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AGENDA PAPERS FOR

HEALTH SCRUTINY COMMITTEE MEETING

Date: Tuesday, 12 December 2017

Time: 6.30 p.m.

Place: Committee Rooms 2&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.	**MINUTES**		1 - 8
	To receive and, if so determined, to agree as a correct record the Minutes of the meeting held on 31 October 2017.		
3.	**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.		
4.	**HEALTH INEQUALITIES**		9 - 54
	To receive a presentation of the Interim Director of Public Health.		
	The attached documents are for background information only and will not be discussed at the meeting.		
5.	**CHILDHOOD DIET**		
	To receive a presentation of the Interim Director of Public Health.		
6.	**DOMESTIC ABUSE**		
	To receive a presentation of the Interim Director of Public Health.		

7. **PREVENTION/BEHAVIOUR CHANGE**

To receive a presentation of the Interim Director of Public Health.

8. **SUBSTANCE ABUSE**

To receive a presentation of the Interim Director of Public Health.

9. **PHYSICAL ACTIVITY**

To receive a presentation of the Interim Director of Public Health.

10. **SEXUAL HEALTH**

To receive a presentation of the Interim Director of Public Health.

11. **MALNUTRITION IN ADULTS**

To receive a presentation of the Interim Director of Public Health.

12. **CQC RISK SUMMIT**

To receive a verbal update from the Chairman of the Committee.

13. **CQC CONSULTATION: REPORTING AND RATING NHS TRUSTS' USE OF RESOURCES** 55 - 82

To receive and discuss the consultation paper of the Care Quality Commission.

14. **GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE** 83 - 84

To receive a report of the Vice Chairman of the Committee.

15. **HEALTH UPDATES**

To receive a verbal update from the Chairman of the Committee.

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

Any other item or items (not likely to disclose "exempt information") 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.

THERESA GRANT
Chief Executive

Membership of the Committee

Councillors J. Harding (Chairman), Mrs. P. Young (Vice-Chairman), Miss L. Blackburn, Mrs. J.E. Brophy, Mrs. A. Bruer-Morris, R. Chilton, Mrs. D.L. Haddad, J. Lloyd, K. Procter, S. Taylor, Mrs. V. Ward and M. Young (ex-Officio)

Further Information
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M32 0TH.

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HEALTH SCRUTINY COMMITTEE

31 OCTOBER 2017

PRESENT

Councillor J. Harding (in the Chair).
Councillors Mrs. P. Young (Vice-Chairman), Miss L. Blackburn, Mrs. J.E. Brophy, Mrs. A. Bruer-Morris, R. Chilton, J. Lloyd, K. Procter, S. Taylor and Mrs. V. Ward.

In attendance

Matthew Colledge	Chairman of Trafford CCG
Cameron Ward	Interim Accountable Officer, Trafford CCG
Dr Nigel Guest	Medical Officer, Trafford CCG
Stephen Gardner	Director of Strategic Projects, MFT
Cathy Rooney	Director for Safeguarding and Professional Development

APOLOGIES

Apologies for absence were received from Councillors Mrs. D.L. Haddad and M. Young.

18. MINUTES

That the minutes of the meeting held 12 September 2017 be agreed as an accurate record and signed by the Chairman.

19. DECLARATIONS OF INTEREST

The following declarations of personal interest were made;

- Councillor Brophy in relation to her employment by Lancashire Care Foundation Trust.
- Councillor Bruer-Morris in relation to her employment within the NHS.
- Councillor Harding in relation to her employment by a mental health charity, and member of the Board of Trustees for Trafford Carers.
- Councillor Chilton in relation to his employment by General Medical Council.
- Councillor Taylor in relation to her employment by the NHS.
- Councillor Lloyd in relation to her position on the board of the Trafford Domestic Abuse service.

20. SINGLE HOSPITAL SERVICE UPDATE

The Director of Strategic Projects (DSP) for Manchester Foundation Trust (MFT) took the Committee through the report that had been submitted with the agenda. It was highlighted to the Committee that all preparatory actions for the merger had been completed in time for the creation of MFT. Further, there had been no unexpected incidents or failures following the merger. The next step was to begin work on a number of small changes over the first 100 days of the new

organisation. The DSP then described the second phase of the Single Hospital Service which involved MFT merging with North Manchester Hospital.

Following the update from the DSP Committee members were given the opportunity to ask questions. Members posed a large number of questions, the majority of which were focused upon the merger with North Manchester. The questions included what were the plans for the Accident and Emergency department at North Manchester, the process for separating North Manchester from Pennine Foundation Trust who was currently running the hospital, and what the reasons were for merging with North Manchester. The DSP gave in depth responses to the Committees questions and Members were satisfied with the answers received. The Chairman of the Committee thanked the DSP for attending the meeting and requested that a further update be provided in January 2018.

RESOLVED:

1) That the DSP be thanked for attending the meeting.
2) That a further update be provided in January 2018.

21. ALL AGE FRONT DOOR

The Director for Safeguarding and Professional Development (DSPD) went through the report that had been circulated with the agenda. The Committee were told that the aim of having an all age front door was to streamline interaction so that the public only have one number to ring for any issue that they may have. Trafford still had both the MARAT multidisciplinary team and the Adult Screening teams in place and had not yet switched to having a single point of access. The two teams had been Co-located and the adult screening team were scheduled to be joined by members of Greater Manchester Police from 6th November.

It was originally believed that there would be a large amount of crossover of work between the two teams which would enable the services to be streamlined and improve efficiency. So far the main area of crossover identified had been with regards to domestic abuse and it was hoped that more areas would be identified now that the teams were co-located. The project was being progressed slowly to ensure that a single point of access would work before the systems were changed.

Committee Members asked a number of questions including what feedback had been received from users, how would the new service be advertised to the public, and what links were in place with housing associations. The DSPD gave detailed responses to the Committee's questions and the Chairman of the Committee requested a further update of the service be provided once it had switched to a single front door.

RESOLVED:

1) That the report be noted.
2) That a further update be brought to the Committee once the single front door is implemented.

22. ADULT AND CHILDREN'S JOINT SAFEGUARDING BOARD

The DSPD presented the report which had been distributed with the agenda. The report covered the background of safeguarding boards within Trafford, the changes that had been made in legislation and why following those changes the three statutory partners (Trafford Council, Trafford CCG, and Greater Manchester Police) had decided to merge the adult and children's safeguarding boards. The Committee were informed of the benefits but also the possible risks that the transition would bring; it was due to these risks that the implementation of the transformation was being conducted at a slow pace. One of the key advantages to the new structure was the reduction of the duplication of work. Work that affected all age groups such as domestic violence, modern slavery, and mental health had been identified an area where duplication was likely. An independent Chairman had been appointed to the new board and the Council were in the process of conducting legal tests to ensure that it met all requirements prior to implementation.

Following the report Committee Members were given the opportunity to ask questions. One Committee Member asked how high the levels of domestic abuse were within Trafford. The DSPD did not know the figures offhand as that area was dealt with by the MARAC team but stated that she would be able to provide a report to the Committee. The DSPD went on to inform the Committee that 90% of cases that came through children's safeguarding were linked to domestic abuse. In response to the DSPD's offer Committee Members confirmed that they would like a report on the levels of domestic abuse within Trafford to be provided.

The Chairman of the Committee asked how lessons were learnt and how that learning was cascaded following serious case reviews. The DSPD responded that following such a review multiple learning events are arranged, some held during the day and others on an evening, in order to maximise the number of partners and organisations that can attend. This model was being used for children's services and the Council was in the process of extending the model to adult services as well. The Chairman thanked the DSPD for attending the meeting and requested that a further update be brought to the Committee 6 months after the establishment of the new Board.

RESOLVED:

1) That the DSPD be thanked for attending the meeting.
2) That a report on the levels of domestic abuse within Trafford be provided for the Committee.
3) That an update on the progress of the new Safeguarding Board be brought to the Committee 6 months after the Board has been established.

23. INTEGRATED CARE

As officers were unable to attend the meeting this agenda item was tabled for the next meeting of the Committee.

RESOLVED: That this agenda item be tabled at the next meeting of the Committee.

24. NEW MODELS OF CARE AND TRANSFORMATION BID UPDATE

The Chairman of Trafford CCG gave a brief introduction of the Transformation plan to the Committee. The introduction included an assurance that members of the Transformation team would be available throughout the Transformation process to update the Committee on any areas requested. The Committee were informed that Trafford's bid for £22M of Transformation funding had been successful and that the implementation of the bid would be a unique process and opportunity for Trafford to bring about a new way of delivering services unlike anything seen before.

The Interim Accountable Officer (IAO) for Trafford CCG then went through the presentation that had been circulated with the agenda. As the Committee had seen the presentation in advance only the main points were covered. The challenges that both Trafford Council and Trafford CCG faced were laid out and the IAO explained how the new structure of the two organisations would enable them to overcome those challenges.

The Medical Officer for Trafford CCG then described the new model of primary care which was one of the main programmes of work within the Transformation plan. The new model involved bringing together all primary care services into a single organisation with a single ethos. The new model was to have work streams that focused upon prevention, planned care access, the urgent care offer, domiciliary care, specialised primary care, and medicine optimisation.

In addition to these changes the Committee were told that there were opportunities for improvements to be made at the practice level which would be undertaken concurrently with the overarching umbrella changes. The Chairman of Trafford CCG concluded the presentation by noting that all aspects of the Transformation plan had been conducted elsewhere but that nowhere else had combined all of the separate aspects on such a large scale.

Following the presentation Committee members posed a series of questions to the representatives of Trafford CCG. One Member enquired as to the role that the Trafford Coordination centre (TCC) would play in the Transformation Plan. The IAO replied that the TCC was improving steadily and had a continually increasing capacity but that it still was not fulfilling its potential and offered to share the TCC Key Performance Indicator (KPI) data with the Committee. The Medical Officer for Trafford CCG confirmed that the TCC was a fundamental part of the new model of care and that it was being aligned to fit the purposes of the new model. The Chairman of the Committee asked whether the Committee could visit the TCC before Christmas and the Chairman of Trafford CCG agreed to the request.

Another member of the Committee asked about accessibility of information among the various organisations and professionals involved in the delivery of the new model of care. The Medical Officer for Trafford CCG acknowledged that there were a large number of systems that needed to work together and informed the Committee that many of these were already in place. The Committee were told that another IT solution was still to be implemented which would allow staff to access their own profiles and data from a wide number of locations across Trafford. This solution would be pivotal in enabling the flexible ways of working which were required for the new models of care to work.

The final question posed by the Committee was how the new organisation and the GPs that hadn't signed up would meet the new Greater Manchester standards. The Medical Officer for Trafford CCG stated that the dashboard which was already being used by Trafford GPs would be aligned with a combination of the GM standards and localised targets in order to hold GP members to account.

RESOLVED:

1) That the update be noted.
2) That a visit to the TCC be arranged for Committee before Christmas.
3) That KPI data for the TCC be shared with the Committee.

25. GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE UPDATE

The Vice Chairman of the Committee had circulated an update on the most recent meeting of the Greater Manchester Joint Health Scrutiny Committee prior to the meeting. Committee Members were asked whether they had any questions and none were raised.

RESOLVED: That the update be noted.

26. HEALTH UPDATES

The Chairman of HealthWatch Trafford informed the Committee that they had attended a 2 day GM wide health and wellbeing summit which was to feed into the GM investment plan and that a report of the event was being written up. HealthWatch Had received an update from Trafford CCG on the TCC and had been told that they're looking at doubling the number of patients logged on the system from 1500 to 3000. They had also been informed that progress had been slow with the TCC due to their not being a lead officer in place. That position had now been filled and so there should be a marked improvement.

The Chairman of the Committee drew Member's attention to the briefing paper in respect to moving treatment room from Firsway to Chapel Road Clinic. The Committee agreed that a formal response should be sent stating their concerns regarding the distance that some residents would have to travel from areas such as Ashton on Mersey. The Committee also wanted the response to enquire whether anything could be offered from the centre at Medway and to include their concerns about the long term viability of the Firsway practice.

RESLOVED:

1) That the update from HealthWatch Trafford be noted.
2) That a response to the briefing paper containing the points above be sent to Pennine Care.

The meeting commenced at 6.40 pm and finished at 8.42 pm

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Date of Meeting	Agenda Item	Action	Officer/Organisation Responsible	Due date	Completed
01-Mar-17	URGENT CARE CENTRE UPDATE	That the work of Helen Hurst be reported to the Committee in six months' time.	Mary Burney/CMFT	Dec-17	
01-Mar-17	TRAFFORD COORDINATION CENTRE	That Trafford CCG provide information to the Committee relating to all pathways within Trafford with adequate explanation.	Gina Lawrence/Trafford CCG	ASAP	
01-Mar-17	TRAFFORD COORDINATION CENTRE	That Councillor Mitchell be kept informed of progress on work relating to the Stroke pathway.	Gina Lawrence/Trafford CCG	ASAP	
01-Mar-17	INTEGRATED CARE	That the Trafford Integrated Network Director attends the first Committee meeting of the 2017/18 Municipal year.	Richard Spearing/Trafford Council	Jan-18	
01-Mar-17	TASK AND FINISH GROUP UPDATE	That a report on Children and Young People's Wellbeing to be submitted to the Committee in the 2017/18 municipal Year.	Young Peoples Mental Health Task and Finish Group	Jan-18	
27-Jun-17	NWAS UPDATE REGARDING PROGRESS SINCE CQC INSPECTION	That NWAS are to provide another progress update to the Committee in six months' time.	Head of Service for NWAS	Jan-18	
27-Jun-17	PROOF OF CONCEPT	That a further update be provided to the Committee in 6 months' time.	Head of Partnerships & Communities	Jan-18	
12-Sep-17	HEALTHY YOUNG MINDS	That the staffing structure of the service be sent to Committee Members.	Jan Trainor/Cathy Rooney	ASAP	
12-Sep-17	HEALTHY YOUNG MINDS	That the Committee receive a further update in 6 Months' time.	Cathy Rooney	Mar-18	
12-Sep-17	GREATER MANCHESTER HEALTH AND WELLBEING STRATEGY	That the Committee receive a further update in 12 Months' time.	Warren Heppolite/Sandy Bering	Sep-18	
12-Sep-17	TRAFFORD MENTAL HEALTH TRANSFORMATION	That the Committee receive a further update in 6 Months' time.	Ric Taylor	Mar-18	
12-Sep-17	TRAFFORD MENTAL HEALTH TRANSFORMATION	That Councillor Brophy meets with the LCMHLD to discuss questions in more detail.	Ric Taylor/Councillor Brophy	ASAP	

31-Oct-17	SINGLE HOSPITAL SERVICE UPDATE	That a further update be provided in January 2018	Stephen Gardner	Jan-18	
31-Oct-17	ALL AGE FRONT DOOR	That a further update be brought to the Committee once the single front door is implemented	Cathy Rooney	TBC	
31-Oct-17	ADULT AND CHILDREN'S JOINT SAFEGUARDING BOARD	That a report on the levels of domestic abuse within Trafford be provided for the Committee.	Cathy Rooney	ASAP	
31-Oct-17	ADULT AND CHILDREN'S JOINT SAFEGUARDING BOARD	That an update on the progress of the new Safeguarding Board be brought to the Committee 6 months after the Board has been established.	Cathy Rooney	TBC	
31-Oct-17	NEW MODELS OF CARE AND TRANSFORMATION BID UPDATE	That a visit to the TCC be arranged for Committee before Christmas.	Alex Murray	ASAP	Y
31-Oct-17	NEW MODELS OF CARE AND TRANSFORMATION BID UPDATE	That KPI data for the TCC be shared with the Committee.	Cameron Ward	ASAP	
31-Oct-17	HEALTH UPDATES	That a response to the briefing paper containing the points above be sent to Pennine Care.	Alex Murray	ASAP	Y

TRAFFORD COUNCIL

Public Health Annual Report

2015

Foreword

Public Health has seen one of the most monumental transitions in the last forty years, with the return of responsibility for Public Health to Local Authorities from 1st April 2013, and further opportunities for Public Health in the Greater Manchester devolution agreement.

Over the last century great Public Health advances such as water sanitation, improved housing and highways, employment opportunities and better healthcare have been made, enhancing, protecting and nurturing good health amongst communities. More recently the recession has focussed our attention on addressing the underlying social conditions which are the root causes of ill health. The current challenges and opportunities are to find new, cost effective ways of giving children the best start in life, keeping people well and ensuring people have a healthy old age.

Public Health has been the responsibility of Trafford Council for over two years now, and Trafford Council has contributed greatly to improving the health of its residents and reducing health inequalities. The key challenge for Trafford communities is to work towards improving the length and, importantly, quality of life for all residents. Being physically located in Trafford Town Hall has enabled me to build even closer relationships with council and community services and I am proud to use this Annual Report to showcase some of the great programmes and projects happening a cross Trafford.

The past few years have been financially challenging for Trafford Council and financial constraints are likely to remain in place for the foreseeable future. There is a great deal of resilience in our communities, and a proven track record of delivering excellent Public Health services using an evidence-based, assets-based, "economics of prevention" approach. I want to use this Annual Report to celebrate the assets that we have in our diverse communities and the varied and valuable work taking place that is helping to make Trafford one of the healthiest and happiest places to live in Greater Manchester.

Abdul Razzaq
Director of Public Health
Trafford Council

Contents

The Public Health Journey in Trafford

5 July 1948

Park Hospital (now Trafford General), the first NHS hospital, opened by Aneurin Bevan

- Doctors, nurses, dentists, opticians, all worked together to deliver integrated care to all, free at the point of delivery, for the first time in the UK
- Medical Officers of Health in local authorities still led Public Health functions
- Life expectancy in the UK: 66 years for men; 71 years for women
- Infant mortality (deaths of babies under one year old) 34 per 1,000 live births

1974

Public Health functions moved out of Local Authorities

- All but environmental health duties moved to health authorities
- Medical Officer for Health role terminated

1992

Manchester Metrolink opened

- The line runs through Trafford from north to south, with its southernmost station in Altrincham

3 November 2014

Greater Manchester devolution agreement

- Plans include devolving new powers and responsibilities to Greater Manchester, and Greater Manchester adopting a directly elected Mayor for the city region
- Infant mortality 4.3 per 1000 livebirths nationally, 2.3 per 1000 in Trafford

1940 1960 1980 1990 2000 2010

1960s onward

Decline and Regeneration in Trafford

- 1960s & 70s: Economic recession – declining industry in Trafford Park
- 1987: Trafford Park Development Corporation formed: responsibility for Trafford Park and the surrounding industrial area
- 1998: 1,000 companies attracted to the area, increased employment levels and business opportunities
- To this day Trafford Park remains Europe's largest industrial estate

1986

The Association of Greater Manchester Authorities (AGMA) Established

- AGMA represents the 10 local authorities of Greater Manchester
- It works in partnerships with private, public and voluntary organisations inside and outside the region

AGMA
ASSOCIATION OF GREATER MANCHESTER AUTHORITIES

1 April 2013

Responsibility for Public Health returns to local authorities

- As outlined in the the Health and Social Care Act 2012, local authorities are now responsible for improving the health of the local population and for public health services including most sexual health services and services aimed at reducing drug and alcohol misuse.
- The council remains responsible for providing social care services (such as residential care) for those in need

Where next for Public Health in Trafford?

Exciting opportunities for:

- **Integrating health and social care**
- **Co-producing better health outcomes for everyone in our communities**
- **Working together, building on community assets**
- **Tackling inequalities by tackling the wider determinants of health**

Image: Charles J. B. Aldis. An early MOH in London. Image from: http://blog.wellcomelibrary.org/2014/01/the-work-of-a-19th-century-medical-officer-of-health/

Locality Working in Trafford

Working as part of Trafford Council has brought new opportunities for Public Health to work in partnership with local communities on the wider factors underlying health. This will ensure residents are centrally placed in improving health and increasing healthy life expectancies in the borough.

Locality Working is a new approach to partnership working. It brings together residents, businesses, community groups, councillors and public service providers as equals to work on new projects, making use of the people, places, assets and community spirit that thrives within Trafford.

The Trafford Locality Working programme has four elements, all following a local 'community development' approach:

- **Locality Projects** – where the needs and strengths of our communities meet with local goals and residents can become involved with solving local issues and supporting their communities
- **Locality Partnerships** – made up of councillors, partners and residents, take leadership in Locality Working, engaging residents and others involved and celebrating success
- **'Be Bold' media campaign** – showcases how residents can make a difference to their neighbours and themselves by being more active, volunteering, joining local groups or simply by being more neighbourly
- **'Community Builders'** – training 270 front-line staff and councillors on how to unlock the strengths within communities by listening, connecting, signposting and supporting residents to take action.

Locality Working will also help to ensure that Greater Manchester Devolution is connected to, influenced by and directly benefits the people of Trafford.

Residents and communities are our greatest untapped asset. Communities that are involved in decision-making about their area and the services within it, that are well networked and where neighbours look out for each other, have a huge impact on health and wellbeing.

The pioneering 'localities' programme is creating the conditions for community assets to thrive, removing barriers for our services to work alongside communities in ways that are empowering, engaging and meaningful.

Transparency and resident involvement is increasing local accountability and democracy, enabling an honest conversation with residents and stakeholders. This will also help to change the relationship between services and residents, changing roles and expectations and giving residents a more active role in their communities.

Examples of Locality Working in Trafford

- **Engaging communities in taking positive action** – Make Sale Smile micro-grants helped 34 residents to turn their 'Be Bold' ideas into reality. Two local residents created Sale Arts Trail, bringing 1,500 people into the town centre, improving health and wellbeing and increasing spend in local businesses
- **New ways to tackle old issues** – Community-led alley way improvements. Agencies, councillors and residents came together to work on cutting down fly-tipping in Old Trafford
- **Enabling new partnerships to form** – Red Rose Forest, Trafford Housing Trust, Trafford Council, local businesses, councillors and Urmston Community Panel, together with residents, are improving Urmston Meadows. The community involvement will ensure that positive changes are sustained.

