AGENDA PAPERS FOR

HEALTH AND WELLBEING BOARD

Date: Friday, 21 January 2022

Time: 10.00 a.m.

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

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

1. **ATTENDANCES**

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

2. **MINUTES** — To Follow

   To receive and if so determined, to approve as a correct record the Minutes of the meeting held on 24 September 2021.

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 RECEIVED 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 items appearing on the agenda and will be submitted in the order in which they were received.

5. **CDOP ANNUAL REPORT** — 1 - 26

   To receive a report from the Acting Director of Public Health.

6. **PUBLIC HEALTH ANNUAL REPORT** 27 - 42

To receive a report from the Acting Director of Public Health.

7. **HEALTH VISITING AND SCHOOL NURSING REVIEW** 43 - 54

To receive a report of the Acting Director of Public Health.

8. **LOCAL GOVERNMENT ASSOCIATION HEALTH AND WELLBEING BOARD RESET** To Follow

To receive a presentation from the Acting Director of Public Health.

9. **NHS AND INTEGRATED CARE SYSTEM DEVELOPMENTS** 55 - 80

To receive a presentation from the Shared Accountable Officer.

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.

SARA SALEH
Deputy Chief Executive

Membership of the Committee

Councillor J. E. Brophy, Councillor J. Harding, Councillor J. Holden, Councillor C. Hynes, Councillor J. Slater (Chair), C. Davidson, D. Eaton, H. Fairfield, Dr. M. Jarvis, M. Noble, E. Roaf, M. Roe, R. Spearing, A. Worthington, P. Duggan, S. Radcliffe, J. Wareing, C. Hemingway, D. Evans, M. Hill, A. Seabourne, J. McGregor, M. Gallagher, J. Coulton, Nagra, E. Calder and Dr. I. Muhammad (Vice-Chair).

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 **Thursday, 13 January 2022** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall; Talbot Road, Stretford, Manchester, M32 0TH.

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Learning from Child Death Reviews

Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2019/2020, 2020/2021

Learning from Child Death Reviews: Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2019/2020, 2020/2021 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, Acting Director of Public Health, Trafford Council, and STT CDOP Chair**
- **Eleanor Roaf, DPH Trafford, Trafford Council**
- **Shelley Birch, Child Death Overview Panel Manager (Tameside, Trafford and Stockport), Trafford Council.**
- **Eleanor Banister, Public Health Intelligence and Early Intervention and Prevention Lead, Public Health, Stockport Council**
- **Beenish Hanif, Public Health Intelligence Manager, Public Health, Trafford Council.**
- **Jacqui Dorman, Public Health Intelligence Manager, Policy, Performance and Intelligence, Tameside Council.**

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.

Due to the pandemic, we did not produce a report last year, and so this report, *Learning from Child Death Reviews; the Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2019-21*, covers two years, and 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 as we do not wish to add to anyone's grief.

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

3. What we know about the children who died and cases that were closed in 2019/2020 and 2020/21

Key points from data analysis:

- The panel received 79 notifications in 2019/21, bringing the 7 year total across STT to 347
- There is no clear trend towards a higher or lower notification rate, although the annual rate has fallen slightly over the last four years. The seven year average is 3.0 notifications per 10,000 population aged under 18.
- Infants aged under 1 year continue to make up the largest proportion of notifications (42 notifications or 53% of total).
- The factor of ethnicity is difficult to comment on as the recording of ethnicity in notified cases is not complete
- The notification rate is higher than average in children who live in areas of STT ranked in the most deprived 20% in England, but the gradient across deprivation quintiles is less clear.
- The number of cases closed by the panel in 2019/21 (67) was again lower than previous years.
- Two thirds(67.6%) of infants who died had a low birth weight; more than three-quarters of infants who died were premature (78.3)
- After perinatal/neonatal event (26.9%), the two most common categories of death were chromosomal, genetic and congenital anomalies (19.4%) and sudden unexpected and unexplained deaths (17.9%).
- Modifiable factors were identified in 35 (52%) closed cases. Smoking, substance misuse and co-sleeping were the most common factors recorded,
- Two-fifths (27 or 40%) of closed cases were expected deaths.

4. Recommendations

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 reduce the number of pregnant women, partners and household/family members 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.

VI. 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.
   c. Ensuring that young people and their parents are supported to reduce their drug or alcohol use
   d. Ensure all women are aware of the support in place to address domestic abuse

VII. 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.

VIII. Health and Wellbeing Boards to improve the outcomes for babies by taking actions to reduce the numbers and proportions of children who are born prematurely and / or with low birthweight:
   a. Reducing the number of women who smoke or use alcohol or other drugs in pregnancy (see above)
   b. Ensuring all women are supported to access high quality antenatal care from early in their pregnancies.
   c. Encourage only one embryo to be implanted in IVF procedures, to reduce the risks from multiple births
   d. 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, reduce her BMI.
   e. 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. This work should start in childhood, as we know that children who are overweight or obese are more likely to be obese/overweight as adults, and that achieving a healthy weight while still growing is easier than losing weight as an adult.

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Learning from Child Death Reviews

Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2019/2020, 2020/2021

1. Introduction

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This report, Learning *from Child Death Reviews; the Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel, 2019-21* describes why children who lived in Stockport, Tameside and Trafford died and presents eight recommendations from this learning.

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3. The Child Death Overview Process

The Stockport, Tameside and Trafford Child Death Overview Panel (STT CDOP) undertakes a review of all child deaths (excluding those babies who are still born, and planned terminations of pregnancy carried out within the law) up to the age of 18 years 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 reviews each case in a structured and consistent manner in line with Working Together, 2018[ii].

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

The pandemic has had an impact on every aspect of life and work. Before the pandemic the panel met quarterly and in person. During Spring and early Summer 2020, the panel was paused due to the significant pressure on services and panel members. Delays in case completion as the hospital had staffing issues and medical staff were moved to Covid wards. There were also delays in coronal processes which impacted on case information.

From January 2021 the panel moved to being virtual and met monthly to ensure that cases were reviewed at an appropriate time. This so far has been highly effective. It has supported attendance and engagement in case discussions.

During the pandemic the notification process was amended to ensure Covid was captured as the cause, or contributing factor a death.

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

4. Implementing Local Learning

A Strategic Child Death Group has 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. Due to the pandemic this Board has paused, however, it is planned to meet again in the new year.

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 2020, Stockport, Tameside and Trafford had an estimated combined population of 171,485 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 (2020)		Number	63,903	50,956	56,626	648,590	12,093,288
			% of Total (all ages)	21.7%	22.4%	23.8%	22.8%	21.4%
2	Proportion of 0-17 year olds belonging to Black & Minority Ethnic Groups (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) (2019/20)	Absolute	Number	6,859	8,941	5,051	123,529	1,685,298
			%	12.0%	19.5%	10.0%	21.2%	15.6%
		Relative	Number	8,407	11,064	6,230	151,064	2,065,267
			%	14.7%	24.2%	12.3%	26.0%	19.1%
5	Live births (2019)		Number	3,040	2,796	2,505	34,396	610,505
			Rate (per 1,000 females aged 15-44 years)	58.7	66.7	58.1	60.7	57.7
6	Low birth weight of term babies (2019)		Number	68	75	52	986	16,048
			%	2.5%	3.1%	2.3%	3.2%	2.9%
7	Infant mortality (2018-20)		Number	41	35	13	497	7,111
			Rate (per 1,000 live births)	4.3 (CI 3.1-5.9)	4.3 (CI 3.0-6.0)	1.7 (CI 0.9-3.0)	4.9 (CI 4.4-5.3)	3.9 (CI 3.8-4.0)
8	Child mortality 2018-20)		Number	19	17	14	249	3,627
			Rate (DSR per 100,000 population aged 1-17)	10.8 (CI 6.5-17.0)	12.4 (CI 7.2-19.9)	8.8 (CI 4.8-14.8)	13.7 (CI 12.1-15.6)	10.8 (CI 10.4-11.2)
9	Looked After Children (2020)		Number	370	705	380	5,980	80,080
			Rate (per 10,000 population aged 0-17)	58	139	67	93	67

Source: Maternal and Child Health Profiles (2021)[iii].

6. What we know from CDOP Notifications and Closed Cases, 2019/2020, 2020/2021

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 2019 and 31st March 2021.

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 2019/20 and 2020/21. 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 2019/20 and 2020/21. In many cases there is more than a year between notification and closure.

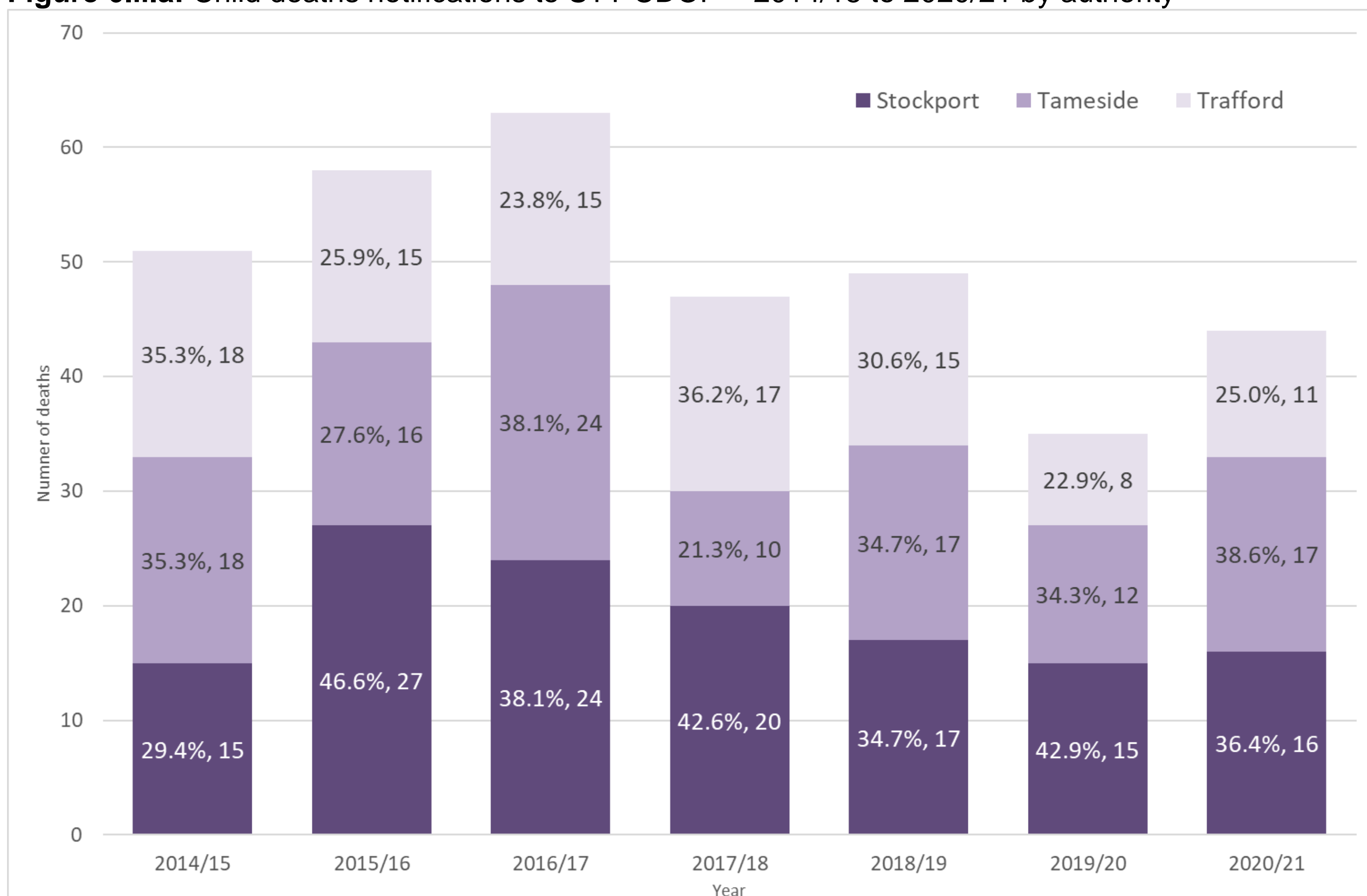
Therefore notifications show epidemiological pattern of deaths for the year under review, whereas closed cases provide intelligence about cases from a range of years.

6.ii. Demographic breakdown of notifications

6.ii.a. Number of notifications

The panel received 35 notifications in 2019/20 and 44 in 2020/21, both years lower then 2018/19 when 49 notifications were received. The split by local authority was 31 (39.2% of total) in Stockport, 29 (36.7%) in Tameside, and 19 (24.1%) in Trafford. The 2019/21 notifications bring the seven year total across STT since 2014/15 to 347. Aggregating the seven years gives a split by local authority of 38.6% (134) in Stockport, 32.9% (114) in Tameside, and 28.5% (99) in Trafford.

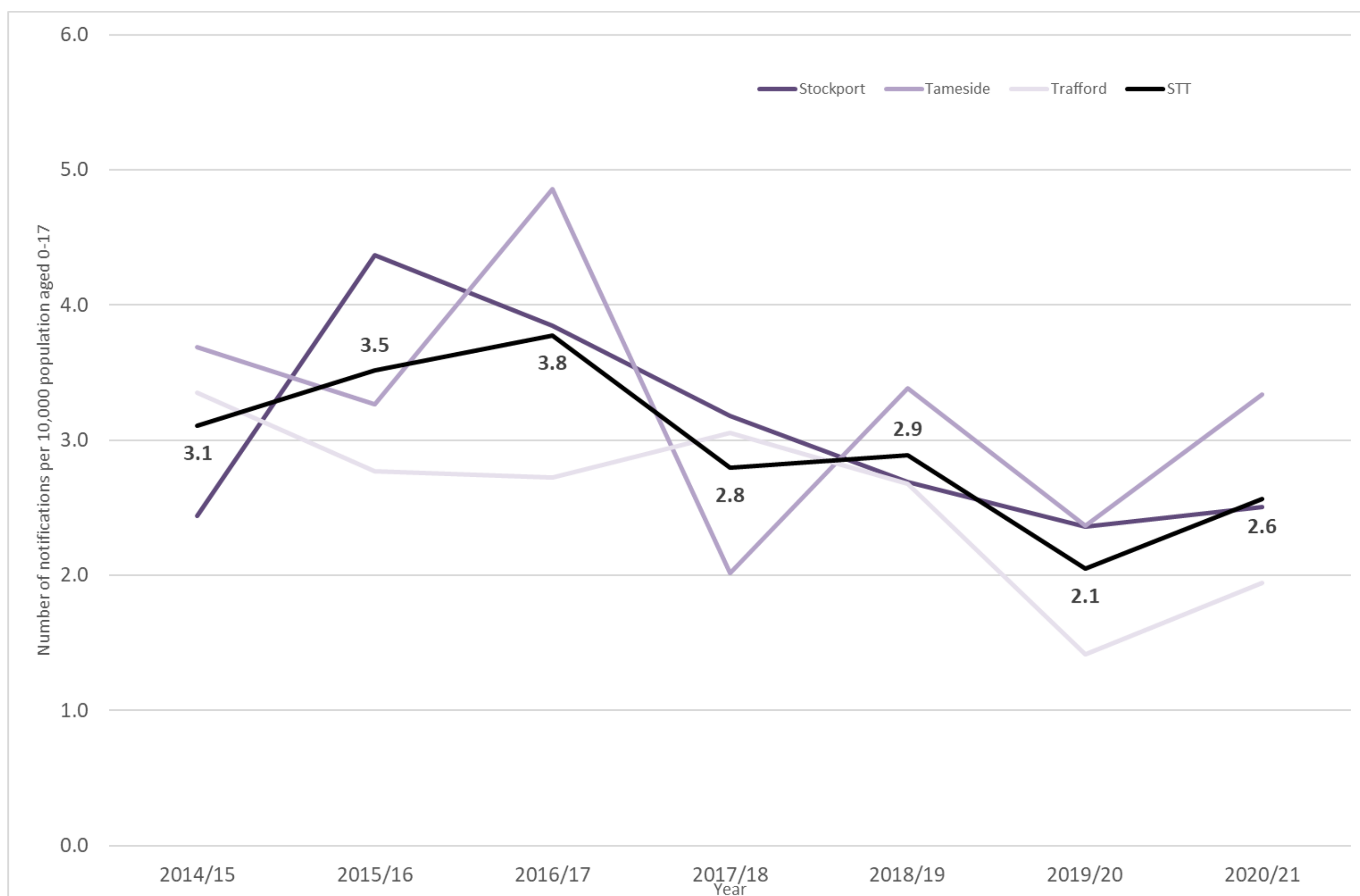
Figure 6.ii.a: Child deaths notifications to STT CDOP – 2014/15 to 2020/21 by authority



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 44 notifications in 2020/21 give a rate of 2.6 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. 2019/20 had the lowest level of notification at 2.1 per 10,000, but this is still within tolerance. The seven year aggregated notifications give a rate for STT of 3.0 per 10,000, which is similar in Stockport (3.1 per 10,000) and Tameside (3.3 per 10,000) but slightly lower in Trafford (2.6 per 10,000). It is worth noting that nationally, early indicators suggest that the child death rate dropped in the UK in 2020, especially for the under 10s, as children were at low risk from Covid, and were significantly less likely to die from infectious diseases, or underlying conditions [iv].

