Intelligence Lead highlighted what the census covered, including data on population demographics, health, and education, and spoke about how important this was in helping to plan and deliver services. The Board were asked to note the useful

features including its high response rate (98% at Trafford level), methodology, and geography. Resources from the Trafford data lab were shared and the Board were made aware of the limitations of the census, one being that it only offered a snapshot of the status of the population, which made it difficult to use the data to determine cause and effect. The data was self-reported, which meant people answered questions in different ways. The Public Health Intelligence Lead mentioned that it was important not to over interpret data.

The Public Health Intelligence Lead informed the Board of two approaches for how to use census data to inform public health. One example of how the data had been used effectively was in examining how many disabled people within each ward were affected by their disability on a day-to-day basis. The Public Health Intelligence Lead then offered observations and questions which could be taken from the data and spoke to the Board of the importance of asking questions of data to ensure conclusions were not based upon mere observations of the data.

The Public Health Intelligence Lead then presented questions that the board could help the public health team with and asked if the Board had any suggestions as to how the census data could support the work of the health and wellbeing board.

The Trafford Integrated Network Director agreed that the census data was a powerful tool when used in conjunction with the information held by services using the neighbourhood model.

The Trafford Community Collective Representative relayed his interest in using the data around inequality to see changes from 2011 to 2021, and how this could help to inform the approach for tackling inequalities within Trafford. The Corporate Director Adults and Wellbeing added that it would be interesting to look at how the borough had changed across the decade particularly with regards to the ageing population within the borough.

The Housing Strategy and Growth Manager asked how the data could be used to monitor the role of housing, and its impact on public health. The Corporate Director for Adults and Wellbeing added that it would be interesting to looking at the impact of the affordability of housing within the borough.

The Director of Strategy at MFT asked whether there was scope to look at acute hospital data and data from other sources to form broader insights. The Public Health Intelligence Lead replied that using data from multiple sources was a powerful tool. However, you had to be certain that the data could be used for those purposes and that you were not breaching GDPR.

The Chief Executive of Trafford Leisure asked what steps had been taken to get around the challenges of language to achieve such a high completion rate. The Public Intelligence Lead responded that the Office for National Statistics had gone to great lengths to address language barriers but there were still areas and demographics with lower return rates than others.

RESOLVED: That the presentation be noted.

6. TOBACCO DEEP DIVE

The Public Health Programme Manager presented the actions and results following the Health and Wellbeing Board's deep dive the year before. Since that deep dive the Trafford's tobacco alliance had been launched which was a collective partnership of stakeholders who looked at reducing smoking. A CLEAR assessment had taken place which had highlighted where the alliance was performing well and where they needed to improve. Trafford had performed quite poorly overall, but the analysis had been conducted prior to the partnership being formed. The Board were provided with an overview of each of the indicators and their meaning.

The alliance had conducted an updated smoking needs assessment and the data had shown Trafford was still below the English and GM data which was good. There had been a slight increase post pandemic, however, the data did not provide the full picture, with less gathered face to face and a greater reliance upon telephone interviews. Higher smoking rates were seen within Stretford, Partington, and Sale Moor. Higher rates were also seen by those who worked in routine and manual job roles. Trafford's statistics were lower than Greater Manchester (GM) in all areas, including young people and those with substance dependence. The results showed that 90% of young people had never smoked and 77% had never tried a vape.

The next steps for the tobacco alliance were shared by the Public Health Programme Manager, which involved, reviewing the CLEAR assessment, the needs assessment, supporting the groups identified as needing support, and developing a strategy and action plan. A team away day had been scheduled to look at these challenges. Finally, the board were notified that the high impact action plans were in the process of being completed.

The Chair mentioned the importance that vaping should remain important to the alliance, due to the number of young people taking it up.

The Trafford Integrated Network Director spoke of the importance of the neighbourhood model and of the work which had been done to reduce smoking within North Trafford, which was proving difficult. The Trafford Integrated Network Director raised doubts around young people smoking data as it did not reflect the experience of his children and their friends.

The Public Health Programme Manager agreed with the issue of young people and vaping, as it was something that had increased in recent years, with smoking decreasing. She mentioned that young people were more likely to lie in a survey, which caused issues with the statistics. A research project was due to commence in September to look at vaping level among young people.

The Housing Strategy and Growth Manager suggested organising a meeting with housing associations around reducing smoking due to higher prevalence of smoking social housing. The Public Health Programme Manager responded that there had been interest from 'Great Places' to start a pilot project around interventions within social housing. The Housing Strategy and Growth Manager

felt that working with 'Great Places' was a good start but engaging L&Q and Irwell Valley social housing groups would have a larger impact due to the level of stock they had within Trafford.

The Corporate Director for Place also challenged vaping data, saying how it was really high within schools across all years. He felt that communications around vaping form the council needed to be clearer, as there was a mix of messages going out. The Corporate Director for Place also mentioned that greater communication was needed around the health and environmental consequences of vaping. The Public Health Programme Manager responded agreed that the messaging could be confusing, especially with the way vapes were marketed with bright colours and flavours which appealed to young people.

The Chief Executive of Trafford Leisure asked how early children were made aware of the issues of vaping/smoking. The Public Health Programme Manager responded that this was being done from year six, with posters placed across schools to raise awareness, as well as increased promotion within secondary schools. The Chief Executive of Trafford Leisure spoke of the organisation highlighted the issues of smoking and vaping to young people on work placements. She felt having more interventions and more creative ways to allow young people to access smoking cessation would be a good option for the alliance.

Trafford Community Collective's Representative offered to meet to look at neighbourhood engagement as smoking cessation was one of the leading agenda items for his organisation. He also highlighted the opportunity to link it with some of the housing work.

A Governance Officer spoke of data that suggested posters can sometimes trigger vaping more, rather than decrease the levels. He also mentioned how in Canada and Australia smoke free places, were also vape free places, with much lower levels of smoking in both places compared to the UK. The Public Health Programme Manager replied that the posters were designed to educate and dispel myths about smoking and vaping. She agreed with aligning smoke free with vape free, and this was something that would become more prevalent to discussions in the future.

The Associate Medical Director agreed with all that had been said. He felt children were enticed by the sweet flavours and bright colours and by misconceptions that vaping was safe. He spoke about data indicating that vaping could cause chronic lung disease, so people starting to vape earlier was worrying.

The Chair thanked all for their contributions before moving the recommendations of the report which were agreed.

RESOLVED: That the report be noted and the recommendations be approved.

7. PHARMACY UPDATE

The Public Health Programme Manager introduced the update and reminded the board of Trafford's pharmaceutical needs assessment 2022-25. Trafford had a greater number of pharmacies than the GM and England average, although there was a current gap in provision within Partington on Saturday afternoons or Sundays. Work was being done to see if any pharmacies in the area would be interested in opening on a rota basis, however this was difficult as Trafford did not hold the contracts.

The Public Health Programme Manager informed the Board of the recent pharmacy closures of Lloyds Pharmacies based in Sainsburys in Altrincham, Sale, and Urmston. However, Trafford was coping and had a good level of provision in place. The Public Health Programme Manager stated that the Partington issue was more prevalent however, a recent announcement from Boots, who were planning to close 300 stores where there was coverage within 3 miles, meant that it could become a concern. As of the meeting there had been no announcements for closure to Boots Pharmacies based in Trafford.

The Public Health Programme Manager continued, highlighting changes to commissioned service for pharmacies associated with Emergency Hormonal Contraception (EHC) and smoking cessation. A SCS service had been launched, which would take smoking cessation referrals from hospitals. The Cure service in GM was in place to support inpatients to stop smoking. A swap to stop pilot was ongoing nationally and the team planned to look at the end of August to see whether Trafford could obtain any funding.

The Chair of Healthwatch Trafford asked about out of hours provision within GM, and the lack of it within Trafford. The Public Health Programme Manager recognised the troubles of this in Trafford and how it was difficult to address them as the Council did not hold the pharmacy contracts, just the contracts for the services commissioned by the Council. Communication was taking place with pharmacies to encourage additional out of hours provision, but the Council's ability to affect the level of provision were limited.

The Trafford Integrated Network Director raised concerns around the lack of pharmacy provision in Partington on certain days, especially for the disabled population of Trafford and Partington specifically (where one in four people were registered as disabled).

The GP Board Representative shared her concerns regarding pharmacy closures and the struggles being faced by the remaining pharmacies that were in operation.

The Deputy Place Lead for Health and Care Integration asked about the impact of pharmacy closures so far and if the remaining pharmacies had sufficient capacity. The Public Health Programme Manager responded that an impact was not being seen yet, as many of the closures were located near to other pharmacies. However, she mentioned how possible Boots closures could have a bigger impact in the future.

The Chair of Healthwatch Trafford felt that better communications were required to inform the public what medication was available where, as the level of medication access was concerning. The Public Health Programme Manager seconded this concern. Trafford's aim was for all residents to be within half a mile of a pharmacy, with almost everyone currently within a mile. The Deputy Place Led for Health and Care Integration agreed that communications could be improved.

RESOLVED: That the update be noted.

8. BETTER CARE FUND

The Corporate Director for Adults and Wellbeing presented the verbal report regarding the better care fund. The aim was to bring the full and final report to the next meeting of the Board, with the final report requiring sign off by NHS England.

Following the update Board Members were given opportunity to ask questions but none were raised.

RESOLVED: That the update be noted.

9. WOMEN'S VOICES

The Public Health Consultant introduced the item by providing some context to the organisation, which had been established following the publication of the National Women's Health Strategy in July 2022, which highlighted data of women feeling let down by the NHS. She referred to the National Strategy and possible areas for improvement, including provision for menopause, and mental health and wellbeing. Trafford's shared approach – 'One Voice Raises Another – was then presented to the board.

The Neighbourhood Engagement Coordinator began the presentation by speaking about her background and how she got involved with the programme, having previously worked on responding to women who came out after the pandemic with stories of violence against women. The Board were informed of work done in Trafford to establish the multi-agency, Women's Voice Core Group, which extended the voices of women in Trafford. The group aimed to bring together women who have had both good and bad experiences with the services which Trafford provides, offering them the opportunity to sit across the table from those who control the services. The Trafford Women's Voices event held in December 2022, drew evidence from lived experience and conversations. 85 people attended the event, which was incredibly successful. Two women shared their personal stories at the event which had a very powerful affect upon the audience.

The Neighbourhood Engagement Coordinator provided Board Members with ideas as to what the group wanted to achieve next. This included a plan to continue the conversation and develop further relationships for change. A Trafford POWER pledge had been written and the goal was to have as many organisations and individuals sign up to it as possible, beginning with locality-based women's alliance groups.

Several members of the board relayed how impressed they were with the presentation, what had been achieved so far, and agreed with the plans moving forward.

The Chair thanked the Neighbourhood Engagement Coordinator for her presentation.

RESOLVED:

1) That the presentation be noted.
2) That the Board agree to support the plans of Trafford Women's Voices going forward.

The meeting commenced at 10.00 a.m. and finished at 11:58 a.m.

TRAFFORD COUNCIL

Trafford Housing Strategy

2024-2029

Health & Wellbeing Board, September 2023

Caroline Siddall – Housing Strategy & Growth Manager

Trafford Housing Strategy

- Trafford Council are in the process of developing a new Housing Strategy to cover the period 2024 – 2029.
- Consultation began on 15th May 2023 when a survey was launched to gather the views of Trafford residents on housing in the borough.
- Listening sessions with key stakeholders took place during June to gather further views on housing in Trafford.
- The responses from the survey and the listening sessions are being to shape the new Housing Strategy.

Trafford Housing Strategy 2018-2023

- Trafford's last Housing Strategy launched in June 2018 and ran until March 2023.

- Delivery of the Strategy was led by Trafford's Strategic Housing Partnership.

- Each year since the Strategy launched, an Annual Statement has been published on the Council's website to provide an update on delivery of the Strategy.

Trafford Housing Strategy 2018-2023

The Housing Strategy 2018-2023 had 7 Strategic Priorities:

1. To accelerate housing growth.
2. To support inclusive economic growth.
3. To create neighbourhoods of choice through a better mix of homes and attractive, accessible environments.
4. To reduce inequalities across the borough.
5. To improve residents' health and wellbeing.
6. To increase the range of, and residents access to, opportunities.
7. To reduce homelessness.

Achievements

977 new build residential units completed which is an increase of 323% from 2021/22.

255 new build affordable residential units completed is an increase of 338% from 2021/22.

The Trafford Affordable Housing Fund (TAHF) was established to bring together S106 monies for affordable housing off-site contributions from developers.

L&Q with funding from TAHF have developed 30, 1 and 2 bed social rented properties in Timperley.

The refurbishment of Lindow Court, Sale is due to start in June 2023 bringing forwarded 10 social rented units funded from TAHF.

A Joint Venture established with Bruntwood to redevelop the Civic Quarter and Stretford Mall.

Joint Venture with L&Q established to regenerate the Tamworth area of Old Trafford.

New Student Accommodation at the former Warwick House has been completed (Academy Apartments) to provide UA92 1st year students

Achievements

The Trafford Housing Need and Demand Assessment 2023 is underway.

Older People's Housing Strategy 2020-2025 produced and launched in 2020.

Empty Homes Strategy 2020-2025 produced and launched in 2020.

Supported Housing Strategy 2023 - 2028 produced and launched in 2023.

Homeless Strategy 2019-2024 produced and launched in 2019.

347 households prevented from becoming homeless in 2022/23 which is a 12% increase from 2021/22.

Average length of stay in B&B for families reduced from 20 days in 2021/22 to 14 days in 2022/23.

336 households re-housed from the Council's housing register in 2022/23.

Housing Strategy 2024 – 2029

The development timeline for the new Housing Strategy 2024-29 is as follows:

- Initial Strategy Consultation - 15th May – 30th June 2023
- Listening Sessions - 5th – 26th June 2023
- First Draft completed - October/November 2023
- Final version completed - December/January 2023/24
- Public Consultation - February/March 2024
- Final amendments - April/May 2024
- Strategy launch - June/July 2024

Consultation Survey Findings

The resident survey opened on 15th May 2023 and ran for 6 weeks. We received 176 responses. Some insights from the responses received:

25% of respondents are experiencing disrepair. 18% in PRS, 26% in social housing, 56% homeowners.

The most commonly experienced disrepair were structural defects (61%) and damp & mould (48%).

32% are considering moving to a different property. Of these, 88% intend to remain in Trafford.

40% intend to move in 18+ months, 23% in 6-12 months, 19% within 6 months, and 18% in 12-18 months.

The most common reasons for wanting to move are “to become a homeowner” and “to live in a larger property”.

77% of those considering moving would prefer to become a homeowner than rent from a private or social landlord.

72% believe the main housing issue in Trafford is affordability.

Lack of social housing, inadequate supply/ availability of housing, and poor infrastructure were the next three most commonly identified housing issues.

Demographic of Respondents

The largest majority (28%) of respondents reported a household income of between £20,001 and £40,000; 12% had a household income of less than £20,001 and 16% had a household income between £40,001 and £60,000. 16% of respondents had a household income of over £60,001.

The main source of income of respondents is as follows; 64% employment; 16% pension, 5% welfare benefits, 1% student finance. 14% preferred not to say.

The respondents area of residence within Trafford is as follows; 46% Sale, 13% Stretford, 12% Urmston, 11% Partington, 11% Altrincham, 3% Hale & Bowdon, 2% Carrington, and 2% Old Trafford.

Gender

61% female, 28% male, 2% non-binary, 1% other. 8% preferred not to say.

Age

37% 55+, 16% 41-50, 13% 25-35, 11% 51-54, 10% 36-40, 5% 16-24. 9% preferred not to say.

Ethnicity

78% White British, 6% White Other, 2% Asian/ Asian British, 2% Mixed/Multiple Ethnic Groups, 1% Other Ethnicity. 11% preferred not to say.

Sexual Orientation

71% heterosexual, 3% gay, 3% bisexual, 2% other, 1% lesbian. 20% preferred not to say.

Disability

69% do not have disability, 19% have a disability. 12% preferred not to say.

Housing Circumstances of Respondents

25% of respondents were experiencing disrepair in their home. Of these, 50% were homeowners, 23% were in social housing, and 16% were in private rented homes.

61% of respondents experiencing disrepair had structural defects in their property. 48% had issues with damp and mould, 27% had electrical defects, 2% had vermin/infestations, and 7% had 'other' disrepair issues.

32% of respondents are considering moving. Of these, 88% wanted to remain in Trafford. The most common reason was to become a homeowner.

Property Type

87% house, 11% flat, 4% bungalow, 1% refuge

Tenure

67% homeowner, 13% social tenant, 10% private tenant, 9% lodging with family, 1% shared ownership, 1% temporary accommodation, 1% other

Household Makeup

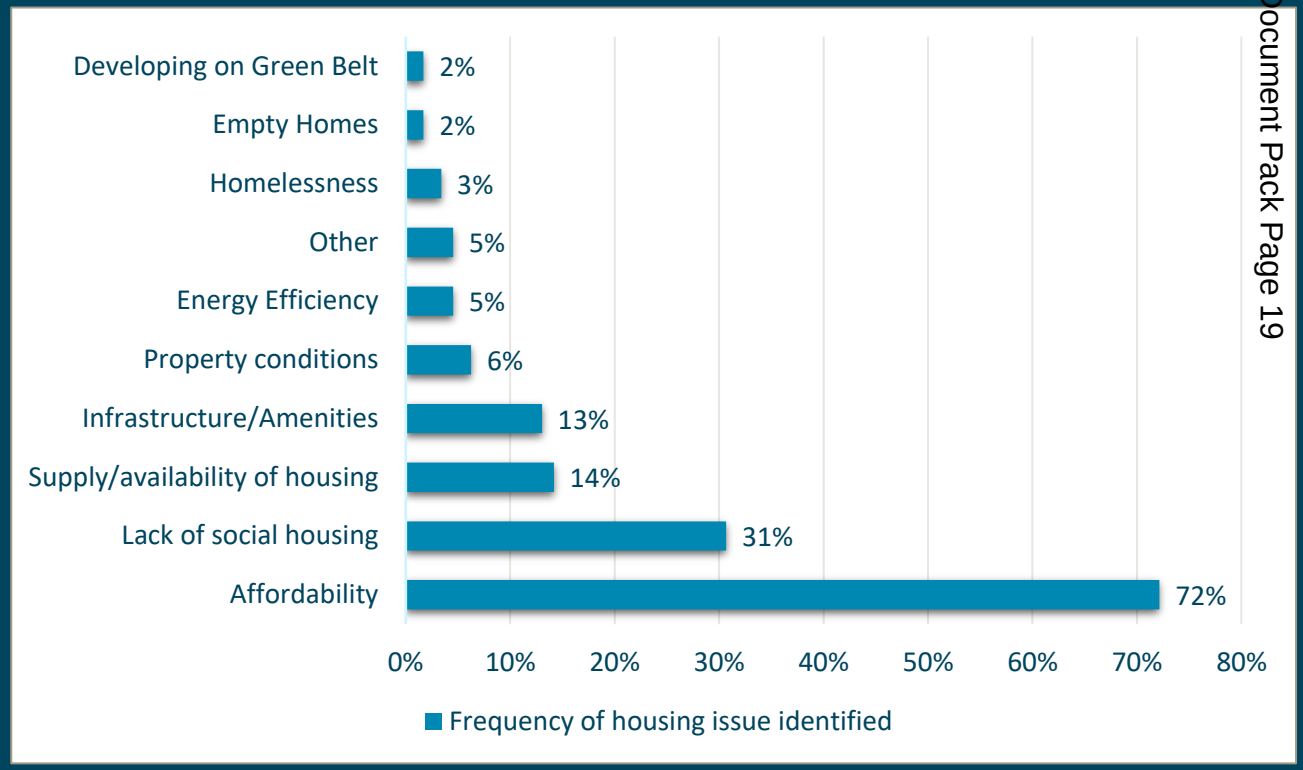
56% living with partner, 25% living alone, 17% living with parents/ family, 1% homeless, 1% living with friends, 1% other

TRAFFORD COUNCIL

Main Housing Issues in Trafford

Respondents were asked what they believed to be the main housing issues in the borough. This was an open question with respondents entering their response into a blank text box. From the responses, 9 clear themes emerged:

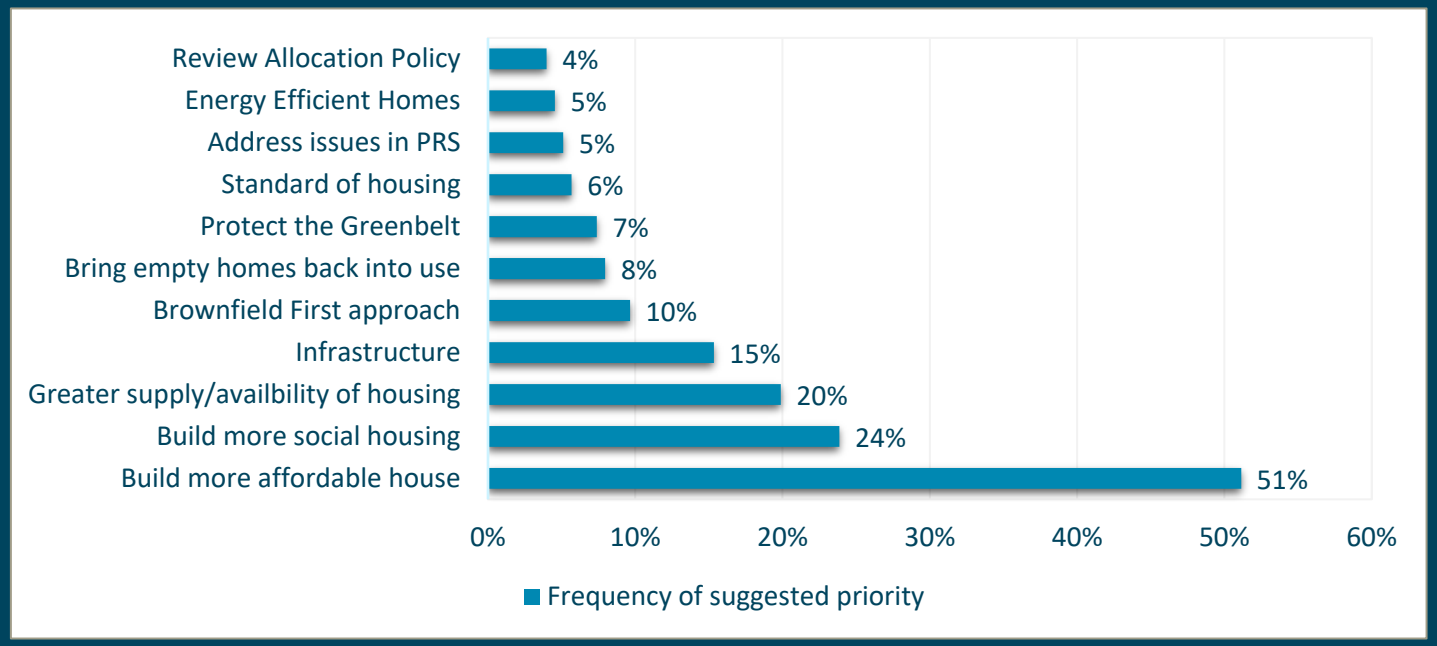
- Poor Infrastructure/insufficient amenities
- Homelessness
- Energy efficiency
- Availability of housing
- Affordability
- Empty homes
- Lack of social housing
- Developing on Greenbelt
- Poor property conditions



The above chart shows the frequency of each theme occurring in respondents answers. 72% of respondents referenced affordability in their response, 31% referenced a lack of social housing, 14% referenced supply/availability of housing, and 13% referenced poor infrastructure and/or a lack of amenities when describing what they believe to be the main housing issues in Trafford.

Suggested Priorities

Respondents were asked what they believe the priorities should be for the new Housing Strategy 2024-2029. Responses were analysed and grouped into key themes, which are listed opposite:



The above chart shows the frequency of each theme occurring in respondents answers. 51% of respondents suggested building more affordable housing, 31% referenced a lack of social housing, 14% referenced supply/ availability of housing, and 13% referenced poor infrastructure and/or a lack of amenities when describing what they believe to be the main housing issues in Trafford.

- Build more affordable housing
- Build more social housing
- Increase housing supply/ availability
- Develop infrastructure / increase amenities
- Take a Brownfield First approach
- Bring empty properties back into
- Protect the Greenbelt
- Increase standard of housing
- Review Allocations Policy
- Address private rented sector issues
- Improve energy efficiency of new and existing homes

Listening Session Findings

The Listening Sessions asked attendees a series of questions, here is what people said:

Housing Strategy 2024 – 2029: Draft Strategic Priorities

1. **Increase the supply of housing in Trafford and build more 'truly' affordable homes.**

Current stock and tenure, house process/rentals, current and future housing delivery, affordable housing pipeline, truly affordable homes…

2. **Ensure Trafford residents can access and sustain their homes.**

Access to housing, Trafford Home Choice, Allocations Policy, Homeless Prevention, Tenancy Support…

3. **Ensure homes meet current and future needs in Trafford.**

Housing Need Assessment, Sustainability, Zero Carbon, Retrofit, Fuel Poverty, Property Conditions (damp & mould)…

4. **Create neighbourhoods of choice that addresses inequalities and places people want to live.**

Place making, Trafford Design Guide/Code, Places for Everyone, Infrastructure needs, health inequalities…

Housing Strategy 2024 – 2029

Health & Wellbeing Board Questions

1. What do you think are the key housing issues in Trafford?
2. What do you think is meant by ‘truly affordable housing’ and what can we do to increase affordable housing in Trafford?
3. What do you feel are the issues in the Private Rented Sector ?
4. What can we do to address the sustainability and zero carbon challenges for new and existing homes?
5. What can we do to end homelessness?
6. What should be done to create neighbourhoods of choice that address inequalities?

TRAFFORD COUNCIL

Report to: **Health & Wellbeing Board**
Date: **15th September 2023**
Report for: **Information**
Report of: **Gareth James, Deputy Place Based Lead for Health and care Integration, NHS GM (Trafford)**

Report Title

Locality Performance Assurance Framework

Purpose

This paper provides an update on the developing Locality Performance Assurance Framework and recent developments building on previously communicated update at various Trafford HSC System governance (Health and Social Care Steering Group and Trafford Locality Board).

The detail in the paper is sat within the context of the emergent and evolving GM Operating
Model and focusses on the GM and Locality core components of the suggested framework.

Recommendations

The Board are asked to:

a) Note the progress on producing a comprehensive Locality Performance Framework.
b) Discuss how the proposed Locality Performance Assurance Framework interacts with the Health and Wellbeing Board priorities, plans and approach to measurement.
c) Support the work to deliver improvements against the Locality Outcomes aspirations.

Contact person for access to background papers and further information:

Name: Thomas Maloney, Programme Director Health and Care, NHS GM Trafford and Trafford Council
Telephone: 07971556872

1. Introduction

1.1 It has been previously agreed by Trafford Locality Board (TLB) that the locality would look to incrementally build a Locality Performance Assurance Framework to reflect the accountabilities of TLB. This framework will be subject to change as the Greater Manchester Operating Model is implemented and as the arrangements surrounding delivery and prioritisation of the GM Joint Forward Plan deliverables become clearer. The report provides the background and context to the work carried out to date and aims to mobilise a discussion on possible opportunities to connect the work of the Locality Board with the work of the Health and Wellbeing Board from a performance perspective.

2. Background and Context

2.1 Trafford's Locality Board has historically received a regular performance report. This report was originally developed for the Clinical Commissioning Group (When in operation) and is NHS focused based on the NHS System Oversight Framework.

2.2 Amendments have been made to the format of the report as the accountabilities for delivery have started to shift and we now need to agree a new set of performance metrics and reporting schedule to reflect the wider accountabilities of TLB, work which is very much underway.

2.3 There is a commitment the framework will be built incrementally and may be subject to change should governance and / or accountabilities shift as clarity is received on the GM Operating Model and any changes to the proposed locality delegations linked to the recent Governance and Leadership Review conducted by Carnall Farrar.

3. Progress Update

3.1 Table 1 provides an overview of the proposed components of the framework and timetable for production. The table also contains an update on the progress to date in curating each component of the framework.

3.2 Suggested governance in the table is current thinking and may well change as parts of our governance emerge and settle – namely the role of the Finance Performance ad Sustainability Group.

Table 1:

Spatial Level	Area	Description	Metrics to developed by	Progress	Governance
National	1. NHS Oversight Framework: National Framework (draft 23/24 Metrics)	Indicators which NHS England holds NHS GM to account for and form a significant part on the ICB's assessment against the NHS Oversight Framework. The NHS Greater Manchester "performance network" * has split these indicators to determine which one's localities are accountable for delivering and areas where delivery sits with GM System Boards. Still need to go through GM governance structures to be agreed. *Is an informal meeting of commissioners, BI leads and performance leads currently employed in a mixture of NHS GM and locality teams.	National / GM Performance Network	Prioritised by GM informatics. Production has been delayed, first report available September/October 2023.	**Health and Social Care Steering Group** with escalation to **Locality Board**
	2. Better Care Fund	National programme to encourage NHS and local government to join up health and care services to commissioning person-centred health and social care services which achieve improved patient and service user experiences and outcomes.	National / Reform Leads set trajectories	In place.	**Health and Social Care Steering Group** with escalation to **Health and Wellbeing Board** and **Locality Board**

Greater Manchester	3. Locality Outcomes: GM Programme	Patient flow indicators submitted in response to the Price Waterhouse Cooper analysis which NHS GM will hold localities to account for.	Reform Leads set trajectories	Expect data to be flowing from GM product by September/October 2023. As a holding position, doing as much as possible locally. Update in the second part of this paper.	**Health and Social Care Steering Group** with escalation to **Locality Board**
	4. Joint Forward Plan	GM's Strategic Plan. Many of the deliverables will already be embedded in Trafford's work programmes e.g., alcohol. When the final framework is available these will be cross-referenced within the locality.	Ruth Boaden		TBD
Local	5. Provider Collaborative Deliverables	2023/24 priority programmes as determined by the Collaborative. **NB -** this won't duplicate measures used elsewhere in the Locality Framework	Tom Maloney working with Trafford Provider Collaborative Board as part of objective setting work	• **Resilient discharge programme:** recommended / agreed set of strategic measures (10 in total) which have been through the M&T RDP Board (awaiting confirmation to ensure alignment with **Home First Programme**). Propose picking 1-3 measures which aren't replicated elsewhere in the framework for inclusion. Agreeing these via the Trafford RDP Tactical Delivery Group. • **Urgent Care** – subset of the M&T UC metrics Board, these reflect the national aspirations set out in operational planning round, winter letter and local priorities. • **Neighbourhoods** – plans are in development. LCO co-ordinating a piece of work to look at outcomes / deliverables at neighbourhood level. • Recommending **patient stories** and more qualitative information to be embedded within this framework**.**	**Trafford Provider Collaborative** with escalation to Locality Board
	6. Health and Care elements of the corporate plan	Council's vision and priorities for the borough and the priorities identified, as an organisation, as being key to the delivery of that vision.	Sarah Haugeberg		**Health and Social Care Steering Group** with

					escalation to **Locality Board**
	7. Other health and social priority areas not picked up above e.g. ASC, Children's HWBB strategy	Other priorities have been identified across the locality, for example, children's services and elements of adult social care. It is to be determined whether accountability for these areas need to be held by the Locality Board, elsewhere, or elsewhere with escalation through to Locality Board.	Nathan Atkinson Sally Atkinson Sarah Haugeberg	**Urgent Care:** Refreshing the Manchester and Trafford Urgent Care Board Dashboard. The expectation is the dashboard is produced once by GM Informatics and can be accessed by users across GM and the Locality, ensuring one version of the truth.	TBD
	8. Inequalities	Identify a basket of indicators and ensure measurement of inequality (the gap) is on an equal footing with measurement of overall performance.	Helen Gollins		TBD

4. Key Considerations

4.1 There are a number of key considerations relevant to the HWBB. The Board are asked to:

- Consider how the development of the framework links with existing and/or planned work in relation to the Health and Wellbeing Strategy and the agreed SMART Action Plans, mirroring the Deep Dive exercise undertaken in 2022.
- How do we ensure visibility of HWBB performance priorities in the framework?
- Discuss the governance implications – how does the proposed reporting arrangements fit with HWBB expectations?
- Discuss opportunities to connect performance across the TLB and HWBB
- Explore how health inequalities data and intelligence is embedded throughout the framework and discuss what the role of the HWBB is in ensuring as a system we can measure progress?

5. Recommendations

5.1 The Board are asked to:

a) Note the progress on producing a comprehensive Locality Performance Framework.

b) Discuss how the proposed Locality Performance Assurance Framework interacts with the Health and Wellbeing Board priorities, plans and approach to measurement.
c) Support the work to deliver improvements against the Locality Outcomes aspirations.