For further information please see

'Be Bold... Be the Difference' website
www.traffordpartnership.org/BeBold

'Community Builders' website
www.traffordpartnership.org/BeBoldCampaign/CommunityBuilders.aspx

An example of our Old Trafford and Stretford Environmental micro-grants
www.thebackgallery.wordpress.com/about-2

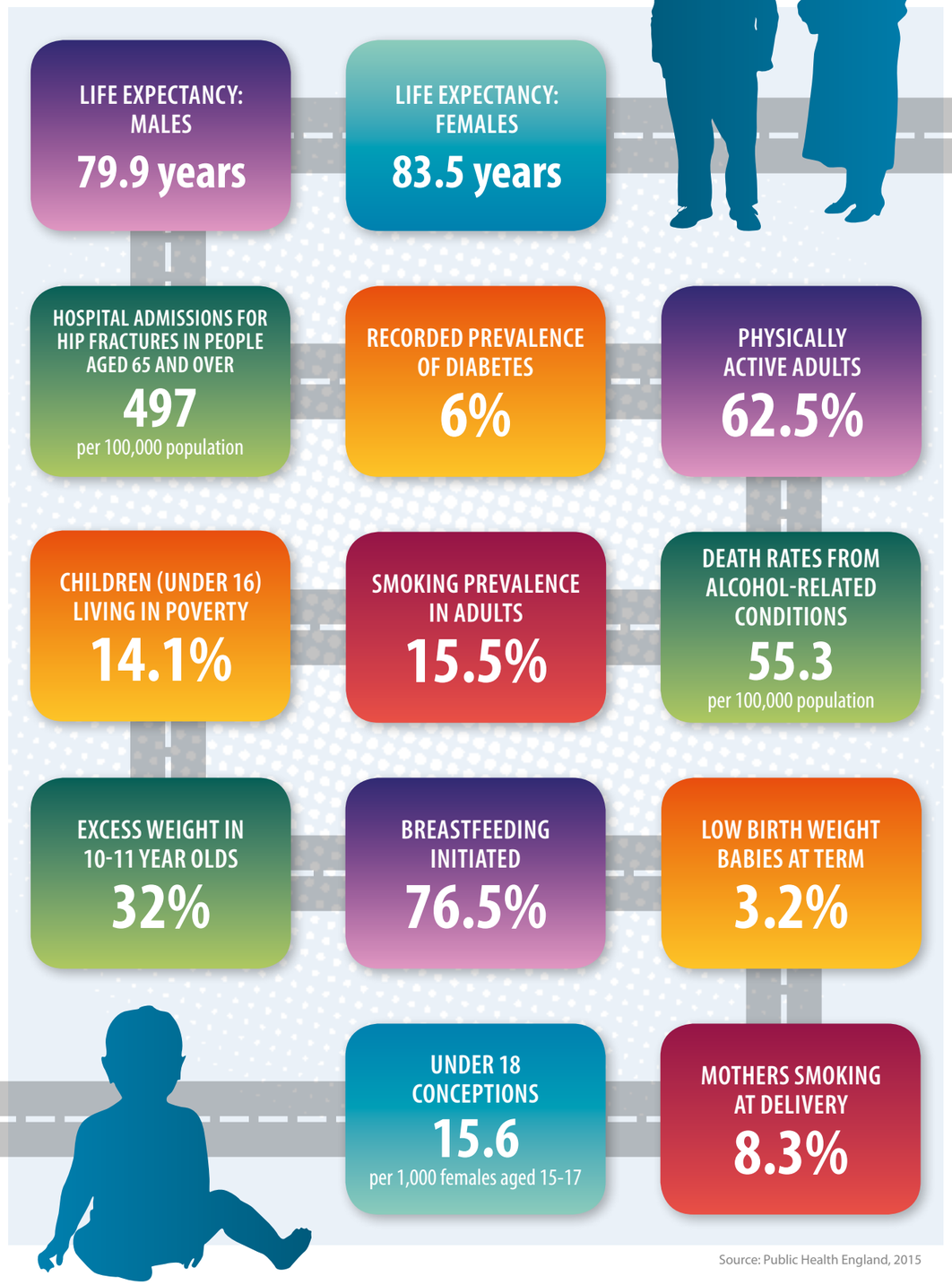
Greater Manchester Devolution Arrangement

Trafford and the nine other local authorities which make up Greater Manchester have worked closely together for 30 years. The Association of Greater Manchester Authorities (AGMA) was established in 1986 and the Greater Manchester Combined Authority (GMCA), in 2011. This history of strong joint working and the push from central government to create a 'Northern Powerhouse' has set the stage for the devolution agreement, 'Devo Manc'. The agreement is an ambitious plan to establish a locally elected mayor for Greater Manchester who would work with GMCA, taking responsibility for key elements of public sector spending in the area. The elections are due to take place in early 2017 and the mayor would initially have a budget of £1billion.

The devolution arrangement in Manchester would mean that responsibility for regional decision-making and financial matters relating to housing, planning and transport are held within Greater Manchester. The administration would also control the £6billion health and social care budget for the region which has already been brought together under GMCA. Devolution promises to encourage further integration of public services, reduce the inefficient overlap of services and support prevention efforts, while allowing decisions to be made 'closer to home' for the benefit of local populations. This is a good opportunity to work across some traditional service, organisational and geographic boundaries to improve the health and wellbeing of the population. It will address physical and mental health; primary and secondary care; health and social care; treatment and prevention and will also advise on areas such as urban design and transport policy.

Many of Trafford's public health challenges described in this report are also shared by other Greater Manchester local authorities. We have already started to work with other areas to provide stronger services, for example, working on joint commissioning of sexual health services. Devolution provides an exciting opportunity to take this work to the next level. A population health focus could combine the spending power of the region and put health at the centre of all our public spending.

Overview of Health in Trafford



Source: Public Health England, 2015

Increasing Healthy Life Expectancy

Life expectancy describes how many years a person can expect to live from birth. The average life expectancies for men and women living in Trafford are slightly higher for England as a whole (79.9 years for men and 83.5 years for women). These figures mask variations in life expectancy across the borough. In general, communities in the north of Trafford have lower life expectancies than those in the South.

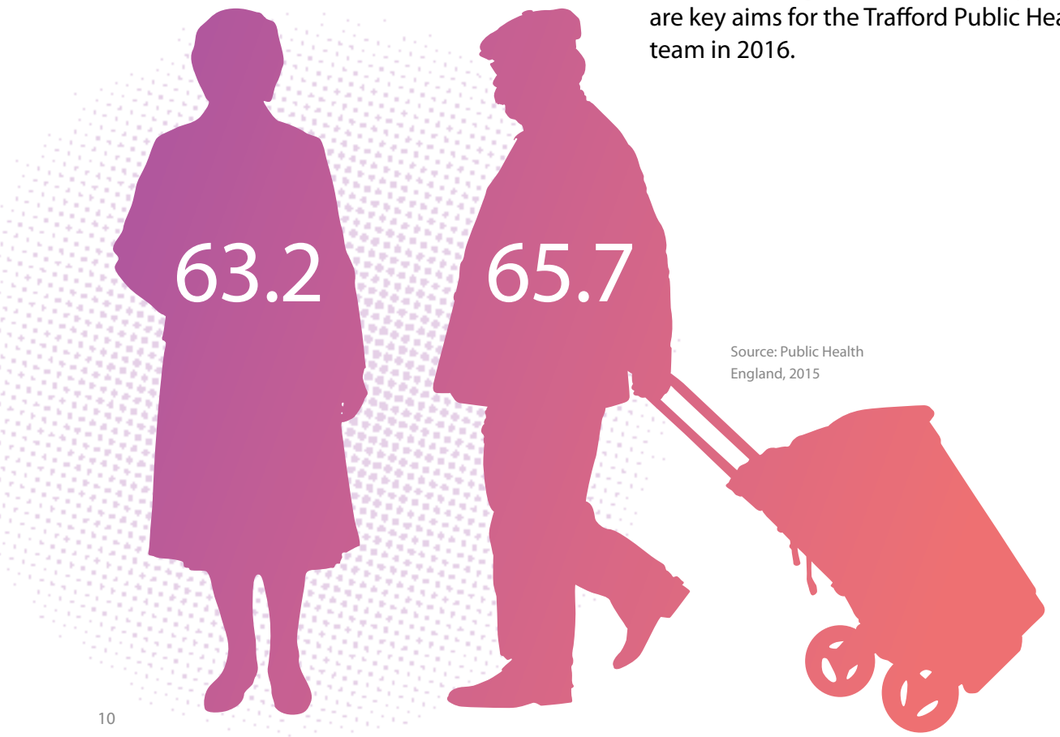
Healthy life expectancy is the number of years a person is likely to live in a healthy state. This is a good pointer to the population's general health and gives an idea of the population's need for health and social care services. Healthy life expectancies at birth for men and women in Trafford are 65.7 years and 63.2 years respectively. For women in particular, this represents a lower figure than we might expect. Addressing this would lead to better health for Trafford residents and reduce the need for health and care services in the area.

Recently published data on deprivation by local authority areas shed more light on healthy life expectancy. These data show that, although levels of deprivation in Trafford are relatively low, (Trafford is in the third of local authorities with the lowest levels of deprivation in the country) levels of health in the borough are considerably worse than would be expected. In fact, Trafford is amongst the bottom third of local authorities in England for health outcomes.

A map showing further data on deprivation and health across Trafford is available at *www.infotrafford.org.uk/deprivation#options*.

Data from a new report show that people in Trafford with serious mental health conditions have a high rate of early death and that this is significantly higher than elsewhere in the country (available at: *thersa.org/mentalhealth-data*).

Focussing on raising healthy life expectancy, whilst reducing the identified inequalities, are key aims for the Trafford Public Health team in 2016.



Source: Public Health England, 2015

Starting Well

Helping our children and young people to grown into healthy and successful adults starts with protecting and supporting their health and wellbeing before birth.

In 2014, 24.2% of Trafford's resident population (56,370 people) were aged 0-18 years, with this figure expected to increase over the next five years[1]. Trafford celebrates diversity across its communities with over a quarter of school aged children (27.2%) coming from black and minority ethnic backgrounds.

According to the annual Child Health profile produced by Public Health England (available at: *www.chimat.org.uk/resource/item.aspx?RID=242359*), Trafford children do similar or better than the England average in 30 of the 32 health measures. The greatest challenges in Trafford however, are the health and social inequalities, which are often masked by Trafford's good outcomes. Approximately 14.1% of children aged 0-16 in Trafford (an estimated 7,157 children) live in poverty[2].

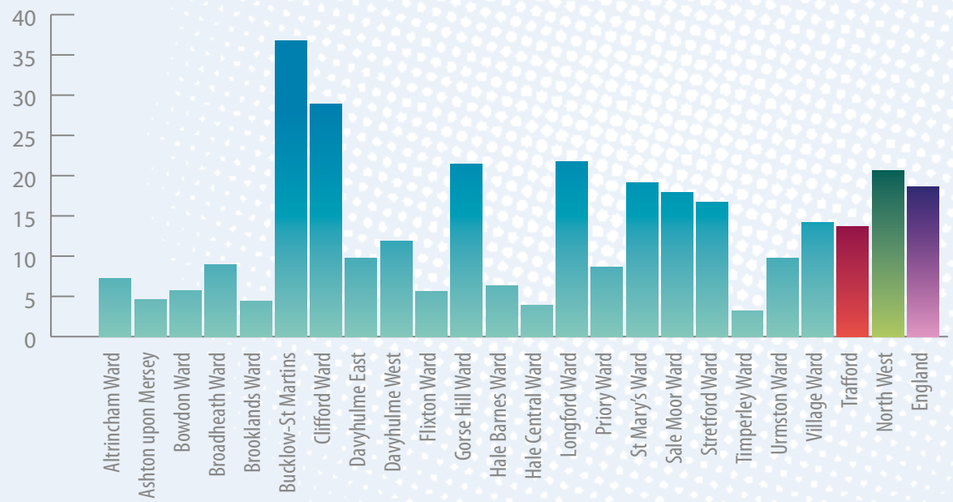
We know that the impact of deprivation is bigger in some communities, for example in areas of Partington, Sale West and Old Trafford. Poverty and deprivation can damage the health and wellbeing of children and young people.

Other factors associated with variations in the health of children or young people include:

- **Disability**
  – it is estimated that 1 in 20 children in Trafford is living with a disability)[3]
- **Involvement in safeguarding arrangements or becoming a Looked After Child**
  – across Trafford there are on average 320 children in care, 263 children with a child protection plan and 690 children in need[4]
- **Witnessing domestic violence and abuse**
- **Living with a parent with mental health issues**
- **Parental alcohol and substance misuse problems**

% of all Children in Poverty Across Trafford Localities

Source: infotrafford, 2015



Starting Well

Ensuring a good start in life

Trafford has excellent schools and the Council's children's services received a good classification from Ofsted in 2015. Partnerships in Trafford also support our goal to maximise children's life chances.

Other activities across Trafford include;

- Trafford's **Smoking Cessation Service** providing specialist support to pregnant smokers.
- **Dedicated infant feeding support** for new mothers, to provide help in starting and continuing breastfeeding. Trafford has recently been awarded the UNICEF Baby Friendly award, recognising the high quality of this support.

UNICEF Baby Friendly Initiative

Trafford Infant Feeding Coordinator Jackie Hall said: "The Baby Friendly accreditation ensures that, however a mother chooses to feed her baby, she can be confident that our services will support her to form a strong bond with her child."

Alison, 36, says despite breastfeeding her oldest three children, she encountered difficulties feeding daughter Jasmine, who is now 14 months.

She said: "When I first had problems I was a bit embarrassed about asking for help because I felt I should be able to do it but the staff and volunteer peers were so approachable and gave me different techniques to try.

"Coming to the groups has been great, you get the chance to talk to people in the same situation and there's a real sense of community."

She added: "When I had my first baby in 1996 there weren't places you could go to feed and I ended up using disabled toilets. Things have come such a long way and it's great to know I can go into a shop or a leisure centre and feed Jasmine if she needs it without worrying."

The Baby Friendly Initiative, set up by UNICEF and the World Health Organisation, is a global programme which provides a practical and effective way for health services to improve the care provided for all mothers and babies.

Parents who would like advice and support around feeding their baby should speak to their health visitor in the first instance.

- Trafford has a low teenage pregnancy rate, with 66 pregnancies amongst girls aged under 18 in 2013. The national **Family Nurse Partnership** was introduced in Trafford in 2014, aiming to improve the outcomes for babies of young mothers by providing intensive support for the first two years. Our local bespoke programmes, **Young Bumps** and **Butterflies** are achieving great results, offering friendly, experienced advice and support to our younger parents in the borough.
- Our **school nursing service** in Trafford has recently benefitted from a comprehensive review and increased investment. Services provided include a broad school-based immunisation programme and drop-in sessions for young people to raise mental or physical health concerns.
  - The school nursing service is responsible for measuring reception and year six children as part of the **National Childhood Measurement Programme** (NCMP). Of the children measured in 2013/14, 78.1% of reception aged children and 66.6% of year 6 children were of a healthy weight. This is a higher proportion than the national figure. Lower proportions of Trafford children were obese than the national average (7.9% of reception aged children and 17.4% of year 6 children)[5]
- **Trafford Child and Adolescence Mental Health Service** (CAMHS) which provides specialist mental health services, is undergoing a transformational review. We are working to deliver the recommendations from the national programme to ensure that young people's mental health needs continue to be met.
- **Trafford 0-11 and 11-18 Early Help Hubs** aim to improve the health of children and young people and reduce inequalities in health. The 'Talkshop' facility, for 11-18 year olds, based in Sale, promotes good sexual health and the Sexual Health Outreach Team (SHOT) offers a specialist service to young people aged between 11-18yrs. Services include: pregnancy testing, support and referral for termination of pregnancies, chlamydia screening, condom distribution, advice and information and one-to-one support for any safeguarding and child sexual exploitation issues.

Living and Staying Well

Healthy children and young people grow into healthy adults. Working to improve the health and wellbeing of our adult population is vital in building strong communities in Trafford and sustainable economies, to support the population into older age. This in turn contributes to increasing healthy life expectancies in the borough.

Physical Activity

Today many people have increasingly sedentary lives: driving to save time; watching television; working in offices; obesity and its associated conditions are on the increase and our children are the most inactive generation ever.

Currently many people in the UK do not manage the recommended 150 minutes of moderate physical activity each week.[6,7]

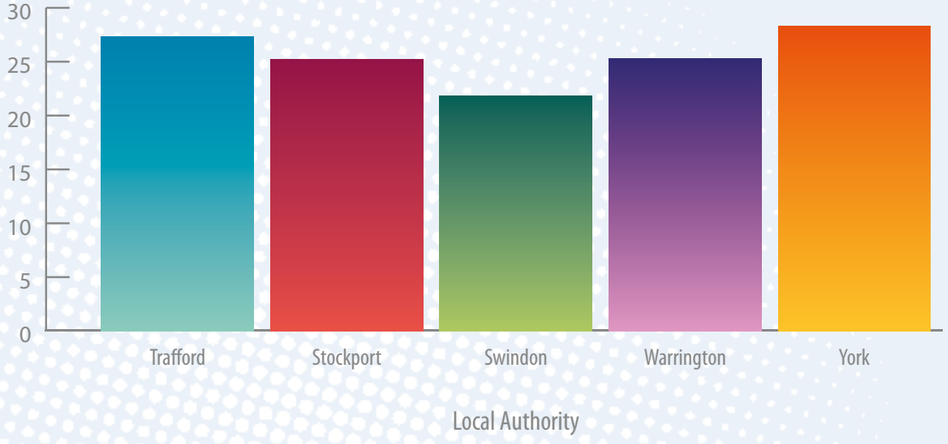
The health benefits of physical activity are well known: the most physically active people have around a 30% lower risk of death compared to those who are less active[8].

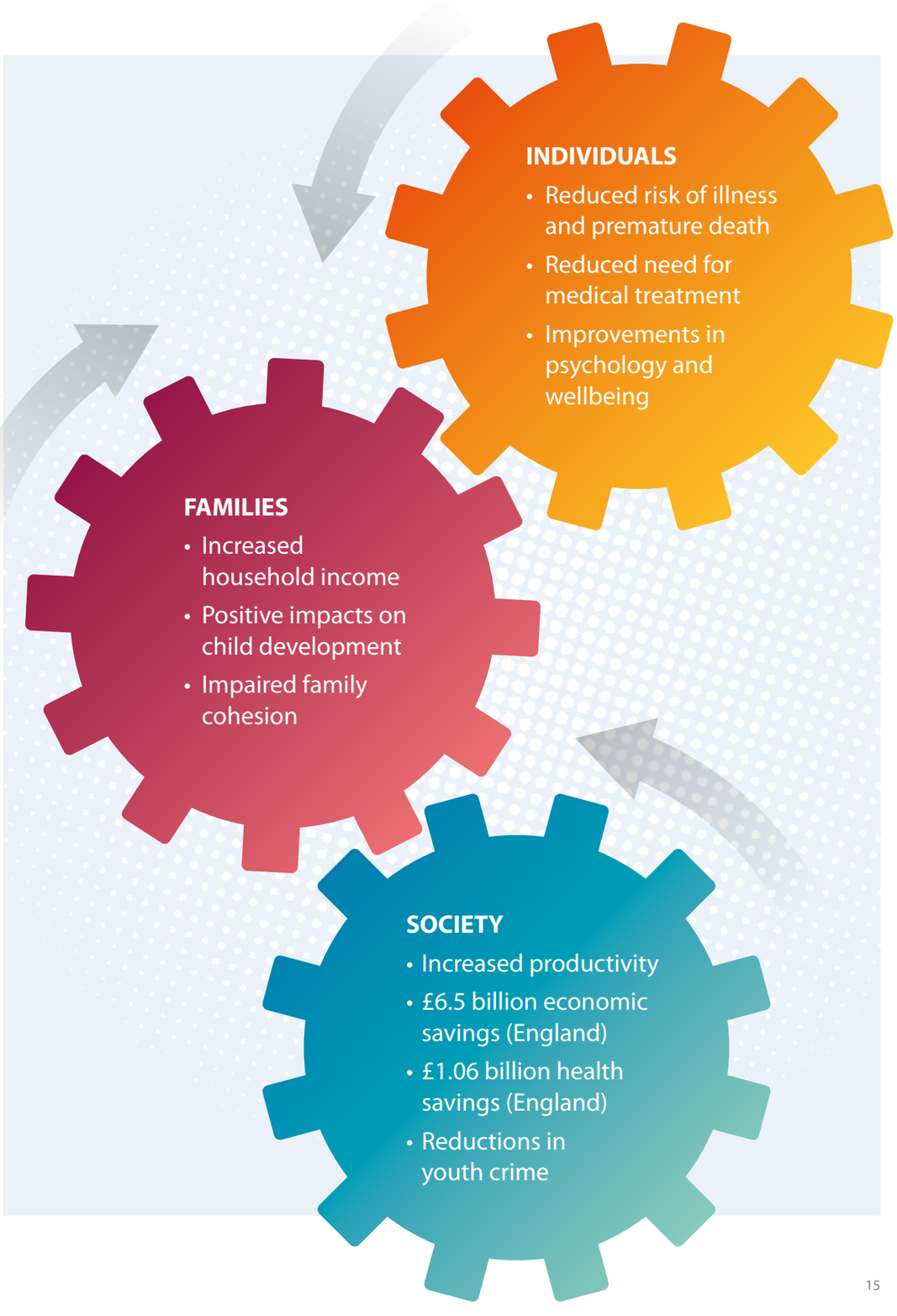
Trafford physical activity levels compare favourably to other similar areas but there is scope for improvement[9].

Wider effects of increases in physical activity would have positive impacts at all levels of the community[10,11].