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

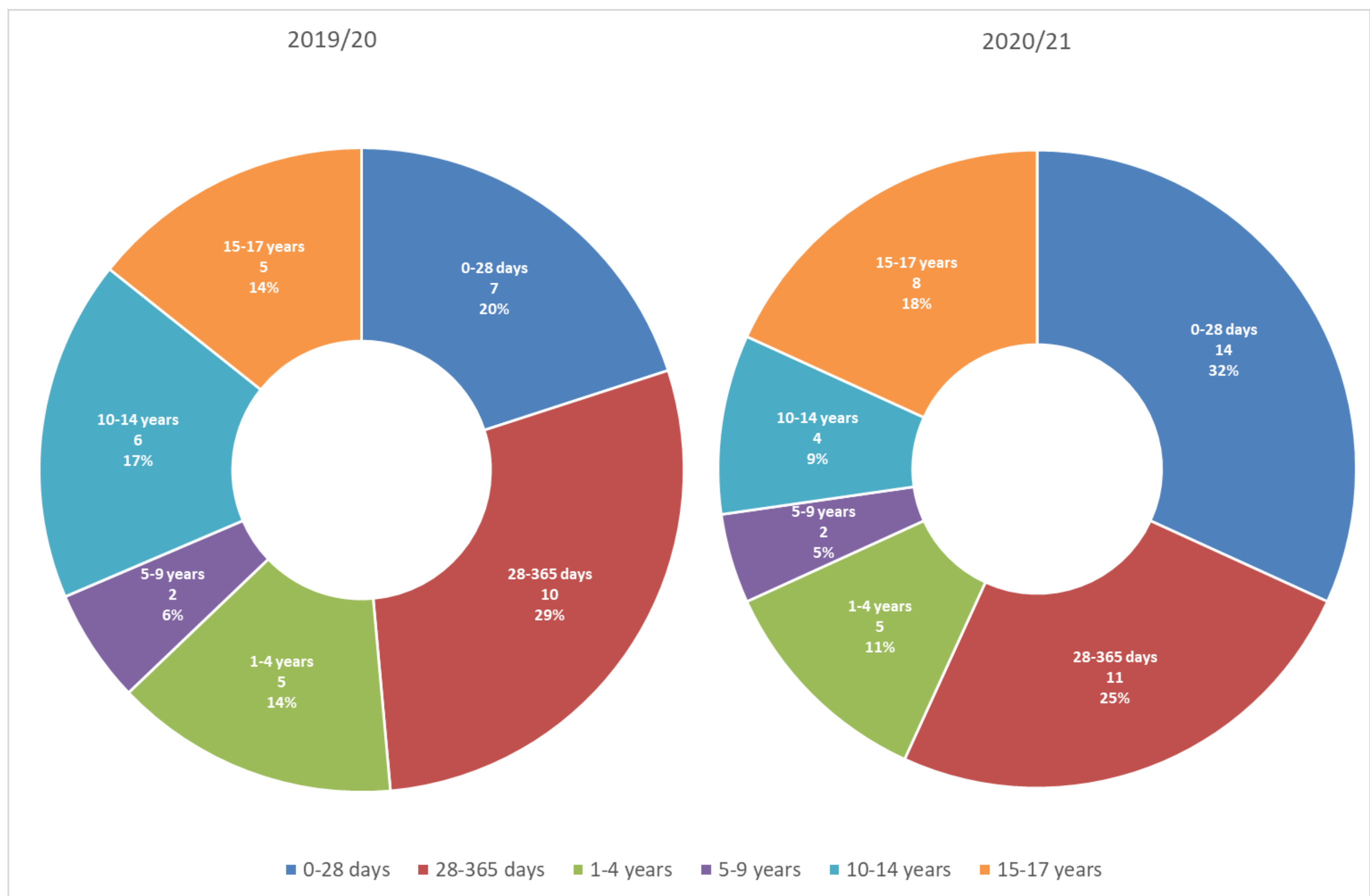


6.ii.c. Age breakdown of notifications

Of the 79 notifications in 2019/21, 21 (26.6%) were neonates (i.e. aged under 28 days) and 21 (26.6%) were aged between 28 days and 1 year. This means that over half (42 or 53.2%) 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 (38.7% compared to 26.6% for STT). This is a topic we will return to in the coming year, in order to establish any underlying causes of this.

Reviewing the 21 notifications of deaths of children aged over 1 year, at STT level the distribution across age groups was fairly even with 10 (12.7%) aged 1 to 4 years, 4 (5.1%) aged 5 to 9 years, 10 (12.7%) aged 10 to 14 years, and 13 (16,5%) aged 15 to 17 years. Any differences between the three authorities in this distribution are difficult to detect due to the small numbers involved.

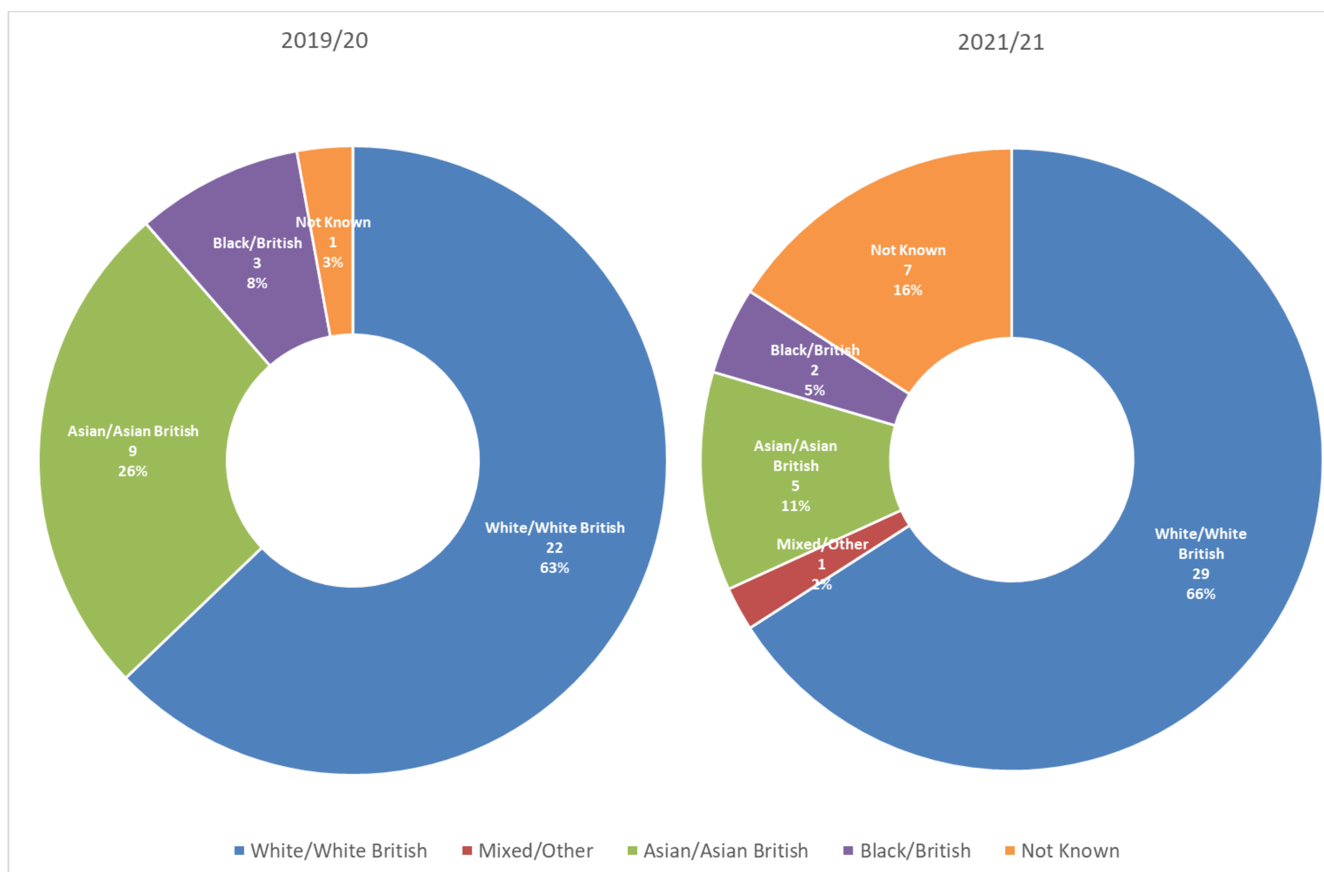
Figure 6.ii.c: Age breakdown of child death notifications



6.ii.d. Ethnicity breakdown of notifications

Of the 79 notifications during 2019/21, 20 (25.3%) 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%) given the small numbers involved. However, there are 8 notifications (10.1% of total) where ethnic group is not known (these are cases which are still open to CDOP pending further information). If, for instance, all these unknown cases were of non-White children then this would bring the proportion of deaths which were of non-White children to 35.4% which may suggest that these children are overrepresented among children who die. We need to improve our recording of ethnicity in order to better understand what, if any, impact it has on child death rates locally.

Figure 6.ii.d: Ethnic group breakdown of notifications

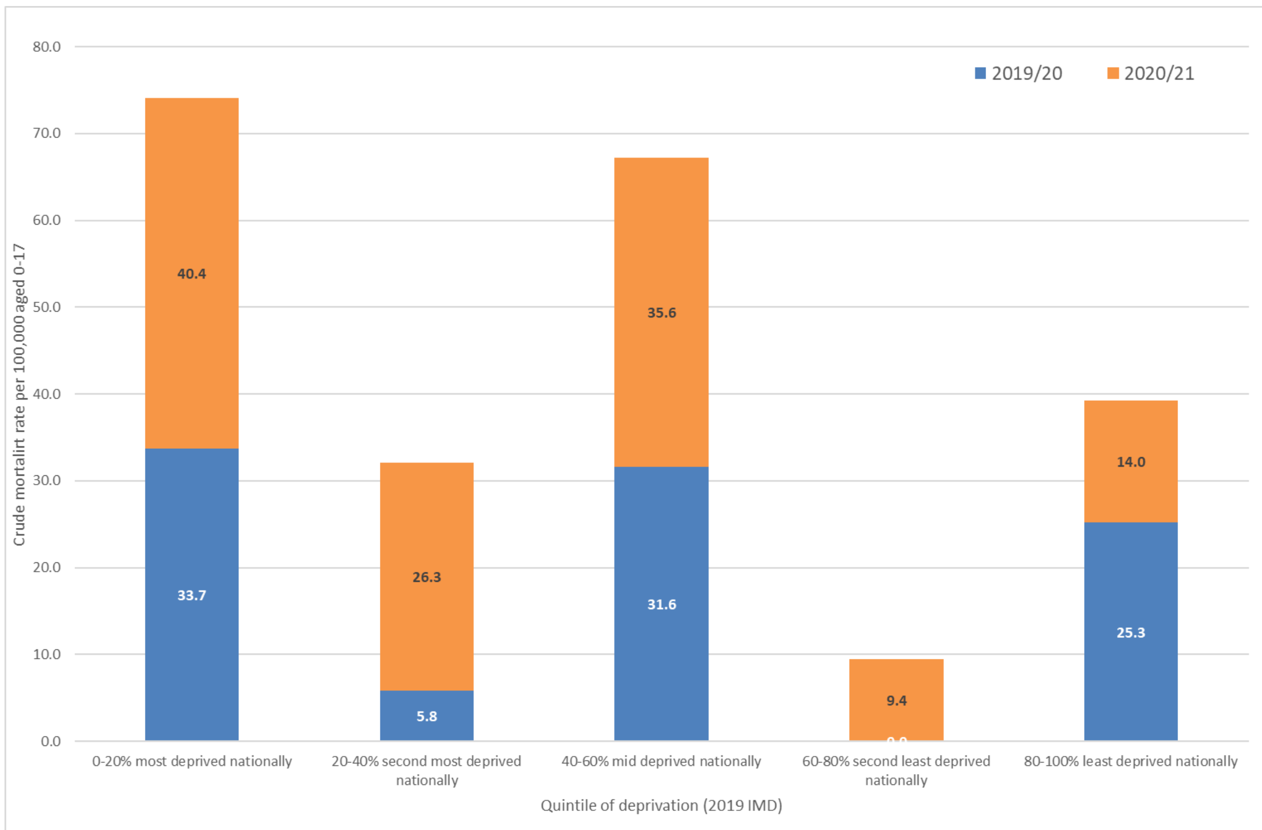


6.ii.e. Deprivation breakdown of notifications

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 79 notifications across STT, 33 (41.8%) were of children who lived in small areas which rank in the 20% most deprived in England, a crude rate over the two years of 74.,1 per 100,000 aged 0-17. Whether there is tendency towards higher child death notification rates in more deprived areas of STT in 2019/21 is unclear, partly because of the relatively small number of deaths involved. However, the crude rate in areas ranked in the 20% most deprived areas in England (74.1 per 100,000) is twice as high as in the least deprived 20% (39.3 per 10,000), but there is significant variation between the quintiles with the mid deprived quintile having a rate not much below that of the most deprived.

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



6.iii. Analysis of cases closed during 2019/20 and 2020/21

6.iii.a. Number of closed cases

In 2019/21, 67 cases were closed by the panel:

- 38 were closed in 2019/20 and 29 and 2020/21

- 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 27 (40.3%) in Stockport, 25 (37.3%) in Tameside and 15 (22.4%) in Trafford.

- Only 22 (14.9%) were notified to CDOP within the same financial year as they were closed.

- The average (mean) number of days from notification to close was 422.13, but varied by authority from 354.7 for Trafford cases, 389.9 for Stockport cases to 497.4 for Tameside 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 and multiple births

In 2019/20 24 (63.2%) of cases closed by the panel in were infants (age <1 year), in 2020/21 13 (44.8%) of cases closed by the panel in were infants (age <1 year), 37 in total .Among these:

- 16 (43.2%) had very low birthweight (<1,500g), and a further 9 (24.3%) had a low birthweight (1,500-2,499g); bringing the proportion with low birthweight to two-thirds (25 out of 37 or 67.6%). 11 had a birthweight above 2499g, 1 was unknown.
- In comparison in 2019,485 live births across STT were of low birthweight, which is 5.8% of the total live births. These figures are not directly comparable, but if we assume approximately 970 low birthweight births across two years in STT, 25 deaths gives a crude mortality rate of 2.5% for low weight births, and with an approximate 15,700 non-low weight births across two years in STT, 13 deaths gives a crude mortality rate of 0.1% for non-low weight births. While this analysis should be treated with caution due to the small numbers and the lack of definitional consistency, it is clear that having a low birthweight greatly increases the risk of a baby dying in their first year of life.

Of the babies who died within 12 months of their birth:
- 13 of the 16 babies (81.3%) with very low birthweight died within 28 days of their birth
- 2 of the 9 babies (22.2%) with low birthweight died within 28 days of their birth
- 4 of the 11 babies (36.3%) with birthweight >2499g died within 28 days of their birth
- All 16 babies with very low birthweight were premature (<37 weeks), with 14 being extremely premature (<30 weeks).
- 5 of the 9 babies with low birthweight were premature, none were extremely premature.
- 14 (37.8%) were extremely premature (<30 week), and a further 15 (40.5%) were premature (30-36 weeks); bringing the proportion who were premature to more than three-quarters (29 out of 37 or 78.3%). 8 (21.6%) were full term.
- In comparison in 2019 across the North West (figures are not available at local authority level routinely), 1.3% of live births were before 32 weeks gestation, 6.8% live births were

between 32 and 36 weeks gestation and 91.6% live births were over 37 weeks gestation. Prematurity therefore adds greatly to the risk of a baby dying in its first year of life.

- 12 of the 14 babies (85.7%) who were extremely premature died within 28 days of their birth
- 5 of the 15 babies (33.3%) who were premature died within 28 days of their birth
- 4 of the 11 babies (25.0%) who were full term died within 28 days of their birth
- 10 (27.0%) were multiple births (1 triplet, 9 twins – 2 from the same pregnancy and 7 single twins).
- In comparison across England and Wales, 3.0% of maternities resulting in a live birth were twins and 0.1% of maternities resulting in a live birth were triplets or higher multiples.
- 8 (80%) of the multiple births died within 28 days of their birth, and all these 8 were extremely premature and had a very low birthweight
- Of the other 2 multiple births, one was premature with a low birthweight and one was full terms with a birthweight >2499g, both of these deaths were a sudden infant death,

Overall, therefore, prematurity, low birthweight, and being one of a multiple birth all increase the risks of a baby dying in its first year of life. These factors are clearly not independent of each other but any steps that can be taken to reduce the risk of any of these three factors being present will help reduce our infant mortality rate and the impact of a baby's death on families in our boroughs.

