# AGENDA PAPERS FOR

## HEALTH AND WELLBEING BOARD

**Date: Friday, 19 July 2019**

**Time: 9.30 am**

**Place: Flixton House, Flixton Rd, Urmston Manchester M41 5GJ**

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

1. **ATTENDANCES**

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

2. **MEMBERSHIP OF THE COMMITTEE 2019/20** 1 - 2

To note the Membership of the Board including the appointment of Chair and Vice Chair as agreed at the annual Council meeting 22 May 2019.

3. **TERMS OF REFERENCE 2019/20** 3 - 4

To note the Terms of Reference of the Committee for the 2019/20 municipal year as agreed at annual council 22 May 2019.

4. **MINUTES** 5 - 8

To receive and if so determined, to approve as a correct record the Minutes of the meeting held on 10 May 2019.

5. **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.

6. **QUESTIONS FROM THE PUBLIC**

A maximum of 15 minutes will be allocated to public questions submitted in writing to Democratic Services (democratic.services@trafford.gov.uk) by 4 p.m. on the working day prior to the meeting. Questions must be relevant to

the remit of the Board and will be submitted in the order in which they were received.

7. **HEALTH AND WELLBEING BOARD 'WAYS OF WORKING'** 9 - 32

To receive a presentation and supporting documents from the Interim Director of Public Health.

8. **CHILD DEATH OVERVIEW PANEL** 33 - 42

To receive presentation and reports form the Interim Director of Public Health.

9. **CIRCULATED DOCUMENTS** 43 - 98

To receive a number of additional documents for information.

10. **KEY MESSAGES**

To consider the key messages from the meeting.

11. **QUESTIONS AND ANSWERS FORM OBSERVERS**

An opportunity for any observers present to ask questions of the Board.

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

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

**SARA TODD**
Chief Executive

Membership of the Committee

Councillors S. Johnston (Chair), J. E. Brophy, Miss L. Blackburn, J. Harding, C. Hynes, J. Slater, M. Bailey, C. Daly, C. Davidson, D. Eaton, H. Fairfield, Dr. M. Jarvis, M. Noble, E. Roaf, M. Roe, R. Spearing, A. Worthington, P. Duggan, S. Radcliffe, Rooney, Hemingway, S. Donnellan, D. Evans, M. Hill and Pritchard.

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

Alexander Murray, Democratic and Scrutiny Officer,
Tel: 0161 912 4250
Email: alexander.murray@trafford.gov.uk

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# TRAFFORD COUNCIL

## MEMBERSHIP OF COMMITTEES 2019/20

**Notes on Membership:**

(1) The Council Membership is nominated by the Leader of the Council.

(2) The Chair for the Health and Wellbeing Board will rotate on an annual basis between Trafford Council and NHS Trafford Clinical Commissioning Group.

(3) * Denotes that this position must be represented on the HWB as per the Health and Social Care Act 2012 (Note: at least one Councillor, one member of each relevant CCG, a representative of the local Healthwatch organisation plus any other members considered appropriate by the Council, must be appointed.)

| COMMITTEE | NO. OF MEMBERS |
|---|---|
| HEALTH AND WELLBEING BOARD | 5<br>(plus *Corporate Director of Children Services, Corporate Director of Adult Services, *Director of Public Health and 16 External Partners) |

| LABOUR GROUP | CONSERVATIVE GROUP | LIBERAL DEMOCRAT GROUP | GREEN PARTY GROUP |
|---|---|---|---|
| Councillors: | Councillors: | Councillors: | Councillors: |
| Executive Member for Health, Wellbeing and Equalities<br><br>Executive Member for Adult Social Care<br><br>Executive Member for Children's Social Care | Shadow Executive Member for Health, Wellbeing and Equalities | Jane Brophy | - |
| **TOTAL 3** | **1** | **1** | **0** |

Membership of the Health and Wellbeing Board shall also comprise of:

- NHS Trafford Clinical Commissioning Group (3 representatives: Chair, Chief Operating Officer and Clinical Director/Representative)
- Chair of Health Watch
- Third Sector (2 representatives)
- Independent Chair Children's Local Safeguarding Board
- Independent Chair Adult Safeguarding Board
- Chair of the Safer Trafford Partnership - GMP
- Chair of the Trafford Sports and Physical Activity Partnership
- Chief Executive Officers of health care providers (4): (Central Manchester University Hospital NHS Foundation Trust; University Hospital South Manchester NHS Foundation Trust; Pennine Care NHS Foundation Trust; Greater Manchester West Mental Health NHS Foundation Trust)
- Greater Manchester Fire and Rescue Service Representative
- Greater Manchester Health and Social Care Partner Representative

**HEALTH AND WELLBEING BOARD**

Terms of Reference

1. To provide strong leadership and direction of the health and wellbeing agenda by agreeing priority outcomes for health and wellbeing.

2. To develop a shared understanding of the needs of the local population and lead the statutory Joint Strategic Needs Assessment (JSNA).

3. To seek to meet those needs by producing a Joint Health and Wellbeing Strategy for Trafford and ensure that it drives commissioning of relevant services.

4. To drive a genuine collaborative approach to commissioning of improved health and care services which improve the health and wellbeing of local people and reduces health inequalities.

5. To promote joined–up commissioning plans across the NHS, social care and public health.

6. To have oversight of local Clinical Commissioning Group (CCG) and local authority commissioning plans.

7. To operate as a thematic partnership within the context of the Sustainable Community Strategy Trafford 2021 and align its work to the Trafford Partnership in that capacity.

8. To improve local democratic accountability and engage with the Health and Wellbeing Forum which includes Trafford residents, service providers and other key stakeholders to understand health and wellbeing needs in Trafford.

9. To monitor and review the delivery of health and wellbeing improvements and outcomes through robust performance monitoring.

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**HEALTH AND WELLBEING BOARD**

**10 MAY 2019**

**PRESENT**

Councillor J. Baugh, C. Daly, D. Evans, Councillor J. Harding, Dr S. Johnston (Vice Chair), Fairfield, Councillor J. Lamb, Councillor J. Lloyd (in the Chair), R. Spearing, E. Roaf, S. Radcliffe and C. Hemingway

In attendance

| | |
|---|---|
| Kerry Purnell | Head of Partnerships and Communities |
| Sarah Grant | Senior Partnerships and Communities Officer |
| Alexander Murray | Democratic and Scrutiny Officer |

Also Present

Councillor C. Hynes

**APOLOGIES**

Apologies for absence were received from Councillors M. Bailey, D. Eaton and P. Duggan

**37. MINUTES**

RESOLVED: That the minutes of the meeting held 11 January 2019 be agreed as an accurate record and signed by the Chair.

**38. DECLARATIONS OF INTEREST**

There were no additional declarations made.

**39. QUESTIONS FROM THE PUBLIC**

No questions were submitted.

**40. ROLES AND RESPONSIBILITIES OF THE HEALTH AND WELLBEING BOARD IN THE WIDER PARTNERSHIP STRUCTURE**

The Head of Partnerships and Communities delivered a presentation to the Board. The presentation covered the process through which the Council's priorities had been selected. The Board were shown the full Trafford Partnership Structure from Community Partnerships and groups through to Greater Manchester Committees. The Head of Partnerships and Communities spoke about the need to take a whole sector approach as set out by a GM White Paper on Unified Public Services which laid out 6 Key Features of the Operating Model for all Public Service, Health and Care Organisations in GM. The Board were told that Trafford needed to adapt the GM approach in order to make it fit for purpose within the area. The Head of

Partnerships and Communities then informed the Board of a number of other documents and the partnership context which would further shape the process.

It was stressed to the Board that that they could no longer work in isolation and instead needed to think of their role as a leader in partnership across the whole system. This required a shift from being reactive to proactive and to influencing rather than controlling. The Board were then shown a list of effective leadership behaviours that the Council needed to exude in order to be effective in its new role.

The Interim Director of Public Health then delivered another presentation to the Board about its role moving forward. While there had been a large amount of change to the Board in the last few years the Board still had to change a lot in order to be effective at promoting Health and Wellbeing in the area. The Interim Director stated that the Board was still not seen as a driver of improvement or change in Trafford's Health and Social care landscape.

The Interim Director of Public Health then showed Members the statutory requirements of the Board. The requirements were minimal with a lot of the Board's work to be decided by each authority. The Interim Director asked Board Members for their ideas on how the Board could fulfil its role going forward.

Members gave a wide range of suggestions about how the Board could improve and how it should function going forwards. Some Members felt that the Board should be focused upon ensuring that strategies were in place and noted that there was a current lack of strategies especially around mental health and suicide prevention.

Members discussed whether the Board should be holding officers, departments, and organisations to account. It was suggested that while there should be holding to account it should be limited to specific areas where the Board was directly responsible e.g. the creation of the JSNA and the Board should generally look to influence others rather than holding them to account.

Members also stated that the Board needed to look at the impact that they were having in the area and what the outcomes of meetings and attending them were.

The interim Director of Public Health outlined the two key dimensions of the Health and Wellbeing Board which were improving health and wellbeing via actions within health and social care services, and actions to address the wider determinants of health. She suggested that it was easier to focus more upon the health and social care aspect as it was easier to measure and was more within the control of members but that the Board had to start include recommendations regarding the wider determinants of health which meant being proactive and shifting the focus to improving people's lifestyles and the environment and context in which they live..

There were a number of issues raised around communication. Members felt that there was inadequate communication between the Board and other parts of the system. Members were keen to understand the overall governance structure and where all of the Boards fell within that structure, especially the position of both the

Joint Commissioning Board and the Public Sector Reform Board. A Member noted that three partnership boards met on the same day but questioned whether that was delivering the expected value. There was always a lunch time session but very few Board Members stayed to share information or network with each other.

Another Member had attended the Stronger Communities Partnership and noted that the partnership was doing a lot of work that the Board could align itself with and support. The Member felt that the goals and aims of the two Boards were very different and that there needed to be better communication and shared working between these Boards.

It was felt that there was a lack of communication with members of the public. Members suggested that the Board needed to look at how information was disseminated to the public and to professionals to ensure it was fit for purpose as strategies could be developed but there is no point if they are not being accessed by the public. Part of this discussion focused around how to increase the voice of the public and residents within meetings. As meetings were held in pubic and members of the public had the opportunity to put questions to the Board It was felt that the publishing of the meetings needed to improve. One Member spoke about General Practitioners and Head teachers as both a source of information for the Board and as a mechanism that can be used to disseminate information.

The Interim Director of Public Health then asked the Board to consider how the Board could function differently going forward.

Members agreed that the Board had to link in with the work of other Boards. The Inclusive Growth and Poverty Board was highlighted as one Board to align work with as they also looked at improving the wider determinants of health. Members also discussed how the Board could communicate issues to the public so they understood them and in a way that empowered people to get involved.

The Interim Director of Public Health restated that the Board needed to impact change within the Borough not just focus upon strategic goals/direction. One way it was suggested that this could be done was through Board Members being personally responsible and taking what they learn at the Board away and discussing it within their organisation to bring about change.
The Interim Director of Public Health then showed the Board a slide which depicted how they envisioned the Board could work and asked Members for further Comments.

The suggestions from the Board that were received included; that the Board should look to promote place based work and work alongside Community interest partnerships, that all the information that is available to the public should be mapped out to make it easily accessible, and that the Board should champion the use of co-production within services as there was not enough being done across Trafford.

One member suggested that the partnership structure should centre around the neighbourhood delivery model (the butterfly) with the prioritise listed around the

side with links to the Boards and Sub Boards which were responsible for delivering those priorities.

Following the discussion there was a short break during which the Interim director of Public Health put together all the ideas that had been expressed during the meeting. The ideas were split into sub sections of what, how, actions, role of the board, functions of the Board, and operation of the Board. The interim Director of Public Health told members that they would take these points away and create a report which would be delivered at the next meeting of the Board.

RESOLVED:

1. That the presentations and discussion be noted.
2. That the Interim Director of Public Health create a report based upon the discussions to be brought to the next Board meeting.

The meeting commenced at 9.30 am and finished at 12.00 pm

# Trafford's Health and Wellbeing Board

## Our purpose, our structure, and our expectations of members

### Background and context

Health and Wellbeing Boards (HWBB) have been in place across England since 2013, with the goal being to improve health through the following:

- improved partnership working;
- development of a shared understanding of local needs via the Joint Strategic Needs Assessment;
- development of strategies to improve health and wellbeing.

Appendix A sets out the statutory guidance relating to HWBBs

### The Health and Wellbeing Board in Trafford

Trafford's HWBB has a strategic, advisory role. It sets the strategic direction and outcomes required for improved population health and reducing inequalities, and has two functions within this:

- to identify health outcomes to be commissioned
- to influence the wider determinants of health

It discharges these two functions in the following ways:

- through the development of strategies in key areas (via its life course sub boards), in collaboration with other parts of the system, including commissioners, providers and strategic user/carer/neighbourhood partnerships
- by improving health through action in health and social care services. This will lead to a direct and measurable change in health outcomes and in reduced costs to the health and social care system, provided that partners are held to account for delivery of the strategies.
- by influencing the wider determinants of health: through addressing the factors that make it more likely that people will experience poor health.

The Health and Wellbeing Board is a key part of our Partnership structures in Trafford, working in conjunction with the Trafford Partnership Board, the Joint Commissioning Board (JCB) and the Local Care Alliance (LCA) and the Local Care Organisation (LCO). As such, it has a key role in ensuring that our shared objectives as set out in the NHS 10 Year Plan, Trafford's Long Term Plan, and our Trafford Together priorities, and GM Health and Social Care Partnership, are reflected in our strategies and the outcomes we expect.

The strategies relating to health and social care, once agreed, will be given to the JCB to commission against, with the LCA being the delivery vehicle, and will inform the place based plans being developed to reduce inequalities between

neighbourhoods. Implementation will be monitored and evaluated, and the high level indicators reported back into the HWBB**.**

Topics that relate to the wider determinants of health will be referred for action or consideration to the Trafford Partnership Board, with a requirement to report back on progress to the HWBB. The HWBB should become the key vehicle for strategic development of some key areas such as climate change, clean air, or poverty reduction.

**Developing an effective HWBB**

In order to develop a strong and effective HWBB, we need to be clear on our aspirations, with a well described 'plan on a page'. The HWBB also needs to exert its influence on partner organisations, via their representatives on the Board, ensuring that all are held to account for delivery against our shared objectives.

In order to achieve this, we need to be able to show our aspirations for 10 years, but also have measures of our impact in one year and our adoption of high impact changes. These impacts will be measured through changes in outcomes by place, by organisation, as employers and collectively.

In order to deliver this, we need to strengthen our connection to other key Boards and Partnerships. These include the Safeguarding Board, the Inclusive Growth Board and the Stronger Communities Board. This requires system leadership, clarity of purpose and scope and a focus on shared topics, with clear plans for the links and interdependencies between boards.

**Enablers of an effective Board**

An effective HWBB will be underpinned by a robust Joint Strategic Needs Assessment, and linked work on evidence based interventions, returns on investment and savings plans. It will also rely on Individual and organisational commitments and pledges – for example, as organisations we must demonstrate how we deliver our priorities by changing policies for staff. Changing policies for our workforce can have major implications for population served, given the number of people that we collectively employ in Trafford or within Greater Manchester.

It also requires all members to work to shared commitments and principles. These include a commitment to the following:

- invest in activities which maximise of the value of health and incentives for healthy behaviour.
- develop an environment where the promotion of healthy choices is the default option
- minimise factors that create a culture and environment which promote unhealthy behaviour.
- ensure that strategies and services are effective in reducing internal inequalities in Trafford between different neighbourhoods and sub-populations

Furthermore, in order to be effective, the HWBB needs effective methods of engaging with the public and delivering place based working. Most of the goals of the HWBB will not be delivered without the active engagement of the public  Services have a huge role to play in both listening to and understanding local needs, but also in working to co-produce cost effective solutions to meet these needs. The starting point for this is via local partnership structures, which may be place based or may reflect communities of interest. Resourcing this activity and measuring its impact will be crucial to success.

**Requirements of HWBB members**

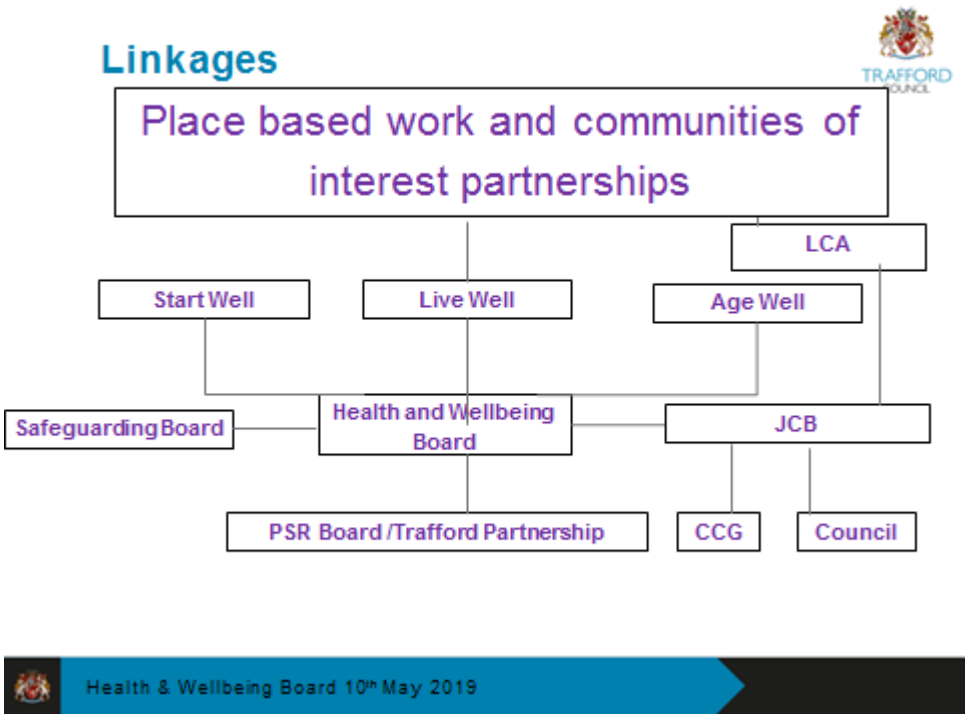
HWBB members should

- support each other  to be effective system leaders and to consider how they become champions of delivery in their own organisations and wider networks. This will include progressing work through their own organisational structures.
- be clear on the role of the Board within the Partnership structure
- understand the Board's role in the wider public service system (including Greater Manchester dynamics)
- maximise the impact of the Board through its relationship with  the Local Care Alliance and through influencing the wider determinants of health
- understand the role and reporting processes for the sub-Boards
- reduce any duplication of role between Boards, and improve communication and joint working
- agree short (1-2 year), medium (3-5 year) and long term (5-10 year) objectives

The Health and Wellbeing Board members have two roles: to act as advocates for positive behaviour change in their own organisations and wherever they can exert a leadership role, and to work through the Board as a body corporate to effect change.

**Proposed Governance and Relationship Structure**

The diagrams below describe the proposed relationship between key boards and groups. This assumes that all decisions (including regarding resource allocations) are made by the CCG Governing Body and by the Council Executive Committee, and these are then communicated to the Joint Commissioning Committee, which is expected to become a formal joint subcommittee of the CCG and the Council..  The JCB will be informed by the HWBB and its JSNA regarding the commissioning required to meet population needs and improve outcomes  - including reducing inequalities between different sub populations in the borough.




**Trafford Partnership Board** - overarching, borough wide, multi-agency reference group, influencing the wider determinants of health.

**HWBB** has a strategic, advisory role, with two functions: to identify health outcomes to be commissioned via the Joint Commissioning Board (JCB), and delivered by integrated health and social care via the Local Care Alliance (LCA); and to influence the wider determinants of health (via the Trafford Partnership).

**Joint Commissioning Board** sets objectives and describes commissioning principles. May become a shared sub-committee of the Council Executive and CCG Governing Body, with delegated decision making authority, in order to deliver shared objectives, as well as reporting to the Greater Manchester JCB

**Local Care Alliance** – system leaders, including providers working together to deliver services to meet defined outcomes as directed by the JCB, using the principles above. Delivering to a place based methodology and works with neighbourhoods and borough wide depending on local need.

**Other strategic partnerships and neighbourhood structures** – deliver resident input, engagement and co design of services and strategies.

Appendix A

**Statutory guidance on Health and Well being Board**

A local authority must establish a Health and Wellbeing Board for its area.

(2)The Health and Wellbeing Board is to consist of—

(a)subject to subsection (4), at least one councillor of the local authority, nominated in accordance with subsection (3),

(b)the director of adult social services for the local authority,

(c)the director of children's services for the local authority,

(d)the director of public health for the local authority,

(e)a representative of the Local Healthwatch organisation for the area of the local authority,

(f)a representative of each relevant clinical commissioning group, and

(g)such other persons, or representatives of such other persons, as the local authority thinks appropriate.

Duty to encourage integrated working
(1)A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

(2)A Health and Wellbeing Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

(3)A Health and Wellbeing Board may encourage persons who arrange for the provision of any health-related services in its area to work closely with the Health and Wellbeing Board.

(4)A Health and Wellbeing Board may encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together.

(5)Any reference in this section to the area of a Health and Wellbeing Board is a reference to the area of the local authority that established it.

Other functions of Health and Wellbeing Boards

(1)The functions of a local authority and its partner clinical commissioning groups under sections 116 and 116A of the Local Government and Public Involvement in Health Act 2007 (“the 2007 Act”) are to be exercised by the Health and Wellbeing Board established by the local authority.

(2)A local authority may arrange for a Health and Wellbeing Board established by it to exercise any functions that are exercisable by the authority.

(3)A Health and Wellbeing Board may give the local authority that established it its opinion on whether the authority is discharging its duty under section 116B of the 2007 Act.

(4)The power conferred by subsection (2) does not apply to the functions of the authority by virtue of section 244 of the National Health Service Act 2006.

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NHS
Trafford
Clinical Commissioning Group

**Report to**: CCG Governing Body
**Date:** 2nd July 2019

**Report of** Trafford Long Term Strategic Framework for Reform and Sustainability in Health and Social Care 2019 – 2024/5
**SLT Lead:** Sara Radcliffe, Corporate Director of Commissioning – Trafford CCG and Trafford Council

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**Report Title:** Trafford Long Term Strategic Framework for Reform and Sustainability in Health and Social Care 2019 – 2024/5

**Report Summary:**

Trafford is developing a long term plan for the reform and sustainability of the health and social care system. We will have one plan for the Council and the CCG. We will work for it to be an owned direction with our colleagues, partners and stakeholders during a year long process of engagement from July 2019. This document outlines the five year strategic framework for system reform and sustainability, which is built on one year delivery plans for service change.

**Recommendations:**

1. This framework is agreed as a shared framework for the long term plan for health and social care
2. This framework is to cover the five year period and in doing so will have one year delivery plans
3. This framework will be worked through with colleagues, partners and stakeholders so that our ambitions are joint and owned
4. A worked up plan with rolling programmes will be brought back to both meetings in October 2019.
5. That the seven Council corporate objectives set out in section 2.1 of the report be formally adopted by the CCG.