% of population doing at least three 30 minute sessions per week

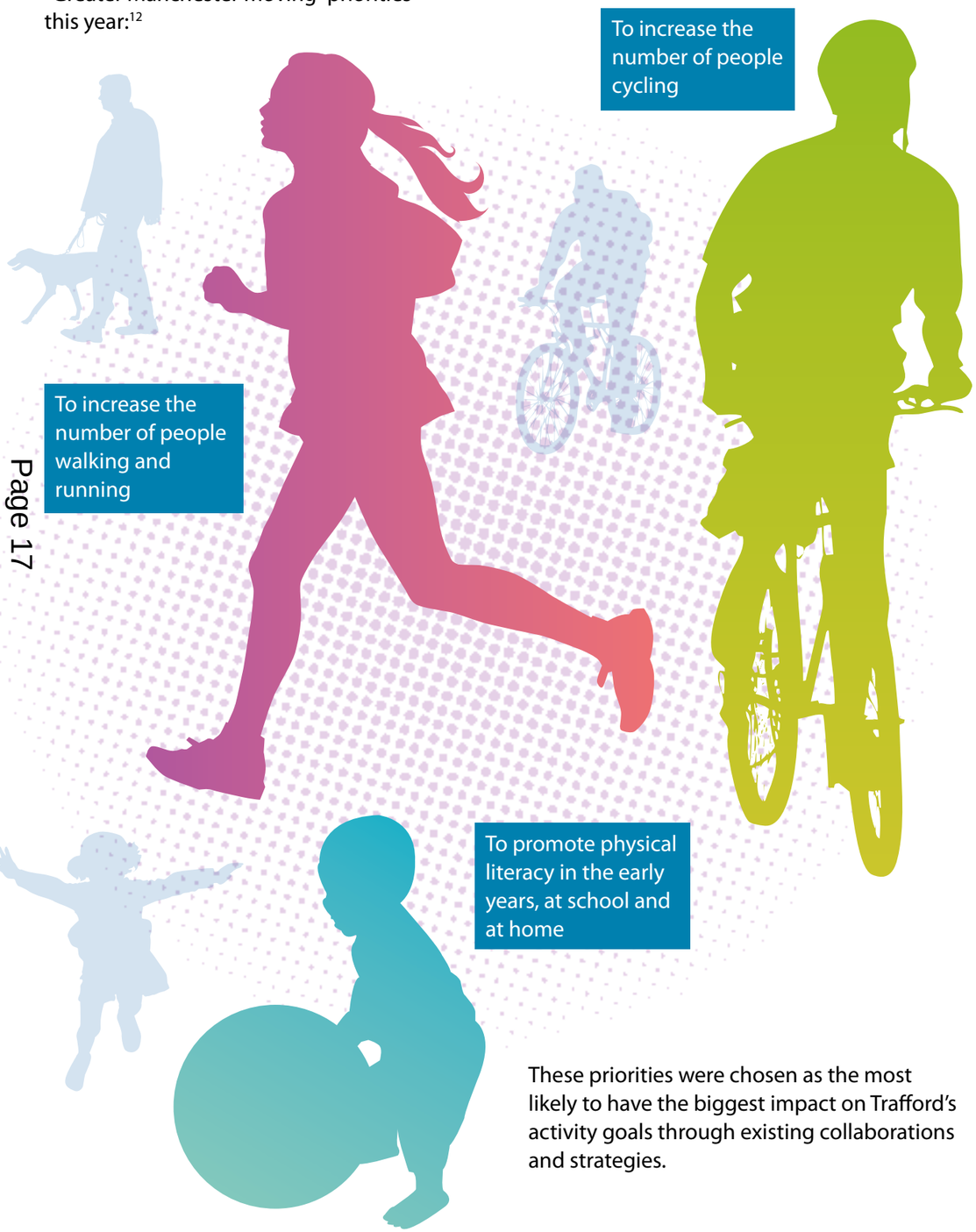
Source: Sport England. 2014/15





Living and Staying Well

Trafford is focussing on three of the "Greater Manchester moving" priorities this year:[12]



These priorities were chosen as the most likely to have the biggest impact on Trafford's activity goals through existing collaborations and strategies.

Increasing the number of people walking or running

Currently, the proportion of people in Trafford who walk for at least 10 minutes at least 5 times a week is lower than that in Greater Manchester or England[13].

Trafford	Gtr Manchester	England
41.8%	44.1%	47.2%

The following projects aim to increase the number of people walking and running in Trafford:

1. Promotion of physical activity in GP settings – helping staff to encourage people to exercise using local opportunities and partners.
2. **Healthy Hips and Hearts** programme – exercises to reduce frailty and improve mobility in older people.
3. **Learning from Liverpool East Activity Partnership** (LEAP) – analysis of a programme encouraging residents to take up sport and physical activity which could be applied in Trafford.

Increasing the number of people cycling

Trafford performs relatively well on the number of people who cycle at least 5 times a week:[13]

Trafford	Gtr Manchester	England
3.6%	1.8%	2.5%

Local priorities include increasing the number of people who cycle recreationally or for sport and who use a bicycle for daily journeys, including commuting to work or

Cycling improves health and reduces the number of cars on the roads, positively impacting on congestion and air quality.

We are working on an ambitious programme in partnership with Transport for Greater Manchester (TFGM) and British Cycling to increase the number of identified recreational routes within and beyond Trafford. This includes guided rides along scenic local routes pitched at various ability levels.

Full details are available at *www.goskyride.com*

Promote Physical Literacy in the early years, at school and at home

Greater Manchester Sport is supporting parents of young children to engage in physical activity through play.

Trafford's world famous sporting institutions provide inspiration to residents. They make an ideal platform on which to build the public health strategy for increasing physical activity in Trafford. Salford Quays is one of the country's largest open water swimming venues. Trafford also has a rich history and heritage of parks and green space, providing a stage for a wide range of activities which both reflect and define the local culture.

Living and Staying Well

Smoking

Smoking is the biggest single cause of preventable early death in Trafford, and also a major cause of inequalities in rates of death and ill health across the borough[14].

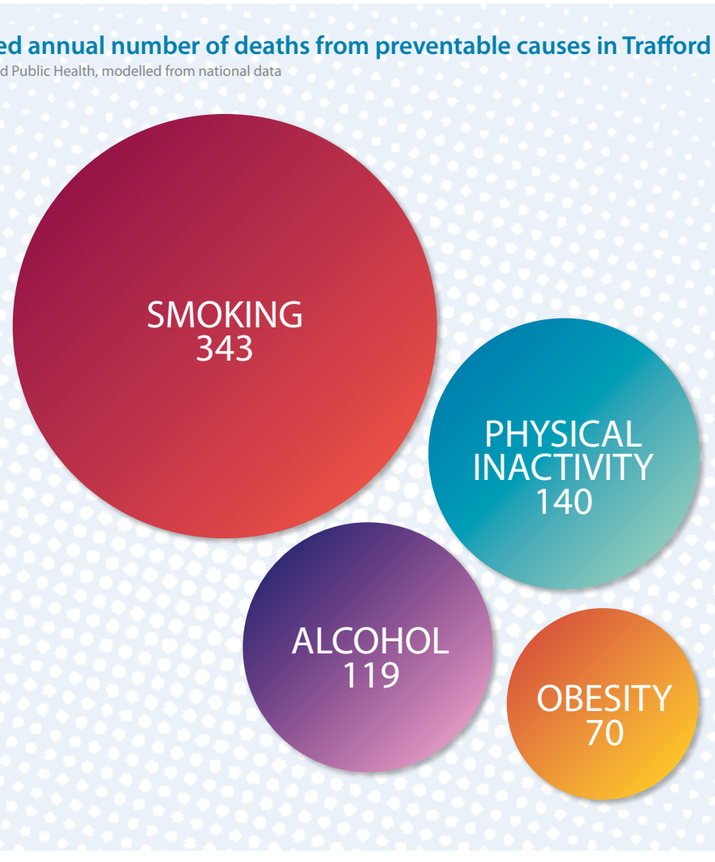
One in eight deaths from cardiovascular disease is smoking-related[15].

Adult smoking rates have fallen across Trafford, but this masks higher rates amongst certain communities, such as those with higher levels of deprivation. Support for people wanting to quit smoking in Trafford is available through –

- Local GP practices and pharmacies.
- **Trafford Specialist Stop Smoking Service**, which offers face to face appointments with trained advisors at nine clinics across the borough. Referrals can be made from a range of professionals including GPs, pharmacists, midwives, and learning disability teams. Stop smoking services offer tailored interventions for people making quit attempts, including nicotine replacement treatments and behavioural support.

Estimated annual number of deaths from preventable causes in Trafford

Source: Trafford Public Health, modelled from national data



Alcohol

Alcohol is a key cause of preventable premature death, chronic illness and hospital admissions in Trafford[16]. The number of hospital admissions caused by alcohol in Trafford has risen year-on-year for the past decade[16].

Safe drinking levels are: up to 21 units per week for men and "up to 14 units per week" for women[17]. Approximately 27% of Trafford adults regularly drink more than this every week[16].

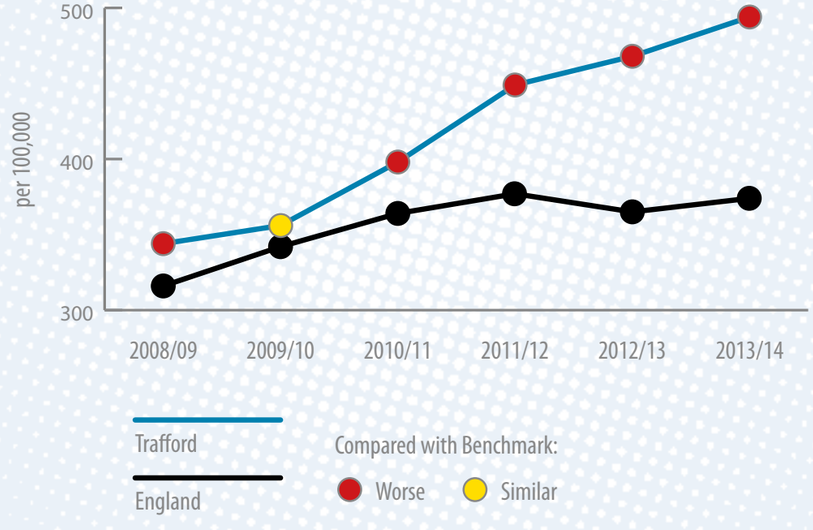
About 6.5% of adults in Trafford regularly drink very high risk amounts - that is, over 50 units per week for a man and over 35 units per week for a woman[16].

Support for people experiencing problems with alcohol in Trafford, includes:

- **Trafford Alcohol Navigation Service** provided by Phoenix Futures. This offers a bespoke treatment plan for anyone over the age of 11 in Trafford experiencing problems with alcohol, enabling individuals to make positive changes in their lifestyles.
- **The Recovery Abstinence Service** provides on-going support for people who have achieved abstinence, and has developed the "Future Skills" gardening initiative. This partnership agreement with Age UK provides a free gardening service to elderly residents in the Trafford Area and allows service users to get involved and learn new skills.

Trends in alcohol-specific hospital admissions for Trafford

Source: PHE, 2015



Living and Staying Well

Mental Health

Mental health is a key part of overall health and wellbeing. Unfortunately, mental health problems are quite widespread in the UK population, with about one in four British adults experiencing at least one mental health problem in any one year[18]. Anxiety and depression are the most common mental health problems, with around 1 in 10 people affected at any one time. These can be severe and long-lasting and often have a big impact a person's ability to get on with life. Other less common mental health problems include as bipolar disorder and schizophrenia.

Mental health conditions can be important causes of inequalities in health. Poorer people, the long-term sick and unemployed people are more likely than the general population to be affected by common mental health problems for over 18 months[19].

In Trafford, there is evidence that, despite some improvements in the quality of mental health care, more still needs to be done for this vulnerable population.
A recent national report found people with mental health conditions in Trafford have a disproportionately high rate of early death, even compared with people with mental health conditions in other parts of the country. This is despite a finding of relatively good access to health checks for people with mental health conditions in the area (*thersa.org/mentalhealth-data*).

Mental Health remains a priority for the Trafford Health and Wellbeing Board[20]. Approaches for Trafford must include work on the wider determinants of health for people with mental health conditions.This includes work with partners such as Trafford Housing Trust on local mental health and wellbeing programmes. These approaches will contribute, not only to reducing health inequalities, but also to improving rates of healthy life expectancy across the borough.

Substance Misuse

Greater Manchester West offers a bespoke treatment plan for anyone over aged 18 and over who may need support with prescribed medications, enabling individuals to make positive changes in their lifestyles.

Trafford achieves the highest completion rate for opiate misuse treatment in the North West. We are also working hard to detect the rising trend of New Psychoactive Substances or legal highs to ensure individuals are receiving appropriate treatment.

NHS Health Checks

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia by identifying risks and providing health improvement advice[21]. Everyone aged between 40 and 4 years is invited to attend an NHS Health Check every five years, with the exception of those who have certain long term conditions. Health Checks highlight how individuals' personal risks can be reduced through lifestyle changes such as quitting smoking, losing weight and drinking less alcohol, as well as giving people support to achieve these changes.

In Trafford over 5,000 people every year attend their NHS Health Check either at their GP practice or a local pharmacy[22].

Cancer Screening

Disease prevention and early diagnosis are important for improving health outcomes and life expectancy in Trafford. All eligible people are invited to have screening tests for breast cancer, bowel cancer and cervical cancer. Cervical Screening is delivered by GPs and breast and bowel screening through national programmes. For more information about cancer screening programmes, please see *www.nhs.uk/Livewell/preventing-cancer/Pages/cancer-screening.aspx* for more information.

The proportion of people in Trafford accepting a screening test varies considerably by locality and population group. Uptake of screening tends to be lowest in localities in the North of Trafford, which also sees some of the worst health inequalities in the borough. Increasing the numbers of people in these areas attending for screening tests could help to tackle these inequalities.

Public Health is working in partnership with health services, council partners, community and third sector organisations across Trafford to encourage and support people to have their cancer screening tests. Research is being analysed into why people may not go for screening tests and local groups and charities such as Macmillan, Cancer Research UK and Voice of BME-Trafford are working together with communities to help inform and engage people with screening programmes.

In 2014-2015, Trafford celebrated the highest cervical screening coverage rate in Greater Manchester. Schemes such as the 'One Minute' social media campaign, which promoted cervical screening to women across the borough, contributed to a range of approaches leading to this success. In Public Health, we hope to sustain this figure, improve uptake rates for breast and bowel screening, and reduce inequalities between groups in Trafford in 2016. This will cut the number of Trafford residents affected by cancer in the future.

Work, the Economy and Health – Good Quality Jobs

The conditions in which we work have a huge impact on our health; good quality jobs can improve and protect health, whereas poor quality work can be damaging to health and can also worsen inequalities across the population[23]. The UK economy has continued to grow following its peak before the 2008 financial crisis and we now have lower levels of unemployment[24]. This, however, has come hand-in-hand with increases in part time employment, more zero hour contracts and more in-work poverty[25-27].

Low-quality work can harm health through:

- Poor working conditions
- Psychological or social conditions at work
- Poor pay or insufficient hours
- Temporary or insecure work, with the risk of job loss

Employment and Worklessness in Trafford

Trafford is one of the economic powerhouses of Manchester but many of its skilled residents are employed by businesses in other areas of Greater Manchester.

Over 77% of the working age population in Trafford are in employment. This is higher than the figure for either the North West (71%) or the UK (73%)[28].

The biggest group of unemployed people claiming benefits in Trafford is those claiming Employment Support Allowance and Incapacity Benefit (5.6%). This is lower than both the North West and UK rates.

The proportion of Trafford residents claiming the main out-of-work benefits (7.6%) is also lower than the equivalent proportion in the North West or the UK (11.2% and 9.4% respectively).

Inequalities throughout the borough mean that the more deprived areas of Trafford also have the greatest proportions of residents with no qualifications and the highest unemployment rates[29].

Underemployment (not having access to as much work as they would wish) is a problem for some in Trafford. Occupations with the highest rates of underemployment include labourers, cleaners and catering staff[28].

What can be done:

- Local partnerships can draw on what is known about what constitutes 'good' and 'poor' quality work and can learn from emerging quality job promotion strategies, to develop better jobs for their local populations.
- Creating skilled jobs is crucial to creating good quality jobs, as skilled work typically has more protective elements and less health-adverse conditions.
- Local authorities should encourage the creation of jobs where workers are valued, receive a living wage at minimum, have opportunities for promotion and are protected from adverse conditions (such as shift work) where possible.

The Trafford Employment Skills and Enterprise Group, a subgroup of the Trafford Partnership involving local government, employers and the voluntary sector. It works to support recruitment to local businesses and to maximise employment and training opportunities for Trafford residents. Programmes include:

- **Nu-Traxx** – a programme aimed at improving employability skills in young people and moving them into employment
- **Working Well Programme** – in which Employment Support Allowance (ESA) claimants are assigned a key worker, providing intensive and tailored support for a period of two years
- **Stronger Families Programme** – integrating a number of services to create packages of support aimed at reducing anti-social behaviour, improving school attendance, and helping parents overcome barriers to work. This has seen good results in Trafford and is to be expanded in 2016 to support more families facing difficulties.

Living and Staying Well

Health Protection

Health protection is about reducing or preventing the harm caused by infectious diseases and hazards in the environment: for example chemicals and radiation. Local authority Public Health departments, working with Public Health England and the NHS, are responsible for planning to prevent such health threats and arranging responses to outbreaks or incidents. Immunisations, discussed in other parts of the report, are also important in the fight against infectious disease.

In Trafford one of the main health protection priorities is tackling healthcare associated infections such as MRSA. All cases undergo full investigation and root cause analysis in order to learn lessons and prevent future cases.

Public Health Protection Functions in Trafford

Prevention
Potential threats to population health, including environmental hazards and infectious diseases, can be targeted through joint working with the environmental health department in the council. Trafford Council works closely with Public Health England, using data and expert advice to set up local prevention strategies, for example for the prevention of tuberculosis.

Planning and Preparedness
The Secretary of State has a legal duty to protect the health of the population. This involves Public Health England (PHE) providing information to local agencies. The Director of Public Health (DPH) in Trafford provides information and advice and acts on behalf of the local authority, making sure robust plans are in place to protect the health of local residents, for example in preparing for a possible influenza outbreak. The DPH is also a local leader here, escalating any concerns to the correct authorities.

Partnership Working
Strong working relationships locally are important in health protection planning. Trafford Council works closely with NHS England, NHS Trafford Clinical Commissioning Group and provider organisations in health protection work. The DPH in Trafford Council chairs the multi-agency health protection forum, which provides assurance to the Trafford Health and Wellbeing Board that robust plans and arrangements are in place to protect the population of Trafford. The DPH also co-chairs the Local Resilience Partnership, participating and raising awareness of emergency plans in place for the local community.

Ageing Well

Trafford currently has a slightly higher percentage of older people than the profile of Greater Manchester as a whole and the life expectancy for men and women in the borough is better than the national average, at 79.5 years for men and 83.5 years for women[1].

The Future…

By 2020, there will be 3,000 more people aged over 65 years living in Trafford: of these, 1,000 will be aged over 90 years.

Older people provide the backbone of much family support and volunteer based services, but an ageing population can present a significant challenge to health and social care services and infrastructure.

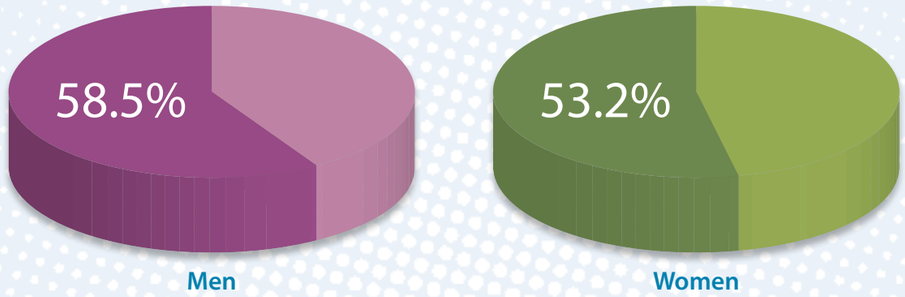
Future Needs

Future needs and demands for health and social care depend on more than just life expectancy. To estimate population needs, we also need to know the numbers of people supporting friends and family in older age and the levels of poor health and disability among older people.

Comparisons of total life expectancy with 'disability-free life expectancy' (the number of years after age 65 that people can expect to live without significant disability) give an indication of expected demand for health and care services.

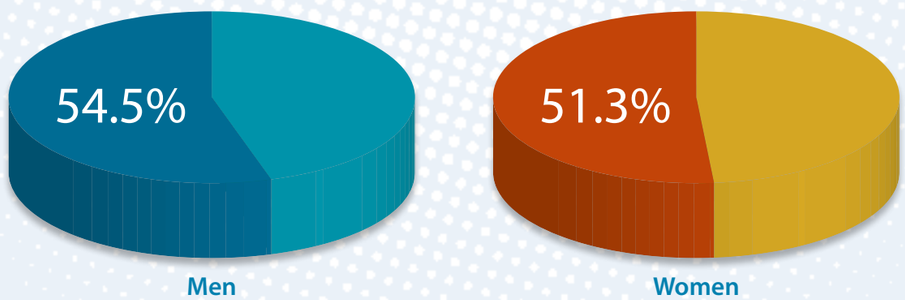
Number of people in the UK at age 65 expected to live over half their remaining lives free from disability

Source: Office of National Statistics. Disability-free life expectancy, 2015



Number of people in Trafford at age 65 expected to live over half their remaining lives free from disability

Source: Office of National Statistics. Disability-free life expectancy, 2015



We can see from the figures that people in Trafford are living with disability for longer than expected from the national figures.