System working to address health inequalities

Trafford Health and Wellbeing Board

Trafford
Integrated Care Partnership

15th September 2023

Part of Greater Manchester Integrated Care Partnership

There's a lot of talk about health inequalities!

Trafford
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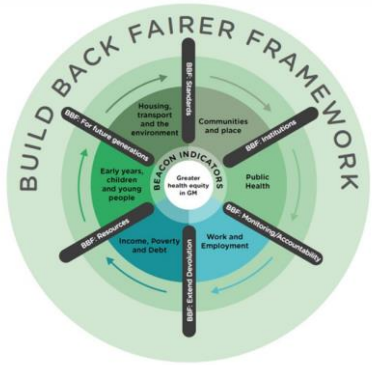
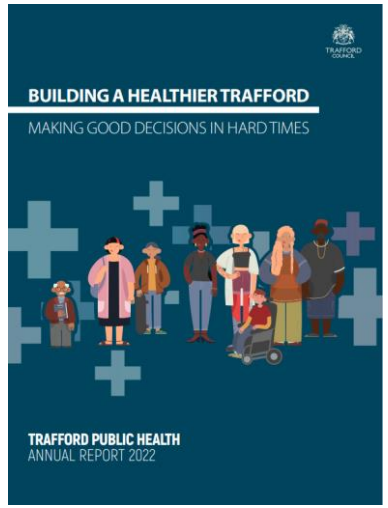
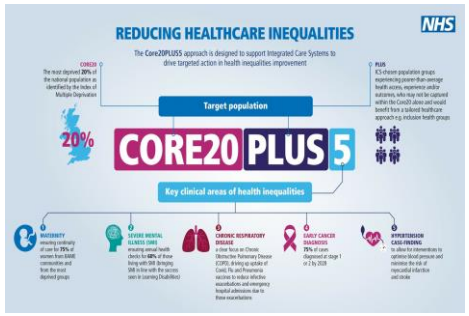
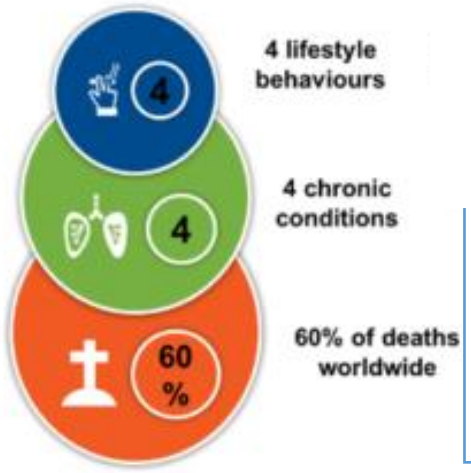






National → GM → Trafford

What makes us healthy leads to inequalities. Causes of the causes…



Socio economic conditions (~50%)

- Education
- Housing
- Income and work
- Relationships
- Environment

4 health behaviours (~30%)

- Physical activity
- Nutrition
- Smoking
- Alcohol

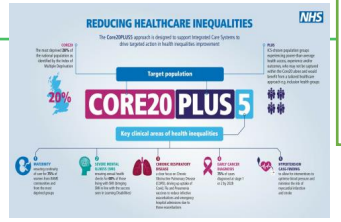
4 chronic conditions (~20%)

- Diabetes
- Heart diseases
- Lung diseases
- Cancer
- Mental Health
- Maternity
- Oral Health

Life expectancy

60% of deaths worldwide

+ Quality of life



The Vitality Institute (2016). Communicating Non-communicable Diseases: From 3Four50 to 4Four60. https://bit.ly/3nchaP5

World Health Organization. Global Status Report on Noncommunicable Diseases 2010. Geneva, Switzerland: WHO Press; 2011

Life expectancy has plateaued but the gap between the most and least deprived in Trafford is reducing, though still stands at 6.6 (male) and 5.1 (female) years

Trafford
Integrated Care Partnership

Information on inequalities between the most and least deprived quintile of Trafford, 2014 to 2016 to 2020 to 2021

Male	2014-16	2017-19	2020-21
Life expectancy most deprived quintile	74.9	75.6	74.9
Life expectancy least deprived quintile	83.5	83.0	81.5
Gap	8.6	7.4	6.6

Female	2014-16	2017-19	2020-21
Life expectancy most deprived quintile	79.5	80.8	80.4
Life expectancy least deprived quintile	86.0	86.6	85.4
Gap	6.5	5.8	5.1

Source: Office for Health Improvement and Disparities based on ONS death registration data and mid year population estimates for the relevant years, and Department for Levelling Up, Housing and Communities Index of Multiple Deprivation 2019 (for 2017 to 2019 and 2020 to 2021 data) and Index of Multiple Deprivation 2015 (for 2014 to 2016 data). Where provided, results for 2020-21 are based on 2020 population data.

What are the (immediate) causes of that gap in life expectancy in Trafford (2020-21)?

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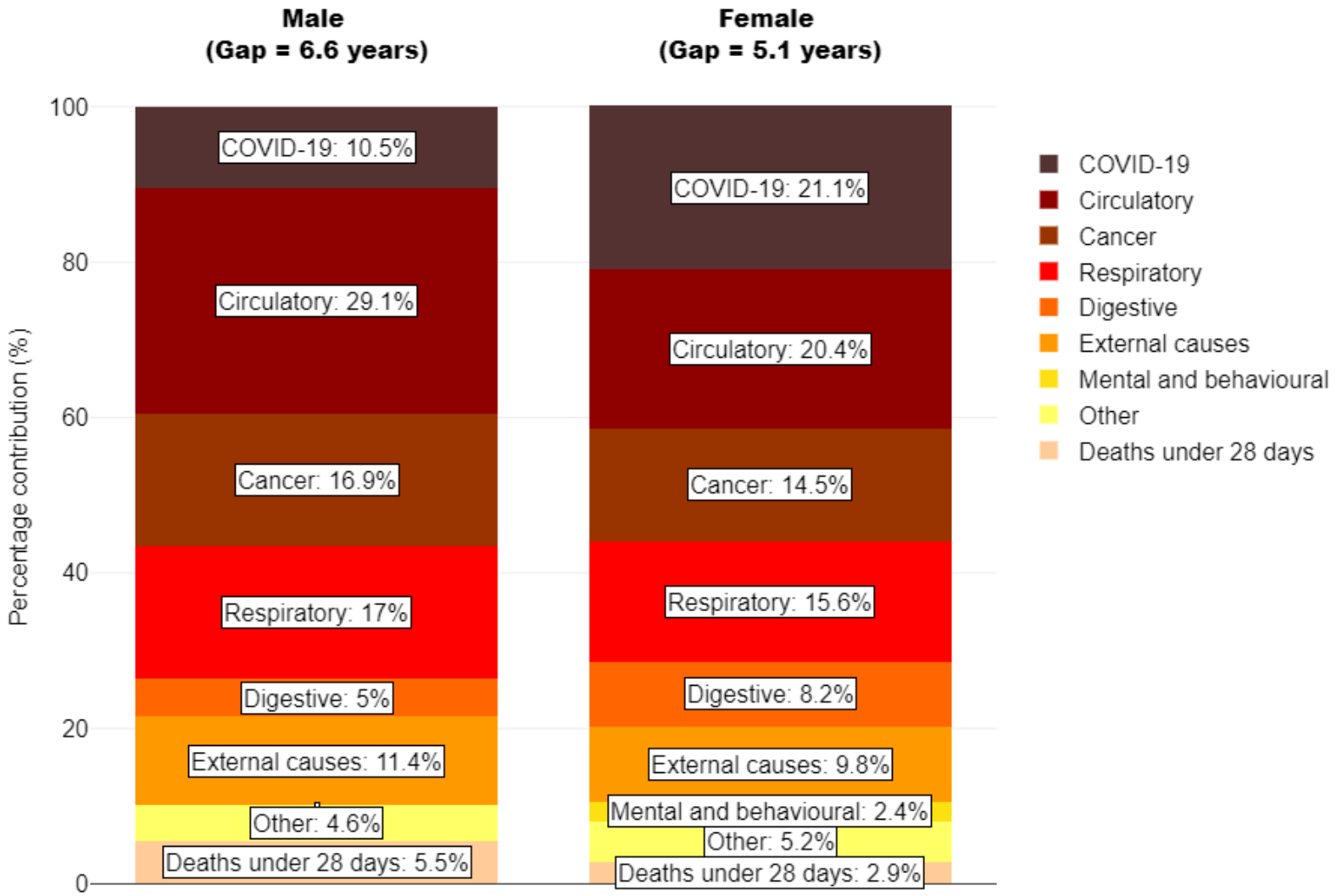

These conditions also lead to illness and poorer quality of life. They vary by geography…

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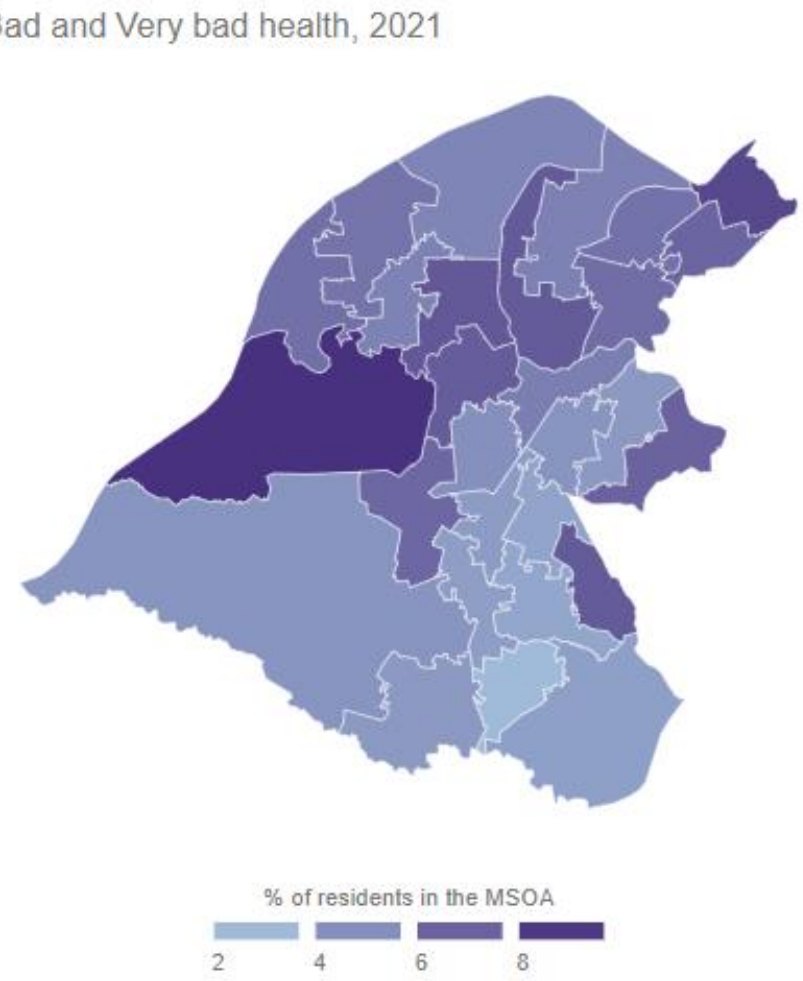
Self-reported health by area and by ethnicity (Census 2021)



Source: Census 2021

And they vary by different groups…

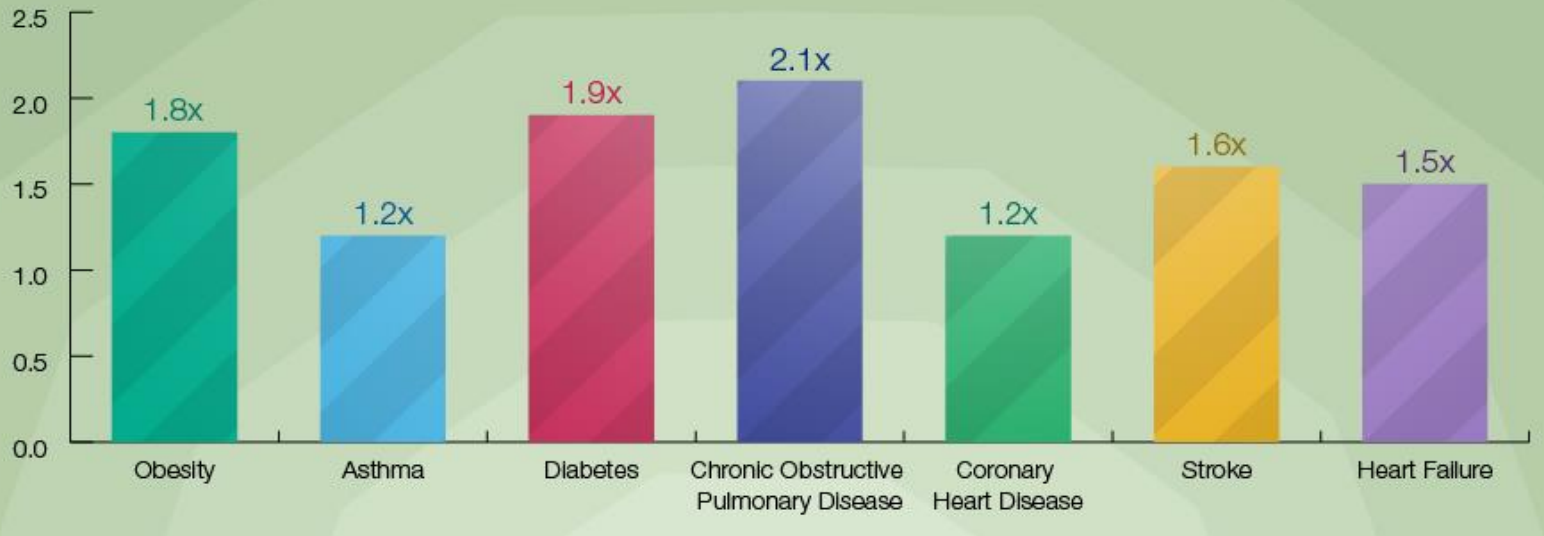
Trafford
Integrated Care Partnership

Public Health England

Health Matters

Adults with severe mental illness (SMI) are more likely to have physical health conditions

When compared to **the general population** of the same age group, **people with severe mental illness (SMI)* aged 15-74** are more likely to have:



*Sample of people with SMI registered with a general practice

Risk factors for ill health are not evenly spread…

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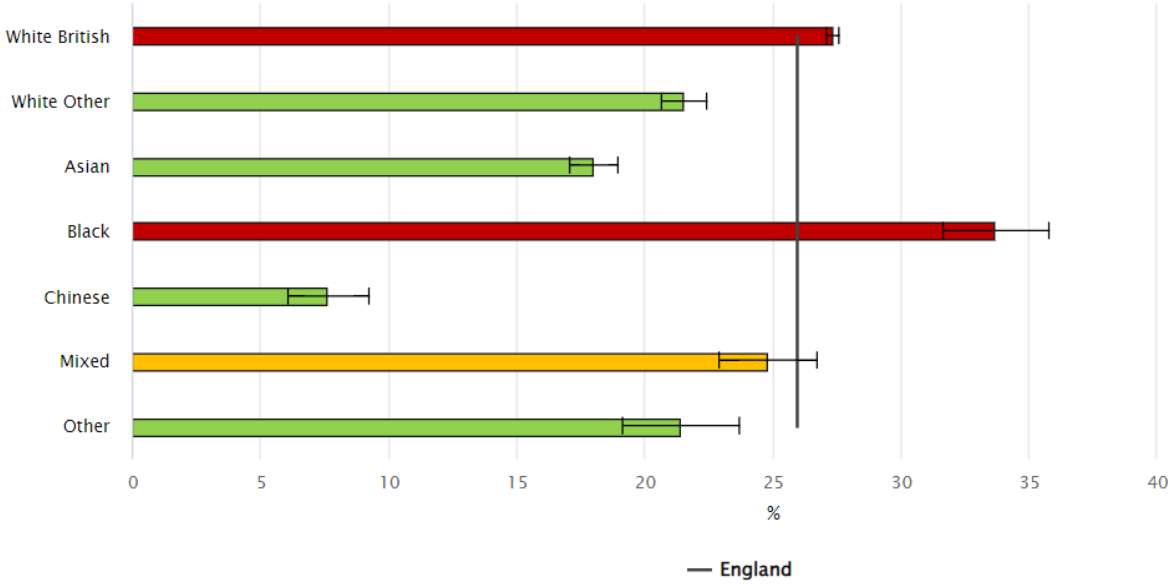
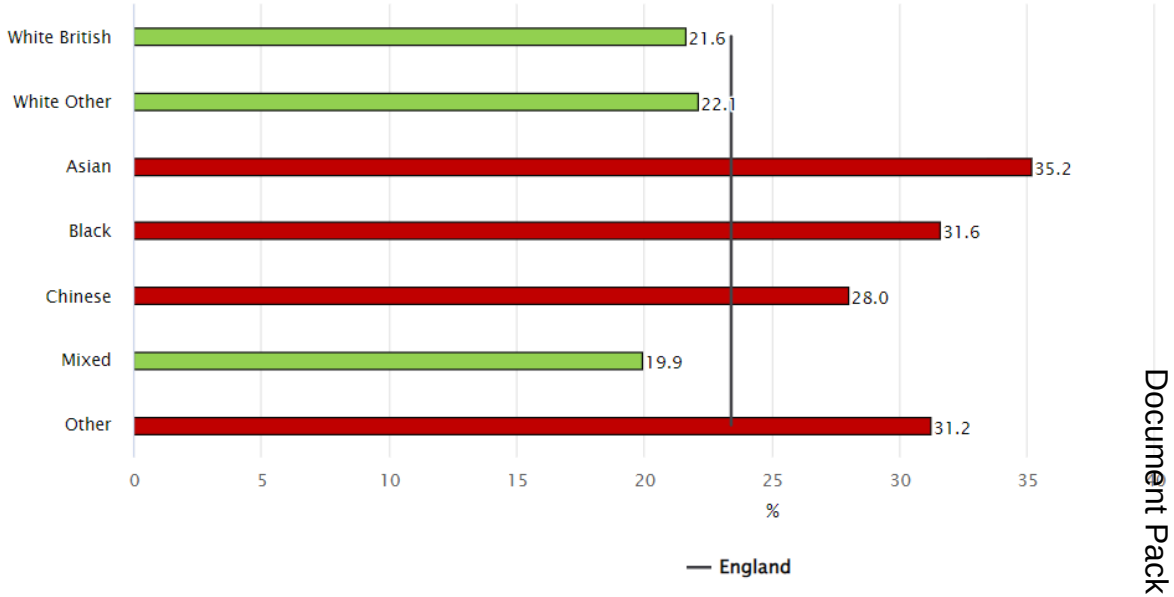
Integrated Care Partnership

E.g. percentage of adults who are classified as obese and who engage in physical activity varies by ethnic groups

Obesity



Physical inactivity



Source: Active Lives survey, 2020/2021

Smoking is still the number one cause of preventable deaths

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Integrated Care Partnership

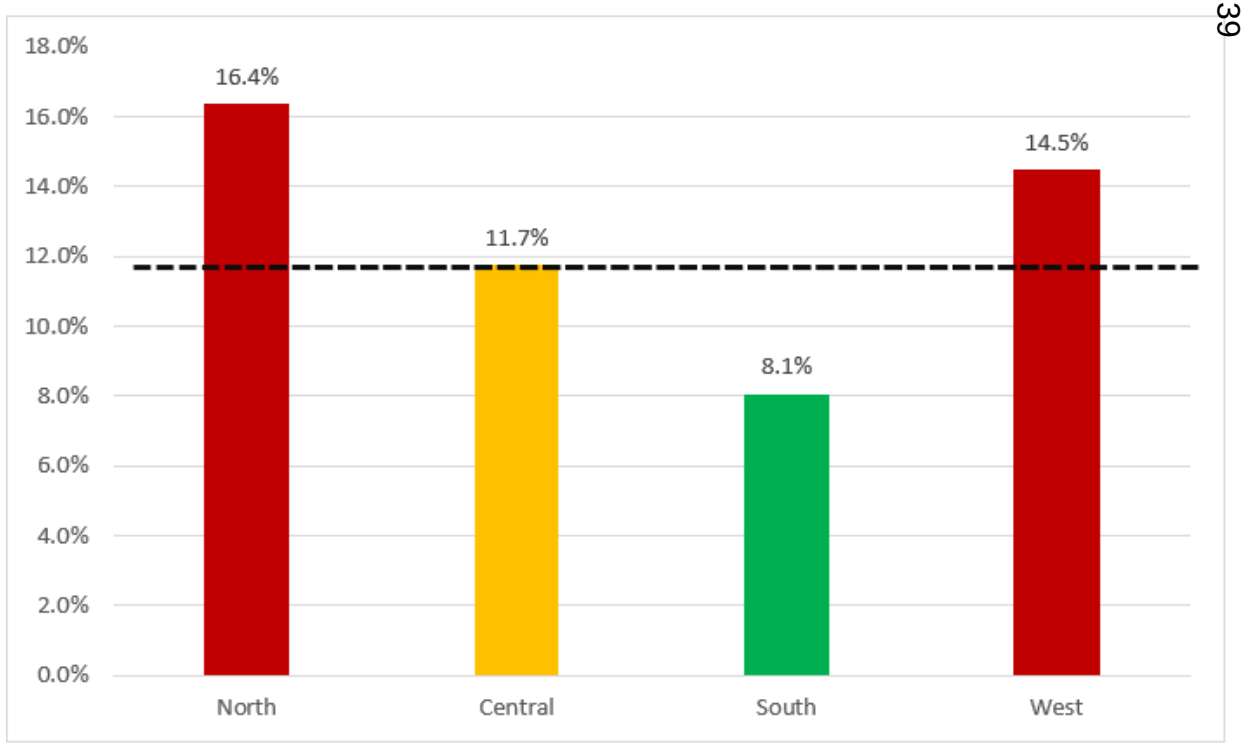
Overall smoking prevalence in Trafford estimated at 11.1% (2021 data) but much higher in some groups and communities e.g.:

- People with serious mental ill-health (SMI)

The national smoking rate for people with SMI is 40.5%. This is over 3 times the rate when compared to the general population. In Trafford, our SMI smoking rate is 35%, slightly below national average. This roughly equates to 880 SMI smokers in Trafford.

- 'Routine and manual' workers

Nationally the smoking rate is 24.5% for this population cohort, almost double the general population. In Trafford, our rate is almost in-line with the national average at 23.4%.



GP data on Trafford locality smoking rates 2023

The reasons people can't live healthier lives are complex and intertwined with their health…

Trafford
Integrated Care Partnership

For example, less than a quarter of our adult carers have as much social contact as they would like*.

This ranks Trafford at the lower end among similar areas in 2021/22.

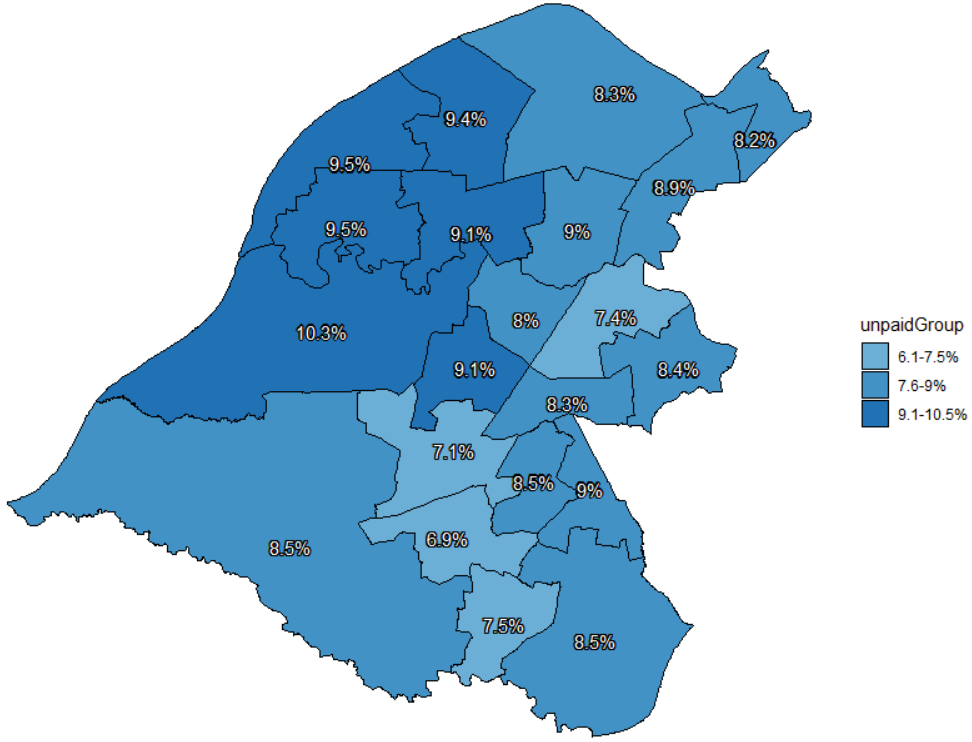
Carers UK, 2019b) found carers are more likely to report having a long term condition, disability or illness than non-carers.

Intense carers (at least 20-49 hours a week) were more likely to be physically inactive, smoke cigarettes, gain weight, and eat unhealthily.

They were more likely to self-report or have a diagnosis of depression or anxiety.

Carers who had given up work to care were more likely to be smokers and have common mental disorders (Future Care Capital, 2019; Tseliou, 2019).

Unpaid carers (2021 census breakdown by ward)



*Source: Adult Social Care Outcomes Framework (ASCOF) based on the Personal Social Services Survey of Adult Carers, NHS Digital

Different partners(hips) need to work at different 'levels' of the driver diagram to make sustainable changes – where do you have influence or direct responsibility?

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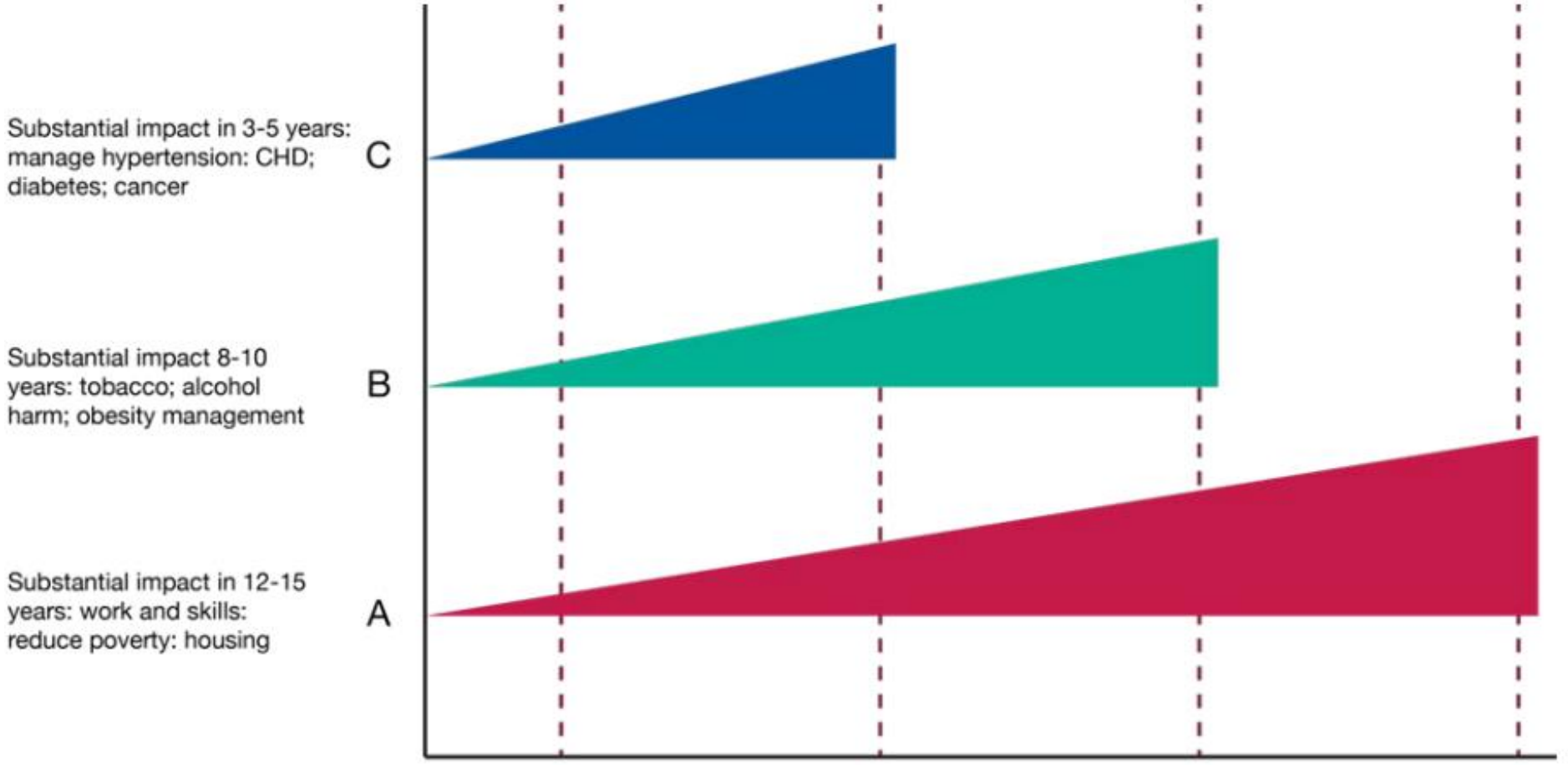

Reducing health inequalities: system, scale and sustainability (publishing.service.gov.uk)

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So what's happening in Trafford?

What's going on in Trafford…

Trafford
Integrated Care Partnership

Primary Care Quality Assurance Group and Action Plan

Trafford Council Corporate Priority – Tackling Health Inequalities

Trafford Health and Wellbeing Strategy and priorities 2019-2029

Trafford Poverty Strategy

GM Primary Care Blueprint and PCN leads

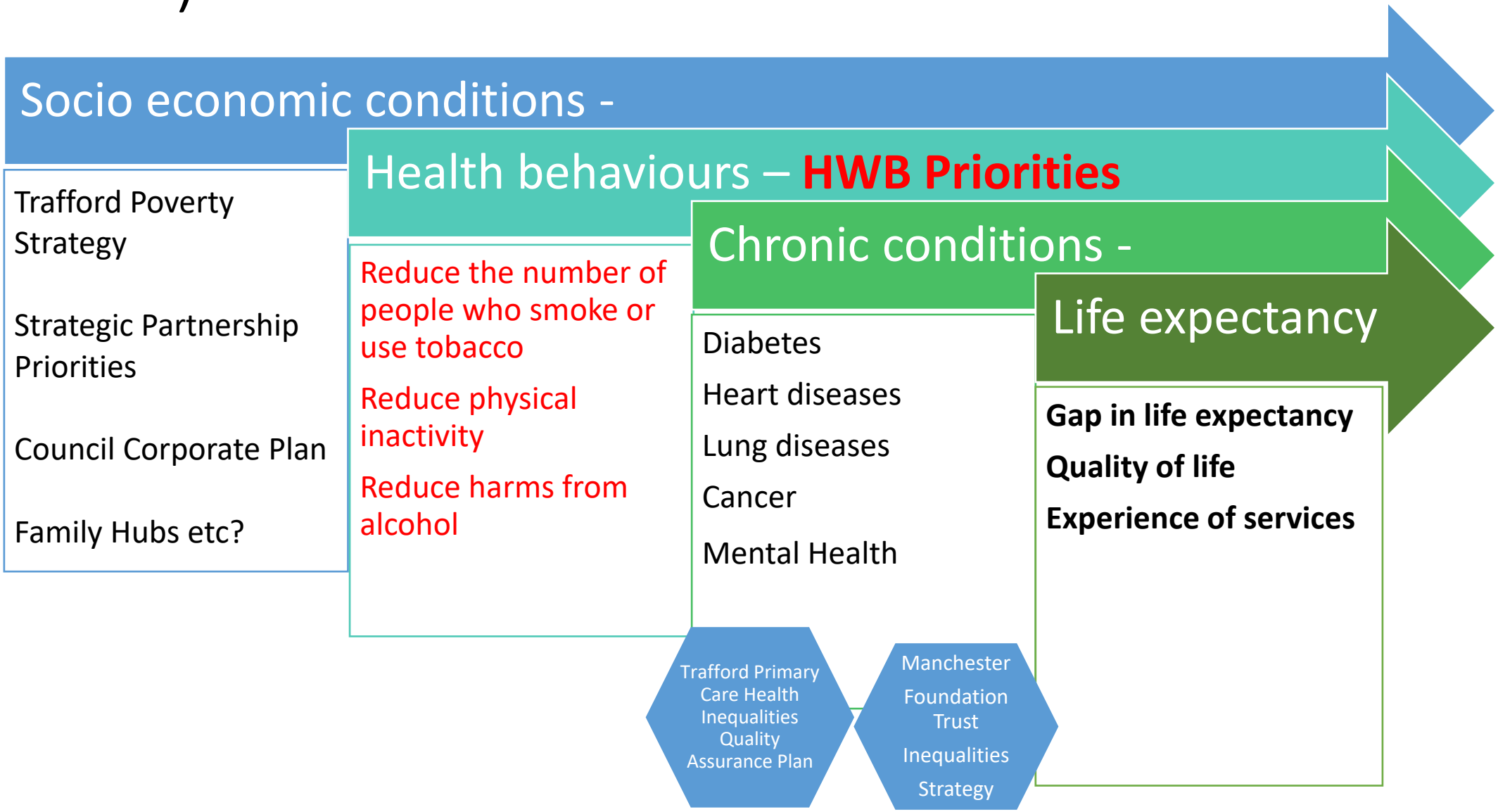
Manchester NHS Foundation Trust Inequalities Strategy

Build Back Fairer for Greater Manchester

Trafford Locality Plan 2019-24

Healthy Lives Services – voluntary sector

How does it all fit together for Trafford (a start)?



