AGENDA PAPERS FOR

HEALTH AND WELLBEING BOARD

Date: Thursday, 20 February 2020

Time: 9.30 a.m.

Place: Flixton House, 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. **MINUTES** — 1 - 6

   To receive and if so determined, to approve as a correct record the Minutes of the meeting held on 18 October 2020.

3. **DECLARATIONS OF INTEREST**

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

4. **QUESTIONS FROM THE PUBLIC** — 7 - 14

   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.

5. **CDOP ANNUAL REPORT** — 15 - 38

   To receive a report from the Director of Public Health.

6. **HEALTHY WEIGHT DECLARATION** — 39 - 42

   To receiev a report from the Director of Public Health.

7. **LOCALITY PLAN** 43 - 52

To receive a presentation form the Director of Integrated Health and Social Care Strategy.

8. **PREVENTION WORKSHOP**

For Board Members to split up into small groups to work on the following topics relating to prevention:

- What is understood by 'prevention' in your organisation?
- What actions are currently underway?
- What do we need to commit to collectively?
- What outcomes are we aiming for and how will we measure progress towards them?

9. **KEY MESSAGES**

To consider the key messages from the meeting.

10. **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.

11. **LUNCH TIME SESSION**

An additional session will be held following the Health and Wellbeing Board for Board Members 12:00 – 13:30.

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. 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, Pritchard, A. Seabourne and J. McGregor.

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

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

This agenda was issued on **Wednesday 12 February 2020** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall; Talbot Road, Stretford, Manchester, M32 0TH.

Members of the public may film or record this meeting. Any person wishing to photograph, film or audio-record a public meeting is requested to inform Democratic Services in order that necessary arrangements can be made for the meeting. Please contact the Democratic Services Officer 48 hours in advance of the meeting if you intend to do this or have any other queries.

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HEALTH AND WELLBEING BOARD

18 OCTOBER 2019

PRESENT

S. Johnston (in the Chair).
Councillor J. Brophy, Councillor Miss L. Blackburn, Councillor J. Harding, Councillor J. Slater, M. Bailey, D. Eaton, H. Fairfield, Dr. M. Jarvis, E. Roaf, R. Spearing, S. Radcliffe, D. Evans and M. Pritchard.

In attendance

Sarah Grant	Partnerships and Communities Manager
Alexander Murray	Governance Officer

Also in attendance

Michael Armstrong
Rebecca Pennington
Judith Collins

APOLOGIES

Apologies for absence were received from Councillors C. Hynes, C. Daly, C. Davidson, M. Noble, M. Roe, A. Worthington, P. Duggan, C. Hemingway, S. Donnellan and M. Hill.

11. MINUTES

RESOLVED: That the minutes of the meeting held 19 July 2019 be agreed as an accurate record and signed by the Chair.

12. DECLARATIONS OF INTEREST

No additional declarations of interest were made.

13. PUBLIC HEALTH ANNUAL REPORT

The Director of Public Health introduced the report and informed the Board that the focus of this year's report was Climate Change. The Public Health team had been energised while putting together the report and were now champions for battling climate change. A workshop on climate change was booked for the first of November and a second workshop was being organised which all members were invited to attend.

The Director of Public Health then gave a brief overview of the report which showed how a person's carbon footprint was calculated and the carbon footprint of everyday items and services. The report covered four areas which were; food, transport, buildings and energy, and fashion. The following those four sections the

report then drew conclusions and set out actions that people and organisations could take to reduce their carbon footprint.

Councillor Brophy asked about how this was being publicised to the public.
The Director of Public Health responded that it would be made available on the Council's website and while the Council would not be printing a large number of copies they would make it available to residents.

The Chair asked Board Members to take this on board and to take actions away from the meeting. The Chair stated that Members would be asked what actions they had taken at the next meeting.

The Executive Member for Adults Services asked if there was anything that the Council could do to tackle climate change through procurement. The Director of Public Health responded that the Council were currently looking to add carbon footprint into the social value part of the Procurement work.

Councillor Blackburn asked whether the annual report could be circulated to all Councillors and the Board agreed this would be done.

RESOLVED:

1) That the report be noted by the Board.
2) That Board Members be invited to the Climate Change Workshop.
3) Board Members to report actions they have taken to reduce their Carbon Footprint at the next meeting.
4) That the report be circulated to all Councillors.

14. LOCALITY PLAN PRESENTATION

The Director of Integrated Health and Social Care Strategy delivered the presentation on the Council's locality plan to the Board. The presentation provided an overview of the transformational work that was ongoing in Trafford as part of the delivery of the locality plan. Within the Trafford locality model there were four neighbourhoods used by the Council which overlapped with the five primary care networks used by Trafford CCG. Trafford Council and CCG were moving to a place based approach with the Locality Plan linking the Public Sector Reform programme and the NHS 10 year plan together to create a whole area transformation of how services were delivered.

The Board were informed that within the new model social value was to play an important role in the commissioning of services. This involved considering the value services brought to the area, such as staff development, and taking stock of the wider impact they had upon the community and environment. MFT and GMMH already had social value programmes in place and Trafford would be working with them to develop the Trafford model.

The Director of Integrated Health and Social Care Strategy went through slides detailing the key parts of Public Sector Reform and Primary Care Reform before showing a slide which linked them together in the Health and Social Care pillars of

reform. The Board were told that Trafford would be taking a joint approach in creating Trafford's 10 year NHS plan.

All of this work was supported by five key areas which were; People and Workforce, Digital Strategy, Estates Strategy, Financial Reform, and the Engagement Strategy. The Director of Integrated Health and Social Care Strategy informed the Board how each of these areas fed into the overall plan and would help to deliver change. The first year of the engagement plan was highlighted as being particularly critical in facilitating Trafford moving towards a culture of co-production across all services.

The Board were told that the locality plan had to be written and signed off within six weeks. The document would be an officer style document, in the first instance, for submission to Greater Manchester which needed to tick a number of boxes to be signed off and for funding to be released. Once this had been done another version would be written that was easier to read and more user friendly.

The Executive Member for Adult's Services stated her frustrations with tick box exercises and asked how this plan was to be more effective than previous top down transformations. The Director of Integrated Health and Social Care Strategy responded that the tick box exercise was to assure that the plan aligned with the NHS long-term plan. The Director of Public Health added that lessons had been learnt from previous transformation attempts and this one was different as they now had more data and more knowledge about the factors that impacted upon health. By taking a local level, holistic approach the Locality Plan would transform the whole system from the bottom up rather than only changing one or two elements at a strategic level and expecting the impact to trickle down to the local level.

Councillor Brophy asked about how the Council and CCG were going to change so that co-production would work. The Director of Integrated Health and Social Care Strategy agreed that it was a shift in the way that Trafford were working. This was why staff development was a vital part in delivering this change as was switching to a new model of commissioning.

Councillor Brophy then asked about plans for digital health services especially for young people. The Director of Integrated Health and Social Care Strategy answered that they were aware young people wanted to interact differently with health services using technology rather than accessing face to face services and that they viewed their health differently. This was why Trafford's digital and engagement strategies were listed as key supporting areas to deliver the Locality Plan. As Trafford needed the digital infrastructure to enable them to offer digital options and they needed to engage with young people to ensure that those options met their needs.

Councillor Blackburn asked whether there were a lot more young people coming into the health care workforce. The Director of Integrated Health and Social Care Strategy responded that young people wanted different things from employers, which was something that would be picked up within the People Strategy. The Trafford Integrated Network Director added that services did attract younger

people and so it was important that Trafford had the right offer in place to ensure those jobs fitted with young people's plans for their lives.

RESOLVED: That the presentation be noted by the Board.

15. CHILDREN SERVICES IMPROVEMENT PLAN

The Interim Corporate Director of Children's Services gave a brief overview of the work that had been done since March following the Ofsted inspection and subsequent inadequate rating. A plan on a page had been developed and circulated to Board Members. The plan on a page gave a high level view of the work streams that the Council had implemented in order to deliver improvement and how they all linked together.

Ofsted had visited the Council during the week and had found that Trafford's leaders knew their services much better and there had been a lot of improvement. However, it was noted that Trafford had a long way to go and that while the Council collected lot of data they were not using it in the best way. The Board were told that the Interim Corporate Director's long term replacement would be starting in January 2020 which would only be about a month prior to the next inspection which was due in February or March 2020.

RESOLVED:

1) That the update be noted by the Board.
2) That Ged Rowney be thanked for all the work that he had done as the Interim Corporate Director of Children's Services.

16. BETTER CARE FUND

The Corporate Director of Adult's Services gave a brief overview of the report on the Better Care Fund. The Overview covered; the four conditions set by the government policy framework, how Trafford's plans had been submitted to NHS England, the Health and Social Care Commissioning Advisory Board assurance that the national conditions had been met, and an outline of the plan of how the BCF would be used. The Board were told that if they agreed to sign off the plan that the Health and Social Care Commissioning Advisory Board would oversee its delivery. The Board were then asked to sign off the plan as had been outlined to them. Board Members were given the opportunity to ask questions but none were raised and the Board agreed to sign off the plan.

The Corporate Director of Adult's Services also informed the Board that another £1M of the transformation fund had been agreed to be released which would support six new projects.

RESOLVED:

1) That the Board agreed to sign off the Better Care Fund plan.
2) That it be noted by the Board that the Health and Social Care Commissioning Advisory Board continue to oversee the management of the Better Care Fund.

The meeting commenced at 9.00 am and finished at 9.53 am

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Dear Health and Wellbeing Board,

I heard of this board's existence this weekend through a project my son has been set in school. I've lived in Stretford for 20 years and my extended family live in Timperley and Altrincham, so I visit the more affluent areas of the borough regularly. I have been made aware this weekend that people in the more affluent areas of Trafford are living for longer in good health.

I want to make a plea and I'll keep it brief.

Stretford is ugly! We have a severe lack of street trees. Along with poor town planning, which means there's no distinguishable town centre, but I'm here for the street trees. Further south from here can definitely be called the leafy suburbs, but why do they get all the pretty trees?

Lower education levels, income, more alcohol dependence, less exercise, more smoking and consequently more depression are apparently what we're all up to here in the northern half of the borough. Wow, they are complicated issues to solve.

Planting more trees is simple step though! I'm sure you'll know all about therapeutic landscapes and their effects on mental health. We need to be given half a chance in the northern half of the borough, it's so scruffy and miserable looking. Trees would be an instant improvement and could be enjoyed for generations to come. Not to mention probably do a bit to negate air pollution. We've probably got the worse end of that too because we're next to Trafford Park.

I would be so very grateful and somewhat shocked, as I feel this is a long shot, if you could please mention my plea at your next meeting?

Thank you for your time reading this,

Kind regards,

Trafford resident.

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Dear Trafford Resident,

Following your query back in November officers from Trafford Council's Partnerships and Communities department contacted our Tree Unit Manager whas provided the following response:

" All of the councils tree stock on the highway and in parks and open spaces is recorded and mapped on the councils tree management system which is called Woodplan.

Historically, Stretford and Old Trafford has less tree cover than the likes of Hale and Bowdon. However, more trees are being planted in Stretford and Old Trafford, on the highway and in the available parks and open spaces to address this balance."

In addition to this the Council have an adopt a tree programme which allows residents to pay for trees to be planted in their area. I have attached the tree adoption form for your information and in case you would like to take part in or spread awareness of this programme.

If you have any further queries please do not hesitate to contact me.

Kind regards,

Alexander James Murray
Governance Officer,
Governance Services,
Trafford Council,
2nd Floor,
Trafford Town Hall
Talbot Road
Stretford
Manchester
M32 0TH

Phone: 0161 912 4250
Email: alexander.murray@trafford.gov.uk

Trafford Council is a well-performing, low-cost council delivering excellent services to make Trafford a great place to live, learn, work and relax. You can find out more about us by visiting www.trafford.gov.uk

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WOULD YOU LIKE TO ADOPT YOUR OWN TREE?

Trafford MBC and Red Rose Forest are working together on a project called Green Streets which is bringing greenery to the streets of Trafford.