Some of the causes of this poor health in older age are diabetes, cardiovascular disease and falls. Trafford is doing less well than the England average in some of these areas, including:

- Reducing death from preventable causes
- Uptake of NHS Health Checks
- Cancer screening
- Diabetic retinopathy screening
- Injuries due to falls in people aged over 65
- Fuel poverty

So improving our performance in these areas to at least the England average would significantly improve the health of our population and greatly reduce the need for services[30].

Inequalities across Trafford mean that health in the north of the borough is, on average, significantly worse than in the south[29].

Lifestyle Factors

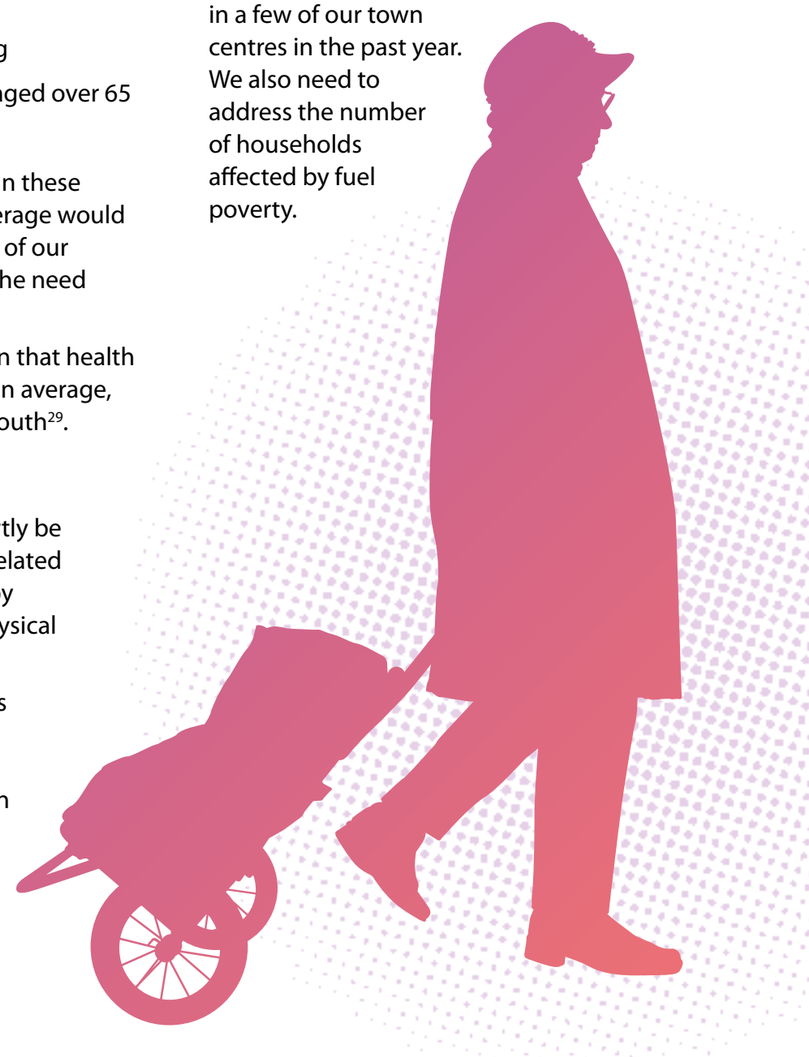
Improvements in health can partly be achieved by reducing lifestyle-related ill health, caused, for example, by smoking, alcohol use, lack of physical activity and obesity.

We have established programmes in all of these areas, but their reach and impact is variable. Improvements here would mean that everyone across Trafford could access the support they need to make lifestyle changes, ensuring our adult population ages well.

Environmental Factors

Changes to the environment in which people live can reduce the risks they face or can make healthier choices easier.

For example, changing street and pavement design and introducing dementia friendly standards for shops and cafes make it easier for people with visual or memory impairment to get out and about and retain their independence. In Trafford, dementia friendly initiatives have been introduced in a few of our town centres in the past year. We also need to address the number of households affected by fuel poverty.



Final Words

During the last two years, Public Health has established a positive start in the Local Authority, developing successful relationships with a range of partners within Trafford and the surrounding areas. Major challenges remain, crucially, the need to tackle persisting inequalities in health, whilst improving overall healthy life expectancy through a life course approach. A strong focus on ill health prevention will support the transformative challenges facing the Trafford in the coming years.

Abdul Razzaq
Director of Public Health
Trafford Council

References

1. Office for National Statistics. *Population mid-year estimates 2013*. London. 2015.
2. Public Health England. *Public Health Profiles. Child Health Profile 2015; Trafford.* London. 2015.
3. Trafford Council. *Joint Strategic Needs Assessment: 2012.* Available at: www.infotrafford.org.uk/jsna.
4. Trafford Council, DCS Safeguarding Governance Group. *Monthly Safeguarding Activity Report: July 2015.*
5. Health and Social Care Information Centre, (2015) National Child Measurement Programme 2013-2014.
6. Department of Health. *Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers.* London. 2011.
7. Chief Medical Office. Department of Health. *At least five a week: Evidence on the impact of physical activity and its relationship to health.* London. 2004.
8. Morris JN, Heady JA, Raffle PA, Roberts CG, Parks JW. Coronary heart disease and physical activity of work. *Lancet.* 1953: 265;1053-1057.
9. Sport England. *Active People Survey 9.* Available at: http://www.sportengland.org/research/about-our-research/what-is-the-active-people-survey/.
10. Allender S, Foster C, Scarborough P and Rayner M. The burden of physical activity-related ill health in the UK. *Journal of Epidemiology and Community Health*. 2007: 61; 344-348.
11. Ossa D & Hutton J. *The economic burden of physical activity in England.* London. 2002.
12. Greater Sport: Greater Manchester Sports Partnership. *Greater Manchester Moving.* Available at: http://www.greatersport.co.uk/get-active/greater-manchester-moving.
13. Department of Transport. *Walking and cycling statistics: Proportion of residents who walk or cycle for recreational purposes (CW040).* London. 2015.
14. Public Health England. *Tobacco profile for Trafford.* 2015. Available at: http://www.tobaccoprofiles.info/
15. Action on Smoking and Health (ASH). *Smoking statistics.* 2014. Available at: http://ash.org.uk/files/documents/ASH_107.pdf .
16. Public Health England. *Trafford alcohol profile.* 2015. Available at: http://fingertips.phe.org.uk/profile/local-alcohol-profiles
17. NHS Choices. *Alcohol Units.* 2015. Available at: http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx
18. The Office for National Statistics. *Psychiatric Morbidity report.* London. 2001.
19. National Statistics. *Better Or Worse: A Longitudinal Study Of The Mental Health Of Adults In Great Britain.* London. 2003
20. Trafford Council. *Trafford Joint Health and Wellbeing Strategy 2013-2016.* Available at: http://www.infotrafford.org.uk/hwbstrategy.
21. Public Health England. *NHS Health Checks website.* Available at: http://www.healthcheck.nhs.uk/
22. Public Health England. *NHS Health Check Data* – October 2015. Available at: http://www.healthcheck.nhs.uk/interactive_map/north_of_england/north_west/?la=Trafford&laid=90
23. Bell, R., et al., *Work, stress and health: The Whitehall II study.* J. Ferrie, Editor. 2004. International Centre for Health and Society/Department of Epidemiology: London.
24. PwC. *UK Economic prospects.* 2014. Available at: http://www.pwc.co.uk/the-economy/publications/uk-economic-outlook/ukeo-nov2014-prospects.jhtml
25. Office for National Statistics, *People and proportion in employment on a zero-hour contract:* 2000-2012, October to December, each year (ONS Labour Force Survey). 2014.
26. Unite. *Government must act to halt rise in zero hours.* Available at: http://www.unitetheunion.org/news/governmentmustacttohaltriseinzerohours/
27. MacInnes, M.D. *Monitoring Social Exclusion and Poverty 2014.* Joseph Rowntree Foundation, 2014.
28. Nomis. *Labour Market Profile – Trafford.* 2016. Available at: www.nomisweb.co.uk
29. Department for Communities and Local Government. *Indices of Multiple Deprivation (IMD) 2015.* Available at: http://www.infotrafford.org.uk/deprivation#info
30. Kippin, H. Randle, A. *Managing Demand: Building Future Public Services.* 2014. Available at: www.thersa.org/discover/publications-and-articles/reports/managing-demand-building-future-public-services

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For further information on the work programmes included in this report, please visit www.trafforddirectory.co.uk

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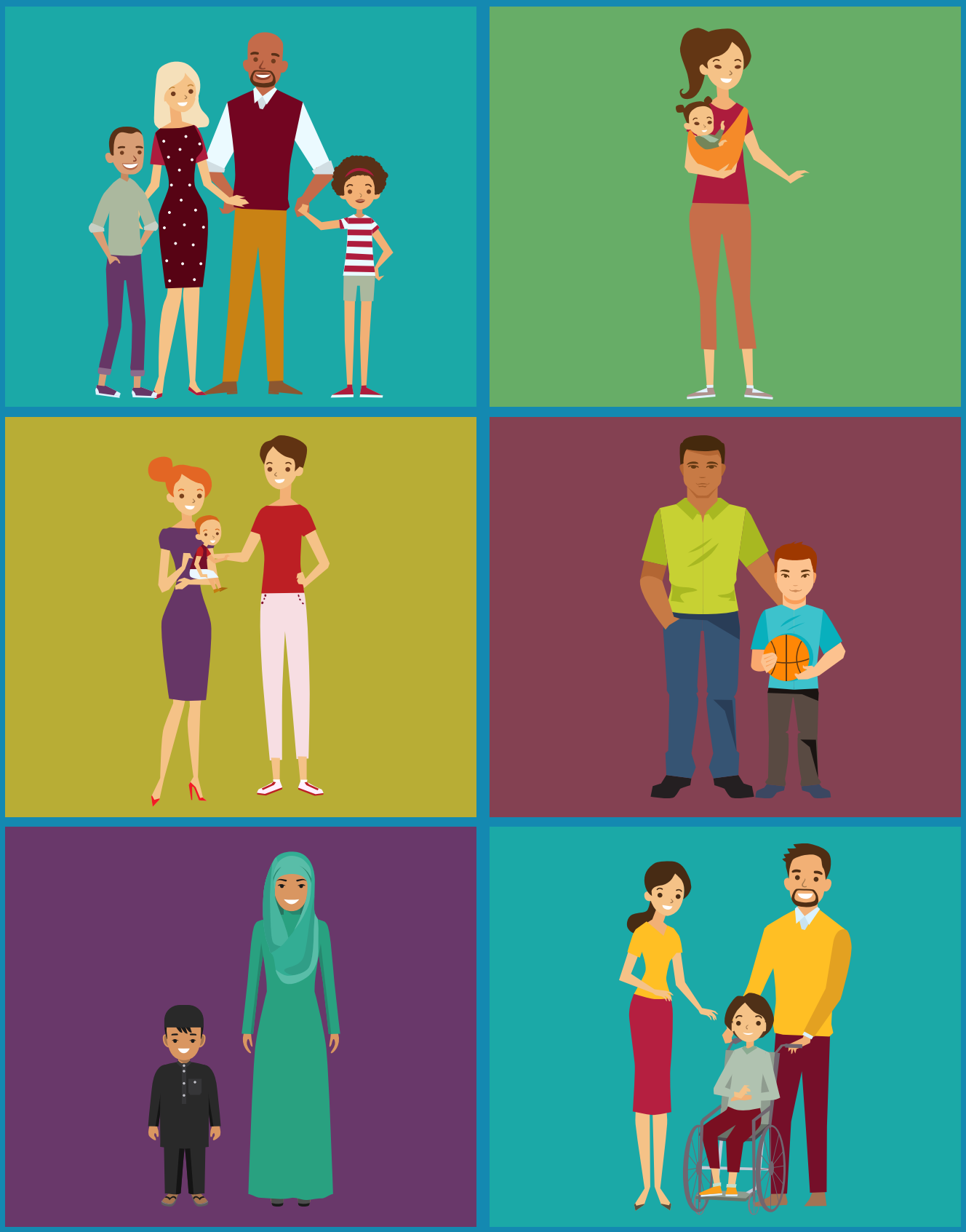


Report of the Director of Public Health

Trafford 2016/17

Foreword by Cllr John lamb

Executive Member for Health and Wellbeing

The report of the Director of Public Health is an important document of interest to all those who work towards a healthy resident population in Trafford. While Trafford on the whole has a healthy population, this masks some areas where health outcomes are poor and where much work is still needed.

We are reminded that five priorities have been identified which inform the work of the Health and Wellbeing Board and other plans. These are reducing the impact of mental illness, reducing physical inactivity, reducing the number of people who smoke or use tobacco, reducing harms from alcohol and improving cancer prevention, particularly through screening. The recommendations that accompany these areas need to be acted upon but I just wish to draw attention to one area that I believe we can all immediately take action on, and that is the reduction of physical inactivity.

The benefits to people, of any age, of engaging in some sort of regular physical activity to a minimum level of exertion are well documented. This can range from engagement with organised sport to brisk walking around the local park. Some good work has already been undertaken in Trafford to encourage inactive residents to become more active but there is a lot more that can be done in this area by our communities. Regular physical exercise ensures that we are less likely to need the services of health professionals for a longer period of our lives. Quite simple exercise regimes done individually or in groups are a very effective way of maintaining physical and mental health and a challenge for community leaders and activists is how we encourage residents to engage with what has been described as the best 'health pill' available.

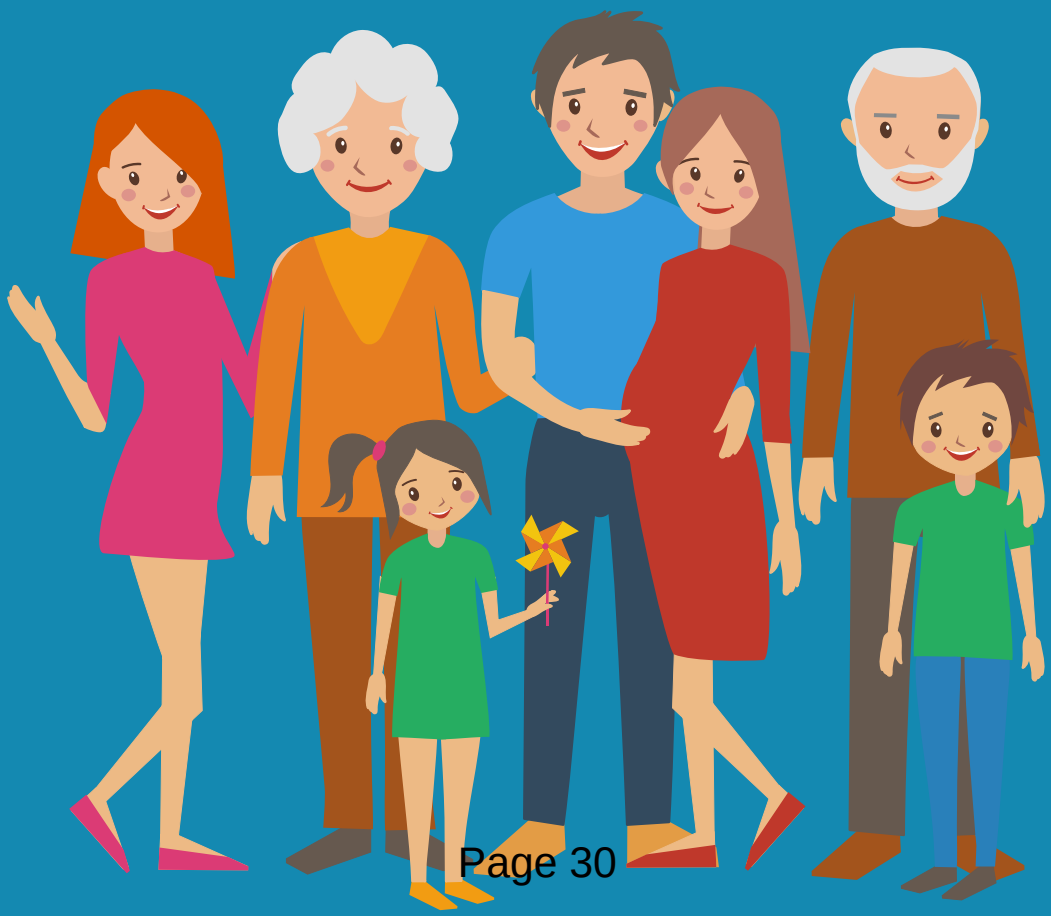
This report then sets out the challenges for health professionals and our communities and its recommendations are designed to improve our chances of a healthy life, which is the foundation of all that we aspire to as human beings.

Acknowledgements by Eleanor Roaf, Interim Director of Public Health

I would like to thank everyone who has contributed to and helped shape this report, including all members of the Health and Well Being Board.

Particular thanks go to Kate Hardman, Public Health Intelligence Analyst; Paul Burton, Public Health Intelligence Analyst; Helen Gollins, Public Health Consultant; Julie Hotchkiss, Public Health Consultant; Christine Camacho, Public Health Registrar; Sam Mansfield, Commissioning Officer; Judith Williams, Clinical Specialist (Dietetics) & Senior Practitioner (Weight Management); Vimi Jhatakia, Project Support Officer and Bo White, Specialist Commissioner, Clinical and Public Health Commissioning.

Contents



Introduction

Overall, health in Trafford is good, and we should celebrate this. On most measures, the health of people in Trafford is similar to the national average, and excellent compared to most of the rest of Greater Manchester. With its good schools and high quality housing, and plentiful access to green spaces, Trafford is a highly desirable place to live.

In last year's Public Health Report, we described how, despite the good picture overall, there were some outcomes where we performed poorly, especially when we compare ourselves to our **statistical neighbours**, (the boroughs that are most similar to ourselves in population structure and social conditions). In particular, we discussed **improving our healthy life expectancy**, which is how long we can expect to live before a major condition or disability affects our daily lives.

To improve healthy life expectancy, and to reduce the inequalities gap, we identified five key areas for improvement:

1	2	3	4	5
To reduce the impact of **mental illness**	To reduce **physical inactivity**	To reduce the number of people who smoke or use **tobacco**	To reduce harms from **alcohol**	To improve **cancer prevention** and **screening**

Addressing these priorities is the main focus of our Health and Wellbeing Board, and the issues also feature within our Locality Plan and our Transformation plans.

In this report, we are focussing specifically on how these issues affect the life chances of our children and young people.[1] We need to ensure that all of our population can access the benefits of living in Trafford, making our motto '*No one held back, and no one left behind*' a reality.

We want children to be born into circumstances that support and encourage them, and enable them to develop positive habits that will stand them in good stead as they get older. Some individual lifestyle choices can enhance or damage health, so we need to make the healthy choices easier, and the unhealthy choices harder. We know that the statutory, voluntary and business sectors can make changes to the environment in which people live, work and play, in order to increase health-promoting behaviour.

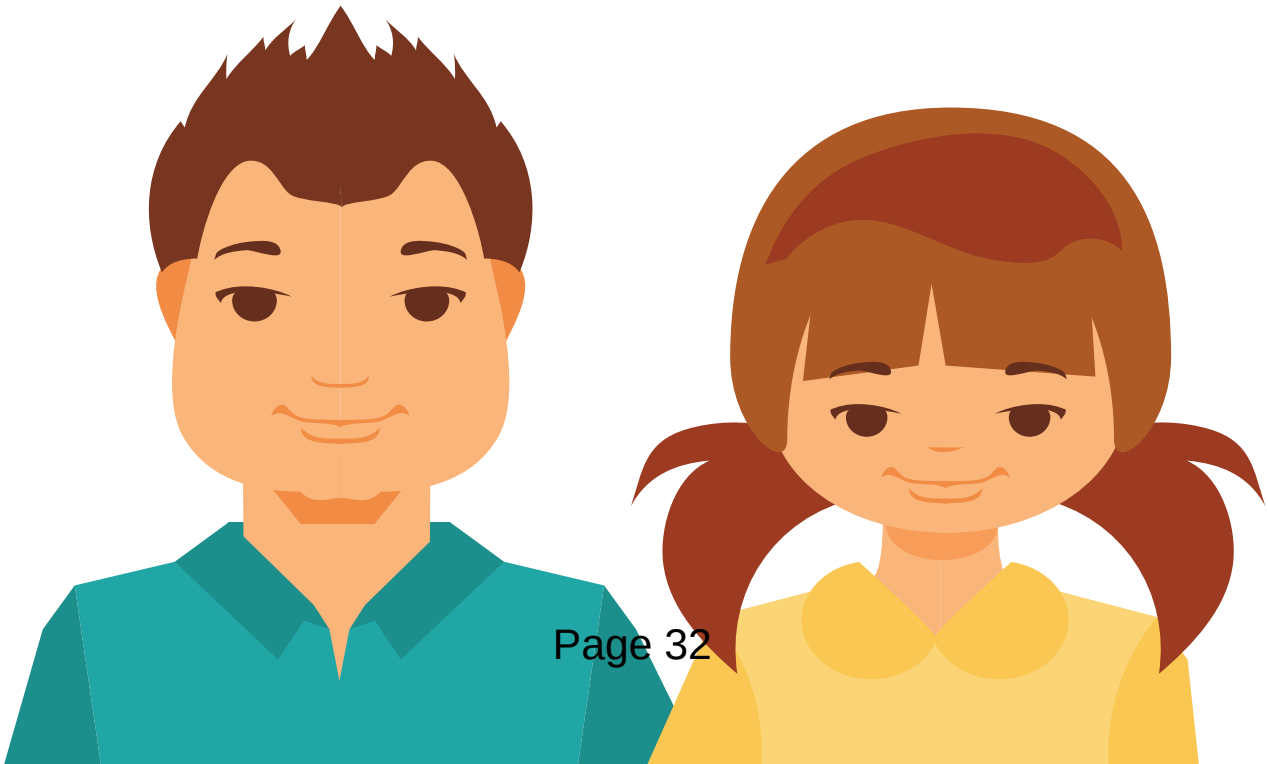
At the same time, we need to increase the value that people place on their health and so maximise the chances of achieving a healthy and productive life. Our self-image and perception of worth start to be formed very early in life, and children raised in a loving, nurturing environment are more likely to develop positive feelings towards themselves. So, to get the best outcomes we need to start early.