Our Draft Neighbourhood Model

Trafford
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- Tackling neighbourhood health inequalities requires action in 4 key areas: Data quality, community engagement, access to services, risk identification and stratification (NHS Confed)

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So what approach should we take?

Things to consider….

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- Some interventions improve overall population health but risk widening health inequalities with **concerted effort,** particularly proactive universal interventions (eg cancer screening, NHS Health Checks etc)
- For many issues (e.g. obesity, alcohol misuse), biggest impact comes from intervening among group with highest overall burden of disease – this isn't necessarily the people at the highest risk and/or those with highest levels of inequality
- 'Proportionate universalism' often the favoured approach within services – how do we build this into specs etc and test if its right – are we brave enough?

Key Questions

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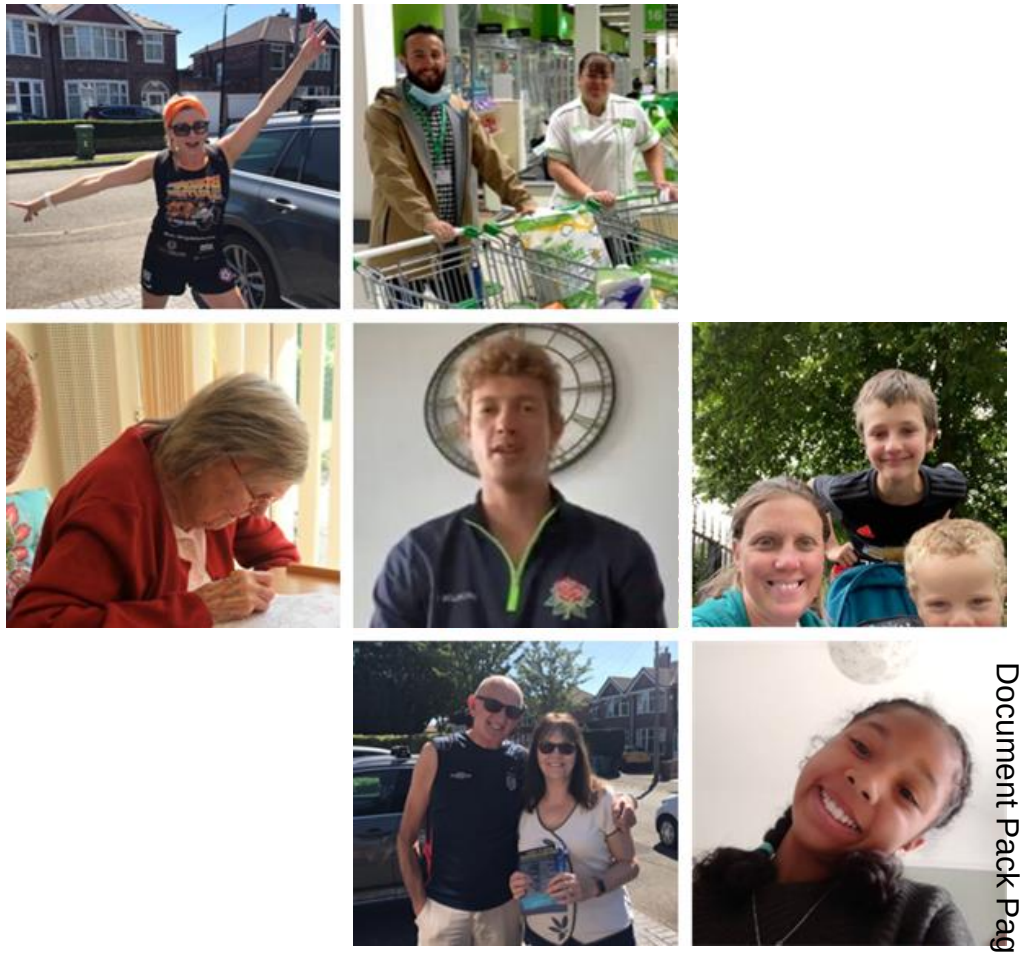
Integrated Care Partnership

- Do we want to 'focus' on a few key population groups, causes or experiences, if so which or how do we decide?
- We have HW priorities and other system priorities, therefore do we identify specific inequalities / interventions to focus on?
- Do we need a tactical group to align programmes, provide challenge and identify opportunities / risks? Learning from Making Manchester Fairer.
- How do we capitalise on the planned refresh of the Trafford Locality Plan and ensure the collective efforts across our system have maximum impact on tackling health inequalities?



TRAFFORD COUNCIL

Report to: **Health & Wellbeing Board**
Date: **September 2023**
Report for: **Information**
Report of: **Helen Gollins, Director of Public Health**

Report Title

Trafford, Stockport, Tameside joint Child Death Overview Panel Annual Report 2021-22

Purpose

The death of any child is a tragedy. It is therefore important that we understand why our children die and what as a system we can do differently to prevent this from happening or, if inevitable, ensure the child has the best death possible and their family and carers are supported throughout.

Each year the Stockport, Tameside and Trafford (STT) Child Death Overview Panel publish a report, 'Learning from Child Death Reviews', to describe why children who lived in Stockport, Tameside and Trafford died, to learn from the circumstances as far as possible, and present recommendations for the future. This report summarises findings from 2021/22 for the Board's consideration, particularly of the included recommendations, summarised below, and of any other relevant action to be taken in Trafford.

Summary

- The panel received 39 notifications in 2021/22 across STT.
- There is no clear trend, although the annual notification rate has fallen slightly over the last five years compared to the first three.
- Infants aged under 1 year accounted for 39% of total, though in Trafford the three year infant mortality rate is significantly lower than in Stockport and Tameside
- The recording of ethnicity in notified cases is not complete enough to analyse.
- The notification rate is higher than average in children who live in areas of STT ranked in the most deprived 20% in England, but the gradient across deprivation quintiles is less clear.
- The panel closed 45 cases in 2021/22 (67), 80% of these cases were from 2019/20 or 2020/21. Covid affected closure rates.
- Just over a half (54%) of infants who died had a low birth weight; and 56% of infants who died were premature.
- In 2021/22 chromosomal, genetic and congenital anomalies makes up the largest category of cause of death for closed cases (15 deaths, 33%), perinatal/neonatal event makes up the second largest category (12 deaths, 27%).
- Modifiable factors were identified in 11 (24%) closed cases. Smoking, domestic violence, perinatal mental health and substance misuse were the most common factors recorded.
- Just over a half (56%) of closed cases were expected deaths.

Recommendations

The Board is asked to:

- Note and sign-off the report
- Consider each of the recommendations included in the report and identify any on-going activity to meet these. These map closely to the previous year's annual report which are shown at the Appendix with our initial review of Trafford's / CDOP's response
- Make any further recommendations for partners or other Boards for their information or action, at Trafford or GM level

Recommendations included in the report are:

I. Health and Wellbeing Boards should continue their work to address the longstanding causes of increased risk of child deaths. These include:
   a. Obesity; particularly in children and women of childbearing age
   b. Smoking by pregnant women, partners, and household members / visitors
   c. Parental drug and alcohol abuse
   d. Domestic abuse
   e. Mental ill health
   f. Co-sleeping
   g. Multiple embryo implantation during IVF procedures.

II. In line with the recommendations of previous CDOP annual reports, Maternity services should
   a. Ensure that all women are supported to access high quality antenatal care from early in their pregnancies.
   b. Deliver safe, evidence based healthy weight interventions, so that when a women books with the service and she is recorded as not being a healthy weight she is supported to maintain or, if safe to do so, reduce her BMI.

III. All CDOP partners should continue working to ensure the robust data recording of protected characteristics as required under the Equality Act 2010.

IV. The CDOP chair should work with CDOP panel members and the STT Child Death Review Partners on an ongoing basis. This should include (as a minimum):
   a. Reviewing the draft annual report and agree its recommendations
   b. Providing an update on the actions taken in response to the recommendations in the previous annual report.
   c. Maintaining an awareness of the cases awaiting panel discussion and responding to any challenges and changes within the management of the CDOP process.

V. The data used to compile the annual report should be stored in a consistent format to enable a rolling 5-year look back review to identify robust trends and provide a firmer basis for specific recommendations to the health and wellbeing board. This should inform the recommendations in annual reports from 2024-25 onwards

Outline review of CDOP Recommendations 2020-21 (which include all of 2021-22)

Recommendation	Trafford response…
I. Health and Wellbeing Boards should continue their work to address the	

longstanding causes of increased risk of child deaths. These include:	
Obesity; particularly in children and women of childbearing age	Outside of pregnancy support (see recommendation II), Trafford Public Health commission a number of interventions for adults, children, young people and families. The Healthy Weight Steering group are progressing sign off on the Healthy Weight Strategy, which sets out the whole system approach to making Trafford a place where it is easier for residents to achieve and maintain a healthy weight. This includes specific work on school food, vending policy and advertising policy and links to physical activity plans. Infant feeding is part of Trafford's healthy weight and Start for Life strategies. This will be supported particularly in the North pilot, through the Family Hubs focus on 1001 critical days. There is also a commitment amongst GM colleagues to work with OHID and ICB to develop best practice around infant feeding and ensuring the best start in terms of healthy eating.
Smoking by pregnant women, partners, and household members / visitors	As part of the Saving Babies Lives National Programme v3 Greater Manchester commission the smokefree pregnancy service. In Trafford this supports a nominated midwife and Midwife Support Workers in MFT to offer specialist smoking support to women who are pregnant, with regular visits and early first contact to emphasise the importance of the issue. As part of the offer, women will be provided with NRT and a CO monitor for home use. There is also an incentive scheme to encourage women to validate their quit status, with vouchers provided to any women who can validate their successful quit with a CO reading of 3 or below. For the wider population a full multi-agency Tobacco Control strategy and action plan is in development following an event in September. Trafford Council commission stop smoking interventions through pharmacies and GPs. We have also commissioned targeted support who are disproportionately affected by smoking harm e.g. young people and those with SMI.
Parental drug and alcohol abuse	Trafford Council commissions the holding families programme from Early Break, which is a whole family approach to parental drug/alcohol use. We have supported the service to generate referrals for their next programme beginning in September. Trafford Council also commission Early Break to deliver young people substance misuse support and an alcohol outreach prevention service.
Domestic abuse	Trafford has a full programme of awareness raising work including both public and professional awareness, led by our main provider Trafford Domestic Abuse Service (TDAS) with partners. This includes posters, business cards, website information, training sessions and events. Services are working with a wide range of settings such as schools, sporting associations, hairdressers, GPs,

	pubs to increase awareness and make access as easy as possible
Mental ill health	An all-age strategy is being developed for Trafford and will include specific aspects for parents and carers. This will need to be developed with the Safeguarding Partnership and guidance to ensure responses to parental mental ill health are supportive whilst ensuring the welfare of the child. One of Trafford's Suicide Prevention Partnership strategy priorities for 2022-25 is to raise awareness of the risk of suicide and self-harm in specific groups a large CPD awareness sessions have been held for professionals as well as materials and sessions for the public. GM Self-Harm and mental wellbeing resources for young people and one for parents/carers will be made available shortly.
Co-sleeping	The HV team promote key messages to all clients with babies of all ages, particularly with under 1 year as part of routine universal contacts. The HV service also provide Care Of Next Infant support to families who have experienced sudden and unexpected death of a baby or child. Messages within the red book are highlighted at every contact with the HV service. As part of Safer sleep week (13th – 19th March 2023) student Health Visitors were asked to promote safer sleep campaign in their practice areas and developed a project wall in clinic settings for key messages. There was also an opportunity to highlight ICON messages (abusive head trauma). In addition to the promotion in community clinics, the safer sleep and ICON information were posted daily on social media platforms during the safe sleep week of action.
Multiple embryo implantation during IVF procedures.	The Human Fertilisation and Embryology Authority (HFEA) is responsible for the regulation of IVF services in England and has been working since 1991 to reduce the multiple birth rate following IVF. Their work included the implementation of restrictions on triple embryo transfer, and a move to encouraging women to choose to have only one embryo transferred – termed the 'one at a time' policy. This policy, together with a target to reduce multiple births below 10%, has seen multiple births fall from 28% in the 1990s to 6% in 2021. Multiple births have fallen but remain higher than average in black ethnic groups and privately funded patients. This trend is linked to higher multiple transfer in these groups than in other ethnic groups and NHS funded patients.
II. In line with the recommendations of previous CDOP annual reports, Maternity services should	
Ensure that all women are supported to access high	MFT deliver quality, safe and personalised care, focused on community delivery. There is a lead matron with responsibility and experience around public health

quality antenatal care from early in their pregnancies.	nursing and focus on health improvement and improving links in the community. This also brings together specialist midwives and MSWs to support particular groups such as refugee and asylum seeker populations; young parents and women experiencing obesity. A recognised gap was parent education but a new post has been recruited to, to deliver most appropriate antenatal classes which are not just about delivery itself but about support available before or after including perinatal mental health and financial support. MFT will work with partners to identify what parents would most benefit from, considering different areas of Trafford.
Deliver safe, evidence based healthy weight interventions, so that when a women books with the service and she is recorded as not being a healthy weight she is supported to maintain or, if safe to do so, reduce her BMI	Public Health commission a Tier 2 Community Weight Management service provided by Slimming World, who work in partnership with the Royal College of Midwives (RCM) and can support women from pre-conception to post-natal period. For pregnant women, the focus is not on weight loss, but on healthy lifestyle changes, with the support of their midwife or healthcare team. The tier 3 Specialist Weight Management Service (SWMS, commissioned by ICB) supports pregnant women when referred by their GP or midwife. Specialist midwives at MFT run a clinic with the Consultant for women with a BMI over 40 but also see women with BMI of 35-39 and give healthy eating advice, safe exercise in pregnancy and go through maternity pathway and clinical implications. Referral pathways to healthy weight service above are being strengthened and reviewed with midwives.
III. All CDOP partners should continue working to ensure the robust data recording of protected characteristics as required under the Equality Act 2010	Gaps in ethnicity data are routinely questioned at CDOP panel, to ensure that any data on ethnicity on partners' systems is shared
IV. The data used to compile the annual report should be stored in a consistent format to enable a rolling 5-year look back review to identify robust trends and provide a firmer basis for specific recommendations to the health and wellbeing board. This should inform the recommendations in annual reports from 2024-25 onwards	We are compiling data prospectively to allow a 5-year review to be completed. 5 years of data will have been collected by the end of 2025. Discussions with GM CDOP colleagues are ongoing to enable a GM-wide review, though resource not yet identified. Either anonymised data or annual reports to be used to compile a 5-year sub-region review

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Learning from Child Death Reviews

Annual Report of Stockport, Tameside and Trafford (STT) Child Death Overview Panel

2021/2022

Document Control

Date	Version	Forum/Officer	Purpose	Amendments
26.04.23	1	Eleanor Banister	First draft	Yes
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Learning from Child Death Reviews: Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel 2021/2022 has been prepared on behalf of Stockport, Tameside and Trafford Child Death Overview Panel and Stockport, Tameside and Trafford Child Death Review partners by:

- **Ben Fryer, Consultant in Public Health, Stockport Council, and STT CDOP Chair**
- **Eleanor Banister, Public Health Intelligence and Early Intervention and Prevention Lead, Public Health, Stockport Council**
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Please send all comments to Shelley Birch, Shelley.birch@tameside.gov.uk.

Executive Summary

1. Introduction

The death of any child is a tragedy. It is therefore important that we understand why our children die and what as a system we can do differently to prevent this from happening or, if inevitable, ensure the child has the best death possible and their family and carers are supported throughout.

Each year the Stockport, Tameside and Trafford (STT) Child Death Overview Panel publish a report, 'Learning from Child Death Reviews', to describe why children who lived in Stockport, Tameside and Trafford died, to learn from the circumstances as far as possible, and present recommendations for the future. This report summarises findings from 2021/22.

2. Data protection

Losing a child is a distressing time; every care has been taken to ensure the data presented does not lead to the identification of any individual children and their families as we do not wish to add to anyone's grief.

Professionals who require the more detailed data analysis can request a copy of the data by emailing Shelley Birch, shelley.birch@tameside.gov.uk.

3. What we know about the children who died and cases that were closed in 2021/22

Key points from data analysis:

- The panel received 39 notifications in 2021/22, bringing the 8 year total across STT to 386
- There is no clear trend towards a higher or lower notification rate, although the annual rate has fallen slightly over the last five years compared to the first three years. The four year average is 2.6 notifications per 10,000 population aged under 18.
- Infants aged under 1 year accounted for 15 notifications (39% of total) which is slightly lower than in previous years in STT, where a half of child deaths were aged under a year
- The factor of ethnicity is difficult to comment on as the recording of ethnicity in notified cases is not complete.
- The notification rate is higher than average in children who live in areas of STT ranked in the most deprived 20% in England, but the gradient across deprivation quintiles is less clear.
- The panel closed 45 cases in 2021/22 (67), this is higher than the totals in the previous two (pandemic affected) years. 80% of these cases were from 2019/20 or 2020/21.
- Just over a half (54%) of infants who died had a low birth weight; and 56% of infants who died were premature.
- In 2021/22 chromosomal, genetic and congenital anomalies makes up the largest category of cause of death for closed cases (15 deaths, 33%), perinatal/neonatal event makes up the second largest category (12 deaths, 27%) followed by cancers and trauma / injuries both 6 deaths (16%) each.
- Modifiable factors were identified in 11 (24%) of closed cases. Smoking, domestic violence, perinatal mental health and substance misuse were the most common factors recorded.
- Just over a half (56%) of closed cases were expected deaths.

4. Recommendations

The CDOP Chair has identified five recommendations for Stockport's, Tameside and Trafford's Health and Wellbeing Boards to endorse and sponsor. These recommendations have been approved by the Child Death Review Partners in Stockport, Tameside and Trafford.

I. Health and Wellbeing Boards should continue their work to address the longstanding causes of increased risk of child deaths. These are recurring modifiable factors in recent CDOP cases, and their contribution to child deaths is supported by a broad evidence base. They include:
   a. Obesity; particularly in children and women of childbearing age
   b. Smoking by pregnant women, partners, and household members / visitors
   c. Parental drug and alcohol abuse
   d. Domestic abuse
   e. Mental ill health
   f. Co-sleeping
   g. Multiple embryo implantation during IVF procedures.

II. In line with the recommendations of previous CDOP annual reports, Maternity services should
   a. Ensure that all women are supported to access high quality antenatal care from early in their pregnancies.
   b. Deliver safe, evidence based healthy weight interventions, so that when a women books with the service and she is recorded as not being a healthy weight she is supported to maintain or, if safe to do so, reduce her BMI.

III. All CDOP partners should continue working to ensure the robust data recording of protected characteristics as required under the Equality Act 2010.

IV. The CDOP chair should work with CDOP panel members and the STT Child Death Review Partners on an ongoing basis. This should include (as a minimum):
   a. Reviewing the draft annual report and agree its recommendations
   b. Providing an update on the actions taken in response to the recommendations in the previous annual report.
   c. Maintaining an awareness of the cases awaiting panel discussion and responding to any challenges and changes within the management of the CDOP process.

V. The data used to compile the annual report should be stored in a consistent format to enable a rolling 5-year look back review to identify robust trends and provide a firmer basis for specific recommendations to the health and wellbeing board. This should inform the recommendations in annual reports from 2024-25 onwards

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Learning from Child Death Reviews

Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel 2021/22

1. Introduction

The death of any child is a tragedy. It is therefore important that we understand why our children die and what as a system we can do differently to prevent this from happening or, if inevitable, ensure the child has the best death possible and their family and carers are supported throughout.

Each year the Stockport, Tameside and Trafford (STT) Child Death Overview Panel publish a report, 'Learning from Child Death Reviews', to describe the mortality trends for children and why children who lived in Stockport, Tameside and Trafford died, to learn from the circumstances as far as possible, and present recommendations for the future. This report summarises findings from 2021/22.

2. Data protection

Losing a child is a distressing time; every care has been taken to ensure the data presented does not lead to the identification of any individual children and their families.

Professionals who require the more detailed data analysis can request a copy by emailing Shelley Birch, shelley.birch@tameside.gov.uk.

3. The Child Death Overview Process

The Stockport, Tameside and Trafford Child Death Overview Panel (STT CDOP) undertakes a review of all child deaths (excluding those babies who are still born, and planned terminations of pregnancy carried out within the law) up to the age of 18 years who are either normally resident in one of the three boroughs, or, if they consider it appropriate, any non-resident child who has died in their area. The Child Death Review Partners and CDOP adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018[i]. The CDOP reviews each case in a structured and consistent manner in line with Working Together, 2018[ii].

There are four CDOPs across Greater Manchester, including STT CDOP. It is recommended that CDOPs serve a total population of 500,000, with an average of 60 child deaths per year. The geographical footprint of STT CDOP covers an estimated population of 762,000 people (ONS 2021 Mid Year Estimate), receives an average of 40 to 50 notifications per year and includes a network of NHS health, police and social care providers for this cluster.

From January 2021 the panel moved to being virtual and monthly to ensure that cases were reviewed in a timely manner, this was from a previous pre-pandemic structure of quarterly face to face meetings. The change so far has been highly effective; it has supported attendance and engagement in case discussions.

The CDOP is accountable to each locality's Health and Wellbeing Board. Appendix A provides more information about the CDOP process with links to local membership and arrangements.

4. Implementing Local Learning

A Strategic Child Death Group has previously been established to ensure that action is taken to address any emerging issues or trends from CDOP. This group will be re-activated in 2023 to ensure system ownership and change as a result of CDOP learning. Stockport, Tameside and Trafford Health and Wellbeing Boards are accountable for the work of this group.

The emerging NHS Greater Manchester ICS provides opportunities to strengthen and formalise existing links between the CDOP system and the NHS Integrated Care System, with CDOP findings contributing to quality improvement activities in the NHS. The Strategic Child Death Group and GM CDOP chairs will continue working with NHS colleagues to develop a clear plan for this.

5. What we know about children who live Stockport, Tameside and Trafford

Understanding our population across STT is important for us to contextualise the circumstances in which our children and young people die.

Figure 5.i: Stockport, Tameside and Trafford within Greater Manchester.

Source: Trafford Public Health, 2019.

In 2021, Stockport, Tameside and Trafford had an estimated combined population of 168,400 under 18 year olds (ONS 2021 Mid Year Estimate). Table 5.ii, provides an overview of the characteristics of the children and young people who live in each of the three boroughs.

It is important to understand the similarities and differences between the boroughs when reviewing the number of notifications and the conclusions from the closed cases; with Tameside having higher levels of poverty and looked after children and Trafford having a more ethnically diverse young population.

Local profiles for each borough can be found in Appendix B.

Table 5.ii: Overview of the characteristics of the children and young people who live Stockport, Tameside and Trafford.

	Indicator			Stockport	Tameside	Trafford	GM	England
1	Population aged 0 to 17 years (2021)		Number	62,515	51,134	54,751	653,244	11,761,656
			% of Total (all ages)	21.2%	22.1%	23.2%	22.8%	20.8%
2	Proportion of 0-24 year olds belonging to Black, Asian & Minority Ethnic Groups (2021)			18.3%	21.6%	32.1%	34.0%	26.7%
3	Projected growth in 0 to 17 population (2020-2030)		Number	2,702	-279	1,082	9,622	144,517
			%	4.2%	-0.6%	1.9%	1.5%	1.2%
4	Children in Low Income Families (under 16s) (2020/21)	Absolute	Number	6,352	8,073	4,644	115,051	1,641,209
			%	11.1%	17.6 %	9.2%	19.7%	15.1%
		Relative	Number	8,138	10,234	5,767	144,770	2,003,734
			%	14.2%	22.3 %	11.4%	24.8%	18.5%
5	Live births (2021)		Number	3,227	2,525	2,413	33,445	595,948
			Rate (per 1,000 females aged 15-44 years)	60.0	57.0	54.6	56.5	54.3
6	Low birth weight (2021)	of term babies	Number	48	46	42	815	14,986
			%	1.7%	2.1%	1.9%	2.7%	2.8%
		of all babies	Number	216	140	148	2,336	39,826
			%	6.8%	6.0%	6.3%	7.2%	6.8%
7	Infant mortality (2019-21)		Number	41	34	13	523	7,036
			Rate (per 1,000 live births)	4.4 (CI 3.1-5.9)	4.4 (CI 3.0-6.1)	1.8 (CI 1.0-3.1)	5.2 (CI 4.8-5.7)	3.9 (CI 3.8-4.0)
8	Child mortality (2018-20)		Number	16	19	17	220	3,471
			Rate (DSR per 100,000 population aged 1-17)	8.9 (CI 5.1-14.5)	13.8 (CI 8.3-21.6)	10.8 (CI 6.3-17.3)	n/a	10.3 (CI 9.9-10.6)
9	Looked After Children (2022)		Number	447	666	359	6,027	82,170
			Rate (per 10,000 population aged 0-17)	72	130	66	92	70

Source: ONS Population and Census Data[iii]; OHID Maternal and Child Health Profiles (as at 26-04-2023)[iv].

6. What we know from CDOP Notifications and Closed Cases 2021/2022

This annual report considers the learning from child death cases that were notified to the STT CDOP and were reviewed and closed by the panel between 1st April 2021 and 31st March 2022.

6.i. Data analysis

When a child dies, any or all of the agencies involved with the child inform CDOP. This is referred to as a 'notification'. The administrator then begins the process of gathering information from all official sources who may know the child and/or family in order to build a picture of the circumstances leading up to the death of the child. Once this process is complete and all other investigations involving the Coroner, Police or Children's Services have been concluded, the CDOP reviews each case. Having assessed all the available information the panel, made up of professionals from a number of agencies, discuss the relevant points and reach a conclusion regarding the category of death and any modifiable factors or issues specific to that case. At this point the 'case' is considered by the CDOP to be 'closed'.

In this section the analysis of factors that are "fixed" (i.e. age and sex, ethnicity, and deprivation of area of mother's residence) is of ***notifications*** to the panel during 2021/22. This is a reasonable proxy of deaths that have occurred within this period because the period between death and notification is usually only a matter of days, and this gives a better unit of analysis for considering epidemiological patterns in child deaths across the STT CDOP area. Birthweight and gestation is also "fixed" in this sense and would ideally be analysed at notification level, but this information is often not available until later in the review process.

Factors such as category of death, whether the death was expected or not, and whether any modifiable factors were present are not determined until the case is closed by CDOP and so analysis of these factors relates to cases ***closed*** during 2021/22. In many cases there is more than a year between notification and closure.

Therefore notifications show epidemiological pattern of deaths for the year under review, whereas closed cases provide intelligence about cases from a range of years but where the investigations are complete.

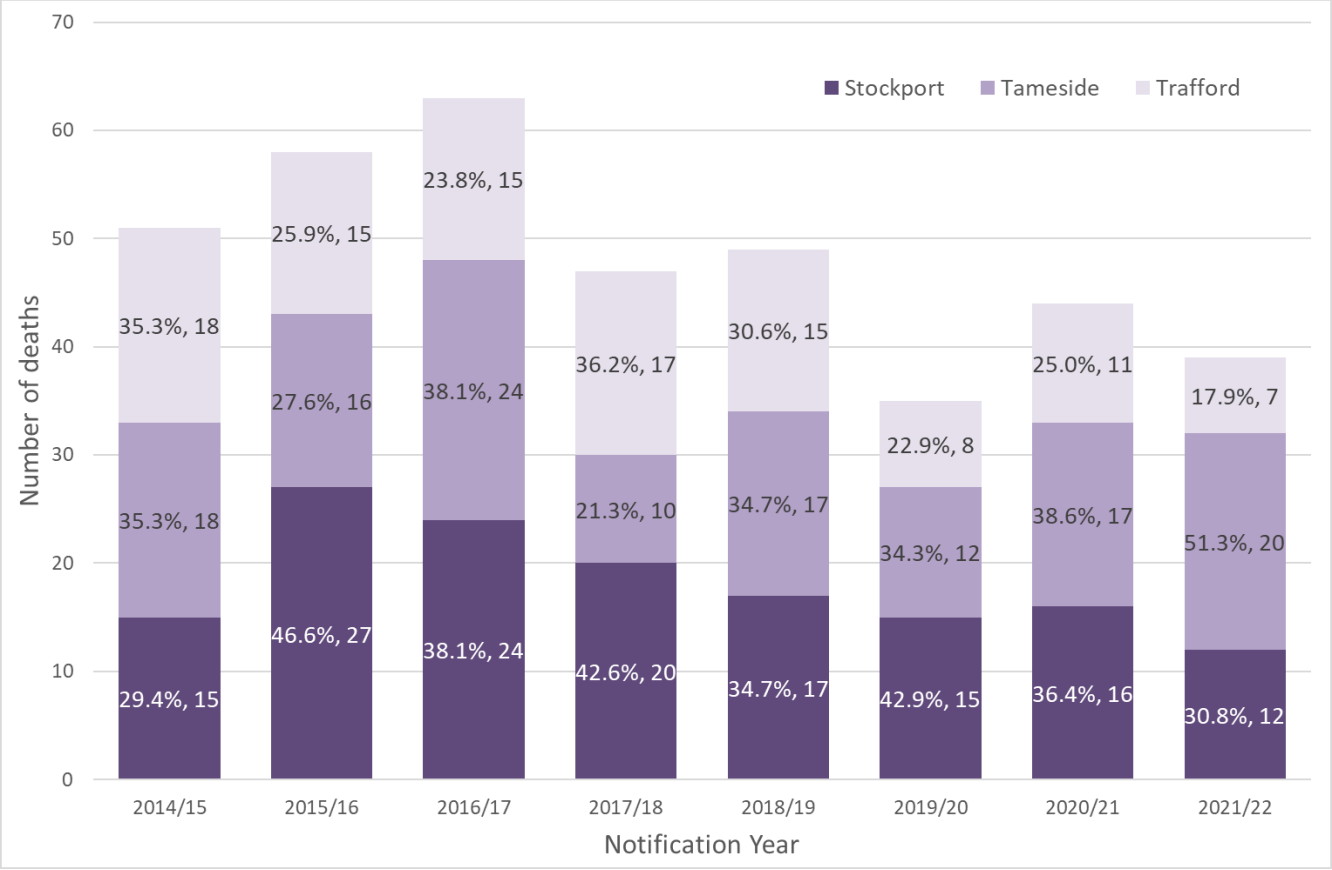
6.ii. Demographic breakdown of notifications

6.ii.a. Number of notifications

The panel received 39 notifications in 2021/22, a level similar to the average of the previous four years. The 2021/22 notifications bring the eight year total notifications across STT since 2014/15 to 386.

The split by local authority in 2021/22 was 12 (30.8% of total) in Stockport, 20 (51.3%) in Tameside, and 7 (17.9%) in Trafford; due to small number variation this is not a statistically significant difference for the one year period. Aggregating the eight year total gives a split by local authority of 37.8% (146) in Stockport, 34.7% (134) in Tameside, and 27.5% (106) in Trafford; with Stockport's proportion being similar to the borough's 0-17 population share (37.3%), Tameside slightly higher (29.7%) and Trafford slightly lower (32.9%).