As part of the Green Streets Project we would like to offer residents with the opportunity to adopt their own street tree on the pavement outside of their house or a suitable commemorative tree to be planted within a park or open space.

For a cost of between £70 & 90 + VAT (dependant on choice of species) residents will receive:

- a tree of your choice from a vast list of appropriate tree species.

Adopted street trees will also be registered on Trafford MBC's tree database along with the tree's details.

How do I go about adopting a street tree?

Simply complete the attached form and return it to the address provided. A member of Trafford MBC will contact you to arrange a site inspection and discuss detailed arrangements in relation to costs and the time and date of planting.

By adopting a street tree you will be making a valuable contribution to your local and global environment.

Did you know that;

- streets with trees can have up to 85% less dust particles in the air that we breathe
- trees can help to filter out vehicle-borne carbon emissions
- trees can help to reduce noise pollution by as much as 6 – 8 decibels
- trees convert carbon dioxide (the biggest contributor to ozone depletion) into oxygen
- trees can counteract the effects of global warming by absorbing light, releasing moisture and reflecting heat

Tree Adoption Form

Please fill in the form and post to the address at the bottom of the page or, email the form to robert.reid@trafford.gov.uk. A tree officer will then contact you to finalise the details. If you require any further information please contact the Tree Management Unit on 0161 912 5538.

Name ---

Address ----------------------------------

Day Time Tel No ----------------------------------

Choice of Street Tree

Please tick your chosen species of tree.

The majority of the trees offered are ornamental species, which are appropriate for street planting as they do not grow excessively high and do not have aggressive root systems. The other trees listed are suitable in some highway situations, parks and open spaces.

The Council's experienced Tree Management Unit will carry out the planting and aftercare of the trees. The trees will be heavy standards, which are approximately 3 meter's tall, and due to their size will form an impressive tree within a short period of time. Supplied in 65-120 litre pots, dependant on the choice of tree, the trees are provided with a protective tree guard to prevent vandalism, tree stakes to hold the tree stable until the root system has become established.

TREE SPECIES AND LOCATION SUITABILITY	TREE DETAILS	TICK BOX
Prunus Sargentii Rancho HIGHWAY or PARK	Small attractive upright flowering cherry, with pink blossom and fine orange and crimson autumn colour. Grows up to about 7m	
Prunus umineko HIGHWAY or PARK	Medium upright flowering cherry with white blossom and red Autumn colour. Grows to 8m	
Pyrus calleryana Chanticleer HIGHWAY or PARK	Ornamental upright flowering pear tree with white blossom, orange and red autumn colour. Grows to 8m	
Sorbus aucuparia HIGHWAY or PARK	Excellent native tree, the Rowan or Mountain Ash has white flowers, red berries and grows to approx 7m	
Betula jacquemonti HIGHWAY or PARK	The Himalayan Birch has an upright growth habit, brilliant white bark and grows to about 10m.	
Malus tschonoskii HIGHWAY or PARK	Upright apple with white blossom, small fruit, with a good, red, Autumn colour. Grows to 6m.	
Prunus amanogawa HIGHWAY or PARK	Japanese upright cherry with shell pink blossom with fabulous bronze Autumn colour. Grows to 6m	
Prunus x hillieri Spire HIGHWAY or PARK	An outstanding upright cherry tree with pink blossom, red / purple Autumn colour, growing to 8m at full maturity.	
Sorbus aria Lutescens HIGHWAY or PARK	Small, compact, rounded tree with silvery-white spring foliage, producing berries in the autumn. Grows to 6m.	
Liriodendron tulipifera HIGHWAY or PARK	Tulip tree has a broad pyramidal crown, tulip shaped flowers in maturity and yellow autumn colour. Grows to 15m.	
Quercus robur Fastigiata HIGHWAY or PARK	Upright Oak, has a columnar crown, an effective street tree. Grows to 15m	
Fraxinus excelsior Jaspidea HIGHWAY or PARK	Golden Ash has a large pyramidal crown, and fantastic yellow autumn colour. Grows to 15m	
Ginkgo biloba HIGHWAY or PARK	The Maidenhair Tree is a survivor of the prehistoric times, has a conical crown, unique-shaped leaves and is pollution resistant. Grows to 10m.	
Liquidamber styraciflua HIGHWAY or PARK	Sweet Gum, large tree with corky bark, magnificent crimson and gold autumn colour. Grows to 12m.	
Betula papyrifera HIGHWAY or PARK	Paper birch is a medium tree with a conical habit, has white papery bark and attractive	

	yellow autumn foliage. Grows to 10m	
Betula nigra HIGHWAY or PARK	River Birch has unique flaking orange bark, pyramidal crown. Grows to 8m	
Sorbus hupenhensis HIGHWAY or PARK	Hupeh Rowan is a small columnar tree with stunning red autumn colour. Grows to 6m	
Acer campestre 'Nanum' HIGHWAY or PARK	Field Maple with an upright growing habit with yellow autumn colour. Grows to 7m	
Fagus sylvatica PARK	The Common Beech is one of the most majestic, native trees to the British Isles. Good Autumn colour and grows to 20m+.	
Crataegus Monogyna HIGHWAY or PARK	Hawthorn tree with white flowers, later producing red fruits for birds.	
Malus Evereste HIGHWAY or PARK	Carb apple tree with white flowers and small orange/yellow fruit.	
Prunus cereasifers nigra HIGHWAY or PARK	Cherry plum with black / /purple leaves and pink flowers in the spring.	
Prunus subhirtella Autumnalis HIGHWAY or PARK	Autumn Cherry with orange / yellow autumn colours and white flowers in Autumn.	
Quercus robur PARK	The English Oak is a long-lived wonderful choice of tree for parkland. The environmental benefits of the English Oak are second to none and its deeply grained bark gives all year round appeal.	
Acer platanoides PARK	The Norway Maple is relatively fast growing, displays good autumn colour and makes a good park tree. Grows up to 20m+	
Betula pendula PARK	The Silver Birch has a semi-weeping habit, attractive bark and makes a good park tree. Grows up to 15-20m	
Castanea sativa PARK	The Sweet Chestnut is a versatile and beautiful, fast growing, large tree and is particularly attractive in early summer. Grows to 20m+	

Forms should be returned to: -

The Tree Unit
Mossview Centre
Mossview Road
Partington
Manchester
M31 4DX

TRAFFORD COUNCIL

Report to:	**Health & Wellbeing Board**
Date:	**20th February, 2020**
Report for:	**Information / Decision**
Report of:	**Stockport, Tameside and Trafford Child Death Overview Panel, 2018/19**

Report Title

Learning from Child Death Reviews. Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2018/2019.

Purpose

From October 2019, accountability for the CDOP system shifted from Local Safeguarding Partnerships to the Health and Wellbeing Board. This annual report describes the characteristics of the children who died in Trafford during 2018/2019 and the learning from those cases that were reviewed and closed during this period.

Recommendations

The report includes eight recommendations for the Health and Wellbeing Board to agree.

Contact person for access to background papers and further information:

Name: Helen Gollins, Deputy Director of Public Health & Chair of Stockport, Tameside and Trafford's CDOP, helen.gollins@trafford.gov.uk, tel: 0161 912 4276.

Learning from Child Death Reviews

Annual Report of Stockport,

Tameside and Trafford's

Child Death Overview Panel, 2018/2019

Document Control

Date	Version	Forum/Officer	Purpose	Amendments
21/01/20	Draft V0.1	STT Strategic Group STT CDOP Panel	Consultation and comment	Additional recommendations
04/02/20	Final	STT Strategic Group STT CDOP Panel STT Public Health leads	Presentation to locality Health and Wellbeing Boards and sign off	

Learning from Child Death Reviews: Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2018/2019, has been prepared on behalf of Stockport, Tameside and Trafford Child Death Overview Panel and Stockport, Tameside and Trafford Child Death Overview Panel Strategic Group by;

- **Helen Gollins, Deputy Director of Public Health (Interim), Trafford Council, and STT CDOP Chair**
- **Shelley Birch, Child Death Overview Panel Manager (Tameside, Trafford and Stockport), Trafford Council.**
- **Kate Hardman, Public Health Intelligence Analyst, Public Health, Trafford Council.**
- **Jacqui Dorman, Public Health Intelligence Manager, Policy, Performance and Intelligence, Tameside Council.**
- **Eleanor Bannister, Public Health Intelligence and Early Intervention and Prevention Lead, Public Health, Stockport**

Please send all comments to Shelley Birch, Shelley.birch@tameside.gov.uk.

Executive Summary

1. Introduction

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

This report, *Learning from Child Death Reviews; the Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2018/2019*, describes why children who lived in Stockport, Tameside and Trafford died and presents eight recommendations from this learning.

2. Data protection

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

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

3. What we know about the children who died and cases that were closed in 2018/2019

Key points from data analysis:

- The panel received 49 notifications in 2018/19, bringing the 5 year total across STT to 268. There is no clear trend towards a higher or lower notification rate: the rate has hovered around a five year average of 3.2 notifications per 10,000 population aged under 18.
- Infants aged under 1 year continue to make up the largest proportion of notifications (28 notifications or 57% of total).
- The factor of ethnicity is difficult to comment on: recording of ethnicity in closed cases is more complete, but notifications would provide a better representation of whether children from certain ethnic groups are overrepresented in child deaths.
- The notification rate is higher than average in children who live in areas of STT ranked in the most deprived 20% in England, but the gradient across deprivation quintiles is less clear.
- The number of cases closed by the panel in 2018/19 (40) was lower than previous years.
- Three-quarters of infant who died had low birth weight; 9 out of the 10 babies with very low birthweight were extremely premature.
- After perinatal/neonatal event, the two most common categories of death were chromosomal, genetic and congenital anomalies, and infection.
- Modifiable factors were identified in 15/40 (38%) closed cases.
- Just over half (21 or 53%) of closed cases were expected deaths.

4. Recommendations

The CDOP Strategic Group has identified eight recommendations for Stockport's, Tameside and Trafford's Health and Wellbeing Boards to endorse and sponsor.

I. **All CDOP partners to ensure the robust data recording of protected characteristics as required under the Equality Act 2010.**

II. **The CDOP Strategic Group to progress a CDOP 5 year look back review to identify robust trends and inform strategic decision making.**

III. Tameside CDOP to use the data provided by the 5 year review to understand the boroughs expected and unexpected death pattern.

IV. STT CDOP representative to engage with the Greater Manchester CDOP system about the 5 year data review to share methodology and outputs.

V. Health and Wellbeing Boards to improve the outcomes of babies affected by their mother's weight by;

- **a. working with maternity services to deliver safe, evidence based healthy weight interventions, so that when a women books with the service and she is recorded as not being a healthy weight she is supported to maintain or if safe to do so support her to reduce her BMI.**
- **b. working with Public Health Directorates to support the delivery of healthy weight interventions at a population level, thereby promoting the healthy weight of women of childbearing age.**

VI. Health and Wellbeing Boards to reduce the number of pregnant women and parents who smoke by;

- **a. working with Public Health Directorates and Maternity providers to support the delivery of the Baby Clear programme to all pregnant women ensuring continued support once the baby has been born.**
- **b. working with Public Health Directorates to support the delivery of smoking cessation interventions at a population level, thereby reducing the risk of smoking to children.**

VII. Health and Wellbeing Boards promote improvements in mental health and resilience by;

- **a. working with Public Health Directorates to better understand the relationship between self harm and suicide and to ensure services are commissioned that respond to the risks posed from this behaviour.**
- **b. ensuring there is collaborative working between the CDOP Strategic Group and Greater Manchester Suicide Prevention Programme to ensure Children and Young People are included in the work programme and that this is cascaded to localities.**

VIII. Health and Wellbeing Boards to support a reduction in co-sleeping and promote safe sleeping by;

- **a. working with Public Health Directorates in partnership with Health Visiting and Maternity services to ensure all families receive appropriate safe sleeping interventions.**
- **b. working with Public Health in partnership with Health Visiting colleagues to implement a safe sleeping awareness campaign to all front line services that are in contact with families with infants.**

Content

		page
1.	Introduction	6
2.	Data protection	6
3.	The Child Death Overview Process	6
4.	Implementing Local Learning	6
5.	What we know about children who live in Stockport, Tameside and Trafford	7
6.	What we know from CDOP Notifications and Closed Cases, 2018/19	9
	6.i. Data analysis	9
	6.ii. Demographic breakdown of notifications	9
	6.ii.a. Number of notifications	9
	6.ii.b. Notification rate	10
	6.ii.c. Age breakdown of notifications	11
	6.ii.d. Ethnicity breakdown of notifications	12
	6.ii.e. Deprivation breakdown of notifications	13
	6.iii. Analysis of cases closed during 2018/19	14
	6.iii.a. Number of closed cases	14
	6.iii.b. Birthweight and gestation	14
	6.iii.c. Categories of death	15
	6.iii.d. Modifiable factors	15
	6.iii.e. Expected deaths	16
7.	Recommendations	17
8.	How will we know we have made a difference?	18
9.	Summary	18
	Appendix A: CDOP Responsibilities and Arrangements	19
	Appendix B: Borough Child Profiles	20
	i. Stockport	20
	ii. Tameside	21
	iii. Trafford	22
10.	References	22

Learning from Child Death Reviews

Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2018/2019

1. Introduction

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

This report, Learning *from Child Death Reviews; the Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2018/2019*, describes why children who lived in Stockport, Tameside and Trafford died and presents eight recommendations from this learning.