1. A child is aged up to 19 years, but up to 25 years if they have complex and additional needs

Child Health in Trafford

It is estimated that 234,700 people are resident in Trafford[I], with 26% of our population aged between 0-19 years, 57% aged between 20-64 years and 17% aged over 65 years. By 2030, it is estimated that the population of Trafford will increase by 10%, in line with predictions for England.

Trafford generally does well on most child health and wellbeing indicators. Women smoking during their pregnancy, starting breastfeeding, children being in the healthy weight range and exam results at age 16 are all better than the England average. Areas of concern include hospital and A&E attendances for young children and levels of physical inactivity in teenagers[II]. You can access Public Health Children's Outcomes at **https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-overview/.**



One of the greatest challenges in Trafford is the impact of health and social inequalities as these are often masked by Trafford's good outcomes for most of its population. Economically, compared to the England average, nearly twice as many people in Trafford fall into the most affluent fifth of the population (39%) and only half as many (9%) are in the most economically deprived group. About 6,000 (14%) of children live in low income families. We tend to use "in receipt of free school meals" as a measure of deprivation in school age children.

In Trafford, 80% of the population report their ethnicity as White British. Of the remaining 20%, the biggest proporation of people are Asian and Asian British[IV]. The communities with the highest proportion of people from black and minority ethnic groups (BME) are often those disproportionally affected by deprivation.

In Trafford on 31st March 2017, there were 384 children in care, 257 children on a child protection plan and 625 children on a Child in Need Plan. These children are more likely to come from families affected by deprivation. Between 2011 and 2016, the number of children in care increased by a quarter (24.5%)[V]. Trafford has higher rates of children in care than many other similar areas.

Making sure that all children are developing at the expected rate is important in planning and designing services to meet children's needs. One way of assessing a child's development is to see whether they are ready for school when they leave the reception year. They should have basic levels of personal, physical and social skills, and the ability to communicate so that they can learn in a classroom setting. We call this "school readiness". In Trafford, three quarters (74%) of school children are deemed to be 'school ready', which is above the national average. However, just under half (47%) of Trafford's children who are eligible for free school meals are classed as 'school ready' which is much worse than national figures (2015/16). This shows that we are not doing well for our most vulnerable children[VI].

This inequality, which is evident by age 5, is perpetuated throughout Trafford's education system. According to the latest published data, overall 72% of children achieved 5 good GCSEs (A* to C), but the figure was only 39% of children with free school meal status.

Figure 1: shows an overview of Trafford's child health outcomes[iii].

Key

Statistical significance compared to England

Better Similar Worse


Low birth weight
Breastfeeding initiation
Admissions of babies <14 days
Admissions for respiratory infections
Primary School
Vaccinations (age 2-5)
Accident/deliberate injury admissions (age 0-4)
Physically active (age 15)
Low life satisfaction (age 15)
Alcohol-specific admissions (under 18)
Admissions for self-harm (age 10-24)
Young adults
Admissions for asthma (under 19)
Road traffic accidents (under 15)

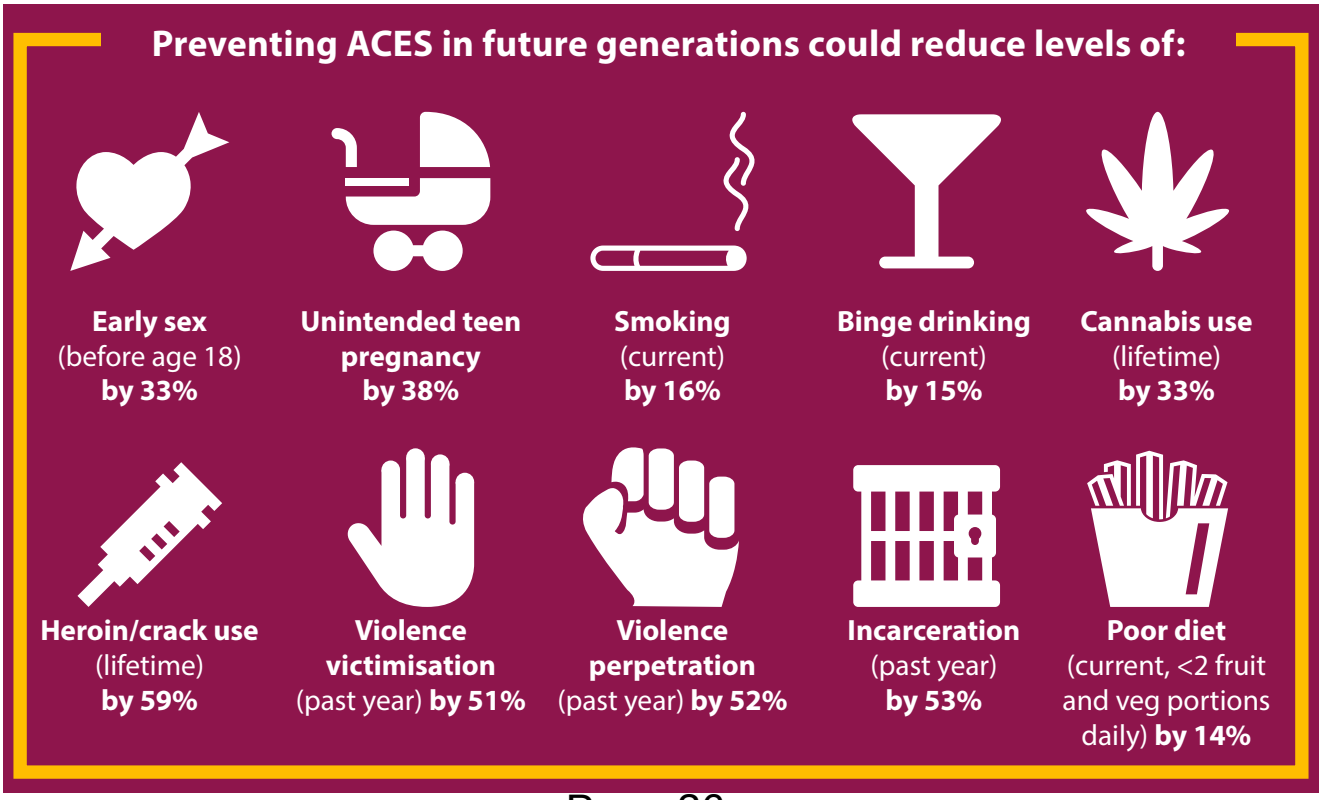
Understanding the impact of adverse childhood experiences (ACEs)

Recent research has shown that the impact of events in childhood is much greater than had been previously understood. Children experiencing neglect or abuse have poorer health, educational, and economic outcomes in adulthood. Adverse childhood experiences (ACEs) impact on a child's social and physical development. Living in an adverse environment or prolonged exposure to adverse experiences subject the developing body to an extended period in the "fight or flight response" which can alter the way the brain, nervous and immune systems develop[VIII].

Preventing or minimising the impact of ACEs will have a considerable impact on the health, wellbeing, economic productivity and sustainability of our borough. ACEs can be direct (e.g. physical or emotional abuse) or indirect (e.g. witnessing domestic abuse or having a family member with poor mental ill health) and the impact appears to be cumulative, with the risk of poor outcomes increasing with the number of ACEs suffered.

Children and young people exposed to ACEs have, over their life course, an increased risk of poor health outcomes and health harming behaviour such as poor mental health, binge drinking, illicit drug use and premature death[IX]. We know that most of our safeguarding activity results from the impact of the toxic trio - mental health problems, substance misuse and domestic abuse. We also know that children who have been looked after are at higher risk of poorer outcomes for both mental and physical health.

Figure 2: Adverse Childhood Experience[x] (aged 18 to 60 years)



As a borough, in order to protect and improve our children's health and wellbeing and support them to become healthy and productive adults, we need to prevent ACEs and address the impact they have on our population. There are examples of good practice from across the UK where services including schools, police divisions and early help hubs have become ACE aware, incorporating questions about service users' experiences and those of their children into routine enquiry.

Agencies should have appropriate screening processes in place to identify the risk factors and signs. These signs include inconsistent attendance at school, being particularly withdrawn and reluctant to participate in activities, reluctance to talk about the home situation, deterioration in personal hygiene and appearance, and loss of weight. Staff should be confident to talk to the child about this and be aware of specialist services to refer them to for support.

Public Health Recommends

- Trafford Partnership should become ACE aware, supporting a programme of structured awareness raising and training to all staff with the aim of improving health and social care outcomes.
- Operational staff working with children or families should have up to date knowledge of ACEs, including how to identify these and how to mitigate the impact.
- ACE enquiry should feature in all assessments for interventions such as Early Help or Safeguarding, or those that involve behaviour change.

Our Public Health Priority Areas

Our five Health and Wellbeing Board priorities are intrinsically linked to ACEs. Each priority is discussed below with reference to the health of children and young people.

Reducing the impact of mental illness and improving emotional wellbeing

> *"The emotional wellbeing of children is just as important as their physical health. Good mental health allows children and young people to develop the resilience to cope with whatever life throws at them and grow into well-rounded, healthy adults".*
>
> Mental Health Foundation, 2016

Much evidence supports the impact of social factors on poor mental health need and the link between physical health, disability and mental health[XI] .

About 1 in 8 children and young people in Trafford aged 5-16 suffer from a diagnosable mental health disorder: that is, on average, 2 to 3 children in every school class. This means about 3,500 children in Trafford at any one time will be experiencing mental health problems. The most common type of these is conduct disorder which represents over half of the total.

1 in 8 children and young people will experience mental health problems

About six percent of children and young people deliberately self-harm, which equates to about 3,000 people in Trafford. In addition, about 3,000 young people between 16-24 will have an eating disorder. This does not include younger children so is likely to be an underestimate of the total number of people requiring support in Trafford[2].

Up to 15% of women experience mental health problems during pregnancy or in the months following the birth of their baby. Of the 2,800 births in Trafford in 2015 an estimated 340-420 mothers were affected. This is important because mental health problems in parents are associated with a higher rate of mental health problems in their children.

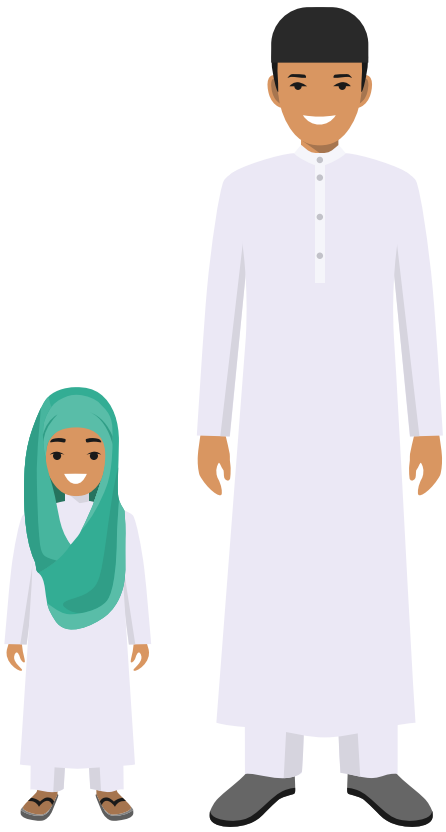
2. All of these figures are estimates based on national surveys which have been applied to the Trafford population so the numbers are not exact but it gives an indication of the high level of need in Trafford

The Mental Health Foundation recommends the following things to help keep children and young people mentally well:

- being in good physical health, eating a balanced diet and getting regular exercise
- having time and the freedom to play, indoors and outdoors
- being part of a family that gets along well most of the time
- going to a school that looks after the wellbeing of all its pupils
- taking part in local activities for young people[XII].

Public Health Recommends:

- Mental health acknowledged to be just as important as physical health (parity of esteem), with mental health and wellbeing becoming everybody's business.
- That Trafford Partnership promotes mental health and wellbeing, by ensuring all organisations:
    - promote resilience, prevention and early intervention
    - understand the importance of parenting and the impact of poor mental health, drug or alcohol use on people's ability to parent well
    - improve access to effective mental health support, including for those with long term physical conditions
    - train staff to work with people with mental health issues
    - evaluate services and interventions so we can monitor our progress.

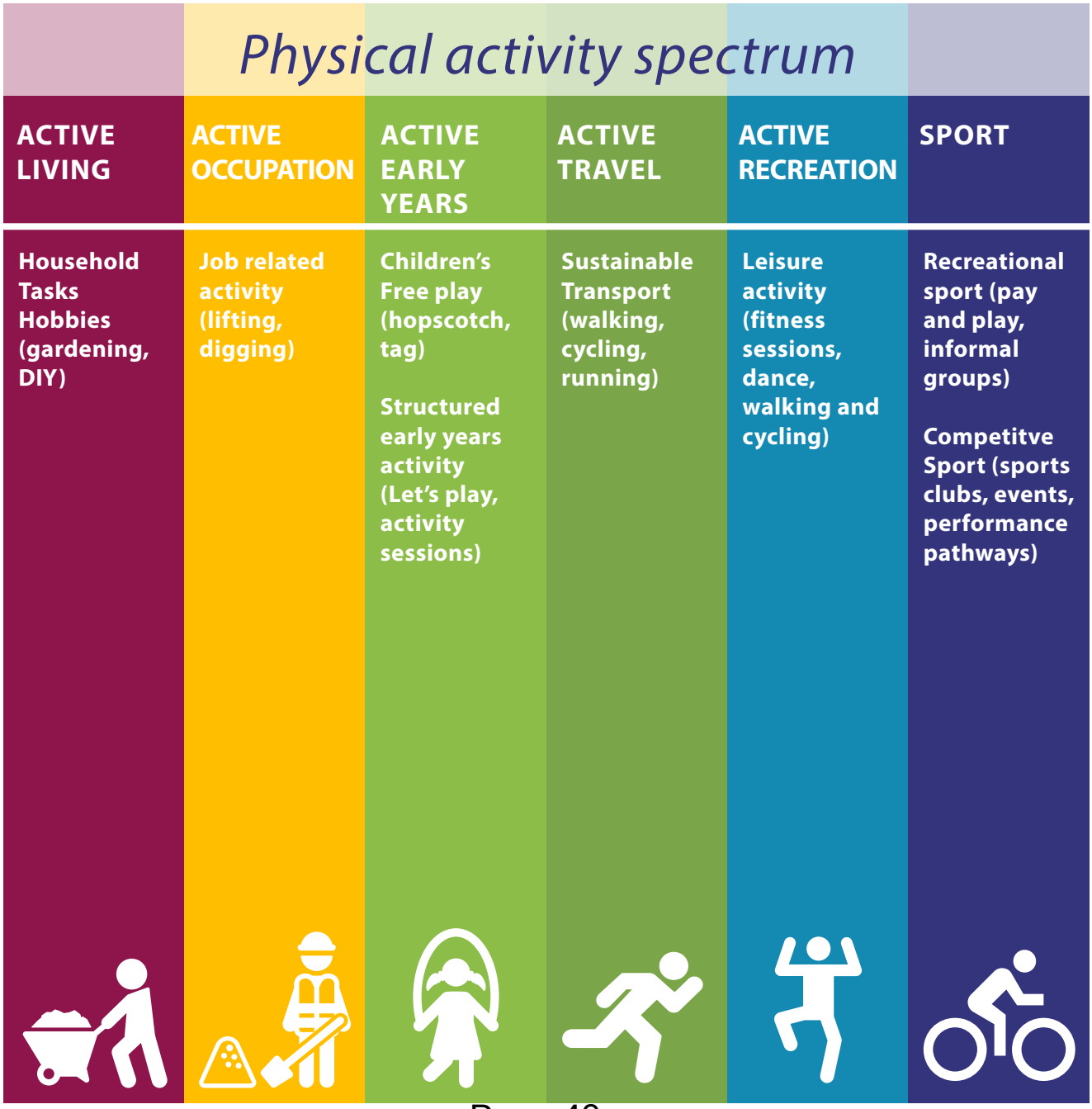


Increasing physical activity

Physical activity is associated with many health benefits for children, such as muscle and bone strength, health and fitness, improved quality of sleep and healthy weight. There is also evidence that physical activity and participating in organised sports and after school clubs is linked to improved academic performance[XIII].

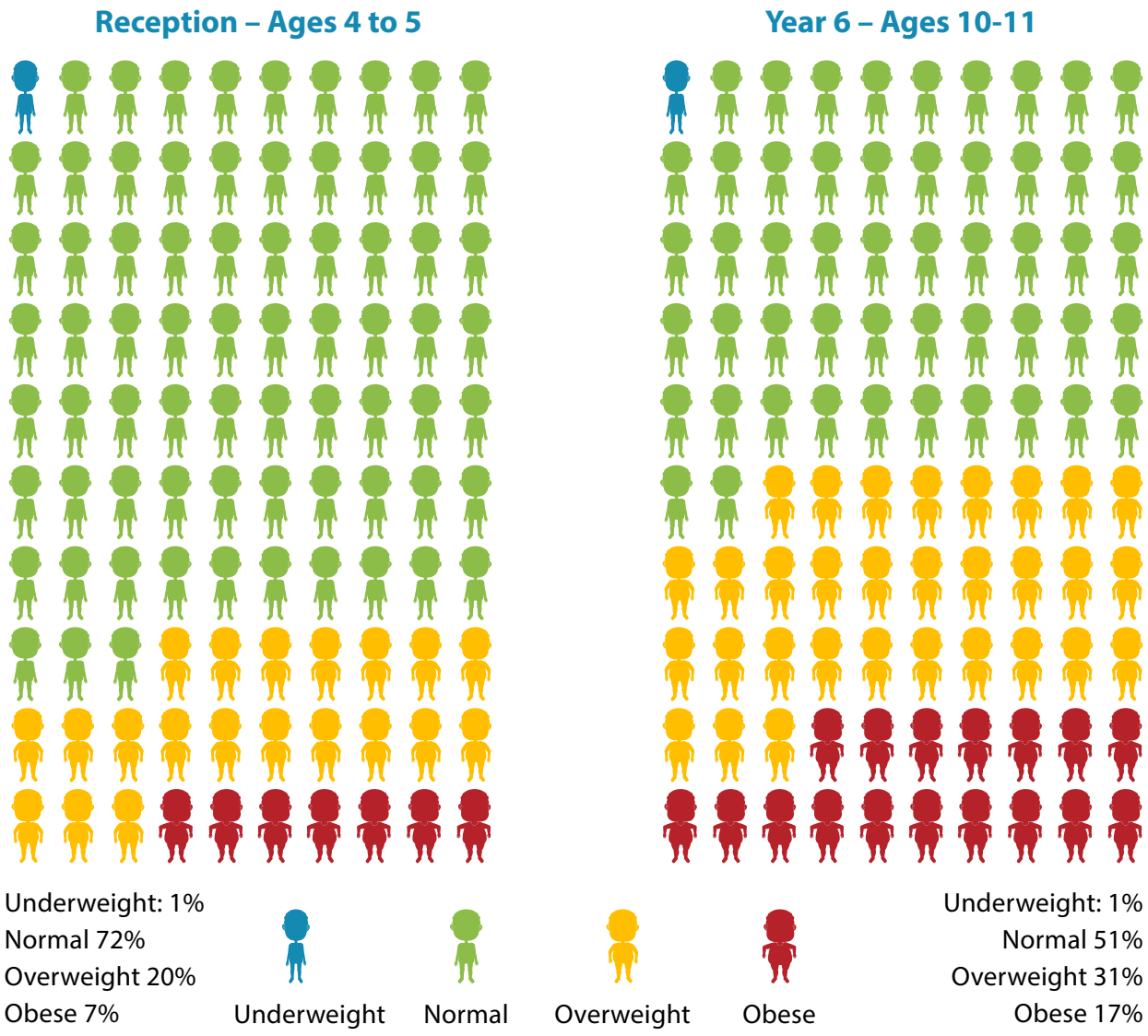
'Physical literacy' is a term used to describe the motivation, confidence, physical competence, knowledge and understanding to value and take responsibility for engagement in physical activities for life. Ensuring that all our children reach a good level of physical literacy in the early years is vital, as, without this, they will fall behind their peers in the development of the skills needed to maintain and enjoy an active lifestyle. In Trafford, our health visitors and school nurses have been working with others to increase physical literacy levels in our young children, and this is proving to be hugely popular with children and families.

Figure 3: Physical Activity Spectrum



Only 11% of 15 year olds in Trafford report being active for at least an hour a day, every day, which is worse than the national average[XIV]. Over a quarter of children are overweight or obese at age 5, rising to nearly half of children by the end of primary school.

Figure 4: Summary of children's weight in Trafford 2015/2016[XV]



Charley and Ronan[3] are two Trafford children who, with the support of Public Health services, have improved their health and wellbeing by becoming more physically active.

Case Study 1: Healthy Weight and Physical Activity

Ronan is six and severely obese. He was referred by the asthma nurse to the Children's Weight Management Service (CWMS) as he struggled to exercise due to his weight.

Ronan, alongside various members of his family, completed the CWMS behavioural, multicomponent family-based programme. His parents worked on making changes for the whole family.

Each session included education on a relevant aspect of a healthy lifestyle followed by individual goal setting and problem solving. Ronan received sessions on the importance of eating regular meals and eating plans, the Eatwell guide, portion sizes, drinks and label reading.

Ronan's family, as a whole, made lifestyle changes;

- Increasing the amount of fruit and vegetables eaten
- Having fewer sugary drinks – drinking more water
- Reducing fatty and sugary snacks
- Increasing activity, bought active play equipment and completed Balance, a 12 week physical activity programme delivered by Trafford Leisure Trust
- Using low fat cheese

At the end of the programme, Ronan's parents reported that he was able to reduce his asthma medication, they had needed to make fewer trips to A&E and the Asthma Nurse was attending less often.