Figure 6.ii.a: Child deaths notifications to STT CDOP – 2014/15 to 2021/22 by authority

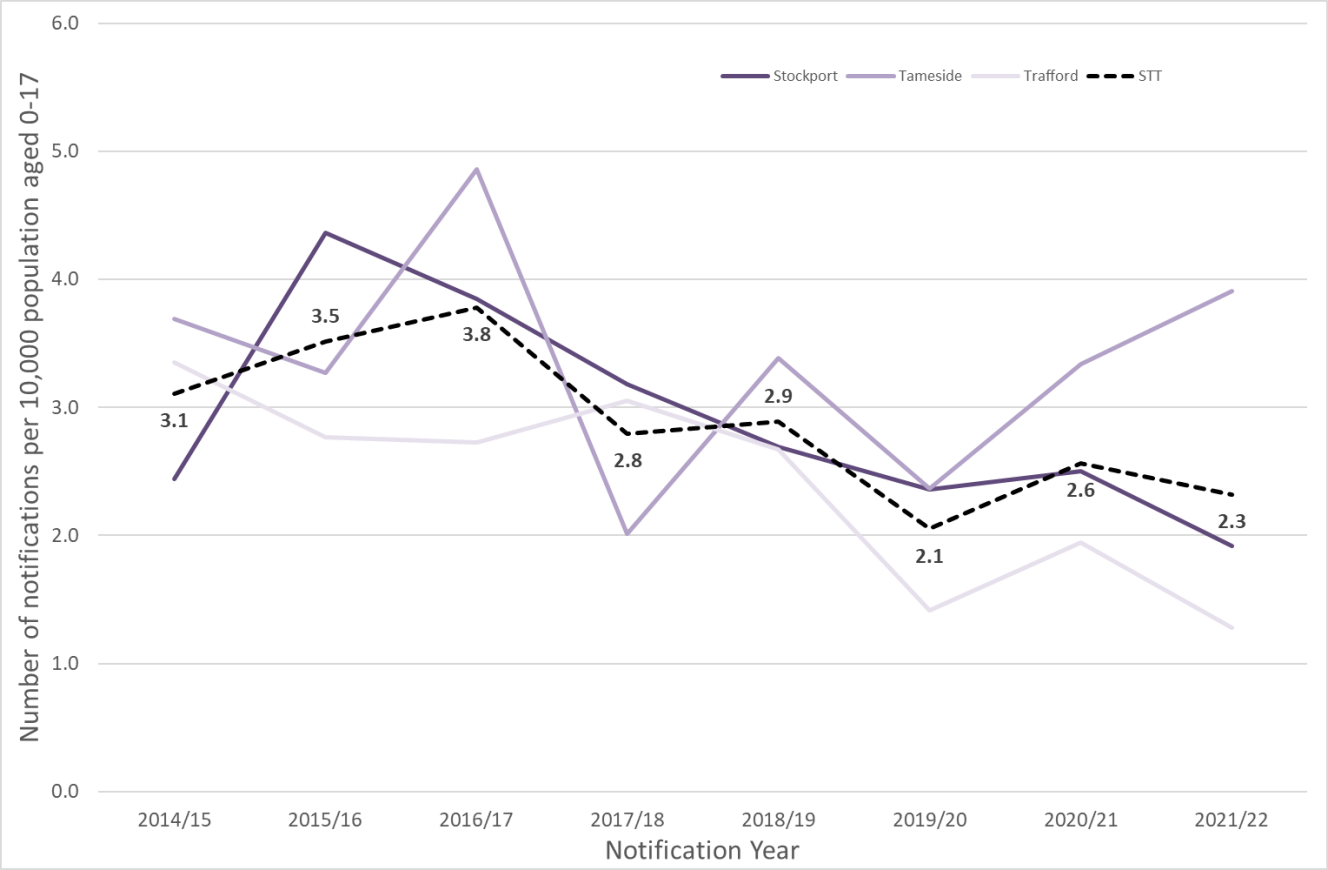


6.ii.b. Notification rate

At local authority level the notification rate tends to fluctuate year on year due to the relatively small numbers, and so it is difficult to detect underlying trends. Aggregating the notifications for STT smooths out some of this fluctuation: the 39 notifications in 2021/22 give a rate of 2.3 per 10,000 population aged under 18, which is very similar to the average over the last four years (2.6 per 10,000 2017/18-2020/21), which probably indicates that the notification rate is around the same level.

The eight year aggregated notifications give a rate for STT of 2.9 per 10,000, which is similar in Stockport (2.9 per 10,000), slightly higher in Tameside (3.4 per 10,000) and slightly lower in Trafford (2.4 per 10,000).

Figure 6.ii.b: Trend in child death notification rate (per 10,000 population aged under 18) – 2014/15 to 2021/22 by authority



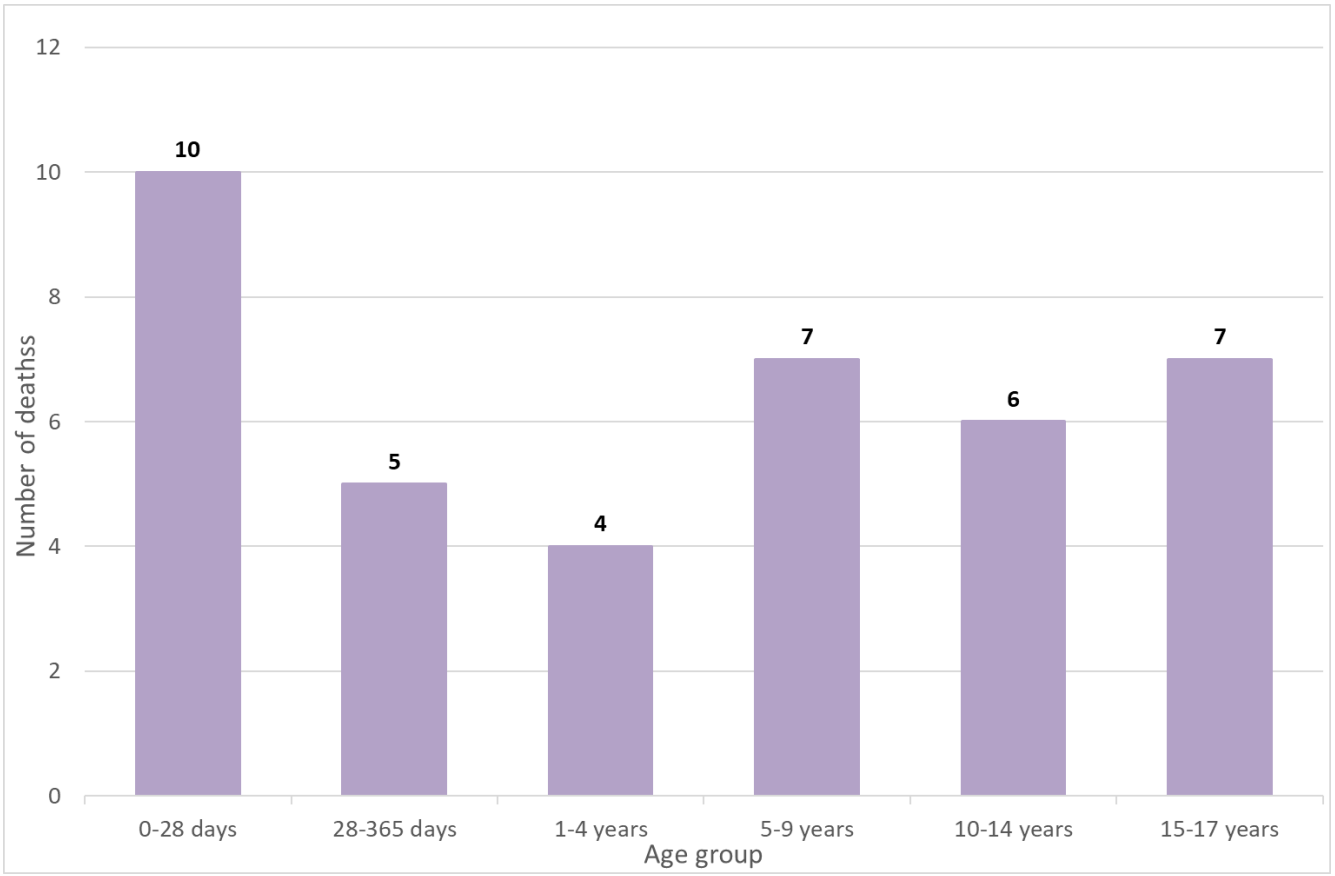
6.ii.c. Age breakdown of notifications

Of the 39 notifications in 2021/22, 10 (25.6%) were neonates (i.e. aged under 28 days) and 5 (12.8%) were aged between 28 days and 1 year. This means that around two-fifths (15 or 38.5%) of notifications across STT are infants (i.e. aged under 1 year). This is slightly lower than in previous years in STT, where a half of child deaths were aged under a year.

Differences in age patterns between the three authorities within STT can be difficult to detect due to the small numbers; however, as with previous years there does seem to be a consistent pattern that in Stockport a higher proportion of child deaths are of neonates (50.0% compared to 38.5% for STT).

Reviewing the 24 notifications of deaths of children aged over 1 year, at STT level the distribution across age groups was fairly even with 4 (10.3%) aged 1 to 4 years, 7 (17.9%) aged 5 to 9 years, 6 (15.4%) aged 10 to 14 years, and 7 (17,9%) aged 15 to 17 years. Any differences between the three authorities in this distribution are difficult to detect due to the small numbers involved.

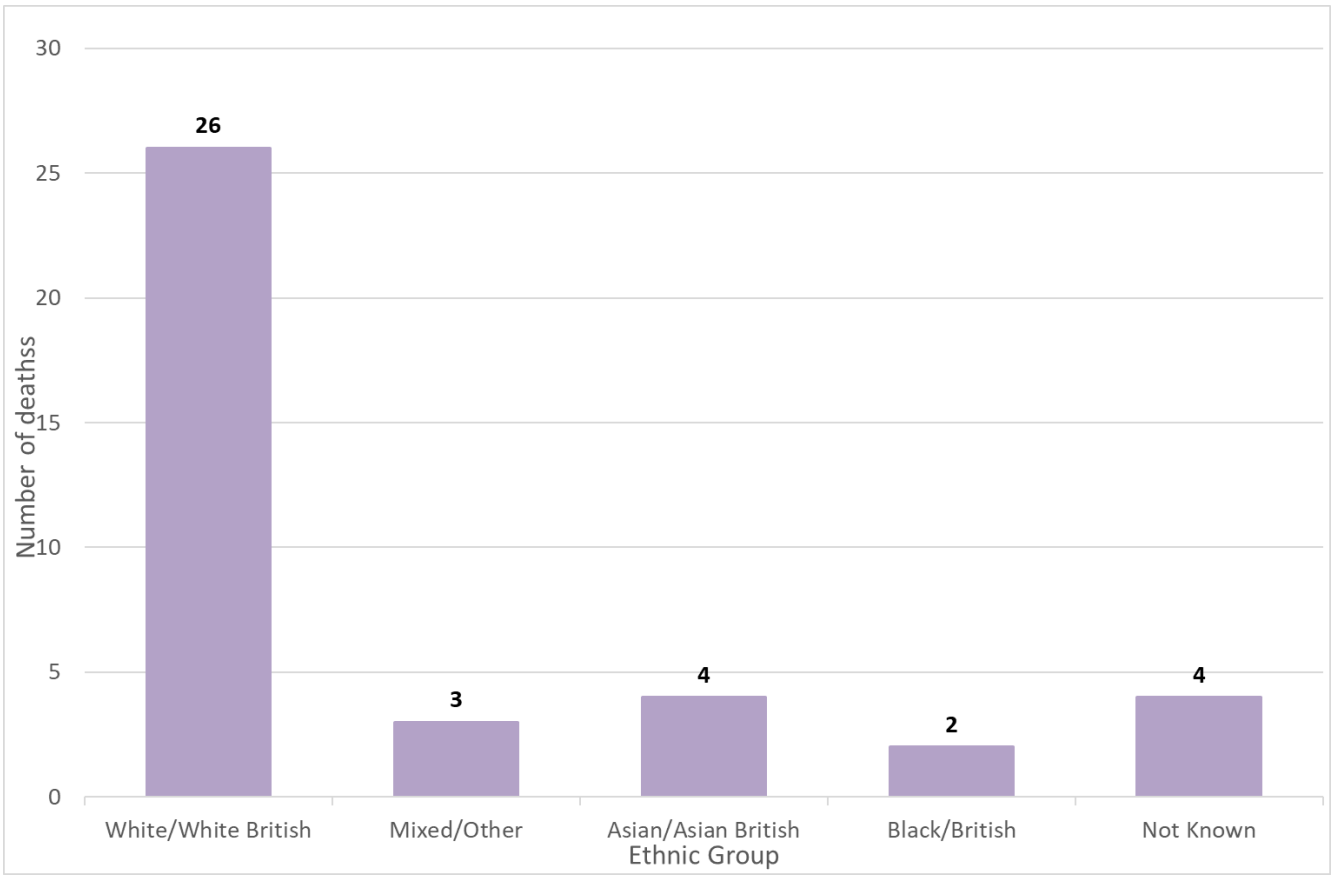
Figure 6.ii.c: Age breakdown of child death notifications 2021/22



6.ii.d. Ethnicity breakdown of notifications

Of the 39 notifications during 2021/22, 9 (23.1%) belonged to a non-White group. This is in line with the estimated proportion of the STT child population belonging to non-White groups (23.7% aged 0-24 at the 2021 Census). However, there are 4 notifications (10.3% of total) where ethnic group is not known (these are cases which are still open to CDOP pending further information). If, for instance, all these unknown cases were of non-White children then this would bring the proportion of deaths which were of non-White children to 33.4% which may suggest that these children are overrepresented among children who die.

Figure 6.ii.d: Ethnic group breakdown of notifications 2021/22

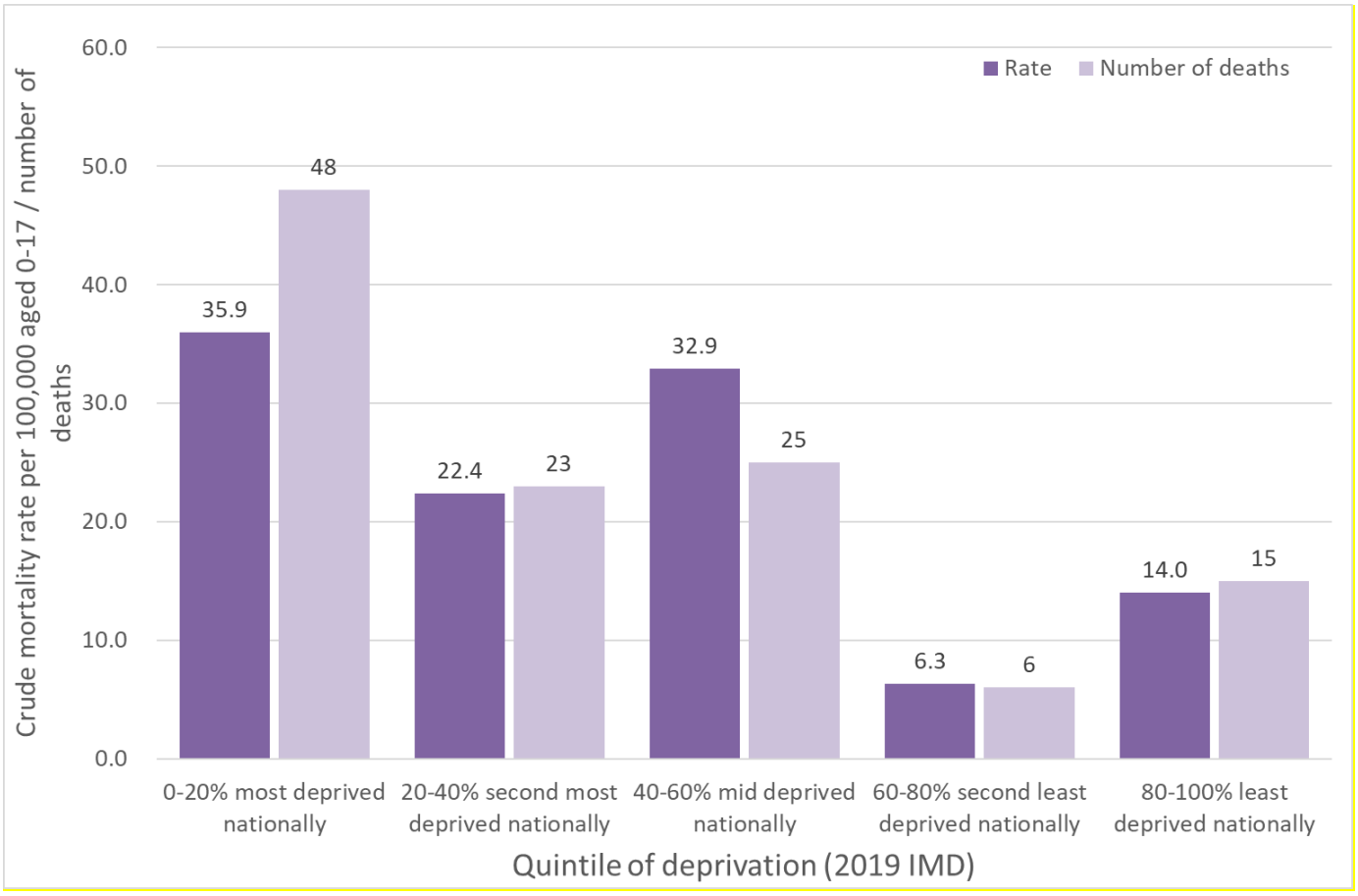


6.ii.e. Deprivation breakdown of notifications

Trafford is the least deprived district in Greater Manchester. Based on the 2019 Index of Multiple Deprivation it ranks 191st of 317 districts in England (where a rank of 1 is the most deprived district) and only 8.7% of Trafford small areas (LSOAs) rank in the 20% most deprived in England. Stockport is also one of the less deprived districts in Greater Manchester, ranking 130th in England on IMD 2019 and with 16.3% of LSOAs ranked in the 20% most deprived. Tameside is much more deprived with an IMD 2019 rank of 28th most deprived in England and 42.6% of LSOAs ranked in the 20% most deprived in England.

Of the 39 notifications across STT, 15 (38.5%) were of children who lived in small areas which rank in the 20% most deprived in England, a crude rate over the last three years of 35.9 per 100,000 aged 0-17. There is tendency towards higher child death notification rates in more deprived areas of STT; but because of the relatively small number of deaths involved the trend is perhaps not as clear as it could be with variation between the quintiles with the mid deprived quintile having a rate not much lower than that of the most deprived.

Figure 6.ii.e: Notification rate (crude child mortality rate) according to national deprivation quintile of mother's area of residence April 2019 – March 2022.



6.iii. Analysis of cases closed during 2021/22

6.iii.a. Number of closed cases

In 2021/22, 45 cases were closed by the panel:

- This is higher than the totals in the previous two (pandemic affected) years (38 closed in 2019/20, 29 in 2020/21) but is substantially lower than a peak of 64 cases closed by the panel in 2010/11.

- The breakdown by authority was 19 (42.2%) in Stockport, 13 (28.9%) in Tameside and 13 (28.9%) in Trafford.

- Only 2 (4.4%) were notified to CDOP in 2021/22, 20 (44.4%) were notified in 2020/21 and 16 (35.6%) in 2019/20; 7 cases (15.6%) were notified in either 2018/19 or 2017/18.

- The average (mean) number of days from notification to close was 666 (almost 2 years), but varied by authority from 598 days for Stockport cases, 667 days for Tameside cases to 765 days for Trafford cases,

- Deaths of children aged over 1 year tend to take longer to close (763 days comparted to 581 days), probably reflecting the circumstances and causes of death.

- The rate limit on closing cases is determined by the process of gathering the information required by the panel. This work is time consuming and can't be completed until all other processes (including coroner's inquests) have been completed. The panel process itself does not contribute significantly to the duration from notification to closure.

6.iii.b Birthweight and gestation and multiple births for deaths < 1 year

In 2021/22 24 (53.3%) of cases closed by the panel were infants (died within 12 months of their birth). Among these:

- 6 (25.0%) had very low birthweight (<1,500g), and a further 7 (29.2%) had a low birthweight (1,500-2,499g); bringing the proportion with low birthweight to half (13 out of 25 or 54.2%). 9 had a birthweight above 2499g (37.5%) , 2 were unknown (8.3%).
- In comparison in 2021 504 live births across STT were of low birthweight, 6.4% of the total live births with a birthweight recorded. These figures are not directly comparable, but if we assume approximately 500 low birthweight births in 2021/22 in STT, 16 deaths gives a crude mortality rate of 3.2% for lowweight births, and with an approximate 7,300 non-low weight births across STT, 7 deaths gives a crude mortality rate of 0.1% for non-lowwieght births. This analysis should be treated with caution due to the small numbers and the lack of definitional consistency; **however it is clear that having a low birthweight increases the risk of a baby dying in their first year of life.**
- 3 of the 6 babies (50.0%) with very low birthweight died within 28 days of their birth
- 2 of the 7 babies (28.6%) with low birthweight died within 28 days of their birth
- 3 of the 9 babies (33.3%) with birthweight >2499g died within 28 days of their birth
- All 6 babies with very low birthweight were premature (<37 weeks), with 4 being extremely premature (<30 weeks).
- 5 of the 7 babies with low birthweight were premature, with 1 being extremely premature. One birth was full term and one had an unknown gestation.

- 6 of the total 25 infant deaths (24.0%) were extremely premature (<30 week), and a further 8 (32.0%) were premature (30-36 weeks); bringing the proportion who were premature to more than a half (14 out of 25 or 56.0%). 9 (37.5%) were full term and 1 (4.2%) had an unknown gestation.

- In comparison in 2021 across the North West (figures are not available at local authority level routinely), 1.3% of live births were before 32 weeks gestation, 6.8% live births were between 32 and 36 weeks gestation and 91.7% live births were over 37 weeks gestation. **Prematurity therefore adds greatly to the risk of a baby dying in its first year of life.**
- 4 of the 6 babies (66.7%) who were extremely premature died within 28 days of their birth
- 1 of the 8 babies (12.5%) who were premature died within 28 days of their birth
- 4 of the 9 babies (44.4%) who were full term died within 28 days of their birth

- 1 (4.0%) was a multiple birth (a single twin).
- In comparison across England and Wales in 2021, 2.7% of maternities resulting in a live birth were twins and 0.1% of maternities resulting in a live birth were triplets or higher multiples.
- In previous STT CDOP report the level of multiple births has been much higher, and we may be seeing a small number variation impact for this lower number in 2021/22.

6.iii.c Place of death of closed cases

The place of birth is not included in the dataset, however the place of death is included as shown in the table below, and shows a reasonably even split across the main providers in the area.

Table 6.iii.c.i: Place of death for deaths < 1 year in 2021/22

	Area of Residence			All STT
Hospital of death	**Stockport**	**Tameside**	**Trafford**	
St Marys Hospital	6	3	2	11
Tameside Hospital		5		5
Stepping Hill Hospital	3			3
Wythenshawe Hospital	1			1
Other hospital (1 each)	1	3		4
Total	**11**	**11**	**2**	**24**

Table 6.iii.c.ii: Place of death for deaths >1 year in 2021/22

	Area of Residence			All STT
Hospital of death	**Stockport**	**Tameside**	**Trafford**	
St Marys Hospital	1		4	5
Tameside Hospital		1		1
Stepping Hill Hospital	5			5
Wythenshawe Hospital	2		2	4
Other hospital (1 each)			2	2
Elsewhere (non hospital)		1	3	4
Total	**8**	**2**	**11**	**21**

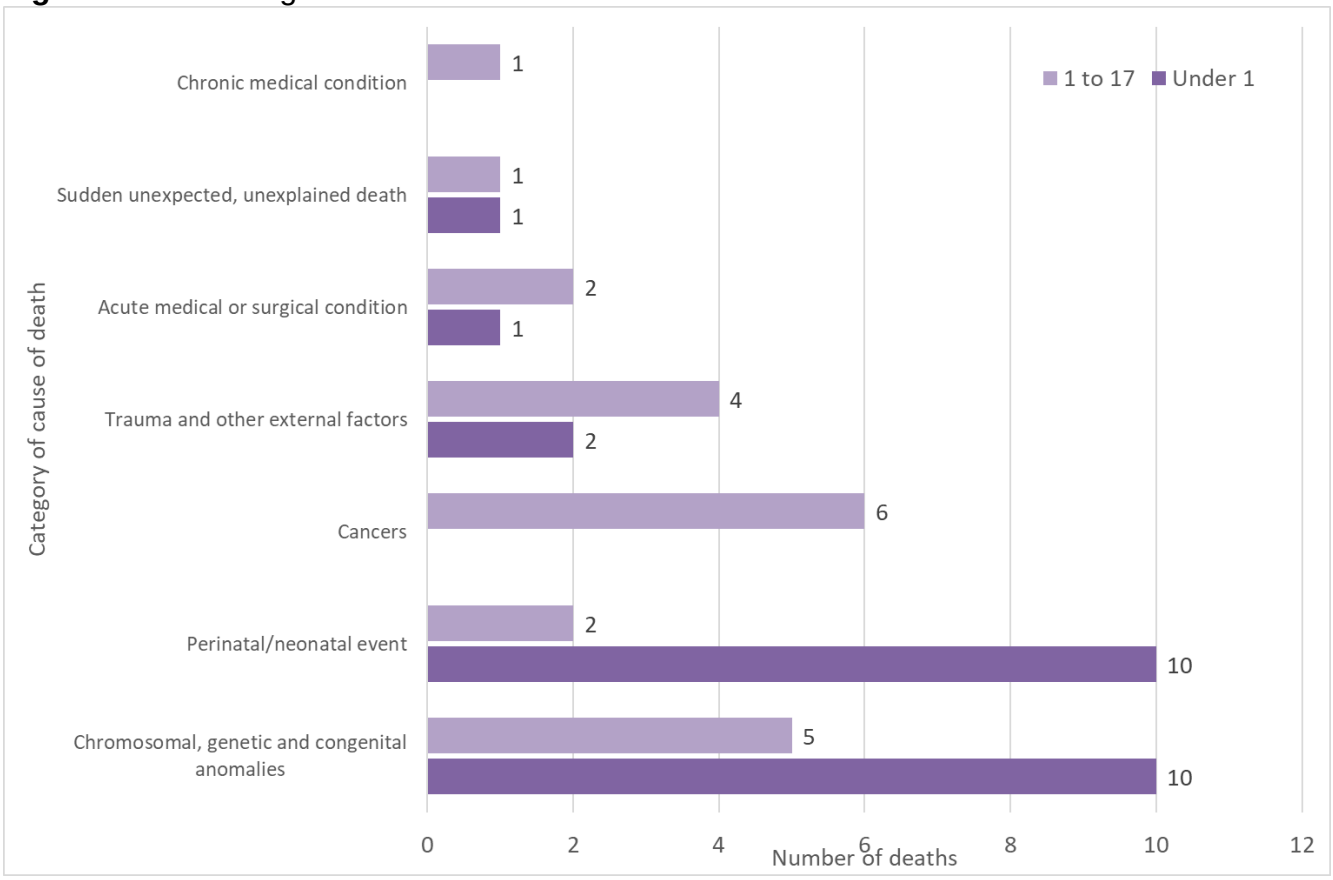
6.iii.d. Categories of cause of death

In 2021/22 chromosomal, genetic and congenital anomalies makes up the largest category of cause of death for closed cases (15 deaths, 33%), perinatal/neonatal event makes up the second largest category (12 deaths, 27%) followed by cancers and trauma / injuries both 6 deaths (16%) each.

The 21 closed cases of children aged over 1 year were spread across a range of categories, the majority of deaths aged under a year were dure to chromosomal, genetic and congenital anomalies or perinatal/neonatal event .

One record mentioned COVID-19 coronavirus as a contributory factor, in terms of the mental health and wellbeing of the child. This is understood to be the impact of lockdown and other restrictions, rather than the impact of the infection itself.

Figure 6.iii.d: Categories of cause of death in cases closed



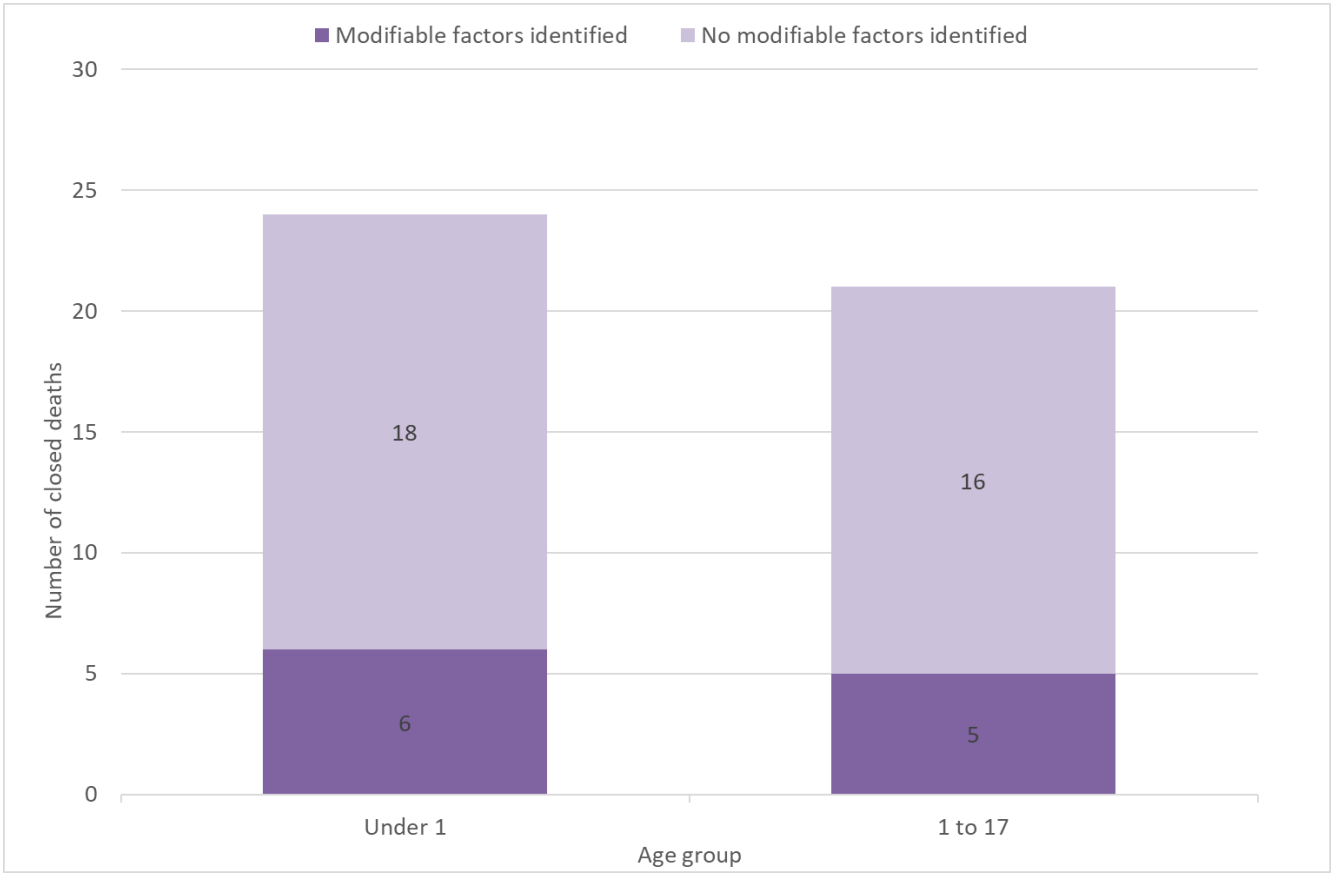
6.iii.e. Modifiable factors

Modifiable factors were identified in 11 (24%) of cases in 2021/222. This is noticeably lower than the roughly 50% of cases that had modifiable factors identified in 2019-2021

Present modifiable factors included:

- Parental smoking (mentioned in 7 cases)
- Domestic violence (mentioned in 5 cases)
- Parental mental health (mentioned in 5 cases)
- Parental Substance misuse (mentioned in 3 cases)
- Parental alcohol misuse (mentioned in 2 cases)
- Leaving unattended (mentioned in 2 cases – by water and at height)
- Other factors with one mention each:
    - Child's substance misuse
    - Risk taking behaviours of child
    - Missed opportunities to support parents
    - Information sharing between agencies
    - Injuries inflicted on child
    - Reckless driving
    - Mothers BMI
    - Co-sleeping
    - COVID-19 impact on child

Figure 6.iii.e: Proportion of closed cases with a modifiable factor

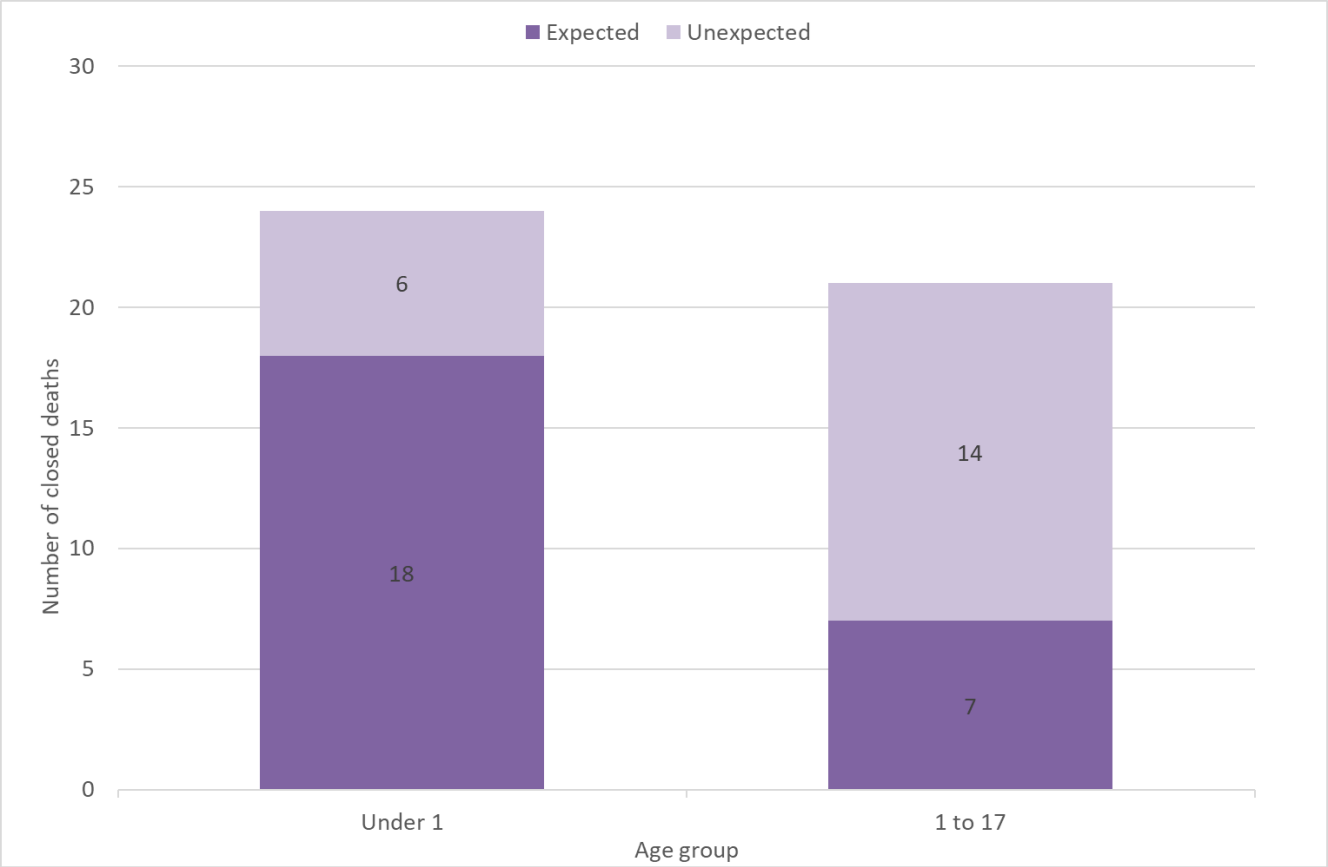


6.iii.f. Expected deaths

Around a half (25 or 55.6%% in 2021/22) of closed cases across STT were deaths which were expected. This is slightly higher than in recent years. The proportion expected was higher for infant deaths (75.0%) when compared to deaths for those aged 1-17 years (33.3%).