2. Data protection

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

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

3. The Child Death Overview Process

The Stockport, Tameside and Trafford Child Death Overview Panel (STT CDOP) undertakes a review of all child deaths (excluding 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 one of the three boroughs, and if they consider it appropriate any non-resident child who has died in their area. The Child Death Review Partners and CDOP adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018[i]. The CDOP review each case in a structured and consistent approach in line with Working Together, 2018[ii].

There are four CDOPs across Greater Manchester, including STT CDOP. It is recommended that CDOPs require a total population of 500,000, with an average of 60 child deaths per year. The geographical footprint of STT CDOP reflects the network of NHS health providers, Police and social are providers for this cluster.

The CDOP reporting arrangements changed from October 2019. The Health and Wellbeing Boards are now responsible for local CDOP arrangements; prior to this, the local Safeguarding Partnerships were responsible.

Appendix A provides more information about the CDOP process with links to local membership and arrangements.

4. Implementing Local Learning

A Strategic Child Death Group has been established to ensure that action is taken to address any emerging issues or trends from the CDOP. With membership including Public Health and Safeguarding, this group aims to ensure system ownership and change as a result of CDOP

learning. Stockport, Tameside and Trafford Health and Wellbeing Boards are accountable for the work of this group.

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

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

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

Source: Trafford Public Health, 2019.

In 2018, Stockport, Tameside and Trafford had an estimated combined population of 169 451 under 18 year olds. Table 5.ii, provides an overview of the characteristics of the children and young people who live in each of the three boroughs.

It is important to understand the similarities and differences between the boroughs when reviewing the number of notifications and the conclusions from the closed cases.

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

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

	Indicator		Stockport	Tameside	Trafford	GM	England
1	Population aged 0 to 17 years (2018)	Number	63,141	50,223	56,087	639,284	11,954,618
		% of Total (all ages)	21.6	22.3	23.7	22.7	21.4
2	Proportion of 0-17 year olds belonging to Black & Minority Ethnic Group (2011)		14.7	16.3	25.3	27.4	25.5
3	Projected growth in 0 to 17 population (2020-2030)	Number	2,702	-279	1,082	9,622	144,517
		%	4.2	-0.6%	1.9	1.5	1.2
4	Children in Low Income Families (under 16s) (2016)	Number	7,105	8,580	5,085	108,775	1,707,835
		%	13.5	18.9	11.6	19.5	17.0
5	Live births (2018)	Number	3,302	2,784	2,641	34,776	
		Rate (per 1,000 females aged 15-44 years)	64.3	66.7	61.4	61.9	59.2
6	Low birth weight of term babies (2017)	Number	67	83	61	1,015	16,534
		%	2.28	3.29	2.53	3.21	2.82
7	Infant mortality (2015-17)	Number	52	35	32	538	7,734
		Rate (per 1,000 live births)	5.1	4.1	3.8	4.9	3.9
8	Child mortality (2015-17)	Number	15	17	20	273	3,752
		Rate (DSR per 100,000 population aged 1-17)	8.5	12.7	12.5	-	11.2
9	Looked After Children (2018)	Number	360	615	380	5,660	75,420
		Rate (per 10,000 population aged 0-17)	58	124	68	89	64

Source: Maternal and Child Health Profiles (2019)[iii].

6. What we know from CDOP Notifications and Closed Cases, 2018/19

This annual report considers the learning from child death cases that were notified to the STT CDOP and were reviewed and closed by the panel between 1st April 2018 and 31st March 2019.

6.i. Data analysis

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

In this section the analysis of factors that are "fixed" (i.e. age and sex, ethnicity, and deprivation of area of mother's residence) is of ***notifications*** to the panel during 2018/19. This is a reasonable proxy of deaths that have occurred within this period because the period between death and notification is usually only a matter of days, and this gives a better unit of analysis for considering epidemiological patterns in child deaths across the STT CDOP area. Birthweight and gestation is also "fixed" in this sense and would ideally be analysed at notification level, but this information is often not available until later in the review process.

Factors such as category of death, whether the death was expected or not, and whether any modifiable factors were present are not determined until the case is closed by CDOP and so analysis of these factors relates to cases ***closed*** during 2018/19. In many cases there is more than a year between notification and closure.

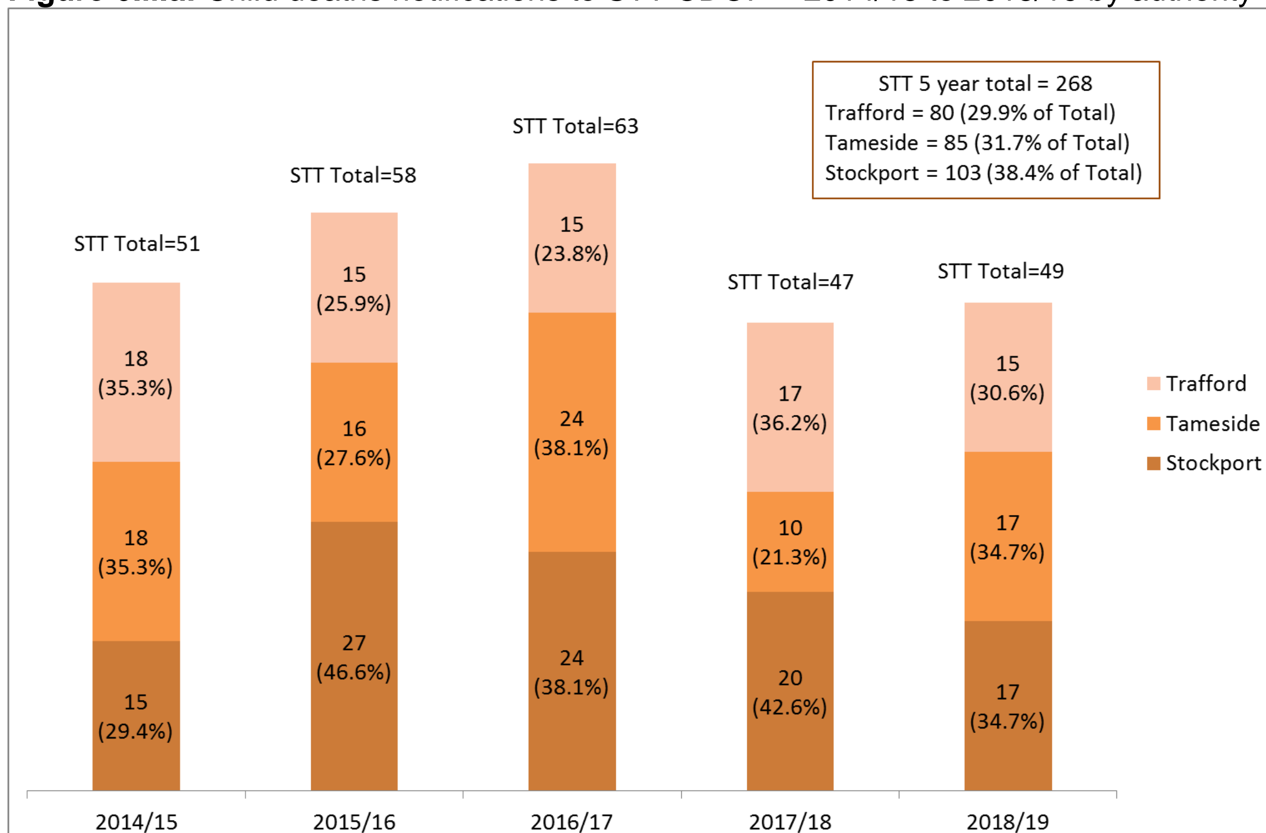
Therefore notifications show epidemiological pattern of deaths for the year under review, whereas closed cases provide intelligence about cases from a range of years.

6.ii. Demographic breakdown of notifications

6.ii.a. Number of notifications

The panel received 49 notifications in 2018/19. The split by local authority was 17 (34.7% of total) in Stockport, 17 (34.7%) in Tameside, and 15 (30.6%) in Trafford. The 2018/19 notifications bring the five year total across STT since 2014/15 to 268. Aggregating the five years gives a split by local authority of 38.4% (103/268) in Stockport, 31.7% (85/268) in Tameside, and 29.9% (80/268) in Trafford.

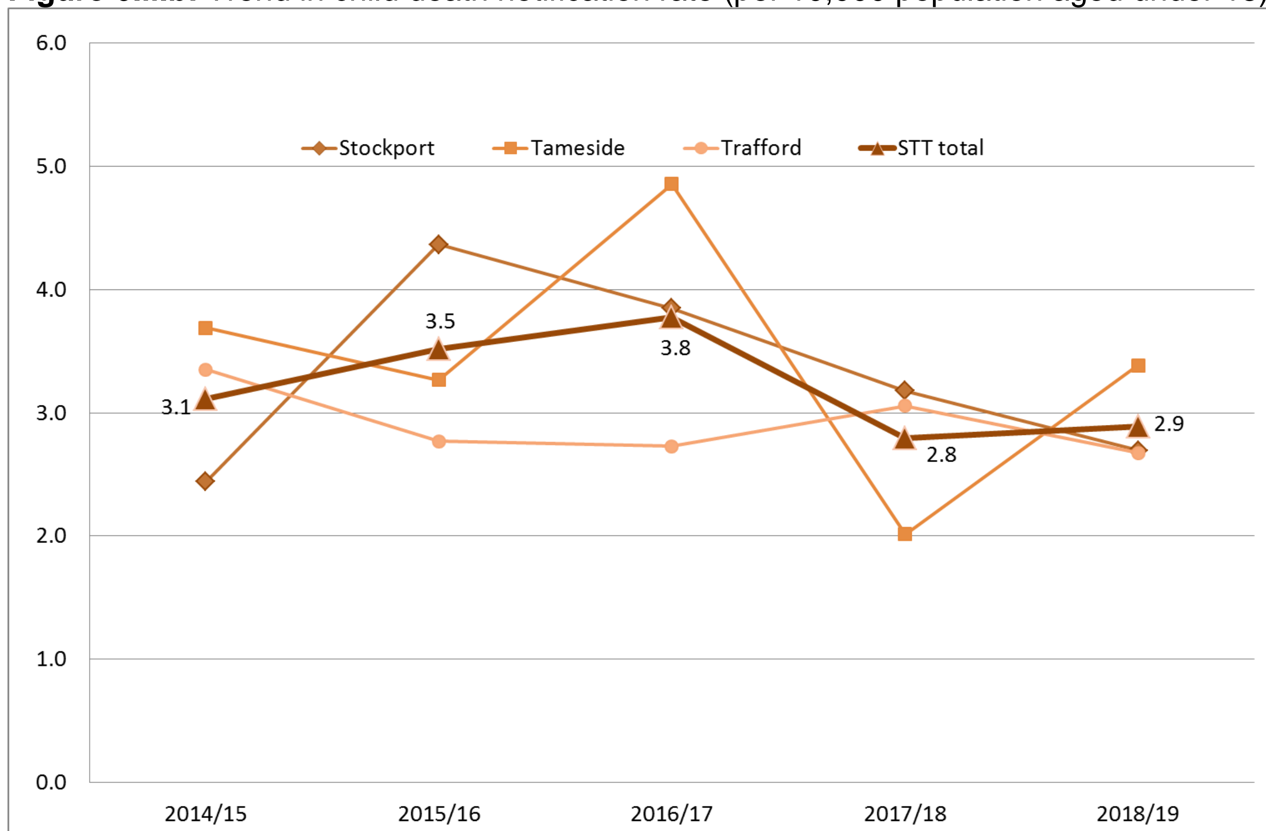
Figure 6.ii.a: Child deaths notifications to STT CDOP – 2014/15 to 2018/19 by authority



6.ii.b. Notification rate

At local authority level the notification rate tends to fluctuate year on year due to the relatively small numbers, and so it is difficult to detect underlying trends. Aggregating the notifications for STT smooths out some of this fluctuation: the 49 notifications give a rate of 2.9 per 10,000 population aged under 18, which is very similar to 2017/18 (2.8 per 10,000), but also similar to 2014/15 (3.1 per 10,000), which probably indicates that the notification rate is hovering around the same level. The five year aggregated notifications give a rate for STT of 3.2 per 10,000, which is similar in Stockport (3.3 per 10,000) and Tameside (3.4 per 10,000) but slightly lower in Trafford (2.9 per 10,000).