Ronan successfully reduced his BMI and became a healthier weight, his father and mother also became a healthier weight, and the family have ongoing contact with his school nurse, in line with Trafford's Children and Young People's Healthy Weight Pathway.

Judith Williams, Clinical Specialist (Dietetics) and Senior Practitioner (Weight Management), Pennine Care NHS Foundation Trust says, *"Ronan shows how childhood weight management can give such significant health improvements now as well as for the future. We encourage a family approach and it was great to see how all the family benefitted from completing the programme."*

3. Ronan is not the child's real name

Case Study 2: Improving confidence and self-esteem by being physically active

Charley Evans was 12 when she was referred to the Balance Physical Activity Programme in January 2016 by the Children and Young People's Weight Management Service.

It was felt that Charley would benefit from increased levels of physical activity. This bespoke programme for the family gave some very positive results. The Balance Programme provided Charley, her mum and sister with the opportunity to undertake physical activity together in a fun and safe environment with the support of Trafford Leisure's Active Living Leader.

The focus of Charley's programme was to assist with her confidence levels, increase her self-esteem and increase her exercise levels to aid weight loss. In addition to the group session that Charley and her family attended, they accessed additional supported sessions in the gym and swimming.

Confidence was also an issue for Charley and the programme significantly helped this, with Charley becoming an ambassador for subsequent participants. Her attendance at the sessions was excellent and her commitment to change was noticeable. She used the knowledge she had gained regarding physical activity levels and food choices to aid and support others in the groups.

She won the Trafford Physical Activity Recognition Award at the 2016 Trafford Sports Awards, and went on to represent Trafford at the Greater Manchester Awards.

Charley started at secondary school in September and the Balance programme provided her with a strong foundation during this period. She successfully made new friends whilst on the programme which gave her a much needed boost in her self-esteem.

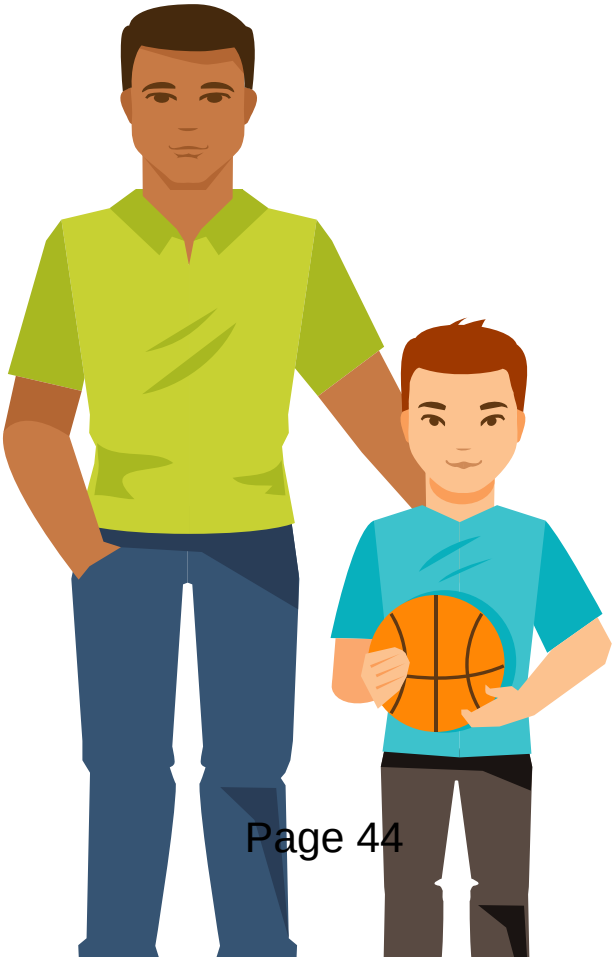
The whole family changed their habits and attitudes and regularly undertook more activity and exercise outside the structured sessions, such as bike rides, playing in the park and Charley played more sport at school which she had never done before.

Helen, Charley's mum commented *"I feel this is an absolutely brilliant opportunity for kids that are either overweight, lack self-esteem or just don't get enough exercise. It takes them out of their comfort zone in a friendly and encouraging manner"*

Public Health Recommends

For Trafford people to be more physically active, we should:

- Promote community wide understanding of the importance of physical activity.
- Support communities to be more active by ensuring that the environment we live in is safe, green and clean, making outdoor activity pleasant and giving parents the confidence to let children play outside.
- Encourage physical literacy from birth to promote lifelong physical activity.
- Invest in and promote the use of active travel (walking, cycling, or using public transport), as this has been shown to be a highly cost effective method of increasing physical activity[XVI].
- Make every contact count: encourage primary care and front line staff to promote physical activity.
- Support staff to exercise using local opportunities and partners. An innovative example of a CCG and LA collaboration can be found here: **www.reading.gov.uk/PRBeatTheStreet2015**.
- Make sure the activities we offer or promote encourage everyone to be active. Activities offered should be evidence based, accessible and appropriate to different age groups and needs. There should be a variety of both sport and leisure activities, for example running clubs, led walks and dancing. Gardening or allotments can also be a great way of keeping active and spending time outside.

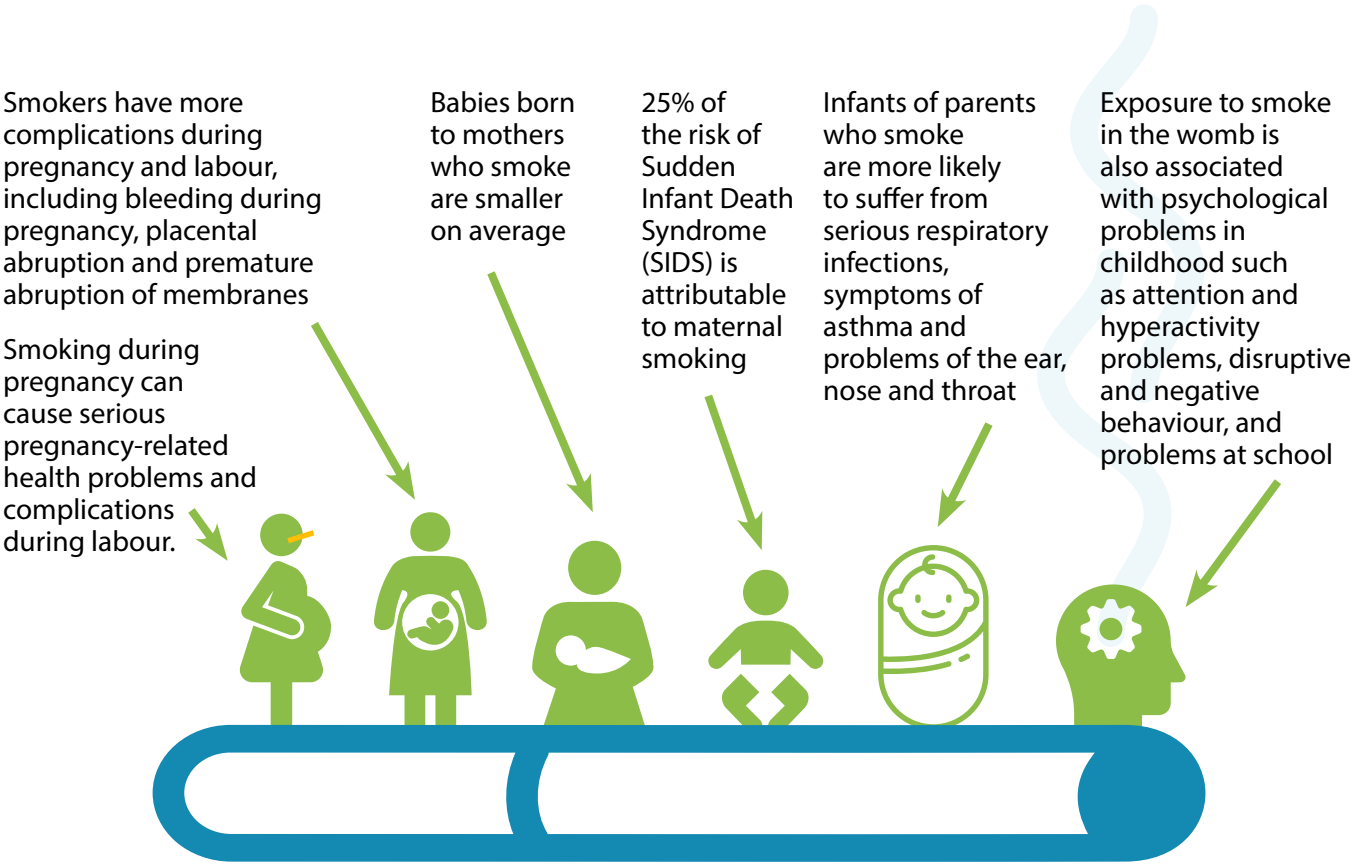


Reducing the number of people who smoke or use tobacco

Exposing a child to tobacco smoke is very harmful, and we should be encouraging all parents to keep their child's surroundings smoke free. We know that many women manage to avoid smoking during pregnancy, but are unable to maintain this longer term. In Trafford 7.5% of women report being smokers at the time when their baby is born, and this may be an underestimate. Take 7 Steps Out is an initiative aiming to change habits to make adult carers move away from the child (for instance going outside) before lighting up a cigarette.

Some of the harms from smoking to children and mothers are summarised in figure 5. About 15% of the adult population are smokers, and 5% of 15 year olds reported smoking regularly[XVII]. However, smoking rates are much higher in economically deprived areas, and this adds to the risks faced by children in these areas. The number of people smoking has been decreasing since the ban on smoking in public places came into effect. We must continue to "de-normalise" smoking as this is the most effective way of preventing young women who will become mothers in the future from ever starting smoking.

Figure 5: Overview of harms to mother and baby from smoking



Electronic cigarettes (e-cigarettes) provide an option for those women who cannot quit smoking while pregnant. E-cigarettes contain nicotine, but not the carcinogens and other dangerous chemicals which tobacco contains, therefore although not risk-free, they are much safer than tobacco cigarettes.

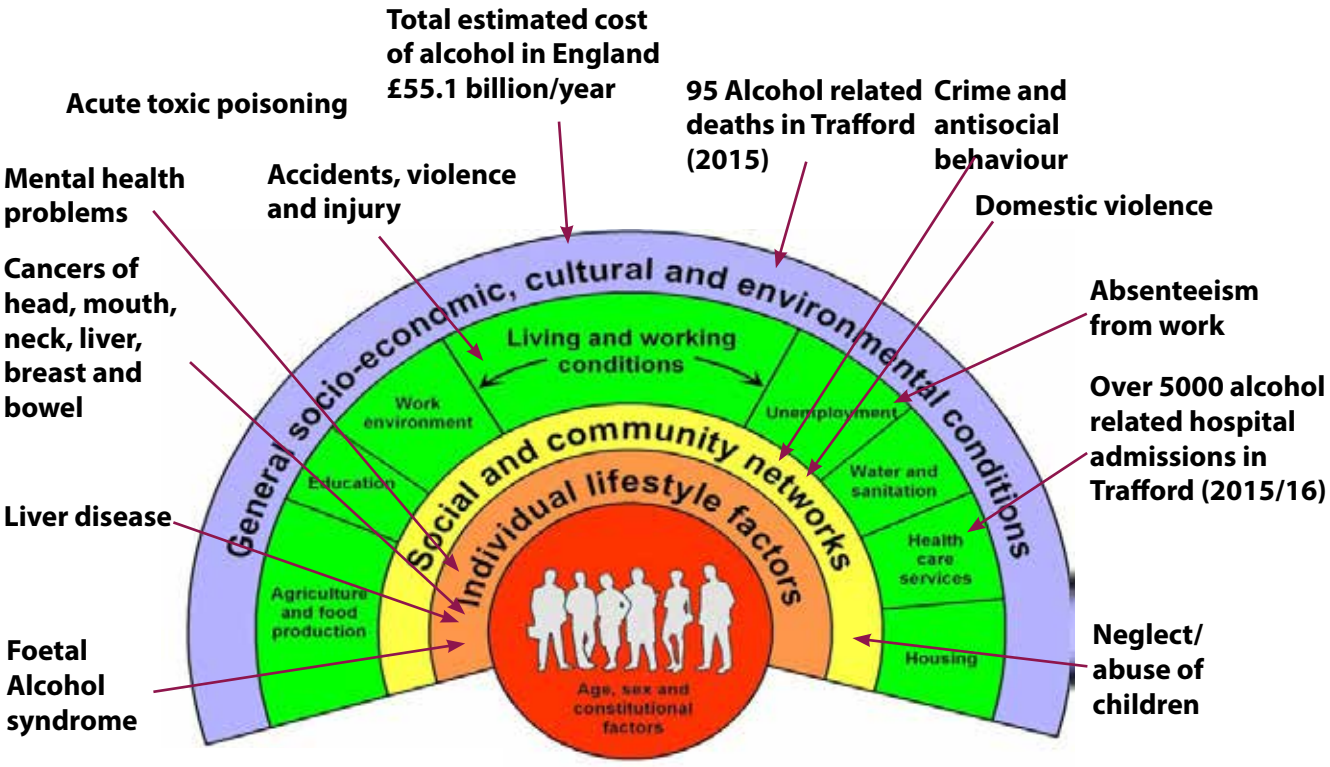
Public Health Recommends

- Midwives, health visitors and other staff who come into contact with children, young people and their families should be trained in smoking cessation brief interventions as a minimum, ensuring that every contact is an opportunity for health improvement.
- All Trafford organisations and workplaces should have smoke free workplace policies.
- Trafford playgrounds and school perimeters should become smoke free. Prevailing social norms have a huge impact on the desirability of smoking.
- Every attempt to "de-normalise" smoking must be undertaken to stop children adopting this habit.
- Trafford residents who smoke tobacco should be supported to stop smoking, particularly those adults who may smoke around children.
- Parents and adults who smoke should consider switching to e-cigarettes, as this does not produce toxic fumes. However, ideally, parents should be strongly encouraged not to smoke or vape near children, as even vaping may help re-normalise smoking.

Reducing harms from alcohol

There are many potential harms from alcohol consumption. Parental alcohol misuse is strongly correlated with family conflict and with domestic violence and abuse. This poses a risk of immediate significant harm to children and of longer-term negative consequences. Some of the harms from excessive alcohol consumption are shown in figure 6.

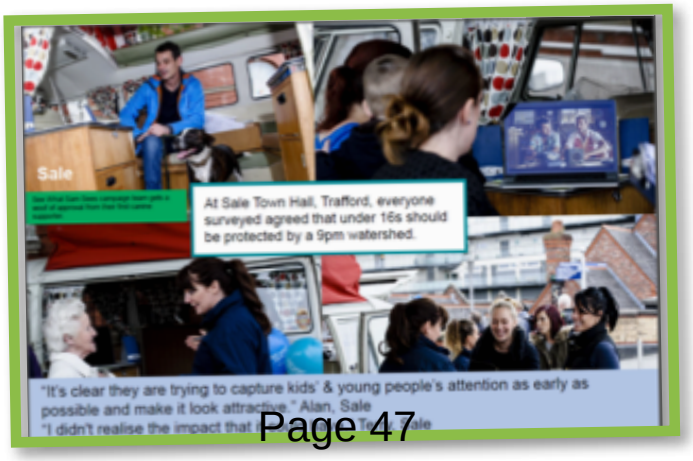
Figure 6: Summary of harms from alcohol consumption



Based on the Dahlgren and Whitehead (1991) model

There is evidence that how parents behave influences their children's later drinking behaviour; what parents do, not what they say is important. Acting as a role model in regard to their alcohol use, frequency and amounts is more important than what parents say or the rules they set[XVIII].

A campaign called "See what Sam sees" was run in Greater Manchester and the roadshow was brought to Sale in 2016. This raised awareness about the impact of alcohol advertising on children, and raised the profile of the issue within Greater Manchester. You can watch the video at https://www.youtube.com/watch?v=KZQ9OrJW1JM&gl=CO&hl=&app=desktop



Public Health Recommends

The following actions could reduce alcohol-related harm in Trafford:

- Earlier identification of people experiencing harm from alcohol and taking action to address this, including increased delivery of brief interventions such as the use of AUDIT-C by GPs and other healthcare professionals.
- Continued lobbying through Greater Manchester Health and Social Care Partnership for the introduction of minimum unit pricing.
- All Trafford organisations and workplaces should have workplace policies relating to alcohol.
- Pursue initiatives to reduce the density of licenced premises and reduce the availability of high strength, low cost alcohol.
- Identify people who attend hospital very frequently with conditions related to alcohol dependence so that they can be offered intensive social support.
- Support the 'Dry January' initiative and Alcohol Awareness Week.
- Work with parents to help them recognise what powerful role models they are, and to realise that children will copy their behaviours.

To improve cancer prevention and screening

Childhood cancer is relatively rare and diverse.[XIX] Between 2012-2014, 257 children and young people died from cancer in the UK. Survival rates have greatly increased in recent years, and 82% of those affected survive for 5 or more years.

Much cancer prevention work focusses on adults; however, for local public health teams, it is important that we protect our children and young people by supporting them to develop positive health habits. This includes being physically active, maintaining a healthy weight and reducing the harm caused by alcohol and tobacco, thereby reducing the risk of developing cancer in adulthood.

Figure 7: Causes of Cancer

A key public health intervention in childhood is to promote the uptake of Human Papilloma Virus (HPV) vaccine which can prevent some cervical cancers[XX]. HPV is passed through sexual contact.

Research indicates that the HPV vaccine could prevent two thirds of cervical cancers in women under the age of 30 years by 2025, but only if uptake of the HPV vaccination is at 80%[XXI].

School age girls are offered the vaccine in years 8 and 9 when they are 12 or 13 years old. The vaccination is given to girls at this age because their immune systems are at their strongest before puberty begins; also it is important that the vaccination is given before they become sexually active.

In Trafford, during the 2015-2016 school year, 78.3% of year 8 girls and 84.1% of year 9 girls received the required two doses of the vaccination[XXII]. Local uptake is slightly below national uptake rates and our local school nursing team continues to work hard to improve this rate.

Public Health Recommends

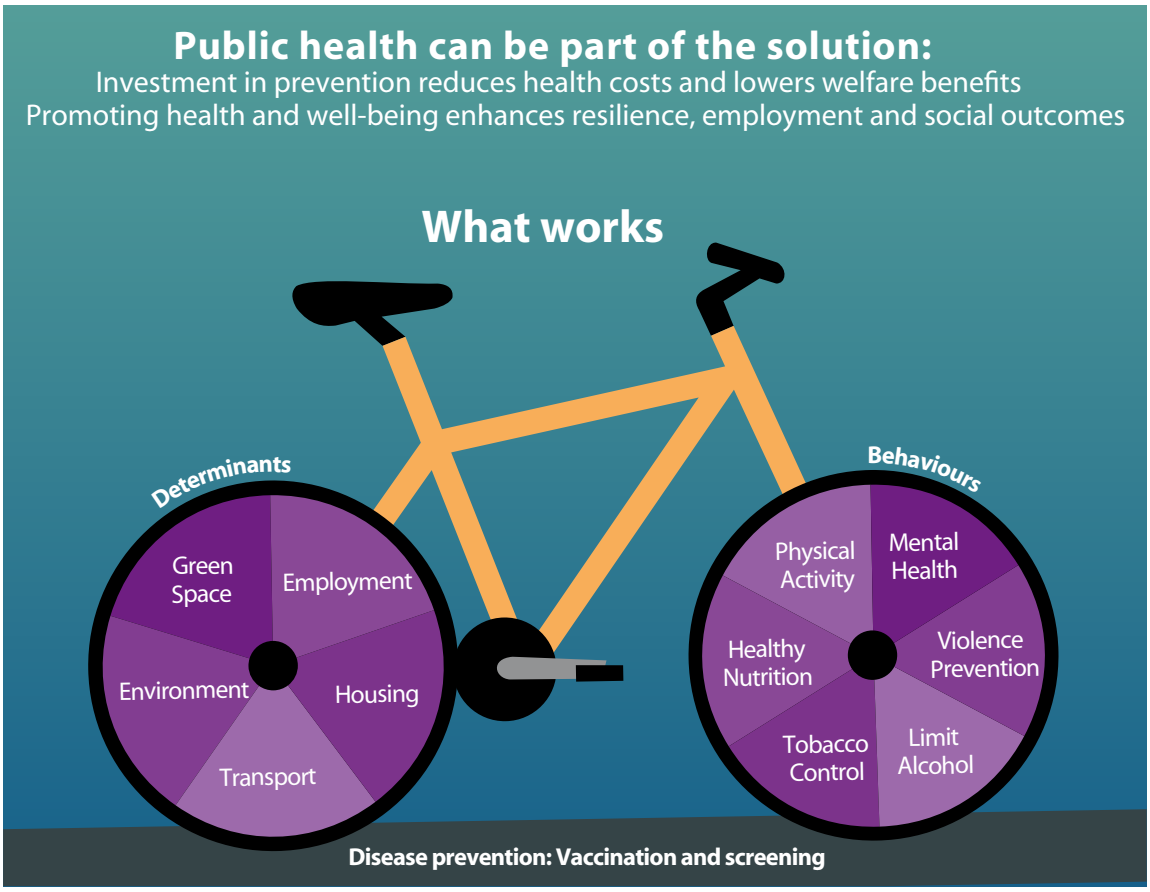
- Trafford's children and families receive the information and opportunities required to encourage them to adopt and maintain healthy lifestyles.
- Children and young people understand the benefits of screening, and understand how to access this when eligible.
- Smoke free Trafford is promoted.
- HPV vaccination uptake across all schools and relevant population groups is increased.

Director's Summary and Closing Comments

We have briefly reviewed data for Trafford, evidence for interventions, and examples of best practice for 5 key priority areas with a view to improving outcomes for children and young people. Improving these outcomes, and reducing our internal inequalities, will lead to a happier, fitter and healthier population, with better employment prospects and greater resilience.