At local authority level, the proportion expected was higher in Stockport (73.7%) average in Tameside (53.8%) and lower in Trafford (3087%), although due to small numbers this wis not a significant difference at this level.

Figure 6.iii.f: Proportion and numbers of deaths as expected and unexpected



7. Recommendations

The CDOP Chair has identified five recommendations for Stockport's, Tameside and Trafford's Health and Wellbeing Boards to endorse and sponsor. These recommendations have been approved by the Child Death Review Partners in Stockport, Tameside and Trafford.

I. Health and Wellbeing Boards should continue their work to address the longstanding causes of increased risk of child deaths. These are recurring modifiable factors in recent CDOP cases, and their contribution to child deaths is supported by a broad evidence base. They include:
   a. Obesity; particularly in children and women of childbearing age
   b. Smoking by pregnant women, partners, and household members / visitors
   c. Parental drug and alcohol abuse
   d. Domestic abuse
   e. Mental ill health
   f. Co-sleeping
   g. Multiple embryo implantation during IVF procedures

II. In line with the recommendations of previous CDOP annual reports, Maternity services should
   a. Ensure that all women are supported to access high quality antenatal care from early in their pregnancies.
   b. Deliver safe, evidence based healthy weight interventions, so that when a women books with the service and she is recorded as not being a healthy weight she is supported to maintain or, if safe to do so, reduce her BMI.

III. All CDOP partners should continue working to ensure the robust data recording of protected characteristics as required under the Equality Act 2010.

IV. The CDOP chair should work with CDOP panel members and the STT Child Death Review Partners on an ongoing basis. This should include (as a minimum):
   a. Reviewing the draft annual report and agree its recommendations
   b. Providing an update on the actions taken in response to the recommendations in the previous annual report.
   c. Maintaining an awareness of the cases awaiting panel discussion and responding to any challenges and changes within the management of the CDOP process.

V. The data used to compile the annual report should be stored in a consistent format to enable a rolling 5-year look back review to identify robust trends and provide a firmer basis for specific recommendations to the health and wellbeing board. This should inform the recommendations in annual reports from 2024-25 onwards

8. How will we know we have made a difference?

Each borough will integrate the recommendations into the appropriate local systems for action and monitoring. The three public health departments will be asked to report on actions taken against the previous year's recommendations each year. Each HWB will need to ensure that its respective member organisations are accountable for progress.

9. Summary

When a child dies it is so important that the parents, carers and professionals, who were part of this experience understand the circumstances of the death. NHS, LA organisations and other partners have a responsibility to review each case, identify good practice and poor practice.

Learning must affect practice so as a system we can prevent avoidable deaths from happening or, if inevitable, ensure the child has the best death possible and their family and carers are supported throughout this experience.

Appendix A: CDOP Responsibilities and Operational Arrangements

Ai: Child Death Overview Panel Responsibilities

CDOP responsibilities are:

- to collect and collate information about a child's death, seeking relevant information from professionals and where appropriate family members.
- to analyse the information obtained, to confirm or clarify the cause of death, to determine any contributing factors, and to identify any learning arising from the child death review process that may prevent future death.
- to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths and will promote the health safety and well-being of children.
- to notify the relevant locality's Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected.
- to notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it is identified there are any errors or deficiencies in an individual child's registered cause of death.
- to provide specific data to NHS digital through the National Child Mortality Database.
- to produce an annual report for Child Death Review Partners on local patterns and trends in child deaths, and any lessons learned, and actions taken and the effectiveness of the wider child death review process.
- to contribute to local, regional and national initiatives to improve learning from child death reviews including where appropriate approved research carried out within the requirements of data protection.

Aii: Child Death Overview Panel Operational Arrangements

CDOP will;

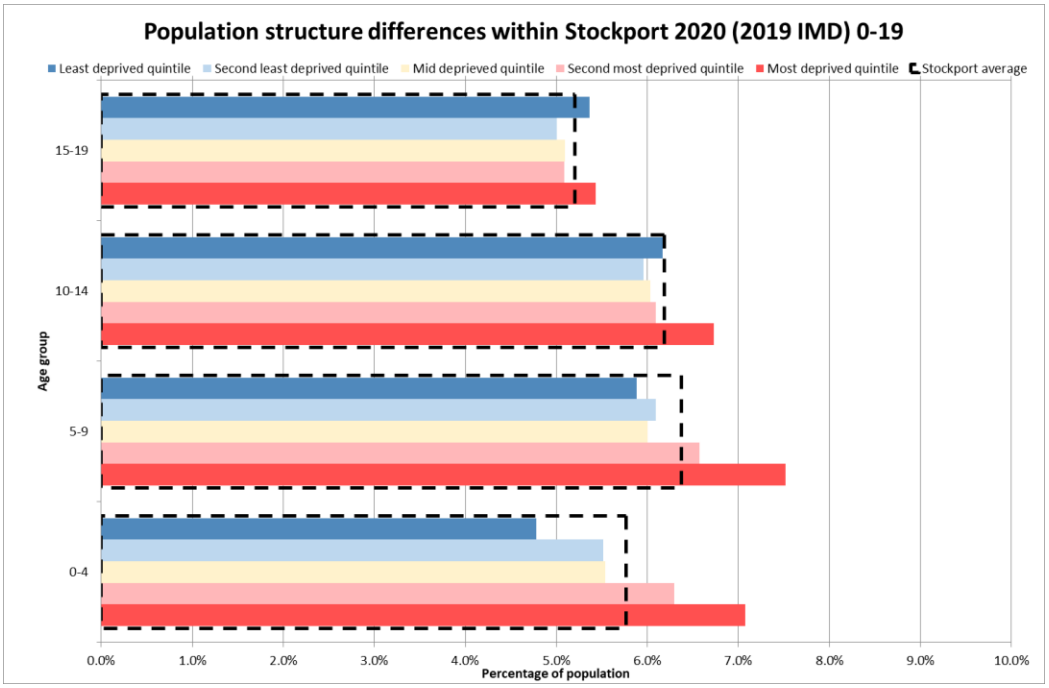
- meet quarterly to enable the deaths of children to be discussed in a timely manner and within the statutory timeframe of six months. Exceptions are where there is a current criminal or coronial investigation.
- ensure that effective rapid response arrangements for sudden deaths are in place, to enable key professionals to come together to undertake enquiries into and evaluate and make an analysis of each unexpected death of a child.
- review the appropriateness of agency responses to each death of a child.
- review relevant environmental, social, health and cultural aspects of each death to ensure a thorough consideration of how such deaths may be prevented in the future.
- determine whether each death had any potentially modifiable factors.
- make appropriate recommendations to Stockport, Tameside and Trafford Safeguarding Partnership's where there are concerns of abuse and neglect in order that prompt action can be taken to learn from and prevent future deaths where possible.
- report and inform the LeDeR process of any deaths of children over 4 years who have a Learning Disability.

Appendix B: Borough Child Profiles

i: Stockport

There are 62,500 children and young people aged 0-17 living in Stockport (ONS Mid-Year Estimate 2021), a population that is currently stable – up 0.2% in the five years since 2016. Due to fluctuations in birth rates there are more children per year aged 5-13 years (around 3,600 per year) than aged 0-4 (3,300 per year) and 14-17 years (3,400). Births reached their lowest level in 2001-2003, at less than 3,000 per year, and then rose to a high in 2012 (3,500), since when numbers have started to fall again, reaching 3,100 by 2021, following the well-known cyclical trend.

Fertility rates are generally highest in the most deprived areas of Stockport and were especially high in these areas between 2009 and 2014 (at over 80 per 1000 females aged 15-44), 60-70% higher than in the most affluent areas), meaning that younger population is much more likely to be deprived than the Stockport average. Data from 2021 shows that fertility rates in the most deprived quintile fell to the Stockport average for the first time, it is not known yet whether this is a short-term pandemic impact or a change in the long term trend.



Stockport's population is not particularly ethnically diverse, when compared to other areas of Greater Manchester, however ethnic diversity is increasing, especially for younger populations. First data from the 2021 Census for Stockport suggests that 82% of the 0-24 population describe their ethnicity as White, 9% as Asian, and 6% as mixed and 3% as black or other. Stockport's non-white population is not evenly distributed, and is largest in Heald Green, Gatley and Heaton Mersey, where less than 60% of the 0-24 year population describe themselves as white.

Health inequalities in Stockport are stark, the borough includes the most deprived GP population in Greater Manchester (Brinnington) and the least (Bramhall); life expectancy is more than 10 years lower in the former than the later. For children and young people this manifests itself in the deprived areas in higher levels of smoking in pregnancy, childhood obesity and children with SEND (special educational needs or disability) and lower levels of breastfeeding, mental wellbeing and educational attainment.

Overall Stockport performs well for childhood vaccinations, maintaining update levels through the pandemic, smoking in pregnancy and child obesity (although levels are increasing). Stockport does however have high levels of hospital admissions for injuries, self-harm and asthma and lower levels of school readiness than expected.

Borough Priorities

- Stockport Council Plan: https://www.stockport.gov.uk/council-plan
- One Stockport Borough Plan https://www.onestockport.co.uk/the-stockport-borough-plan/
- Stockport Family: https://www.stockport.gov.uk/topic/stockport-family
- CDOP https://www.stockport.gov.uk/health-and-wellbeing-board/stockport-child-death-overview-panel-statutory-responsibilities

ii: Tameside

More people now live in Tameside than at any time in the past, with population projections estimating that this will continue to increase over the next 10 years.

The ethnic composition of the Tameside population is also changing, with the last Census (2021) showing that 17.6% of the local population are from an ethnic minority group; this is an increase from the last Census (2011) of 15.8%.

Across Tameside in 2021 there were 51,210 children and young people under the age of 18 years. This is 22% of the total population. Around 17% of children under 16 in Tameside live in poverty and this rises to 25% after housing costs.

In 2022 there were 2,420 babies born in Tameside; 28% of babies were born in the most deprived decile. 6% of babies were born with a low birth weight under 2500 grams, with less than 1% being of very low birth weight (<1500 grams). The highest proportion of births were born to mothers aged 30-34 years (34%). 3% of babies were born to women under 19 years and 19% to women over the age of 35 years.

Health, wellbeing and social outcomes are generally worse in Tameside than the England average. With significantly higher levels of smoking in pregnancy than the England average, low levels of breast feeding initiation and at 6 to 8 weeks.

Population vaccination coverage for 2 year olds across all vaccines has increased in particular for MMR vaccination rates (90% coverage) but there is a significantly higher rate for Dtap/IPV/Hib (95% coverage).

A&E attendances for all young people in Tameside are significantly higher than the England average. In older children hospital admissions for self-harm are similar to the England average, but hospital admissions for Asthma are the highest in England.

School readiness is improving for our 5 year olds but is still significantly worse than the England average, currently 60.1% of children in Tameside are school ready.

Tameside has significantly high numbers of children in care with health and social care outcomes being significantly worse than in the general population.

Please find more information here: Child and Maternal Health - Data - OHID (phe.org.uk)

iii: Trafford

An estimated 59,467 children and young people aged 0-19 live in Trafford which makes up about 1 in 4 (25.2%) of the total population (ONS, Mid-2021 estimates).

In 2021 there were 2,413 live births to mothers resident in Trafford. Trafford's total fertility rate of 1.58 is slightly higher than the rate of 1.55 for England (ONS, 2022). Between the years 2011 and 2021, the Census indicated that the number of children aged under 15 in Trafford decreased from 14,870 to 13,466, a drop of 9.4%. The same sources indicate an increase in the population aged 5 to 19 from 41,634 to 45,650, a rise of 9.6%. (Census Data, Trafford Data Lab). Between the years 2022 and 2037, the 0-19 population in Trafford is projected to decrease by 2.3% (a drop of 1,420 children and young people). (ONS, 2020).

Around a third of children in Trafford (33.1%) belong to an ethnically diverse group, predominantly Asian or Asian British (17.2%), mixed or multiple ethnic groups (8.6%) and Black, Black British, Caribbean or African (3.9%) (Census 2021).

Trafford is the least deprived authority in Greater Manchester, however, there is variation in deprivation within Trafford (Index of Multiple Deprivation). Seven small areas within Trafford ('LSOAs') rank among the lowest 10% in England for deprivation. The Income Deprivation Affecting Children domain of the 2019 Indices suggests that in one area 44% of children are living in income-deprived families.

The rate of children in care (66 per 10,000 population under 18 years of age) in Trafford is similar to the England average 70 per 10,000 population under 18 years of age) (Child and Maternal Health Profile).

Trafford Joint Strategic Needs Assessment's section on children and young people can be accessed at http://www.traffordjsna.org.uk/Life-course/Start-well.aspx.

10. References

[i] HM Government, (2018), *Child Death Review Statutory and Operational Guidance*.
[ii] HM Government, (2018), *A guide to inter-agency working to safeguard children. A guide to inter-agency working to Safeguarding and Protecting the Welfare of Children.*
[iii] Office of National Statistics https://www.ons.gov.uk/peoplepopulationandcommunity
[iv] OHID (Office for Health improvement and Disparities) Maternal and Child Health Profiles, *https://fingertips.phe.org.uk/profile/child-health-profiles.*

TRAFFORD COUNCIL

Report to:	**Health & Wellbeing Board**
Date:	**15th September 2023**
Report for:	**Decision**
Report of:	**Gareth James, Deputy Place Lead for Health and Care Integration, NHS GM Trafford & Nathan Atkinson, Corporate Director for Adults, Trafford Council**

Report Title

Better Care Fund Plan and Narrative 2023/25

Purpose

The report contains two documents for sign off by the Board:

- The BCF Plan 2023/25
- BCF Narrative 2023/25

These documents have already been submitted and approved through the regional assurance process and are currently with the national team for final sign off pending HWBB approval and notification thereof.

Recommendations

The Board is asked to:

1. Sign off the 2023/24 Better Care Fund Plan and Narrative

Contact person for access to background papers and further information:

Name: Thomas Maloney, Programme Director Health and Care, NHS GM Trafford and Trafford Council
Telephone: 07971556872

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HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Health and Wellbeing Board(s) :**Trafford Locality Board**

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils) .

- Trafford Council
- Trafford Locality of Greater Manchester Integrated Care
- Trafford Local Care Organisation (TLCO/Community element of MFT)

How have you gone about involving these stakeholders?

The Trafford BCF plan is a long-term plan which is developed and approved on a rolling annual basis via Trafford's Health and Wellbeing Board. All the relevant partners to the BCF are core members of all our health and social care governance in Trafford and have therefore been fully engaged in the curation and sign off the plan.

The activity within the BCF is a core component of the Trafford Locality Plan (2019-2024) which has been co-designed by system partners and formally adopted through Trafford's Health and Social Care System Governance architecture which is described in more detail under question 5. The Locality Plan was refreshed in 2021 and a further review is anticipated on completion of the GM and Local Operating Model following the transition to ICS arrangements – the BCF will form a fundamental component of the revised plan once actioned.

The BCF outcome measures are monitored and have been evaluated, with key indicators remaining stable or being reduced over the year which evidences positive progress.

Our 23/25 BCF plan will be aligned closely to the planning, design, delivery, and reporting arrangements that span Trafford Locality Board and the Health and Wellbeing Board ensuring a tight system grip on performance, enabling transparent system reporting on all related areas of the wider Section 75, BCF and wider aspirations of the Trafford Locality Plan.

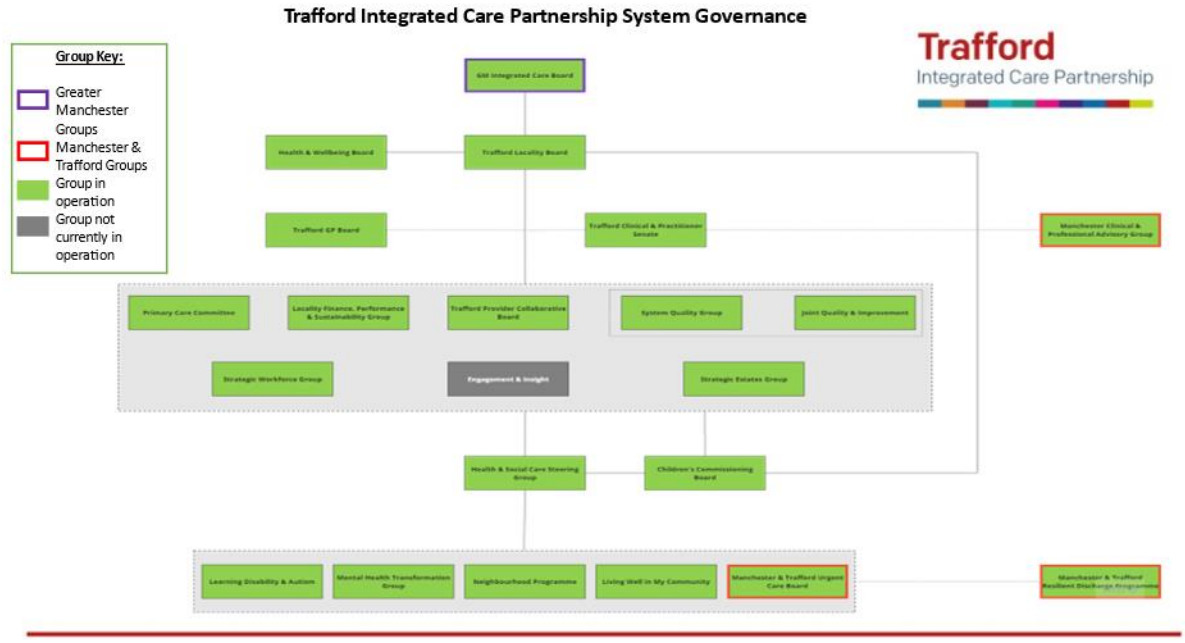
We have ensured that the BCF services/schemes are aligned to the three Trafford Provider Collaborative Board Strategic Priorities (23/24) and the more granular thematic priorities of the various partnership groups that drive forward the work of the BCF schemes are corralled via our regular (monthly) multi-stakeholder Health and Social Care Steering Group.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The health and care governance structure has evolved significantly since the introduction of the ICS arrangements and disestablishment of Clinical Commissioning Groups. The current Trafford system governance is outlined in Figure 1 below and demonstrates our commitment to an inclusive set of governance arrangements across the Trafford system with full partner engagement/membership.

Figure 1:



The behaviours and ways of working which we aspire to have embedded in all our partnerships forums is encapsulated in our Health and Wellbeing Board (HWB), Trafford Locality Board and Trafford Provider Collaborative Board Terms of Reference, all which have been recently updated and formally signed off by partners (Terms of Reference available on request). The Boards function based on the following operating principles:

- Collaborative working
- Embedding a population health management approach
- Value for money
- Promoting innovation, and encouraging new ideas from patients/service users, carers and the workforce
- Champion both locality and neighbourhood service coordination through our integrated neighbourhood model
- Seek to avoid and identify any conflicts of interest

It is important to note the formalised governance that is operational in Trafford, particularly the arrangements of the Trafford Locality Board. The Locality Board incorporates three elements/'forums' and thus carries out three distinct roles:

1. Consultative forum
2. ICB Committee
3. Section 75 Committee

Of particular importance is the Section 75 Committee:

"A forum through which relevant section 75 arrangements are managed ("Section 75 Committee"). Section 75 arrangements will be managed, and decisions will be taken in accordance with requisite delegated authority given to core members of the Section 75 Committee by their respective organisations. Trafford Locality Board partners who do not have delegated authority in respect of section 75 arrangements will be able to participate in discussions regarding the section 75 arrangements, subject to conflict of interest rules, but will not be able to take de cisions in relation to section 75 arrangements."

The final sign-off of the BCF Plan is the responsibility of the Trafford Health and Wellbeing Board. It is also where assurance is sought that the BCF plan not only aligns to the wider aspirations of the Locality Plan but also contributes towards the Health and Wellbeing Strategy, specifically reducing health inequalities.

We committed in the 2019 Locality Plan to work with our partners on how we create together a culture of co-production that becomes our normal way of working – to plan, design and deliver services together with our partners and the Trafford public, where appropriate. The creation of our Locality Board and the Trafford Provider Collaborative Board as described above are the vehicles by which we will deliver against our system priorities, including the aims of the BCF. The Trafford Provider Collaborative Board has three strategic priorities which are refreshed on an annual basis and the detail of the BCF is operationally overseen through these arrangements with formal escalation to both the Health and Wellbeing Board and the Locality Board.

Below is a list of system partners who are active members of some/all of our locality governance arrangements:

- Trafford Council (Various Directorates)
- Manchester Foundation Trust (MFT)
- Trafford Local Care Organisation (Part of MFT)
- Greater Manchester Mental Health Foundation Trust
- Trafford General Practice Board
- Healthwatch Trafford
- MasterCall (Out of hours provider)
- Trafford Community Collective (VCFSE Representative)
- Thrive (VCFSE Locality Infrastructure Organisation)
- Independent Social Care Providers (Nominated representative)
- Trafford Leisure
- Greater Manchester Police
- Department for Work and Pensions

Executive summary

Trafford's BCF Plans this year are in some respects aligned to previous BCF submissions. However, we have built upon these foundations to create innovative and creative models which ensure our people can remain living well at home for as long as practicably possible.

The priorities for Trafford Locality include the following relevant outcomes to the BCF plan:

- Reduced proportion of admissions to long term care with increased proportion of people living independently at home for longer
- Reduced emergency admissions to hospital
- Increased proportion of people who return to living independently following a hospital admission
- Reduced 'No Criteria to Reside'

The targets agreed by system partners are detailed in the main BCF submission template and the following summarises how they will be achieved within the 4 KPIs are as follows:

- **Avoidable admissions- indirectly standardised rate of admission per 100,000 population**

- **Discharge to usual place of residence:** > % of people, who are discharged from acute care to their usual place of residence

- **Permanent admissions to residential & nursing 24 hour care: long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes per 100.000 population**-< % of people being admitted to 24 hour care facilities across the Borough

- **Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services:** >% of people remaining at home following an episode of care/treatment.

National Condition 1: Overall BCF plan and approach to integration

Trafford has a long-standing commitment to integration across health and care. Our section 75 incorporates the BCF, Discharge to Assess (D2A) and Learning Disability provision. The section 75 gives lead commissioning responsibility to the Council for the sourcing of D2A beds and provision of homecare. The ICB leads on the clinical elements.

A joint Trafford Council and NHS GM (Trafford) finance group meets on a regular basis to discuss s75 activity, joint ventures and additional areas of work which may have more indirect impact. It is also pertinent to mention the standing up of a formal Finance, Sustainability and Performance Group which will report into the Trafford Locality Board on locally delegated resources. The Locality Board also receives reports on the s75 performance indicators and activity.

We have built our plan around our place and in Trafford this is our four neighbourhoods, our locality and working with other localities in Greater Manchester. We remain committed in Trafford to ways of working that put into practice, our principles and the difference these make to the people we serve. The principles in our 2019-24 Locality Plan remain a key focus as we recover from the pandemic;

- Together as Partners – co-ordinating across our health and social care system, thinking bigger and doing better using our combined resources to improve outcomes for residents.
- In a Place – being positive about our places and spaces, bringing people who live and work in an area together to build stronger communities.
- With People – putting residents at the heart of what we do, listening and working with people.
- Focusing on Prevention – commitment to taking action early and making every contact count.
- Continually improving – making the most of technology and using data and information to make shared decisions. We will continue to learn and develop our workforce and make the best use of our combined assets

The Age Well programme will focus on the delivery of an initial set of Neighbourhood le d services which are a combination of national must do's and gaps identified through our needs assessment , i.e.:-

- Crisis Reponses
- Case Management
- Enhanced Care in Care Homes

This will support the delivery of Core 20PLUS, to provide the right care and support reduces inequalities and address health needs improving outcomes.
New initiatives are described under the relevant headings to prevent duplication.

National Condition 2

Neighbourhood Working (Better Care at Home)

We aim to achieve the objectives set out in the NHS Long Term Plan, through an integrated neighbourhood model with system partners, looking to support individuals with multiple long-term conditions, including frailty to remain well at home.

With the support delivered by a multi-disciplinary team (MDT) , we are confident that our approach will contribute to reduced avoidable episodes of ill health which result in the need for the individual to access unplanned or emergency care. With holistic assessment, personalised care & support planning, coordinated care by the MDT agreeing interventions and support, people will be supported to stay at home, achieve better outcomes for their health & wellbeing while addressing and reducing health inequalities for this group.

Community including community nursing

In recent years, Trafford has placed great importance on the fundamental role of our Neighbourhood model in ensuring we have a social model for health – rather than a predominantly medical one – which focuses on the importance of people and communities as well as health and care services.

The Trafford Neighbourhood model is consistent with the Greater Manchester Model for Health which is based on core principles of co-production, working with people and communities rather than 'doing to'. The Neighbourhood model is the key to making our model for health a reality, ensuring that people are supported to live well with the support they need, whether they're diagnosed with a long-term condition, cancer, dementia, or they're at the end of their life and receiving palliative care.

Our model aims to bring about a shift in the culture of how people approach health and wellbeing, making it more person-centred and community based. It will allow residents and patients to build more personal resilience, increased confidence in self-management as well as addressing their health and social needs. People will be empowered and supported in their independence. Neighbourhoods will strengthen communities and networks to support individuals where required through localised, enhanced and faster access to services.

Trafford system is committed to work together across different partners and services to make the best use of our resources whilst encouraging collaboration. We want to create opportunities to support residents to prevent ill health. We will embed a population health management method and nurture a 'prevention-first' approach that builds on our community assets. It will be co-owned and designed with our residents to support their health and wellbeing needs now and in the future.

We champion locality and neighbourhood service coordination. We work on the principle that organising health and social care service delivery on Neighbourhood footprints creates opportunities for frontline staff to work together in places. This will improve the quality and integration of services and the extent to which they are joined up for residents. The outcomes will be reduced duplication and ensuring people are in control of their care

This will be delivered via:

- Four core Integrated Neighbourhood Teams (INT's) which consist of case management, children's services, adult social care, community nursing, communication and engagement and care navigators.
- Voluntary, Community, Faith and Social Enterprise sector (VCFSE) offer wrapped around the Core Integrated Neighbourhood Teams.
- Primary Care Networks (PCNs) are a key stakeholder within wider Integrated Neighbourhood Teams, with delivery underpinned by the priorities within the Primary Care Direct Enhanced Service (DES).
- Other services such as Palliative Care Nursing, Learning Disability and safeguarding specialists will also be reached out/brought into the integrated neighbourhood teams in a flexible and adaptive manner.
- Realignment of community nursing roles to support new models of Proactive Care (Anticipatory Care).
- Strategic Leadership will be provided by Neighbourhood Leadership Team which includes leads from; Social Care, District Nursing, Mental Health, General Practice and VSCFE.
- Introduction of Trafford Urgent Community Response Service

Technology and Equipment

Our ethos is to ensure that all our people can remain living well at home for as long as possible and to maximise the opportunities, we must use modern solutions. We are investing in our Technology Enhanced Care (TEC) offer and have explored several options include the using of robotics, sensors and connectivity through the Internet of Things to prompt self-care and support independence.

Age UK Passion for life and dementia

The aim of the service for the Dementia Advisors is to ensure that Trafford residents living with dementia and their carers receive high quality information, advice, advocacy and support which promotes independence, increases choice and focuses on social support, peer networks and community cohesion to enable them to live an independent and fulfilling life. Passion for Life is a Day Service that supports those with a Dementia Diagnosis in various sites across the Borough of Trafford.

1:1 Hours

During the Pandemic, the Trafford system witnessed significant changes in the way Health and Social Care operated, one significant change was that our Social Workers were removed from the hospital sites (except for a duty worker for increased complex situations including Safeguarding. This was mainly driven by the National requirement of all Health Social Care partners developing a Discharge to Assess (D2A) offer to meet increasing demand. We simply needed our resources in the

Community to ensure that we could ensure our residents needs were assessed in a timely manner and enabled to return home as soon as reasonably practicable.

As we witnessed the significant restrictions on our people's liberty being infringed with these high levels of intrusive care, it is important to note that the financial costs were also sizeable and reliant on a Social Care professional assessing our people to reduce/remove the 1:1 associated care.

Therefore, in 2021/2022, the Trafford system made the decision to commission our own 1:1 support with a local Care Agency called Cucumber, with a detailed contact which enabled the Local Authority to deploy & cease care when the person no longer needed it, operating this Trusted Assessor model.

- The benefits to our people meant that they only received the right care at the right time
- We were able to deploy our 1:1 workforce where required & not being reliant on the Care Homes sourcing their own 1:1, sometimes at £27-£30 per hour
- We were able to support more of our people who are 'more complex' quicker as the LA supplied the 1:1 care
- We are paying £17.86 per hour, which is currently less that our framework provider rate
- It was the Right thing to do!

Handy Person Service

We have invested in our practical services this year to support the speedy transition from Hospital to Home with a particular focus on making sure that the home is a safe environment to go home to, and meets the person's needs where these have changed as a result of needing care and clinical interventions. This will include filling service gaps such as the removal and moving of furniture, putting curtain rails up and preparing the home to ensure it is a safe environment to go home to from hospital. The Council have commissioned Helping Hands, a not-for-profit social enterprise to provide this service.