**Contact Officer for background papers and further information:**

Name: Kelly Stephenson
Tel: 07973 639175
Internal Ext: 4434
Email: kelly.stephenson1@nhs.net

## Considerations

| | |
|---|---|
| **Financial implications and approval** | Not applicable at this stage |
| **Risk implications** | Not applicable at this stage |
| **Equality Impact Assessment** | Equality Impact and Risk assessment process will be completed as part of the next phase – We will utilise the Equality Impact Assessment screening tool and the results of engagement with protected groups and others, to understand the actual/potential impact on our intentions in the Long Term Plan. We will identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations. |
| **Communications Issues** | Communications will be built into the wider engagement strategy which will be part of the next phase |
| **Public engagement summary** | Public engagement will be planned as part of the wider engagement strategy |
| **Workforce Implications** | Workforce is at the heart of the plan and will be built into the next phase of work |
| **Legal Implications** | Not applicable at this stage |
| **Financial Approval** | Not applicable at this stage |
| **SLT Sign off** | Sara Radcliffe |

## 1 Introduction

1.1 Trafford is developing a Long Term Plan for the Reform and Sustainability of the Health and Social Care System. Trafford will have one plan for the Council and the CCG and we will work for it to be a shared and jointly owned direction with our colleagues, partners and stakeholders by 2020. Our framework is based on the ambition of commissioning and delivering health and social care based on the needs of Trafford's population, its people and the place that we serve. This Long Term Plan should be seen in the context of Trafford's Locality Plan which is due to be refreshed in 2020.

1.2 This document outlines the framework that the plan will take. The framework is a 5 year plan for system reform and sustainability, it reflects the principles of public sector reform and is built on 1 year rolling delivery plans for service change in both health and social care. These 1 year plans are already being developed and implemented for 19/20 and 20/21. The aim is to deliver financial stability and a highly performing health and social care delivery model for Trafford people.

1.3 This paper includes the following sections that will inform the Long Term Plan:

- How we are improving the outcomes for Trafford people
- Our long term priorities
- Trafford's place based model
- Trafford's reform of its delivery system
- Our underpinning reform strategies
- Working Together

## 2 Trafford Strategic Framework

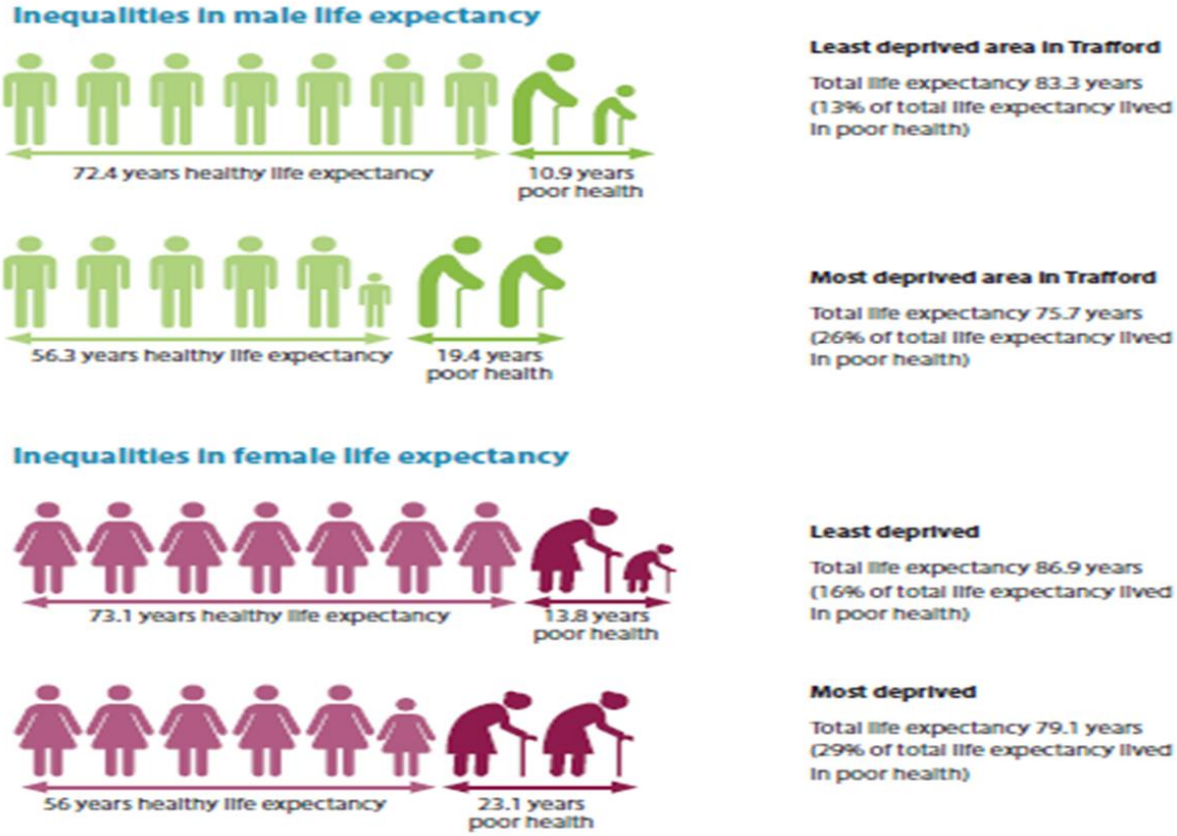
2.1 Our ambition is to reform Trafford based on seven key priorities. We have adopted these seven areas which we believe are key priorities for Trafford, with health and social care being integral to all areas. We believe these are the overarching framework and direction for our Long Term Plan and incorporates, as an approach, the public sector reform principles as a way of working, one Trafford pound, one workforce and one place. They are -

- **Building Quality, Affordable and Social Housing**
  Trafford has a choice of quality homes that people can afford
- **Health and Wellbeing**
  Trafford residents health and well-being is improved and health inequalities are reduced
- **Successful and Thriving Places**
  Trafford has successful and thriving town centres and communities
- **Children and Young People**
  All children and young people in Trafford will have a fair start
- **Pride in Our Area**
  People in Trafford will take pride in their local area

- **Green and Connected**
  Trafford will maximise its green spaces, transport and digital connectivity
- **Targeted support**
  People in Trafford will get support when they need it most

## 3 Trafford Health and Social Care System Context

3.1 Our ambition is to improve the health and social care outcomes for Trafford people. We are building Trafford's integrated health and social care system by focussing on the whole system with the aim of improving outcomes for Trafford people. Our challenge is as demonstrated below.




3.2 We will work to address these gaps and improve outcomes by:

- Building on a whole system approach for integrated commissioning and integrated delivery: population, people and place, which is outcome focussed and measuring what matters.
- A strength based approach, in a place based model - focusing on people, communities and combined assets to co design and co-produce solutions.
- Coordinated care closer to home, in our four neighbourhoods, in Trafford as a locality, working with others localities and with Greater Manchester.
- Influencing the wider determinants of health and wellbeing.
- Our work being driven by public health intelligence.
- Working within a partnership approach

## 4 Long Term Plan Priorities

4.1 Our ambition is to build a reformed and sustainable health and social care system. In order to do this, we will concentrate on two main drivers: **Trafford as a place**, and **system delivery reform** which is needed in order to improve outcomes. This means we need our place to be central to all that we do.

Our place based model of care will be founded upon building a social movement for health creation and wellbeing. This will have three areas:

- Prevention
- Person and Community Centred Care
- Primary and Community Care

Our delivery system reform will be across all age physical and mental health services -

- Intermediate Care
- Unplanned Care
- Planned Care

4.2 We will aim for prevention to be embedded within all our plans and to engage and work with people based on co-production with the public and providers.

## 5 Trafford Place Based Model

5.1 Our ambition is a place based model founded upon building a social movement for health creation and wellbeing. We believe that if we build upon our communities and neighbourhoods, we will be able to create a different way of working and a different approach to wellbeing. This will be embedded and owned within our system for the long term, and able to respond to the national and Greater Manchester agenda. We already have four neighbourhoods, five primary care networks, an integrated health and social care model and a Trafford Partnership approach. These will be our foundation to build upon as we move forward.

5.2 We also believe people are at the centre of the place based model. Not only in approach through person and community centred care but an integral part of the model through our workforce and carers, paid and unpaid. We recognise that workforce is traditionally an enabler, which it is. However, we believe we need to make people, which includes the Trafford workforce, as central and integral to the work that we do. We believe that we should build a movement where developing and empowering people is a fundamental part of the model and a foundation for cultural change across the system. Our place based model will enable us to do the following.

- Deliver an integrated health and social care place based model by 2022. A central component to the model is the community and social care integrated delivery model which we continue to develop. We will utilise existing structures and partnerships. Building upon our Local Care Alliance, which is made up of health and social care providers and commissioners across the acute, primary, community and voluntary sector. As well as working with our wider system partners in the independent care sector.
- Address wider determinants of health, reducing the health gap caused by inequality, using evidence based preventative services embedded across all providers and programmes of work focusing on our neighbourhoods.
- Commission and deliver a person and community centred care approach in all the work that we do. Prevention will be across all commissioning so that Every Contact Counts.
- Transform and sustain the primary care system, delivering place based care closer to home through integrated neighbourhood provider systems.
- Have an integrated workforce delivering care closer and directly supporting the place based delivery model.

## 6 Trafford System Delivery Reform

6.1 Our ambition is to deliver reform which is person centred. We will concentrate on major system reform areas with our partners. Our health and social care delivery model will have:

- An integrated urgent and emergency care system across Trafford that is safe, coordinated and people centred.
- An integrated intermediate care system where people are rehabilitated in their own home or as close to home as possible.
- An integrated planned health and care system with consistent and evidence based pathways of care as close to home as is possible.

6.2 Reformed delivery will be all age, across mental and physical health, and will be outcome focused, high performing and financially sustainable. It will be underpinned by an enhanced range of community services, including access to bed based services only when necessary for a person's needs, and people being seen by the right practitioner, in the right place and at the right time.

## 7 Trafford's underpinning reform programmes

7.1 Our ambition is for our system to be of the highest quality and underpinned by reform and a modernised approach. We will focus on four areas that we believe are pivotal to sustain change, these are culture, digital solutions, our built estate and financial and contracting systems.

- A changed culture, which will run throughout our plan. Fundamental to this is how we move to a system based on co-production (see appendix 1). The requirement for the system to embed a culture of learning and innovation will enable us to be able to constructively challenge practice in both commissioning and delivery. By strengthening the connectivity between partners it will enable us to innovate and change the way we work, to move us forward together in the coproduction and co-design of services.
- Increased use of digital solutions and strategies to deliver services and information, our citizens and neighbourhoods to be more independent and stay healthier for longer. Our workforce will have improved tools and access to information.
- A shared estate that will meet the growing and changing needs of the population, supporting the strategic direction of providing a greater range of services in primary care settings.
- Our financial and contracting mechanisms will be reformed to deliver an integrated system including a pooled budget arrangements to support the commissioning and delivery of the placed based model. We will underpin the long term plan with a five year financial plan which is aligned to system reform.

## 8 Working Together

8.1 Colleagues across the CCG and Council have been involved in writing this framework over the last few weeks. We have focussed initially on colleagues within the CCG and council, but this is not our ambition nor where we want to be.

8.2 We want this framework to be the start of a year-long process of engagement which means by July 2020 our long term plan will be owned within Trafford by colleagues, partners and stakeholders. This may mean that we will all need to reassess how we do things and how we deliver programmes. As stated previously we do have 1 year rolling delivery plans for service change in both health and social care. These are already being developed and implemented for 19/20 and 20/21 but we will do this work in the context of moving to a more shared and owned long term plan.

8.3 However we believe that in order to achieve reform which is sustainable the plan has to be owned and understood not told and sold. We have discussed the framework with the Local Care Alliance (partners in appendix 2) and there is agreement to the direction. However, we need to start to change the way we work, and we believe that we can do this by engaging differently with the Local Care Alliance and with other partners, such as those in the Trafford Partnership, over the next year. The difference we think we could achieve by prioritising this approach is outlined below.

- Strengthening partnerships with our diverse local communities; building on local ideas and using the strengths of individuals and partner organisations to give us new opportunities and ways to improve the health of our communities.
- Involving people directly in decisions about services, working with community advocates such as local businesses, voluntary groups, volunteers and schools as well as others to help shift the conversation onto preventing ill health, being active in pursuing health and wellbeing and shaping the future of health and care services.
- Identifying key partners, stakeholders and understanding factors that influence how best they should be engaged in the work, and also how best they could deliver services.
- Identifying local and system champions – system leaders who can identify this work as a corporate priority and leaders who are active in the communities, with local knowledge and contacts who can make a difference.

8.4 By the summer of 2020 we want to have moved, as a system, into a space where we have shared responsibility and we are looking to embed a way of working based on a collaborative partnership approach: engage, co design and co-produce. By doing his we will have a shared and owned system wide Long Term Plan to take us through to 2024/5. Therefore seeing partners as part of how Trafford commissions and delivers services.

## 9 Conclusion

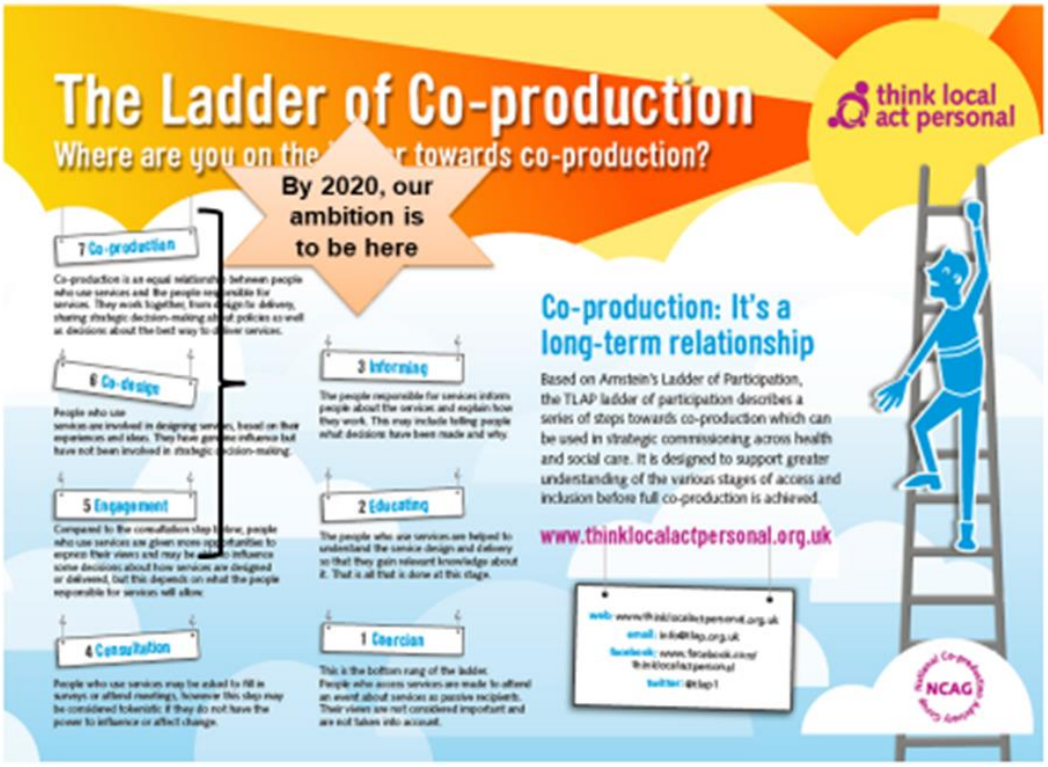
9.1 We believe Trafford needs a Long Term Plan for 2024/5 which we are starting to build, with one year rolling delivery plans. We believe this plan needs to be shared and owned with our colleagues, partners and stakeholders. This in itself is a part of reforming the system to make it more sustainable in the future. Our ambition is to transform in five keys areas as outlined in the diagram below.


## 9 Recommendations

9.1 The recommendations are outlined below.

- This framework is agreed as a shared framework for the long term plan for health and social care.
- This framework is to cover the five year period and in doing so will have one year delivery plans.
- This framework will be worked through with colleagues, partners and stakeholders so that our ambitions are joint and owned.
- A worked up plan with rolling programmes will be brought back to both meetings in October 2019.
- That the seven Council corporate objectives set out in section 2.1 of the report be formally adopted by the CCG.

## Appendix 1 – ladder of coproduction




## Appendix 2 Local Care Alliance Partners

| | |
|---|---|
| Trafford CCG | Trafford Council |
| Pennine Care Foundation Trust | Manchester Foundation Trust |
| Thrive (VCSE) | Greater Manchester Mental Health Trust |
| Mastercall OOH Provider | Primary Care (TPH) |
| And the LMC and Healthwatch as advisory partners | |

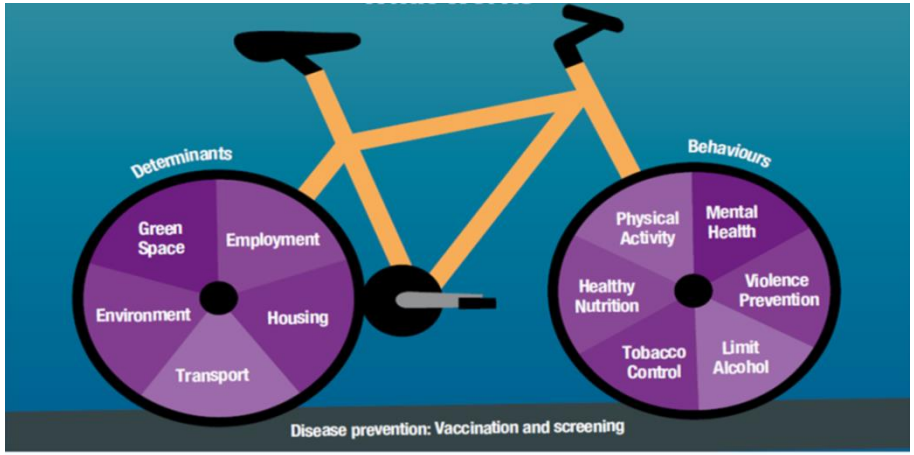
# Trafford Health and Wellbeing Strategy 2019-29

The Trafford Health and Wellbeing Board exists to improve population health outcomes. It does this through strategy development, improving partnership working, and using our knowledge of local needs from our Joint Strategic Needs Assessment to improve our services. In Trafford we are focussing on using the HWBB to increase the number of years people spend in good health. This is measured by *Healthy life expectancy (HLE)*. 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. The variation across the borough for this indicator is greater than for life expectancy, and in general communities in the north of the borough fare much worse than those in the south, putting additional burdens on these communities.

In Trafford we have a 16 year inequality or difference gap between our most affluent and most deprived communities[1]. To improve HLE, we are focussing on preventing poor health and on promoting wellbeing, as this will reduce health and social care costs, and enhance resilience, employment and social outcomes. The actions required must address the 'wider determinants' of health such as clean air, housing, transport, employment and the environment we live in, as all of these have a role in driving our behaviours, as can be seen in the diagram below. We also need to ensure that our actions help reduce the borough's carbon footprint, and reduce the impact of climate change on our population

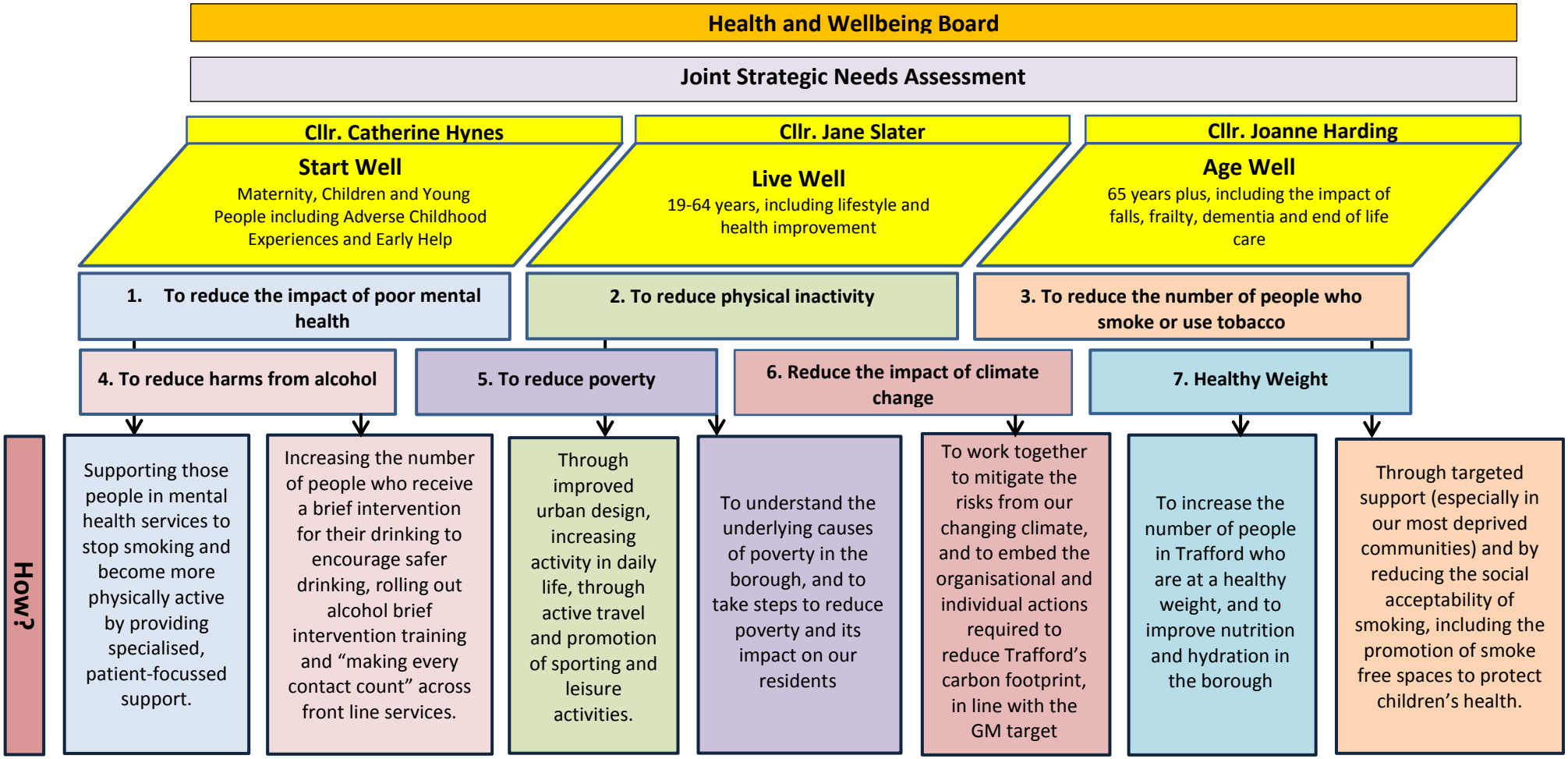
## How?