Figure 6.ii.b: Trend in child death notification rate (per 10,000 population aged under 18)

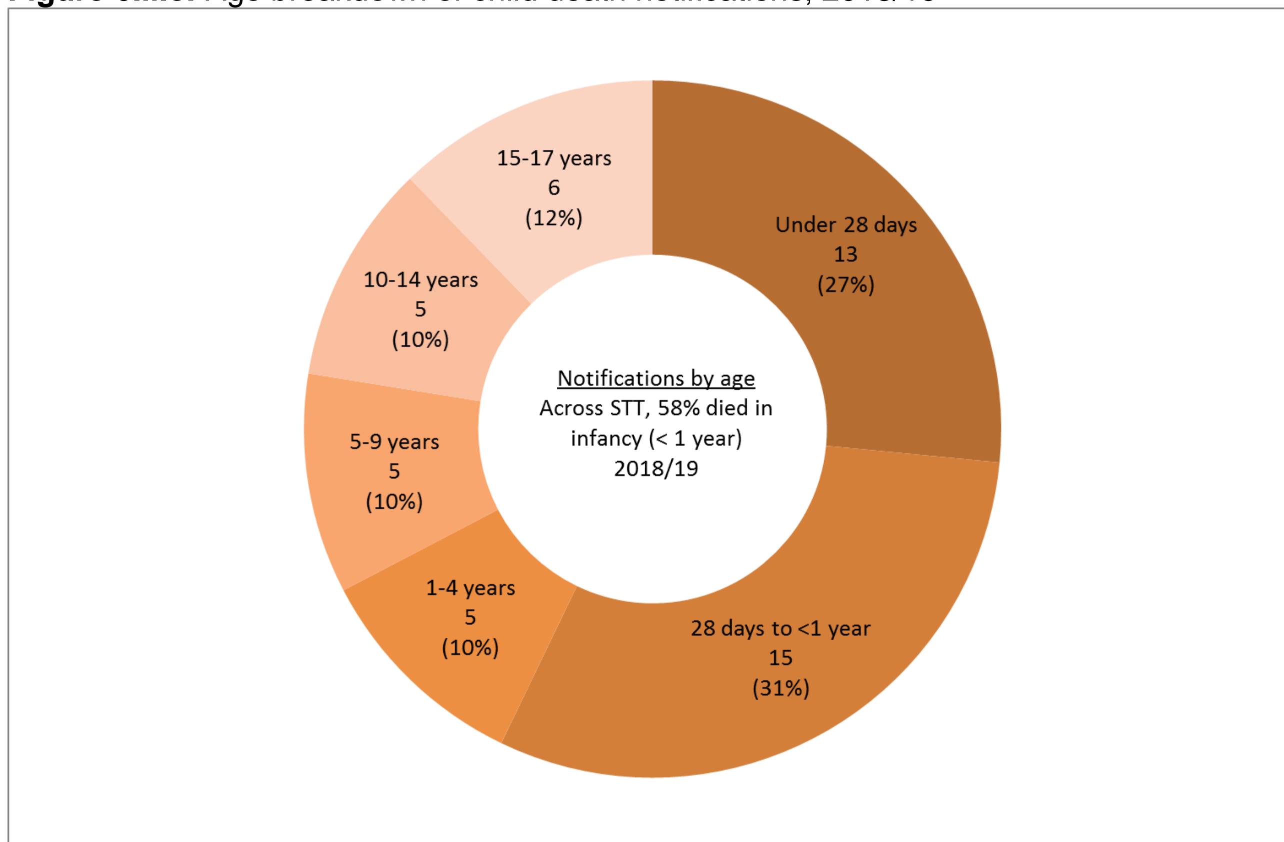


6.ii.c. Age breakdown of notifications

Of the 49 notifications in 2018/19, 13 (26.5%) were neonates (i.e. aged under 28 days) and 15 (30.6%) were aged between 28 days and 1 year. This means that over half (28 or 57%) of notifications across STT are infants (i.e. aged under 1 year). This is in line with previous years in STT and Greater Manchester. Again, differences in age patterns between the three authorities within STT can be difficult to detect; however, there does seem to be a consistent pattern that in Stockport a higher proportion of child deaths are of neonates (41.2% compared to 26.5% for STT). When considering cases which were closed during 2018/19, the age distribution is different with a higher proportion of deaths occurring at age under 28 days (42.5%) than for notifications over the same period (26.5%). This is likely to be explained by the fact that deaths of older children tend to take longer to close and so these deaths tend to get distributed over more years when annual analysis is of closed cases rather than notifications.

Reviewing the 21 notifications of deaths of children aged over 1 year, at STT level the distribution across age groups was fairly even with 5 (23.4%) aged 1 to 4 years, 5 (23.4%) aged 5 to 9 years, 5 (23.8%) aged 10 to 14 years, and 6 (28.6%) aged 15 to 17 years. Any differences between the three authorities in this distribution are difficult to detect due to the small numbers involved.

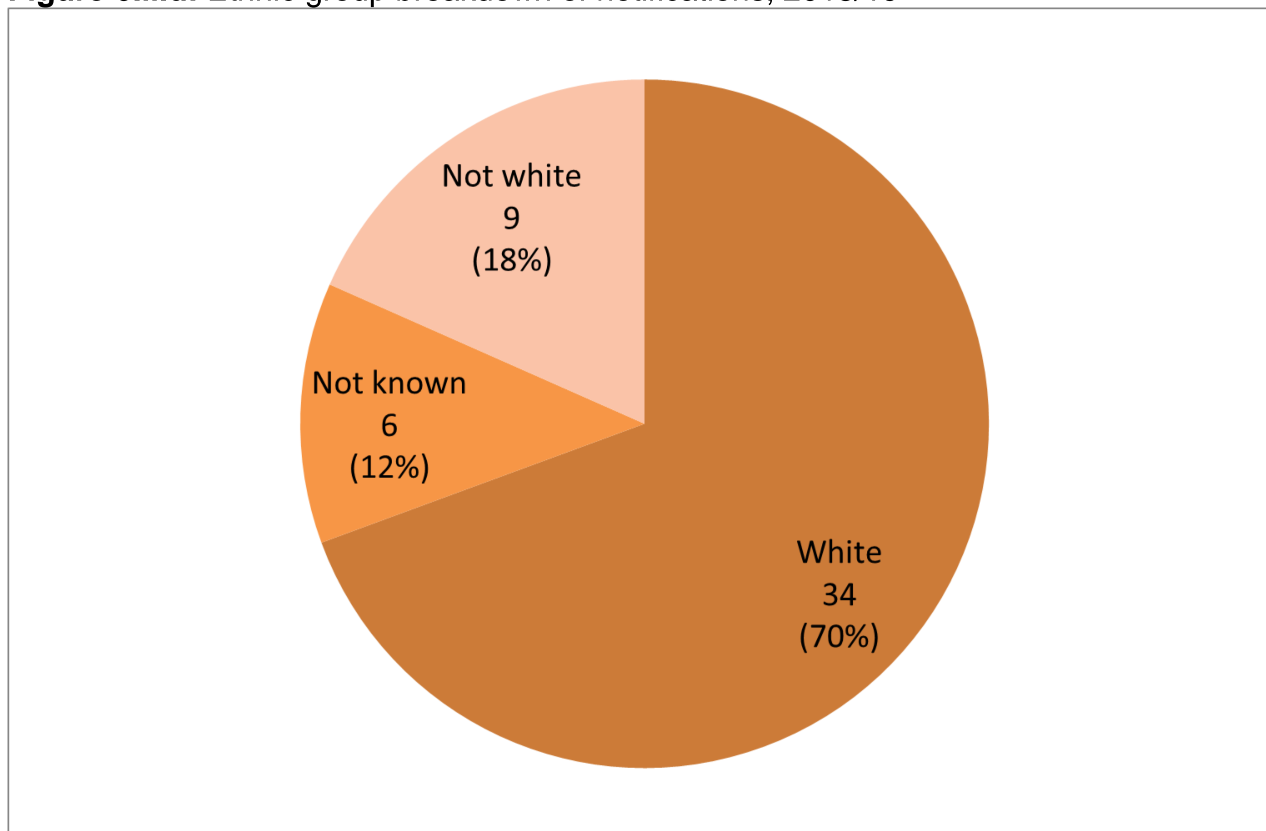
Figure 6.ii.c: Age breakdown of child death notifications; 2018/19



6.ii.d. Ethnicity breakdown of notifications

Of the 49 notifications during 2018/19, 9 (18.4%) belonged to a non-White group. This is in line with the estimated proportion of the STT child population belonging to non-White groups (20%). However, there are 6 notifications (12.2% of total) where ethnic group is not known (these are cases which are still open to CDOP pending further information). If, for instance, all these cases were of non-White children then this would bring the proportion of deaths which were of non-White children to 30.6% which may suggest that these children are overrepresented among children who die. Indeed, when considering cases closed in 2018/19, 16 out of 40 cases (40%) were BME; however, this does not provide a reliable way of comparing BME deaths with the proportion of the population from BME group because the in-year closed cases represent children who died over many years. It is recommended that the ethnic group pattern among 2018/19 notifications should be reviewed when the remaining notifications are closed.