6.iii.c Place of death of closed cases

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

Table 6.iii.c: Place of death for deaths < 1 year in 2019/20 and 2020/21

Hospital of death	**All STT**
St Marys Hospital	10
Tameside Hospital	10
Stepping Hill Hospital	7
Wythenshawe Hospital	5
Other (1 each)	3
Unknown	2
Total	**37**

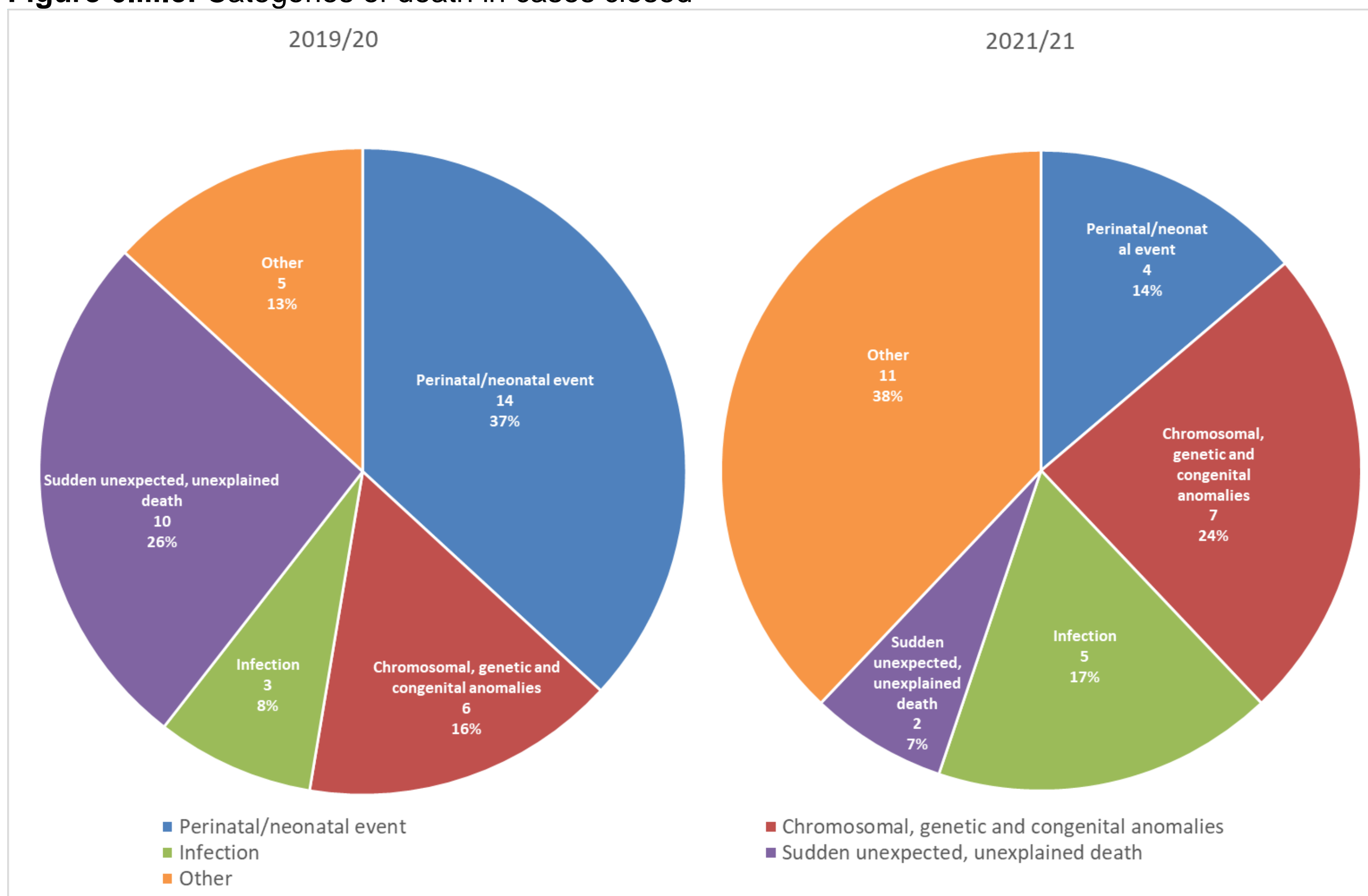
6.iii.c. Categories of death

In line with previous years, in 2019/20 the category of perinatal/neonatal event makes up the largest category of death with 14/38 (37%) closed cases, followed by 10 (26%) sudden unexpected and unexplained deaths at and 6 (16%) of children who died had chromosomal, genetic and congenital anomalies.

The 17 closed cases of children aged over 1 year were spread across a range of categories, the majority (9 or 90%) of the sudden unexpected and unexplained deaths were aged under a year.

In 2020/21 the other category was the most common cause (11/29 or 38%) covering a range of chronic medical conditions, acute medical condition and external causes of injury. Chromosomal, genetic and congenital anomalies accounted for 7 (24%) of cases, followed by infections (5 or 17%). No records mentioned COVID-19 coronavirus as a contributory factor.

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



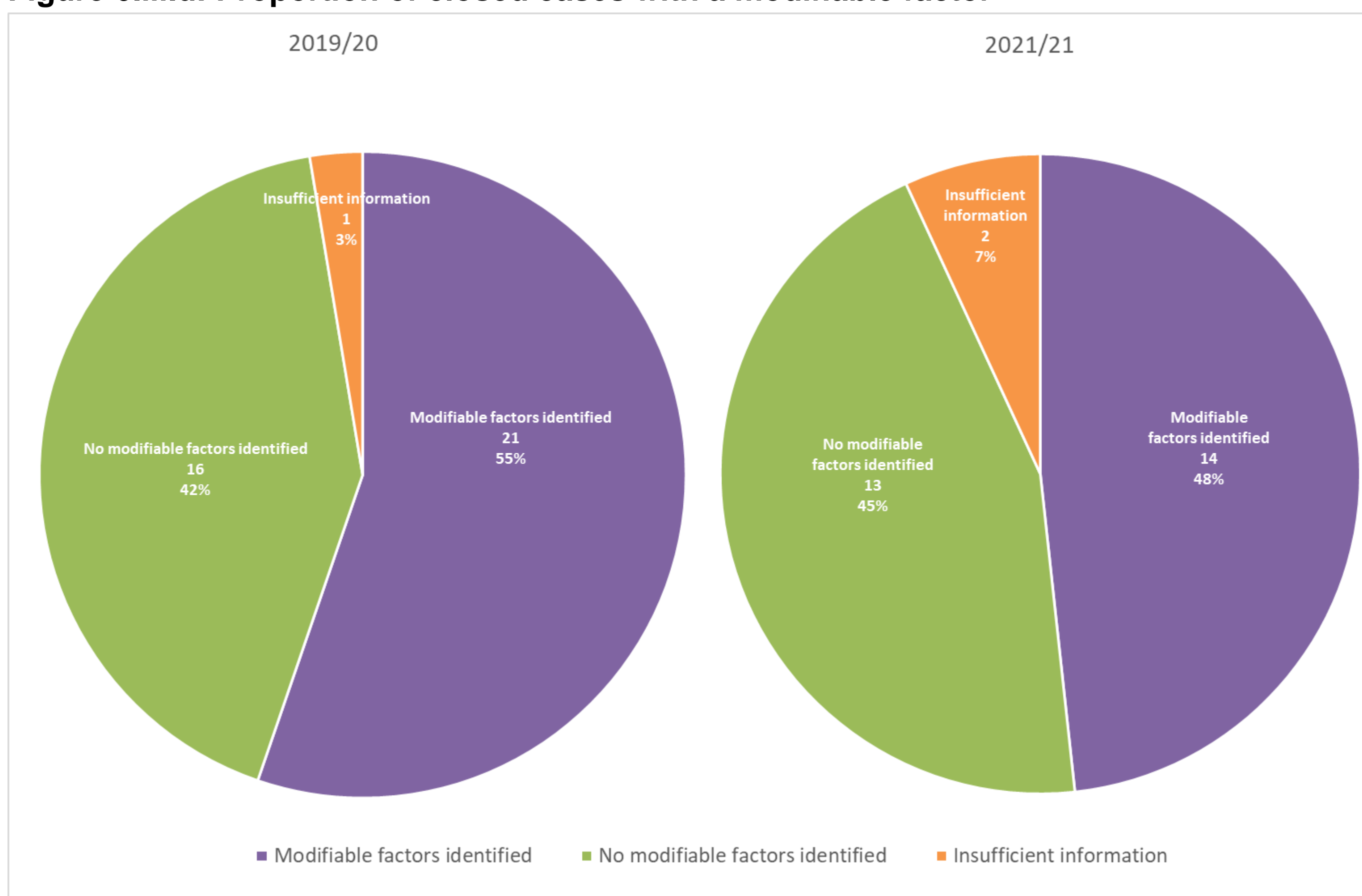
6.iii.d. Modifiable factors

Modifiable factors were identified in 21(55%) of closed cases in 2019/20 and 14 (48%) of cases in 2020/21.

Present modifiable factors included:

- Parental smoking (mentioned in 14 cases)
- Substance misuse (mentioned in 10 cases)
- Co-sleeping (mentioned in 6 cases)
- Domestic violence (mentioned in 5 cases)
- High maternal BMI (mentioned in 4 cases)
- Maternal mental health (mentioned in 3 cases)
- Neglect (mentioned in 2 cases)
- Missing / not attending appointments (mentioned in 2 cases)
- Monitoring of IVF / assisted pregnancy (mentioned in 23 cade)
- Other factors with one mention each:
    - Lack of safety device on blind
    - Being a young carer
    - Presence of play equipment
    - Overheating
    - Gang culture.

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



6.iii.e. Expected deaths

Around two fifths (16 or 42% in 2019/20 and 11 or 38% in 2020.21) of closed cases across STT were deaths which were expected. At local authority level, the proportion expected was higher in Trafford (53%), average in Stockport (44%) and lower in Tameside (28%), 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

7. Recommendations

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 reduce the number of pregnant women, partners and household/family members 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.

VI. 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.
   c. Ensuring that young people and their parents are supported to reduce their drug or alcohol use
   d. Ensure all women are aware of the support in place to address domestic abuse

VII. 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.

VIII. Health and Wellbeing Boards to improve the outcomes for babies by taking actions to reduce the numbers and proportions of children who are born prematurely and / or with low birthweight:
   a. Reducing the number of women who smoke or use alcohol or other drugs in pregnancy (see above)
   b. Ensuring all women are supported to access high quality antenatal care from early in their pregnancies.
   c. Encourage only one embryo to be implanted in IVF procedures, to reduce the risks from multiple births
   d. 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, reduce her BMI.
   e. 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. This work should start in childhood, as we know that children who are overweight or obese are more likely to be obese/overweight as adults, and that achieving a healthy weight while still growing is easier than losing weight as an adult.

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 2021/22 Annual Report cycle.

9. Summary

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

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

Appendix A: CDOP Responsibilities and Operational Arrangements[v]

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.

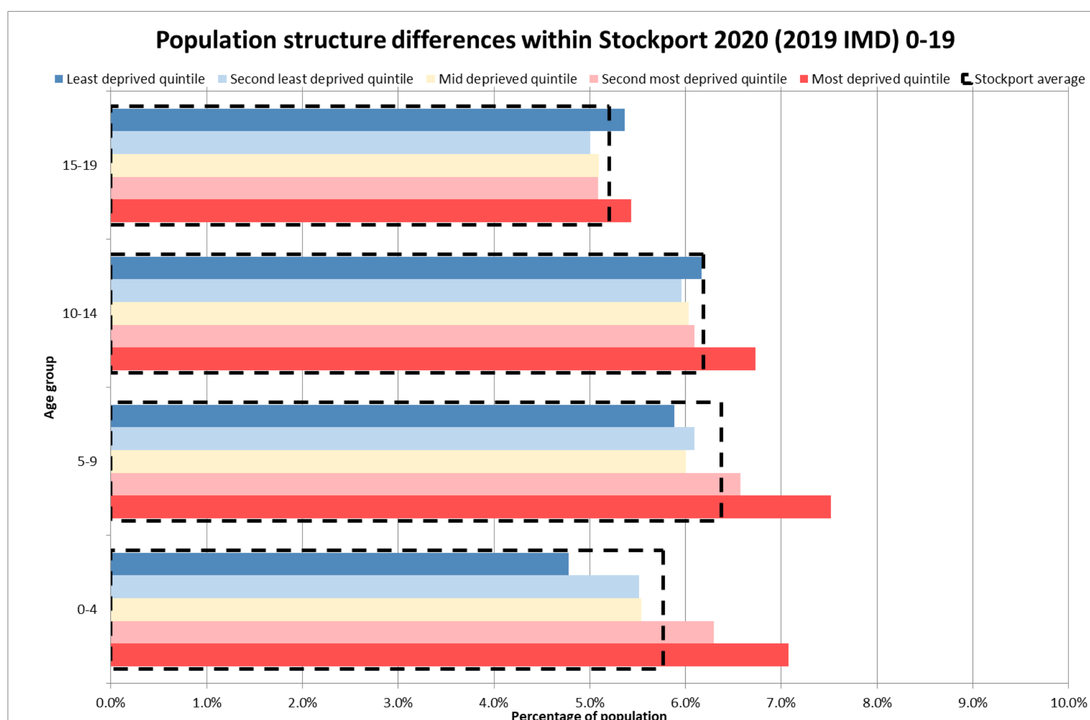
The full description of local CDOP arrangements for Stockport, Tameside and Trafford can be found here:
www.traffordccg.nhs.uk/docs/Publications/STT-CDOP-implementation-plan-June-2019.pdf

Appendix B: Borough Child Profiles

i: Stockport

There are 63,900 children and young people aged 0-17 living in Stockport (ONS Mid-Year Estimate 2020), a population that is growing slightly – up 3.3% since 2015. Due to fluctuations in birth rates there are more children per year aged 4-11 years (around 3,700) than aged 0-1 (3,200) 2-3 and 15-17 years (3,400). Births reached their lowest level in 2001-2003, at less than 3,000 per year, and then rose to a high in 2012 (3,500), since when numbers have started to fall again, reaching 3,100 by 2020, following the well-known cyclical trend.

Fertility rates are highest in the most deprived areas of Stockport, currently 39% 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 Asian, and 5 % as other. Stockport's BAME population is not evenly distributed, and is largest 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
- One Stockport Borough Plan https://www.onestockport.co.uk/the-stockport-borough-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. This is under review and a new One Stockport Health and Care Plan will be published soon.
- Stockport Family: https://www.stockport.gov.uk/topic/stockport-family
- CDOP https://www.stockport.gov.uk/health-and-wellbeing-board/stockport-child-death-overview-panel-statutory-responsibilities

ii: Tameside

The resident mid-year population estimate (2020) was 227,117 residents. 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%.

Deprivation is higher in Tameside with approximately 11,064 (24.2%) children under 16 years living in relative poverty, and 8,941 (19.5%) children living in absolute poverty which is based on whether households have less than 60% of the current median household income to live on after housing costs. (2019/20)

In 2020/21 there were 2,765 babies born in Tameside; 27% of babies were born in the most deprived decile. 5% of babies were born with a low birth weight under 2500 grams, with less than 0.5% being of very low birth weight (<1500 grams). The highest proportion of births were born to mothers aged 25-34 years (55%). 1% of babies were born to women under 18 years and 17% to women over the age of 35 years.

Health, wellbeing and social outcomes are generally worse in Tameside than the England average. However levels of smoking in pregnancy have reduced significantly in recent years to 10.2% (2021) of pregnant women still smoking at time of delivery, similar to the England average. Levels of breast feeding initiation and at 6 to 8 weeks is still significantly lower than the England average.

Population vaccination coverage for 2 year olds across all vaccines has reduced in the last few years and we are now similar to the England average for MMR vaccination rates (94% coverage) but have a higher rate for Dtap/IPV/Hib (96% coverage).

A&E attendances for 0-4 year olds in Tameside are significantly higher than the England average. Hospital admissions for asthma in children and young people under 19 years is currently the highest in England at 405/100,000

Prevalence of obesity in reception (12%) and year 6 children (21%) is significantly higher than the England average and 33% of five year olds experience visually obvious tooth decay

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.