The Health and Wellbeing Board is focussed on our residents' journeys through life, taking a life course approach that reflects the public health needs of that age group. We aim to improve outcomes at each stage while ensuring that seven overarching priorities are considered, and ensuring interventions are evidence based, measurable and add value.




*Source:* WHO (2013a).

[1] *PHE, (2017) Slope Index of Inequality in HLE, 2009-13 pooled data, https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/*




## How will we know we have made a difference?

Multiagency Boards will oversee each life course area, and have partnership action plans, focusing on the priority areas. We have produced a performance dashboard for our key indicators so that we measure our progress, monitoring improvements in Healthy Life Expectancy overall (from a baseline of 2013-15) but also the Slope Index of Inequality (SII) in healthy life expectancy (from a baseline of 2009-13) which is a measure of inequality or how much healthy life expectancy in Trafford varies with deprivation.

We will only achieve the desired outcomes by working with our population and with partners in Trafford and across Greater Manchester and measuring the difference we make. Members of the Board are responsible for ensuring that actions and approaches agreed by the Board are delivered in their own organisations.

## Lead:

**Eleanor Roaf**, *Director of Public Health (Interim)*

**Trafford Health and Wellbeing Board Outcomes Framework - May 2018 update**

| Objective/Indicator | Source | Year | Unit | Trafford value | Comparators | | | | Change | Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Stockport | Best in peer group | North West | England | Since previous period | |
| **Improve healthy life expectancy** | | | | | | | | | | |
| Healthy life expectancy at birth (Male) | PHOF 0.1i | 2015-17 | Years | 64.0 | 61.7 | 66.9 | 61.2 | 63.4 | ↑ | |
| Healthy life expectancy at birth (Female) | PHOF 0.1i | 2015-17 | Years | 65.3 | 64.7 | 66.5 | 65.3 | 63.8 | ↓ | |
| Slope Index of Inequality in healthy life expectancy (Male) | PHOF 0.2vi | 2009-2013 | Years | 15.8 | 17.3 | 8.7 | | | | |
| Slope Index of Inequality in healthy life expectancy (Female) | PHOF 0.2vi | 2009-2013 | Years | 16.1 | 16.6 | 7.8 | | | | |
| **Reduce harm from alcohol** | | | | | | | | | | |
| Admission episodes for alcohol-related conditions (Narrow) | PHOF 2.18 | 2016/17 | DSR per 100,000 popn | 613 | 673 | 527 | 719 | 636 | ↑ | |
| Admission episodes for alcohol-related conditions (Broad) | LAPE 9.01 | 2017/18 | DSR per 100,000 popn | 2,405 | 2,622 | 2,055 | 2,405 | 2224 | ↓ | |
| Admission episodes for alcohol specific conditions | LAPE 6.02 | 2017/18 | DSR per 100,000 popn | 755 | 821 | 360 | 818 | 570 | ↓ | |
| Admission episodes for alcohol-specific conditions - Under 18s | LAPE 5.02 | 2015/16 - 2017/18 | Crude rate per 100,000 | 42.5 | 61.5 | 23.2 | 47.6 | 32.9 | ↑ | |
| Alcohol related mortality | LAPE 4.01 | 2017 | DSR per 100,000 popn | 49.6 | 50.3 | 39.3 | 55 | 46.2 | ↑ | |
| Alcohol-specific mortality | LAPE 2.01 | 2015-17 | DSR per 100,000 popn | 13.4 | 15.7 | 7.9 | 14.8 | 10.6 | ↑ | |
| Smoking status at time of delivery | PHOF 2.03 | 2016/17 | Proportion | 6.7 | 10 | 6.3 | 13.4 | 10.8 | ↑ | |
| Smoking prevalence at age 15 - Current smokers (WAY) | PHOF 2.09i | 2014/15 | Proportion | 5.3 | 7.1 | 4.7 | 8.0 | 8.2 | | |
| **Improve mental health and reduce the impact of mental illness** | | | | | | | | | | |
| Suicide rate | PHOF 4.10 | 2015-17 | DSR per 100,000 popn | 7.3 | 9.0 | 7.3 | 10.4 | 9.6 | ↑ | |
| Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate | PHOF 1.08iii | 2017/18 | Percentage point | 67.7 | 73.2 | 59.9 | 68.4 | 68.2 | ↓ | |
| Self-reported wellbeing - people with a high anxiety score | PHOF 2.23iv | 2017/18 | Proportion | 18.8 | 19.8 | 13.9 | 20.4 | 20 | ↓ | |
| Excess under 75 mortality rate in adults with serious mental illness | PHOF 4.09i | 2014/15 | Indirectly standardised ratio | 480.3 | 334.2 | 217.8 | 401.2 | 370 | ↑ | |
| Emergency hospital admissions for intentional self-harm | PHOF 2.10ii | 2017/18 | DSR per 100,000 popn | 163.4 | 217 | 122.8 | 234.5 | 185.5 | ↑ | |
| **Increase physical activity** | | | | | | | | | | |
| Percentage of physically active adults | Active Lives | 2016/17 | Proportion | 64.6 | | | 61.4 | | ↑ | |
| Percentage of 15 year olds physically active for at least one hour per day seven days per week | PHE PA Profiles | 2014/15 | Proportion | 11.4 | 13.6 | 18.8 | 13.2 | 13.9 | | |
| Percentage of adults who do any walking, at least five times per week | PHE PA Profiles | 2014/15 | Proportion | 43.0 | 44.3 | 55.2 | 48.5 | 50.6 | | |
| Percentage of adults who do any cycling, at least three times per week | PHE PA Profiles | 2014/15 | Proportion | 3.0 | 3.7 | 14.8 | 3.4 | 4.4 | | |
| Utlisation of outdoor space for exercise/health reasons | PHOF 1.16 | Mar 2015 - Feb 2016 | Proportion | 18.7 | 17.8 | 25.8 | 17.5 | 17.9 | ↑ | |
| Excess weight in adults | PHOF 2.12 | 2016/17 | Proportion | 56.1 | 61.1 | 56.1 | 63.3 | 61.3 | | |
| Child excess weight in Year 6 | PHOF 2.06ii | 2016/17 | Proportion | 33.1 | 31.9 | 27.3 | 35.2 | 34.2 | ↑ | |
| **Increase cancer screening rates** | | | | | | | | | | |
| Under 75 mortality rate from cancer considered preventable | PHOF 4.05ii | 2014-16 | DSR per 100,000 popn | 81.9 | 82.5 | 67.1 | 92 | 79.4 | ↓ | |
| Cancer diagnosed at an early stage | PHOF 2.19 | 2016 | Proportion | 55.9 | 57.1 | 60 | 51.9 | 52.6 | ↓ | |

Key to colour coding: Red = statistically significantly worse than England; Amber = not statistically significantly different from England; Green = statisticallly significantly better than England; Grey = not compared
(1) Peer group comparison is among Trafford's 15 nearest statistical neighbours (CIPFA)
(2) Colour coding of arrow denotes whether upward/downward trend represents improvement or deterioriation, but does not denote statistical significance of this change

**Trafford Health and Wellbeing Board Performance Framework**

| Objective/Indicator | Source | Year | Unit | Trafford value | Comparators | | | | Change | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Stockport | Best in peer group (1) | North West | England | Since previous period (2) | Trend |
| **Reduce harm from alcohol** | | | | | | | | | | |
| Number in treatment in specialist alcohol misuse services | LAPE 14.01 | 2016/17 | Number | 336 | 539 | 625 | 14192 | 80454 | ↓ | |
| Successful completion of treatment for alcohol | LAPE 15.01 | 2016 | Proportion | 54.9 | 36.6 | 59.8 | 43.6 | 38.7 | ↑ | |
| Proportion of adults screened using an AUDIT alcohol screening questionnaire in primary care | Local | | | Awaiting data | | | | | | |
| Number of brief interventions | Local | 2017/18 | Number of claims | 1803 | | | | | | |
| Number of extended interventions | Local | 2016/17 | Number of claims | 88 | | | | | | |
| **Reduce harm from tobacco** | | | | | | | | | | |
| Number setting a quit date | PHE LTCPs | 2016/17 | Crude rate per 100,000 smokers aged 16+ | 359 | 5,685 | 11,177 | 4,673 | 4,434 | ↓ | |
| Successful quitters at 4 weeks | PHE LTCPs | 2016/17 | Crude rate per 100,000 smokers aged 16+ | 73 | 2,014 | 5,194 | 2,153 | 2,248 | ↓ | |
| Cost per quitter | PHE LTCPs | 2016/17 | Crude rate - £ | 20,172 | 1,222 | 367 | 550 | 493 | ↑ | |
| The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months | QoF | 2016/17 | Proportion | 89.4 | 86.9 | | | 88.8 | | |
| New indicator: Smoking prevalence in adults - socio-economic gap in current smokers | PHE LTCPs | 2017 | Ratio | 3.08 | 3.77 | 1.73 | 2.55 | 2.44 | | |
| **Improve mental health and reduce the impact of mental illness** | | | | | | | | | | |
| Access to IAPT services: People entering IAPT (in month) as % of those estimated to have anxiety/depression | PHE | Sep-17 | Proportion | 11.8 | 16.4 | 31.1 | | 15.5 | ↔ | |
| Patients with severe mental illness who have a comprehensive care plan | QoF | 2016/17 | Proportion | 81.7 | 85.1 | | | 79.0 | | |
| Patients with severe mental illness who have a record of blood pressure in last 12 months | QoF | 2016/17 | Proportion | 83.3 | 86.5 | | | 82.2 | | |
| Patients with severe mental illness who have a record of alcohol consumption in last 12 months | QoF | 2016/17 | Proportion | 81.8 | 85.8 | | | 81.4 | | |
| Eligible patients with severe mental illness who have a record of cervical screening in last 5 years | QoF | 2016/17 | Proportion | 73.7 | 75.2 | | | 70.0 | | |
| **Increase physical activity** | | | | | | | | | | |
| Number of GP referrals to physical activity scheme | Local | | | Awaiting data | | | | | | |
| **Increase cancer screening rates** | | | | | | | | | | |
| Breast cancer screening coverage | PHOF 2.20i | 2017 | Proportion | 74.4 | 72 | 80.4 | 73.2 | 75.4 | ↑ | |
| Cervical cancer screening coverage | PHOF 2.20ii | 2017 | Proportion | 75.5 | 75.5 | 78.1 | 72 | 72 | ↑ | |
| Bowel cancer screening coverage | PHOF 2.20iii | 2017 | Proportion | 58.5 | 59.3 | 64.2 | 58 | 58.8 | ↑ | |

| Health checks | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check | PHOF 2.22iii | 2013/14-16/17 | Proportion | 72.1 | 81.2 | 100 | 72.2 | 74.1 | | |
| Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check | PHOF 2.22iv | 2013/14-16/17 | Proportion | 51.6 | 59.1 | 63.2 | 52.5 | 48.9 | | |
| Cumulative percentage of the eligible population aged 40-74 who received an NHS Health Check | PHOF 2.22v | 2013/14-16/17 | Proportion | 37.2 | 48 | 53 | 37.9 | 36.2 | | |

Key to colour coding: Red = statistically significantly worse than England; Amber = not statistically significantly different from England; Green = statisticallly significantly better than England; Grey = not compared

(1) Peer group comparison is among Trafford's 15 nearest statistical neighbours (CIPFA)

(2) Colour coding of arrow denotes whether upward/downward trend represents improvement or deterioriation, but does not denote statistical significance of this change

**TRAFFORD COUNCIL**

**Report to:** **Health and Wellbeing Board**
**Date:** **19 July 2019**
**Report for:** **Information**
**Report of:** **Eleanor Roaf, Director of Public Health**

## Report Title

Health and Wellbeing Board's responsibility for oversight of child deaths in Trafford.

## Summary

This paper informs the Health and Well Being Board of their new statutory requirement and accountability for the oversight of all child deaths in Trafford.

It outlines the current arrangements and the new processes to ensure that we are compliant with national legislation. The Health and Well Being Board will scrutinise the CDOP (Child Death Overview Panel) process, receive information such as the annual report and consider emerging trends in child deaths with the aim to prevent further deaths.

## Recommendation(s)

Members of Trafford's Health and Wellbeing Board are asked:

i. to confirm and accept the responsibility for governance of CDOP to be transferred from Trafford's Safeguarding Board to the Health and Wellbeing Board.

ii. to ensure that mortality reviews of all children who have died within their services are carried out using a multi-agency model of review.

iii. to note that they will receive the 18/19CDOP report upon completion.

Contact person for access to background papers and further information:

Name: Helen Gollins, Deputy Director of Public Health, Trafford Council
Extension: ex 4276

**Health and Wellbeing Board's responsibility for oversight of child deaths in Trafford**

## 1. Purpose of the paper

This paper has been prepared to inform the Health and Well Being Board of their new statutory requirement and accountability for the oversight of all child deaths in Trafford.

It outlines the current arrangements and the new processes to ensure that we are compliant with national legislation. The Health and Well Being Board will scrutinise the CDOP (Child Death Overview Panel) process, receive information such as the annual report and consider emerging trends in child deaths with the aim to prevent further deaths.

## 2. Background

Since 2008, in line with Working Together to Safeguard Children guidance, there has been a statutory requirement for Local Safeguarding Children Boards (LSCB) to ensure that the deaths of all children under the age of 18 years (excluding stillbirths and legal terminations of pregnancy) are reviewed. The purpose of a review is to identify any matters relating to the death that are relevant to the welfare of children or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If CDOPs find action should be taken by a person or organisation, they must inform them. In addition, CDOPs:

- must, at such times as they consider appropriate, prepare and publish reports on:
    - what they have done as a result of the child death review arrangements in their area, and
    - how effective the arrangements have been in practice;
- may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process - the person or organisation must comply with the request, and if they do not, the CDOP (CDR Partners) may take legal action to seek enforcement.

Under the current structure, CDOP reports are presented and considered by the Trafford Safeguarding Executive Board. The Wood Review (2016) identified the need for change in the way that child deaths reviews are completed. The review recommended the transfer of the responsibility to Local Authorities and Clinical Commissioning Groups (CCGs). The Child Death Review Statutory and Operational Guidance (England) was published in October 2018 which sets out the requirement and legal responsibility for CDOPs and Child Death Review Partners (CDR Partners) to ensure that the deaths of children normally resident in their area are reviewed.

## 3. Changes outlined in the Operational Guidance

CDOPs will no longer be part of the revised Local Safeguarding Partnership (LSP) arrangements and as of October 2018 the national line of accountability was transferred from the Department for Education (DfE) to the Department for Health and Social Care (DHSC). In Greater Manchester CDOP accountability and reporting will be to the Health and Wellbeing Boards (H&WB), who will scrutinise the process and receive information such as the annual report and emerging trends in child deaths across the region.

The purpose of this paper is to ensure that the Trafford Health and well Being Board is clear on the statutory requirement to carry out a review for all child deaths, irrespective of cause, age 0 – 17 years (before the child's 18th birthday), excluding stillbirths and legal terminations of pregnancy. This is to ensure that there are:

- clear reporting structures for CDOP findings to the Health and Wellbeing Board in Trafford.
- clear processes are in place for child reviews to take place.
- clear procedures continue to share information with the CDOPs.

- information gathered is used to identify emerging themes with the aim to prevent further deaths.
- effective services are commissioned and provided to bereaved families who have suffered the death of a child.

### 4.i. Local Position

The DfE recommendation that CDOPs require a total population of 500,000 or higher. Trafford is included in the GM CDOP arrangements, the current four existing panels will continue to meet. Trafford is part of the CDOP with Tameside and Stockport localities.

| GM CDOPs | GM Coronial Jurisdiction | Population |
|---|---|---|
| Tameside, Trafford & Stockport CDOP | Manchester South Coroner's Office | 750,657 |

### 4.ii. Stockport, Tameside and Trafford Membership

Until recently the Stockport, Tameside, and Trafford CDOP had an independent chair, however since May, the chair ship has transferred to a Public Health Consultant. Membership is one a rotational basis and is under review as per the Child Death Review Statutory and Operational Guidance, 2018. The current membership is as follows:

- Helen Gollins – Trafford Public Health
- Shelley Birch – Joint CDOP manager
- Dr Rashad Nawaz – Consultant Community Paediatrician - Trafford
- Ann Evans – Palliative care nurse – Trafford
- Claire Mee – MFT south midwifery - Wythenshawe
- Jane Connell - Designated Doctor Safeguarding Children Stockport
- Catherine Fleming – Safeguarding Board Manager – Stockport
- Sharon Hyde – Head of Midwifery – Stockport
- Dr Munera Khan – Consultant Paediatrician - Tameside
- Julie Parker - Designated Nurse Safeguarding Children
- Estelle Mathieson - Detective Superintendent GMP
- Andrea Edmondson – Safeguarding Practitioner NWAS

### 4.iii. GM CDOP Network

CDOP Chairs and CDOP Coordinators/Managers currently come together to form the GM CDOP Network. This Network meets on a quarterly basis to ensure that the approach to data collection, application of modifiable factors and interpretation of data is consistent across GM. The GM CDOP Network also highlight any emerging themes in child deaths across GM, share good practice and work together to support the GM CDOP Annual Report.

### 4.iv. Annual Reports

In line with Working Together Guidance, the Tameside Trafford and Stockport CDOP prepares a local annual report containing relevant statistical analysis, information and recommendations for the Trafford Safeguarding Executive Board. Trafford Health and Well Being Board will receive these upon completion.

**5. Child Death Mortality Reviews**

The Manchester University NHS Foundation Trust undertake a significant amount of work through the processes of investigating all neonatal and child deaths, when a child dies or is taken to one of the Trust's sites.

There is a requirement for all CDMR reviews to be submitted to the CDOP area of residence so that further analysis of data can be made. The Tameside, Trafford and Stockport CDOP are currently working on the arrangements for this new requirement and will inform the Health and Wellbeing Board when completed.

**6. Recommendations for 2019/20**

Members of the Health and Wellbeing Board are asked to:

i. confirm and accept the responsibility for governance of CDOP to be transferred from Trafford's Safeguarding Board to the Health and Wellbeing Board.

ii. ensure that mortality reviews of all children who have died within their services are carried out using a multi-agency model of review.

iii. note that they will receive the 18/19 CDOP report upon completion.

**Paper produced by:** Helen Gollins, Deputy Director of Public Health, Trafford Council, helen.gollins@trafford.gov.uk, and Dr Donna Sager, Public Health Consultant, Stockport Council, donna.sager@stockport.gov.uk,, 24th June 2019.

# Stockport, Tameside and Trafford Child Death Overview Panel

# Statutory Responsibilities and Arrangements Implementation Plan, June 2019

# Signatories to the Stockport, Tameside and Trafford Child Death Overview Panel Implementation Plan, 27th June 2019

## Stockport

**Anita Rolfe, Executive Nurse, NHS Stockport Clinical Commissioning Group**

**Chris McLoughlin, Director of Children's Services, Stockport Local Authority**

**Dr Donna Sager, Director of Public Health, Stockport Local Authority**

## Tameside

**Steven Pleasant MBE, Chief Executive Officer, Tameside Metropolitan Borough Council and Accountable Officer, Tameside and Glossop Clinical Commissioning Group**

## Trafford

**Nikki Bishop, Chief Finance Officer, Trafford NHS Clinical Commissioning Group**

**Cathy Rooney, Director for Early Health and Children's Social Care, Trafford Council**

**Eleanor Roaf, Director of Public Health, Trafford Council**

**Stockport, Tameside and Trafford Child Death Review Partners**

**Child Death Overview Panel Statutory Responsibilities and Arrangements**

## 1. Overview

The Child Death Review Partners for Stockport, Tameside and Trafford will ensure that all child deaths are reviewed under the requirements of the Children Act 2004 as amended by the Children and Social Work Act 2017 and Working Together 2018.

## 2. Purpose

Stockport, Tameside and Trafford Child Death Review Partners will ensure that the Child Death Overview Panel (CDOP) will undertake a review of all child deaths (excluding both those babies who are still born and planned terminations of pregnancy carried out within the law) up to the age of 18 years normally resident in Stockport, Tameside and Trafford and if they consider appropriate any non-resident child who has died their area. The Child Death Review Partners and CDOP will adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018.

"*The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths."* (Working Together to Safeguard Children, 2018).

## 3. Child Death Review Partners Statutory Responsibilities

The Stockport, Tameside and Trafford Child Death Review Partners have made arrangements for a structured and consistent approach to review all deaths of children under 18 years of age in line with Working Together, 2018.

It is recommended that CDOPs require a total population of 500,000, with an average of 60 child deaths per year. There are four GM CDOPs, of which Stockport, Tameside and Trafford CDOP is one.

| GM CDOPs | GM Coronial Jurisdiction | Population |
|---|---|---|
| Tameside, Trafford & Stockport CDOP | Manchester South Coroner's Office | 750,657 |

The geographical footprint of Stockport, Tameside and Trafford CDOP reflects the network of NHS health providers, Police and Social Care providers for this cluster. The arrangements are as follows:

- The child death review process will be modelled on, and adhere to, Child Death Review Statutory and Operational Guidance (2018) this will include the continued utilisation of the Child Death Overview Panel as the chosen forum for reviewing all child deaths.
- The Child Death Review Partners will work with Greater Manchester partners to determine funding for a Designated Doctor for Child Death and a Lead Nurse for the Child Death Review process which incorporates the Link/Key worker role as stated in the statutory guidance and as required by 29 September 2019.
- The partners will continue to be able to access an electronic case management system. This will support data submission into the National Child Mortality Database.
- The Partners will have oversight and be assured of the development and progress of the Child Death Review Process and CDOP through agreed governance and reporting mechanism.
- The Child Death Review Partners will publicise information regarding the arrangements for reviewing child deaths in Stockport, Tameside and Trafford.

**4. Child Death Overview Panel Responsibilities**

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

**5. Child Death Overview Panel Operational Arrangements**

CDOP will;

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

**5.i.** Panel Membership

The Child Death Overview Panel is chaired by a Public Health Consultant, the vice chair will also be a Public Health Consultant. This will be reviewed annually when the terms of reference are reviewed.

CDOP is a multi-professional panel. The core membership will include senior representatives from the following agencies:

- Public Health, Public Health Consultant
- Designated Doctor for Child Deaths (and a hospital clinician if the Designated Doctor is a community doctor or vice versa)
- Children Social Care, Strategic Lead for Front Door
- Greater Manchester Police, Detective Inspector
- Clinical Commissioning Group, Designated Nurse for Safeguarding Children
- Primary care, Named General Practitioner for safeguarding children
- Maternity Services, Head of Midwifery

- Children's Community Health Services, Strategic Health Service Lead
- Lay representation

This membership will be one of the above designations from one of the three boroughs. The CDOP will be representative of Stockport, Tameside and Trafford, and will rotate borough two every years.