Home Care Capacity

Throughout the pandemic we accessed several centrally funded grants, one of which supported one of our providers to purchase a vehicle.

This has enabled the provider to delivery in excess of 500 additional homecare hours in areas of the Borough where transport links are extremely limited, and time restrained and where employees did not have access to their own vehicles.

We have agreed to extend this model through 2023/24.

Stroke Support Service

Stroke Association delivers Stroke Recovery Service for Trafford residents who have experience d a stroke, their families, and carers. The service works with local community stroke teams and other partner organisations to ensure the service is complements the local system and that together they improve people affected by stroke's long-term outcomes

- Coordinated support throughout your stroke journey
- Home visits and/or regular telephone calls

- Emotional support
- Tailored information including communication tools
- Assistance with accessing community-based support
- Support for carers and family members including monthly carers drop in at Trafford General Hospital for newly diagnosed stroke survivors.
- Living well after stroke groups
- Childhood Stroke Support Team has been supporting parents of children who have had a stroke

Ascot House

Ascot House is our 24 hour intermediate care facility within the Borough of Trafford for both community and hospital discharge.

Ascot House is the longstanding provider of Trafford's intermediate care provision, enabling the Trafford system to monitor changes in demand and capacity over a substantial period of time The utilisation of intermediate care beds at Ascot House has maintained relatively consistent levels over the last few years enabling the system to anticipate periods where demand will peak. The number of beds commissioned at Ascot House as been sufficient to manage demand and no additional capacity has been commissioned from alternative providers. Whilst temporary closures of units due to Covid outbreaks impacted on the number of beds open between 2020-2022, 35/36 beds have been consistently open at Ascot House (IMC Unit) between April 2022- March 2023, with the Year to Date (YTD) average occupancy rate of 79%, with a low of 59.3% (April 22) and a high of 92.3% (July 22).

Whilst beds were not up to full establishment of 36 beds in previous years, average YTD occupancy in 20/21 and 21/22 was 73%.

Through the efforts of service and improvements made with regards to patient flow, occupancy rates within Ascot House have improved over time however, utilisation remains under 80% which indicates there is an ability to drive greater utilisation or a review of the number of beds required.

Ascot House currently provides a therapy-led (rather than nursing) model of care. Working in partnership, Trafford system is undertaking a review of this model during 23/24 to identify if there is there is an unmet need for patients with nursing needs who would benefit from bed based intermediate care. Through the introduction of the Rapid MDT in Discharge to Assess beds, the service will identify any patients who should be stepped down from a Pathway 3 bed to intermediate care within the current criteria, and those we could have been supported within intermediate care setting if there was an increase in nursing provision.

This review is also considering the impact of the introduction of Trafford's Community Response service and whether this will enable more patients to be discharged directly home with support, thereby reducing the number of intermediate care beds required within the system.

The impact of introduction of new service offers and their impact on intermediate care bed-based utilisation will be monitored via the Trafford Resilient Discharge Programme and the D2A Assurance Dashboard with reports to Trafford Provider Collaborative on a quarterly basis.

Health Recovery Beds

Throughout 2022-23 it was identified that there was a relatively small number of patients who required a period of recovery prior to receiving rehabilitation or prior to long -term care needs being able to be assessed, taking them outside of D2A pathway 3 assessment period of 8 weeks. Prior to 2022-23 a patient would have experienced a long length of stay in hospital impacting on patient experience and flow through hospital sites.

Subsequently, in January 2023, the Trafford system introduced health recovery beds which are spot purchased in local care homes. This new pathway and provision are managed and commissioned via Trafford's Urgent Care Control Room, which is run and managed by Trafford's Urgent Care Integrated Health & Social Care Team within the Trafford Local Care Organisation (TLCO). To date, 8 health recovery beds have been commissioned and has included:

- Patients who require fractures to heal before rehabilitation can be delivered.
- Stroke patients who have received intensive rehabilitation within specialist stroke units and determined to require long-term residential or nursing care.

Trafford Community Response

Trafford Community Response (TCR) is part of the Trafford Local Care Organisation (TLCO) and provides assessment and short-term interventions including crisis intervention and supported hospital discharge with therapy / nursing input where required.

There are four main aims of TCR:

- Support people to remain at home
- Help people avoid going into hospital unnecessarily.
- Help people return home from hospital as soon as they are medically safe to do so
- Prevent people from having to move into a residential home until they really need to.

Services in the TCR will be integrated with health & social care colleagues forming specialist community teams. The service will provide the 2-hour crisis response, support hospital discharge with nursing and therapy input and will over the coming months work to integrate more community services such as Community IV.

The TCR is designed to be a short-term intervention with possible onward referral to another service if appropriate, including other parts of the Trafford Community Response (TCR) service or wider LCO.

The role of the service is to prevent hospital admission and attendance at urgent care services by assessing, diagnosing, and treating people experiencing a health and social care crisis that requires an inter-disciplinary intervention. The team supports a clinical triage process, supporting the point of entry into the Trafford Community Response service. This includes the Northwest Ambulance Service referral via 999 or 111 as well as via ambulance crews on scene. The team provides an intensive support service for up to 48 hours, before either discharging the person, or making onward appropriate referrals.

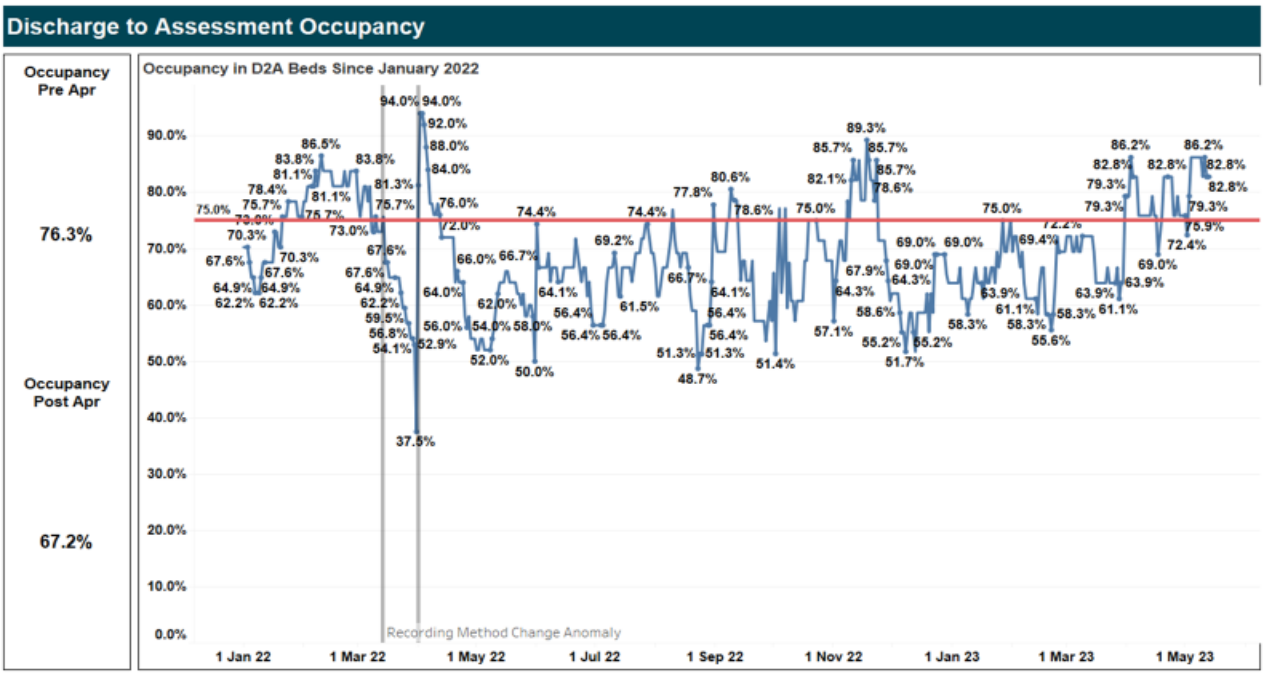
Trafford Resilient Discharge Model

Following the introduction of the hospital discharge guidance and the subsequent increase in residents being discharged for an assessment for long term care into bed-based care, we saw an increase in the complexity of health conditions being managed within a Pathway 3 D2A bed setting, and challenges regarding medications on discharge. This posed significant capacity challenges to General Practice, as these patients required timely review by a clinician. Without timely review and intervention there is an increased risk of patients being readmitted to hospital. Subsequently, the Trafford system commissioned a single GP provider, supported by pharmacists, to provide general practice support for block and spot purchased Discharge to Assess beds. This service provides:

- Temporary Registration of all people
- Provide 3 hours of medical cover per day 5 days per week
- Prescribe both repeat and acute medication as requested/in line with a consultation.
- Action any recommendations from the medicine's optimisation team.
- Service focused on ensuring a safe discharge, proactive care, supporting residents to get the medical care needed by working closely with the wider MDT team and being a single point of contact for primary medical care.
- Leading the MDT approach to care co-ordination.
- Ensuring optimal prescribing support by working in partnership with the dedicated medicines optimisation personnel
- Ad hoc requests from care homes
- Work with the Rapid MDT to D2A Team

Demand and capacity

We monitor capacity and demand across the system together with how we make use of the resources we have commissioned. We look at the number of people under Right to Reside who require support to be discharged, number of people who are discharged across the pathways and available capacity of those services to meet need.



This example shows the activity and use of block purchased D2A beds – we decommission if there is poor response by a provider and/or under use of beds, and spot purchase to increase capacity when there is limited resource.

Our demand predictions are based on the past 3 years level activity and have been in the main fairly accurate – however the key challenges for us is the need to respond to changing activity levels from partners, which is often unprecedented and changes in line with national policy – e.g. increased targets for hospital discharge.

Asset Based Community Capacity

We have employed several Community Link Officers across Adult Social Care to ensure our residents are supported from a preventative perspective. These roles are key to ensuring our people can access universal services and community resources to ensure their needs can be met at neighbourhood level.

Ageing Well Integrated Crisis and Rapid Response - Small team that provides rapid response to crisis in residential and nursing homes for over 65s

Trafford's urgent and emergency care systems have been under significant pressure for a sustained period. Within Trafford an aging population with comorbidities has contributed to increased levels of activity within urgent care across both Manchester and Trafford services.

Similarly, to other localities and areas around the country, Trafford urgent care services have all experienced significant challenges with rising activity levels, increased complexity of need, pressure on beds and in enabling safe and effective discharge. This has meant that the services within the community to support people at home and reduce the need for admission to hospital are becoming even more vital. Urgent Care community services are needing to manage higher levels of demand, acuity, and complexity than traditionally offered. People often have health and social care needs which means that the service offer needs to be provided through a multi-disciplinary approach, with teams working in collaboration with other services. This needs staff with different, developed, and enhanced skills.

Within Trafford our community response service consists of a range of specialists including; Nurses, Social Workers, Therapists and pharmacists.

Trafford Community Response (TCR)

Trafford Community Response (TCR) is part of the TLCO and provides assessment and short-term interventions including crisis intervention and supported hospital discharge with therapy / nursing input where required.

There are four main aims of TCR:

- Support people to remain at home
- Help people avoid going into hospital unnecessarily.
- Help people return home from hospital as soon as they are medically safe to do so

- Prevent people from having to move into a residential home until they really need to.

Services in the TCR will be integrated with health and social care colleagues forming specialist community teams. The service will provide the 2-hour crisis response, support hospital discharge with nursing, social work and therapy input and will over the coming months work to integrate more community services such as Community Intravenous Therapy service (CIV).

The TCR is designed to be a short-term intervention with possible onward referral to another service(s) if appropriate, including other parts of the wider Trafford system service.

The role of the service is to prevent hospital admission and attendance at urgent care services by assessing, diagnosing, and treating people experiencing a health and social care crisis that requires an inter-disciplinary intervention. The team supports a clinical triage process, supporting the point of entry into the Trafford Community Response service. This includes the Northwest Ambulance Service referral via 999 or 111 as well as via ambulance crews on scene. The team provides an intensive support service for up to 48 hours, before either discharging the person, or making onward appropriate referrals.

Integrated Crisis and Rapid Response – Alternative to Transfer (ATT)

The Trafford ATT Service is provided by Mastercall Healthcare. The service is for referrals directly from NWAS or from a Care Home. The service is for those patients where their condition is not life-threatening, but they may be at risk of admission that day due to a medical need. The service provides advice, guidance, and medical intervention where necessary. A senior clinical assessment takes place with a GP who can also arrange to visit the patient in their own home or refer on appropriately.

- Patients can be referred into the service via 999/111/NWAS pathways, GMCAS and Care homes directly
- The service is available 24 hours a day 365 days a year including Bank Holidays
- The ATT service triages all referrals and offer an appropriate response to the presenting issue. This may entail management digitally or through a face-to-face visit, verbal treatment advice, reassurance, or signposting.
- Urgent medical care resolution- potential follow up with Primary Care within the 2-hour response time
- All age all conditions Minimal exclusions
- Short-term assessments and interventions for people in their own homes or place or residence/on scene resolution (to be left in place of safety i.e. in a building)
- All ages in Trafford (no under 2 unless red refusal); any Trafford resident or Out of Area patient within the locality on scene
- GPs supported by wider MDT consisting of ACP/CP/TN/Pharmacist (meds management team)
- ATT/+ is Paramedic and Care Home referral 24/7. Referrals are also accepted from Greater Manchester Clinical Assessment Service (GMCAS) and LCAS directly booked.

The service also supports Red Refusals (unless under 2) within the community via NWAS.

The ATT service is a well-established service within Trafford. The developments taking place around the establishment of a Trafford Community Response also provides further opportunity to integrate and join up the different services available within the locality.

Integrated Crisis and Rapid Response – Trafford Patient Assessment Service (TPAS)

TPAS is the Clinical Assessment Service provided by Mastercall Healthcare who is the Out of Hours (OOH) provider for the Trafford locality. The TPAS supports the Urgent Treatment Centre (UTC) at Trafford General Hospital (TGH) for people who have been referred to the service via 111/999 or another alternative route such as GPs, OOH, ATT, Community Health & Social Care and received an outcome of attend the UTC at TGH.

Most cases that are referred to the TPAS are closed as advice and/or a prescription and do not need to see anyone face to face. Others are referred or booked into an appropriate service if they cannot be closed following initial conversation/consultation. This direct booking will also be undertaken by the TPAS and could be to a range of services across the system that are now interconnected because of the direct booking functionality including UTCs, Emergency Departments and Primary Care.

Clinical Assessment Service models are a key component mandated in the Integrated Urgent Care (IUC) service specification that turned the 111 signposting and referral service, primarily manned by call handlers with junior clinical support, into a full clinical service for Trafford.

Mastercall runs the TPAS service 8am-8pm in line with UTC operating times (note the TPAS operates 8am-8pm and is separate to the GMCAS).

All the service above will reduce the number of unplanned admissions to hospital for chronic ambulatory care sensitive conditions and emergency hospital admissions following a fall for people over the age of 65.

Falls

Within Trafford there are four priority areas in relation to falls:

1) Promote awareness of falls prevention to our residents and increase availability of strength and balance activity for older people.

2) Raise awareness and provide training for health and social care staff of the importance of falls prevention, and support them in delivering evidence based interventions

3) Focus particularly on preventing falls in Care Home and Social Care settings, including Home Care and unpaid carers, including exploring the increase of TEC and 1:1 additional support, additional training for the care home settings has also been provided including the encouragement of the adoption of the Safe Steps and Restore2 tools.

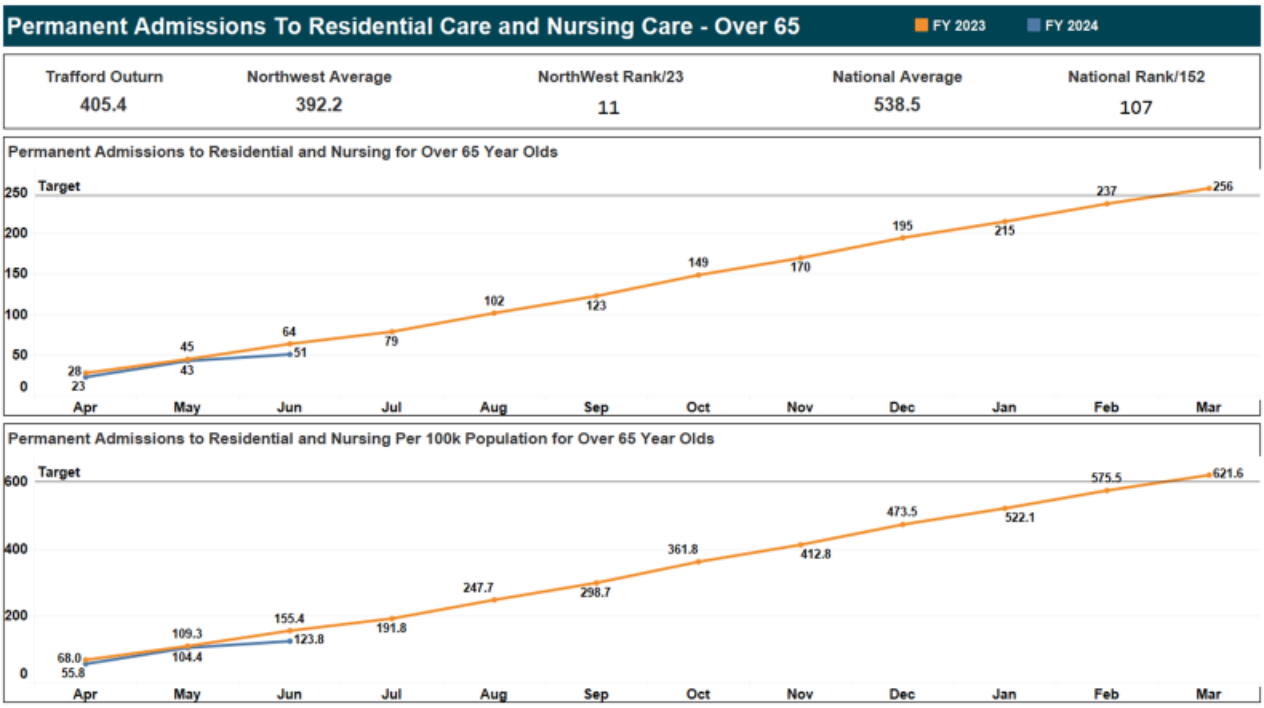
4) Review, revise and embed local falls prevention pathways. Trafford patients who experience a fall and are appropriate for lifting and support rather than conveyance to hospital are referred to the THT falls service via NWAS and will be lifted within their own place of residence.

In addition to this Trafford are also part of a wider GM Falls scheme provide s additional resilience to residents who may have experienced a fall.

Residential and Nursing Care Home admission

Our figures for long term admission continue to decrease year on year as more people choose to stay living at home with care and support . The reablement service we offer together with TEC builds peoples' confidence in making that decision. We only accommodate people in residential and/or nursing care homes where their needs cannot be met safely anywhere else. We have also funded a system Discharge to Assess (D2A) Programme non recurrently, which include GP an integrated assessment service to support discharge pathway choice for people in and out of D2A, therapy support as well as provision of beds and homecare. We continually review and skill up our reablement service to be able to meet the needs of people being discharged from hospital. Outcomes are continually monitored to look at how performance can be improved. Through our Section 75 we have invested in a crisis response service which will support this cohort of patients to stay well at home.

Long-term admission to residential care from D2A beds, is already low, and we are seeking to further reduce this through the expansion of the Rapid MDT which enables people to return home much more quickly. In addition, we have established a new post which will focus on ho using pathways where there is a barrier to someone returning directly home.



National Condition 3

Adults Discharge Fund (ADF)

We have six schemes funded through the ADF as detailed in the BCF Planning template (Excel). To maintain patient flow, the speed, complexity, and numbers of people being discharged has significantly increased along with the unit costs. Trafford has the highest bed cost in Greater Manchester. The cost of D2A beds is in keeping with these rates particularly as the speed with which people enter and leave D2A beds means that the care home staff have an average of 15 times the amount of assessment and discharge work that they have to do for every D2A bed as compared with an ordinary long-term bed. Our targets are 60 people per week which is an increase of 10 on last year. This is putting significant impact on our budget which is not fully offset by the ADF given that bed rates and homecare rates have increased considerably in line with the commitment to pay the Real Living Wage and inflationary increases which have hit the care sector particularly hard. In addition, many of our providers pay more than the Real Living Wage to attract and keep staff and maintain a safe service. We also commission Health D2A beds which are for people who require longer-term placements and support which cannot be provided at home, whilst they await a planned clinical intervention. Our GPs are unable to provide a comprehensive primary care service to our residents and the ADF has funded a contribution to the costs of the contract with a single practice to provide D2A cover. This arrangement enables the provision of complex support to the homes and facilitates the provision of continuity of support together with building close working relationships with the staff in the care homes. In addition, pharmacy support to people in D2A beds is also partially supported through the ADF. This alleviates the pressure on care homes and pharmacies due to the numbers being discharged and prevents the risk of people not having the right medication at the right time.

Trafford Resilient Discharge Programme

The Trafford system has reviewed our High Impact Change Model for transfers of care as part of our Strategic Locality Resilient Discharge Programme (RDP). This programme is aimed at ensuring compliance with; national guidance, clinical safety, providing quality care at the right time and meeting our ambition to ensure that our people can remain Living Well at Home or to a place of residence which meets their assessed needs and outcomes.

Our model of care delivers:

- Acute Trust 'Back to Basics' workstream is to develop a greater understanding of community resources to ensure people are discharged in accordance with our 'Home First principles' are at the point of discharge planning.
- Pathway 3 Discharge to Assess block and spot residential and nursing beds, commissioned within local Care Homes. Our demand modelling has developed since 2017, when we initially embarked on our D2A offer in Trafford.
- To support the timely assessment of residents within Discharge to Assess beds, a Rapid MDT Assessment Team has been established. This multi-disciplinary includes occupational therapy, physiotherapy, nursing, and social care to enable an initial MDT assessment to be undertaken within 48 of admission to a D2A bed. In addition to improving delivery of assessment within the 28-day target for D2A beds, this model ensures that people are on the correct pathway, enabling a change in pathways if clinically. Professionally appropriate

and wherever possible supporting residents to return home. This team subsequently acting as an additional safeguard to support the over prescription of long-term residential care.

- The Rapid MDT model and infrastructure is provided by the Urgent Care Control room as part of its wider system support to provide timely and effective discharge through joint working across the social and health system.
- A small pilot where we adopted the Rapid MDT methodology identified that our people were returning home sooner and between 10-20 days than would have typically been expected with Social Care only interventions.

Community IV Therapies – Delivery of IV in Community to avoid use of hospital capacity

Trafford has a dedicated Community IV service that is provided via the TLCO. This service was commissioned to provide support to 15 patients per month that otherwise would have been in an acute setting/hospital bed.

The IV service supports patients and the local system by:

- Increased patient experience;
- Providing care closer to home;
- Reduction in hospital acquired infection;
- Joined up integrated working between the hospitals and community teams;
- Improvement of patient choice;
- Facilitates early discharge
- Reduces patient admission waiting times by freeing up beds;
- Attendance and admission avoidance (for step up patients)

The Trafford Community IV therapy service aims to ensure the development of:

- An accessible and responsive service that provides patient-centred care either in a patient's home or in an ambulatory clinic setting.
- Provide a service to all Trafford GP registered patients requiring IV therapy in the community. The provision of service delivery for both step-up and step-down patients.
- A focus on outcomes To establish pathways to take patients from A&E, Ambulatory Care, GPs, and the Community Equitable access to the service across the whole of the borough.
- Integration with the local health and social care system.
- Manage patient and public expectations.
- Collaboration and engagement between providers.
- Consistent and proactive use of Shared Care records

Most patients that have been able to access the service have been stepped down from an acute setting; reducing length of stay and reducing the risk of hospital acquired infection/pneumonia whilst providing care closer to home. There is also a cohort of patients within the community who can be stepped up into IV via a community referral usually via a GP or Community service. This then supports both an ED attendance and hospital admission whilst also ensuring the patients can be treated or managed within their own homes where appropriate.

Trafford locality is working with the TLCO to scope the opportunity for enhancement of the service within the locality and the implications for the IV service with the development of the Hospital at

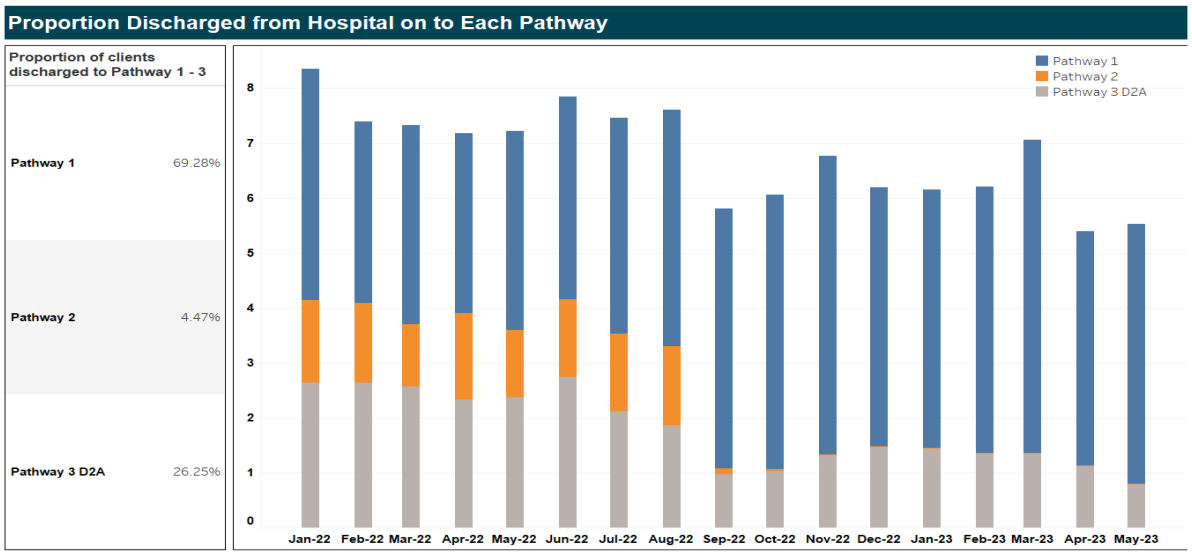
Home programme (incorporating virtual wards) and the enhancement of the Trafford Community Response service

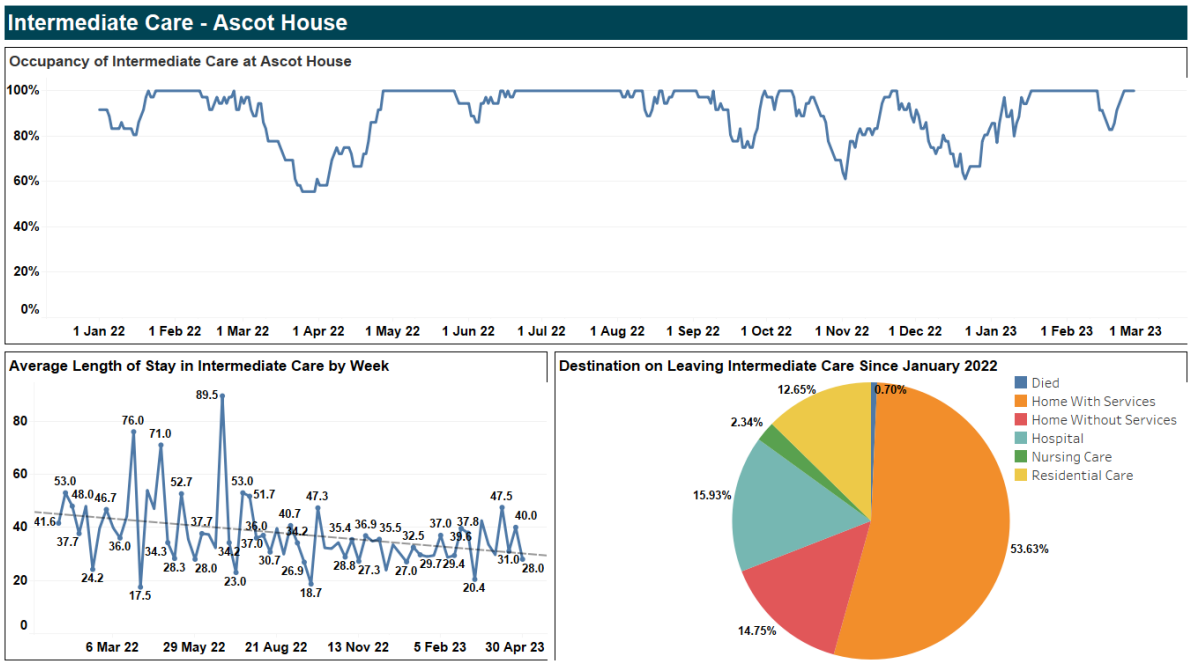
Voluntary Community Faith Social Enterprise (VCFSE) & Statutory Services

Statutory services and our commissioned care and support providers cannot possibly deliver everything for our residents. Consequently, we have decided to invest further in our V CFSE sector to deliver our Living Room projects where our people can attend to not only stay warm but also to engage in meaningful activities including; homework clubs, coffee mornings, afternoon tea, yoga, meaningfulness sessions etc. Further support for our 'Living Rooms' can be found at Trafford Community Hubs (traffordhubs.org)

For example, The Toy House is an inspirational community asset which provides local support to the residents of Urmston (West Trafford locality) and neighbouring areas. They provide a timetable of person-centred activities across an all ages from new mothers, people experiencing mental health associated needs ,older aged adults and adults with a learning disability. The Toy House have asked for additional support to 'grow' their volunteer workforce and we think by promoting our Personal Assistant (PA) offer for those in receipt of Direct Payments (DP's) or Personal Health Budgets (PHB's) is an opportunity to develop a structured approach into paid employment.

As detailed in response to National Condition 2, Ascot House is the long standing provider of intermediate care provision in Trafford. The monitoring of capacity and demand and utilisation of 36 bedded provision is monitored via Trafford's Discharge to Assess Assurance Dashboard which reports to Trafford Provider Collaborative on a quarterly basis. This demonstrates that the current 36 intermediate care beds commissioned are sufficient to meet demand, including periods of increase in demand such as over Winter. Please find current rates of discharges per discharge to Assess pathway and the utilisation of Ascot House below:





As 14.75% of people returning home from Ascot House with no further input from services, this may indicate that there is a over-prescription in the use of bed based rehabilitation and an opportunity for more people to return directly home from hospital with therapy support. This opportunity will be tested through the introduction of the Pathway 1 Discharge to Assess support within the new Trafford Community Response service and the additional community occupational therapy and physiotherapy this provides. The impact of the introduction of this service on the utilisation of Ascot House beds will be closely monitored over the next 12 months, with the outcomes considered within the current review of Trafford's Intermediate Care Model.

Additional Staffing in Care Hub & Control Room

We know that sometimes, people remain in hospital longer than necessary due to reasons which pertain to their accommodation related needs. It may be an environmental issue, health and safety or personal issue. Whilst the needs of the people which fall into the above category may not have 'eligible' care and support needs (under the Care Act, 2014 (Statutory Duty for Local Authority), ensuring people can leave hospital is the right thing to do.

Consequentially, we have secured additional capacity to address the complex housing related issues, our people face by employment of a dedicated Lead (fixed term contract 23/24). Further, we are working more closely with our Housing colleagues to ensure hotel capacity is brokered where required.

Social Work Resource in Emergency Department

We recognise that on occasion our residents are admitted to hospital due to non-medical reasons where they could be cared for at home. We have therefore agreed we will pilot the presence of a Social Worker in the Emergency Department of Wythenshawe Hospital to see if this model would be effective to support our residents more holistically as opposed to a hospital admission.

Early Supported Hospital Discharge-Rapid MDT

We know that once our residents are discharged from hospital and enter our D2A provision, more than 87% of people return home.

This may be because of several reasons, but we believe if we had a Health & Social Care model which met people on their first day this may improve our residents' outcomes even further.

The Council have developed this pilot in partnership with, Greater Manchester Integrated Care, Manchester University Foundation Trust (MFT), who will be providing Occupational Therapy & Physiotherapy assessments & interventions to support individuals during this assessment period.

Provision of Equipment to enable Single Handed Care

The purpose of this project is to ensure our people receive a dignified and less restrictive level of care where their assessed needs have been identified as requiring the support of two registered carers. This project has been delayed due to difficulty in recruiting Occupational Therapy support.