More information can be found here: Child & Maternal health profiles

iii: Trafford

An estimated 59,378 under 18s live in Trafford i.e. about 1 in 4 (24%) of the total population (proportionally slightly higher than England at 22%) *(ONS, Mid-2020 estimates).*

Between 2010 and 2020, Trafford's under-18 population grew by almost 5,350 or 10%, 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 2010 and 2020).* Over the next 10 years, however, growth in this age group is projected to slow to 219 or 0.4% between 2020 and 2030; this is driven by strong growth in the 15-18 year age group, against a decline in those aged under 14 *(ONS, 2020-based subnational population projections).*

In 2020 there were 2,326 live births to mother's resident in Trafford. This is 7% lower than in 2013 when there were 2,817 live births. Trafford's fertility rate (54 live births per 1,000 females aged 15 to 44) is slightly lower than, England (55.3 per 1000) *(ONS, 2020)*and fertility rates tend to be higher in areas of Trafford with 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, (2021) Maternal and Child Health Profiles, *https://fingertips.phe.org.uk/profile/child-health-profiles*.
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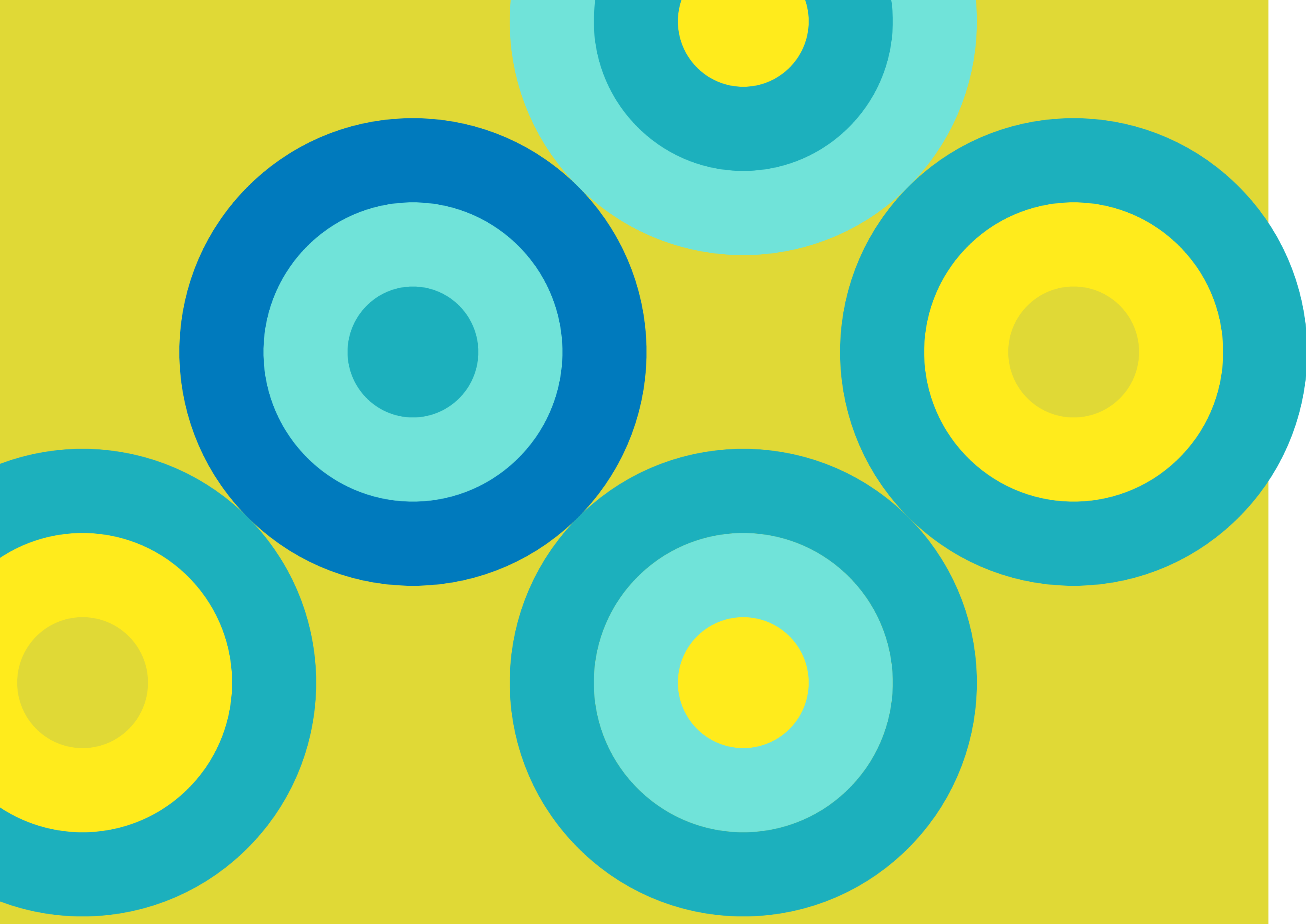
[v] HM Government, (2018), *Child Death Review Statutory and Operational Guidance*.

TRAFFORD COUNCIL

The Costs and Harms caused by Inequality

Trafford
Public Health
Annual Report 2021



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Foreword

Everyone will be only too well aware that we have had another difficult year, with the pandemic still having a major impact on us all. This impact continues to be unevenly felt, demonstrating vividly how poverty and inequality cause harm. People living in low quality or over crowded housing or who are in low waged or insecure employment continue to be disproportionately affected, and we need to work harder to reduce inequalities in the borough.

On top of this, we are starting to see the impact of climate change: we have had a number of significant weather events such as storms and flooding, and there is no sign of this abating. While the most dramatic climate change is showing itself in the Global South, we need to be under no illusion that we will be exempt. This year we came very close to a major flooding of homes, as well as seeing Trafford General Hospital hit by lightning. We need to ensure that our Carbon Neutral Action Plan will deliver the required carbon reductions and at pace.

On a positive note: we are looking forward to the introduction of the Clean Air Zone across Greater Manchester in 2022, which will make a fantastic contribution to the health of our population. Furthermore, Trafford's recently launched Poverty Truth Commission will bring together people in poverty and local leaders to explore creative ways to tackle poverty across the borough. We need to celebrate the changes that we are making, and work together to describe and deliver a more equal and sustainable Trafford, meeting the needs of all.

Eleanor Roaf
Director of Public Health

Helen Gollins
Acting Director of Public Health

Cllr Jane Slater
Executive Lead for Health and Welllbeing

Introduction

Last year, Trafford's Public Health Annual Report was on Covid: our experiences in Trafford and the learning that we gained. Much of this focussed on how Covid highlighted and exacerbated existing inequalities, and the consequent need for a whole system response to reduce inequality in order to improve health.

This year, as a Public Health team, we have continued to spend much of our time responding to the pandemic, but we are also, like all other Public Health teams in England, involved in the system redesign occasioned by the changes to Public Health England and to Clinical Commissioning Groups (CCGs). Major structural change gives opportunities but also can be distracting, and it feels timely to use this year's Public Health Annual Report (PHAR) to focus back on inequality, and the costs and damage that it causes. Too much time was spent last year describing *'health'* and *'the economy'* as if they are in opposition to each other. This misses the critical point that without good health in our population we cannot achieve a healthy economy.

The other learning from the pandemic is that we have shown we can achieve major behavioural change at pace and across the whole population. Some of these changes have been positive, some negative and many mixed, but the recent Intergovernmental Panel on Climate Change (IPCC) report[1] demonstrates that we in the Global North cannot return to our old habits of over-consumption if we are to avert the disaster that climate change will bring. Carbon reduction was a topic explored in the 2019 PHAR and achieving this is more necessary than ever.

Both climate change and health inequalities are complex issues requiring concerted action and bravery if we are to make the changes that will reduce the risks each poses. We rarely find anyone who disagrees that prevention is better than cure, but translating that into doing things differently requires a shift of mind-set, habits and resources and we need to take those harder steps both in our lives and our work.

The aim of this year's report, therefore, is to bring together the evidence for the benefits to our health and our economy of working together to create a more sustainable and equal society in Trafford, in the hope that this will encourage us all to support and implement the necessary changes for a healthy and resilient life.

Both climate change and health inequalities are complex issues requiring concerted action and bravery if we are to make the changes that will reduce the risks each poses.

Chapter 1

What are the costs of inequality, and whom does it harm?

Defining Health Inequalities:

Our health is influenced by a combination of 'fixed' and 'modifiable' factors[2]. Fixed factors are hard for us to alter and include biological factors such as age, sex, and genetic factors. In contrast, modifiable factors can be changed. They include individual behaviour (e.g. diet, physical exercise, smoking, drinking), living environment (e.g. housing quality, air pollution, access to clean water and sanitation) and the healthcare available (e.g. access to vaccinations, specialist hospitals, the doctor to patient ratio)[3]. Of course, both fixed and modifiable factors also interact with each other, and this can increase or decrease an individual's risk of a poor outcome[4].

Health care provision is often mistakenly considered to have the greatest influence on our health[5]. However, it is factors such as where we are born, grow, live, and age, our education and income levels, our living environment, genetics, and our networks of relationships in the society that overall have the most impact on our health[6]. These wider determinants of health affect our behaviour, and can have an impact on our ability and our attitude to accessing services, as well as to likelihood that we will take up habits such as smoking[7]. These lead to avoidable differences in health between different groups in a society: such differences are defined as health inequalities[8].

Impact of Health Inequalities:

Inequality has been shown to lead to many negative outcomes: higher rates of ill-health, shorter life expectancy, higher infant mortality, lack of community cohesion, violence, drug problems, obesity, mental health problems, long working hours, and large prison populations.[9]

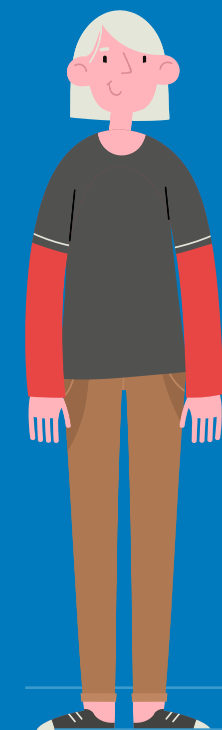
Reducing health inequality is not only about reducing the number of people who live in poverty. Poverty is linked to poor health, but raised levels of inequality negatively affect the health of even the affluent, mainly because inequality reduces social cohesion, a dynamic that leads to more stress, fear, and insecurity for everyone[10, 11]. People live longer[12, 13] in nations with lower levels of inequality, and countries with higher levels of inequality also have worse mental health: for example, a higher risk of schizophrenia[14] and a lower sense of personal well-being[15]. Addressing health inequalities bring benefits to us all, and we need to guard against considering that all interventions and behaviour change should focus on our more deprived populations. For example, when we look at the immediate and long-term health and other threats from climate change, it is our more affluent populations that have the highest carbon footprints and therefore need to change the most.

What is causing our health inequalities in Trafford?

As we emerge from the pandemic, we need to refocus on those risk factors that contribute to inequalities in either healthy life expectancy or life expectancy. Healthy life expectancy is defined as the number of years a person may expect to live in good health, while life expectancy is the total number of years a person is predicted to live. There are large social, financial and emotional costs to individuals, families and society when there is a large gap between the two. Within Trafford, we know that some of the biggest impacts will be made by reducing smoking, alcohol use, physical inactivity, and obesity and by improving mental health amongst the population[16]. In Trafford, diseases associated with these risk factors contribute to most of the difference (76.9% in men and 73.6% women aged 40-79 years old) in life expectancy between the top and bottom quintile, that is, between the twenty percent most deprived and twenty percent least deprived of the population[17].

Reducing these inequalities across Trafford will improve quality of life, reduce service demand, improve health outcomes, and create a fairer, healthy, economically flourishing environment. Our Health and Wellbeing Strategy has been designed to deliver this, and our emerging One System Board shares these same goals. Achieving these goals is urgent. It has got a lot harder for many people to stay physically and mentally healthy during the pandemic. As an example, deaths that can be directly attributable to alcohol misuse went up by 18.6% in the UK in 2020[18]. We need to understand whether these changes will remain as life returns to normal, and to consider how to tackle them if so.

Reducing these inequalities across Trafford will improve quality of life, reduce service demand, improve health outcomes, and create a fairer, healthy, economically flourishing environment.



Chapter 2

Key issues in Trafford

Deprivation

Trafford is arranged into 5 Primary Care Networks (PCNs). Across the five networks the levels of deprivation vary with the North and West more deprived than Sale Central, South or Altrincham Health Alliance. This is illustrated by the map below. People who live in the most deprived areas tend to have a lower healthy life expectancy than those living in the least deprived areas, with those in the most deprived areas more at risk of certain health conditions. These inequalities are largely preventable. More information on to this can be found within our Joint Strategic Needs Assessment: http://www.traffordjsna.org.uk/About-Trafford/Key-demographics/Deprivation.aspx

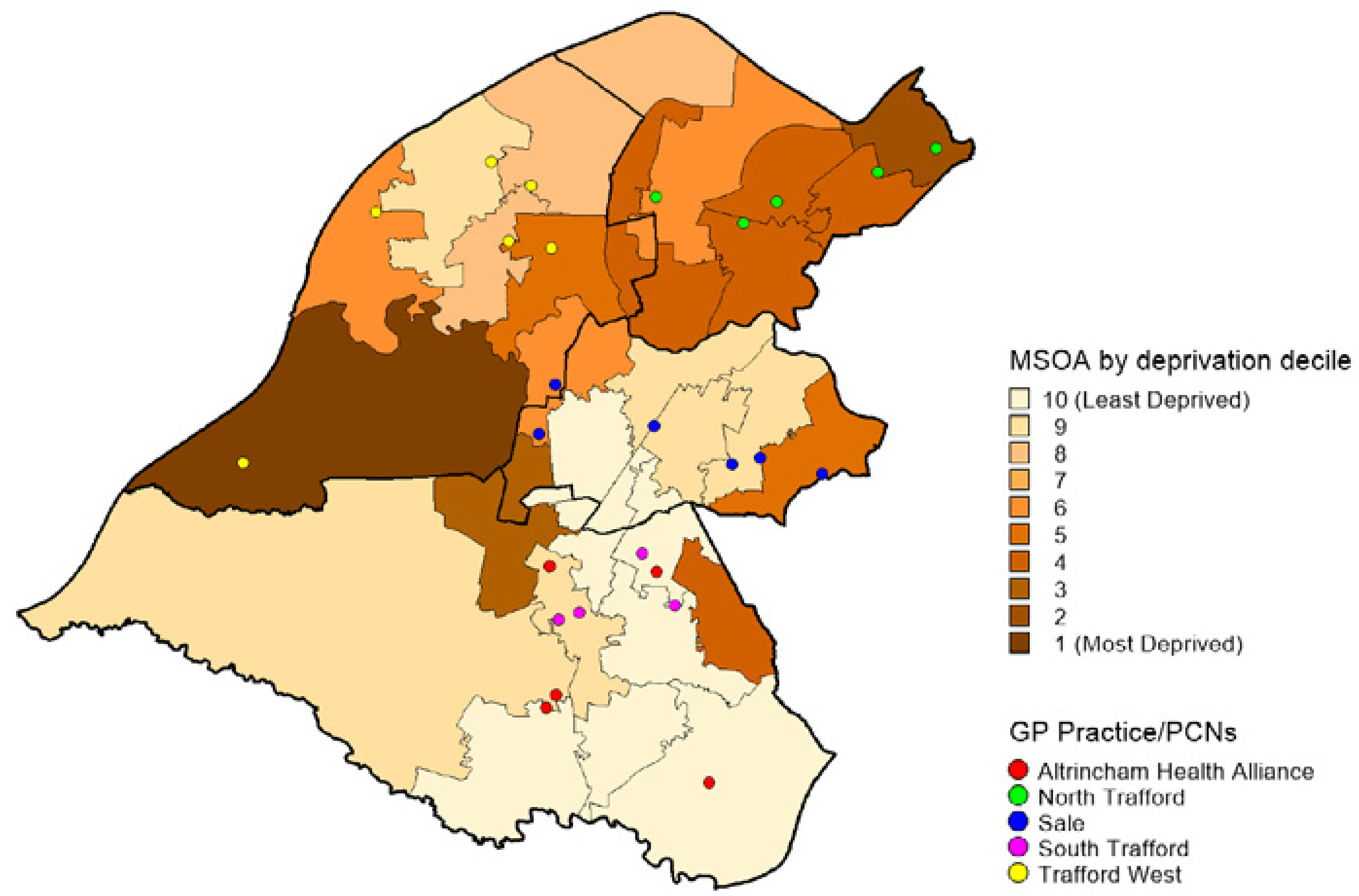


Figure 1: Middle Layer Super Output Areas in Trafford illustrating deprivation and Primary Care Network. These super output areas each have a similar size population.

Cardio-vascular disease (CVD) deaths – By calculating a standardised mortality ratio (SMR) we can compare the rates we see locally with the numbers we would expect to see compared to the general population. An SMR over 100 shows that our death rate is higher than the expected number, and an SMR below 100 means they are lower. In Trafford, the SMR for CVD deaths for men aged under 75 has increased to 108 in 2020 compared to 99.6 in 2018. Amongst women aged under 75 there has been a small increase from 38.6 in 2018 to 42.5 in 2020. Overall, the risk of dying from CVD has increased in both men and women in Trafford.

Cancer deaths – The average SMR of cancer deaths in Trafford was 96.4 between 2015 and 2019, which is slightly below the England average. However, there are differences between the different wards in Trafford. Figure 1 below shows that people in the most deprived wards are more likely to die from cancer than those in the least deprived wards. For example, Timperley, which is the least deprived ward has a Standardised Mortality Ratio (SMR) of 78.8, whereas Gorse Hill has an SMR of 143.0, almost double the risk.