In addition to the core membership of CDOP, relevant experts from health and other agencies will be invited as necessary to inform the discussion and may include;

- Healthy Young Minds, Consultant Clinical Psychologist
- Education, Director of Education
- Early Years, Head of Early Years
- Children's Community Nursing Team , Palliative Care Nurse

**5.ii.** Quoracy

The Child Death Overview Panel will be quorate if there are five or more core members present at the meeting, this must include attendance by lead professionals from health and the two Local Authorities.

**5.iii.** Decisions and Disputes

Decisions will be normally reached by consensus. In the event of a disagreement, a vote of members of the panel will be taken. In the event of a failure to resolve an issue, the chair will discuss this further with the Designated Doctor for Child Death and the Vice Chair to come to a resolution.

**5.iv.** Conflict of Interest

Panel members must declare any conflict of interest at the outset of each meeting. Panel members should not lead discussions if they are the named professional who had responsibility for the care of the child prior to her death.

**5.v.** Confidentiality

All information discussed at the Child Death Overview Panel is **strictly confidential** and must not be disclosed to a third party without discussion and agreement of the Chair. A confidentiality agreement will be read by all members of the panel at the beginning of each Stockport, Tameside and Trafford CDOP meeting.

**6. Governance and Accountability**

The Child Death Overview Panel is accountable to the Stockport, Tameside and Trafford Child Death Review Partners.

Minutes of each meeting are recorded and are available with permission from the Chair to the Child Death Review Partners.

A summary of key learning will be developed and reported to the Child Death Review Partners. The Chair of the Child Death Overview Panel will report quarterly to:

- Locality Health and Well Being Boards for Stockport, Tameside and Trafford.
- Locality Safeguarding Partnerships within Stockport, Tameside and Trafford.

The report will include numbers of child deaths reviewed, recommendations, learning and any delays on reviewing child deaths due to criminal or coronial investigations.

The data will also be used in the annual CDOP report for Greater Manchester, allowing any Greater Manchester themes or issues to be identified.

The chair of the Child Death Review Panel and Designated Doctor for Child Death will write and present an Annual Report. This will be presented to the Child Death Review Partners and to Stockport, Tameside and Trafford Health and Wellbeing Board's and Safeguarding Partnerships.

Any concerns regarding responsibilities and functions of the child death review process and the Child Death Overview Panel will be reported and escalated to the Child Death Review Partners by the Chair or Vice Chair of CDOP.

**7. Implementation**

The CDOP plan will be implemented on 29th September 2019; at this point the Stockport, Tameside and Trafford Child Death Overview Partners will take responsibility for the implementation of the new arrangements as set out within this document.

**8. Publication**

The Stockport, Tameside and Trafford Child Death Review Partners and Child Death Overview Panel arrangements will be published on:

- Stockport NHS CCG website
- Tameside NHS CCG website
- Trafford NHS CCG website
- Stockport Local Authority website
- Tameside Local Authority website
- Trafford Council website
- Stockport Safeguarding Children Partnership website
- Tameside Safeguarding Children Partnership website
- Trafford Safeguarding Partnership website

**The Child Death Review Partners will also notify NHS England of the new arrangements by emailing** England.cypalignment@nhs.net **before the 29th June 2019**

**TRAFFORD COUNCIL**

**Report to:** **Health & Wellbeing Board**
**Date:** **19th July 2019**
**Report for:** **Information**
**Report of:** **Infection Control & Prevention Service**
**Eleanor Roaf, interim Director of Public Health**

## Report Title

Trafford Community Infection Prevention & Control Annual Report 1st April 2018-31st March 2019

## Purpose

To provide the Health and Wellbeing Board with a report on the work of the Infection Control & Prevention Service in Trafford

## Recommendations

1. **To note the contents of the report**
2. **To commend the efforts of Trafford's Infection Prevention and Control team in reducing the risks from infections in Trafford**
3. **To note the ongoing requirement for support and training for care homes and GPs, in order for standards to be maintained**
4. **To consider the support organisations can give on meeting immunisation standards, especially in relation to flu**

Contact person for access to background papers and further information:

Name: Eleanor Roaf Phone 0161 912 1201

# Trafford community Infection Prevention & Control Annual report (April 1st 2018- March 31th 2019)


**Authors:**

**Eleanor Roaf, Trafford Director of Public Health**
**Phil Broad, Modern Matron, Infection Prevention and Control**

## Contents



**Abbreviations**

IPC – infection prevention and control
IPCT – Infection prevention and control team
PCFT – Pennine Care Foundation Trust

## 1. EXECUTIVE SUMMARY

High standards of infection prevention and control are essential to ensure people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday clinical and social care practice and must be applied consistently by everyone.

Good management and organisational processes are also crucial in ensuring high standards of infection prevention and control. This should result in effective prevention, treatment and containment of infection. Effective action relies on accumulating a body of evidence that also takes account of current guidance and best practices around hygiene and cleanliness.

It is the purpose of this Annual Report to evaluate such evidence and practice for compliance against the Infection Prevention and Control (IPC) work plans that were included as part of the previous 2018-19 Annual Report. Improvements in the delivery of the Infection Prevention and Control service aim to achieve zero tolerance to healthcare associated infections, by building on improvements made during the last 12 months and continuously reviewing priorities for improvement during 2018-19. The Infection Prevention and Control Plan work plan for commissioned services is included in the report and has been embedded in the work program for the community Infection Prevention and Control Team within Pennine Care NHS Foundation Trust, the Operating Plan and Commissioning Corporate Objectives, Public Health Directorate, Health Protection and Resilience plans and objectives.

This report describes Infection Prevention and Control activity, arrangements and progress with the work plan for the period April 2018 – March 2019, and will highlight the achievements made by the service, in helping to reduce the burden of health care associated infections in the community, and to meet the challenges of organizational change and emergence of antimicrobial resistant organisms, such as Carbapenamase producing Enterobactericeae (CPEs)

### Legal framework for cleanliness and Infection Prevention and Control

The Infection Prevention and Control program and priorities for 2014-2015 was built on the previous Code of Practice 'The Health and Social Care Act 2008*: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance'*. This Code of Practice applied to NHS organizations was used by the Care Quality Commission (CQC) to assess whether NHS trusts complied with the Health and Social Care Act 2008.

The Health and Social Care Act 2008 '*Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance'* sets out what registered providers of health and social care services should do to ensure compliance with the registration requirement for cleanliness and infection.

**HCAI Performance Summary**

2018-19 MRSA Bacteraemia & Clostridium difficile infection (CDI)

| Organism | Objectives | Actual |
|---|---|---|
| MRSA Bacteraemia | Zero tolerance | 2 |
| CDI Trafford CCG (Trust & none Trust apportioned cases) | 64 | 72 |
| CDI (Trafford none Trust apportioned ) | -------- | 37 |
| E-coli Bacteraemia | 5% reduction over previous year 173 | 183 6% increase |

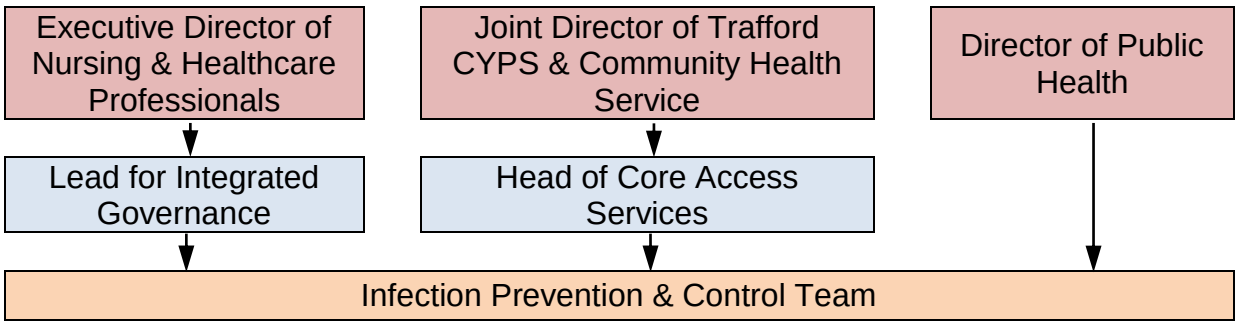
## 2. INFECTION PREVENTION AND CONTROL ARRANGEMENTS

### 2.1 Infection Prevention and Control service (IPCS)

The Trafford community IPCS aims to provide a comprehensive proactive service which is responsive to the needs of service within the Trafford public health economy along with key stake holders, including Pennine care foundation NHS trust (PCFT) provider services, independent contractors, private providers, and local authority commissioned services and the public, and is committed to the promotion of excellence within the everyday practice of infection prevention and control. Central to this is providing advice, support and education for all staff across all the disciplines within the community provider and commissioned services. This remit extends to the provision of advice and support for schools, nurseries, care homes, general practitioners, dentists local authority commissioned social care and care agency staff and the general public. The IPCS has responsibility for the monitoring, surveillance and investigation of infections and for advising on preventative and control precautions. This is done as a collaborative partnership between PCFT, Trafford CCG and Trafford local authority.

The IPCS is part of the Nursing Directorate within PCFT, Trafford borough. The Modern Matron (Infection Prevention and Control) is line managed by an operational manager with responsibility for specialist nurses, and the Infection Prevention and Control nurses are line managed by the Modern Matron.

**REPORTING AND GOVERNANCE ARRANGEMENTS 2018 -19**



## 2.2 Trafford Director of Public Health (DPH)

The DPH for Trafford with responsibility for health protection including infection prevent and control is Eleanor Roaf. The roles of the DPH transferred to the Local Authority on 1st April 2013 as part of the Health and Social care Act 2012 changes. The DPH has an assurance role for health protection, exercised through the Trafford Health Protection Forum. Health protection is a mandated service for the Local Authority and is included in the Memorandum of Understanding between Public Health, NHS Trafford CCG along with PCFT.

## 2.3 Microbiological Support

A Memorandum of Understanding is in place with Trafford Division of Central Manchester FT (CMFT) Microbiology Department to provide specialist microbiological advice to Trafford CCG. Arrangements are in place which ensure CDI and MRSA results are communicated to the team on a daily basis, via telephone call/messages.

## 2.4 Trafford Health protection forum

The Health protection forum Infection Prevention and Control group is chaired by the Director of Public Health. The group meets bi-monthly to oversee the development and implementation of the Trafford Community Infection Prevention and Control work plan and strategy, and to monitor the performance of providers. It ensures that Trafford community has in place effective systems and processes to fulfill its responsibilities in the delivery of high standards of care and meet the standards within the Health & Social Care Act (2008), Code of Practice. The Infection Prevention and Control Group's terms of reference are shown in **Appendix A**.

## 2.5 Working in partnership with other agencies and organisations

Throughout 2018-19 the IPCS has promoted collaborative working with the local secondary and primary care providers across the full range of infection prevention and control issues. In addition to attending meetings of the Trafford Health Protection Forum as members of the Infection prevention and Control group, team members also attend meetings relating to the investigation of incidents of MRSA bacteraemia and community attributed Clostridium Difficile, providing further opportunities for sharing information, and for building and maintaining good working relationships with hospital IPC teams.

The IPCS also delivers infection prevention and control services to Local authority employed and commissioned care staff, developing strong collaborative links with key Social Service providers, private nursing and residential care homes, and care agencies. The Infection Prevention and Control service also attends Nursing forum chaired by the CCG personalised care team.

The IPCS also attends the CCG performance group (POIG), where matters pertaining to IP&C support to primary care, along with the education sub group which develops training for primary care staff.

Across the wider Greater Manchester (GM) footprint the Infection control team attend IP&C confederation meetings facilitated and chaired by NHS England, along with GM collaborative network meetings which are held across GM.

## 3 MEETING INFECTION PREVENTION AND CONTROL STANDARDS

### 3.1 The Health & Social Care Act 2008, code of practice for the prevention and control of infections and related guidance (revised October 2010)

The Health and Social Care Act 2008, establishes the CQC and sets out a legal framework for the regulation of health and social care activities. Regulations made under the Act describe health and social care activities that may only be carried out by registered providers, and also provide details of the requirements for registration. Failure to comply with the statutory requirements set out, is, therefore, a breach of registration, under the Health and Social Care Act 2008. The CQC has a wide range of tough enforcement powers which it can use to respond to such breaches, with information about enforcement activities being made available to commissioners of healthcare and the public.

**Monitoring compliance with the Health and social care act (2008), code of practice for the prevention and control of infection and associated guidance**

- Bi monthly review of code of Practice Assurance for Pennine care FT, updated at the infection control committee meeting

**Assurance Systems at NHS Trafford**

Specifically the Trafford health protection system has the following arrangements and assurance systems in place for the management of healthcare associated infections:

- The Director of Public Health for the Trafford
- A Modern Matron Infection Prevention and Control lead Nurse Post, Band 8 A 1x WTE
- Infection Prevention and Control Nurses Band 6 X 2 1.4 WTE
- Assistant practitioner x 1 band 4 0.8 WTE
- Trafford Health Protection Forum (chaired by the DPH) meeting every 4 months
- Infection Prevention and Control annual report(s) to Trafford Health Protection Forum and NHSTrafford?
- Monthly infection control/public health updates provided to NHS Trafford CCG Performance officers integrated governance (POIG) meetings
- Updates by the Trafford DPH to the Trafford Health and Well Being Board.

# 4 ENHANCING SERVICE CAPABILITY OF INFECTION PREVENTION AND CONTROL

## 4.1 Education and Training

Infection Prevention and Control is a vital component of an effective risk management program which strives to improve the quality of patient care and the health of staff through the prevention and control of infection. “Infection Prevention and Control is everybody’s business” is an adage widely promoted in PCFT, and central to overall strategy is the delivery of quality training and education.

With a rapidly moving agenda, provision of training to a wide range of front line health and social care staff, is deemed a priority for the IPCT. Within PCFT, clinical staff are able to undertake level 2 IPC training via an eLearning package or by attending a 45 minute face to face training session delivered by a member of the IPCT, non-clinical staff are also able to undertake training via an e-learning package. Staff directly employed/commissioned by the local authority and care home employees from throughout the borough are provided with a 2 hour training package, which includes a UV hand hygiene test. Training for care home staff is provided at their place of work, whilst sessions provided for Local Authority employees, are delivered at Trafford Town Hall. GP practices are also offered a 1+1/4 hour face to face presentation at the quarterly GP education forums, or at their place of work on request. Training content for all groups attending, is tailored to meet their particular needs, with sessions throughout the year, which are positively evaluated by the delegates.

For the 18 nursing homes and 22 residential care homes settings from whom the local authority commission services, annual infection control inspections/audits of the workplace are undertaken followed by a training presentation delivered on the same day, allowing observations to be linked into the core content of the presentation, thus giving the training greater relevance to the needs of staff working there.

See **Appendix B** for the 2018-19 training figures.

## 4.2 Audits and Inspections

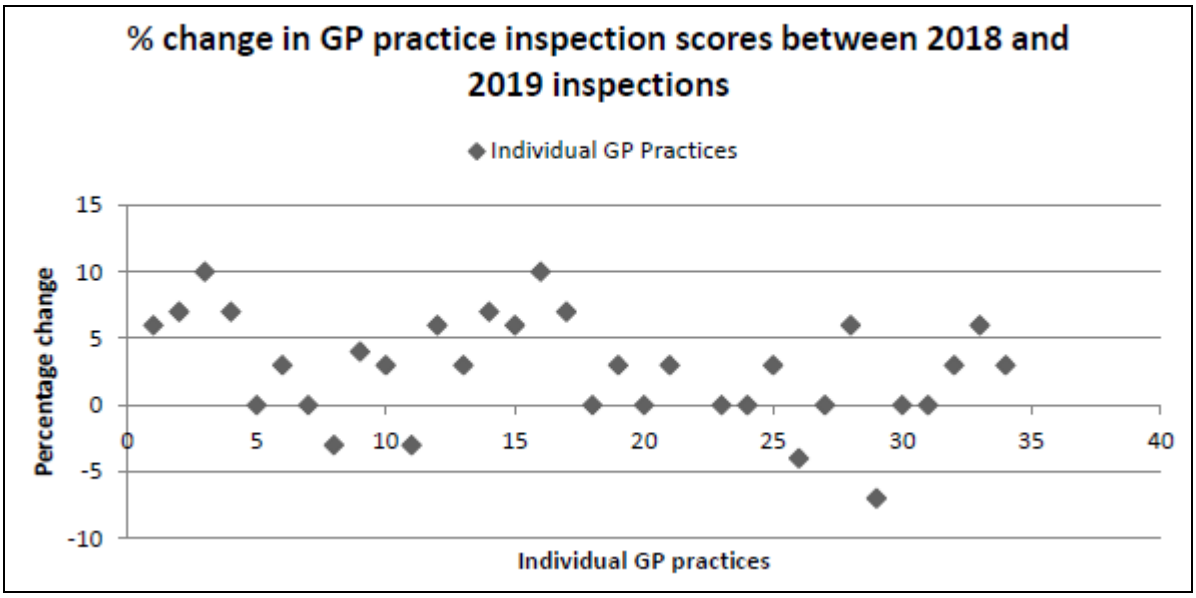
The IPCT endeavors to ensure that audit forms part of the proactive service, and that feedback action plans and re-inspection form part of the process of monitoring and quality assurance.

### Health centers/clinics and primary care settings.

A clean, safe environment, in which clinical services are delivered, is a priority for all providers of health care. All community health Centre’s and clinics previously managed and owned by NHS Trafford are inspected yearly by the infection prevention and control service as part of the cycle of premises inspections. Premises where Pennine care FT deliver services receive a yearly inspection, reports are forwarded to the Pennine audit department, and action plans followed up by the community IP&C team. GP practices which are co-located at the health Centre’s where Pennine care FT deliver their services , along with standalone GP practices are also inspected annually, with reports and action plans with the results listed below. GP inspection reports are forwarded to Practice managers and the CCG primary care performance officer. Also included in the cycle of planned visits, is the out-of hours GP walk in Centre, based at Trafford General Hospital, and for PCFT the Physiotherapy outpatient services based at Trafford and Altrincham hospitals are inspected annually as part of the trusts environmental audit program .

## GP Practices

Support for GPs includes an inspection of the practice setting, plus an associated RAG rated report and action plan, focusing on compliance with the '*Health and social care act (2008), code of practice on the prevention and control of infections and related guidance'* in preparation for CQC registration inspection. The overall pattern is of improving performance in the Infection Control Team's inspections.



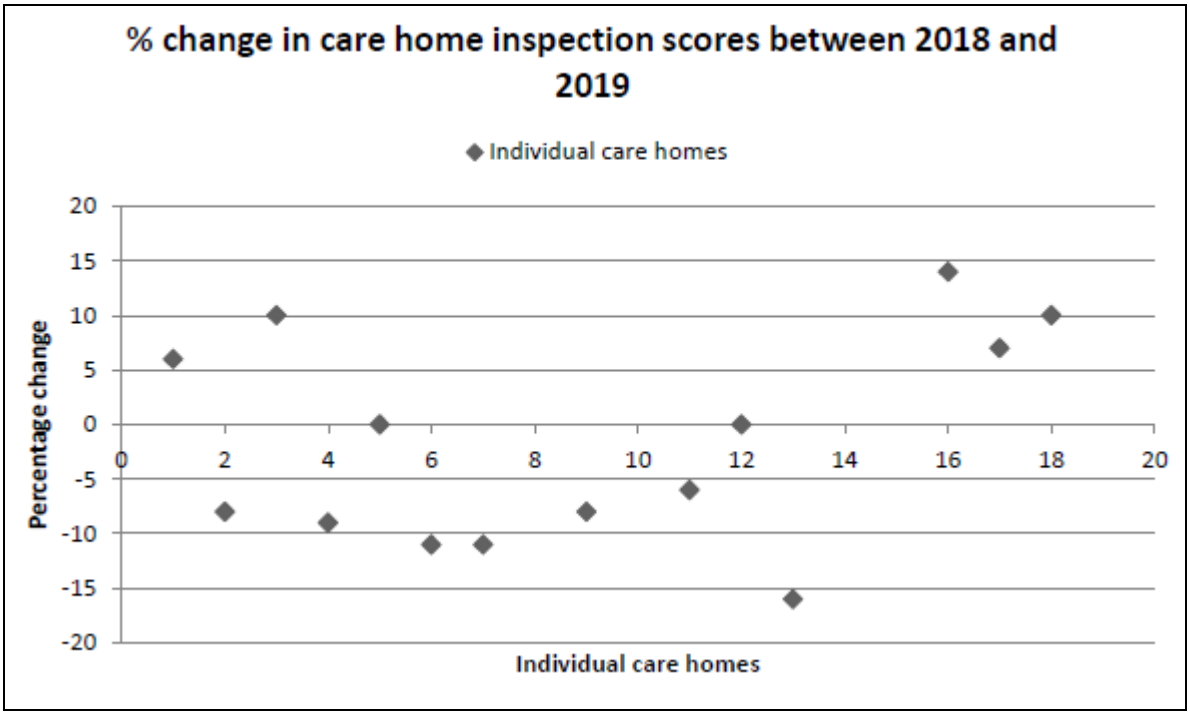

See Appendix D for data

## Care Homes

Care homes with nursing registration infection prevention and control support provided to care homes with nursing registration within the Trafford borough is afforded a high priority. Settings are inspected on an annual basis, and progress with action plans monitored through re-inspection the following year. Where inspection results have fallen below an acceptable threshold, settings are re-inspected within a 3-6 month period to check progress with an agreed action plan. This year's data shows a more variable pattern with some homes improving but with standards slipping in a number of cases. We will be looking at the trends and themes within this in order to inform future training.