Figure 6.ii.d: Ethnic group breakdown of notifications; 2018/19

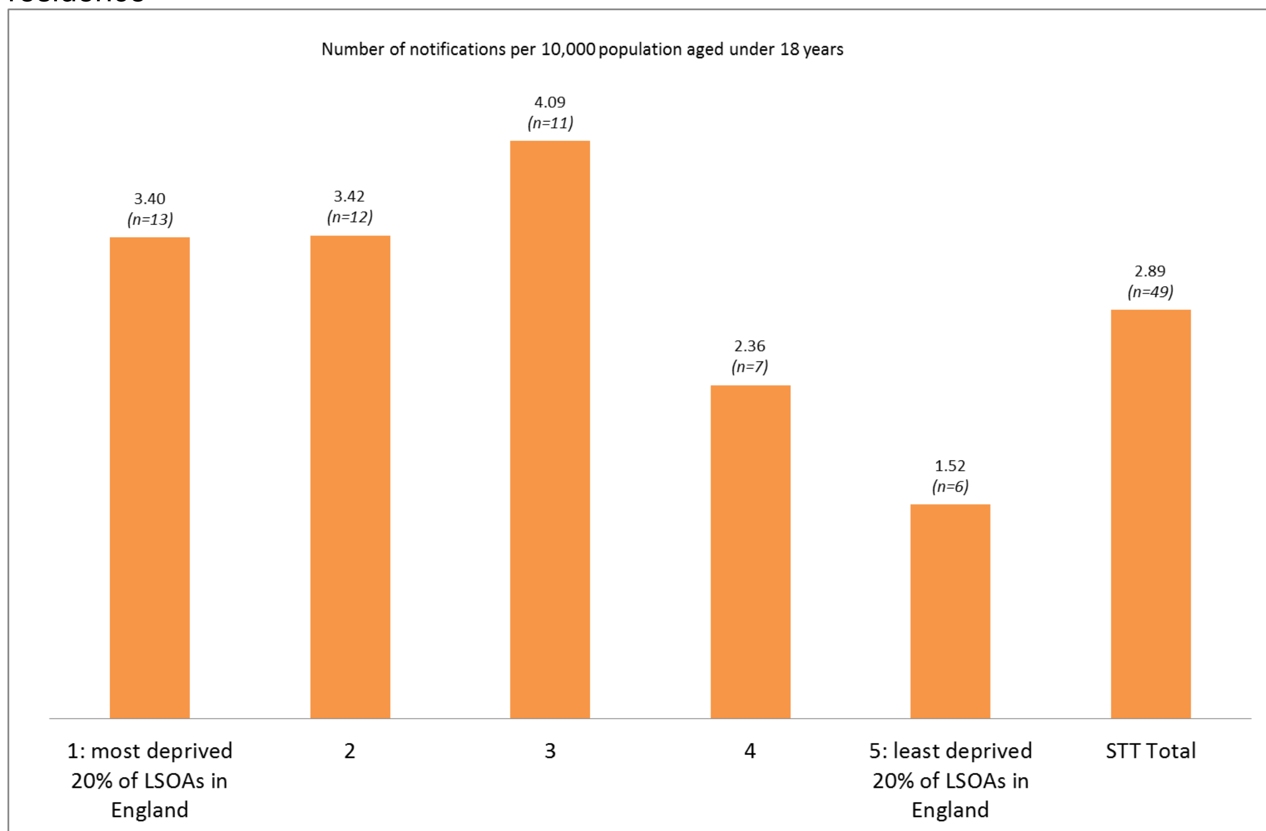


6.ii.e. Deprivation breakdown of notifications

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

Of the 49 notifications across STT, 13 (27%) were of children who lived in small areas which rank in the 20% most deprived in England. Whether there is tendency towards higher child death notification rates in more deprived areas of STT in 2018/19 is unclear, partly because of the relatively small number of deaths involved. However, the rate in areas ranked in the 20% most deprived areas in England (3.40 per 10,000) is twice as high as in the least deprived 20% (1.52 per 10,000), but reaches a peak (4.09 per 10,000) in the middle quintile.

Figure 6.ii.e: Notification rate according to national deprivation quintile of mother's area of residence



6.iii. Analysis of cases closed during 2018/19

6.iii.a. Number of closed cases

It is important to note that CDOP did not meet as regularly in 2018/19 as previous years due to the capacity of the CDOP administrator and a change in CDOP chair.

In 2018/19, 40 cases were closed by the panel:

- This is lower than previous years, and substantially lower than a peak of 64 cases closed by the panel in 2010/11.
- The breakdown by authority was 17 (43%) in Stockport, 10 (25%) in Tameside and 13 (33%) in Trafford.
- Only 5 (12.5%) were notified to CDOP within the 2018/19 financial year.
- The average (mean) number of days from notification to close was 433, but varied by authority from 421 for Tameside cases, 422 for Trafford cases and 449 for Stockport cases. Deaths of children aged over 1 year tend to take longer to close, probably reflecting the circumstances and causes of death.

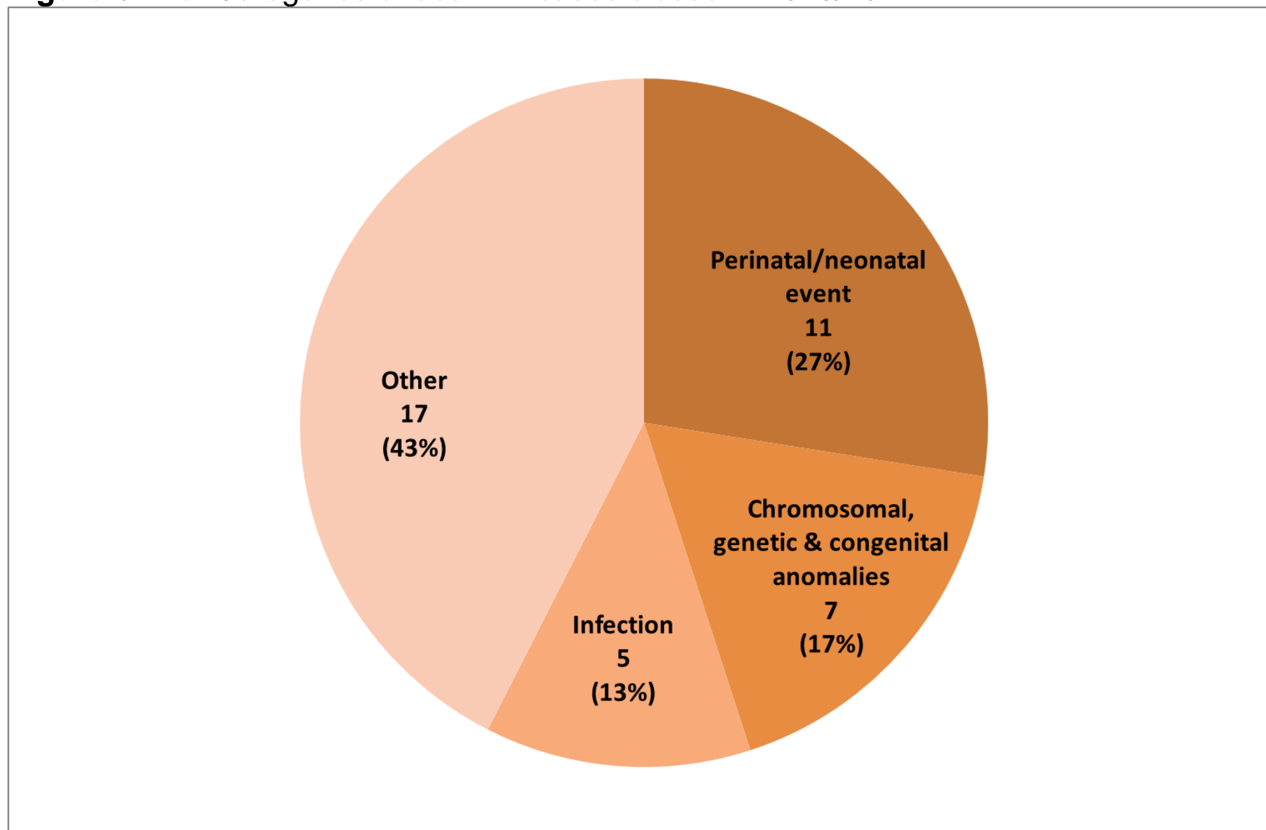
6.iii.b Birthweight and gestation

23 (57.5%) of cases closed by the panel in 2018/19 were infants (age <1 year). Among these 10 (43.5%) had very low birthweight (<1,500g), and a further 7 (30.4%) low birthweight (1,500<2,500) bringing the proportion with low birthweight close to three-quarters (17 out of 23 or 73.9%). All 10 babies with very low birthweight were premature, with 9/10 extremely premature.

6.iii.c. Categories of death

In line with previous years, the category of perinatal/neonatal event makes up the largest category of death with 11/40 (27.5%) closed cases, followed by chromosomal, genetic and congenital anomalies making up 7 (17.5%) of cases. The 17 closed cases of children aged over 1 year were spread across a range of categories.

Figure 6.iii.c: Categories of death in cases closed in 2018/19.



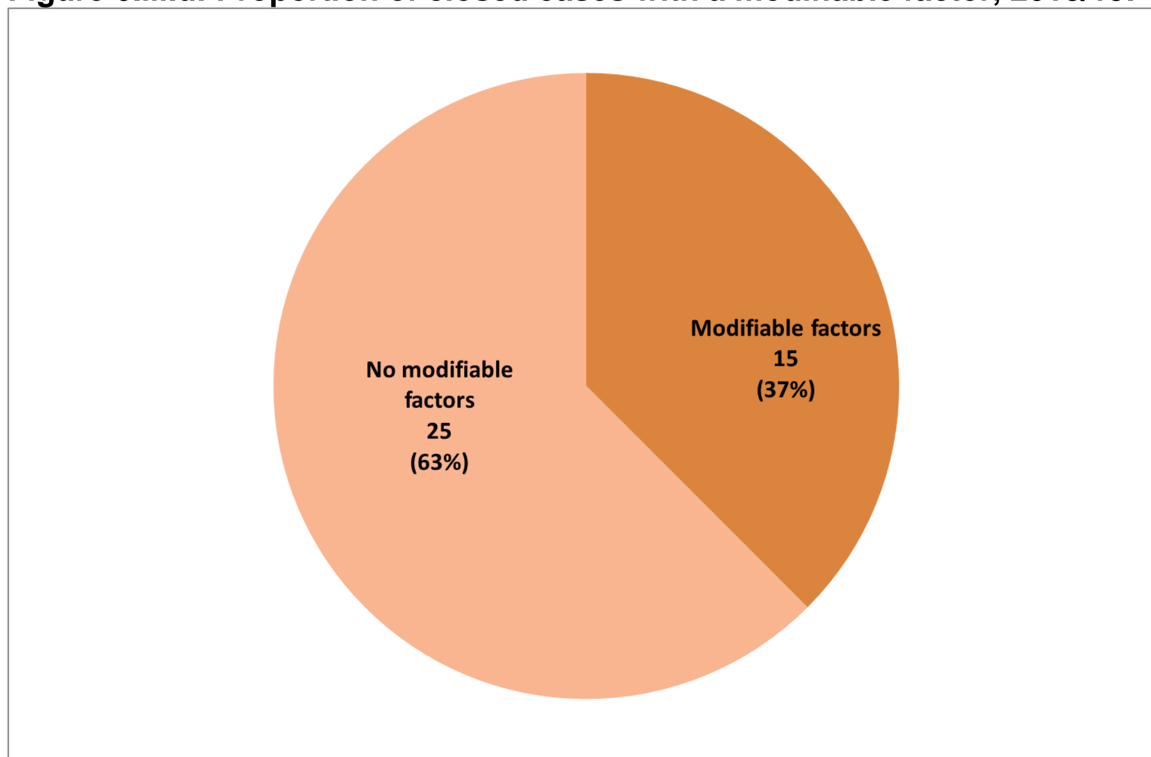
6.iii.d. Modifiable factors

Modifiable factors were identified in 15/40 (38%) of closed cases, similar to the proportion across Great Manchester as a whole (39%), but somewhat lower than the proportion for STT in 2017/18 (47%). According to authority, the proportion was lower in Trafford and higher in Stockport but the number at local authority is small such that it is difficult to attribute this difference to a factor other than chance variation. Present modifiable factors included:

- High maternal BMI (mentioned in 3 cases)
- Parental smoking (mentioned in 2 cases)
- Issues with service provision (mentioned in 6 cases)

A confidential data attachment is available which details the modifiable factors.