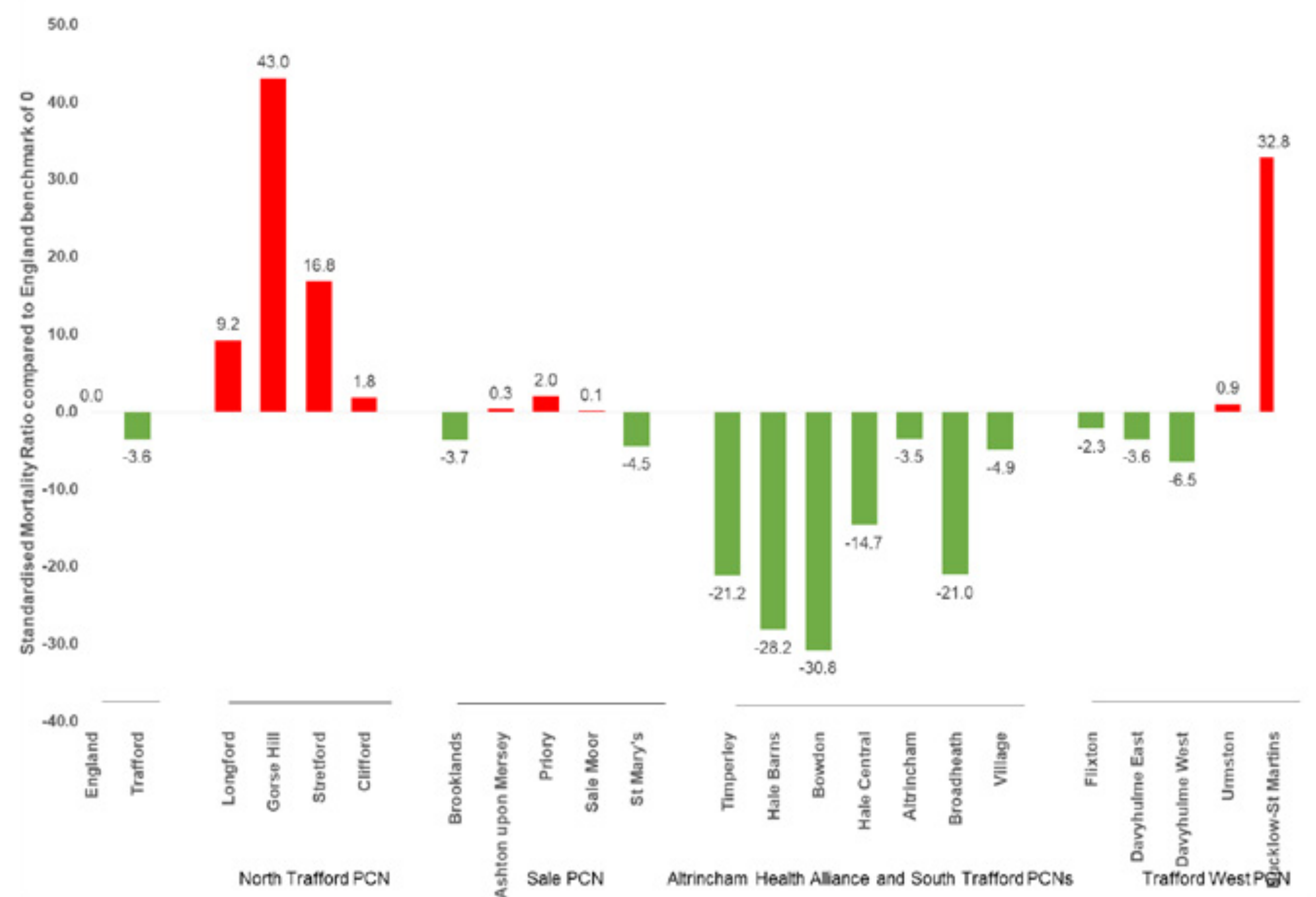


Figure 2: Standardised Mortality Ratio of Cancer deaths, all ages. Compared to the England average (100), at ward level, grouped by Primary Care Network

Diabetes

The data below in Figure 3 show that diabetes is also more prevalent in the most deprived areas of Trafford.

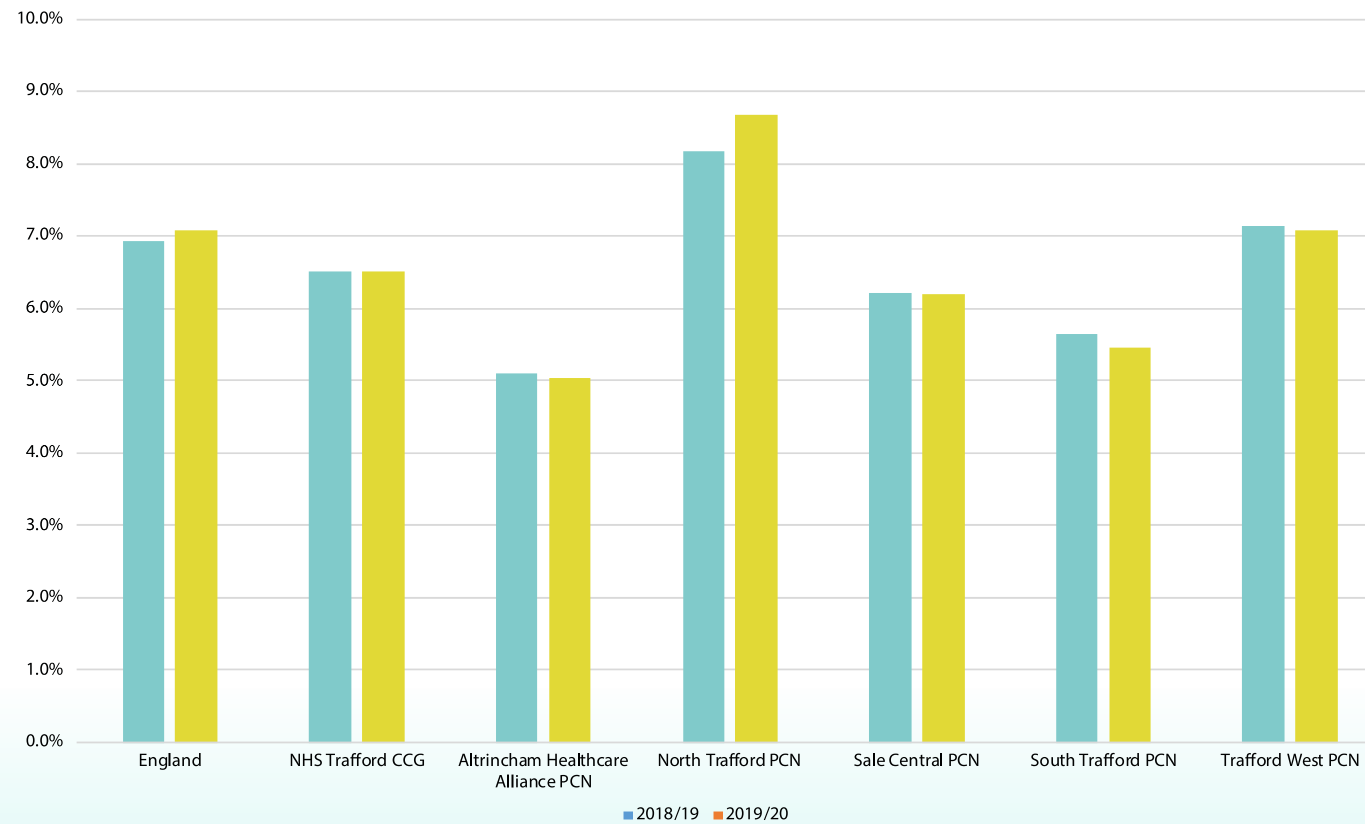


Figure 3: Diabetes prevalence for those aged 17+ according to PCN, Trafford CCG or England average.

Chapter 3

Designing and delivering health and social care in Trafford

Neighbourhood working

As the health and social care system transitions into an Integrated Care System it is important that we take this opportunity to improve our relationship with residents, partners and stakeholders across Trafford, because it is only through working together that we can create healthier, more equal communities and tackle issues such as obesity, physical inactivity and other risk factors contributing towards cancer, diabetes and cardiovascular disease.

Role of the One System Board

Our emerging One System Board includes leaders from key health and social care organisations, charged with ensuring our services can prevent and respond to our many challenging issues. It will make collective decisions on services to be provided using population benefits rather than the benefits to a particular provider. Its aim is to work towards a model of care which is closer to home and co-produced with citizens, staff and partners. It will prioritise its resources on tackling inequalities by focusing on the wider determinants of health, taking action to prevent ill health, and working on improving access to effective treatment, care and support. This way of working will be critical if we are to reduce risks such as physical inactivity, smoking, or obesity and as a consequence, deaths from cancer, cardiovascular disease and diabetes. We need to ensure that the One System Board is held to account for the delivery of prevention targets as well as delivery of treatment services, as traditionally resources for prevention have often been sacrificed in order to deliver immediate care needs. This adds system costs and reinforces inequality, and makes our health and social care system unsustainable even in the short term, as Covid is demonstrating. What is more, we will need to ensure that sufficient resources are directed to the voluntary, community, faith and social enterprise (VCFSE) sector to make co-production and engagement reality rather than rhetoric.

Preventing and tackling long term conditions

When we look at increasing healthy life expectancy, we often start by considering how we prevent people from developing long term health conditions (LTCs). LTCs are conditions for which there is currently no cure, and which are managed with drugs or other treatment. As people get older, the chances of having a long-term condition such as high blood pressure or diabetes increases. Being from a lower income group increases the chances of LTC[19] and therefore, preventing and tackling LTCs helps reduce inequality.

In this report, we will look at how we are tackling obesity and diabetes, which are both strongly linked to an increased risk of cardiovascular disease and cancer [20 21] but in many cases can be prevented. Other risk factors that affect the quality and length of life are also discussed in the Joint Strategic Needs Assessment (referenced above).

We also need to reflect on the impact of the pandemic. Covid has had a big impact on people with long term conditions (LTCs) in two different ways: they are more likely to be severely ill if they catch Covid, and there has been a reduction in the availability of prevention and treatment services during the pandemic. While the NHS was focused entirely on treating people with Covid, there were many people whose regular treatment was disrupted, and in some cases stopped altogether.

This was not just confined to hospital treatment, as many local staff were re-deployed onto the 'Covid frontline' leading to the suspension of community services, including key preventative programmes such as NHS health checks. In addition, the 'Protect the NHS' messaging meant that many people did not seek medical advice where they might normally have done, including avoiding participating in regular long term condition reviews within primary care[22].

As part of the local recovery plan Trafford CCG has identified five priority long term conditions (asthma, diabetes, depression, hypertension and obesity) as ones where our outcomes for patients could be improved. Work is now underway to improve prevention and treatment of these to reduce health inequalities across Trafford and improve quality of life as well as life expectancy. These areas map well to the Health and Well Being Board strategy, as maintaining a healthy weight and being physically active reduces asthma, diabetes, hypertension and (obviously) obesity risk. These conditions are also ones where a combination of pharmaceutical and non-pharmaceutical interventions give the best outcomes, and improving people's mental health is key to delivering long term behaviour change.

Chapter 4

Getting it right from the start

This year has provided many challenges for parents and children under five, with the restrictions in place to limit the spread of Covid meaning both parents and children have missed out. Most parents of babies and young children have not been able to access professional, peer, friends and family support in person and the opportunities for babies and toddlers to interact and develop socially and emotionally have been curtailed. Moreover, parents who are younger, have a lower income or are from a Black, Asian or Minority Ethnic (BAME) background are likely to have had an even more difficult time and have found it more difficult to access services that they need[23]. While life is now returning to normal, we do not know what the consequences of this disrupted early start will be, and what we may need to put in place to compensate.

Breastfeeding

One key indicator for children is the percentage of children being breastfed at 6-8 weeks of age. There are proven benefits from breastfeeding, for the baby and the mother[24]. It can help reduce the risk of obesity and cardiovascular disease,[25] improve the emotional bond between the mother and child [26], and can also help with brain development [27]. Despite this, the UK has some of the lowest rates of breastfeeding in the Global North.

Breastfeeding rates are influenced by a number of factors including deprivation and ethnicity, with white women, and women from more deprived areas, less likely to breastfeed. In Trafford in 2018/19, breastfeeding prevalence at 6-8 weeks ranged from 49% in West to 61% in the North and 69% in South[28]. The West and North are more deprived than the South, but the West, while less deprived than the North, has a larger white population, which may help explain its lower rates[29].

Breastfeeding rates have been increasing in every area except the South since 2018/19 Despite this there is still a gap between the South at 69% and the West at 56%[30] although it is promising that the gap has narrowed.

We therefore need to:

- Work with our health visitors and others to ensure that all our parents/carers, babies and toddlers have access to the right level of support, no matter their background, with a strong universal offer as well as focussed resources on those who need it most.
- Support mothers to breastfeed their children to ensure children have the best chance of benefitting from the huge range of advantages of breastmilk brings.

Children

Covid 19 has had a huge impact on our daily lives, and this has been felt by everyone, whatever their age. Children's education has been hugely disrupted. For a large part of the last 18 months most children could only receive their education online, which required access to technology and a good internet connection: a big inequality issue straight away. For a significant period, activities outside the home were restricted and even access to some play areas in parks was not permitted at times.

Our children's mental health has suffered during this time, and we are seeing an increase in demand to our children and young people's mental health services, including our children's eating disorder services. Locally, we have seen an increase in demand for our children and young people's mental health services, commissioned for our 0-25-year-olds since April 2020. Services are continuing to see a rise in demand each quarter. The most notable increase is in our specialist children's mental health service (CAMHS) which saw 490 referrals between April – June 2021, up from 233 in the same quarter in 2020, which is an increase of 110%.

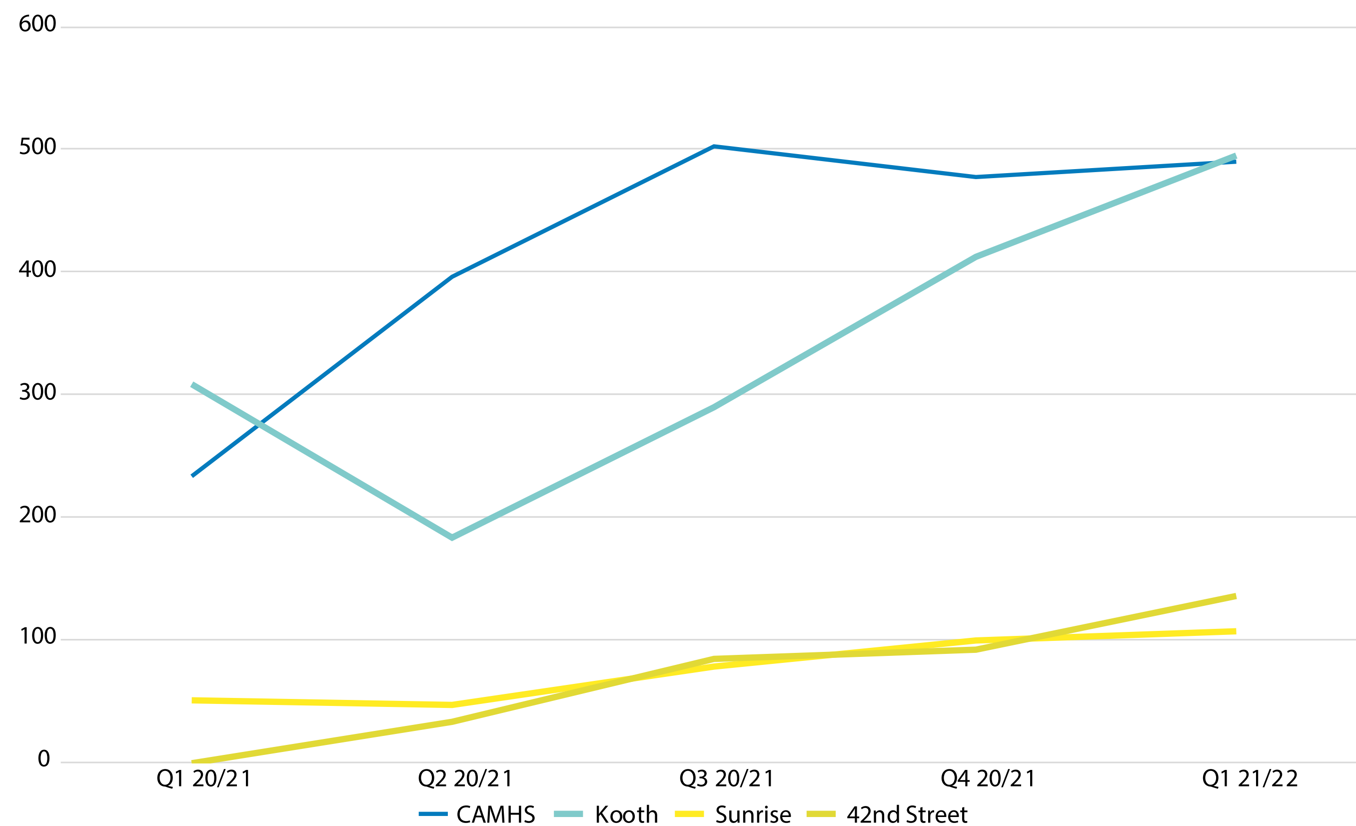


Figure 4: Trafford 0-25 new referrals/registrations into services since COVID (Source: Trafford internal contract monitoring data)

Our children's mental health has suffered during this time, and we are seeing an increase in demand for our children and young people's mental health services, including our children's eating disorder services.

Chapter 5

The impact of obesity

Obesity is a complex issue, caused by several factors[31], and is a highly stigmatised condition.[32, 33] We know that eating habits have changed in the pandemic. Reduced access to physical activity, and stretched incomes may have led to increased snacking, and thereby led people to eat more calories than they can expend and to buy less healthy food because it may be cheaper and more convenient[34]. Eating habits have also changed within families. Children living in families where they could previously have received free meals at school are likely to have been particularly disadvantaged. The number of people using food banks increased whilst incomes were stretched and at times the availability of food was disrupted. Very worryingly, in the North West of England we have seen an increase in the number of children who are classified as obese by the National Childhood Measurement Programme. The prevalence of obesity in reception age children increased from 10.8% to 15.1 % between 2019-20 and 2020-21[35] and for year 6 children it increased from 22.8% to 25.8%[36]. The inequalities in rates of overweight/obese children are widening across England, with an increase in children in more deprived areas who are overweight or obese, and a widening gap between these children and those living in the most affluent areas. This is most noticeable in reception age children where both the obesity rate and the gap has increased between the most and least deprived children.