**Delivery of infection prevention and control training and audit to Trafford registered nursing homes 2018-19**

- 1 ½ hour inspection, follow by report and action plan
- 2 hours of infection prevention and control Training.
- Includes an individual UV light hand hygiene assessment
- Request minimum number of delegates 10
- Training to be undertaken by the workforce every two years




See Appendix E for data

Copy of Report/action plan to:

- CCG personalised care team
- Director of public health
- CQC (allocated inspector)
- Local authority Lead commissioner

**Delivery of infection prevention & control audit to Trafford's residential care homes 2018-19**

- 2 hour inspection, with report/action plan
- 2 hours of infection prevention and control Training.
- Includes an individual UV light hand hygiene assessment
- Request a minimum number of 10 delegates
- Training to be undertaken by the workforce every two years

**Infection control inspection results**

| Setting/establishment | Date 2017-18 | Overall RAG rating | Number of reds out of 8 | Date 2018-19 | Overall RAG rating | Number of reds out of 8 |
|---|---|---|---|---|---|---|
| Data Anonymised | 20.4.17 | | 0 | **5.4.18** | | 0 |
| | 15.6.17 | | 0 | **28.6.18** | | 1 |
| | 18.7.17 | | 0 | **3.9.18** | | 0 |
| | 12.4.17 | | 0 | **2.5.18** | | 2 |
| | 07.4.17 | | 0 | **24.5.18** | | 0 |
| | 23.5.17 | | 1 | **9.5.18** | | 1 |
| | 1.8.17 | | 0 | **3.10.18** | | 0 |
| | 27.2.18 | | 2 | **14.2.19** | | 1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 21.6.17 | | 0 | **20.6.18** | | 1 |
| | 18.4.17 | | 0 | **25.4.18** | | 0 |
| | 15.8.17 | | 1 | **08.08.18** | | 1 |
| | 14.6.17 | | 0 | **11.7.18** | | 1 |
| | 26.4.17 | | 1 | **12.4.18** | | 0 |
| | 1.11.17 | | 1 | | Closed | |
| | 24.8.17 | | 0 | **9.10.18** | | 0 |
| | 1.6.17 | | 0 | **14.6.18** | | 0 |
| | 6.3.18 | | 0 | **5.3.19** | | 2 |
| | 12.2.18 | | 1 | **12.2.19** | | 2 |
| | 31.5.17 | | 0 | **31.5.18** | | 0 |
| | 4.10.17 | | 0 | **7.6.18** | | 0 |

Copy of Report/action plan to :

- Director of public health
- CQC (allocated inspector)
- Local authority commissioners

### 4.3 Infection prevention and control Policies

The Trafford based community IPCT work collaboratively with Pennine Care IP&C colleagues to review policies for the trust, which are then submitted to PC FT IGC for approval, All IP&C policies have been reviewed in the current reporting year. For care homes and general medical and dental practice, in addition to resources produce by the DH and PHE (previously HPA), guidance developed locally within the local health economy and guidance policy documents supported by the CCG, such as the antimicrobial formula and cold chain policies is also promoted.

### 4.4 Decontamination

The Infection Prevention Control Nurse, delegated to lead on decontamination liaises with appropriate stakeholders within PCFT and with external independent contractors and agencies around the decontamination agenda, which includes compliance with the Department of Health, Health Technical Memorandum 01-05 Decontamination in Primary Care Dental Practices (2008).

The infection control service offers advice and support to general dental practices (GDPs), reviewing plans for setting up Local Decontamination Units in practices, undertaking inspections and delivering staff training at the request of individual practices, and on request accompanying Commissioners and CQC on performance visits. In the reporting, 1 visit were undertaken in support of general dental practices.

With respect to Pennine care FT work stream the Community IP&C team undertake an annual inspection of the One Stop resources center, which includes an inspection of the equipment decontamination unit.

### 4.5 Hand hygiene

The Hand Hygiene Strategy is embedded within the PCFT hand hygiene policy. The strategy describes the arrangements for monitoring hand hygiene practice, audit, and training, and for ensuring senior trust management, individual staff and members of public understand both their individual and collective responsibilities.

Hand Hygiene continues to be very much at the forefront of the local and national agenda for Infection Prevention and Control together with 'bare below the elbows' initiative aiming to improve the effectiveness of hand hygiene performed by health care workers.
The hand hygiene standards promoted within the provider service are also used for guidance purposes, to inform stakeholders in the wider health economy.

The IPC team, with the support of the hand hygiene champions, continues to place a high priority on raising awareness of correct hand hygiene practice amongst all services within PCFT. Hand hygiene is also given high priority in the annual training program of training for independent contractors and care home providers, including use of the UV hand hygiene assessment equipment and challenging non-compliance in the work place.

**Infection control / Hand hygiene champions** Pennine Care FT ( Trafford division) have hand hygiene champions/links embedded within team s across all the teams, and contribute to undertaking quarterly hand hygiene audits amongst staff with patient contact. In 2018-19 overall pass rate was 97-98%, with most none compliance issues related to the wearing of rings with stones, which is main issue also identified in primary care and the care home sector. Any action plans relating to area of none compliance are followed up by the infection control service who contact relevant stakeholders to provide the necessary assurance
The Infection control service works closely with the champions and membership of the group continues to grow, chairing quarterly meetings which provide an opportunity for discussion and support in relation the successes and challenges associated with optimizing hand hygiene compliance across the borough.

On world hand hygiene day (5 May), the focus for everyone should be on prevention of sepsis in health care. PCFT infection control teams will be promoting this in our respective areas, engaging with staff and members of the public to emphasize the importance of effective hand hygiene.

### 4.6 Infection prevention and control initiatives

Before the winter season the training was well attended, and positively evaluated by the delegates.

Infection control service delivered a training and education event to key stakeholders in the care home sector for the management of Outbreaks of D&V and respiratory illnesses. The

## 5. ACHIEVEMENTS DURING 2018 - 19

### 5.1 MRSA blood stream infections (BSI)

Surveillance of MRSA blood stream infections is mandatory for acute, general and specialist Trusts; with figures made available to the public via the Department of Health and Public Health England web sites. The post infection review (PIR) carried out after each MRSA BSI, seeks to establish its cause and any contributory factors, assigning cases to the CCG, acute Trust or third party as appropriate. MRSA BSI a Key performance indicator and a component of the CCG's quality management systems as commissioners. The Infection control service completes a PRI for all community attributed cases

**DH objectives for 2018-19**

MRSA blood stream infections (Zero Tolerance) 2 cases assigned to CCG ( community attribution) in 2017-18, both cases had a Post infection review (PIR) conducted with the process lead by the CCG. One case indicated lapses in care from the both the care home provider and the hospital in respect the management of a urinary catheter n.

**MRSA Positive Results**

Laboratory results are reported by telephone, by microbiology laboratory at CMFT. As appropriate, they are followed up with care home managers, clinical staff, General Practitioners and Provider services staff, in order to provide advice and support in relation to infection prevention and control precautions and treatments. In the 2018-19 reporting period 36 cases were followed up by the team .

**5.2 2017-18 Clostridium difficile infection (CDI)** figures from HCAI data capture system please note: the tables below are repeated in the appendices

**2017-18 DH CDI objectives =64 cases**

| Organism | Objectives | Actual |
|---|---|---|
| **CDI (Trafford WHE)** | 64 | 72 |
| **CDI (Trafford none Trust apportioned** | None | 34 |

Trafford has adopted the Clostridium difficile investigation tool for nursing and residential care homes document developed by the Health Protection Agency (now known as Public Health England) in conjunction with an adapted version of the Clostridium difficile data collection tool provided with NHS England Guidance on C. difficile objectives for 2017-18. Once again in 2017-18 there were no outbreaks of CDI reported from care home settings within Trafford.

The Guidance within the document has been developed to undertake effective management and care of patients with suspected or confirmed Clostridium difficile Infection (CDI), limit the transmission of the infection to other patients/residents and provide advice around the involvement of a medical officer. Its aims are to enable staff delivering care within Community care home settings to understand the multifactor causes of *Clostridium difficile* Infection (CDI), prevent Clostridium Difficile Infection where possible, allow health care staff to appropriately manage and control the infection and minimise discomfort and suffering and maintain dignity and confidentiality.

**Trafford CDI cases April 2018 - March 2019**

Figures indicate that Trafford was 8 cases above its cumulative monthly objective for 2018-19. Previous years have indicated a 50/50 +/- 5% split between hospital and community attributed cases

**Analysis of results**

- 49% of all cases attributed to Secondary care.
- 51% of all cases attributed to (none Trust) Community

**Comment**

- Community attributed cases outside objective

| CDI | Apr-2018 | May-2018 | Jun-2018 | Jul-2018 | Aug-2018 | Sep-2018 | Oct-2018 | Nov-2018 | Dec-2018 | Jan-2019 | Feb-2019 | Mar-2019 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ALL cases on HCAI DCS | 5 | 3 | 9 | 5 | 9 | 8 | 4 | 5 | 4 | 12 | 4 | 4 | 72 |
| Community attributed cases on DCS | 1 | 0 | 3 | 3 | 6 | 4 | 2 | 4 | 4 | 7 | 1 | 2 | 37 |
| Trust cases | 4 | 3 | 6 | 2 | 3 | 4 | 2 | 1 | 0 | 5 | 3 | 2 | 35 |
| **Trust cases by Hospital** | | | | | | | | | | | | | |
| MRI & TGH | 1 | 2 | 4 | 2 | 1 | 3 | 2 | 0 | 0 | 1 | 2 | 1 | 19 |
| Wythenshawe | 3 | 1 | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 3 | 0 | 1 | 12 |
| SRFT | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 2 |
| Christie | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 2 |
| Other | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Analysis of completed RCA's for community attributed CDI Toxin positive cases notified to the IP&C

Service April 2016 – March 2017 indicates antibiotic use in of RCAs. No lapses in care have been

identified from the GP

PHE has applied the new definitions to the 2018/19 data to allow for comparison in 2019/20,
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/791582/Table_2_Monthly_CDI_2P_February_2019.ods

**Analysis of CDI RCA's April 2018 March 2019**

| 2018-19 | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Antibiotics Prescribed** | 0 | 1 | 3 | 3 | 3 | 3 | 2 | 2 | 1 | 3 | 1 | 2 | 24 |
| **PPIs** | 0 | 0 | 3 | 1 | 4 | 2 | 1 | 1 | 1 | 1 | 1 | 0 | 15 |
| **Patient from care home** | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 |
| **High risk &/or co morbidities** | 0 | 1 | 1 | 2 | 4 | 2 | 2 | 2 | 1 | 2 | 1 | 1 | 19 |
| **Relapse cases** | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 5 |
| **RCA's completed** | **0** | **1** | **3** | **3** | **7** | **3** | **3** | 5 | 1 | 3 | 1 | 2 | 32 |

Please note that the above table includes only cases reported to the IP & C team. There were 3 occassions when requested information was not returned by GP surgeries preventing an RCA from being completed.

**CDI Preventative strategy for 2018-19**

Complete an assessment tool on each GP reported CDI toxin positive specimen in collaboration with GP, NHS Trafford CCG's clinical pharmacist, acute trust, and care providers to identify key themes and possible lapses in care.

- Attend the CCG monthly performance officers group meeting where CDI cases are reviewed, possible lapses in care identified, and lessons learned fed back to all relevant stakeholders.
- Continue collaborative working with local acute trusts and participate in the combined Manchester monthly validation meetings where cases are reviewed.
- Deliver GP training at individual practices and attend GP forum events to promote appropriate prescribing including antimicrobial stewardship, tagging of notes, appropriate specimen collection and infection prevention and control precautions.
- Notify Pennine Care NHS FT staff if patients that they have contact with have a CDI positive laboratory result, and give infection prevention and control advice accordingly.
- Continue to undertake regular audits of care homes within Trafford and give training regarding CDI.
- Notify care home provider of any residents who have a CDI positive laboratory result. Provide infection prevention and control advice. In cases of CDI toxin positive request they implement the Public Health England CDI care pathway for Care Homes.
- Organise and a deliver a bespoke diarrhoea and vomiting outbreak event available for all care homes within Trafford to provide education, training and advice in outbreak management (including CDI).
- Write to each GP reported community CDI case providing written advice and guidance including contact details of the team should further advice be required. Provide alert card for patient to show to health care providers they come into contact with to inform of CDI history.
- Attend bi-monthly Trafford Health Protection Meeting reporting CDI figures and highlighting lapses in care.

**RCA Analysis** RCA undertaken for 100% of community attributed cases, notified to IP&C team by the lab.

RCAs carried out relate to GP reported cases. Pre-72 hour cases reported to the Trafford team by hospital staff, are followed up and any information which can contribute to the hospital RCA is forwarded. With respect to future arrangements, it is the intension for a member of the Trafford community infection control team to attend monthly case meetings to review secondary care cases to promote a collaborative (whole health economy approach) to following up Pre and Post 72 hour CDI cases.

### 5.3 Medicines Management support

Antibiotic resistance poses a significant threat to public health. One of the roles of the Medicines Management Team (MMT) at the Trafford PCT is to reduce antibiotic resistance and unnecessary expenditure associated with inappropriate antibiotic prescribing.

Of particular concern is *Clostridium difficile* infection, which remains a key issue on which NHS organisations have been mandated to implement national guidance that includes restriction of broad spectrum antibiotics, and in particular second and third-generation cephalosporin's and clindamycin.

Broad spectrum antibiotics, such as quinolones and cephalosporin's, need to be reserved to treat resistant disease, and should generally be used only when standard and less expensive antibiotics are ineffective.

The Trafford Medicines Management Team has works closely with the IPCT to reduce the incidence of *Clostridium difficile* infections (CDI) across Trafford. Work is ongoing and includes:

- Review of the Trafford Antibiotic Guidelines to reduce the use of antibiotics highly correlated with CDI. The majority of first line antibiotics are now those with a reduced risk of causing CDI, yet have a good evidence base for being effective for the relevant infection(s).
- Addition of a two page alert in the new Antibiotic Guidelines to highlight medicines associated with CDI risk in susceptible individuals.
- The production and dissemination of prescribing alerts to all Trafford GP's, Dentists and non-medical prescribers on a regular basis to highlight the current trajectory of CDI cases versus the DOH target. In addition, tips to reduce the incidence of CDI are also included.
- Letters sent to the GP of any patient that has tested positive for C.Difficile toxin to highlight the need to be prudent with antibiotic prescribing and the use of other medicines that may increase the risk of relapse.
- Aiding root cause analysis when required information is missing by visiting the GP practice directly.
- Conducting practice based audits on vulnerable patients taking long term proton pump inhibitors (PPIs) to determine if the dose can be reduced or stopped altogether, as PPIs are a risk factor for CDI.

- Revision of the evidence base surrounding the use of probiotics as an alternative measure to reduce antibiotic associated CDI.

**HCAI organism surveillance**

**2018-19 MRSA/ MSSA/E Coli bacteraemia/Klebseilla/Pseudomonas**

**MRSA cases (Community attributed) April 2018-March 2019**

| Apr-2017 | May-2017 | Jun-2017 | Jul-2017 | Aug-2017 | Sep-2017 | Oct-2017 | Nov 2017 | Dec-2017 | Jan-2018 | Feb-2018 | Mar-2018 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 2 |

**MRSA cases (hospital attributed) April 2018-March 2019**

| Apr-2017 | May-2017 | Jun-2017 | Jul-2017 | Aug-2017 | Sep-2017 | Oct-2017 | Nov 2017 | Dec-2017 | Jan-2018 | Feb-2018 | Mar-2018 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2* | 2* | 0 | 0 | 0 | 0 | 0 | 0 | 2* | 0 | 0 | 1* | 7 |

***All From Wythenshawe hospital**

**Total MSSA cases April 2018-March 2019**

| Apr-2017 | May-2017 | Jun-2017 | Jul-2017 | Aug-2017 | Sep-2017 | Oct-2017 | Nov 2017 | Dec-2017 | Jan-2018 | Feb-2018 | Mar-2018 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3 | 5 | 5 | 4 | 4 | 4 | 6 | 7 | 4 | 3 | 4 | 4 | 53 |

**MSSA cases (Community attributed) April 2018-March 2019**

| Apr-2017 | May-2017 | Jun-2017 | Jul-2017 | Aug-2017 | Sep-2017 | Oct-2017 | Nov 2017 | Dec-2017 | Jan-2018 | Feb-2018 | Mar-2018 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 3 | 3 | 4 | 1 | 4 | 4 | 6 | 4 | 2 | 3 | 3 | 38 |

**Total Pseudomonus cases April 2018-March 2019**

| Apr-2017 | May-2017 | Jun-2017 | Jul-2017 | Aug-2017 | Sep-2017 | Oct-2017 | Nov 2017 | Dec-2017 | Jan-2018 | Feb-2018 | Mar-2018 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 2 | 1 | 1 | 1 | 1 | 1 | 4 | 2 | 4 | 0 | 0 | 17 |

**Pseudomonus cases ( community attributed) April 2018-March 2019**

| Apr-2017 | May-2017 | Jun-2017 | Jul-2017 | Aug-2017 | Sep-2017 | Oct-2017 | Nov 2017 | Dec-2017 | Jan-2018 | Feb-2018 | Mar-2018 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 2 | 1 | 0 | 0 | 7 |

**Total Klebseilla cases April 2018-March 2019**

| Apr-2017 | May-2017 | Jun-2017 | Jul-2017 | Aug-2017 | Sep-2017 | Oct-2017 | Nov 2017 | Dec-2017 | Jan-2018 | Feb-2018 | Mar-2018 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2 | 4 | 4 | 4 | 2 | 5 | 1 | 1 | 1 | 4 | 3 | 3 | 34 |

**Klebseilla cases ( community attributed) April 2018-March 2019**

| Apr-2017 | May-2017 | Jun-2017 | Jul-2017 | Aug-2017 | Sep-2017 | Oct-2017 | Nov 2017 | Dec-2017 | Jan-2018 | Feb-2018 | Mar-2018 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2 | 4 | 3 | 4 | 1 | 3 | 0 | 1 | 1 | 2 | 3 | 2 | 26 |

**Total Ecoli cases April 2018-March 2019**

| Apr-2017 | May-2017 | Jun-2017 | Jul-2017 | Aug-2017 | Sep-2017 | Oct-2017 | Nov 2017 | Dec-2017 | Jan-2018 | Feb-2018 | Mar-2018 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 | 17 | 17 | 20 | 16 | 14 | 13 | 16 | 15 | 18 | 8 | 16 | 184 |

**Total Ecoli cases (community attributed) April 2018-March 2019**

| Apr-2017 | May-2017 | Jun-2017 | Jul-2017 | Aug-2017 | Sep-2017 | Oct-2017 | Nov 2017 | Dec-2017 | Jan-2018 | Feb-2018 | Mar-2018 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 | 16 | 14 | 15 | 14 | 11 | 10 | 14 | 14 | 15 | 6 | 13 | 156 |

The National objective for the reduction in healthcare associated GNBSI by 2023-24 is 25% by 2021-22, based on the 2016/17 year end data.

In the current reporting a quality premium attached in respect to reducing the number and rate of E.coli bacteraemia. The community Infection Prevention and Control service have responded by reviewing all the cases reported on the HCAI DCS system with a view to following up any identified cases from care home settings and where possible patients with a urinary catheter in situ.

A consolidated spreadsheet of cases was sent to the medicines management team following up any cases where repeat antibiotics are prescribed for UTI's and any association with anti-microbial resistance. E.coli education and awareness has been included in all face to face training with care homes, GP training events and link worker updates.

Some national studies have indicated that <50 % of cases have a possible health care association, however It must be emphasised that E.coli bacteraemia cases that do have a possible healthcare association, that hand hygiene, continence, hygiene, hydration and anti-microbial prescribing are key factors to consider .

In the reporting year 2018-19 there were 152 E.coli bacteraemia cases highlighted in Trafford on the HCAI DSC showing 76 female and 58 male split along with 2 babies affected. I have found that the age bracket who is more vulnerable is the 66-100. Of this age bracket of the 136 cases there were 101 people affected whilst in the 51-65 age bracket there was 22 people affected and in the 0-50 age bracket there were 12 people affected. Of these 136 cases 20 of these people affected were from care homes. Of the 136 cases 6 cases where receiving wound care, 7 cases had a urinary catheter, 2 with stomas and 1 with a urostomy. The community Infection Prevention and Control Team undertake a monthly review the cases reported through the HCAI Data capture system and undertake a follow up of cases where the patient is a care home resident, and /or is identified with a wound or urinary catheter, to ensure core elements of care are being documented such as adherence to ANTT practices and principles.

It has been acknowledged that whilst there has not been an increase in the amount of E.coli positive results nor has there been a reduction in these figures.

In order to achieve a reduction for the next reporting year the service will look into these cases further and provide appropriate training/advice and support where required in order to highlight the importance of hydration and good hygiene precautions.

### 5.4 Outbreaks 2018-19

Greater Manchester Health Protection Unit continues to monitor all statutorily notifiable diseases within the borough under the Public Health (Control of Disease Act) 1984 and the Public Health (Infectious Disease) Regulations 1988. Preventing outbreaks largely depends on the prompt recognition of a single case of infection associated with a condition or organism likely to give rise to an outbreak. Specific organisms that pose a risk of transmission to others for example Clostridium difficile in a care home, or organisms with unusual antibiotic resistance are reported to the community infection control team. Management of outbreaks/incidents continues to take precedence over other work.

**Management of D&V outbreaks in care homes**

The IPCT responds immediately to all reported outbreaks, providing infection prevention and control support, advice, guidance, education, surveillance, ensuring multi agency reporting procedures are followed. Upon reporting an outbreak, the care home is provided with an outbreak pack, containing guidance on management of affected residents and staff, and the environment, in order to minimize risk of transmission and/or prolonged or deteriorating illness. Guidance provided emphasizes the importance of 48 hour isolation or exclusion for all affected residents or staff, and deep cleaning prior to lifting of restrictions on admissions and visiting. Good communication between secondary care and community health and social care providers is also strongly emphasized as a prerequisite for limiting transmission and prevention of wider community outbreaks.

**2018-19 D&V outbreaks**

| Name of setting | Number of residents | Dates setting closed | residents presenting with symptoms |
|---|---|---|---|
| Data Anonymised | 50 | 14.6.18 - 21.6.18 | 9 |
| | 23 | 13.11.18 - 23.11.19 | 11 (confirmed case Norovirus) |
| | 46 | 26.1.19 - 28.1.19 | 4 |
| | 42 | 21.5.18 - 26.5.18 | 4 |
| | 41 | 23.7.18 – 27.7.18 | 4 |
| | 40 | 11.3.19 – 25.3.19 | 9 |
| | 33 | 14.6.18 – 26.6.18 | 16 |
| | 34 | 28.12.18 – 8.1.19 | 21 |
| | 60 | 24.9.18 – 3.10.18 | 8 |
| | 36 | 11.12.18 – 19.12.18 | 9 |
| | 77 | 20.7.18 – 23.7.18 | 3 |
| | 54 | 21.2.18 – 27.2.18 | 4 |
| | 79 | 26.1.19 – 1.2.19 | 6 |
| | 200+ | 4.2.19 | 76+ |
| | 200+ | 22.11.18 | 20+ |

Specimens were requested and ILOG numbers obtained from all the care home settings however information received from Stakeholders indicates specimens were not being taken

**Influenza/Respiratory infections (Data Anomynised)**

| Name of setting | Number of residents | Dates setting closed | Number of residents presenting with symptoms | Treated with antiviral medication |
|---|---|---|---|---|
| * | 81 | 24.5.18-14.6.18 | 10 ( 4 residents hospitalised) 4 patients tested positive for pneumococcal infection | residents given or offered + prophylactic antibitics for pneumococcal infection |
| | 4 | 8.2.19-13.2.19 | 2 ( both patients hospitalised) | All residents given or offered |
| | 31 | 28.1.19-6.2.19 | 15 (1 resident hospitalised) | All residents given or offered |
| | 21 | 14.3.19-21.3.19 | 3 | All residents given or offered |

* [redacted] **nursing home outbreak**

This was a mixed respiratory outbreak with the largest number of cases found to have pneumococcal infection of a serotype not covered by vaccination. There were 10 cases in total, of which 4 were confirmed *Streptococcus pneumoniae* (*Pneumococcus*), one had *Influenza A* and one had *Rhinovirus*. Nine of the 10 cases were on the ground floor, one was on the first floor and in total six cases were hospitalised. Antiviral and antibiotic prophylaxis was provided and the outbreak was declared closed on 14th June.