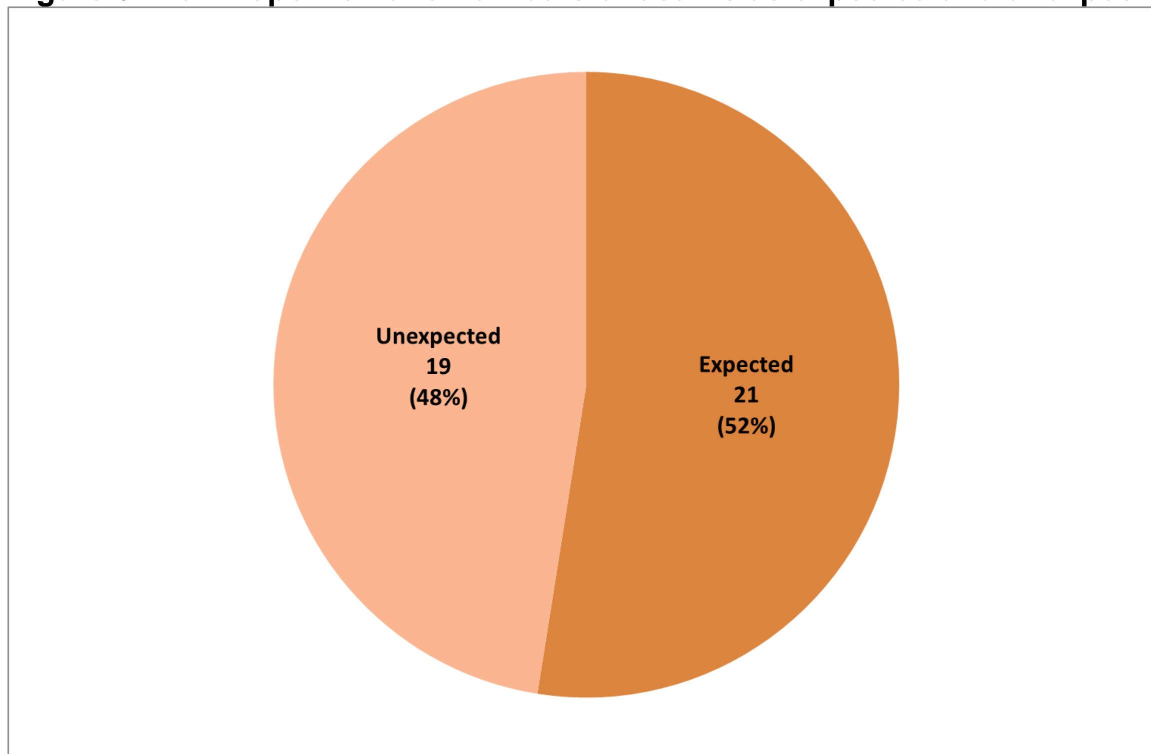
Figure 6.iii.d: Proportion of closed cases with a modifiable factor, 2018/19.



6.iii.e. Expected deaths

Just over half (21 or 52%) of closed cases across STT were deaths which were expected, very similar to the proportion for Greater Manchester (58%), but lower than the STT figure for 2017/18 (74%). At local authority level for 2018/19, the proportion expected was higher in Trafford (77%) and lower in Tameside (20%), but again the number at local authority level is too small to show any significant difference at this level.

Figure 6.iii.e: Proportion and numbers of deaths as expected and unexpected, 2018/19



7. Recommendations

Although the numbers are small and for some issues difficult to draw conclusions from, for the children and families affected it is important that change happens to prevent future avoidable deaths occurring. The success of the recommendations relies on local partners working collaboratively to improve the outcomes for children's health and wellbeing.

The CDOP Strategic Group has identified eight recommendations for Stockport's, Tameside and Trafford's Health and Wellbeing Boards to endorse and sponsor.

I. **All CDOP partners to ensure the robust data recording of protected characteristics as required under the Equality Act 2010.** This action is important for the identification of trends and supports the equity of the interventions commissioned using the data.

II. **The CDOP Strategic Group to progress a CDOP 5 year look back review to identify robust trends and inform strategic decision making.** The review which would use data from April 2014 to March 2020, will be led by the three Public Health data analysts reporting into the CDOP Strategic Group. The review will provide a full epidemiologic profile of child mortality within and across the three boroughs and seek to determine trends around age, deprivation and ethnicity. The review document would be presented to each Health and Wellbeing Board summer 2020.

III. **Tameside CDOP members to use the data provided by the 5 year review to understand the boroughs expected and unexpected death pattern.**

IV. **STT CDOP representatives to engage with the Greater Manchester CDOP system about the 5 year data review to share methodology and outputs.**

V. **Health and Wellbeing Boards to improve the outcomes of babies by;**
   a. **working with maternity services to deliver safe, evidence based healthy weight interventions, so that when a women books with the service and she is recorded as not being a healthy weight she is supported to maintain or if safe to do so support her to reduce her BMI.**
   b. **working with Public Health Directorates to support the delivery of healthy weight interventions at a population level, thereby promoting the healthy weight of women of childbearing age.**

VI. **Health and Wellbeing Boards to reduce the number of pregnant women and parents who smoke by;**
   a. **working with Public Health Directorates and Maternity providers to support the delivery of the Baby Clear programme to all pregnant women ensuring a continued support once the baby has been born.**
   b. **working with Public Health Directorates to support the delivery of smoking cessation interventions at a population level, thereby reducing the risk of smoking to children.**

VII. **Health and Wellbeing Board promote improvements in mental health and resilience by;**
   a. **working with Public Health Directorates to better understand the relationship between self harm and suicide and to ensure services are commissioned that respond to the risks posed from this behaviour.**
   b. **ensuring there is collaborative working between the CDOP Strategic Group and Greater Manchester Suicide Prevention Programme to ensure Children**

and Young People are included in the work programme and that this is cascaded to localities.

VIII. Health and Wellbeing Boards to support a reduction in co-sleeping and promote safe sleeping by;

c. **working with Public Health Directorates in partnership with Health Visiting and Maternity services to ensure all families receive appropriate safe sleeping interventions.**
d. **working with Public Health in partnership with Health Visiting colleagues to implement a safe sleeping awareness campaign to all front line services that are in contact with families with infants.**

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

Each borough will integrate the recommendations into the appropriate local systems for action and monitoring. The STT CDOP Strategic Group will oversee the progress of these recommendations. The HWB will be accountable for the progress of these recommendations. The recommendations will be reported as part of the 2019/20 Annual Report cycle.

9. Summary

In summary, from October 2019, the CDOP system changed with accountability shifting to local Health and Wellbeing Boards. The CDOP process is also changing with the Trust where the child died becoming responsible for managing multi-agency Child Death Mortality Reviews and identifying a Designated Doctor for child deaths as per the 2018 guidance[iv]. STT CDOP members are engaged with the Greater Manchester to support the implementation of the new system.

When a child dies it is so important that the parents, carers and professionals, who were part of this experience understand the circumstances of the death. NHS, LA organisations and other partners have a responsibility to review each case, identify good practice and poor practice. Learning must affect practice so as a system we can prevent avoidable deaths from happening or, if inevitable, ensure the child has the best death possible and their family and carers are supported throughout this experience.

Appendix A: CDOP Responsibilities and Operational Arrangements

Ai: Child Death Overview Panel Responsibilities

CDOP responsibilities are:

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

Aii: Child Death Overview Panel Operational Arrangements

CDOP will;

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

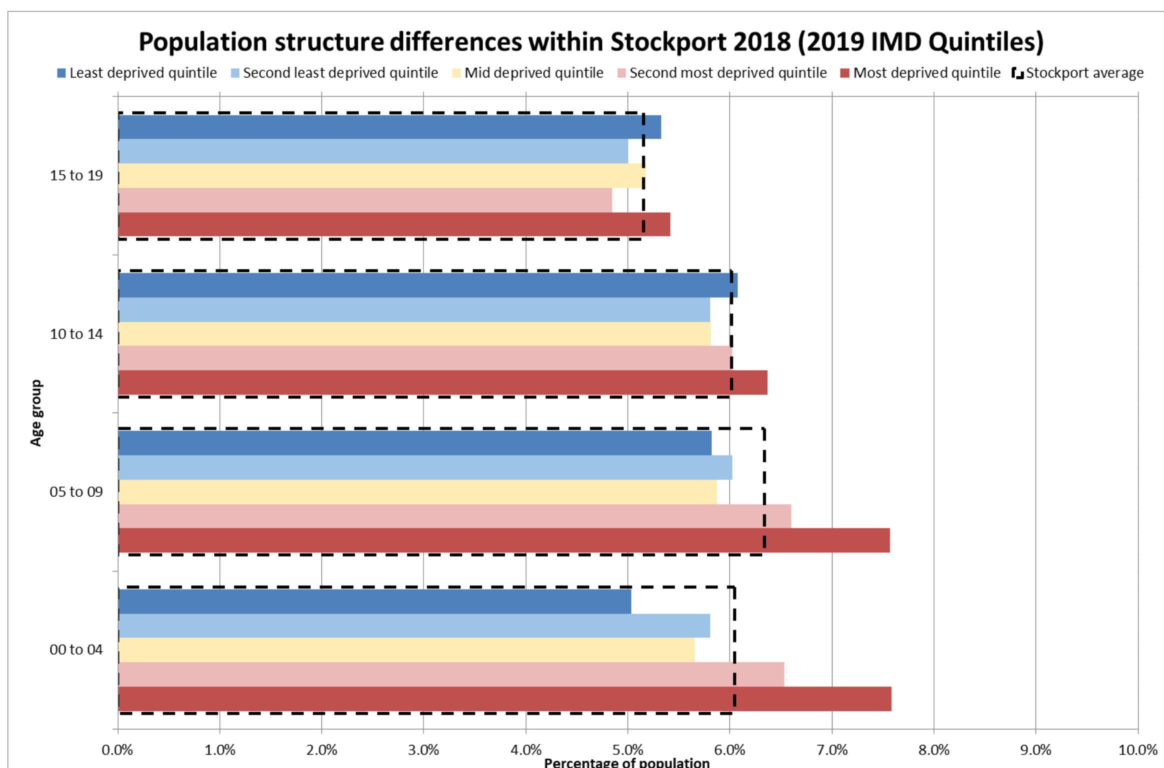
The full description of local CDOP arrangements for Stockport, Tameside and Trafford can be found here:
www.traffordccg.nhs.uk/docs/Publications/STT-CDOP-implementation-plan-June-2019.pdf

Appendix B: Borough Child Profiles

i: Stockport

There are 62,370 children and young people aged 0-17 living in Stockport (ONS Mid-Year Estimate 2018), a population that is growing slightly – up 2.4% since 2008. Due to fluctuations in birth rates there are more children per year aged 2-9 years (around 3,650) than aged 0-1 and 10-17 years (3,320). Births reached their lowest level in 2001-2003, at less than 3,000 per year, and then rose to a high in 2012 (3,500), since when numbers have started to fall again, reaching 3,300 by 2018, following the well-known cyclical trend.

Fertility rates are highest in the most deprived areas of Stockport, currently 40% higher than in the least deprived areas, and were especially high in these areas between 2009 and 2014 (at over 80 per 1000 females aged 15-44), 60-70% higher than in the most affluent areas), meaning that the under 10 population in particular is much more likely to be deprived than the Stockport average.



Stockport's population is not particularly ethnically diverse, when compared to other areas of Greater Manchester, however ethnic diversity is increasing, especially for younger populations. Sample data from Stockport GP Practices in 2019 suggests that 82% of the 0-17 population describe their ethnicity as White, 8% as Asain, and 5 % as other. Stockport's BAME population is not evenly distributed, and is greatest in Heald Green, Gatley and Heaton Mersey.

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

Stockport JSNA

- Overall summary (all ages): http://www.stockportjsna.org.uk/wp-content/uploads/2016/04/2015-16-JSNA-Key-Summary.pdf

- Key issues for children: http://www.stockportjsna.org.uk/wp-content/uploads/2016/04/2015-16-JSNA-Implications-for-Children-and-Young-Peoples-Services.pdf

Borough Priorities

- Stockport Council Plan: https://www.stockport.gov.uk/council-plan
- Stockport Health and Wellbeing Strategy: https://www.stockport.gov.uk/health-and-wellbeing-board/joint-health-and-wellbeing-strategy, contains hyperlinks to other key strategies too
- Stockport Family: https://www.stockport.gov.uk/topic/stockport-family

ii: Tameside

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

The ethnic composition of the Tameside population is also changing, with the last Census (2011) showing that 15.8% of the local population are from an ethnic minority group; this is an increase from the last Census (2001) of 7.4%.

Across Tameside in 2018 there are estimated to be 50,223 children and young people under the age of 18 years. This is 22% of the total population. Around 26% of children in Tameside live in poverty and this rises to 35% after housing costs.

In 2018 there were 2,843 babies born in Tameside; 26% of babies were born in the most deprived decile. 8% of babies were born with a low birth weight under 2500 grams, with less than 1% being of very low birth weight (<1500 grams). The highest proportion of births were born to mothers aged 25-34 years (61%). 1% of babies were born to women under 18 years and 19% to women over the age of 35 years.