It is hard for people to lose weight and so seeing more children are overweight or obese at a young age is concerning. Children who are overweight or obese are more likely to be overweight or obese as an adult, which increases the risk of some cancers, diabetes, stroke, heart disease and being overweight or obese can have a negative impact on a person's mental health. We also know that ultra-processed foods are associated with higher rates of obesity [37]. Therefore, we need to work with communities to design environments that support them to live active, healthy lives and provide access to high quality food at affordable prices.

As well as this, we need to understand family dynamics. Not only do families influence the eating habits of children but there is evidence that the parent of the same sex as the child is more influential[38]. This means that if a mother is overweight or obese, the daughter is more likely to be so as well. This highlights that any efforts to address healthy eating and weight management within a family cannot treat the family as a homogenous group. It is necessary to consider the relationships between family members and how that affects individuals within the family unit.

Weight management and Diabetes Prevention

As mentioned above, obesity is linked to diabetes, and both are strongly linked to an increased risk of cardiovascular disease and cancer. We also know, as shown in data above, that people in more deprived areas of Trafford are more likely to have diabetes. We are therefore very pleased to be working with the National Diabetes Prevention Programme, a service for people at high risk (as measured by their blood sugar levels, blood pressure, age, ethnicity and family history) of developing type 2 diabetes. This is often known as being 'pre-diabetic'. The programme supports people to change their diet and physical activity habits in order to reduce their risk of developing diabetes.

In Trafford from 1st April 2019 to 30th November 2021 there have been 641 referrals made into the NHS National Diabetes Prevention Programme; a rate of 270 per 100,000 population. Of these referrals, 302 (47%) started the programme, There is a time lag between referral and attendance at their first session so the uptake is expected to increase.

The referral rate in some, but not all of the least deprived areas is higher than in the most deprived areas, and of the 302 people who have attended at least one session, 38% were from the least deprived quintile compared to 10% from the most deprived quintile.

So in Trafford, disappointingly, more people from affluent communities attend this programme than people from less affluent communities, even though prevalence of both non-diabetic hyperglycaemia (NDH – or pre-diabetes) and type 2 diabetes is greater in our least affluent communities, and so in these areas more people are likely to benefit from the programme. Failing to engage these people in the service will exacerbate health inequalities as diabetes can cause a number of other diseases and reduce healthy life expectancy. We therefore need to:

- undertake targeted outreach with specific communities and groups that are more likely to be living with excess weight, and at higher risk of developing diabetes at a lower BMI.
- work with General Practices that serve communities at higher risk of living with excess weight and developing type 2 diabetes to support identification of high risk patients.

We have commissioned a range of services for people who need support with weight loss, to complement those commissioned nationally, and engaged with local VCFSE sector organisations to work with at a hyper-local neighbourhood level to give support to access these services.

Chapter 6

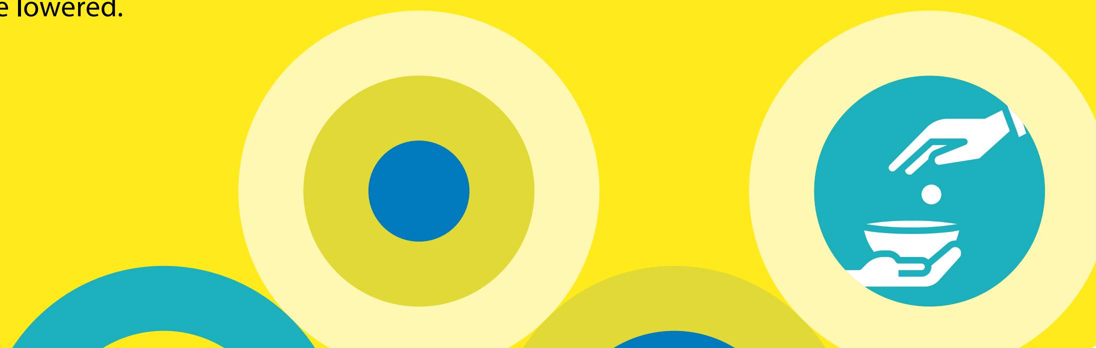
Inequalities in choices

As highlighted earlier in the report, the social determinants of health have a huge impact on our health and on the choices we can make.

People with a higher income are less likely to be stressed, more likely to be able to access and buy good nutritious food, live closer to green and blue spaces, have a better education and live in an area with lower pollution. All these factors mean they are more likely to be in good health. There is a downside: with a higher income people are also more likely to over-consume resources, and consequently use more carbon and to create more air pollution. However, the impact of this carbon use and the pollution emitted by cars falls more heavily on poorer people.

Poverty

People who are less well-off have a different life experience to those with a higher income. They may be on means tested state benefits, which can be stigmatising and therefore damaging to people's mental health and sense of self. Statistically, they are more likely to have a long-term health condition, which could affect their ability to work, which will also cause stigma[39, 40]. They are more likely to be living in poor quality or overcrowded accommodation which can be harmful to mental and physical health [41]. They are less likely to have reached a high standard of education, so are more likely to be in low-income employment, or unemployed [42]. Money and other worries can affect people's ability to think clearly about other aspects of their lives, and can reduce feelings of control over their lives[43]. According to Maslow's hierarchy of needs, thinking about the longer term health impacts of behaviour requires basic physiological needs to be met. For many people in poverty in this country, these needs will not be felt to be secure[44]. This in turn may make people less likely to seek medical advice in a timely manner and may make them less able to act on the advice, especially when taking the advice would cost time or money[45]. Overall, this means that many people in poverty lack choices, and/or may not feel that their actions are going to have any impact on their health or other outcomes. All these factors can make people both more likely to experience poor health and less able to take steps to improve their health, which then makes it more likely that their life expectancy and healthy life expectancy will be lowered.



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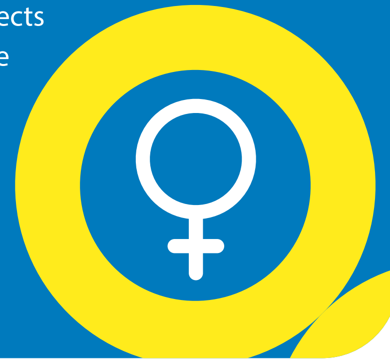
Women

Women are often the main person providing childcare in families and care for other dependants. This can often lead them to need to work part time, to take ad-hoc time off to deal with emergencies, or to need to work very locally. All these factors can limit their employment opportunities and can often lead to them taking lower paid jobs. Statistically, being an unpaid carer is bad for your health and can increase stress levels[46]. Women are not only more likely to work part time but also to earn less than men even when doing the same role. As we know, a lower income can have a significant impact on someone's choices and health.

During the pandemic many of us worked from home, and for many of us this gave advantages through a reduced commute. However, in households with children, women picked up more of the responsibility for childcare and since the reopening of the economy, women are more likely to continue to work from home so that they can, for example, fetch from school and manage the running of the home. While this is convenient in the short term, in the longer term this may lead to further disadvantage to women in the workplace as we know that people who work from home are less likely to be given a promotion for a variety of reasons[47] so there is a risk that in the longer term they will suffer not only financially but also through higher stress levels by being at a lower level within an organisation[48].

Notwithstanding the discrimination women face in the workplace and in other aspects of their lives, they are more likely to seek healthcare than men. Despite this, they are more likely to experience poorer health outcomes[49] although they have longer life expectancy. The health of family members is often seen as women's responsibility, and women are likely to encourage their partners to access health services [50,51,52]. Perhaps this is because health is seen as a female construct and therefore that they should play that role not only with their dependants but with the significant men in their lives. This 'emotional load' can add to the stress women feel.



Race/Ethnicity

People from a non-white background are disproportionately likely to experience poorer health outcomes and report poorer experience of health services. Recent research has shown that black women are more likely to die during childbirth than their white British counterparts, and that this difference cannot be fully explained by differences in socio-economic status.[53] We read frequent reports of black women being disbelieved when they report health issues in pregnancy, and it is not surprising that this then leads to a mistrust in the health system more generally.

Structural racism also contributes to health inequalities through, for example, differences in access to employment and housing. Even with the same level of education as a white British person, people from a non-white British background are more likely to be in lower paid and less senior roles[54]. This type of discrimination can understandably have a negative impact on someone's mental and physical health and therefore a negative impact on their healthy life expectancy, as well as with their trust in services and systems[55,56].

To summarise: people from a non-white British background experience many factors which negatively impact on their health and are more likely to have poor experiences when accessing health services and to experience discrimination other parts of their lives such as employment. This makes it less likely that they will trust institutions, feel they are able to make positive choices, or have control over their lives.

Intersectionality

In this chapter we have looked at how negative experiences can reduce choice and agency. When we add together the impact of race, sex /gender and poverty, we can see how cumulative negative experiences can lead someone not to seek healthcare services[57]. Furthermore, it can mean that those people who would most benefit from healthcare services are the least likely to do so. We see this consistently with preventative services such as screening or more recently uptake of Covid 19 vaccine, where people from more deprived groups, even though they were at relatively higher risk from Covid because of job or housing conditions, were paradoxically the least likely to come forward for vaccination – with a lack of trust in the vaccine being the most common reason given[58]. To address this, we need to focus on the wider determinants of health and on tackling inequality, racism and other forms of discrimination to win back this trust. If we achieve this, those who need the health services the most will find it easier, and be more prepared, to access them and this will help reduce our longstanding inequalities in health outcomes.

To succeed, we need to listen and respond to people's experiences, and support them to lead service design. We must not approach people as a homogenous group with one attribute. Rather, we need to work with communities not only to build trust but to respond to their needs. We are doing this through our work focussed on community engagement to co-produce the services communities need, but this needs to become embedded throughout our services, systems and processes.

Chapter 7

Reducing Inequalities through increasing trust

Voting and why it matters

Voting is important for many reasons, but not least because political parties of all colours are more likely to focus on issues that are of concern to people who vote. If there are systematic differences between people who are likely to vote, and those who are not, then inequalities can be exacerbated. For example, poor health has been shown to reduce voter turnout in deprived communities, but not more affluent ones.[41,59] Furthermore, young people and people from ethnic minority groups are less likely to register to vote, whilst unskilled workers and long-term unemployed people are more disengaged from the formal political process than people from other occupational backgrounds[60]. This means that issues that predominately affect younger or poorer people, while they may be of major interest to politicians, may be less likely to affect election results than matters that affect older people. This may mean that the older people's perspective is heard more loudly, and this can turn into a vicious cycle, with the lack of relevant policies meaning that people from more disadvantaged groups see less point in voting, as well as having less confidence that their vote will make a difference. Despite this, there is good evidence to show many people who choose not to vote remain strongly interested in political issues.[43] However, disengagement from the formal electoral process is important because it may point to a lack of trust in the systems around them, with potentially serious implications for public services.

To take an example: in Trafford, the Covid vaccination programme has shown how important trust is to increasing uptake of the vaccine. One of the frequent reasons we have heard for not getting vaccinated is that people don't trust it. Similarly, lack of trust that voting leads to change is a reason often given for not voting.

Relationship between COVID-19 vaccine uptake/voter turn out and IMD for Trafford Wards

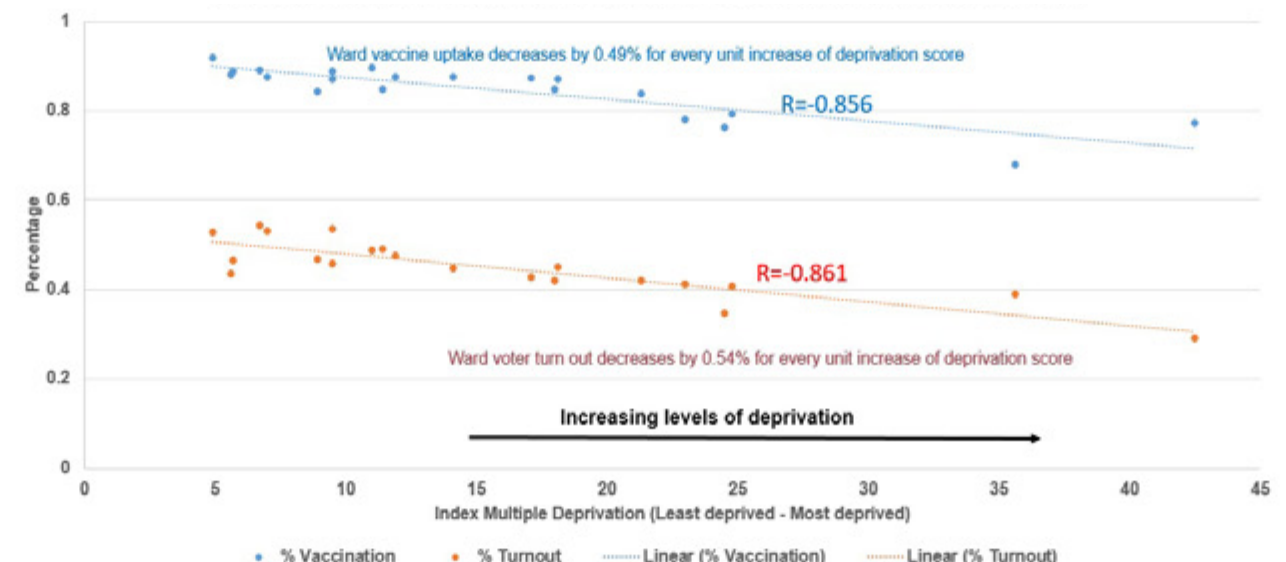


Figure 5: Relationship between Covid-19 Vaccine Uptake/ Voter turnout and by IMD for Trafford Wards turnout

Correlation can be used to see if there is a relationship between two factors. It doesn't mean that one causes the other, but it can be used to see if as one factor changes, what happens to the other. Values range between 0 and +/- 1, and the closer they are to 1, the closer the relationship between the factors. There is a strong negative correlation (r = -0.86) between deprivation in Trafford wards and Coronavirus vaccination and deprivation and turnout in the 2021 local election. This means that in Trafford, the less deprived the ward is, the more likely it is that residents of that ward will accept the vaccine or participate in elections and vice versa. With an R^2 value of >0.7, it implies deprivation is a strong factor that may be influencing both vaccine hesitancy and reduced participation in elections in Trafford.

As noted in the second Marmot review[61], community engagement can improve the sense of control and self confidence amongst people and increase social cohesion. Creating Indicators of possible disaffection such as voter turnout at elections could be a key 'early warning' sign of trust breaking down. Within this, we are interested in relative differences in turnout between deprived and affluent areas rather than absolute numbers who vote.

We know that trust can be increased by

- Increasing the amount of public engagement when it comes to designing services. The more say the public have in their community the more ownership they will feel about their area[62].
- Increased community engagement with local residents[63,64]. Not everyone wants to be involved in designing services, but they do want their voices heard and needs understood. Community Champions can play a key role in this[65].
- Tackling poverty and the underlying causes of health inequalities.

To take an example: in Trafford, the Covid vaccination programme has shown how important trust is to increasing uptake of the vaccine.

Chapter 8

Recommendations

To improve the health and resilience of our population, improve sustainability and reduce inequalities we need to:

- Use the measures in our Corporate Plan to identify and improve the wider determinants of health, thereby reducing heath inequality
- Set targets for reductions in inequalities between our most and least deprived groups (and subgroups) in key indicators such as school readiness and educational attainment[66], smoking, physical activity, air pollution, and obesity.
- Reduce poverty through ensuring all workers receive a living wage and/or appropriate benefits where required
- Reduce the risks to our population from climate change by ensuring that our carbon reduction plan meets the net zero requirement in time, and engage our population in honest discussions on how we do this without creating avoidable harm or increasing inequality.
- Work with communities to lead service design so that services better meet the needs of the people who need them the most.
- Explore the extent that we can use measures such the uptake of screening or vaccination, or turn out at elections, as proxy measures of engagement and trust.
- The Council to lead by example in:
  - → Tackling inequality and discrimination in all its forms, such as through increasing diversity within the workforce.
  - → taking account of all employees' needs including providing equitable access to training, development, and opportunities for advancement, no matter where someone works.
  - → Providing opportunities to work flexibly, part time and remotely.

Specific Recommendations on weight management and diabetes prevention: to improve outcomes and reduce inequalities in these measures we need to:

- Work with communities to tackle the stigma of overweight and obesity.
- Ensure planning takes account of health policies to reduce the number of takeaways and increase the number of outlets that provide affordable, healthy food.
- Ensure all schools (including academies) provide school meals that meet or exceed the School Food Standards.
- Support our population to become more physically active, and in particular to build physical activity into people's everyday lives through measures such as active travel (walking, cycling, and using public transport) thereby improving air quality and reducing carbon emissions too.
- Encourage and enable children and their parents/carers to walk or cycle to school through a comprehensive School Streets offer for Trafford.
- Evaluate success of locally and nationally commissioned support services for weight loss and diabetes prevention, in order to determine what works best for different Trafford communities.
- Continue to work with VCFSE organisations and groups to ensure that the people who need support with managing their weight can access it.
- Contribute to the Waiting Well programme to support people waiting for hospital procedures and appointments to maintain and improve their health while they are waiting.