While we have focussed on indicators that might be seen as being about personal choice and lifestyle, such as smoking, physical activity or alcohol use, all of these indicators are enormously influenced by the environment in which children live. As parents, we can take some steps to improve our children's lives and prospects, but many factors are outside our immediate control. As a Council, we need to work with our partners to ensure that the environment in which we live maximises the chance that all children can get the best possible start in life. This means providing access to the highest quality of public transport, food, housing, employment and the built environment (including access to green spaces). This is because these are the factors that help deliver the best possible outcomes for our population, and support people to make the healthy choice, for themselves and for their children. Figure 7 below summarises this well, showing how the wider determinants of health drive behaviours.

Figure 7: Public Health as part of the solution



World Health Organisation, (2014) *The case for investing in Public Health.*

The challenge for the Trafford Partnership is how to deliver a high quality environment that promotes and protects the health and wellbeing of our children. This will need us to question and change some of our own bad habits and behaviours (whether these are about poor diets, inactivity, smoking or alcohol use, or over reliance on the car) and will also require us to use all the levers at our disposal, such as policies, planning and licensing, to make a demonstrable positive impact on our health and that of our children.

References

[I] ONS, mid-2016 estimates. Population estimates - Office for National Statistics [Internet]. 2017 [cited 2017 May 2]. Available from: **https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates**

[II] Public Health England. Public Health Profiles [Internet]. 2017 [cited 2017 Jun 13]. Available from: **https://fingertips.phe.org.uk/profile-group/child-health**

[III] Public Health England. Public Health Profiles [Internet]. 2017 [cited 2017 Jun 13]. Available from: **https://fingertips.phe.org.uk/profile-group/child-health**

[IV] ONS, (2016) Ethnicity by Local Authority, **www.ons.gov.uk/**

[V] Public Health England. Public Health Profiles [Internet]. 2017 [cited 2017 Jun 13]. Available from: **https://fingertips.phe.org.uk/profile-group/child-health**

[VI] Public Health England. Public Health Profiles [Internet]. 2017 [cited 2017 Jun 20].]. Available from: **http://fingertips.phe.org.uk/profile/wider-determinants/data#page/1/gid/1938133119/pat/6/par/E12000002/ati/102/are/E08000009**

[VII] Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. Fair society, healthy lives: strategic review of health inequalities in England post 2010. Marmot Review Team; 2010.

[VIII] Bellis MA, Lowey H, Leckenby N, Hughes K, Harrison D. Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. J Public Health. 2014;36(1):81–91.

[IX] Matilda Allen, Angela Donkin. *The impact of adverse experiences in the home on the health of children and young people, and inequalities in prevalence and effects.* London: Institute of Health Equity; 2015.

[x] Bellis, M. Hughes, K. Leckenby, N. Perkins, C. Lowey, H. (2014) National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England, BMC Medicine201412:72

[XI] World Health Organisation, (2012) Risk to *Mental Health: An Overview of Vulnerabilities and Risk Factors.*

[XII] Mental Health Foundation, (2017) *Children and Young People*, **www.mentalhealth.org.uk/a-to-z/c/children-and-young-people.**

[XIII] Public Health England. Change4Life: evidence review on physical activity in children [Internet]. L ondon: PHE; 2015 [cited 2017 Jun 13]. Available from: **https://www.gov.uk/government/publications/change4life-evidence-review-on-physical-activity-in-children**

[XIV] Public Health England. Public Health Profiles [Internet]. 2017 [cited 2017 Jun 13]. Available from: **https://fingertips.phe.org.uk/profile-group/child-health**

[XV] Public Health England. Public Health Profiles [Internet]. 2017 [cited 2017 Jun 13]. Available from: **https://fingertips.phe.org.uk/profile-group/child-health**

[XVI] NICE, (2016) Public Health Guidance 41, **www.nice.org.uk/guidance/ph41.**

[XVII] Public Health England. Public Health Profiles [Internet]. 2017 [cited 2017 Jun 13]. Available from: **https://fingertips.phe.org.uk/profile-group/child-health**

[XVIII] Ryan SM, Jorm AF, Lubman DI. Parenting factors associated with reduced adolescent alcohol use: a systematic review of longitudinal studies. Aust N Z J Psychiatry. 2010;44(9):774–783.

[XIX] Cancer Research UK, (2016) Children's Cancer Statistics, **www.cancerresearchuk.org/health-professional/cancer-statistics/childrens-cancers**

[XX] Jo's Trust, (2017) HPV, https://jostrust.org.uk/about-cervical-cancer/hpv

[XXI] Jo's Trust, (2017) HPV, https://jostrust.org.uk/about-cervical-cancer/hpv

[XXII] Public Health England, (2016), HPV vaccine coverage data by LA, **www.gov.uk/government/statistics/annual-hpv-vaccine-coverage-2015-to-2016-by-local-authority-and-area-team.**

Consultation:

Reporting and rating NHS trusts' use of resources

Published: 8 November 2017

Deadline to return responses: 10 January 2018

Contents

1. Introduction

1. NHS services are facing increasing challenges. Hospitals have seen substantial rises in the last five years in attendance at A&E departments and overall numbers of emergency and elective admissions, and with fewer available beds in hospitals, people are waiting longer for treatment. Although the NHS continues to provide many high-quality services, this situation is not sustainable. As set out in *Implementing the Forward View: Supporting providers to deliver*, these challenges require strong and inclusive leadership, engaging staff to maximise their contribution, stabilising finances and improving efficiency. They also require the national oversight and regulatory bodies to play their part by reducing burdens on providers and behaving more consistently.

2. CQC and NHS Improvement are committed to working together to recognise the fact that effective use of resources is fundamental to enable health and care providers to deliver and sustain high-quality care for patients. The Health and Social Care Act 2008 recognises the relationship between the quality of care and the efficient and effective use of resources, and requires the Care Quality Commission (CQC) to have regard to the latter within its overall purpose as a quality regulator. One of CQC's four priorities in *Shaping the future*, CQC's strategy for 2016-2021, is to encourage improvement, innovation and sustainability in care. NHS Improvement offers the support providers need to give patients consistently safe, high-quality, compassionate care within local health systems that are financially sustainable.

3. CQC and NHS Improvement have therefore been working together closely to develop, test and implement an approach to assessing, reporting on and rating how efficiently and effectively NHS trusts and NHS foundation trusts (referred to as 'trusts') are using their resources to provide high-quality care for patients.

4. In December 2016, NHS Improvement and CQC jointly published a consultation on the proposed methodology and framework for assessing use of resources in trusts. Since then, NHS Improvement has tested the approach in a number of trusts and refined its assessment. In August 2017, we jointly published the final assessment framework and methodology for the assessments alongside a joint response to the consultation. NHS Improvement began assessments of non-specialist acute trusts in October 2017.

5. This consultation covers the final steps in the full implementation of the process that CQC and NHS Improvement will use to report on and rate trusts' use of resources. We are asking for views on our proposed approach to how CQC will award a final rating for a trust's use of resources after NHS Improvement has assessed this and proposed a rating and draft report. We are also asking for views on how the use of resources rating should be combined with CQC's existing trust-level quality ratings, and how those combined ratings should be displayed on CQC's website.

1.1 How CQC and NHS Improvement work together

6. CQC's purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and to encourage care services to improve. CQC's role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and to publish the findings, including performance ratings to help people choose care.

7. NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and some independent providers. It oversees trusts, forming views of their support needs in areas including quality, operational performance, finance and use of resources, leadership and improvement capability, and strategic change. By holding providers to account and, where necessary, intervening, it helps the NHS to meet its short-term challenges and secure its future.

8. CQC and NHS Improvement remain separate organisations with distinct legal duties. In particular, CQC carries the power to provide ratings of trusts, and decisions on all final judgements about ratings for the use of resources remain with CQC.

9. As described in the December 2016 consultation on the well-led framework and in CQC's consultation on its updated guidance for trusts, CQC has worked with NHS Improvement to strengthen the emphasis on sustainability and good financial governance in its assessments under the well-led key question. CQC will be working jointly with NHS Improvement to assess financial and resource governance aspects in its trust-level inspections of the well-led key question. The increased focus on financial management and sustainability in these assessments will complement the Use of Resources assessment, and ensure that we take a rounded approach to assessing trusts' performance and leadership.

10. CQC and NHS Improvement will operate according to the following principles, in line with our duty to cooperate:

    - **working together** in the effective discharge of our respective functions,[*] while recognising that each organisation is legally and operationally **independent**
    - greater **alignment** between our organisations so that our definitions, measurement and operations are based on a single shared view of quality
    - working to remove **duplication** between our organisations

[*] The references to 'we' throughout refer to the respective functions of both CQC and NHS Improvement.

- focusing on **quality,** and demonstrating that it should and can be maintained and improved alongside **financial sustainability**.

1.2 Our previous consultation on the approach to assessing use of resources

11. On 20 December 2016, NHS Improvement and CQC jointly published a consultation on the proposed methodology and framework to assessing use of resources in NHS trusts. The consultation ran until 14 February 2017.

12. That consultation focused on the approach to the assessment of a trust's use of resources, including the indicative metrics, key lines of enquiry (KLOEs) and ratings characteristics for the assessment. We also asked for general views on whether a rating for use of resources should, in future, be combined with existing CQC quality ratings.

13. On 8 August 2017, we published our joint summary and response to the consultation, which described the feedback on our proposals, the work carried out to test and further refine the approach, and our plans to take the work forward. Feedback from the consultation is discussed in section 4.2 below.

1.3 NHS Improvement's Use of Resources assessments

14. On 8 August 2017, we also published the full assessment framework and methodology to be used when NHS Improvement assesses trusts' use of resources. This describes the assessment process, with the KLOEs and prompts, as well as the initial metrics and the rationale for including them.

15. NHS Improvement began using the use of resources framework and methodology to assess non-specialist acute trusts' use of resources in October 2017. It has published a brief guide for non-specialist acute trusts on how these assessments are being carried out. The findings from the Use of Resources assessment will feed into NHS Improvement's considerations of improvement support needs, as part of the Single Oversight Framework (SOF).

16. Until our approach is finalised, based on this consultation, CQC will be piloting how it integrates the Use of Resources assessments with its inspection, reporting and rating processes.

2. This consultation

17. This consultation builds on our earlier consultation on assessing trusts' use of resources, and the findings of the initial testing work that has been undertaken in the first half of 2017. We are now asking for your views on:

    - Our proposed approach for how CQC will reflect NHS Improvement's assessment of trusts' use of resources in published CQC inspection reports and trust-level ratings.
    - How the new use of resources rating can be combined with CQC's existing five quality ratings, to generate new combined trust-level ratings.

18. We ask specific questions on our proposed approach throughout this consultation document with a full list at the end of the document. All questions are also on the online webform: www.cqc.org.uk/useofresources for this survey.

19. We will use the responses from this consultation to shape our final approach to rating use of resources, as well as the feedback from engagement events, the results of the current CQC piloting period, and the feedback we receive on any reports and shadow ratings published during this period.

2.1. How to respond to the consultation

20. We look forward to receiving the views of providers and other stakeholders on our proposals. Please respond by **5pm on 10 January 2018** through our online consultation webpage: www.cqc.org.uk/useofresources – this is the easiest way to respond. Please email hospitalsconsultation@cqc.org.uk if you have any difficulty accessing the consultation.

2.2. Confidentiality

21. Please let us know if all or part of your response is confidential or if you wish to remain anonymous, so that we do not include this in our published summary of responses. We will do our best to meet all requests for confidentiality, but because NHS Improvement and CQC are public bodies subject to freedom of information legislation, we cannot guarantee that we will not be obliged to release your response (including, potentially, your identity) or part of it even if you say it is confidential.

3. Developing and publishing use of resources reports and ratings

3.1 Introduction

22. To enhance its ongoing oversight of trusts, NHS Improvement has started to carry out assessments to determine how effectively they are using their resources to deliver high-quality, safe, efficient and sustainable care for patients. As set out in the published framework, Use of Resources assessments will focus on delivery and performance at trust level currently, and over the previous 12 months in the context of five key lines of enquiry: clinical services; people; clinical support services; corporate services, procurement, estates and facilities; and finance.

23. NHS Improvement will draw on a wide range of evidence that will include: a basket of initial use of resources metrics, which includes the finance metrics from the Single Oversight Framework (SOF) and productivity metrics from the Model Hospital; additional data or information collected by NHS Improvement and shared by trusts; local intelligence from its day-to-day interactions with the trust; and evidence gathered on a structured on-site assessment.

24. NHS Improvement will use the evidence from its assessment and from the resulting report and proposed rating for use of resources, alongside the more frequent data and insight it considers under the SOF, to determine the provider's support needs.

3.2 Trusts that will receive a Use of Resources assessment

25. As set out in our previous consultation and response, the Use of resources Assessment will initially only be carried out at non-specialist acute trusts.

26. Trusts currently classed as non-acute that deliver some acute services are currently out of the scope of the assessment. This is because the availability and quality of productivity metrics for non-acute trusts is currently not sufficient to support a robust assessment of a trust's use of resources. NHS Improvement is undertaking a significant programme of work to understand the productivity of non-acute trusts, and emerging metrics and benchmarking in these areas will be published on the Model Hospital portal in due course.

27. Information gathered during the assessments will help to inform the future approach for other trusts and the assessment approach and process will be revised as needed, for example, when new organisational forms emerge.

28. NHS Improvement will start working with community and mental health trusts in the coming months to better understand how the use of resources framework can best be applied to these organisations.

3.3 Scheduling Use of Resources assessments

29. Through our regular engagement and monitoring work, CQC and NHS Improvement will work together to agree the appropriate timing of Use of Resources assessments for each trust.

30. Under CQC's next phase of regulation, which began in June 2017, we intend that all trusts will have received at least one inspection of the well-led key question at the trust level by spring 2019, along with an inspection of at least one core service.

31. The Use of Resources assessments will, in future, be aligned with the regular scheduling of CQC inspections of the well-led key question at the trust level. Once the schedules are aligned, non-specialist acute trusts for which CQC is planning a well-led inspection will also receive a Use of Resources assessment from NHS Improvement.

32. Use of Resources assessments will normally be carried out before CQC's scheduled well-led inspection takes place. This is so that information from the Use of Resources assessment can inform CQC's discussions with the trust as part of the inspection of the well-led key question, and to enable the report and rating for use of resources to be reviewed and published as part of CQC's post-inspection processes. NHS Improvement's regional teams will work with trusts to determine the date of the on-site component of the Use of Resources assessment.

33. CQC and NHS Improvement's regional teams will continue to work closely together to share information about providers in their areas. Where NHS Improvement or CQC has concerns about the finances, financial governance or operational productivity of a trust, this could result in bringing forward the planned date of the scheduled well-led inspection and Use of Resources assessment.

3.4 Developing a use of resources report

34. After carrying out the in-depth Use of Resources assessment, NHS Improvement will write a brief report about the information gathered in the assessment.

35. As with CQC's reports on its inspections of the quality of services, the use of resources report will consist of a summary of the trust's overall performance, along with evidence presented against each of the key lines of enquiry in the Use of Resources assessment framework.

36. The report and proposed rating will be subject to an internal quality assurance and calibration process at NHS Improvement, involving moderation at both regional and national level.

37. NHS Improvement will provide the draft report, along with a proposed rating (see Section 3.5), to CQC's inspection team that is responsible for inspecting the well-led key question for that trust.

3.5 Determining a use of resources rating

38. Trusts will be awarded a rating for their use of resources at the overall trust level, using CQC's four ratings levels of: outstanding, good, requires improvement or inadequate. Use of resources ratings will not apply at service or location level.

39. This rating will be proposed by the NHS Improvement team that conducted the in-depth Use of Resources assessment. The proposed rating will be generated by comparing the evidence gathered in the assessment against the published characteristics for the four ratings levels, using judgement and taking into account good practice and recognised guidelines. The ratings characteristics are included as part of the Use of Resources assessment framework.

40. CQC will determine the final use of resources rating, in line with its legal powers to award ratings to services. In determining the rating, CQC will confirm that the Use of Resources assessment was conducted according to the published framework and that the evidence in the use of resources report supports the rating.

41. The final use of resources rating will be decided at a CQC Ratings Approval Meeting, chaired by CQC's Chief Inspector of Hospitals or a Deputy Chief Inspector. Information on how CQC awards ratings is available on the CQC website here.

42. Members of the NHS Improvement team that carried out the Use of Resources assessment may attend the Ratings Approval Meeting to discuss the evidence and proposed use of resources rating. The decision on the final rating will legally remain with CQC.

3.6 Factual accuracy checks of the use of resources report

43. The report for use of resources will be sent to the trust for comment before it is finalised. This will normally be sent as part of the CQC inspection report for the trust, following the inspection of the well-led question. Trusts can challenge the accuracy and completeness of the evidence used to reach the findings and decide the proposed rating. This is consistent with the approach CQC is already taking for its quality assessments and reports.

44. NHS Improvement staff will review any factual accuracy comments that CQC receives about the use of resources report. If a trust challenges evidence relating to the Use of Resources assessment, NHS Improvement will review the evidence in light of the trust's comments, working with CQC.

45. We may make changes to the proposed rating for use of resources as a result of factual accuracy comments from the trust. In these circumstances, a further Ratings Approval Meeting may be required to consider the updated evidence and agree the new rating before the report is published. We will explain how any factual accuracy comments received from the trust have been addressed, including how these have affected ratings decisions.

46. Further information on CQC's factual accuracy checking process for trusts is available on the CQC website here.

3.7 Requests to review the use of resources rating after publication

47. As with CQC's ratings of quality, trusts will have the opportunity to request a review of the use of resources rating after their full inspection report is published. Trusts have five working days after publication of the report to inform CQC of their intention to request a review of a rating.

48. Trusts may request a review of the use of resources rating on the basis that CQC did not follow the correct process for making ratings decisions. Rating reviews cannot be requested solely on the basis of a disagreement with the judgements or the evidence presented in the report – this is dealt with at the factual accuracy stage.

49. Where CQC receives a request to review the use of resources rating, it will first assess whether the request for a review falls within the permitted grounds (i.e. that the correct process was not followed). The provider's profile page on CQC's website will show that a rating review has been requested.

50. Where the request for a rating review relates to the use of resources rating, CQC will work with NHS Improvement using a process consistent with CQC's wider rating review processes. The request for a review will be handled by NHS Improvement staff who were not involved in the original Use of Resources assessment, and they will have access to an independent reviewer.

51. CQC's Chief Inspector of Hospitals makes the final decision on each rating review. Where a rating is changed following a review, the report and ratings will be updated on CQC's website as soon as possible. Ratings can go down as well as up as part of the ratings review process.

52. Full information on the rating review process is available on CQC's website here.

53. The rating review is the final CQC process for challenging a rating. However, trusts can challenge the ratings elsewhere, such as by applying for a judicial review.

3.8 Enforcement and improvement action following the assessment

54. NHS Improvement uses the finance and use of resources theme of the SOF to help identify a trust's potential support needs in relation to improving financial sustainability, efficiency and compliance with sector controls such as agency staffing and capital expenditure (see Figure 1 for metrics). The Use of Resources assessment will feed into this.

55. The SOF already provides the flexibility to take into account qualitative evidence to assess how trusts may be supported to improve. Where there are triggers of concern, NHS Improvement considers the relevant circumstances, including the provider's local context, the credibility of its plans, and its capacity and capability for improvement, to decide whether to offer targeted support on a voluntary basis or whether to take regulatory action to mandate support.*

56. NHS Improvement has a further set of criteria that it uses to determine if a trust should be placed in special measures for finance.** NHS Improvement and CQC are considering whether changes are needed to special measures, given the evolution of our respective oversight and regulatory approaches.

Consultation questions

Q1a. Do you agree with the proposals for CQC's process to develop and award final ratings for use of resources and publishing reports?

Q1b. Please tell us the reasons for your answer.

Q2. Do you have any suggestions for making this process work better?

* Support is mandated where there is actual or suspected breach of the provider licence and formal enforcement action, ie mandated support, is considered appropriate.

** See Strengthening financial performance and accountability in 2016/17.

4. Combining the use of resources rating with CQC's existing quality ratings

4.1 Introduction

57. CQC awards all trusts an overall rating of the quality of their services, based on the results of its assessments. The overall quality rating is awarded by aggregating the trust-level ratings of CQC's five key questions on the quality of care:

    - Are they safe?
    - Are they effective?
    - Are they caring?
    - Are they responsive to people's needs?
    - Are they well-led?

58. By law, care providers have to display these ratings. They must display them in the places where they provide care, somewhere that people who use their services can easily see them. They must also show their ratings on their website, if they have one.

59. CQC provides information on its approach to rating trusts on its website. This includes the principles and detailed aggregation rules and limiters that are used in generating ratings at different levels of the organisation, from the core services up to the overall trust rating.

60. Based on this consultation, CQC and NHS Improvement are introducing an approach for trusts to receive a rating for their use of resources, which will be published alongside CQC's rating of quality. Once we have fully introduced this approach, CQC intends to introduce a new combined rating for trusts that receive a rating for both their quality and their use of resources.

61. We are seeking views in this section on how we should combine the use of resources rating with CQC's existing quality ratings at the trust level, to form this new combined rating.

4.2 Feedback from our previous consultation

62. In our consultation published in December 2016 on the Use of Resources assessment approach, we asked for views on how the use of resources rating might, over time, be combined with CQC's trust quality ratings. We gave some illustrative examples of how the ratings might be combined, but did not consult on specific options or proposed rules for combining the ratings.

63. As set out in our summary and response to the consultation, published on 8 August 2017, 65% of respondents agreed that the ratings should be combined over time.

64. Respondents noted that combining ratings could help to increase alignment between the work of CQC and NHS Improvement, by creating a holistic and comprehensive view of the quality and sustainability of services.

65. Some respondents also highlighted concerns about combining ratings. These included:

- The risk that the quality rating would be diluted by adding use of resources and the risk of masking poor quality. It was argued that CQC ratings should continue to be about the quality of care as experienced by people who use services.
- The risk of increasing the complexity of ratings.
- The risk that the use of resources rating would result in more trusts receiving less positive ratings due to the current financial challenges in the sector.