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

Population vaccination coverage for 2 year olds across all vaccines has reduced in the last few years and we now have significantly lower rates than the England average for MMR vaccination rates (90% coverage) but have a higher rate for Dtap/IPV/Hib (95% coverage).

A&E attendances for 0-4 year olds in Tameside are significantly higher than the England average. In older children hospital admissions for self-harm are similar to the England average, but admissions for asthma, mental health issues, substance and alcohol misuse are significantly higher.

School readiness is improving for our 5 year olds but is still significantly worse than the England average, currently 66% of children in Tameside are school ready.

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

Please find more information here: child-health-profiles

iii: Trafford

An estimated 56,000 under 18s live in Trafford i.e. about 1 in 4 (24%) of the total population (proportionally slightly higher than England at 21%) *(ONS, Mid-2018 estimates).*

Between 2008 and 2018, Trafford's under-18 population grew by almost 6,000 or 12% which is substantially more than the growth seen in this age group across Tameside, Stockport and England as a whole *(ONS, Mid-year estimates for 2008 and 2018).* Over the next 10 years, however, growth in this age group is projected to slow to 3,000 or 5.3% between 2018 and 2028; this is driven by strong growth in the 10-17 year age group, against a slight decline in those aged under 10 *(ONS, 2016-based subnational population projections).*

In 2018 there were 2,641 live births to mother's resident in Trafford. This is 7% lower than in 2008 when there were 2,841 live births. Trafford's fertility rate (61 live births per 1,000 females aged 15 to 44) is slightly higher than, England (59 per 1000) and fertility rates tend to be higher in areas of Trafford with higher and a higher Black and Minority Ethnic (BME) population.

The proportion of Trafford under-18s belonging to BME group is growing: in the 2001 Census, 15.5% (or 7,500) under 18s were from a BME group. By the 2011 Census this had grown to 25.3% (or 13,100). More recent data from the 2019 School Census indicate that approaching a third of Trafford school children now belongs to a BME group.

Trafford is the least deprived authority in Greater Manchester – only 5.7% of small areas in Trafford rank in the 10% most deprived in England; however, children who live in these areas tend to fare worst on a range of indicators of health and wellbeing. The Income Deprivation Affecting Children domain of the 2019 Indices suggests that 11.7% of Trafford 0-15 year olds are living in poverty, but this rises to 44% in one small area.

Children and young people in care are among those who can be particularly vulnerable to poor health and social outcomes. Trafford's rate of children in care has been rising over time and is high relative to other similar authorities.

Trafford Joint Strategic Needs Assessment's section on children and young people can be accessed at http://www.traffordjsna.org.uk/Life-course/Start-well.aspx. The Health and Wellbeing Board has three life course sub-boards including "Start Well and Ready for Life" which has three priorities to:

- improve school readiness, particular in children eligible for Free School Meals
- improve mental wellbeing and resilience, in particular by tackling Adverse Childhood Experiences (ACEs); and,
- increase the proportion of children who have a healthy weight.

10. References

[i] HM Government, (2018), *Child Death Review Statutory and Operational Guidance*.
[ii] HM Government, (2018), *A guide to inter-agency working to safeguard children. A guide to inter-agency working to Safeguarding and Protecting the Welfare of Children.*
[iii] Public Health England, (2019) Maternal and Child Health Profiles, *https://fingertips.phe.org.uk/profile/child-health-profiles.*
[iv] HM Government, (2018), *Child Death Review Statutory and Operational Guidance*.

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TRAFFORD COUNCIL

Report to: Health & Wellbeing Board
Date: 20th February 2020
Report for: Decision
Report of: Director of Public Health

Report Title

Healthy Weight Declaration

Purpose

This report outlines the purpose and process of signing up to the Healthy Weight Declaration.

Recommendations

To progress Trafford Council's adoption of the Healthy Weight Declaration.

Contact person for access to background papers and further information:

Name: Jane Hynes
Telephone: ext. 1899

1. Introduction

Trafford's Health and Wellbeing Strategy (2019 – 2029) identifies seven priority areas, of which healthy weight is one. The aim is to increase the number of people within Trafford who are a healthy weight, and to improve nutrition and hydration across the borough.

Improved health and wellbeing is one of Trafford Council's corporate priorities, with the specific aim to reduce health inequalities between different communities in the borough. Obesity is strongly linked to deprivation in both adults and children, and the people living in our most deprived communities have significantly shorter healthy life expectancy than those in our least deprived areas.

2. Context

Achieving and maintaining a healthy weight is challenging and complex, with more than 60% of adults in England being overweight or obese. Being overweight can be prevented, but it is a normal reaction to an abnormal environment, where it is very difficult to achieve and maintain a healthy weight given all the external factors and influences on our lives. We therefore need to look at the whole system of social, economic and environmental factors that impact on weight.

Overweight and obesity can have serious implications on health, with increased risk of cardiovascular disease, type 2 diabetes, vascular dementia and cancer and significantly reduces life-expectancy.

Diet and obesity-related ill-health has a huge financial impact on the NHS with estimates that it costs the UK around £6 billion each year, before we consider the economic and societal impacts due to reduced productivity and obesity-related illness that make people unable to work. This brings the wider cost of obesity to society to around £27 billion per year.

In Trafford, an estimated 57% of adults (18+) are overweight or very overweight which equates to approximately 135,000 people. By the age of 11 (Year 6), nearly one third of children are overweight or very overweight, with higher prevalence of excess weight being strongly associated with increasing deprivation.

3. Current work

Trafford has a multi-agency Healthy Weight Steering group which is overseeing the development of a new healthy weight strategy and whole system approach to tackling excess weight. This approach looks at the system of factors which combine to influence excess weight and where changes can be made within this system to have the greatest positive impact.

One action which has demonstrated positive outcomes in helping to change the system in other local authorities is to adopt and sign up to the Local Government Healthy Weight Declaration.

4. The Healthy Weight Declaration

The Healthy Weight Declaration has been developed to support local authorities to demonstrate commitment at a leadership level to develop and implement policies that promote healthy weight and improve the health and well-being of the local population.

There is no one size fits all solution to obesity; it will take action at many different levels before we see any significant progress. However, local authorities have an important role to play. We control planning, public and environmental health, leisure and recreation and

regeneration and this declaration is a vehicle to take the sort of whole-systems approach needed to tackle this complex issue. The declaration can have an impact across local authority departments, making sure the council works as one to achieve maximum impact and, ideally by working with other local partners, will have an impact far beyond council controlled areas.

The declaration includes fourteen standard commitments with the opportunity for local authorities to add local commitments relevant to our needs and aspirations. The standards have been developed through consultation with an expert stakeholder group and are based on robust evidence. The commitments are:

- Engage with the local food and drink sector where appropriate to consider responsible retailing.
- Consider how commercial partnerships with the food and drink industry may impact on the messages communicated around healthy weight to our local communities.
- Review provision in all our public buildings, facilities and via providers to make healthy foods and drinks more available, convenient and affordable, and limit access to high-calorie, low-nutrient foods and drinks.
- Increase public access to fresh drinking water on local authority controlled sites.
- Consider supplementary guidance for hot food takeaways, specifically in areas around schools and parks.
- Advocate plans with partners to address the causes and impacts of obesity.
- Protect our children from inappropriate marketing by the food and drink industry such as advertising and marketing in close proximity to schools, giveaways and promotions within schools, at events on local authority controlled sites.
- Support action at a national level to help local authorities reduce obesity prevalence and health inequalities in our communities.
- Ensure food and drink provided at public events include healthy provisions, supporting food retailers to deliver this offer.
- Support the health & wellbeing of local authority staff and increase knowledge and understanding of unhealthy weight to create a culture that normalises healthy eating.
- Invest in the health literacy of local citizens to make informed healthier choices
- Ensure clear and comprehensive healthy eating messages are consistent with government guidelines.
- Consider how strategies, plans and infrastructures for regeneration and town planning positively impact on physical activity.
- Monitor the progress of our plan against our commitments and publish the results.

These actions do not all need to be done at once, or prior to signing up to the declaration – we will prioritise and work systematically through the standards, identifying those where work is already being undertaken. This work will be led by Public Health, linking into the new Healthy Weight Strategy and whole system approach, and guided by the healthy weight steering group. It will, by definition, involve a wide range of stakeholders, both internal and external to the Council in order to make progress.

5. Recommendations

We ask that the Board:

- agrees to progress with signing the Healthy Weight Declaration as a tool to gain leadership support and promote the Council's commitment to addressing poor diet;
- identifies an elected member Champion who will help to get the Declaration through the democratic progress.

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TRAFFORD COUNCIL / TRAFFORD CCG

Report to:	**Health & Wellbeing Board**
Date:	**20th February 2020**
Report for:	**Information**
Report of:	**Sara Radcliffe, Director of Integrated Health and Social Care Strategy**

Report Title

Trafford Together Locality Plan – Delivery Model

Purpose

This paper highlights recent developments following the publication of the Trafford Together Locality Plan – specifically in relation to the delivery model that has been agreed by the Local Care Alliance (LCA), the supporting system governance aligned to the six pillars of reform and the weekly Locality Plan Working Group.

The paper articulates the strategic and operational aspects of the delivery model including system accountability and structure and schedule of LCA system board meetings.

Recommendations

1. Note the developments in relation to the delivery of the Trafford Together Locality Plan and support the approach outlined.

Contact person for access to background papers and further information:

Name: Sara Radcliffe
Contact details: 07970230363 / sara.radcliffe1@nhs.net

1. Introduction

This paper highlights recent developments following the publication of the Trafford Together Locality Plan – specifically in relation to the delivery model that has been agreed by the Local Care Alliance (LCA), the supporting system governance aligned to the six pillars of reform, and the role of the weekly Locality Plan Working Group. The paper articulates the strategic and operational aspects of the delivery model including the system accountability, structure and schedule of LCA system board meetings to channel the efforts of the system towards the aspirations of the Locality Plan.

2 System Accountability / Ways of Working

2.1 Through the membership of the LCA System Board key stakeholders are engaged throughout all levels of the programme. System Board members represent senior leadership from member organisations and the role of board members includes responsibility to lead and contribute to relevant pillars of reform as described in the Locality Plan. Colleagues have a responsibility for meaningful engagement in the planning and delivery of health and social care system change and are pivotal in disseminating key messages and actions into their own organisations and beyond.

2.2 The LCA has agreed an approach which is described below. It builds from the existing Memorandum of Understanding (MOU) which was signed by each partner organisation. The approach agreed by the LCA reflects the growth and maturity of the Board over the last 20 months which retains the commitment to the principles within the MOU, but builds on the growing maturity of key partnerships and relationships which manifests itself into a structured and delivery driven programme approach.

2.3 The diagram (Appendix A) depicts the 'System Connectivity and Accountability' in its current state and has been created to highlight the key leadership roles (Senior Responsible Officers), pillars of reform, enabling work programmes and governance which drives and supports the delivery plan.

2.4 The transformation of services will take place in the existing system architecture that underpins the Trafford Together Locality Plan six pillars and enabling programmes, with a recurrent focus on 'place' through Trafford Local Care Organisation (TLCO) and the Primary Care Networks, enabling person and community centred care.

3 Local Care Alliance System Board: Programme Approach

3.1 The LCA System Board has committed to thematic focuses for each of the Board meetings in 2020. In January we have received updates and had focussed discussion on Prevention and Social Value and are due to receive

detailed discussions on Primary Care, Planned Care and Urgent Care (February LCA System Board) – Using an agreed framework these discussions have culminated in specific and tangible actions which have been immediately progressed by relevant partners.

3.2 Fundamental to our Locality Plan and supported by the LCA is the importance of developing and maintaining our sense of 'place'. Person and community centred approaches is a fundamental driver for change and core component of our Locality Plan and therefore we wish the meetings of the Board to be reflective of our written plans in a meaningful manner. The LCA will utilise our community assets and rotate meetings across the borough which will provide members the opportunity to learn and understand our communities furthermore, realising the differences and nuances of our diverse communities which in turn will influence our delivery plans both in-year and over the life course of the Locality Plan.