The debrief session covered areas of good practice and areas for improvement and resulted in some recommendations, mostly applicable locally but some also for wider application as well.

What went well

The following points were identified through the debrief session:

- All members of the OCT were very keen to work together on the outbreak and all wanted to find solutions.
- Trafford Council having a budget in place for extraordinary events made the response easier as this paid for the Mastercall GP session at the care centre and antibiotic prophylaxis.

The debrief session also highlighted the following areas for improvement:

- The care home GP was unable to prescribe prophylactic antibiotics and an out-of-hours provider was required to conduct a session at the care home, which involved additional planning and funding and led to some delays.
- Stocks of antivirals and antibiotics were not always readily available.
- Pharmacists are unable to prescribe antivirals outside of flu season so arrangements with GPs needed to be made to allow this to happen. For the same reason, prescription of antivirals was also difficult for GPs.
- No patient group directive (PGD) was in place for antibiotics and as pneumococcal outbreaks are rare; a standard PGD may not cover all scenarios.
- There was no plan in place for providing staff and residents with prophylactic antivirals and/or antibiotics in outbreaks out of flu season. Having a pre-arranged clear outline how these should be delivered and by whom would have helped organise this more efficiently.
- There was a query about the swabbing techniques used and whether this was sufficient for pneumococcal disease and influenza. Whilst the technique is unlikely to affect the result of the swab it was agreed that further education on swabbing techniques would be beneficial.
- Many email addresses were not up to date for making contact with key partners and distribution of invitations to/minutes of OCT
- Records for vaccinations need to be kept more accurately by care homes and GPs.
- The care home did not have up to date contact details for all their staff, making distribution of information difficult when not at work.
- There was difficulty getting residents vaccinated and it was felt that patients' own GPs shouldn't be relied upon to provide vaccinations in an outbreak situation. More proactive vaccination could have reduced the need for reactive vaccination, although would not have prevented this specific outbreak.
- Care homes fall into a gap between a health care employer with responsibilities and responsibility lying with employees own GP. Care homes rarely have an occupational health department that can provide vaccinations.
- Isolation was an issue due to many of the patients suffering from dementia, this may be a common occurrence in similar settings.
- A lot of work was done out of hours with little resource and this could have perhaps been better anticipated in normal office hours.

**Staff seasonal flu uptake**

Pennine care FT ( Trafford division) 2017/18 percentage flu uptake as 61%. However, it was not known if this percentage was for frontline staff or for staff overall (we think it was for staff overall). For the current reporting year there was a 61% uptake of patient facing staff in Trafford. A total of 608 vaccines were given across PCFT/Social Care this year compared to 562 last year, with a n increase in uptake from Co-located local authority staff .
Overall uptake across PCFT is 73.46% uptake for all staff groups and that divisions should report their own local data due to tableau inaccuracies.

The Infection control inspections undertaken between Jan-March 2019 for Trafford primary care practices highlighted that an average staff uptake of seasonal flu as over 70%.
Individual practice uptake range between 100% and the lowest > 15%. 4 practices reported uptake as below 70% .

## 5.6 Emerging organisms

**Measles & Mumps**

**Measles:** In the latter half of the reporting year there has been an above average number of cases being reported, with a small numbers becoming lab confirmed. Most cases have been reported from the London area, although across GM, there have been a number of confirmed cases from the Jewish community in Salford, and a small number of cases within the Oldham area. Health protection teams across GM have been updating their local responses to a measles outbreak, and work is on-going by immunisation teams/staff to promote uptake of MMR and identify unvaccinated groups and individuals

**Mumps:** During the reporting period the number of cases has been above seasonal average on a background of raised notifications across the North West. Cases have been noted from the area in central and south Manchester and the age range is indicative of the student population, Along with measles, health protection teams are promoting uptake of MMR and identifying unvaccinated groups and individuals

**UK**

Candida Auris

Candida auris (C.auris) is a fungus that, when it enters the bloodstream, can cause dangerous infections that can be life-threatening**.** In April 2015, a hospital patient in London, tested positive for C.auris. Within a week, the patient one bed over contracted it too. A month later, two more people caught it. When hospital workers tested the intensive care unit, they found C. auris growing on the floor, radiators, windowsills, equipment monitors and keypads. Despite thorough cleaning and infection control measures, within 16 months, 50 people were colonized by the fungus, though luckily, none died. In other hospitals, C. auris was transmitted from patient to patient by contaminated temperature probes, blood pressure cuffs and computer keyboards. Worryingly, not only did it stick around in the environment, in many cases, it was hard to treat C. auris is often resistant to antifungal medication. Cases of C.auris have now been reported from other health care settings, and there is a worrying trend that it is becoming established in the UK.

**International**

Ebola

In the most recent outbreak of Ebola DRC spanning the reporting year, the number of confirmed and probable cases exceeded 1,000 cases . Cases have remained localised to North Kivu and Ituri provinces. As of 31 March, a total of 1,089 confirmed and probable cases have been reported across 21 health zones. Response efforts have been met with strong community resistance and reluctance to participate. An Ebola treatment centre in Butembo was attacked twice, however authorities quickly responded and damage was minimised and a transit centre for suspected cases in Biena health zone was also attacked. In response, WHO requested further support from UN and local police forces for protection. There are growing calls for greater engagement and partnering with communities in order to both respond to their needs and stem the outbreak. Despite the on-going resistance, attitudes towards vaccination and uptake has been good . According to WHO, more than 90% of people eligible for vaccination accepted it and agreed to post-vaccination follow-up visits. Independent analyses

have also shown that the vaccine is protecting at least 95% of those who receive it in a timely manner.

## 5.7 Antimicrobial resistance

The World Health Organization (WHO) announced its 1st list of antibiotic-resistant "priority pathogens" on Mon 27 Feb 2017, detailing 12 families of bacteria that agency experts say pose the greatest threat to human health and kill millions of people every year. The list is divided into 3 categories, prioritized by the urgency of the need for new antibiotics.

The WHO considers the highest priority are responsible for severe infections and high mortality rates, especially among hospitalized patients in intensive care or using ventilators and blood catheters, as well as among transplant recipients and people undergoing chemotherapy. Included in this highest-priority group are Carbapenem-resistant Enterobacteriaceae, along with Acinetobacter baumannii, which the infections associated with it, typically occur in ICUs and settings with very sick patients. The other bacteria tagged as a critical priority is Pseudomonas aeruginosa, which can be spread on the hands of health-care workers or by equipment that gets contaminated and is not properly cleaned. The list's 2nd and 3rd tiers -- the high and medium priority categories -- cover bacteria that cause more common diseases, such as gonorrhoea, and food poisoning caused by Salmonella.

### Antimicrobial resistance: 2019/20 improvement schemes

NHS England/NHS Improvement has written to CCG Directors of Quality, Nursing and Medicines Optimisation about two new schemes to support acute providers to implement the five-year UK AMR national action plan in 2019/20. The NHS Standard Contract now includes a target of reducing total antibiotic consumption by 1%, from the 2018 baseline, by the end of Q4 2019/20.CQUIN indicators now include improving the management of lower UTI in older people, improving appropriate use of antibiotic surgical prophylaxis in elective colorectal surgery, and uptake of staff flu vaccine.

### UK National Action Plan on AMR

The government has published a 20-year vision and 5-year national action plan for how the UK will contribute to containing and controlling AMR by 2040.

#### CPE

An updated CPE toolkit, now called “Framework of actions to contain Carbapenemase-Producing Enterobacteriales” is in a late stage of development. From early May 2019, there will be a two week pre-consultation period to a wider network (IPS, HIS, RCN, PHE). A consultation and testing period is planned for May – July.

## 5.8 Sepsis awareness

Sepsis is a life threatening condition resulting in organ dysfunction caused by a dysregulated host response to infection. It remains the primary cause of death from infection despite advances in medical care. It is estimated there are more than 250,000 episodes of sepsis annually, with 35-50% mortality rate.

The IP&C team continues to be a core member of the PCFT NEWS and Sepsis Group. This group supports the development, evaluation and implementation for National Early Warning Scores (NEWS)2, NICE (2016) and Sepsis guidelines for children and adult services across PCFT. Throughout 2018-19 the IP&C team promoted World Sepsis Day on 13th September 2018 and sepsis was highlighted and discussed in 2 of our quarterly newsletters. A conference 'Sepsis – A system wide challenge' was attended where implementing NEWS 2 was discussed, along with quality improvement in sepsis awareness and treatment in both the community and inpatient settings was shared. Sepsis continued to be highlighted in 2 of the IP&C quarterly newsletters- particularly sepsis awareness.

The IP & C team supported the World Health Organisation's global SAVE LIVES: Clean Your Hands campaign to improve patient safety and reduce infection with the year's focus on **'Preventing Sepsis in Healthcare'.** Trafford IP&C staff organised a stand at Partington Health Centre on Tuesday 8th May 2018 to highlight the importance of this.

Sepsis awareness continues to be discussed in all presentations to Trafford care homes, domiciliary care agencies and GP surgeries

### 5.9 Asepsis

An aseptic technique should be used by staff members who undertake any procedure that breaches the body's natural defences, including wound care, catheterisation and venepuncture. Education on asepsis is delivered to all residential and nursing care homes as part of their annual infection control training. In Trafford community services Asepsis training is provided for all clinical staff who undertakes procedures that require it. Asepsis training for staff is 3 yearly, with competencies carried out in practice each year. For 2019 to 2020 the IP&C team will continue to support the organisation in the delivery of ANTT sessions and any refresher programmes required within teams.

### 5.10 Enquiries and Advice

The IPCT has also provided advice in response to of enquiries regarding a range of organisms / infectious diseases during 2018-19 has included : CPE's, ESBL's, MRSA, PVL's, E-coli, hand foot and mouth, IGAS,

## 6. APPENDICES

### Appendix A: Trafford Health Protection Forum Terms of Reference

### 1. Background

1.1 Health protection – the control of infectious diseases, including healthcare associated infections and the health effects of non-infectious environmental hazards – presents considerable challenges in Trafford. Although good progress has been made in tackling some of the key problems, major challenges remain.

1.2 Many organisations have a role to play in protecting the public from infections and infectious diseases, and the overlapping roles and responsibilities of the main agencies/departments (particularly the NHS, Public Health in Trafford, Environmental Health and Public Health England), working with many different stakeholder organisations, can be complex.

## 2. Purpose of the group

2.1 The primary role of the Health Protection Forum is to enhance partnership working on health protection in Trafford and to assist the Director of Public Health, who will chair the group, to discharge their responsibility for ensuring oversight of health protection in Trafford, and in providing a "strategic challenge to health protection plans/arrangements produced by partner organization's".[1]

2.2 This will be done by receiving reports from partner organization including evidence that such plans are in place.

2.3 The Forum will provide assurance to the Health and Wellbeing Board (HWB) that robust plans and arrangements are in place to protect the population of Trafford. It will draw to the attention of the Health and Well Being Board any matter of concern in this context.

## 3. Scope

3.1 The Forum will consider health protection issues in, or relevant to Trafford. Topics that are within the scope of the Forum include, but are not restricted to:

- Infectious/communicable diseases in the community.
- Healthcare acquired infections, especially MRSA, Cl. Difficile and including new organism such as Carbapenease producing Enterobacteriaceae (CPE).
- Vaccine preventable diseases and national and all local immunisation programmes.
- Tuberculosis.
- Pandemic influenza.
- Sexually transmitted infections, including HIV.
- Blood borne viruses.
- Environmental hazards.
- Health services emergency planning arrangements and rapid response including CBRN and mass casualty plans.

The forum will also take an overview of national screening programmes.

Issues that are out of scope of the Forum are:

- Business continuity arrangements that are not related to public health emergencies (such as a fuel shortage or extreme weather events).
- Health and social care winter planning, except where there is a health protection element, such as flu vaccination.

## 4. Key responsibilities of the Health Protection Forum

- To provide assurance to the Health and Wellbeing Board as to the adequacy of local arrangements for the prevention, surveillance, planning for, and response to, health protection issues and problems in Trafford.
- To highlight concerns about significant health protection issues and the appropriateness of health protection arrangements for Trafford, raising any concerns with the relevant

[1] 'The new public health role of local authorities'. Department of Health, October 2012.

commissioners and/or providers or, as necessary, escalating concerns to the Health and Wellbeing Board or relevant Chief Executives.

- To provide an expert view on any health protection concerns on which the Health and Wellbeing Board request advice from the Forum.
- To monitor a 'health protection dashboard' in order to assess local performance in addressing the key health protection issues in Manchester
- To monitor significant areas of poor performance through the HPF dashboard and to seek assurance that recovery plans are in place.
- To identify the need for, and review the content of, local plans relevant to significant health protection issues.
- To make recommendations as to health protection issues that should be included in the local Joint Strategic Needs Assessment.
- To seek assurance that the lessons identified from any serious incidents or outbreaks are embedded in future working practices.
- Health protection intelligence or dashboards to be provided by the relevant lead agencies.
- Through the HBW the Forum will hold Greater Manchester PH England Centre, NHS England and Trafford CCG to account in terms of their health protection responsibility.

## 5. Meeting arrangements

5.1 The Group will be chaired by the Director of Public Health and will normally meet four times per year on a tri-monthly cycle. Meetings will normally be of no longer than two hours duration.

5.2 The meetings will be convened by Public Health in Trafford who will provide secretarial support.

5.3 Items for inclusion on the agenda will be sought from all members in advance of each meeting. Draft minutes will be sent electronically to members and then approved at the next meeting.

5.4 Meetings will not be open to the public.

5.5 Conflicts of interest must be declared by any member of the group.

## 6. Reporting arrangements for the Health Protection Forum

The Health Protection Forum will report to the Health and Wellbeing Board on a six monthly basis by submitting formal reports including any concerns or recommendations. An annual report will be produced.

## 7. Membership and quorum

The quorum for the Trafford Health Protection will be one third of its core membership. Representation within that number must include the Chair or Vice Chair. Membership is to be split into two sections, core members and extended member and is noted in the table below. The Chair and Vice-chair are indicated in the list of group members hereunder.

| **Role** | **Representative** |
|---|---|
| **Core Membership** | |
| Director of Public Health (Chair) | Eleanor Roaf |

| | |
|---|---|
| Deputy Director of Public Health and Vice Chair | Helen Gollins |
| Consultant in Communicable Disease Control for Manchester, PHE | Dr Will Welfare |
| Consultant Microbiologist and Infection Prevention and Control Officer Central Manchester Foundation Trust Hospital | Dr Barzo Faris |
| Head of the Community Infection Control Team - core member and Deputy Vice Chair in the absence of Chair and Vice Chair | Philip Broad |
| CYPS – Head of Services or representative | Paula Lee |
| Trafford Clinical Commissioning Group | Gina Lawrence |
| Medicines management link at Trafford CCG | Absar Bajwa |
| Immunisation/Screening Coordinator link (NHS England) | Graham Munslow |
| Practice nursing | Henrietta Bottomley |
| Health Economy Resilience Group representative | Kate Green |
| GM Commissioning Support Unit NHS HERG representative | Brian Dillon |
| CMFT Infection Prevention Control | Sue Jones |
| UHSM Infection Prevention Control | Jay Turner Gardner |
| LMC (GP) representative | Dr Iain Maclean |
| **Extended Membership** | |
| Trafford Council Resilience Forum representative | Nicky Shaw |
| Adults Social Services Representative | Christine Warner |
| Environmental Health – Head of Service or representative | I Veitch/Nigel Smith |
| TB Specialist Nurse | Tracy Magnall |

**Frequency of Meetings: In 2018** The Trafford Health protection forum meet Quarterly, moving to 4 monthly meetings .

**Appendix B: Infection prevention and control Training Records – 2018-19**

**Delivery of Face to face infection control training:**

**2018-19**

| Month | RH | PCFT | GDP | GP | PRV NH | others L/A CCG social care | Total |
|---|---|---|---|---|---|---|---|
| Apr-18 | 16 | 20 | | 47 | | 34 | 117 |
| May-18 | 67 | | | | 7 | | 72 |
| Jun-18 | 44 | 7 | | | | | 51 |
| Jul-18 | 8 | 12 | | 37 | 73 | 1 | 131 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Aug-18 | 10 | 12 | 11 | 18 | 35 | 19 | 105 |
| Sep-18 | 7 | | | | | | 7 |
| Oct-18 | 41 | | | | 32 | 15 | 88 |
| Nov-18 | | | | | 10 | | 10 |
| Dec-18 | | | | 13 | | | 13 |
| Jan-19 | | 8 | | 13 | 26 | 6 | 53 |
| Feb-19 | 17 | | | 19 | 35 | | 71 |
| Mar-19 | | | | 18 | 29 | 8 | 47 |
| **Total** | 210 | 59 | 11 | 165 | 247 | 83 | 783 |

**2017/18 ( face to face Training)**

| Month | RH | PCFT | GDP | GP | PRV NH | others L/A CCG social care | Total |
|---|---|---|---|---|---|---|---|
| Apr-17 | 31 | | | 11 | | | 42 |
| May-17 | 19 | | | | 29 | | 48 |
| Jun-17 | 26 | | | 18 | 36 | 52 | 132 |
| Jul-17 | 8 | | | | 60 | | 68 |
| Aug-17 | 20 | | | 12 | 16 | 17 | 65 |
| Sep-17 | | | | | 23 | 46 | 69 |
| Oct-17 | 15 | | | 24 | 19 | 5 | 63 |
| Nov-17 | | | | | 48 | 7 | 55 |
| Dec-17 | | | | | | 28 | 28 |
| Jan-18 | | | | 10 | 41 | | 51 |
| Feb-18 | 10 | 12 | | 4 | 40 | 6 | 72 |
| Mar-18 | | 12 | 8 | | 6 | 17 | 31 |
| **Total** | 129 | 24 | 8 | 79 | 328 | 178 | 746 |

**Appendix C: Infection Prevention and Control ( IP&C) commissioning Work Plan April 2019- March 2020**

**1. Monitor and report (including IP&C annual report) to Trafford Health Protection Forum** on behalf of LA and CCG commissioners and provider services on key infection IP&C issues:

A] Infectious organisms

- MRSA bacteraemia (NHS Trafford CCG 2018-19 target = zero tolerance)
- CDI (NHS Trafford CCG 2019-20 target = (68)
- GNBSI infection reduction over 5 years inc : Ecoli-bacteraemia ( CCG quality premium )
- MSSA bacteraemia
- National Antimicrobial Resistance strategy ( service to contribute)

B] IP&C support provided for health & social care providers in relation to assurance framework

- Education/training
- Audit/inspection
- Policy review and development (contribute to Pennine care Foundation Trust policies and input into CCG policies)
- Hand hygiene promotion and monitoring

**2. Contribute to monitoring, management and reduction of mandatory reported Health care associated infections**

A] MRSA bacteraemia (2019-20 target = zero tolerance)

- Community attributed MRSA Bacteraemia - Participate in Post infection reviews (PIR) and report to relevant stakeholders
- MRSA positive lab results for community patients - Follow up and provide IP&C advice and support to GPs and other stakeholders

B] Community attributed Clostridium Difficile Infection (CDI) (NHS Trafford CCG 2019-20 target = (68)

Follow up & carry out root cause analysis (RCA), exception reporting and report any 'lapses in care', through the CCG Performance group

- Provide IP&C advice and support to staff & patients for GP reported specimens
- Monitor issues relating to prescribing of antibiotics, PPIs and other immune suppressant therapies, arising from CDI RCA s, refer to medicines management team as appropriate
- Identify relapses in care relating to the management of infections , refer to GP, medicines management team and liaise with acute providers
- Attend post 48 hour CDI validation meeting with Secondary care stakeholders
- Attend Regional HCAI meetings hosted by GM Health and social care partnership

C] Community attributed Gram negative blood stream infections including : E-coli bacteremia, Klebsieilla & Pseudomonas .

- Collect data on community attributed cases reported on the HCAI DCS system
- Follow up community attributed cases from residents of care home settings, requesting completion of a questionnaire/investigation tool.
- Contribute to Trafford CCG, reduction plan for Gram negatice BSI's
- Delivery of training & education sessions, raising awareness, opportunities such as health promotion activities, and include as an agenda item at meetings.

**3. Delivery of support and advice to health and social care providers commissioned in Trafford by LA and CCG**

Care homes – Nursing (total 18), Residential (total 20)

- Annual announced inspection and delivery of training for nursing homes, plus ad hoc inspections, following safeguarding reports, incidents & other issues highlighted by : PHE,CQC and/or LA commissioners.
- Advice and support to Nurseries/early learning years settings/ supported living centres (visits at request of commissioners and other key stakeholders )
- Development of IP&C link worker role for care home providers, and newsletter..