Conclusion

In this report, we have focused on the damage that inequality causes to our society and have identified some actions that we can take to reduce this. To be effective, we will all need to work together differently. We need to develop more trust between public sector bodies and our residents, and we also need to have more honest conversations about the changes to lifestyles and behaviours that will be required if we are to meet clean air and carbon reduction requirements, as well as to address inequalities and improve outcomes for all. Many of these changes will be positive for people, some may be challenging, but the simple truth is that we cannot afford to go on as we are. By acting now, we can take control of our destiny and enable the people of Trafford to adapt and grow to meet these challenges and flourish in the future.

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TRAFFORD COUNCIL

Report to: Health and Wellbeing Board

Date: 21st January 2022

Report for: Information

Report of: Helen Gollins, Acting Director of Public Health

Report Title: Health Visiting and School Nursing review

Summary.

The report provides a summary of the outcome of a recent review of the Health Visiting (HV) and School Nurse (SN) Service. The review has been completed to support a new service specification for the 3 year contract which will commence April 2022.

Recommendation.

Members of the Health and Wellbeing Board are asked to note and accept the outcome of the review.

Contact person for access to background papers and further information:

Name: Dr Donna Sager Consultant in Public Health

Donna.sager1@trafford.gov.uk.

1. Background

1.1. Under legislation, upper tier local authorities are responsible for improving the health of their local population. Trafford Council has a statutory responsibility for commissioning public health services for children and young people aged 0-19 years. These services form part of a whole system approach of support for children and young people's health and wellbeing. NHSE mandation of universal health visiting services was made under section 6c of the NHS Act 2006 and reviewed in 2016.

1.2. This paper provides Health and Wellbeing Board members with the outcomes of the Health Visiting and School Nursing review and highlights revised areas which are likely to be included in the service specification.

2. Contract Status.

2.1. The existing contract for these services through Trafford CCG will cease on 30 June 2022.

2.2. The DPH wrote to Sir Mike Deegan on 30 September 2021 informing MFT of Trafford Council's high level commissioning intentions for our health visiting and school nursing services from the year commencing 1st April 2022. It noted that completion of a comprehensive review of the health visiting and school nursing services in collaboration with the local care organisation, school and children's services, NHS Trafford CCG, service users and wider stakeholders. The letter concluded with a notification of a planned variation to the delivery model from 1st April 2022.

2.3. Trafford Council and MFT are currently discussing the future delivery of these public health services through TLCO. A paper is due to go to Trafford Council's Executive in March 2022 requesting approval of the future arrangements. This will include a recommendation to delegate authority to Corporate Director of Adult Services in consultation with the Corporate Director of Governance and Community Strategy to agree the terms and conditions for service delivery. The Health Visiting and School Nursing as mandated Public health commissioned services, would be included in these future arrangements if approved.

2.4. The new arrangements will require a detailed service specification which is currently being finalised.

3 Introduction to the Review.

Health visiting and school nursing services are integral to the local delivery of the national Healthy Child Programme (HCP). In Trafford, the health visiting service delivers the HCP programme for 0-5 year olds, beginning in pregnancy and continuing until the child begins school and is transferred to the care of the school nursing service. The school nursing service then leads and delivers the HCP for 5-19 year olds.

The school nursing service was extensively reviewed in 2013 and the service specification was updated as a result. The health visiting service has not been reviewed for some time.
Commissioning guidance indicates that best practice is to have an overarching specification for the 0-19 offer which Trafford does not currently have.

This review was initiated in 2019 but was paused while the services transferred from PCFT to MFT. The review was then paused for a second time in March 2020 as the local system responded to the emerging Covid-19 pandemic. Work on the review restarted in September 2020 and is due to be completed in March 2022. Both services will be reviewed in tandem although the focus will initially be on the health visiting service. The review will also be informed by the parallel development of Trafford Team Together, a new Early Help model that is being designed for implementation from April 2021 onwards.

The health visiting and school nursing services in Trafford are delivered by Manchester University Foundation Trust (MFT) having transitioned from Pennine Care Foundation Trust (PCFT) in October 2019.

4 Aims and Objectives of the Review.

The primary aim of the review was to ensure that the health visiting and school nursing services in Trafford are meeting the needs of the populations that they serve and are delivered in line with national guidance and best practice. The review evaluates Trafford's offer to families against the HCP model and how community public health services for 0-19 year olds operate overall.

The objectives of the review were to:

- Evaluate the delivery of the health visiting service against the current service specification, national and regional standards, and clinical best practice guidelines;
- Evaluate the delivery of the school nursing service against the current service specification, national and regional standards, and clinical best practice guidelines;
- Review the cost-effectiveness of current and future models of service delivery for health visiting and school nursing;
- Review and appraise alternative models of delivery for health visiting and school nursing services using examples of best practice in other localities;
- Propose options for the future delivery model for health visiting and school nursing in terms of staffing, skill mix and core activity;
- Describe the role of health visiting and school nursing within the wider system of public services in Trafford, particularly with regards to the new early help model that is under development;
- Update the service specifications for health visiting and school nursing and, if required, develop an overarching specification for children and young people's community public health services;
- Develop a reporting framework of key performance indicators for activity, safety and quality;
- Establish future governance arrangements for routine service monitoring and assurance.

The review has been overseen by a multiagency Programme Board.

4. Methods

The review has 3 core strands:

- A literature review of the current evidence base for health visiting and school nursing, including national and regional commissioning standards and best practice guidelines

- Analysis of population and service-level data including budget and finance information
- Consultation with key stakeholders

5. Evidence Review

The review team has evaluated evidence from a range of sources including

- Public Health England (PHE), NHS England (NHSE) and Department of Health and Social Care (DHSC) policies and commissioning guidance;
- Royal College of Nursing;
- Institute of Health Visiting;
- National Institute for Health and Care Excellence (NICE) guidance and quality standards;
- Case studies from similar localities in the UK

6 Data analysis to support the review

6.1 Key Demographics

- An estimated 60,956 children and young people (CYP) aged 0-19 years live in Trafford, making up around 1 in 4 (25.7%) of the total population (ONS, 2019).
- Recent data on the ethnic group breakdown of Trafford children is available from the school census. In the January 2018, almost a third (30.6%) of children in state-funded primary schools reported belonging to a BME group, predominantly Asian (14.2%), mixed/multiple (8.3%) and Black (3.6%) (Trafford, 2018).
- Between the years 2021 to 2031, the estimated number of children aged 0-4 year old living in Trafford is projected to shrink slightly (-0.5%), lower than the projection for England (-2.9%). The number of 5 to 9 year olds and 10-14 year olds are also projected to shrink slightly (-7.9% and -5.0% respectively), compared to strong growth in 15-19 (15.2%) year olds (ONS, 2020).
- Based on the definition used in the 2019 Indices of Deprivation, 11.7% of Trafford under 16s are living in poverty, but this reaches 44% in one small area of Trafford (IMD, 2019).
- Educational achievement in Trafford is better than average for England; however some groups within Trafford fare worse. For instance, 74.7% of children have reached a good level of development by the end of Reception (statistically better than England average of 71.8% and highest in the north-west), but the equivalent figure for children on free school meals is 56% (significantly similar to the England average of 56.5%) (Child and Maternal Health Profile, 2019).

6.2 Indicators of health and wellbeing

- Indicators of population health and wellbeing among CYP in Trafford are generally better or similar to the England average.
- Infant mortality rate (number of deaths in infants before their first birthday per 1000 live births) is an indicator of the general health of an entire population and reflects the relationship between causes of infant mortality macro-level determinants of health such as economic, social and environmental factors. The infant mortality rate for Trafford is 3.6 per 1000 live births and is statistically similar to England average of 3.9 per 1000 live births (Child and Maternal Health Profile, 2019).
- Neonatal mortality and still birth rate (number of still births and deaths under 28 days per 1000 still births and live births) is 4.9 per 1000 for Trafford similar

to England average of 6.8 per 1000 still births and live births (Public Health Profile, 2018).
- Child mortality rate (deaths due to all causes aged 1-17 years per 100, 000 population) for Trafford (14 per 100,000 population) is similar to England average (11 per 100,000 population) (Child and Maternal Health Profile, 2019).
- However, there are some issues in particular, where similar or better than England does not mean 'good'. For instance, in 2019, one in five (19.9%) Reception children and almost a third (31.6%) of Year 6 children living in Trafford were overweight or obese. Prevalence of obesity doubles between Reception (7.7%) and Year 6 (17.7%). There is a strong association between deprivation and the prevalence of obesity in Reception and Year 6 with obesity prevalence increasing as the level of deprivation increases (i.e. higher prevalence of obesity in deprived areas compared with least deprived areas) (Child and Maternal Health Profile, 2019).
- The rate of children in care (74 per 10,000 population under 18 years of age) in Trafford is significantly higher than the England average 74 per 10,000 population under 18 years of age). Recent trend shows no significant change (Child and Maternal Health Profile, 2019).
- Rates of hospital admissions in certain age groups (e.g. emergency admissions in under 5s) are significantly high relative to England. Local analysis suggests that this is likely to reflect patterns of health seeking behaviour and/or access to community services as opposed to a higher level of underlying illness in the population (Public Health Profile, 2019).

6.3. Additional data which has supported this review includes:

- The full needs assessment for Children and Young People in Trafford http://www.traffordjsna.org.uk/docs/Life-Course/Start-Well/Needs-assessment-for-CYP-aged-0-to-19.pdf

- Improving health outcomes for vulnerable children and young people. http://www.traffordjsna.org.uk/docs/Life-Course/Start-Well/Improving-health-outcomes-for-vulnerable-children-and-young-people-Report-for-Traffor.pdf

7. Consultation to inform the review.

7.1. In May 2021, a health visiting and school nursing service survey was launched at all stakeholders including; children and young people, parents/carers, and professionals in Trafford. The survey was promoted through various children's organisations, including Health, Social Care, Early Help, GPs, Trafford Parent/Carer Forum, Trafford schools bulletin and various Trafford social media channels and websites. A total of 202 responses were received. 55% were parents and carers, Trafford professionals provided 66 responses. A full report is being collated. Summary key themes included.

7.2. Professional responses (Health Visitor and School Nursing)

- Services were identified as being very responsive and supportive when they are working with other teams. They are valued for their expertise and partnership working.
- A number of professionals highlighted that they think the services are understaffed. They highlight the quality of the staff working in the service but

- feel existing resources do not meet existing demand. This was noted in relation to availability at wider meetings (safeguarding, partnerships etc.)
- Professionals indicated the service needs more visibility in Trafford – "who, where and how to contact".
- Covid-19 – a small number of responses commented on the impact of pandemic in terms of service accessibility
- GPs mentioned the positives of the baby clinics which used to take place in their local practices. There were comments on how these improved relationships between Primary Care and the service.
- Poor IT and no joint electronic records impacted on service delivery.
- A number of professionals praised the SN service in regards to their social media presence.

7.3. Responses from parents and carers on the Health Visiting service

- The responders provided some positive feedback about the quality of care provided and the value of the advice given.
- However many of the responders felt that their access to HV was limited and restricted to initial 6 week visits (acknowledged by some to be Covid related), with a request for more longer term relationships.
- There was a clear call for drop in weigh in clinics to be reintroduced and the need for support and advice via drop in clinics.
- Some responses provided suggestions on how to improve the service, which were more support to families with small children between 2-5 not just babies.

7.4. Responses from parents and young people to School Nursing services.

- Whilst those who had worked with a School Nurse were positive about the interaction the majority of the respondents did not have knowledge about the role of a School Nurses.
- Visibility was heightened in terms of immunisations and the weight management programme.

8. Findings from the review

8.1. The initial scoping phase of the review (September-December 2020) identified a number of organisational barriers to optimal service delivery. These issues encompassed a range of functions including IT; finance; and performance, quality and improvement (PQ&I). In light of this, stakeholders requested that a multi-agency Programme Board should be convened to provide strategic oversight of the service review and ensure a collaborative response to system-wide issues that affect the delivery of HV and SN in Trafford.

The Programme Board has met regularly to oversee the development and a significant number of meetings have been held between commissioners and providers to expedite pieces of work.

It should be acknowledged that considerable planning and development time has inevitably been compromised due to TLCO managers and staff having to rightly rapidly expedite the School COVID Immunisation programme.

8.2. The following section highlights the key themes from the review.

Performance

- The HV service generally performs well against mandated standards.

- It is more difficult to evaluate SN performance due to a lack of cohort-level activity data.
- Most HV and all SN activity is captured 'on paper' making it challenging to report and analyse as such limited quality or performance data for either service is routinely reported to public health commissioners.

Staffing

- Recruitment and retention to universal children's services has historically been very stable in all bands across the service. In more recent year significant challenges have been experienced in recruitment to the specialist public health practitioners post in both health visiting and school nursing. This is a reflection of a national shortage of practitioners with the specialist practitioner qualification.
- Flexible approaches to recruitment have been and continue to be considered to maintain a safe staffing level to enable the services to deliver all commissioned elements of the healthy child programme 0-19.
- Whilst the service has actively trained both health visitors and school health specialist practitioners retention at the end of training has been poor, as staff have not accepted jobs with Trafford but taken positions closer to home.

- HV staffing is generally stable but is not at full establishment; individual HVs have large caseloads. There has been a substantial increase in the complexity of HV caseloads; the number of families receiving support above the universal level doubled between July 2020 and February 2021.

- In relation to School Nursing considerable progress has been made in relation to recruitment and retention.

- SN staff report significant demand for safeguarding support which can impact on their ability to deliver other core functions.

- Both HV and SN services have a small admin function split across four locality teams; this model lacks resilience and increases the administrative burden on specialist staff.

- The primary risk to delivering both the current service and any future model is the ongoing shortfall in staffing establishment especially in Health Visiting.

Service delivery

- MFT has recently established a joint senior leadership team across Manchester and Trafford's children's community health services with the potential for greater alignment between the two boroughs.
- Public Health Trafford has committed to maintaining the current funding envelope for HV and SN; while the services are not required to make efficiency savings, there is an emphasis on shifting to a delivery model that is more responsive to local need and maintains the stable provision of core functions.
- NHS England and the Greater Manchester Health & Social Care Partnership has issued commissioning intentions setting out requirements for localities to create dedicated school immunisation teams separate from their core SN service.
- There is an opportunity for a more 'joined up' offer for children, young people and families in Trafford, bringing together partners from the local authority, health services and education.

- The development of a new early help model, Trafford Team Together (TTT), has implications for the HV and SN services; relevant leads from TLCO should continue to be involved in the development of the TTT programme.
- New models for HV and SN have been co-designed by colleagues from MFT/TLCO and Public Health Trafford with significant input from frontline SN staff.
- It is recognised however that the full operational model may take some time to be fully implemented and a staged implementation will be agreed. Any new additional requirements such as an acceleration of the COVID vaccine programme for school aged children will significantly and negatively impact on core provision and consequently delay progress of the new models.

Other

- Four separate locality budgets offer less flexibility than single pooled budgets for HV and SN services
- Roles and responsibilities in some areas have required some detailed analysis particularly in relation to safeguarding, looked after children; and links/inter-dependencies with other teams for example, the Children in Care Nursing team and Children's Social care.

9 Changes to the service specification as a result of the service review.

This section of the report provides an update on a number of key areas in the service specification, these have been discussed with the TLCO Executive Team

9.1 Electronic Patient Record

- The review highlighted considerable service improvements that could be achieved when HV and SN have access to a full electronic patient record (EPR).
- The specification will include the requirement for access to an EPR and providers will be expected to update progress on this at the regular monitoring meetings.
- TLCO Executive team confirmed that the EPR Business case will be considered in January.

9.2. Outcome Framework for children's health outcomes

- As part of the review a new outcomes framework and KPIs for assuring service performance, quality and impact and looking at overall outcomes has been completed. These outcomes align to Trafford's Corporate Plan which identifies the Corporate Priority for 2021 – 2024 "to prevent poor health in children and promote good mental and physical health".
- The Outcome Framework will be included in the specification. The specification will outline the requirement for providers and commissioners to meet quarterly to review performance and progress and to consider emerging pressures.

9.3. Recruitment and Retention.

- The review identifies the current recruitment issues. TLCO have identified a number of approaches for addressing these including skill mix and staff development programmes

- The specification will require evidence of robust vacancy management.

9.4. Administrative Function.

- The review highlighted considerable administrative tasks being taken by HV and SN which were impacting on front line work.

- The specification will require that consideration is given to the most efficient administration support arrangements, which could be creating a centralised admin function for both services. TLCO managers have highlighted they would like to explore this option further.

9.5. Budget

- The budget is currently allocated and managed on a locality basis which impedes the ability to support cross Trafford initiatives when underspend in other localities is made available.

- The specification will require the totality of the HV budget and SN budget to be used in a flexible way to ensure service outcomes are achieved.

9.6. Ongoing new developments.

- It is recognised that service models and new developments in children's services are likely to occur in the length of this contract.

- The specification will require that HV and SN services have on going involvement and oversight of new developments (including Trafford Team Together) and identify to the commissioner any capacity issues which may arise. The senior managers of TLCO have been engaged in defining the contribution of the HV and SN services to the Family Hub proposal.

9.7. Covid and other immunisation priorities

- It is recognised that SN are commissioned by GMH&SCP to deliver a range of school based immunisation schedules which are fully supported by the commissioners.

- The specification will require transparency about and engagement with the commissioners in relation to any new requirements. This will enable the impact on the contract to be considered and reduce the risk of any detrimental impact on outcomes delivered.