4 Locality Plan Working Group – Wednesday Meeting

4.1 The weekly Locality Plan Working Group has remained a pivotal function in driving forward the Locality Plan and compliments and feeds into the structured LCA approach for enhanced distributed leadership and continuous improvement.

4.2 Pertinent developments led by and facilitated by the working group include:

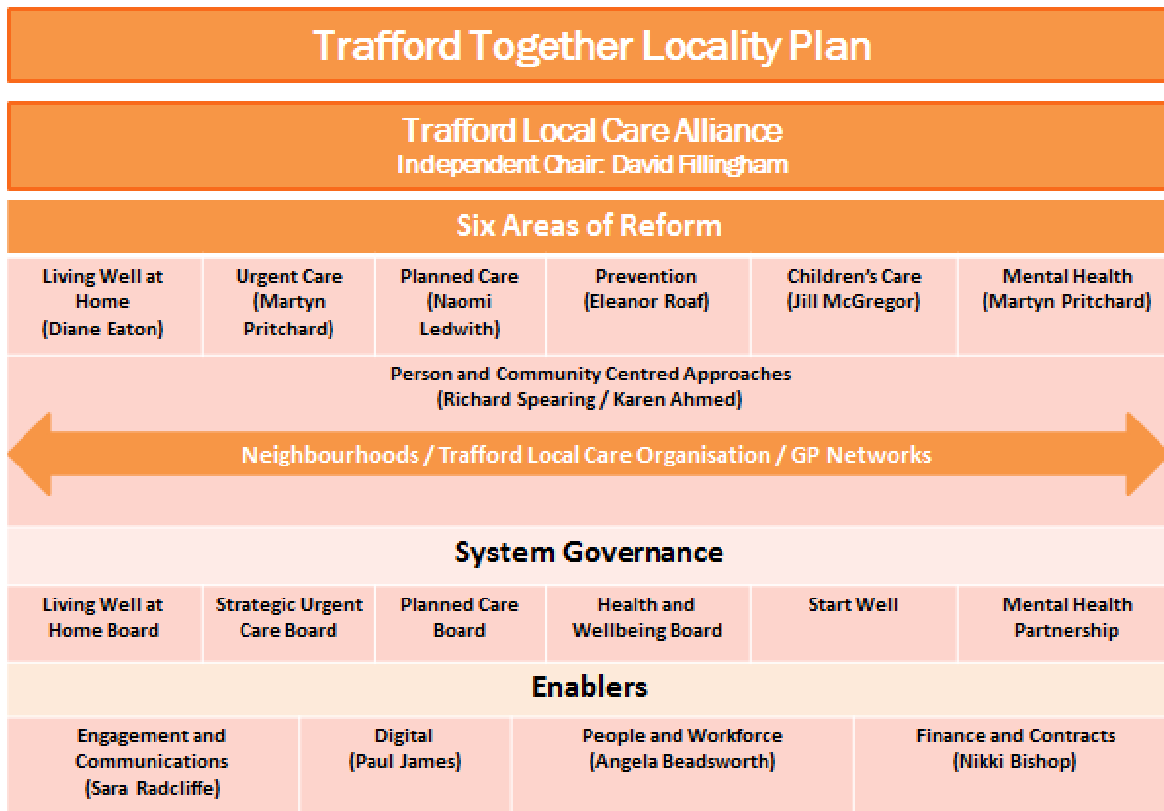
- Identifying SRO support across the key pillars and enablers.
- Strengthening particular connections with the Place Directorate with direct senior leadership involvement, linked to primary prevention.
- Tangible developments working towards the production of an LCA level 'Outcomes Dashboard' for strengthened accountability – helping us quantify if we are making a positive difference to our most vulnerable people, improving population health and enabling connected communities.
- Establishment of a Communications and Engagement Steering Group working closely with all our system partners to co-produce our planned 'Year of Engagement'.
- Established matrix working across the Locality Plan to understand the interdependencies and the benefits possible through collaboration and a set of clear, measureable priorities for each of the key work programmes.

5 Recommendations

5.1 The Health and Wellbeing Board is asked to:

a) Note the developments in relation to the delivery of the Trafford Together Locality Plan and support the approach outlined in this paper.

Appendix A:



Trafford Together Locality Plan

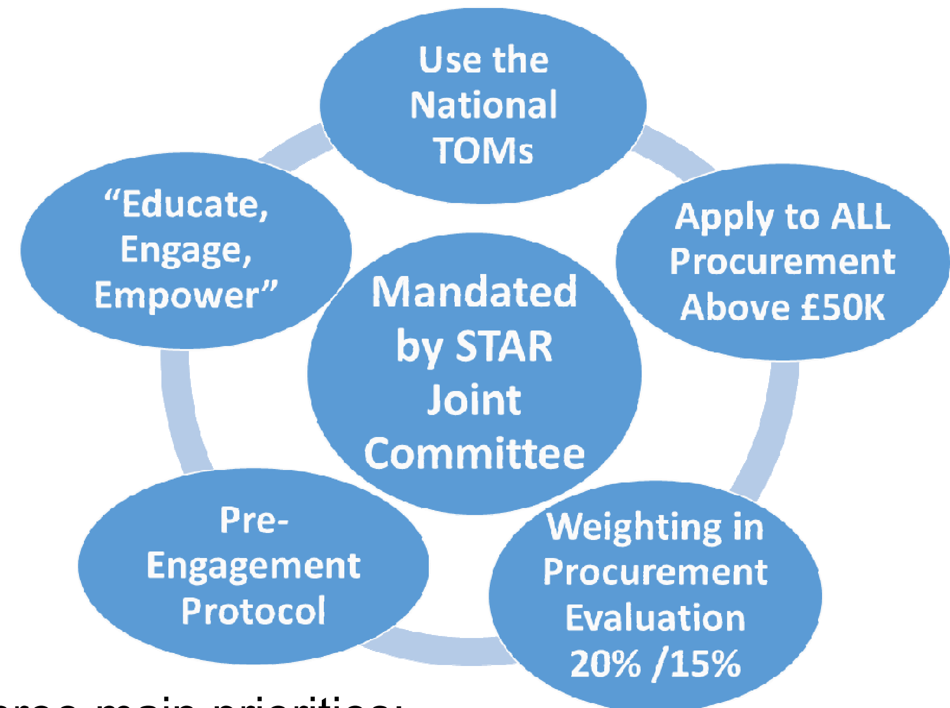
Delivery Plan 2020/21

Our Commitment: Social Value

Work Undertaken with MFT:

- Information sharing on Social Value Priorities and measurement of Social Value outcomes
- Learn around Local Employment and Apprenticeships
- Retrospective exercise underway to discover Social Value from LCO arrangement with the Foundation Trust

Trafford Council



Local Care Alliance – Commitment to three main priorities:

1. Climate Change and Climate Emergency
2. Active Travel
3. Mental Health and Learning Disability and Employment

Our Commitment: Prevention

By 2024, we aim to have prevention and early intervention embedded across the system. This will be achieved by:

- Supporting primary care networks to develop prevention priorities;
- Ensuring clinical pathways include prevention throughout the pathway;
- Supporting health in all policies;
- Taking a placed based approach;
- Ensuring that our social prescribing offers are consistent, sufficient, and easy for practitioners and the public to navigate
- Delivering comprehensive behaviour change services.
- Working with partners to make the necessary improvements to the wider determinants of health.

All partners committed to engage in the development of a comprehensive Prevention Strategy for Trafford, including an agreed Implementation Plan

Our Commitment: Primary Care

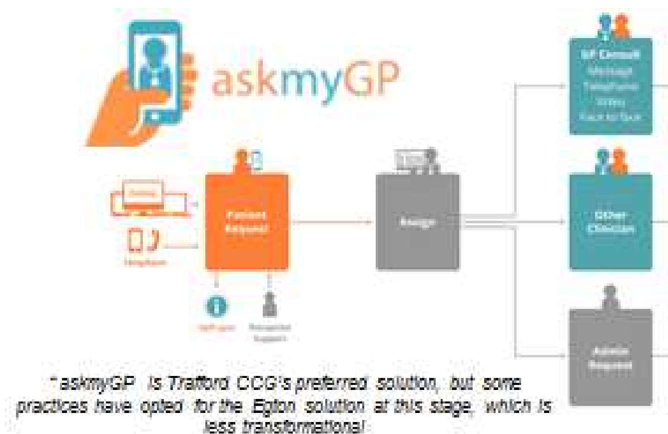
"We will have a transformed and sustainable primary care system, delivering place based care closer to home through integrated neighbourhood systems with wider partners. This will improve population health through improved management of long term conditions, with prevention at the centre of everything we do and will reduce unnecessary demand and activity within secondary care"

Digitally Transforming Primary Care

NHSE are promoting and partially funding a simplified patient journey utilising three digital elements which compliment existing solutions such as NHS.UK and the NHS App:

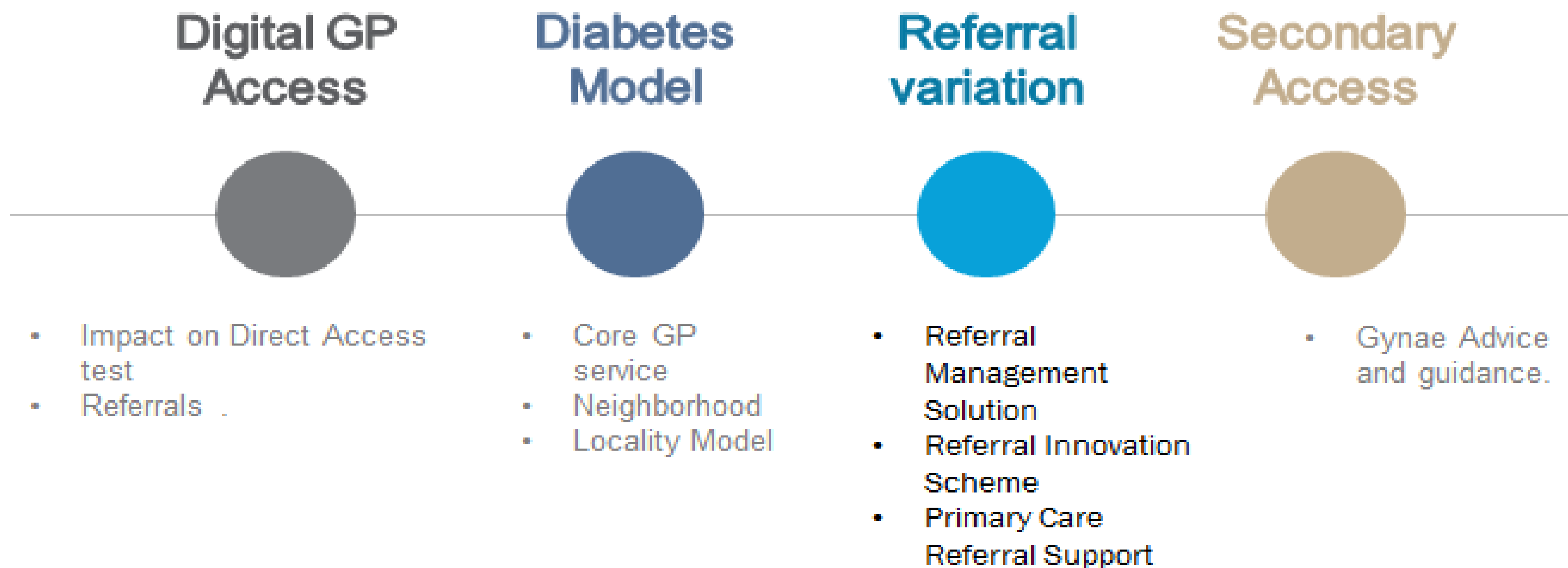
- Questionnaire based consultations
- Online Triage
- Video conferencing

However, bolting a Digital front end onto outdated or ineffective processes will not achieve improvement.



*askmyGP is Trafford CCG's preferred solution, but some practices have opted for the Egton solution at this stage, which is less transformational

Our Commitment: Planned Care



Our Commitment: Urgent Care