**4. Outbreak management support, advice and guidance for**

A] Care homes and supported living centers

B] nurseries & early learning year settings

- ongoing support and advice, monitoring of progress and follow-up of all reported episodes, visits carried out as required
- reporting of outbreaks to key stakeholders including PHE, Local authority, commissioners and community and acute provider services
- Collaborative working with PHE/GM/HPU/laboratory service
- Delivery of annual education session for outbreak management in care home settings

**5. Delivery of bespoke mandatory IP&C training and education to health and social care providers** within the Trafford health economy

- Pennine care FT community provider services
- Care homes ( 38)
- General medical practices (32)
- Local authority employed health care provider staff
- Local authority commissioned home care providers and voluntary sector
- Nursery and early learning year settings ( on request) >100 settings

**6. Delivery of support and advice to Primary care medical Practices in Trafford CCG** (total 32).

- Training, delivered to Practice staff at quarterly GP Education forum events, and individual requests from practices at their place of work .
- Annual inspection of infection prevention and control standards
- Infection control Support/advice pertaining to new premises upgrades/improvements to existing estates

**7. Delivery of support and advice to General Dental Practices within Trafford HE**, ( 32 providing NHS services ) including specialist advice on decontamination and for NHSE (LAT) and CQC, following performance visits

- Training – on request and by arrangement with the practice
- inspection & review of premises/buildings – by arrangement with the practice

8. **IP&C service collaborative working across the Trafford health economy** Attendance at stakeholder meetings, including:

- Community/Acute provider IP&C committees ( when invited)
- Care home SIP meetings
- CCG Quality and performance meetings
  - GM confederation/collaborative partnership (including participation in work-streams)
  - Attend/participate in 4 monthly Health Protection Forum meetings and Quarterly HERG meetings , to include the
  - Attend CCG Performance group meetings

9. **Deliver support advice to intermediate care and assessment unit managed by Trafford Council ,** this includes a biannual Audit/inspection

10. Deliver support and advice to special schools n This includes a 2 yearly inspection and delivery of training to staff every two yers

**11. Health and social care act (2008), code of practice for the prevention & control of infections and associated guidance**
Provision of support and preparation to all community stake holders for CQC visits

**11. Participation in local health promotion activities** applicable to Public Health/infection Control and national and international awareness campaigns :

12. **Provide updates reports for health protection forum meetings and Produce a service annual Report.**

13. **Contribute to the review process of new/updated national guidance including NICE and NHS improvement**

14. **Future service development** including: accession planning (retirement of Lead nurse) and assimilation with MFT, and review of resources.
    - Hand over/ take over during 6 month fixed contract ‘retire and return’
    - Development of service redesign
    - Identify gaps in service provision, resources/knowledge/leadership

**Appendix D: GP Practice Inspection results 2018-19**

| Name | Date of inspection 2018 | (% Score) 2018 | Date of inspection 2019 | (% Score) 2019 |
|---|---|---|---|---|
| Data Anonymised | 17.1.18 | 84% | 28.2.19 | 90% |
| | 18.1.18 | 87% | 7.3.19 | 94% |
| | 1.2.18 | 90% | 5.2.19 | 100% |
| | 17.1.18 | 87% | 28.2.19 | 94% |
| | 27.2.18 | 97% | 26.2.19 | 97% |
| | 8.2.18 | 94% | 6.2.19 | 97% |
| | 27.2.18 | 100% | 26.2.19 | 100% |
| | 8.2.18 | 97% | 7.2.19 | 94% |
| | 16.1.18 | 90% | 18.1.19 | 94% |
| | 6.2.18 | 84% | 7.2.19 | 87% |
| | 17.1.18 | 90% | 12.3.19 | 87% |
| | 6.2.18 | 84% | 7.2.19 | 90% |
| | 13.2.18 | 97% | 16.1.19 | 100% |
| | 1.2.18 | 90% | 5.2.19 | 97% |
| | 7.2.18 | 94% | 15.1.19 | 100% |
| | 6.2.18 | 87% | 7.2.19 | 97% |
| | 1.2.18 | 90% | 5.2.19 | 97% |
| | 7.2.18 | 87% | 15.1.19 | 87% |
| | 8.2.18 | 97% | 13.3.19 | 100% |
| | 16.1.18 | 94% | 18.1.19 | 94% |
| | 16.1.18 | 94% | 18.1.19 | 97% |
| | 18.1.18 | 87% | 7.3.19 | noaccess |
| | 18.1.18 | 87% | 7.3.19 | 87% |
| | 13.2.18 | 97% | 15.1.19 | 97% |
| | 9.1.18 | 87% | 21.3.19 | 90% |
| | 7.2.18 | 94% | 16.1.19 | 90% |
| | 17.1.18 | 94% | 28.2.19 | 94% |
| | 8.2.18 | 84% | 6.2.19 | 90% |
| | 27.3.18 | 94% | 16.1.19 | 87% |
| | 7.2.18 | 87% | 15.1.19 | 87% |
| | 26.2.18 | 87% | 6.3.19 | 87% |
| | 12.1.18 | 87% | 28.2.19 | 90% |
| | 1.2.18 | 94% | 27.2.19 | 100% |
| | 7.2.18 | 87% | 15.1.19 | 90% |

**Appendix E: Score/results from Infection control inspection of Care homes with nursing registration**

| Training venue | Visit Date | 2017-18 | Visit date | 2018-19 |
|---|---|---|---|---|
| Data Anonymised | 12.06.17 | **60%** | 05.7.18 | **74%** |
| | 28.02.18 | **95%** | 19.2.19 | **87%** |
| | 08.11.17 | **70%** | 08.11.18 | **80%** |
| | 10.01.18 | **85%** | 03.1.19 | **74%** |
| | 02.08.17 | **90%** | 18.7.18 | **90%** |
| | 26.06.17 | **85%** | 24.7.18 | **74%** |
| | 11.01.18 | **95%** | 10.1.19 | **84%** |
| | 06.02.18 | **65%** | 20.3.19 | |
| | 9.4.18 | **95%** | 6.3.19 | **87%** |
| | 11.04.17 | **70%** | Closed | |
| | 19.07.17 | **80%** | 02.8.18 | **74%** |
| | 14.02.18 | **90%** | 27.2.19 | **90%** |
| | 27.07.17 | **100%** | 26.7.18 | **84%** |
| | 03.01.18 | **50%** | Closed | |
| | 20.07.17 | **70%** | Closed | |
| | 20.09.17 | **60%** | 28.8.18 | **74%** |
| | 27.06.17 | **80%** | 17.7.18 | **87%** |
| | 15.11.17 | **90%** | 25.10.18 | **100%** |

**TRAFFORD COUNCIL**

**Report to:** **Health & Wellbeing Board**

**Date:** **19th July 2019**

**Report for:** **Information**

**Report of:** **Infection Control & Prevention Service**

**Eleanor Roaf, interim Director of Public Health**

**Report Title**

Trafford Suicide Prevention Plan

**Purpose**

To provide the Health and Wellbeing Board with an update on the developing Suicide Prevention Strategy

**Recommendations**

1. **To note the contents of the report**
2. **To provide any comments on the content of the report and input to the development of the forthcoming action plan**

Contact person for access to background papers and further information:

Name: Eleanor Roaf Phone 0161 912 1201

# Trafford Suicide Prevention Plan 2019

**Hannah Gaffney**
Trainee Clinical Psychologist, Public Health, Trafford Council

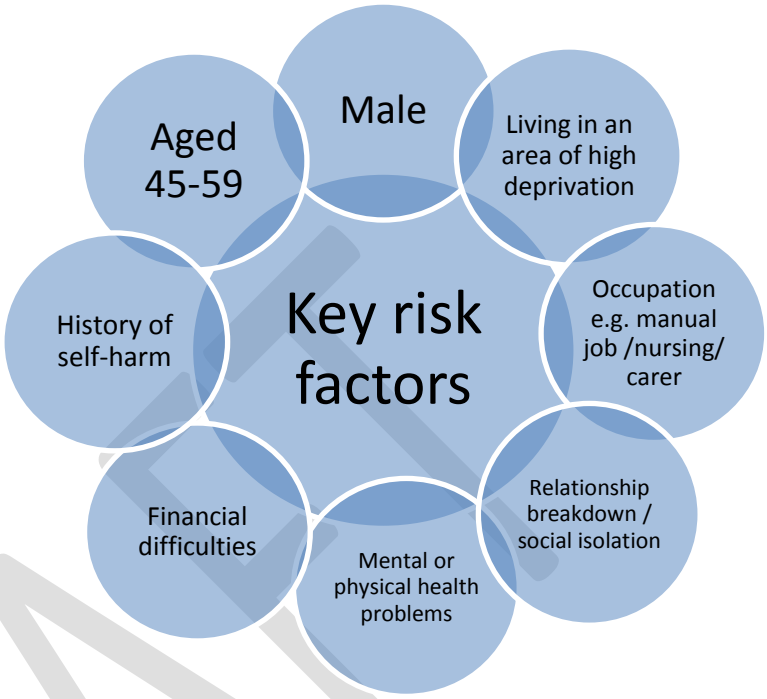
**Ben Fryer**
Public Health Specialty Registrar, Trafford Council

**Ric Taylor**
Lead Commissioner Mental Health and Learning Disability, NHS Trafford CCG

## Summary

Suicide is a major public health problem. In 2017, almost 6000 people in the UK took their own lives. Suicide is the leading cause of death in men between the ages of 35 and 49 and the biggest killer of adults between the ages of 35 and 49. Suicide also has a devastating impact on the individuals, families and communities that are bereaved or affected.

In Trafford, there are on average, 15 people per year who die by suicide. Three quarters of deaths by suicide are men and many people are not in contact with mental health services. This strategy outlines our priorities and action plan to mitigate risk through maximising support for people at risk of suicide and those bereaved or affected by suicide. Ultimately we aim to reduce the number of suicides in the borough.




A range of inter-related social, relational and individual factors contribute to, maintain and increase the risk of suicide. Importantly, talking about suicide does not increase risk. Risk factors in Trafford appear consistent with local and national trends. Given the diversity of risk factors, a whole system approach to support and intervention is crucial.

**Overview of Key Priorities & Actions for Trafford**

Prevention

- Establish a Suicide Prevention Partnership Group & Governance arrangements
- Continue efforts to reduce inequality in the borough
- Link with voluntary and community organisations to maximise whole-system support available for mental wellbeing
- Increase public awareness and reduce stigma through highlighting regional and national suicide prevention campaigns
- Mandate an e-learning training package for council and CCG staff across services to increase recognition of signs, increase awareness and encourage active signposting and support
- Pilot a Real-Time Suicide Data initiative to improve understanding of local suicides e.g. high risk locations

Intervention

- Continued provision of proactive physical and mental healthcare services
- Encourage professionals to ask about mental wellbeing at every opportunity utilising an 'every contact counts' approach
- Increase recognition of depression in primary care particularly in Older Adults and men
- Develop awareness of signs of suicidal ideation for staff groups that have contact with groups at high suicide risk e.g. pharmacists

Postvention

- Routinely signpost people affected by suicide to the new Greater Manchester Suicide Bereavement Information Service
- Utilise existing support services in Trafford as appropriate for suicide bereavement
- Real-Time Suicide Data will increase opportunity to provide timely support to organisations e.g. schools affected by a suicide

# Introduction

Suicide is defined as an act of intentional self-harm leading to death or fatal injury caused by an action of undetermined intent[1] . Globally, nearly 800,000 people die by suicide every year[2]. Suicide is a major public health problem. In England, suicide is the biggest killer of adults between 20 and 34 years old and the leading cause of death for men between the age of 35 and 49[3]. The majority (two thirds) of individuals who die by suicide are not in contact with mental health services[4]. Furthermore, suicide attempts are up to 30 times more common than suicide and are a key predictor of completed suicide[5]. The impact of suicide also goes way beyond the individual affected[6] and can have a devastating impact upon the individuals, families and communities that are bereaved[7]. The suicide rate therefore is an important marker of the underlying mental health of the population.

Suicide and para-suicidal behaviours such as self-harm are preventable. This strategy and action plan aligns with the key priorities of the Trafford Health and Wellbeing Strategy and is tailored to the needs of the population of Trafford. Specifically, in line with the aims of the national and Greater Manchester suicide prevention plans[8], we aim to reduce the suicide and self-harm rate in Trafford and crucially provide better support to the individuals, families and communities affected by suicide and self-harm. To achieve this, a co-ordinated whole systems approach is needed as a large proportion of people who die by suicide in Trafford are not accessing mental health services.

[1] Suicide statistics report 2017. Samaritans. https://www.samaritans.org/sites/default/files/kcfinder/files/Suicide_statistics_report_2017_Final.pdf

[2] National suicide prevention strategies: progress, examples and indicators. Geneva: World Health Organization; 2018. Accessed here: https://apps.who.int/iris/bitstream/handle/10665/279765/9789241515016-eng.pdf?ua=1

[3] Deaths registered in England and Wales (series DR): 2017. Office for National Statistics. 2018. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredinenglandandwalesseriesdr/2017#suicide-accounted-for-an-increased-proportion-of-deaths-at-ages-5-to-19-years-in-2017

[4] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales. October 2017. University of Manchester.

[5] Epidemiology of Suicide and the Psychiatric Perspective. Silke Bachmann. International Journal of Environmental Research and Public Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6068947/pdf/ijerph-15-01425.pdf

[6] How Many People Are Exposed to Suicide? Not Six. Cerel at al., 2018. The American Association of Suicidology.

[7] Preventing suicide in England: A cross-government outcomes strategy to save lives; 2012, updated 2017. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

[8] GM Suicide Prevention Strategy. 2017. Greater Manchester Combined Authority. https://www.gmhsc.org.uk/wp-content/uploads/2018/05/GM-Suicide-Prevention-24.02.17.pdf

In developing this strategy, we have drawn on key policy documents and national and local guidance including the NHS 10 Year Plan (2019)[9], the National Suicide Prevention Strategy (2012, updated 2017)[7], the Cross-Government Suicide Prevention Workplan (2019)[10], the Five Year Forward View for Mental Health[11], the PHE Local Suicide Prevention Planning: A practical resource[12] and NICE guidance on preventing suicide in community settings (2018)[13]. We have also utilised the key findings of a local suicide audit conducted in Trafford in 2015 and Public Health Outcomes Framework (PHOF) data for Trafford between 2013 and 2017.

## National context

In 2017, 5,821 people in the UK took their own lives, with an age-standardised rate of 10.1 deaths per 100,000 population[14]. In 2017/2018, 103,936 people were admitted to hospital as an emergency caused by intentional self-harm, with an age-standardised rate of 185.5 admissions per 100,000 population (fingertips). The suicide risk is increased 49-fold in the year after deliberate self-harm[15]. Suicide and self-harm are often preceded by years of suicidal thoughts and most people who make an attempt to end their life will do so **within the first year of the onset** of suicidal thoughts[16].Nationally, the suicide rate has been broadly declining. However, certain groups remain at heightened risk. **Three quarters of suicides in the UK are male** and this proportion has remained

[9] The NHS Long Term Plan. January 2019. NHS England. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

[10] Cross-Government Suicide Prevention Workplan. 2019. HM Government. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772210/national-suicide-prevention-strategy-workplan.pdf

[11] Five Year Forward View for Mental Health. 2016. NHS England. https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[12] Local Suicide Prevention Planning: A Practical Resource. 2016. Public Health England. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585411/PHE_local_suicide_prevention_planning_practice_resource.pdf

[13] Preventing Suicide in Community and Custodial Settings. 2018. NICE. https://www.nice.org.uk/guidance/ng105/resources/preventing-suicide-in-community-and-custodial-settings-pdf-66141539632069

[14] Suicides in the UK: 2017 registrations. Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations

[15] Hawton K et al. Suicide following self-harm: Findings from the Multicentre Study of self-harm in England: 2000-2012. Journal of Affective Disorders, Vol 175, 147-151

[16] O'Connor R and Nock M. The psychology of suicidal behaviour. The Lancet Psychiatry. 1.1; 73-85. 2014. https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(14)70222-6/fulltext

consistent since the mid-1990s[8]. Males aged 45 to 49 years had the highest suicide rate in 2017 with 24.8 per 100,000 males while females aged 50-54 had the highest rate at 6.8 per 100,000 females[8]. However, rates of deliberate self-harm are two to three times higher in women compared to men[7]. Suicide rates tend to increase with age, being **highest among people aged 45- to 49[8]**. The rates then decrease until the age of 80 to 84 years when they begin to rise again.

People in the **most deprived 10% of society are more than twice as likely** to die by suicide than the least deprived 10% (14.3 compared to 7.1 per 100,000)[17]. **Financial difficulties** have been shown to significantly predict suicidal ideation even when controlling for other socio-economic factors (e.g. age, gender, marital and employment status)[18]. For example, over 420,000 people in **problem debt** think about taking their own life in England each year and 100,000 of these people attempt suicide[10]. A combination of poor practices such as red letters and severe consequences increase the burden on people and can cause and exacerbate psychological distress[10].

Higher risk occupations include **men working in low-skilled manual occupations and skilled building finishing trades**, **women working in the arts and media or nursing profession** and male and female **carers[19]. Relationship breakdown** can also contribute to suicide risk, especially among divorced men[20]. In 2017, the most common method of suicide was hanging, suffocation or strangulation. The second most common was poisoning[8]. Research has demonstrated that almost half (approximately 47% percent) of individuals who die by suicide were **seen in primary care one month prior to their death[21].**

[17] Who is most at risk of suicide? Analysis and explanation of the contributory risks of suicide. 2017. Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/whoismostatriskofsuicide/2017-09-07

[18] A silent killer. Breaking the link between financial difficulty and suicide. 2018. The Money and Mental Health Policy Institute. https://www.moneyandmentalhealth.org/wp-content/uploads/2018/12/A-Silent-Killer-Report.pdf

[19] Suicide by occupation, England: 2011 to 2015. Office for National Statistics.

[20] Men, suicide and Society. Why disadvantaged men in mid-life die by suicide. Samaritans. 2012. https://www.samaritans.org/sites/default/files/kcfinder/files/Men%20and%20Suicide%20Research%20Report%20210912.pdf

[21] Primary care contact prior to suicide in individuals with mental illness. Pearson et al., 2009. British Journal of General Practice. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2765834/pdf/bjgp59-825.pdf

## Greater Manchester context

An audit conducted across all 10 boroughs of Greater Manchester identified 201 suicides or deaths of undetermined intent in 2015. There is significant variation in suicide rates across the boroughs of Greater Manchester with the greatest numbers in the city of Manchester (N=36) and Wigan (N=40) and the least in the borough of Trafford (N=9). Rates of emergency admissions to hospital due to deliberate self-harm are higher in Greater Manchester compared to England (217.9 per 100,000 compared to 185.5 per 100,000 population)[22]. Gender bias is similar compared to national rates (75% male) and around half (52.7% n=95) did not have a mental health diagnosis. A total of 82 men (49%) and 17 women (50%) had physical health issues including asthma, heart disease, injuries and cancer. Around two thirds (69%) of people had visited their GP in the previous month and almost half (49%) had visited their GP in the previous week which is higher than national figures. Many people had researched suicide methods on the internet prior to their death. Generally, the suicide risk factors in Greater Manchester are consistent with the national picture. Physical health issues (e.g. injuries and chronic or severe illness), mental health problems, issues with drugs and alcohol, a recent bereavement and social isolation were factors that appeared associated with greater risk of suicide in Greater Manchester. Furthermore, a significant proportion of cases (49%) had three or more risk factors identified.

## Local picture

Over the 5-year period 2013-2017, 74 Trafford residents died by suicide or undetermined injury[23]. This is an average of 15 people per year. Although the suicide rate for Trafford as a whole is lower (7.3 per 100,000) than England (9.6 per 100,000) and the lowest in the North West and Greater Manchester, striving to reduce the number of suicides and lives affected by suicide remains a key priority.

[22] Public Health Outcomes Framework, Indicator 2.10ii Emergency Hospital Admissions for Intentional Self-Harm. Updated 5th Feb 2019.
[23] Primary Care Mortality Database

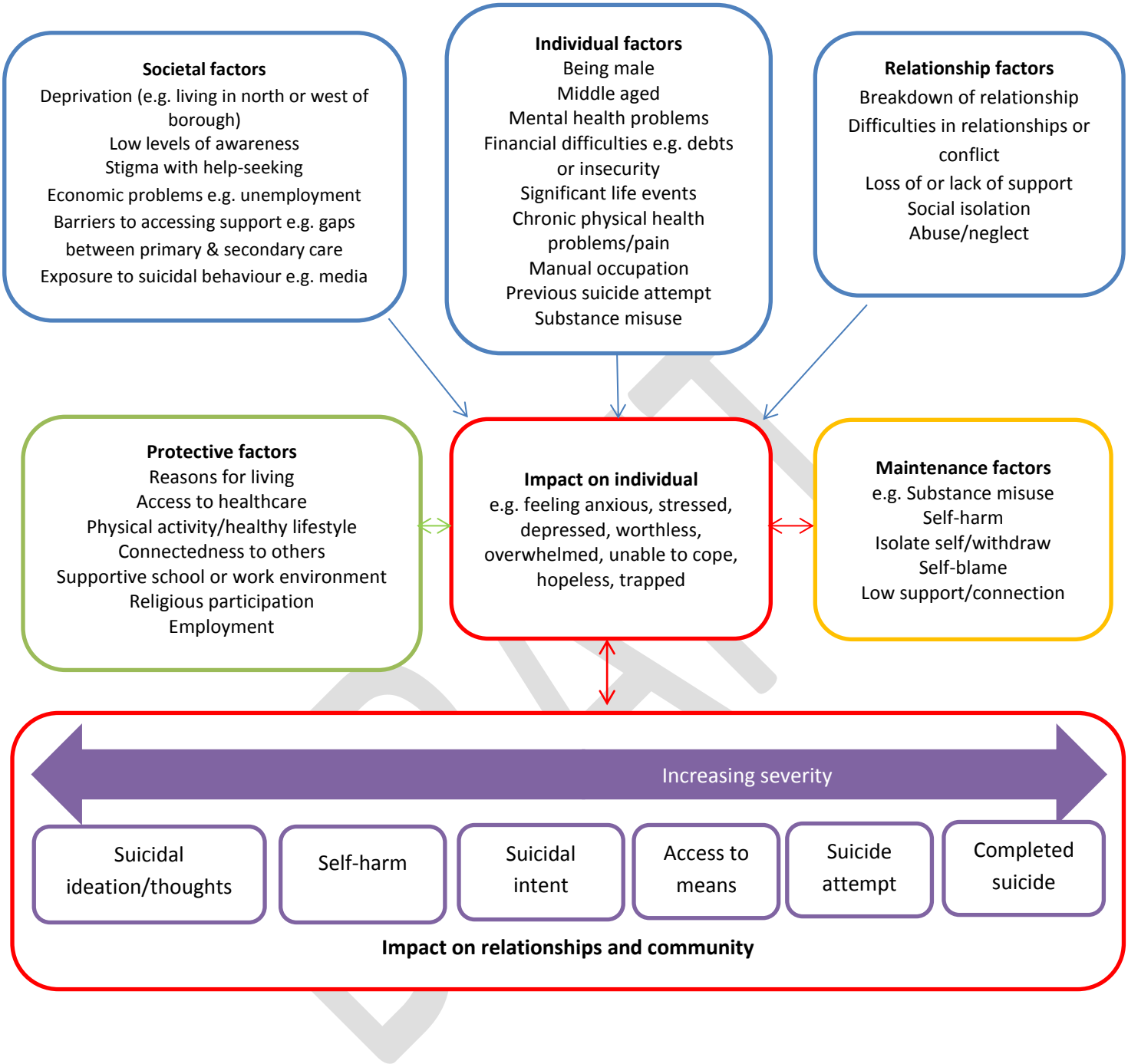
Four times as many men died by suicide compared to females and is consistent with the national and Greater Manchester picture and 40% of deaths were in people under the age of 40. Inequality in Trafford is reflected in the suicide rate, with a rate of 9.8 per 100,000 in the most deprived areas compared to 4.6 per 100,000 in the least deprived. However, the averages are not statistically significantly different[15]. In 2017/2018, there were 371 emergency hospital admissions for deliberate self-harm in Trafford. This is 12.8% lower than age standardised rates for England[24]. The most common method of suicide in Trafford was hanging/strangulation. The results of a local audit conducted in 2015 identified that 89% of people had a physical health problems which is potentially greater than in Greater Manchester and nationally. However, we should be cautious about drawing a firm conclusion about this due to small numbers in the Trafford audit potentially inflating trends.

## Suicide risk formulation (non-exhaustive)

As outlined above, there are a complex range of inter-related social, interpersonal and individual factors that contribute to, maintain and exacerbate the risk of suicide. Furthermore, suicidal thoughts and behaviours exist on a fluid continuum and are important to consider as distinct opportunities for intervention in order to reduce suicides. Understanding the key risks and protective factors in relation to suicide can facilitate appropriate, targeted interventions. Importantly, increasing protective factors at a population level is likely to reduce overall risk through improvements in mental health and wellbeing.



[24] Department for Communities and Local Government, Hospital Episode Statistics (HES) Copyright © 2017, Re-used with the permission of NHS Digital. All rights reserved.