66. This feedback, and the results of other engagement work, has shaped the approach presented in this consultation.

4.3 Why we should combine the use of resources rating with CQC's existing quality ratings

67. Good quality care must be person-centred, cost-effective and sustainable. Rating hospitals on the quality of their services has had a significant impact in focusing attention on quality, right across the NHS. Including the use of resources rating in CQC's approach to awarding overall trust ratings will provide a more complete picture, to ensure that our health services can continue to deliver high-quality, safe care in a sustainable way.

68. Adding use of resources into a combined trust rating will encourage trusts to consider resources and quality together, and to demonstrate their performance on both counts. The Health and Social Care Act 2008 already recognises the relationship between quality of care and the efficient and effective use of resources, and requires CQC to have regard to the latter within its overall purpose as a quality regulator.

69. We know that ratings have different functions for different audiences, which include people who use services, the general public, commissioners, providers and national bodies. In combining the ratings, CQC must ensure that they remain meaningful to all these groups.

4.4 Principles for balancing quality and use of resources in a combined trust-level rating

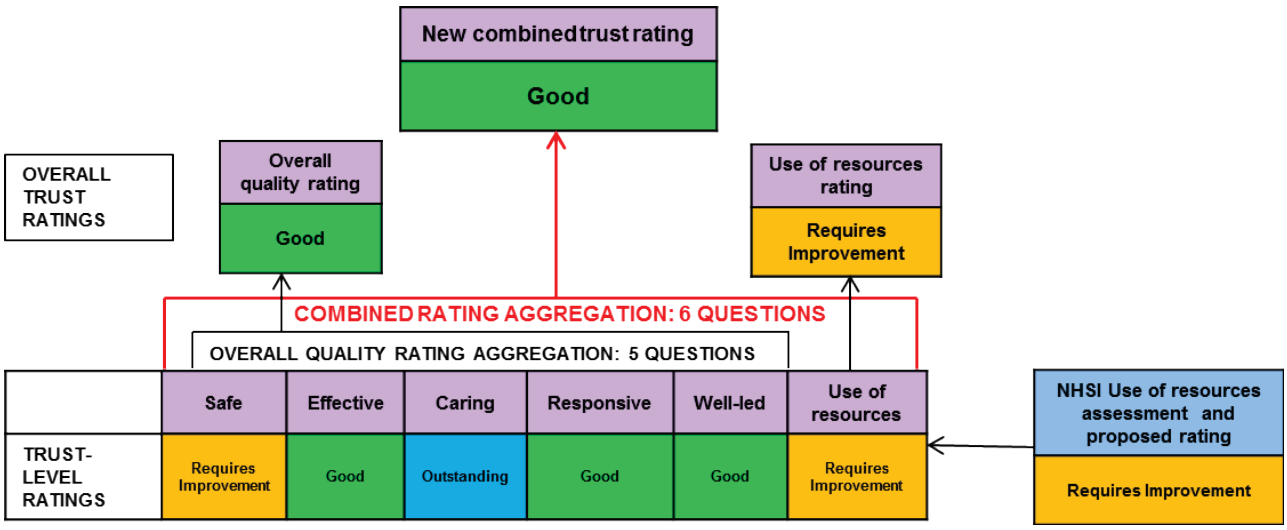
70. Drawing on the feedback received in our earlier consultation and engagement work, we have been guided by the following principles in developing our approach to a combined rating at the trust level:

- Any new combined rating must be clear, meaningful and relevant for people who use services and the public, as well as useful for providers, NHS Improvement and CQC.
- Both quality and resources considerations should carry appropriate weight in the methodology for generating a combined rating.
- The combined rating should avoid any unintended effects, such as undermining incentives for providers to strive to continue to improve quality.

4.5 Proposed approach to combining the use of resources rating with CQC's existing quality ratings

71. We propose that, where a Use of Resources assessment is conducted, the new use of resources rating would be added to CQC's current key questions at the trust level. The resulting six key questions would be weighted equally in generating the new combined rating for that trust. This means that at the overall trust level, CQC will award an overall quality rating, a use of resources rating, and a combined rating generated from across the six key questions. This approach is illustrated in the figure below.

Figure 1: Overview of proposed approach to combining the use of resources and quality ratings



72. This approach to generating a combined trust-level rating is based on a principle that efficient use of resources is one dimension of overall trust performance, of equal importance as other dimensions such as the safety, effectiveness and responsiveness of those services, and whether they are delivered in a caring and well-led manner. It would ensure that CQC's overall ratings judgements maintain a strong focus on the overall quality and safety of service delivery.

73. The approach to incorporating the use of resources rating would be consistent with CQC's current approach to generating overall trust ratings, and should be straightforward for providers and the public to understand. It would also ensure that there was as little difference as possible in the approach to awarding overall trust ratings between non-specialist acute trusts that receive a Use of Resources assessment, and those other providers that currently do not.

Consultation questions

Q3a. Do you agree with our proposed approach to combining the use of resources rating with CQC's existing quality ratings?

Q3b. Please tell us the reasons for your answer.

Q4. Do you have any suggested alternatives for achieving a combined rating?

4.6 Current rules for combining the use of resources and quality ratings

74. CQC has an existing set of rules to guide inspectors when awarding ratings. Under these rules, all five key questions are treated equally, but the rules vary according to the number of service, location or trust-level ratings being combined. Where the aggregation rules do not apply, ratings are awarded based on the averaging of the ratings. CQC also applies ratings limiters to overall quality ratings for trusts, to ensure that the overall quality ratings reflect key organisational requirements.

75. CQC's current ratings principles already include limiters on overall trust ratings where NHS Improvement has concerns that need to be investigated or where it is already taking formal action against a trust.

76. Appendix 1 provides the full set of aggregation principles that apply when CQC combines ratings. In considering how the use of resources rating should be combined with CQC's existing quality ratings to form the new combined rating, our starting point would be to use these existing CQC aggregation rules.

77. Under this approach, the new combined trust-level rating would be generated by combining the use of resources ratings with CQC's existing five trust-level quality ratings), using the relevant aggregation principles in Appendix 1.

78. We believe that in principle this would be the simplest and clearest approach to generating the new combined rating, and would be the most consistent with how CQC generates the overall quality rating.

79. There is a potential risk that, under CQC's existing aggregation rules, adding the sixth key question at the trust level may make it disproportionately difficult for trusts to achieve a combined rating of good.

80. Under our existing aggregation rules, the overall quality rating for a trust is limited to requires improvement where two or more of the key question ratings are requires improvement (under principle 7 in Appendix 1). Applying these same rules when there are six trust-level ratings being aggregated into the combined rating might be seen as setting the bar too high to achieve a rating of good. It could be argued that a trust with, for example, four good ratings and two requires improvement ratings at the trust level should normally receive a combined rating of good rather than requires improvement.

4.7 Proposed change to CQC's aggregation rules for the new combined rating

81. Reflecting on the principles explained in Section 4.4 and in light of the issues raised above, CQC is therefore proposing an alternative to using its standard existing aggregation rules to generate the new combined rating.

82. For the combined rating, CQC proposes to make a change to the principle in the current aggregation rules (principle 7 in Appendix 1) that determines the number of requires improvement ratings at the trust level that would limit the combined rating to requires improvement. When six ratings are being combined, the current CQC rule is:

"The aggregated rating will normally be limited to requires improvement where at least two of the underlying ratings are requires improvement".

Figure 2: Illustration of current principle for CQC requires improvement ratings

Instead of the current rule, CQC would use the following new rule to determine the combined rating at the trust level when the use of resources rating is combined with the existing five trust-level key question ratings:

"The aggregated rating will normally be limited to requires improvement where at least **three** of the underlying ratings are requires improvement".

Figure 3: Illustration of proposed change to principle for CQC requires improvement ratings

83. This change would make it more likely that a trust that receives two ratings of requires improvement from among the six key questions, would still receive a combined rating of good (as long as the other key questions are rated as good or outstanding). In all cases, we apply professional judgement in awarding the final rating.

84. This proposed change to CQC's aggregation rules would only apply to the generation of the new combined rating from the use of resources rating and the trust-level quality ratings. CQC's aggregation rules would be unchanged when generating ratings in other sectors or levels of the ratings framework.

85. Other than this change, CQC proposes to use its normal aggregation rules and limiters when generating the new combined rating.

86. Aggregating six ratings for the new combined rating under CQC's normal aggregation rules has some implications:

- It may be slightly more challenging for trusts to achieve a rating of outstanding when the six trust level ratings are aggregated into the new combined rating, compared with when CQC's existing five key question ratings are aggregated into the overall CQC quality rating. This is because to be rated as outstanding, all the trust-level ratings must be rated as good or outstanding (with at least two of these being outstanding).

- It may be slightly easier for trusts to be awarded a rating of inadequate when the six trust level ratings are aggregated into the new combined rating, compared with when CQC's existing five key question ratings are aggregated into the overall CQC quality rating. This is because any two or more ratings of inadequate among the six trust-level ratings would normally result in an overall combined rating of inadequate (as opposed to two of five). This is regardless of the combination of the other ratings.

87. CQC believes that these effects on ratings of inadequate and outstanding are relatively minor, and we do not expect them to have a disproportionate impact on the distribution of trust ratings across the country. CQC therefore believes that no additional changes are required to the existing set of aggregation rules for generating the new combined rating, other than the change proposed above.

Consultation questions

Q5a. We propose that (other than the rule change proposed below) CQC will use its standard aggregation rules and limiters to determine the new combined rating at the trust level, when combining the use of resources rating with CQC's existing five trust-level key question ratings.

Do you agree with this proposal?

Q5b. Please tell us the reasons for your answer.

Q6a. For the combined rating at the trust level, we propose that CQC changes the principle in its current standard aggregation rules that determines the number of requires improvement ratings at the trust level that would limit the combined rating to requires improvement.

Instead of the current rule, CQC proposes that "The aggregated rating will normally be limited to requires improvement where at least **three** of the underlying ratings are requires improvement".

Do you agree with this proposed change?

Q6b. Please tell us the reasons for your answer.

4.8 Displaying use of resources and combined ratings

88. The public has a right to know how care services are performing. To help them to do this, the Government has introduced a requirement for providers to display CQC ratings. The ratings are designed to improve transparency by providing people who use the services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service has been rated as outstanding, good, requires improvement or inadequate.

89. These requirements will also apply to the use of resources rating and the new combined rating, once those ratings are introduced.

90. CQC will update its ratings display toolkit to help trusts in displaying these ratings, when updated provider guidance is published early in 2018.

91. CQC also displays the ratings for all providers on its website. Each provider has a dedicated profile page on CQC's website, which displays the current ratings for that provider and includes information about the registered services provided, links to full CQC inspection reports, and other information. Once the use of resources and combined ratings take effect, CQC will also update these web pages to display those ratings on each trust's profile page as those ratings are awarded.

92. CQC intends to continue to publish its existing trust-level quality ratings for trusts alongside the new use of resources and combined trust ratings (when these are introduced). CQC's existing quality ratings consist of the five trust-level key question ratings of safe, effective, caring, responsive and well-led, as well as its overall quality rating for the trust. CQC believes that it is important to continue to publish these ratings both to preserve the consistency of the approach to rating non-specialist acute trusts and other providers, and to maintain the ability for trusts and the public to compare ratings over time.

93. CQC is considering a number of options for how the new use of resources ratings and combined ratings for trusts could be displayed on trusts' profile pages on CQC's website. Three possible formats for displaying the new ratings on the web pages are illustrated in Appendix 2.

94. The designs in Appendix 2 are included only to illustrate CQC's proposals. CQC will follow Government Digital Service development and governance processes to develop the final design for use on its website. CQC will also carry out more user research and testing before reaching a final design as part of engagement activity during this consultation period.

5. Next steps

5.1. Piloting quality assurance processes and shadow rating use of resources

95. NHS Improvement started to carry out Use of Resources assessments in October 2017. CQC will begin to incorporate the use of resources reports and ratings into its current regulatory approach with a period of extended piloting.

96. Until our approach is finalised based on this consultation, CQC will be piloting how we integrate NHS Improvement's Use of Resources assessments with CQC's inspection, reporting and rating processes. As we pilot these processes, we also aim to pilot the publication of the reports of some of these initial Use of Resources assessments alongside CQC's existing inspection reports, including indicative or 'shadow' ratings, with the agreement of the trusts involved.

97. NHS Improvement's Use of Resources assessments will proceed as usual during this piloting phase, and will be used by NHS Improvement as part of the SOF.

5.2. Full implementation of CQC's use of resources reports and ratings

98. CQC will introduce the final approach for assessing, reporting on and rating use of resources following the conclusion of the consultation and piloting period.

99. We will publish a summary and response to this consultation in early 2018, setting out the feedback we have received and what we have learned from the piloting and shadow rating of use of resources. CQC will also publish updated guidance for providers and the public, which will include information on how it will award use of resources ratings.

100. Once this final approach is published, CQC will start to publish formal ratings for use of resources alongside its existing quality ratings, for non-specialist acute trusts. When we publish ratings, we will include the date when each rating was awarded.

101. At the same time, NHS Improvement and CQC are working to align the schedule for Use of Resources assessments with CQC's inspection schedule for non-specialist acute trusts. As described in this consultation, this will mean that, as soon as practicably possible, NHS Improvement will normally conduct a Use of Resources assessment for all non-specialist acute trusts where CQC will be carrying out a scheduled inspection of the well-led key question; the Use of Resources assessment will take place in advance of this inspection and will inform it.

102. Once the Use of Resources assessment schedule is aligned with CQC's inspection schedule in this way, CQC will introduce the additional combined ratings at the trust level, based on aggregating the use of resources rating and its existing trust-level quality ratings. At that point, CQC will update its published guidance to explain the approach and rules for generating the combined ratings and advise the date from when those combined ratings will start to be awarded.

Consultation questions

Q1a. Do you agree with the proposals for CQC's process to develop and award final ratings for use of resources and publishing reports?

Q1b. Please tell us the reasons for your answer.

Q2. Do you have any suggestions for making this process work better?

Q3a. Do you agree with our proposed approach to combining the use of resources rating with CQC's existing quality ratings?

Q3b. Please tell us the reasons for your answer.

Q4. Do you have any suggested alternatives for achieving a combined rating?

Q5a. We propose that (other than the rule change proposed below) CQC will use its standard aggregation rules and limiters to determine the new combined rating at the trust level, when combining the use of resources rating with CQC's existing five trust-level key question ratings.

Do you agree with this proposal?

Q5b. Please tell us the reasons for your answer.

Q6a. For the combined rating at the trust level, we propose that CQC changes the principle in its current standard aggregation rules that determines the number of requires improvement ratings at the trust level that would limit the combined rating to requires improvement.

Instead of the current rule, CQC proposes that "The aggregated rating will normally be limited to requires improvement where at least **three** of the underlying ratings are requires improvement".

Do you agree with this proposed change?

Q6b. Please tell us the reasons for your answer.

Thank you for considering the proposals in this consultation - we look forward to receiving your views. Please respond by:

5pm on 10 January 2017

The easiest way to respond is online: **www.cqc.org.uk/useofresources**.

Please email hospitalsconsultation@cqc.org.uk if you have difficulty accessing the consultation.

Appendix 1: CQC's aggregation principles

We follow these principles to determine how we aggregate and combine ratings, and in some circumstances, how we put a limit on ratings.

Reflecting enforcement action in our ratings

Where we are taking enforcement action, we will reflect this in the ratings at the lowest level (key question at individual core service level).

1. Where we have identified a breach of a regulation and we issue a Requirement Notice, the rating linked to the area of the breach will normally be limited to 'requires improvement' at best.

2. Where we have identified a breach of a regulation and we take action under our enforcement powers, such as issuing a Warning Notice or imposing a condition of registration, the rating linked to the area of the breach will normally be 'inadequate'.

Overarching aggregation principles

The following principles apply when we are aggregating ratings.

3. The five key questions are all equally important and should be weighted equally when aggregating.

4. The core services are all equally important and should be weighted equally, except where they are significantly small.

5. All ratings will be treated equally when aggregating unless one of the other principles below applies. **Please note**: We can adjust the following principles for combinations where it is not appropriate to treat ratings equally.

Aggregating ratings

We use the following principles as the basis of the aggregation and use our professional judgement to apply them to the specific combination of underlying ratings.

6. The aggregated rating will normally be 'outstanding' where at least X number of the underlying ratings are 'outstanding' and the other underlying ratings are 'good'.

Number of underlying ratings	Number (X) of underlying outstanding ratings
1 – 3	1 or more
4 – 8	2 or more
9+	3 or more

7. The aggregated rating will normally be limited to ‘requires improvement’ where at least X number of the underlying ratings are ‘requires improvement’.

Number of underlying ratings	Number (X) of underlying requires improvement ratings
1 – 3	1 or more
4 – 8	2 or more
9+	3 or more

8. The aggregated rating will normally be limited to ‘requires improvement’ at best where X number of the underlying ratings are ‘inadequate’.

9. The aggregated rating will normally be limited to ‘inadequate’ where at least Y number of the underlying ratings are ‘inadequate’.

Number of underlying ratings	Principle 8	Principle 9
	Limited to requires improvement where there are (X) number of underlying inadequate ratings	Limited to inadequate where there are (Y) number of underlying inadequate ratings
1 – 3	Not applicable	1 or more
4 – 8	1	2 or more
9+	2	3 or more

Aggregating the overall location or trust levels

We apply additional principles when aggregating to the higher ratings levels (location level and trust level ratings).

10. For each of the key questions of safe, effective, caring, responsive and well-led, the aggregated rating should consist of both:

    - An aggregation of the underlying service ratings
    - An assessment of any relevant hospital or trust level evidence.

11. For foundation trusts only, where NHS Improvement finds a failure to comply with licence conditions or is taking regulatory action, the overall trust rating will normally be limited to 'requires improvement' at best.

12. For foundation trusts only, where NHS Improvement puts a trust 'under investigation', the overall trust rating will normally not be 'outstanding'.

13. For non-foundation trusts, where NHS Improvement finds material issues with a trust or where formal action is required, the overall trust rating will normally be limited to 'requires improvement' at best.

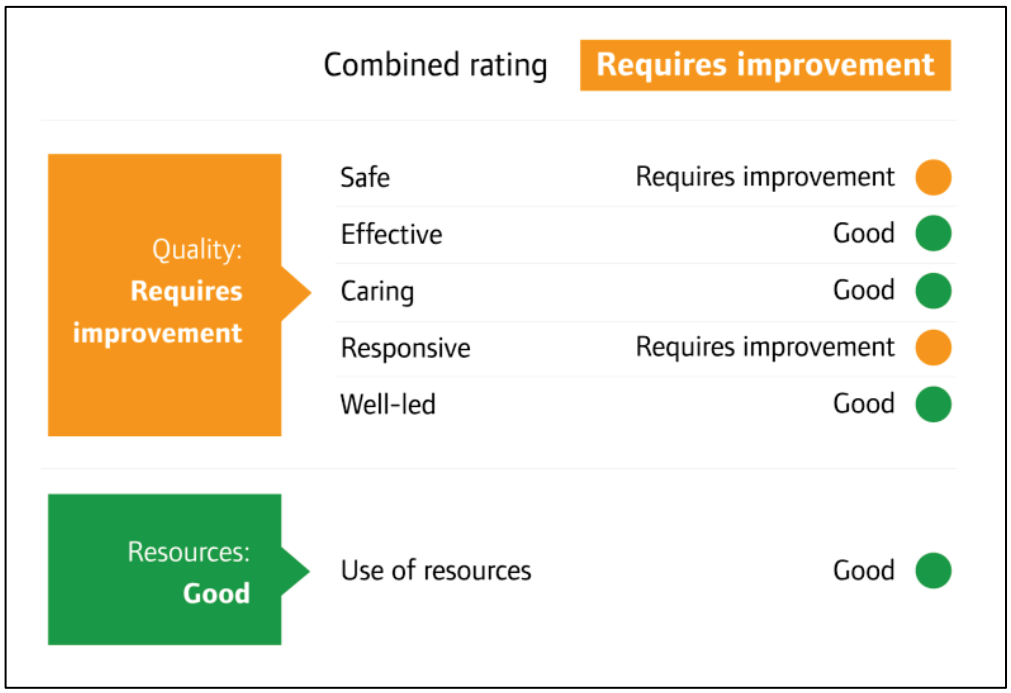
14. For non-foundation trusts, where NHS Improvement finds concerns requiring investigation, the overall trust rating will normally not be 'outstanding'.

15. An overall trust rating will not normally be 'outstanding' unless its score in the most recent national inpatient survey (question relating to overall experience) is higher than the median for the country.

16. An overall trust rating will not normally be 'outstanding' unless, in the most recent NHS Staff Survey, the percentage of staff who would recommend the trust as a place to work or receive treatment is higher than the median for the country.

Appendix 2: Example rating display designs

Ratings design image 1



Ratings design image 2

Ratings design image 3

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Please contact CQC if you would like a summary of this consultation in another language or format.

CQC-395-112017

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Greater Manchester Joint Health Scrutiny Committee Report

There was a Greater Manchester Health Scrutiny Committee Meeting on 8th November 2017.

Meeting concentrated on the new model of Basic Primary Care which was first discussed in Healthier Together. Reduced to basics this will ensure that GP's will take the lead in all cases involving primary care.

It was recognised that there are difficulties in setting such a system up mainly in Data Sharing, what the position is/will be for non UK nationals on the staff and the current need for employing locums to fill junior doctors' positions that are currently still vacant.

The Committee will be monitoring the situation of recruitment and retention of European nursing staff. The situation regarding junior doctors is being addressed by creating a medical bank so employed staff can move between trusts and work where they are most needed but even by doing this there are still not enough regular staff. It was pointed out that two in every 8 doctors are not UK nationals.

Frighteningly enough, Agency staff expenditure across the board is currently £61 million.

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