By maximising a modern approach to equipment, this will result in care only being required to be delivered by one carer as opposed to two: maximising our workforce capacity

We learnt prior to the global pandemic, that this approach worked effectively for both our residents and workforce, and we want to build on this through 2023/2024.

The BCF and the iBCF form part of our approach to discharging some of our Care Act (2014) statutory duties and functions.

Provision of Advocacy

Advocacy Focus delivers a range of statutory advocacy: Independent Mental Health Advocacy (IMHA), Independent Mental Capacity Advocacy (IMCA), Care Act Advocacy, NHS Complaints Advocacy, and Child Protection Advocacy (CPA). A recent addition of support delivered by Advocacy Focus is Peer Advocacy. There are 16 individuals that are members of the group. The service is also preparing for the introduction of LPS (Liberty Protection Safeguards), in the future, and is focusing on bringing the waiting lists down. The Trafford Advocacy Hub currently operates a waiting list due to high demand on services. They are fully staffed in line with our original budget and additional funding has been provided to extend capacity in line with demand. When Advocacy Focus took over the contract in 2018, 71 eligible cases were handed over and active within the service, today they work with an average of 211 people which is a 197% increase in demand.

Quality Assurance & Improvement

We have developed a Quality Assurance Lead to ensure that the care people receive of a high standard and is informed by our people's voice. The post holder also ensures that we have effective, safe, and good quality assurance to enable us to discharge our statutory duties and identify any subsequent learning. The Council commissioning team has co-produced an i-Tool with providers and this tool measures the quality of service. The team work closely with the providers to ensure best practice and develop and monitor improvement plans where there are concerns about the quality of a service. We have monthly meetings where the ICB, TLCO and the Council review the quality of commissioned provision across the system.

Urgent Care Control Room

We have temporarily increased our capacity across both Social Care and Health Assessment and Commissioning resources to ensure that we can support as many people as possible to return to their natural place of residence. The demands on data requests and greater assurance, visibility across the system has further increased, resulting in additional positions initially being tested as a 'proof of concept'.

Supporting unpaid carers

The Trafford system BCF plans and BCF funded services consider support for unpaid carers, and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Respite for Carers

The Trafford system is committed to ensuring that our people can receive the right care at the right time. In order to achieve this, we are developing in collaboration with a homecare provider an overnight support service for our residents during times of need (including overnight7 days a week). This usually occurs when their informal carer has become unwell or has been admitted to hospital.

This approach will ensure that the person being 'cared for' will be able to remain in their own home and will avoid any further distress/unrest or hospital admission. Our Social Care and Health workforce would then undertake an assessment of the person's needs the following working day.

Supporting Health & Wellbeing of Carers

The Carers Centre is a substantial resource for our informal carers, and they have requested support to ensure that our carers are aware of the support that is available to them specifically where their loved one is in a hospital setting. Our Carers Ambassadors will be available initially at our Wythenshawe hospital site and will provide additional resources to enable our carers to make informed decisions.

We believe that all carers have the right to be recognised, respected, valued, and supported both in their caring role and as individuals in their own right. Trafford Carers Centre support our carers through the provision of counselling, digital support, direct payments and information and advice. The Council and the ICS work in partnership with the Carers' Centre to ensure that where the independent assessments carried out by the Carers Centre recommend respite, that Carers breaks are available. Advice, information, and signposting is also provided by our Citizens Advice Bureau, in-house welfare services and our local community hubs.

From April to June 2023, the Centre achieved the following:

The Centre also offers Carers Awareness Training and support the roll out of our Employers for Carers initiative. We have funded a hospital discharge project to support carers of people who are being discharged from Trafford General Hospital. The outcomes are extremely positive at Q1 – A worker has been recruited to lead the work. Drop-ins have been established on each ward and awareness raising events held. The Hospital Discharge lead is now in the process of establishing carers' champions on each ward, together with establishing a carers' group. The lead has also raised awareness generally. The events have led to 28 new referrals for information and support.

Disabled Facilities Grant (DFG) and wider services

The Trafford system works collaboratively across health, housing and social care to maximise the availability of accessible housing to enable people to live for longer in their own homes. We consider all aspects of a person's life – not just the accessibility of their home, but also their access to local facilities and the community. We ensure that where possible, people are offered viable housing alternatives to adaptations, which are often extremely disruptive. We also offer grants to support the move. Where these are not available or desirable, we work with the family to develop a cost-effective solution to maintain independence. We consider the lifetime needs of the disabled person in designing an outcome. Our Older People's Housing Strategy outlines several actions to improve our range of housing choices from providing information to encouraging the development of more extra-care housing to support our population. The actions in this plan are regularly updated.

Older-Peoples-Housing-Strategy-2020-25-A-Plan-on-a-Page.pdf (trafford.gov.uk)

At a Greater Manchester level, we have developed a Healthy Homes initiative and we are seeking additional funding in order to implement the same offer of support across all GM boroughs. We meet regularly to share best practice at a strategic level. Managers of the Adaptations team also meet regularly to discuss operational issues.

GM Healthy Homes Final Report Jan 2023

We also have a number of Ageing Well initiatives to support people earlier on in their care journey, preventing hospital admission and maintaining optimum health for as long as possible. In addition, we also support older people to remain happy and healthy through our Age Well Plan which is based on the WHO Age Friendly Community approach. Age Well Plan (traffordpartnership.org) We work closely with the planning department and our Registered Providers to maximise the availability of

extra care provision within the borough which meets HAPPI standards and are in the process of developing our Market Position Statement for older people to provide a framework for this discussion. The number of adaptations requested are now increasing as we receive more OT assessments from an externally commissioned provider. We regularly review and report back on activity.

Adaptations Report May 23.docx

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Yes - We agreed an RRO in 2018 to enable the provision of

- Moving Assistant Grant – this provides support to people who would live a better life if they moved to an alternative property. The take up of this grant has been very low and we are working with our Registered Providers to promote it again. There is no upper limit for this provision.
- The increase of the DFG upper limit to £50,000 – this particularly supported adaptations for families where there is a disabled child. The table below details those adaptations which are in excess of £50,000 – there is no upper limit in line with our statutory responsibility (and case law) to meet need.

details	gross_grant	certified	landlord (owners left blank)	Age
a ground floor facilities	50,958.03	20-Jun-19	Irwell Valley Homes	47
a ground floor bedroom and shower room facilities	61,769.60	26-Jul-19		55
a ground floor bedroom and bathroom with hoist	56,730.05	30-Aug-19		12
a ground floor facilities	63,549.43	26-Sep-19		35
a ground floor bed/shower room	64,820.84	11-Mar-20		62
a ground floor facilities, wheelchair access to property	58,878.13	02-Jul-20		68
a aquanova scorpio 1800 bath, ramped access rear & fro	55,849.79	09-Mar-21	L&Q	65
a ground floor bedroom/shower room	57,777.55	16-Mar-21	L&Q	6
access to front/back garden & ground floor bed/shower ro	68,933.33	18-Jun-21		6
a ground floor facilities bedroom & wetroom	51,513.36	14-Mar-22	L&Q	83
a ground floor wheelchair accessible bedroom & shower r	81,804.71	14-Dec-22	L&Q	55
a ground floor facilities	117,436.77	10-Mar-23	Irwell Valley Homes	12
a ground floor facilites	84,759.64	14-Apr-23		6
a ground floor facilities	69,853.40	25-May-23	L&Q	7
a ground floor facilities	82,437.26	09-Jun-23	L&Q	44
a ground floor wetroom and clos o mat	60,711.73	13-Jun-23	L&Q	38
a ground floor facilities	78,796.75	16-Jun-23		6
a ground floor facilities	66,915.80	11-Jul-23		5

Equality and health inequalities

Via our established system governance, the Trafford system is working with people, communities and partners, particularly in deprived areas, to improve the physical and mental health of all our residents. The diversity of Trafford's population is one of our greatest strengths and we want all our neighbourhoods to have thriving and healthy communities. However, some groups are currently

disadvantaged – not just in life expectancy but in areas such as housing and poverty that can contribute to poorer health. The recent published Census and our local analysis has helped informed targeted support and activity in our neighbourhood model.

Our ambition to reduce health inequalities is driven by our Health and Wellbeing Board Strategy and Trafford Locality Board and operationalised through our Trafford Provider Collaborative Board which oversees effective delivery of the schemes contained within the BCF. These governance arrangements also ensure that organisational health inequality strategies are connected and that efforts to tackle inequalities across our Trafford Integrate Care Partnership are effectively deployed – including GM system Board efforts to address the priorities laid out in NHS Core 20 Plus 5.

Our Neighbourhood plans, which include priority pathways for change that address inequalities, are planned, designed, and delivered in our four Neighbourhoods. A series of 6 coproduction workshops in each neighbourhood with Trafford citizens and stakeholders have gathered local intelligence to reinforce the PCN, public health and census data which has informed the first iteration of neighbourhood plans – with outcome data being shared back through formal governance via our Locality Performance Framework.

Where applicable, the schemes within our BCF Plan have taken into account the NHS Core 20 Plus 5 clinical areas of focus (Maternity; Severe mental illness (SMI); Chronic respiratory disease; Early cancer diagnosis; Hypertension) and work to ensure these areas are addressed is governed through our Trafford Provider Collaborative Board, with wider support and scrutiny from the Health and Wellbeing Board and specific GM forums.

Conversations have started through Locality Board and Health Scrutiny on planning to support differential neighbourhood spend based on need, to improve outcomes and reduce inequalities. Engagement with the population at Neighbourhood level has commenced in our dedicated Long-Term Conditions and Mental Health programmes, so that services can be shaped to reduce inequalities and prevent the need for urgent care.

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.

4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

7. Please ensure that all boxes on the checklist are green before submission.

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

HM Government

NHS England

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Trafford	
Completed by:	Natalie Foley	
E-mail:	Natalie.Foley@nhs.net	
Contact number:	07785 725 603	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Thu 20/07/2023	<< Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Jane	Slater	jane.slater@trafford.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Mark	Fisher	mark.fisher11@nhs.net
	Additional ICB(s) contacts if relevant	Trafford Place Based Lead	Sara	Todd	Sara.Todd@trafford.gov.uk
	Local Authority Chief Executive		Sara	Todd	Sara.Todd@trafford.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Nathan	Atkinson	Nathan.Atkinson@trafford.gov.uk
	Better Care Fund Lead Official	Joint for Trafford ICB	Gareth	James	gareth.james1@nhs.net
	LA Section 151 Officer		Graeme	Bentley	Graeme.Bentley@trafford.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Trafford

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,469,979	£2,469,979	£2,469,979	£2,469,979	£0
Minimum NHS Contribution	£19,396,441	£20,494,280	£19,396,441	£20,494,280	£0
iBCF	£8,224,415	£8,224,415	£8,224,415	£8,224,415	£0
Additional LA Contribution	£3,280,000	£500,000	£3,280,000	£500,000	£0
Additional ICB Contribution	£1,184,270	£1,184,270	£1,184,270	£1,184,270	£0
Local Authority Discharge Funding	£1,153,050	£1,922,000	£1,153,050	£1,922,000	£0
ICB Discharge Funding	£1,044,156	£1,606,278	£1,044,156	£1,606,278	£0
Total	**£36,752,312**	**£36,401,222**	**£36,752,311**	**£36,401,222**	**£1**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£5,511,918	£5,823,893
Planned spend	£11,928,113	£12,603,244

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£7,468,328	£7,891,035
Planned spend	£7,645,460	£8,091,035

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	193.2	169.8	185.3	135.9

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,067.9	2,003.0
	Count	936	917
	Population	41946	42394

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	91.5%	91.5%	91.5%	91.5%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	816	559

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	92.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Trafford

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	For predicted VCSE numbers, the BRC are currently carrying out a test of change where they are working closley with the interaarted discharge teams based in the acute hospital setting.we are awaiting the results of this project. The reablement numbers are based on the avergae number of clients we have accesing those services in a month. The capacity figures are for community reablement are based on the maximum number of people we have placed in a day and the D2A daily capacity has been calculated by using the average occupancy There is nothing included for Short term domicilary care (pathway 1) as we don't provide this, we operate a SAMS model and have included this demand/capacity under reablement at home (pathway 1).

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

(Select as many as you need)

Trust Referral Source	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	12	12	12	12	12	12	12	12	12	12	12	12
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	Reablement at home (pathway 1)	40	40	40	40	40	40	40	40	40	40	40	40
	Rehabilitation at home (pathway 1)												
	Short term domiciliary care (pathway 1)												
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)												
(Please select Trust/s.....)	Rehabilitation in a bedded setting (pathway 2)	28	28	28	28	28	28	28	28	28	28	28	28
(Please select Trust/s.....)	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	36	36	29	29	29	30	30	34	36	36	36	36
Totals	**Total:**	251	251	244	244	244	245	245	249	251	251	251	251

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	18	18	18	18	18	18	18	18	18	18	18	18
Urgent Community Response	54	75	74	87	69	106	129	114	147	123	99	107
Reablement at home	6	6	6	6	6	6	6	6	6	6	6	6
Rehabilitation at home												
Reablement in a bedded setting	4	4	4	4	4	4	4	4	4	4	4	4
Rehabilitation in a bedded setting												
Other short-term social care												

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	18	30	30	30	30	30	30	32	33	33	32	30
Reablement at Home	Monthly capacity. Number of new clients.	76	76	76	76	76	76	76	76	76	76	76	76
Rehabilitation at home	Monthly capacity. Number of new clients.												
Short term domiciliary care	Monthly capacity. Number of new clients.												
Reablement in a bedded setting	Monthly capacity. Number of new clients.												
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	36	36	36	36	36	36	36	36	36	36	36	36
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	41	41	36	36	36	36	37	42	45	45	45	45

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	30	30	30	30	30	30	30	32	33	33	32	30
Urgent Community Response	Monthly capacity. Number of new clients.	216	300	296	348	276	425	516	456	588	492	396	426
Reablement at Home	Monthly capacity. Number of new clients.	15	15	15	15	15	15	15	15	15	15	15	15
Rehabilitation at home	Monthly capacity. Number of new clients.												

Reablement in a bedded setting	Monthly capacity. Number of new clients.	5	5	5	5	5	5	5	5	5	5	5	5
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.												
Other short-term social care	Monthly capacity. Number of new clients.												

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Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Trafford

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Trafford	£2,469,979	£2,469,979
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£2,469,979**	**£2,469,979**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Trafford	£1,153,050	£1,922,000

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Greater Manchester ICB	£1,044,156	£1,606,278
Total ICB Discharge Fund Contribution	£1,044,156	£1,606,278

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Trafford	£8,224,415	£8,224,415
Total iBCF Contribution	**£8,224,415**	**£8,224,415**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Trafford	£1,289,000	£500,000	Additional contribution to Hospital Discharge Costs
Trafford	£1,991,000	£0	Reserve carry forward
Total Additional Local Authority Contribution	**£3,280,000**	**£500,000**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Greater Manchester ICB	£19,396,441	£20,494,280
Total NHS Minimum Contribution	**£19,396,441**	**£20,494,280**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS Greater Manchester ICB	£1,184,270	£1,184,270	Additional charitable grants and contracts identified in
Total Additional NHS Contribution	**£1,184,270**	**£1,184,270**	
Total NHS Contribution	**£20,580,711**	**£21,678,550**	

	2023-24	2024-25
Total BCF Pooled Budget	**£36,752,312**	**£36,401,222**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Trafford

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,469,979	£2,469,979	£0	£2,469,979	£2,469,979	£0
Minimum NHS Contribution	£19,396,441	£19,396,441	£0	£20,494,280	£20,494,280	£0
iBCF	£8,224,415	£8,224,415	£0	£8,224,415	£8,224,415	£0
Additional LA Contribution	£3,280,000	£3,280,000	£0	£500,000	£500,000	£0
Additional NHS Contribution	£1,184,270	£1,184,270	£0	£1,184,270	£1,184,270	£0
Local Authority Discharge Funding	£1,153,050	£1,153,050	£0	£1,922,000	£1,922,000	£0
ICB Discharge Funding	£1,044,156	£1,044,156		£1,606,278	£1,606,278	£0
Total	**£36,752,312**	**£36,752,311**	**£1**	**£36,401,222**	**£36,401,222**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£5,511,918	£11,928,113	£0	£5,823,893	£12,603,244	£0
Adult Social Care services spend from the minimum ICB allocations	£7,468,328	£7,645,460	£0	£7,891,035	£8,091,035	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

>> Incomplete fields on row number(s):

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
29	D2A Beds	Temporary beds to expedite hospital discharges	Residential Placements	Short term residential care (without rehabilitation or reablement input)		4	12	Number of beds/Placements	Social Care		LA			Private Sector	Local Authority Discharge
30	Homecare (D2A)	Temporary homecare packages to expedite hospital discharges	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		50864	71211	Hours of care	Social Care		LA			Private Sector	Local Authority Discharge

31	Health D2A Assessments	Temporary beds to expedite hospital discharges	Residential Placements	Short term residential care (without rehabilitation or reablement input)		37	80	Number of beds/Placements	Continuing Care		NHS			Private Sector	ICB Discharge Funding
32	GP Cover	GP cover for residents in D2A beds	Residential Placements	Other		75	107	Number of beds/Placements	Primary Care		NHS			NHS	ICB Discharge Funding
33	Medicines Management	Pharmacy cover for residents in D2A beds	Residential Placements	Other		75	107	Number of beds/Placements	Primary Care		NHS			NHS	ICB Discharge Funding
34	D2A Beds	Temporary beds to expedite hospital discharges	Residential Placements	Short term residential care (without rehabilitation or reablement input)		4	4	Number of beds/Placements	Social Care		LA			Private Sector	ICB Discharge Funding
35	D2A Beds	Temporary beds to expedite hospital discharges	Residential Placements	Short term residential care (without rehabilitation or reablement input)		30	11	Number of beds/Placements	Social Care		LA			Private Sector	Additional LA Contribution
36	1:1 hours	Cucumber Scheme	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes	1:1 hours deployed by LA to support				Social Care		LA			Private Sector	Additional LA Contribution
37	Additional Staff ing in Care Hub and Control room	Additional capacity in the care hub and control and Adnin and analytical support	Workforce recruitment and retention						Social Care		LA			Private Sector	Additional LA Contribution
38	Handy Person service	Additional capacity in the adaptations service to prevent delayed discharges.	High Impact Change Model for Managing Transfer of Care	Housing and related services					Social Care		LA			Private Sector	Additional LA Contribution
39	Training	Enhanced Training to providers and Personal Assistants	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Private Sector	Additional LA Contribution
40	Trusted Assessor	Pathway 1 including overnight care and Trusted Assessment with Homecare	High Impact Change Model for Managing Transfer of Care	Trusted Assessment	Person centred trusted assesments				Social Care		LA			Private Sector	Additional LA Contribution
41	Homecare Capacity	Enhancing capacity in homecare through the provision of transport to care	Home Care or Domiciliary Care	Domiciliary care workforce development		26000	26000	Hours of care	Social Care		LA			Private Sector	Additional LA Contribution
42	Equipment	Provision of equipment to enable single handed care.	Assistive Technologies and Equipment	Community based equipment		106	0	Number of beneficiaries	Social Care		LA			Private Sector	Additional LA Contribution
43	Support for Care Homes	to provide one off support payments to care homes to assist with market	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Private Sector	Additional LA Contribution

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Trafford

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	194.3	170.8	185.2	166.0	The 22/23 outturn was 687.56 against a plan of 759 - so 11% better than plan. This is the 2nd best rate in GM and significantly better than the GM average of 907 and national average of 772. As such, I have added in a modest 1% reduction for 23/24.	We are continuing to develop and improve this indicator through a range of initiatives within the locality. This will be achieved through working with system partners and commissioned providers to ensure that where possible reductions are made in avoidable admissions. The Manchester and Trafford system are also focussing on a
	Number of Admissions	487	428	464	-		
	Population	236,370	236,370	236,370	236,370		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	193.2	169.8	185.3	135.9		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,159.1	2,067.9	2,003.0	Target for falls in over 65's for BCF 23/24. The figures for the number of falls in 21/22 and 22/23 were 939 and 936 respectively. This gave age standardised rates per 100,00 pop of 2,162 and 2,068 – roughly in line with national average of 2,100. A further reduction of 2% is factored in for 23/24 resulting from the 4 priority areas for falls	Within Trafford there are four priority areas in relation to falls: 1) Promote awareness of falls prevention to our residents and increase availability of strength and balancy activity for older people. 2) Raise awareness and provide training for health and social care staff of the importance of falls prevention, and support them in delivering evidence based
	Count	935	936	917		
	Population	41,469	41946	42394		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal	Quarter (%)	91.6%	91.5%	90.9%	91.6%	Discharge to usual place of residence 22/23 - outturn of 91.1%, just below target but .6% point improvement on 21/22 figure of 90.5%. Rise from 8th to 6th	We have strengthened our VCSE and extended it to support a 7 day discharge process for people on Pathway 0. The funding is time limited. The pathways
	Numerator	4,288	4,247	4,256	4,286		
	Denominator	4,681	4,643	4,680	4,680		

		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	91.5%	91.5%	91.5%	91.5%	in GM. Aim for 22/23 is to further improve and reach the GM average of 91.5%.	home with reablement support have been streamlined, and work undertaken on ensuring correct referrals to make best use of limited resources - these actions should improve performance in these areas. MFT
	Numerator	4,300	4,300	4,300	4,300		
	Denominator	4,700	4,700	4,700	4,700		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	815.6	552.0	580.3	558.6	We have commissioned a new suite of service responses to enable people to be discharged home with enhanced levels of support where required. We are currently reviewing this and enhancing our low level response and identifying how we can	Reduction of long-term admission to residential care from D2A beds, is already low, and we are seeking to further reduce this through the expansion of the Rapid MDT which eanbles people to return home much more quickly. In addition, we have
	Numerator	338	234	246	240		
	Denominator	41,443	42,394	42,394	42,962		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	92.3%	92.0%	91.9%	92.0%	As a system we have continued to work across all areas to ensure that timely assessment is undertaken either within hospital or within a D2A bed. The D2A beds have had further support through the alignment of Primary care to individual	We have a number of meaures to increase independence and support people to remain at home following discharge including,; enhanced training for carers, syringe drivers for safe and dignfied end of life care, increased use of TEC, services to
	Numerator	179	219	271	275		
	Denominator	194	238	295	299		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Operational Local Health Economy Outbreak Plan

Trafford
June 2023

V15 [REVIEW DATE: 16/06/23]

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11.00	08-02-23	Addition	Added Glossary of Terms and Annex 7 & 8
11.00	12-02-23	Amendment	Update to Part 3 to include other communicable diseases and tables added
11.00	28-02-23	Amendment	Removed CCG & PHE references
12:00	28-04-23	Amendment	Updated following SME comments
13.00	15-05-23	Amendment	Update of DPH
14.00	22-05-23	Amendment	Updated following further SME comments
15:00	16-06-23	Sent	Document sent for approval

Approval

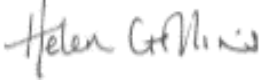
Approving group/body: FOR BOROUGH PLAN	Approval date
Local Health Protection Group	
HERG (for awareness)	
Local DPH	28.2.23
UKHSA North West	03.05.23

Foreword:

Maintaining and improving the health of our communities is at the heart of public service delivery. Health protection and ensuring an effective response to outbreaks of disease is a crucial part of this. Whilst the response to outbreaks is not new and whilst our local health economy routinely demonstrates that it has effective arrangements in place, it is important that we review our arrangements, and that the organisations and people who need to work together in partnership are aware of each other's roles and responsibilities for a range of scenarios.

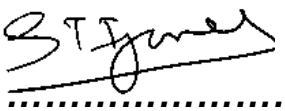
This plan has been developed to ensure clarity on operational roles and responsibilities for each responding organisation in the event of an outbreak. It is intended to act as a companion to the GM Multi-agency Outbreak Plan, providing operational detail helping responders quickly provide an effective and coordinated approach to outbreaks of communicable disease. It is important for each organisation, having signed off this plan, to support staff to engage in appropriate exercising to embed the multi-agency response to an outbreak and create familiarity over key tasks.

Signed



Helen Gollins, Director of Public Health

Signed



Gareth James, Deputy Place Based Lead, NHS GM ICB Trafford

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Glossary of Terms

ASC	Adult social care
CCDC	Consultant in Communicable Disease Control
CCG	Clinical Commissioning Group (now NHS GM ICB Trafford
CHP	Consultant in Health Protection
CICPT	Community Infection Prevention Control Team
DPH	Director of Public Health
FIO	Forward Incident Officer
FT	Foundation Trust
GM ICS	Greater Manchester Integrated Care System
HCAIs	Health Care Associated Infections
HP	Health Protection
HPT	Health Protection Team (at UKHSA)
ILI	Influenza like illness
IPC	Infection prevention and control
ICP	Integrated Care Partnership
LA	Local Authority
LCT	Local Co-ordination Group
LOCT	Local Outbreak Control Team
LRF	Local Resilience Forum
OCT	Outbreak Control Team
OHID	Office of Health Improvement and Disparities
PEP	Post exposure prophylaxis
PGD	Patient Group Direction
TCIPCT	Trafford Community Infection Prevention Control Team
UKHSA	UK Health Security Agency (formerly PHE)

PART 1: AIM, OBJECTIVES and scope OF THE PLAN

1.1 Aim of the Plan

To set out the multi-agency operational arrangements for responding to **outbreaks** of human infectious diseases within the borough of Trafford.

1.2 Objectives of the Plan

- To outline roles and responsibilities at a local operational level
- To outline the key tasks / activities involved in responding to outbreaks
- To give key considerations and outline some specific requirements needed for different outbreaks

1.3 Scope / Context of the Plan

- Outbreak and incidents of human infectious diseases which could impact Trafford.
- Outbreaks and incidents requiring an OCT: see part 2 and 3
- Outbreaks and incidents not requiring an OCT: see part 4

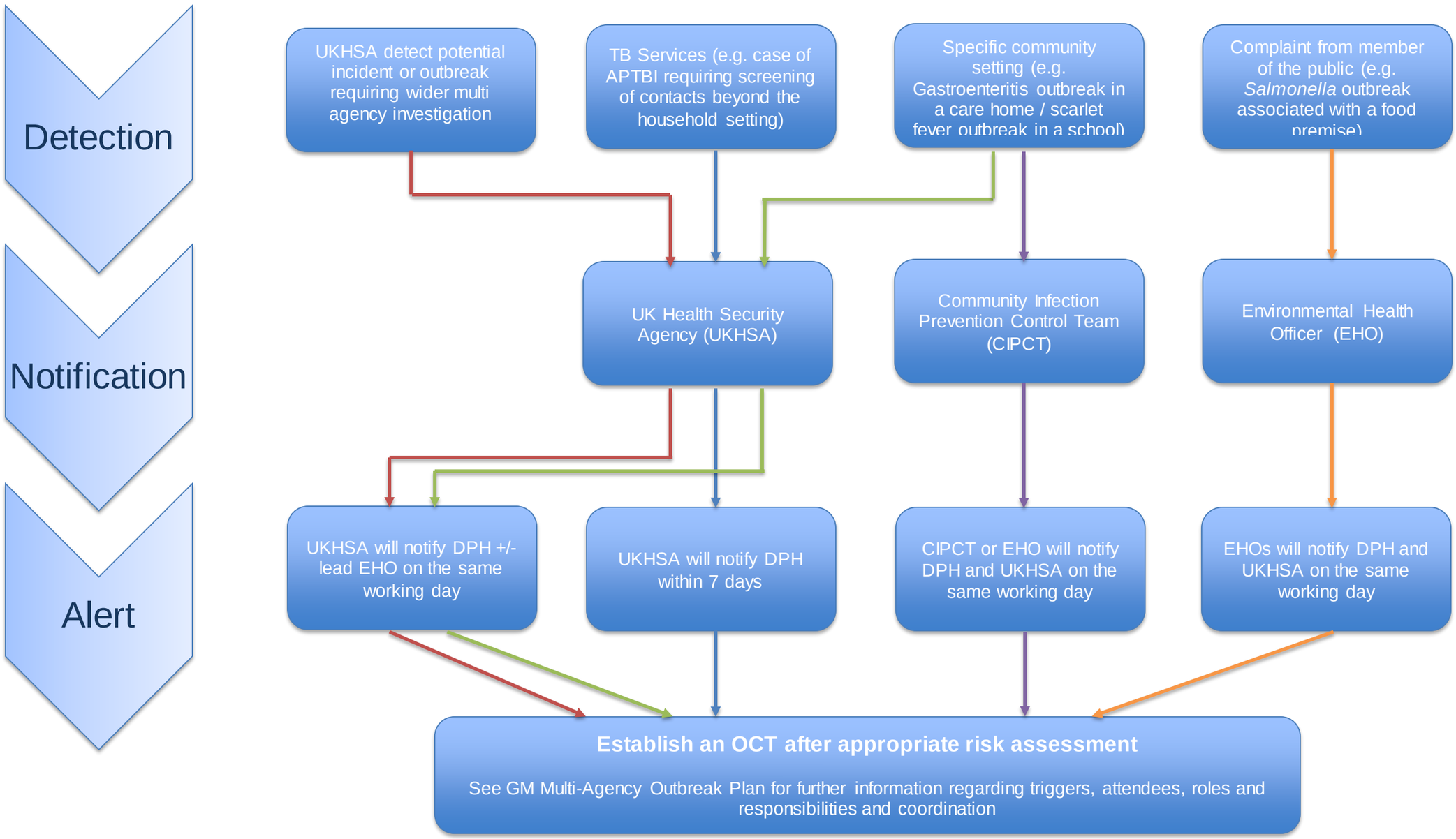
1.4 Complementary Guidance and Documentation

- National: PHE Outbreak operational guidance / UKHSA pathogen-specific guidance
- GM: GM Outbreak Plan (including Legionnaires Disease and High Consequence Infectious Disease (HCID) annexes) / Joint Flu SOP
- Local: Local guidance, standard operating procedures, reporting forms, etc can be found in Part 3 of this Plan.

PART 2: KEY ASPECTS OF OUTBREAK MANAGEMENT

2.1 Detection and Coordination

Outbreaks of disease are usually detected and alerted in the following ways:



2.2 Investigations

Investigation Roles and Responsibilities:

	Response activity		Potential responder(s)		Considerations, comments or potential issues
			In hours (9-5)	Out of hours	
Investigation (NB. Any setting where staff affected have access to Occupational Health, the investigation will be delivered through them)	Questionnaires / Interviews		*UKHSA*	*UKHSA*	*If notifiable (except sexual health clinics)*
			Hospital IPC team	*Hospital IPC team*	*For Acute Trust incidents*
			EHO	*UKHSA*	*Will investigate if foodborne outbreak / Legionella*
	Sampling	Respiratory samples (e.g., swabbing)	*NHS Provider / CIPC Team*	*NHS Provider (MFT and TLCO district nursing team). Care home-employed registered nurses. Mastercall*	*Clinical respiratory sampling will be undertaken by a nurse if nursing bedded facility, or by appropriately experienced care staff in a residential care home. CIPCT will arrange swab delivery (up to 5 sample kits) through UKHSA incident log (ILOG) number to collate results relating to an outbreak. These are delivered by courier to the home. Courier will wait and take samples directly to UKHSA lab for processing. Results vie 'e-lab' to CIPCT or reported via UKHSA on-call Health Protection Team for GM Out of Hours (OOH), weekend, Bank Holidays. if in a registered Care Home or a visiting community nurse if in a residential care home.* *Out of hours GP on call service is provided by Mastercall, with the support of Gemma Lister (Out of Hours service lead) and the Out of hours clinicians could swab up to 10 contacts during weekends or Bank Holiday period.*
		Faecal (GI outbreak)	*Environmental Health Officers*	*UKHSA*	*EHOs will deliver faecal sample kits if required in settings where food, sanitary, or waterborne infection suspected and return to lab for monitoring of results*
		Faecal (GI outbreak in a care home)	*Care home staff*	*Care home staff*	*CIPCT contact microbiology lab/UKHSA to obtain Incident Log (ILOG) number to be written on each specimen form. Care home will take to local GP for lab collection, or home will arrange drop off at hospital lab. Each home are required to keep stock of faecal sample pots, and specimen forms if OOH sample obtained (printed by GP practice on request in hours) CIPCT do not obtain faecal specimens*
		Oral fluid (e.g., Hepatitis (Hep) A outbreak, measles outbreak)	*Nursing bedded home – Nurse* *Residential bedded – CIPCT would be able to assist if requested* *In school or other community setting, community nurses contacted to request assistance on advice from UKHSA*	*N/A*	*Arranged by UKHSA via outbreak control team, can be self-administered or under the direction of CIPCT or community nursing teams*
		Urine test	*GPs, hospital, care home*	*OOH GP, hospital*	*Rarely required in outbreak settings, however potentially requested in pneumococcal outbreak for urinary antigen detection on advice of UKHSA OCT or microbiologist*

		Environmental (e.g., food / water)	*Environmental Health Officers / HSE / Relevant Contractor*	*EHOs*	*If Legionella also consider third party / legal duty holders e.g., water companies The contractor "Bureau Veritas" hold the contract for high risk environmental sampling GM Wide*
		Blood tests (e.g. testing for hepatitis A immunity)	*NHS providers*	*NHS providers*	*This the responsibility of the GP*
		TB test (*Mantoux)*	*TB nurses*	*NA*	*TB Team Lead Nurse: Ryan Noonan; TB Nurse -Tracey Magnall and colleagues at MRI, MFT 0161701 5034.*
		Scabies (skin scrape or clinical assessment)	*Primary care*	*Not needed*	*If 1 or more residents in a care home become symptomatic with scabies rash/itching, CIPCT will offer support and guidance around management and treatment which requires careful co-ordination. Skin scrapings are not obtained by the infection control team. GP or dermatologist (where possible/required) will be called upon for clinical diagnosis*
		Mass blood tests (e.g. IGRA testing) for TB	*TB nurses*		
		Mass X-Ray (incl. mobile x-ray)	*UKHSA with support from local health economy*	*Not needed*	*Unlikely to be required but can use Find and Treat if required. Would be agreed at OCT*
		Transport to lab	*Local lab transport system*	*NA*	*For respiratory samples – suspected Flu or other respiratory viral infection, courier will deliver to care home and return to lab. Other settings may need to return via GP or in some cases arrange own transport/hand delivery to MRI laboratory services for processing*
			Postal	*NA*	*GI samples may go through the post via UKHSA/EHOs*
			Local lab transport system	*Hand deliver*	*Viral swabs, e.g. for suspected outbreak of Influenza, must be delivered to Virology laboratory at MRI. For suspected respiratory outbreak in a care home, transport of oral swabs will be the responsibility of the care home. Postal systems have proved unsuccessful leading to delayed diagnosis*

Prior to an OCT being set up, UKHSA will liaise directly with relevant partners to recommend and coordinate investigations. Once an OCT is set up, the OCT will agree on coordination of investigations.
The types of investigation involved usually include:

- Epidemiological investigation: establishing links between cases/sources based on questioning of cases/NOK and information on settings.
- Microbiological investigations: where a sample is taken and sent for analysis to a laboratory. There are 2 types:
    - Clinical sampling: from human tissue (blood, respiratory secretions, salivary, faeces etc)
    - Environmental sampling: e.g., water, work surfaces etc.