Societal factors
Deprivation (e.g. living in north or west of borough)
Low levels of awareness
Stigma with help-seeking
Economic problems e.g. unemployment
Barriers to accessing support e.g. gaps between primary & secondary care
Exposure to suicidal behaviour e.g. media
Individual factors
Being male
Middle aged
Mental health problems
Financial difficulties e.g. debts or insecurity
Significant life events
Chronic physical health problems/pain
Manual occupation
Previous suicide attempt
Substance misuse
Relationship factors
Breakdown of relationship
Difficulties in relationships or conflict
Loss of or lack of support
Social isolation
Abuse/neglect
Protective factors
Reasons for living
Access to healthcare
Physical activity/healthy lifestyle
Connectedness to others
Supportive school or work environment
Religious participation
Employment
Impact on individual
e.g. feeling anxious, stressed, depressed, worthless, overwhelmed, unable to cope, hopeless, trapped
Maintenance factors
e.g. Substance misuse
Self-harm
Isolate self/withdraw
Self-blame
Low support/connection
Increasing severity
Suicidal ideation/thoughts
Self-harm
Suicidal intent
Access to means
Suicide attempt
Completed suicide
Impact on relationships and community

## National strategic approach

Reducing the number of suicides remains a key priority for the NHS over the next decade[8]. In 2016, The Five Year Forward View for Mental Health document outlined a plan to **reduce the suicide rate by 10% by 2020/21** and progress continues to be made toward this goal[1.]. The National Suicide Prevention Strategy (2012, updated 2017) and Cross-Government Suicide Prevention Workplan (2019) identified six key priorities for suicide prevention nationally (see below) which are reaffirmed by the NHS Long Term Plan, in particular the importance of **post-crisis support** for families and staff that are bereaved by suicide and whom are at heightened risk themselves. These priorities have been used as a basis for developing Trafford's priorities and action plan.

| **National priorities** | |
|---|---|
| 1) Reduce suicide in high risk groups | e.g. middle aged men, people in the care of mental health services, people in contact with the criminal justice system, specific occupational groups such as doctors, nurses, veterinary workers, farmers and agricultural workers, people with a history of self-harm |
| 2) Tailor approaches to improve mental health in specific groups | e.g. reducing inequalities, support for veterans, the LGBT population and young people |
| 3) Reduce access to means of suicide | |
| 4) Provide better information and support to those bereaved or affected by suicide | |
| 5) Support the media to deliver sensitive approaches to suicide and suicidal behaviour | |
| 6) Supporting research data collection and information | e.g. engaging coroners |

## Greater Manchester strategic direction

The Greater Manchester strategic priorities are consistent with national priorities and are based on a whole systems approach focussing on eight priority areas identified within the recent Public Health England guidance for local suicide prevention plans [25]. The Greater Manchester plan emphasises targeting the groups identified by Greater Manchester intelligence and audit that are at highest risk

[25] Appleby,L (2016) 'Priorities for Suicide Prevention action plans' in Local Suicide Prevention Planning – A Practical Resource. Public Health England

of suicides deemed to be the most preventable such as people in mental health services, people with depression and people with a history of self- harm (see table below). It also emphasises the importance of setting up and utilising a 'real time' data approach to suicide intelligence that would allow for more timely identification of suicide and quicker support to those affected e.g. to bereavement support.

| **Greater Manchester priorities** | |
|---|---|
| 1. Reducing the risk in men | In particular middle aged men, with a focus on economic disadvantage such as debt and or unemployment, social isolation and drugs and alcohol misuse. A focus on developing treatment and/or support settings that are more acceptable and accessible by men |
| 2. Preventing and responding to self-harm | A range of services are needed for adults and young people in crisis, and psychological assessment for self-harm patients. Acknowledgement that support for young people will be distinct from that of adults. |
| 3. Children, young people and women during pregnancy and postnatally | Joint working between health, social care, schools and youth services, and includes risk during pregnancy and those who have given birth during the last year. In particular we intend to focus on the increased suicide risk between 15 to 19 year olds. |
| 4. Treating Depression in Primary Care | Safe prescribing of painkillers and anti-depressants, (plus skilling up primary care practitioners in identification and initial management of risk) |
| 5. Acute Mental Health Care Settings | Safer wards and safer discharge (including follow up), adequate bed numbers and no out of area admissions. |
| 6. Tackling High Frequency Locations | Including working with local media organisations and groups to prevent imitative suicides |
| 7. Reducing Isolation and Loneliness | For example, through community based support, good transport links and by working with the third sector with a particular focus on men and older people |
| 8. Bereavement Support/Postvention | The provision of better information and support for those bereaved or affected by suicide and supporting the media in delivering sensitive approaches to suicide and suicidal behaviour |

## Key priorities for Trafford

This suicide prevention strategy forms part of a broader approach for mental health in Greater Manchester and Trafford. Given the complex and inter-related social, interpersonal and individual factors that contribute to, maintain and exacerbate risk, a whole systems approach is crucial. In Trafford, we take a life course approach to intervention through the 'start well', 'live well' and 'age well' themes and the suicide prevention strategy will span across these. Our overarching priority is to reduce suicides by at least 10% (approximately 1 person per year by 2020). We will achieve this by

focussing on objectives that sit within the eight priority areas (see above) identified within the Public Health England guidance for local suicide prevention plans and subscribed to in the Greater Manchester suicide prevention plan.

| Trafford priorities | Rationale | Focus |
|---|---|---|
| 1. Reducing the risk in Men | The majority of suicides in Trafford are male | - Middle aged men<br>- Focus on economic disadvantage such as debt and or unemployment, social isolation and drugs and alcohol misuse<br>- A focus on developing treatment and/or support settings that are more acceptable and accessible by men |
| 2. Preventing and responding to self-harm | Self-harm is a significant risk factor for suicide | - Mental health crisis support e.g. through Mental Health Liaison service and timely assessment for adults and young people who self-harm<br>- Primary Care Mental Health & Wellbeing Service will provide appropriate support to people not under the care of secondary mental health services<br>- Acknowledgement that support for young people will often be distinct from that of adults<br>- Support during transition from child to adult services and into early adulthood remains an important endeavour |
| 3. Improving mental health of children, young people and women during pregnancy and postnatally | Suicide remains second most common cause of death in young people | - Joint working between health, social care, schools and youth services, and includes risk during pregnancy and those who have given birth during the last year<br>- In particular we intend to focus on the increased suicide risk between 15 to 24 year olds |
| 4. Reducing mental distress and improving mental wellbeing and resilience | | - Continue to work with neighbourhoods to maximise existing strengths and community resources using an asset based approach<br>- Access to help and support early to mitigate impact<br>- Safe prescribing of painkillers and anti-depressants<br>- Skilling up primary care practitioners in the identification and initial management of risk<br>- Encourage primary care practitioners to link to the Primary Care Mental Health and Wellbeing Service when identifying mental health issues or factors impacting on mental health (e.g. debts, housing)<br>- Increase identification of depression in older people and increase referral and uptake of talking therapies offered by Trafford Psychological Therapies Service<br>- Increasing physical activity<br>- Increasing timely access to mental health services<br>- Safer wards and safer discharge (including follow up<br>- Adequate bed numbers and no unnecessary/inappropriate out of area admissions or |

| | | | |
|---|---|---|---|
| | | | placements |
| 5. | Reducing inequalities | Trafford has high inequality with residents in the most deprived areas of Trafford most at risk of suicide | - Continuing to address poverty in Trafford<br>- Striving to reduce unemployment<br>- Attracting employers that pay a living wage |
| 6. | Improving mental health of people with long term physical health conditions | Physical health problems are a key risk factor for suicide | - Ensure people are supported to manage their condition and any pain appropriately<br>- Utilise social prescribing to enhance quality of life<br>- Regular condition and medication reviews<br>- Increase access to psychological therapies for people with long term conditions |
| 7. | Reducing isolation and loneliness | Social isolation is a key risk factor for suicide | - Working collaboratively with community based support and the third sector<br>- Access to good transport links |
| 8. | Bereavement support | | - The provision of better information and support for those bereaved or affected by suicide<br>- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour<br>- Real-time data surveillance approach to support a timely offer of bereavement support |

## Action Plan for Trafford (based around the Nine Pillars of the Suicide Safer Communities[26])

| Pillar | Action | Who? | Timescale | Update(s) |
|---|---|---|---|---|
| **1 Establish leadership and governance arrangements** | Establish Suicide Prevention Partnership Group<br><br>Link to Trafford Health and Wellbeing Board via Trafford's Mental Health Partnership (CCG)<br><br>Provide regular updates to the Trafford Health and Wellbeing Board | Suicide Prevention Partnership Group. Members will include people with lived experience, voluntary sector groups, health providers e.g. GP, local emergency workers, housing and commissioners | 31st August 2019 | Initial meeting 6th August 2019 |
| **2 A robust background summary of local area to support goal setting** | This strategy & action plan draws on data from the 2015 Trafford audit of suicides completed as part of the 2015 Greater Manchester audit<br><br>We will support an annual Greater Manchester suicide audit. When this is completed, Trafford data will be extracted and analysed to inform learning<br><br>We will attend the Shining a Light on Suicide Launch event for Greater Manchester to share learning, good practice and strengthen links between agencies | Public Health Team, Trafford Council<br><br>Public Health Team, Trafford Council | Annually<br><br>May 2019 | <br><br>Attended |

[26] LivingWorks Education (2017). Suicide-safer communities: A designation recognizing community commitments to suicide-safety.

| Pillar | Action | Who? | Timescale | Update(s) |
|---|---|---|---|---|
| | We will attend the Greater Manchester Suicide Bereavement Conference in April 2019 | Public Health Team, Trafford Council | April 2019 | Attended |
| **3 Raise awareness of suicide and self-harm prevention in the community** | We will work with Greater Manchester on the Suicide Prevention Campaign 2019 "Shining a light on suicide" and highlight this locally e.g. through email footers, posters, leaflets, twitter and the council website. This campaign addresses common misconceptions by highlighting that suicide is preventable and that 'It is okay to ask about suicide' and this does not increase risk. | Suicide Prevention Partnership Group | Ongoing | |
| | We will establish a network of suicide prevention 'Champions' to advocate for suicide prevention within their work/services and disseminate key messages and support available. | Suicide Prevention Partnership Group | 31st August 2019 | |
| | We will raise public awareness of suicide prevention and reduce stigma e.g. through supporting national campaigns e.g. World Suicide Prevention day (10th Sep 2019 – theme is suicide prevention), World Mental Health Day (10th Oct 2019), The Campaign Against Living Miserably (CALM), Papyrus (Prevention of Young Suicide), Alright Mate, It's OK to Talk and Time to Talk Day. We will continue to organise Grief café/death café events in Trafford to encourage open communication around mental health and wellbeing. We will also support university mental health and wellbeing initiatives. | Suicide Prevention Partnership Group | Ongoing | |
| | We will utilise local newsletters e.g. Staff news emails to disseminate key events, suicide prevention work happening in the borough and training opportunities. | Suicide Prevention Partnership Group – communications teams | Ongoing | Included in Council Staff Newsletter on 21st |

| Pillar | Action | Who? | Timescale | Update(s) |
|---|---|---|---|---|
| | | | | June 2019 |
| | We will collect data on locations in Trafford where incidents of suicide occur. This will support identification of high risk (>1 occurrence) locations. If a high risk location is identified we will work with individuals/agencies that manage the location to reduce/prevent further incidents of suicide at that location e.g. through use of Samaritans publicity. We will also use this data to action a suitable, rapid support response at a system level such as for schools or workplaces. | The Greater Manchester Real-Time Suicide Data pathway will collect and provide the data to Trafford | Ongoing | 12 month pilot begun in June 2019 |
| | Partners such as 42nd Street, Papyrus, Talk Shop and Youth Offending Service will continue to raise awareness of mental health problems and suicide prevention through training to own staff and staff working with Children & Young People in mental health services, schools, colleges and universities. | Listed partner agencies | Ongoing | |
| | The Department for Work & Pensions will continue to provide mental health awareness sessions for their staff. | Department for Work & Pensions | Ongoing | |
| | Greater Manchester Police will continue to assist with mental health calls and ensure information is shared with relevant people to obtain appropriate support within 24 hours. | Greater Manchester Police | Ongoing | |
| **4 Increase mental health and wellness promotion** | We will increase and promote mental wellbeing through reducing health inequalities, promoting a healthy lifestyle and maximising connections within communities. We will strive to cultivate a culture of hope and maintain awareness that we are all vulnerable to mental health difficulties. | Trafford Council (in line with Strategic Outcomes) | Ongoing | |
| | We will continue to foster good inter-agency working in Trafford. | All Stakeholders | Ongoing | |

| Pillar | Action | Who? | Timescale | Update(s) |
|---|---|---|---|---|
| | The New Primary Care Mental Health and Wellbeing Service (PCMHWB) in Trafford will provide an integrated, whole systems approach for individuals with inter-related health and social problems (e.g. debt, employment, housing) in the community through integrated assessment and holistic and integrated support. The service will also support referral and signposting to services that can support with suicide bereavement. | Primary Care Mental Health and Wellbeing Service | Ongoing | 12-month pilot began 1st April 2019 |
| | The Primary Care Mental Health and Wellbeing Service will also support links between people and their communities through a social prescribing model. This has the potential to further increase awareness not just through practitioners and services but throughout communities. | Primary Care Mental Health and Wellbeing Service | Ongoing | |
| | The opportunity for support and intervention through pharmacy staff will also be maximised as they form a key part of community resource that is often well used and well connected. | Suicide Prevention Partnership Group | Sep 2019 | |
| | We will support the recognition of depression in Primary Care, particularly for Older Adults and increase appropriate referrals and uptake of Psychological Therapies through the Trafford Psychological Therapies service. | Primary Care Practitioners | Ongoing | |
| | The Greater Manchester I-THRIVE programme will continue to promote and provide children and young people with psychological support through health services (e.g. Healthy Young Minds), schools and early help hubs, reducing stigma and improving emotional wellbeing for young people. | Greater Manchester I-THRIVE | Ongoing | |
| | We will support the Greater Manchester Parent Infant Mental Health | Greater Manchester | Ongoing | |

| Pillar | Action | Who? | Timescale | Update(s) |
|---|---|---|---|---|
| | Programme to promote mental well-being in the perinatal period and beyond. | Parent Infant Mental Health | | |
| **5 Training for community members, lay persons and professionals in identifying and supporting people with suicidal ideation** | We will mandate an e-learning package on suicide prevention for all council staff and CCG staff to increase recognition of signs, increase awareness and encourage active signposting and support. We will monitor take-up of the online e-learning package and develop a schedule for refresher training. | Public Health Team & Learning and Development Team, Trafford Council | August 2019 | |
| | We will mandate an e-learning package on Mental Health Awareness in the Workplace for Council and CCG staff with managerial responsibilities. We will monitor take-up of the online e-learning packages and develop a schedule for refresher training. | Public Health Team & Learning and Development Team, Trafford Council | August 2019 | |
| | We shall continue to provide training for primary care staff (e.g. GPs, receptionists, practice managers etc.) on presentation of distress and identification of risk, especially in men and older adults and ensure an 'every contact counts' approach. | Suicide Prevention Partnership Group | Ongoing | |
| | Develop awareness of signs of suicidal ideation for staff groups that have contact with public through online training e.g GP receptionists, pharmacists, DWP staff, housing groups, ambulance & contact centre staff, link workers in PCMHWS; homeless teams; foodbank staff; youth services; security staff and hotel workers. | Suicide Prevention Partnership Group | Ongoing | |
| | Trafford Psychological Therapies Service will continue to provide mental health awareness training to non-clinical staff. | Trafford Psychological Therapies Service | Ongoing | |

| Pillar | Action | Who? | Timescale | Update(s) |
|---|---|---|---|---|
| | Promote Mental Health First Aid Training within Trafford potentially through a train the trainer approach. | Suicide Prevention Partnership Group through & Learning and Development Team | Ongoing<br><br>Ongoing | |
| | We will continue to support existing mental health in schools training initiatives. | Suicide Prevention Partnership Group | Ongoing | |
| | We will promote the 'Suicide – Let's Talk' 20-minute training developed in Greater Manchester as part of the Shining a Light on Suicide Campaign to the public through outward facing communication such as the council website and social media channels. | Suicide Prevention Partnership Group – communications team | August 2019 | |
| | A scoping exercise will be conducted to investigate what approaches Trafford council currently use for the appropriate management of council debts e.g. council tax arrears and red letters to residents. We will strive to reduce the psychological impact of these practices and ensure people are signposted to support. | Public Health Team, Trafford Council | September 2019 | |
| | We will develop a written resource specific to Trafford e.g. a 'Flash Card' using clear, descriptive language that outlines support available to people at risk of suicide and how to refer/access. This will be shared as widely as possible, especially with frontline staff. | Suicide Prevention Partnership Group | September 2019 | |
| | We will promote appropriate sharing of information between agencies to facilitate learning. | Suicide Prevention Partnership Group | Ongoing | |

| Pillar | Action | Who? | Timescale | Update(s) |
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| **6 Suicide intervention and ongoing clinical support services** | We will promote the overarching principles of person centred care in clinical services including; curious questioning, maximisation of control and choice, flexible intervention to meet person's needs (not a 'one size fits all' approach), the importance of early intervention, the importance of the person in context e.g. community resources, the use of evidence based interventions and effective risk assessment and management. | Suicide Prevention Partnership Group | Ongoing | |
| | We shall continue to demonstrate a proactive approach in in-patient and mental health services in Trafford e.g. through safer wards, early follow up after discharge, no inappropriate out of area admissions. Awareness that people presenting with low mood may require more active support to engage with services will be key. The impact of these interventions will continue to be monitored. | Suicide Prevention Partnership Group | Ongoing | |
| | We will continue to maximise opportunities for support by providing a range of access options including face-to-face, online and telephone support. | Suicide Prevention Partnership Group | Ongoing | |
| | Trafford Psychological Therapies service will continue to provide timely support for people with mental health problems in primary care. This service will continue to offer support to staff affected by suicide. | Trafford Psychological Therapies Service | Ongoing | |
| | We shall continue to provide a Mental Health Liaison service within A&E to Trafford residents for urgent, timely support for people experiencing a crisis. | Mental Health Liaison service | Ongoing | |
| | We will develop ways of working with men that recognise and build on existing skills and values. | Suicide Prevention Partnership Group | | |
| | Ensure services that come into contact with people at high risk e.g. drug and | Suicide Prevention | September | |

| Pillar | Action | Who? | Timescale | Update(s) |
|---|---|---|---|---|
| | alcohol services, debt services and mental health services have suicide reduction strategies in place and appropriate monitoring. | Partnership Group | 2019 | |
| | We will maintain good awareness of support available and identify inappropriate support or gaps in provision. | Suicide Prevention Partnership Group | Ongoing | |
| | We will support the inclusion of questions regarding mental health/suicidal ideation as part of initial tenancy interviews completed by housing groups (e.g. Irwell Valley Homes and Your Housing Group) and ensure staff are aware of support available to signpost to. | Suicide Prevention Partnership Group | October 2019 | |
| | We will work with local GPs to more readily use the PHQ9 Q9 for groups not presenting with typical symptoms of low mood e.g. frequent attenders with non-specific symptoms such as aches and pains or people living with chronic pain. | Suicide Prevention Partnership Group | October 2019 | |
| | We will continue to provide proactive medicine management including for high risk groups such a people living with chronic pain and/or taking opiate medications. | Trafford CCG | Ongoing | |
| **7 Suicide bereavement support and resources** | We will continue to work with Greater Manchester to support the new Suicide Bereavement Information Service; ensuring local service information is up-to-date and accessible. Our existing service provision in Trafford is not specific to suicide bereavement. However, existing services are able to offer support for bereavement and related difficulties. The Trafford Wellbeing Counselling Service based at the Macmillan Wellbeing Centre can offer bereavement counselling to people who are bereaved by suicide. Furthermore, the Primary Care Mental Health and Wellbeing Service could provide an initial point of contact through a link worker who is able to co-ordinate and signpost to | Suicide Bereavement Partnership Group to work with Paul Barber in GM | Service launched 1st May 2019 | |

| Pillar | Action | Who? | Timescale | Update(s) |
|---|---|---|---|---|
| | relevant services on an individual basis. | | | |
| | We will ensure local police e.g. family liaison officers are aware of the Suicide Bereavement Information Service and relevant contacts and provide resources as needed e.g. 'Help is at Hand' booklets. | Public Health Team, Trafford Council | Pilot began in June 2019 and is ongoing for 12 months | |
| | We will continue to work with Greater Manchester to pilot a real-time suicide data pathway through working jointly with the local coroner. This enables rapid identification of suicides and suspected suicide clusters and facilitates a proactive approach to suicide bereavement support. | Suicide Prevention Partnership Group – communications teams | Ongoing | |
| | We will continue to work with Greater Manchester to encourage sensitive and responsible reporting of suicide in the media and promote adherence to the Samaritans Media Guidelines in relation to coverage of suicide and self-harm. We will also ensure appropriate links to support are offered alongside articles related to suicide. | Suicide Prevention Partnership Group – communications teams | Ongoing | |
| **8 Evaluation measures including data collection and evaluation (audit)** | Annual audit data of completed suicides and deaths of undetermined intent will help us to learn from incidences of suicide in Trafford and ensure recommendations are being implemented. | Suicide Prevention Partnership Group | Ongoing | |
| | We will continue to analyse data on admission rates to hospital with deliberate self-harm. | Public Health Team, Trafford Council | Ongoing | |
| | Improvement in identification rates of depression in older adults | Trafford CCG | Ongoing | |
| | Completion rates for treatment of depression in primary care | Trafford CCG | Ongoing | |

| Pillar | Action | Who? | Timescale | Update(s) |
|---|---|---|---|---|
| | We will use real-time data on locations of suicides to inform our understanding of high risk locations in Trafford (>1 incidence of suicide) and any interventions necessary to reduce risk at these locations. | Public Health Team, Trafford Council | Ongoing | Pilot begun June 2019 |
| **9 Build sustainability in the community** | Reduce socio-economic inequality; continue to improve housing security and affordability; increase job security; provide a living wage; strive to reduce Adverse Childhood Experiences (ACEs); consider building design in town planning; maintain green spaces and 'open air' in Trafford, continue to strive for greater community engagement and cohesion, work collaboratively with other initiatives in Trafford to reduce social isolation, increase parity of physical and mental health services. | Public Health Team, Trafford Council | Ongoing | |
| | Develop a poverty strategy for Trafford | Public Health Team, Trafford Council | Ongoing | |
| | We will work with our community and voluntary organisations to raise awareness of suicide risk and crucially, the help and support available in Trafford | Trafford Suicide Prevention Partnership | Ongoing | |

## Governance

The suicide and self-harm prevention strategy directly aligns with the key aim of the Trafford Health and Wellbeing Strategy to increase healthy life expectancy and reduce inequalities. The strategy will be presented to the Health and Wellbeing Board for comment and support.

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