2.3 Control Measures

Control: Roles and Responsibilities

	Response activity		Potential responder(s)		Considerations, comments or potential issues
			In hours (9-5)	Out of hours	
Control	Advice on infection, prevention & control measures		*CIPCT / EHOs / UKHSA*	*UKHSA*	*All of the agencies listed, advise on precautions and measures taken to control infection, e.g., advice around personal protective equipment, environmental cleaning, hand hygiene, isolation measures, care home closure, emergency transfers/admissions, sampling, treatment, etc. Telephone advice would be supplemented with email information and links to national guidance*
	Exclusion advice, also transfer and movement of affected individuals		*CIPCT / EHOs / UKHSA*	*UKHSA*	*Working to UKHSA and GM-led guidance and documentation for care homes and adult social care settings. Online Health Protection guidelines around exclusion or affected individuals in schools/childcare and community/workplace settings. Support and advice to education/childcare partners form CIPCT, and workplaces in the main from EHOs*
	Treatment and Prophylaxis (Including immunoglobin, vaccines, antivirals, antibiotics and anti-toxins)	Access			*Where Rx/PEP available (not available for all pathogens / outbreaks)*
		Prescription	*GP*	*Mastercall (Out of hours GP provider)*	Mastercall 0161 476 0400 option 2 *Public Health laboratory at MRI will support immunoglobulin provision*
		Dispensary	*Commissioned Community Pharmacies*	*Commissioned Community Pharmacies*	*Antiviral medication stock held by* **Malcolm's Pharmacy, 28 Flixton Road, Urmston, 0161 747 2277** *&* **Conran's Pharmacy 175 Moorside Road, Urmston M41 5SJ, 0161 755 0389.**
		Transport	*Usual pharmacy delivery*	*Care Home Collection*	*May require local response if the standard pharmacy delivery routes are not sufficient.*
		Payment	*ICP or LA*	*ICP or LA*	*Depending on whether antivirals are prescribed during flu season or out of season (as defined by Chief Medical Officer Central Alerting System)*
		Communication with cases / parents (e.g., consent forms)	*Consent - Professional administering the treatment.* *General information – CICN/UKHSA* *UKHSA/Trafford Council would support*	*Out of hours provider/care giver*	*The care giver would be responsible for communicating with their patient.* *Provider management would be responsible for communicating to their own staff. via the Medicines Optimisation in Care Homes team (Ahmed Saquib - saquibahmed@nhs.net or Lesley Buxton - lesley.buxton@nhs.net, or overarching meds optimisation team for cascading information to practices and pharmacies and supporting provision of prescription for anti-virals through GP practice* *Trafford Council for communicating to its own staff, and DPH would take the lead on communicating with elected members and public.* *UKHSA generally lead for press.*

		Mass vaccination	*NHSE, UKHSA, local Public Health, Trafford ICP, MFT and TLCO(both the CIPCT and community nurses)*	*N/A*	*NHSE would determine immunisation policy and pay for the vaccines.* *For delivery:* *Schools – School Nurses, MFT and TLCO* *Nursery – Health Visitors, MFT and TLCO* *Care homes – MFT and TLCOFT. Residential Homes only. All Community nurses will offer assistance where mass vaccination is required within an individual residential care home.* *The arrangements for Care homes registered for nursing are not in the MFT and TLCO contract. The ICP is responsible for commissioning care for all patient needs and would work with UKHSA to put a solution in place. There are two developments underway which may affect this is: 1). the development of a new comprehensive medical support service for care homes and 2) the development of the Primary Care Organisation – as the body which will eventually become responsible for provision of all primary care in the borough.*
		Mass chemoprophylaxis	*GPs*	*Mastercall (Out of hours GP provider)*	*Stocks of antiviral medication held by* Malcolm's Pharmacy, 28 Flixton Road, Urmston, Greater Manchester M41 5AA, 0161 747 2277 *&* Conran's Pharmacy 175 Moorside Road, Urmston M41 5SJ, 0161 755 0389 *Mastercall also holds a stock of antivirals (0161 476 0400 International House, Pepper Road, Hazel Grove Stockport SK7 5BW)*- Katrina Watts (Marsden) and Gemma Piron, 0161 474 2441 or 07824351894.
		BCG immunisation	*TB nurses*	*N/A*	*TB Nurses at MFT – Nurse Lead Ryan Noonan; TB Nurse Tracey Magnall; Team number: 0161 276 4387. Arrangements for children are currently under review with other boroughs in GM.TB*
	Enforcement of control measures		*Local Authority with UKHSA support*	*Local Authority with UKHSA support*	*In practice this has not happened, Environmental Health would only be likely to be involved if a Food Hygiene issue.*

Prior to an OCT being set up, UKHSA will liaise directly with the DPH and other relevant partners to recommend and coordinate control measures. Once an OCT is set up, the OCT will agree on coordination of control measures.

Control measures usually include:

- Identifying and controlling on-going sources. e.g. A cooling tower suspected of aerosolising Legionella, or a food premise with unsafe food preparation practice
- Preventing/limiting onwards spread
- Reducing likelihood of severe illness in specific vulnerable groups: usually by prompt post-exposure prophylaxis (PEP)

Where compliance with recommendations around control measures is an issue, enforcement powers may be used. For the purposes of outbreaks and health protection incidents, the bulk of enforcement powers lie with LA. Further info here: Chartered Institute of Environmental Health Toolkit / DoH guidance on Health Protection regulations

The key partners usually involved depend on which control measures are recommended, but most commonly, they ae:

- EHOs: IPC advice for cases/contacts of GI illness + enforcement powers
- CIPCTs: IPC advice and monitoring for community settings
- GPs: prescribing of Rx and PEP
- School nurses: delivery of PEP (e.g. vaccination) in a school setting
- NHS community providers (e.g. DNs): delivery of PEP in community settings (excluding schools) e.g. traveller site, university, care home…

2.4 Communications

Communications: Roles and Responsibilities

	Response activity		Potential responder(s)		Considerations, comments or potential issues
			In hours (9-5)	Out of hours	
Communications	To public	Setting specific advice letters (e.g. businesses, care homes, supported accommodation settings, day services)	*OCT / LA / EHO / UKHSA*	*UKHSA*	*DPH would likely write to schools and care homes, EHO would likely write to businesses.*
		Update NHS 111	*NHS GM Trafford/ UKHSA*	*UKHSA*	
		Helpline	*Trafford Council*	*Trafford Council*	*Scr and algorithm provided by UKHSA / LA*
		Websites / social media	*Trafford Council*	*Trafford Council*	*Trafford Council and NHS GM Trafford social media and website could be used.*
		Door to door	*Trafford Council*	*Trafford Council*	*Only needed in a community tension type scenario*
	To health partners	Briefings / sitrep's from OCT	*OCT and the stakeholders listed.*	*OCT if severity requires OOH response.*	*Include list of key local health economy partners (e.g. Hospital IPC Team, OOHs GPs, NHS 111, NWAS, Adults / Children's services, Social Care providers, other LA's)*
		Other relevant groups	*Responsibility of each agency*	*Responsibility of each agency*	
	To the media		*Coordinated by UKHSA via OCT*	*UKHSA via OCT*	*Include all partner agencies in discussion of key comms messages*
	To Elected Members / Committees e.g. Health and Wellbeing Boards		*DPH in LA*	*DPH in LA if serious*	
	Internal briefs		*Responsibility of each agency*	*If severity requires OOH response.*	*All agencies involved, NHS, Trafford Council.*

2.5 Funding Arrangements

Guiding principles:

- Protection of human health takes priority over funding challenges/financial discussions

- Where a local arrangement is in place re delivery of a certain aspect of the response (e.g. delivering an immunisation session in a school setting): partners must actively:
  - Involve key decision makers form the relevant agency to formally approve the agreement (i.e. do not assume that the organisation will do it)
  - Consider whether activity should be absorbed in existing contracts or whether additional funding is required and if so, which commissioner will sort this?

- Key commissioners in Trafford health economy include:
  - **NHS GM Trafford**, which commissions: acute services, mental health services, primary care services (GPs, some pharmacy schemes) community services incl. nursing (MFT and TLCO)
  - **Trafford Council, Public Health**, which commissions health services, including *school health and Trafford Community Infection Control Team, Manchester University NHS Foundation Trust.*
  - **Trafford Council, All-age commissioning,** which contracts with care providers, (Care home, home care Extra Care and Supported Living Services), Children's and Adult Social Care, Learning Disability
  - **GM Health and Social Care Partnership (GMHSCP),** which commissions *pharmacy services, immunisations.*
  - **Trafford Council, Environmental Health** which commissions Bureau Veritas as part of a GM contract

PART 3: LOCAL OPERATIONAL ARRANGEMENTS FOR SPECIFIC TYPES OF OUTBREAKS REQUIRING AN OCT

The documents underlined are to be found in the Outbreak Plan Accompanying Local Policies folder, which can all be found on the r: drive of the Council network, r:\IBU\CYPS\Public Health\Health Protection\Outbreak Plan\Accompanying Policies (see screenshot next page). Where there is no local policy, please refer to national guidance, policies and procedures.

- 3a Arrangements for an outbreak of Influenza like illness in a care home
- 3b Arrangements for investigating complex TB incidents
- 3c Arrangements for investigating and controlling a BBV outbreak/incident
- 3d Arrangements for meningococcal disease in a nursery/school/college
- 3e arrangements Hepatitis A in a school or childcare setting
- 3f Arrangements for outbreaks in seldom heard population

3a. Arrangements for an outbreak of Influenza like illness (ILI) in a care home

	Response Activity		Responders		Considerations
			In hours	Out of hours	
Investigations	Detection / Alerting	• Two or more residents or staff suffering from ILI • CICPT or UKHSA GM HPT if OOH alerted by home • Information for affected staff / residents taken • Outbreak email sent to relevant groups • Daily phone call made / Outbreak form sent to home to fill out and return to CICPT ICFT	• CICPT • GP • MFT virology	• UKHSA • Mastercall	** There is a detailed piece of work in progress at GM level
	Sampling	• Swabs to be obtained from up to 5 symptomatic people (most recent onset) • Swabs couriered to and from microbiology/virology at Manchester Foundation Trust (MFT) UKHSA labs for PCR • Sampling for SARS-CoV-2 / COVID-19 to be performed in conjunction.			
Control	Advice IPC	• Increased hand and respiratory hygiene measures advised • Home closed to admissions and visitors • Affected residents isolated until 5 days post symptoms • Affected staff excluded for 5 days • Deep clean before reopening	• CICPT • Mastercall • MFT virology	• UKHSA • Mastercall	• Residents may be difficult to isolate, e.g. dementia / provider configuration may be limited within period buildings
	Treatment / Prophylaxis	• OCT may need to be arranged to discuss management if difficult to contain outbreak and any operational issues identified by CIPCT • Antiviral treatment/prophylaxis prescribed and administered dependant on lab results and			

	Response Activity		Responders		Considerations
			In hours	Out of hours	
		CIPCT liaison with UKHSA HPT			
Comms	To care home	• Advice letters/newsletters/emails/outbreak info pack	• CICPT. • UKHSA comms • UKHSA comms	No out of hours comms needed	
	To health partners	• Outbreak email* • OCT minutes circulated			
	To media	• Coordinated by UKHSA via OCT			

3b. Arrangements for investigating complex TB incidents

	Response Activity		Responders		Considerations
			In hours	Out of hours	
Investigations	Detection/Alerting	• Notifiable disease • UKHSA / TB Nurse or CICPT alerted about greater than usual cases/linked cases • Alert TB services • Identify contacts of infected individuals	• UKHSA • TB services • CIPCT • NHS GM Trafford • Microbiology laboratory	UKHSA	
	Sampling	• Screen contacts / people in affected area • Large scale screening if needed • Relevant testing • Mass x-ray (including mobile x-ray)			
Control	Advice IPC	• Isolation • Hygiene measures • Provide advice/reassurance to worried individuals	• UKHSA • CIPCT • TB services TCIPCT	UKHSA (if necessary)	• Prescribing • Sourcing • Individuals not

	Response Activity		Responders		Considerations
			In hours	Out of hours	
	Treatment / Prophylaxis	• Mass vaccinations – BCG • TB antimicrobial therapy – via PGD or individual prescriptions • Consider latent infections	• NHS GM Trafford • District nursing • General Practice		complying with treatment due to complex social needs (e.g. homeless)
Comms	To public	• Advice letters • Update NHS 111, helpline, social media	• UKHSA comms	• There is no out of hours comms support. Silver Control will decide when comms need to be involved	
	To health partners	• Outbreak email* • OCT minutes circulated			
	To media	Coordinate by UKHSA via OCT			

3c. Arrangements for investigating and controlling blood-borne viruses (BBV)

	Response Activity		Responders		Considerations
			In hours	Out of hours	
Investigations	**Detection/Alerting**	• UKHSA/CIPCT notified when unusual numbers or cluster of cases	• UKHSA • CIPCT • CMFT Virology laboratory • GPs	UKHSA	
	Sampling	• Blood samples for virology • Screening of contacts • Screen for multiple BBVs			
Control	**Advice IPC**	• Explain routes of transmission • Hygiene measures	• UKHSA / Environmental Health • CIPCT • General Practice • Hospital Cons	UKHSA	• Prescribing • Sourcing
	Treatment/Prophylaxis	• PEP treatment for close contacts • Vaccinations for close contacts and other contacts (dependant on virus)			
Comms	**To public**	• Advice letters • Update NHS 111, helpline, social media	• UKHSA • CIPCT		
	To health partners	• Outbreak email* • OCT minutes circulated			
	To media	Coordinate by UKHSA via OCT			

3d. Investigating meningococcal disease in a nursery, school or college

	Response Activity		Responders		Considerations
			In hours	Out of hours	
Investigations	Detection/Alerting	• Meningococcal case notified to UKHSA • Identify close contacts	• UKHSA • CIPCT • School nurses / Health Visitors • Children's Services • Microbiology	UKHSA	
	Sampling	• No screening needed, but highlight symptoms and importance of urgent medical attention • Hospitalisation of anyone displaying symptoms			
Control	Advice IPC	• Highlight symptoms and importance of urgent medical attention	• UKHSA • CIPCT • School nurses / Health Visitors • GPs	UKHSA	• Prescribing • Sourcing
	Treatment/Prophylaxis	• Prophylactic antibiotics for close contacts • Check vaccination status of rest of school/college – offer vaccination for unimmunised			
Comms	To public	• Advice letters • Update NHS 111, helpline, social media	• UKHSA • CIPCT		
	To health partners	• Outbreak email* • OCT minutes circulated			

	To media	Coordinate by UKHSA via OCT			

3e. Investigating Hepatitis A in a school or childcare setting

	Response Activity		Responders		Considerations
			In hours	Out of hours	
Investigations	Detection/Alerting	• Notifiable disease • UKHSA/CIPCT notified of case(s) • Identify close contacts • Identify source	• UKHSA • CIPCT • School nurses / Health Visitors	UKHSA	
	Sampling	• Blood samples from all contacts for Hep A testing – students/staff/household			
Control	Advice IPC	• Increased hand hygiene, extra measures for close contacts	• UKHSA • CIPCT • School nurses / Health Visitors • GPs • NHS GM Trafford meds management • Environmental Health (food hygiene advice).		• Availability of sufficient vaccine • Ensure vaccinations are given in a timely manner
	Treatment/Prophylaxis	• No treatment available • Immunoglobulin therapy for household contacts • Vaccinate contacts			
Comms	To public	• Advice letters to schools/households	UKHSA Comms		

	To health partners	• Outbreak email* • OCT minutes circulated			
	To media	Coordinate by UKHSA via OCT			

3f. Investigating outbreaks in a seldom heard population (e.g measles at a traveller's site)

	Response Activity		Responders		Considerations
			In hours	Out of hours	
Investigations	Detection/Alerting	• Notifiable disease • UKHSA/CIPCT notified of case(s) • Identify close contacts • Identify source	• UKHSA • CIPCT • PH Specialist (Asylum seekers, Refugees & Travellers)	Mastercall	
	Sampling	UKHSA to provide kits if required			
Control	Advice IPC		• UKHSA • CIPCT • PH Specialist (Asylum seekers, Refugees & Travellers) • Environmental Health (food		Health visiting/school nursing maybe engaged depending on the context
	Treatment/Prophylaxis	Advice from UKHSA Mass vaccination onsite			

			hygiene advice).		
Comms	To public	• Advice letters to remaining traveller			
	To health partners	• Outbreak email* • OCT minutes circulated • Messages to GPs re increasing vaccine uptake / bringing forward routine vaccinations			
	To media	Coordinate by UKHSA via OCT			

*In the event of any of these outbreaks an email is sent out stating the location and nature of the outbreak, and the number of people affected. This is used to notify the following:

- Infection Prevention Team
- Adult Social Care
- NW Ambulance Service
- Environmental Health
- Consultant Microbiologists
- UKHSA

PART 4: LOCAL OPERATIONAL ARRANGEMENTS FOR SPECIFIC TYPES OF OUTBREAKS NOT REQUIRING AN OCT

Care homes

- *Management of outbreaks in Care homes:*
  - *Suspected viral Gastroenteritis*
  - *Respiratory (excluding seasonal influenza: this will be covered in Section 2). Often this will still require an OCT except during flu season.*

- *Management of PVL +ve MR/SSA incidents outside of the acute sector. CIPCT assist Primary Care if community incident or outbreak where required, to include advice and guidance around management and advice to patient or setting if required. OCT may be required if numerous cases identified in residential setting.*

- *iGAS (invasive A strep) – would be managed in collaboration with UKHSA*

APPENDICES

Annex 1: Stocks of Laboratory Testing Kits, Medication, and Other Equipment

Type of Stock	Where Located	Quantity	Arrangements for Access
Viral swabs	Meadway Health Centre, Sale, M33 4PP. Kept in the Small meeting room, in large brown envelopes.	Each envelope has 5 sets of swabs with instructions	Open 24/7. Would be the registered Nursing Care Home Manager, if residential care home would be community nursing team (MFT, Clinical Prioritisation Team who take the swabs 0161 975 4734. OOH 0300 323 0303. The care home manager has responsibility to take the specimens (regardless of who took them) **immediately** to the Virology Reception, Clinical Science Building at Manchester FT.
			Swab kits are available from the MRI Laboratory (0161 2768854 Option 1), and a small stock (up to 20 swabs).
Anti-viral	Malcolm's Pharmacy, 28 Flixton Road, Urmston, M41 5AA 0161 747 2277. Conran's Pharmacy 175 Moorside Road, Urmston M41 5SJ. 0161 755 0389. Other arrangements for OOH can be found in the On-Call pack.		Malcolm's pharmacy opening hours 7am-10pm Monday-Saturday 9am-7pm Sunday Conran's pharmacy opening hours 8am-11pm Monday-Saturday 9am-7pm Sunday Instructions for how to access are detailed on the On-Call pack for OOH
Stool specimen kits	Basement of Trafford Town Hall, the Environmental Health "bunker"	Approximately 20 kits	Via Environmental Health, Admin Team 0161 912 4509
Food sampling pots and bags	Basement of Trafford Town Hall, the Environmental Health "bunker"	Approximately 20 kits	Via Environmental Health, Admin Team 0161 912 4509

Annex 2: Potential Outbreak Settings or Sources

These are examples of community settings sometimes associated with outbreaks

- Care homes: nursing, residential, intermediate, extra care, supported living mixed etc
- Schools / Colleges
- Nurseries / Child minders / Play centres
- Children's residential homes and supported accommodation
- University / student accommodation – none in Trafford
- Food outlets
- Petting farms
- Swimming pools / water activity parks
- Dental practices
- Community health care settings (GP practices, Integrated Care centres etc.)
- Prisons / Detention Centres - none in Trafford
- Workplaces
- Ports / airports - none in Trafford
- Hotels
- Leisure Centres
- Travellers Sites
- Private camp sites / holiday parks
- Community Hospitals
- Hostels
- Tattoo Parlours
- Resettlement or bridging hotels

Annex 3: Common Pathogens

Below is a list of pathogens which can commonly cause outbreaks. This list is not exhaustive.

The full list of notifiable diseases is available here:

- Influenza
- Norovirus
- Scabies
- Tuberculosis
- Clostridium difficile
- PVL positive MR(S)SA
- Invasive Group A Streptococcal infection
- E Coli 0157
- Hepatitis A
- Meningitis
- Pertussis
- Legionnaires Disease
- Measles

Annex 4: Common Outbreak Scenarios and Challenges

Below is a list of relatively common outbreak scenarios, the usual response recommended by an Outbreak Control Team, and the common challenges encountered by local health economies in implementing these. It is not possible to cover every scenario, nor be overly prescriptive and specific circumstances of some situations might lend themselves to different practical solutions.

Outbreak Scenario	Recommended response	Usual partners providing the local response (provider + commissioner)	Common challenges for consideration	OOH response required?	Comments
Seasonal influenza outbreak in a care home, supported living scheme	-Swabbing of up to 5 most recently affected residents -Notification to GPs for consideration of AV -Isolation of affected individuals	Care homes MFT district nursing GPs NHS GM Trafford Medicines Optimisation in Care Homes Team	Ensuring swabs are taken promptly to the lab Difficulties in effectively isolating patients especially those who wander	Yes (09:00 -20:00 …not overnight)	NOTE: A dedicated piece of work is in progress at GM level, please refer to final report for detailed considerations
Outbreak of iGAS in a care home	-screening (lab testing) of residents and staff -Treatment of cases, decolonisation of carriers, surveillance of contacts -IPC measures potentially including home closure	-CIPCT -Lab: local/UKHSA -Care home	-who screens +/- treats staff (do care homes have Occupational Health providers?) -safeguarding issues?	No	
Hepatitis A case with suspected source in a primary school	-vaccination +/-HNIg for contacts: households / School (pupils/staff) -IPC measures for individual cases and contacts	-School nurses & support sourcing of vaccine etc.) -GPs -CICNs	-ensuring GPs vaccinate household contacts in a timely manner -delivering a mass vaccination session in a school (logistics,	No	NOTE: also consider scenario where outbreak evolves to a large community outbreak

Outbreak Scenario	Recommended response	Usual partners providing the local response (provider + commissioner)	Common challenges for consideration	OOH response required?	Comments
		-Labs: UKHSA/local	obtaining consent, language barriers, vaccine supply, prescrion/PGD, governance, recording uptake etc.) -catch-up arrangements for those who missed school session		
Two or more cases of meningococcal disease in a nursery, school, college or university setting	-delivery of mass prophylaxis for contacts: antibiotics +/- vaccine	-CICNs -School nurses -Health Visitors -Student health services -GPs -Local trust	As for any mass treatment session: -Sourcing (local stock?) -Prescribing by GP or OOH service via prescription unless agreed PGDs exist and stocks for administration? -Delivery	Yes (09:00 -20:00 …not overnight)	
TB incident with a large number of contacts (e,g, boarding school setting)	-testing of a large number of contacts -treatment of latent infections where appropriate	-TB services -GPs?	-where large number of CXRs are required: local arrangement? -who pays for IGRA testing?	No	NOTE: within TB response, consider issue of preparedness for residents not complying with Rx with complex social needs (e.g. no access to public resources)
GI outbreak linked to a food premise, swimming pool or petting farm	-rapid investigation of potential source in setting: reviewing records, inspection, +/- environmental sampling -faecal sampling for cases	-EHOs -Lab: local/UKHSA	-What is the process for obtaining faecal samples	Yes (09:00 -20:00 …not overnight)	

Outbreak Scenario	Recommended response	Usual partners providing the local response (provider + commissioner)	Common challenges for consideration	OOH response required?	Comments
	-setting-based control measures (e.g. food hygiene advice): recommendation/enforcement -case-based control measures (exclusion etc)				
Large community outbreak of measles	Potentially: -information gathering from large number of cases -setting-specific (e.g. school) mass vaccination sessions -local vaccine catch-up campaign	-CICNs -lab: UKHSA -School nurses - Health Visitors -GPs	-delivering mass vaccination session in school (see Hep A example), including identifying eligible target group based on CHIS -who would pay for local vaccine catch up campaign?	Yes (but not overnight)	
Seldom heard population: -Homeless -Traveller sites Example outbreaks: measles, TB, iGAS	Investigations: Blood samples, skin swabs, respiratory samples. Control measures: IPC advice, medication (Rx/PEP)	-CICNs -Liaison teams -DNs/HVs	-usually the issue is around poor access to NHS services: dedicated out-reach type response often needed (i.e. setting-based, from a trusted team where possible)	Not usually	

Annex 5: Teleconference Details and Protocol

These details will be provided once an outbreak is called. In many circumstances the call would be set up by HPU
Dial-in number:
Chairperson Passcode:
Participant Passcode:

For further information; https://www2.bt.com/static/i/media/pdf/meet_me_intro_ug.pdf
In order for a teleconference to run smoothly, participants must follow certain rules of etiquette while on the call.

Conference call etiquette- Chair

- Send handout materials/documents in advance if possible so attendees will have an opportunity to review beforehand.
- Be on time and stress the importance of being on time to other participants.
- Choose a location with little background noise.
- Determine who will take minutes for the meeting (this should not be the teleconference chair).
- Select a phone with the handset attached**.** Mobile or and cordless phones often add annoying static to the call.
- Draft and if possible, agree an agenda prior to or at the beginning of the call.
- Compile a list of callers in advance if possible.
- At the start of the call, go through the list of callers to establish who is present. Ask them to introduce themselves and their agency.
- Emphasise to all callers that they MUST keep their phones on mute unless they wish to speak.
- Encourage participants to state their name when speaking to ensure it is clear who is contributing.
- Direct questions to a specific person instead of posing them to the audience at large where appropriate.
- Speak clearly and pause frequently especially when delivering complicated material.
- Before ending the call ask all callers if they have any further input.
- At the end of the call, summarise the key actions and agree the next meeting date and time.

Conference call etiquette – Participants

- The ‘mute’ button should be used at all times unless you are speaking to the conference this avoids any background noise pollution
- Callers should treat a conference call like any other meeting.
- Choose a location with little background noise
- Select a phone with the handset attached**.** Mobile or and cordless phones often add annoying static to the call.
- If you do have to use a mobile phone in a car, please park up and turn off the radio and engine to reduce background noise when speaking.
- If calling individually try to avoid using speakerphone as this can lead to excess background noise and may reduce the quality of your call.
- Be sure to keep your mobile phone turned off or at least a few feet away from the telephone you are using as it can create a 'hum' when active.
- Make a list of any issues you need to raise and note where they can slot into the agenda.

- Introduce yourself when speaking.
- Take care not to rustle paper, type or make a noise that might disturb the call when your line is open.
- Speak clearly and pause frequently when delivering complicated material.

Annex 6: Key Contacts

In the event of an outbreak, the following contact details may be of assistance:

Organisation/title/department	*Name/comment*
UKHSA North West	NW UKHSA
Phone(s)	*Email*
Out of hours SPOC is 0151 434 4819	

Organisation/title/department	*Name/comment*
GM Health Protection Team. UKHSA NW	GM HPU
Phone(s)	*Email*
0344 225 0562, opt3	gmanchpu@UKHSA.gov.uk
Out of hours SPOC is 0151 434 4819	

Organisation/title/department	*Name/comment*
UKHSA Public Health Laboratory Manchester	Consultant Virologist and on-call Consultant Virologist
Phone(s)	*Email*
0161 276 8853/4277 or via MRI switchboard out of hours (**0161 276 1234**) and ask for the on-call Consultant Virologist	

Organisation/title/department	*Name/comment*
Public Health Trafford Council	Helen Gollins, Director of Public Health
Phone(s)	*Email*
07817 951555	helen.gollins@trafford.gov.uk

Organisation/title/department	*Name/comment*
Environmental Health Dept	Suzanne Whittaker, Regulatory Services Manager Nicola Duckworth, Team Leader
Phone(s)	*Email*
0161 912 4911 0161 912 4059	suzanne.whittaker@trafford.gov.uk environmental.heatlh@trafford.gov.uk

Organisation/title/department	*Name/comment*
Community Infection Prevention and Control Team,	Anna Anobile

MFT	
Phone(s)	*Email*
0161 912 5176 messages can be left.	anna.anobile@mft.nhs.uk traffordcommunityipcteam@mft.nhs.uk

Organisation/title/department	*Name/comment*
NHS GM Trafford	Gareth James, Deputy Place Based Lead
Phone(s)	*Email*
07971 483708	gareth.james1@nhs.net
Out of hours SPOC for NHS GM Trafford is via NWAS ROCC on 0345 113 0099, Option 1 for GM UEC Hub. Ask for the locality NHS GM Trafford Director On Call.	

Annex 7: OCT Members List

1. Appropriate membership
   - Public Health (Trafford LA)
   - Business/School/Care Home
   - Education (Schools Only)
   - Early Years Team (Early Years Settings Only)
   - Commissioning (Care Homes Only)
   - Commissioning (OP, LD and MH Care Homes Only and Extra Care)
   - Strategic Lead Urgent Care (Admission and Discharge Planning
   - Infection Prevention and Control Team
   - Environmental Health
   - Health and Safety Unit (Schools Only)
   - Communications (NHS Trafford ICB and /or Trafford Council)

Annex 8: OCT Agenda Template

Outbreak Control Team: Business/School/Care Home
Agenda
Day Month 2022, xx:xx-xx:xx, MS Teams

2. Introduction (Reminder of confidentiality and need for accurate records)

3. Appropriate membership
   - Public Health (Trafford LA)
   - Business/School/Care Home
   - Education (Schools Only)
   - Early Years Team (Early Years Settings Only)
   - Commissioning (OP, LD and MH Care Homes Only and Extra Care)
   - Strategic Lead Urgent Care (Admission and Discharge Planning
   - Infection Prevention and Control Team
   - Environmental Health (Early Years/Businesses Only)
   - Health and Safety Unit (Schools Only)

4. Declarations of Conflicts of Interest

5. Duty of Candour

5. Items Not on the Agenda

6. Background
   - Cases & Contacts
   - Covid-19 Secure Review

7. Risk Management/Control Measures

8. Further Investigation

9. Communications

10. Any Other Business

11. Recommendation List with timescale and allocated responsibility

12. Date and time of next meeting

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