- COVID vaccinations – second dose 12-15 – GMH&SCP have commissioned the School Nursing service to deliver this service which is to commence January 10th 2022. GMHS&CP are working to develop a hybrid model with some external staff being commissioned to support clinical leadership with School Nurses. This remains a risk for the existing SN and immunisation team to catch up on previous critical immunisation schedules including the evidence based HPV programme and some of the developments identified below may be delayed. GMHSP have identified funding for longer term recruitment to supporting the COVID vaccination programme but in the interim there are concerns about workforce availability.

10. Service development areas under consideration.

There are a small number of service development areas that are actively under consideration which will be finalised by March. These include

10.1. Consideration of a separate immunisation team and whether this would support this specific function and protect the wider healthy child work. The dedicated immunisation team consists of 1.6 wte staff

10.2 Consideration of an Enhanced Care team which have been operational in Manchester. TLCO/ MFT are currently scoping the resource requirements of such a model and whether such a model would enable School Nurses to continue to advance their wider public health universal activities whilst ensuring safeguarding requirements are met.

10.3. Restarting the National Child Measurement Programme (NCMP) which is a mandated Public Health programme, and the data is used to provide the PHOF indicators on excess weight in children, as well as informing development and monitoring of local childhood healthy weight work.

In 2020-21, nationally the collection of NCMP data was reduced to a 10% representative sample of children in reception and year 6 due to the impact of the Covid pandemic on school attendance throughout the year, and on the workforce who collect the data. For 2021-22, national operational guidance for NCMP is that we should undertake measurements of the full reception and year 6 cohorts, with an expectation of participation rates by eligible children of at least 90%. In order to achieve 90% participation we need to endeavour to measure all reception and year 6 children as in previous years.

The national NCMP report for 2020/21 has now been published, and this shows:

- prevalence of overweight in reception children has increased from 23.0% to 27.7%
- prevalence of obesity in reception children has increased from 9.9% to 14.4%
- prevalence of overweight in year 6 children has increased from 35.2% to 40.9%
- prevalence of obesity in year 6 children has increased from 21.0% to 25.5%

Therefore it is more important than ever that we undertake the full NCMP programme in 2021/22 in order to establish whether this increased prevalence continues to be seen across both age cohorts. In reception, the prevalence has been stable for over 10 years until 2020/21, while in year 6, we have seen increases in prevalence in one year that previously took over 10 years.

Across Greater Manchester, there are pressures on the school nursing services who provide NCMP, however, all those we contacted are expecting the programme to go ahead as usual despite the added pressures of the CYP Covid vaccination programme. Covid has had a huge impact on children's health and wellbeing (physical and mental), and the NCMP helps us to understand the extent of this impact and to be able to plan how to support children's health moving forward. We are currently in discussion with TLCO managers regarding a revised delivery model.

11. Governance and Accountability.

Trafford Public Health commissioners will set up regular monitoring meetings with TLCO to review performance, support strategic alignment and discuss on going developments.

Performance highlight reports will be presented to the Children's Commissioning Board and the Start Well Board.

12. Recommendations.

Members of the Health and Wellbeing Board are asked to note and accept the outcome of the review.

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Trafford TOGETHER

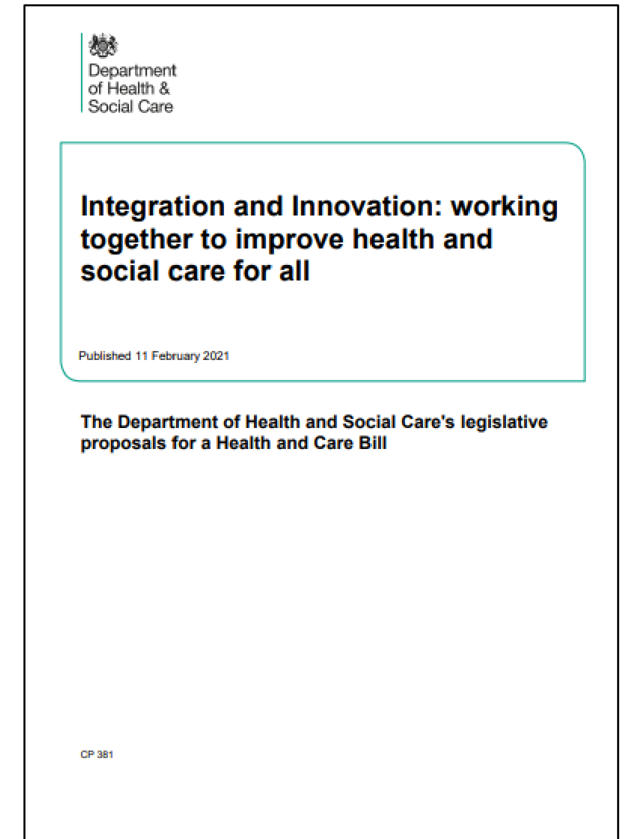
H&SC System Reform Update

Health and Wellbeing Board

Jan 2022

Background

- In February 2021 the NHS White Paper 'Working Together to Improve Health and Social Care' was published.
- This was followed by Health and Care Bill 2021
- Bill mandates establishment of Integrated Care Systems (ICS)
- Including Integrated Care Boards (ICB) and Integrated Care Partnerships (ICP):
  - CCGs will no longer exist as statutory bodies
  - Integrated care systems will be established
  - Statutory NHS functions will be undertaken by integrated care boards


Department of Health & Social Care

Integration and Innovation: working together to improve health and social care for all

Published 11 February 2021

The Department of Health and Social Care's legislative proposals for a Health and Care Bill

CP 381

Recent Changes / Priorities

- Nationally, CCGs and partners have been working towards 1st April for the Integrated Care Board (ICB) to be established. It has now been confirmed in order to allow sufficient time for the remaining parliamentary stages to take place a new target date of **1st July 2022** has been agreed.

- This will provide some extra flexibility to prepare and manage the immediate priorities in the pandemic response, while maintaining momentum towards becoming an ICB.

- National and local plans for ICS implementation will now be adjusted to reflect the new target date, with an extended preparatory phase from 1 April 2022 up to the point of commencement of the new statutory arrangements. During this period:

  - ❑ **CCGs will remain in place as statutory organisations.** They will retain all existing duties and functions and will conduct their business (collaboratively in cases where there are multiple CCGs within an ICS footprint), through existing governing bodies

  - ❑ **CCG leaders will work closely with designate ICB leaders in key decisions which will affect the future ICB**, notably commissioning and contracting

  - ❑ **NHSEI will retain all direct commissioning responsibilities not already delegated to CCGs.**

- Recruitment of GM ICB – Chief Executive, Executive Directors, Non-Executive

Emerging Draft Trafford Locality Operating Model

Transfer of functions from CCG and NHS England via new Heath and Care Act

System (GM)

GM ICS Care Partnership

GM ICS Care Board

Horizontal
- service specialisation
- standardisation

Locality (Trafford)

One System
- Strategic planning
- Commissioning
- Accountability

NHS Manchester University NHS Foundation Trust

Trafford Local Care Organisation
Leading local care, improving you

healthwatch

NHS Greater Manchester Mental Health NHS Foundation Trust

Primary Care

NHS

TRAFFORD COUNCIL

Thematic Partnerships

Rehab | Mental Health | Children's Care

- planning and delivery of integrated care at place
- delegated authority
- delegated budgets

Neighbourhood

Multi-agency Teams

GP Surgery NHS

Geographical
- Co-ordinate care
- Hold delegated budgets
- Hold accountabilities for sub-populations

North Trafford

South Trafford

Central Trafford

West Trafford

Vertical collaboration
- Co-ordinating locality and Neighbourhood Planning and delivery

Improved Access

Health Improvement

Improved Outcomes

Better Care Delivery

Better System Connectivity

Assets Maximised

Efficient Trafford £

Quality of Life improved

Social Value

Trafford TOGETHER

Transitioning from CCG to ICS: Assumptions

- Single ICB running cost – likely to be lower in real terms
- Need common understanding of what is funded from programme budgets
- New structures will need to be affordable
- Likely that there will need to be some standardisation across localities
- ICB executive directors will have leading influence on functional teams (what is done at what level)
- Functions will be a mix of central and place based (hub& spoke)

Transitioning from CCG to ICS: Our Approach

Any changes to structures will be subject to formal consultation:

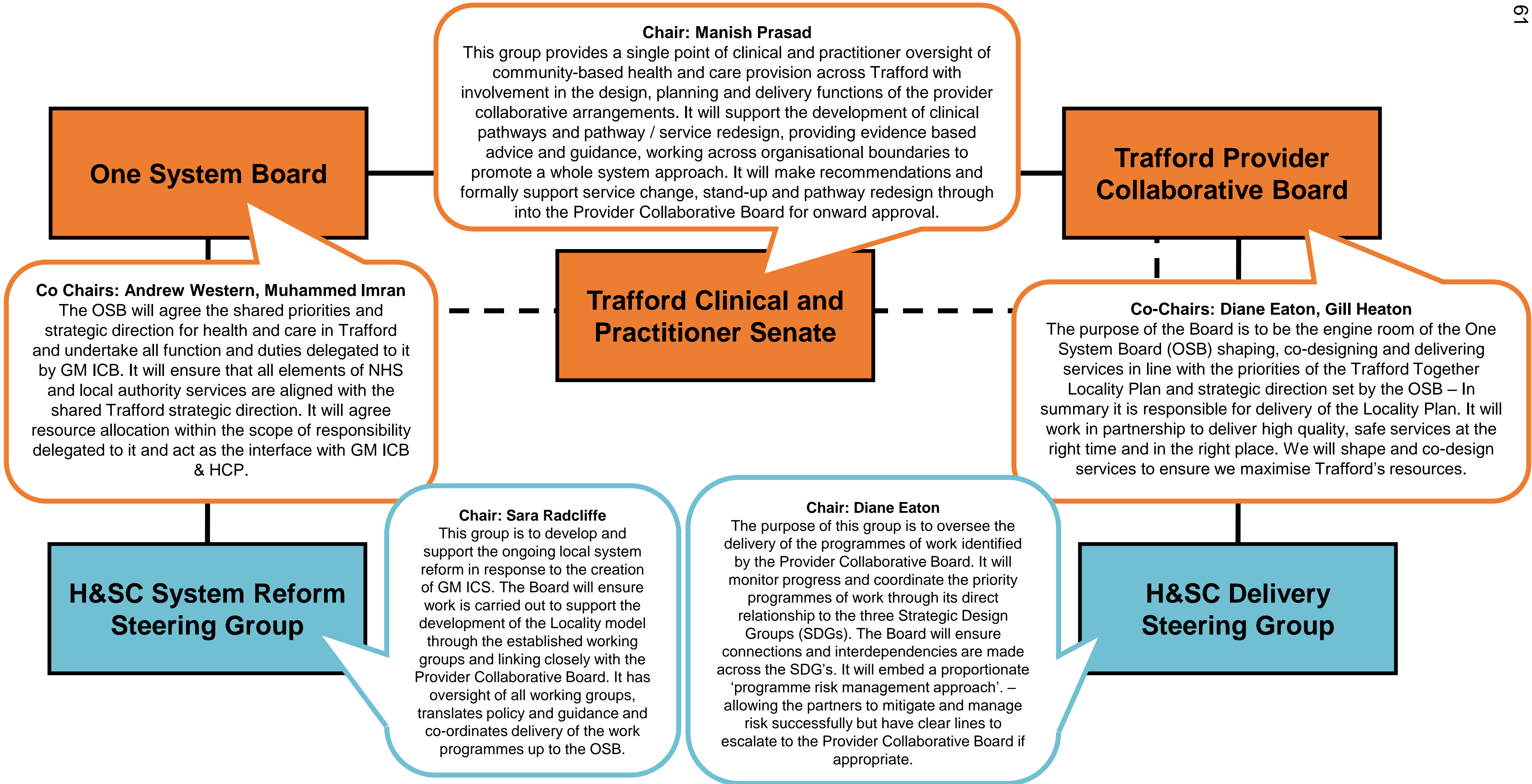
- Won't happen before July 2022
- Minimal changes to support operation of ICB on 1st July 2022

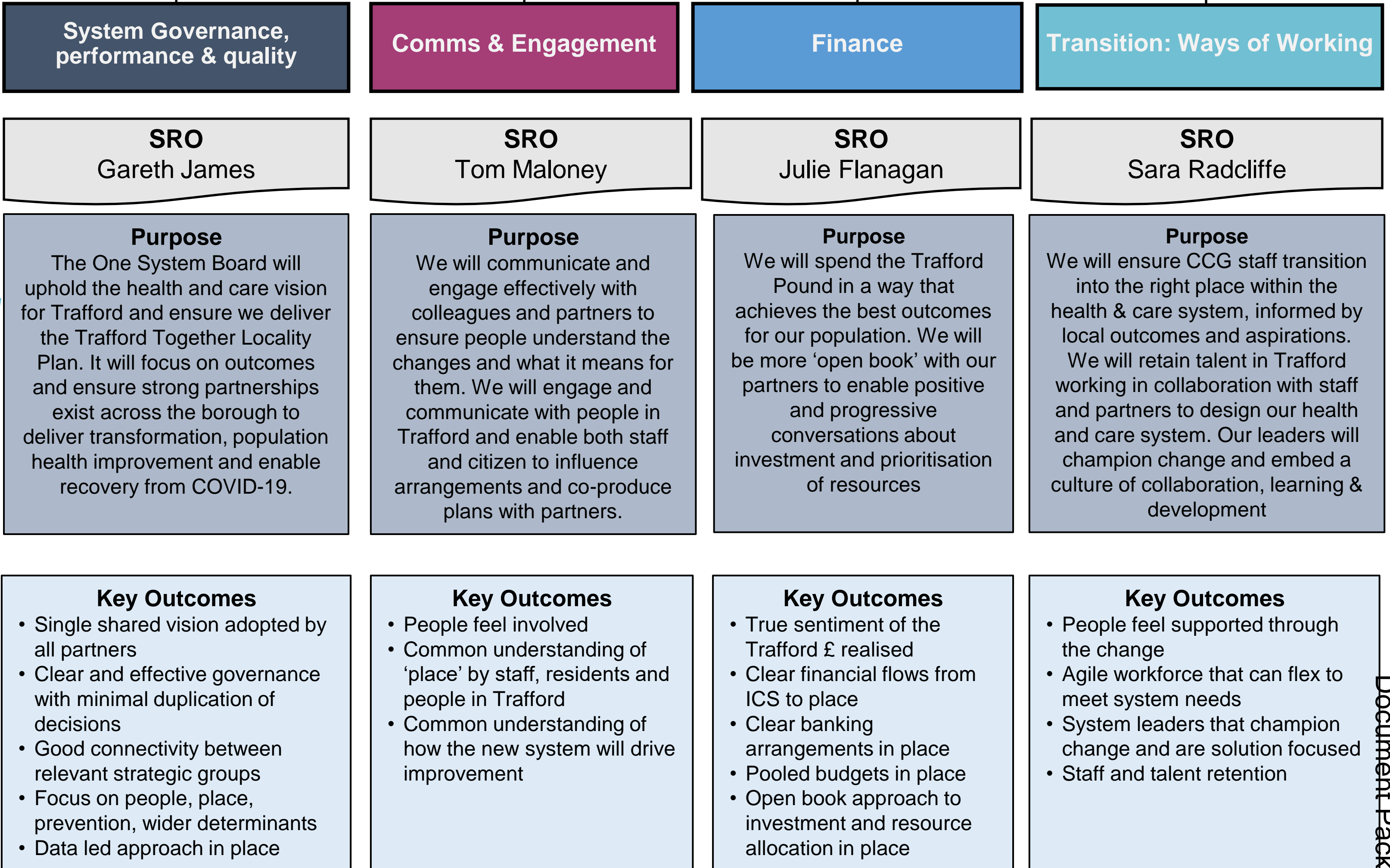
Immediate priority – safe landing into ICS:

- Security and support to staff
- Continuity of service

Subject to any decisions at GM our holding position is that staff will remain in 1 of our 6 teams in our locality

Trafford TOGETHER


One System Board
Chair: Manish Prasad
This group provides a single point of clinical and practitioner oversight of community-based health and care provision across Trafford with involvement in the design, planning and delivery functions of the provider collaborative arrangements. It will support the development of clinical pathways and pathway / service redesign, providing evidence based advice and guidance, working across organisational boundaries to promote a whole system approach. It will make recommendations and formally support service change, stand-up and pathway redesign through into the Provider Collaborative Board for onward approval.
Trafford Provider Collaborative Board
Co Chairs: Andrew Western, Muhammed Imran
The OSB will agree the shared priorities and strategic direction for health and care in Trafford and undertake all function and duties delegated to it by GM ICB. It will ensure that all elements of NHS and local authority services are aligned with the shared Trafford strategic direction. It will agree resource allocation within the scope of responsibility delegated to it and act as the interface with GM ICB & HCP.
Trafford Clinical and Practitioner Senate
Co-Chairs: Diane Eaton, Gill Heaton
The purpose of the Board is to be the engine room of the One System Board (OSB) shaping, co-designing and delivering services in line with the priorities of the Trafford Together Locality Plan and strategic direction set by the OSB – In summary it is responsible for delivery of the Locality Plan. It will work in partnership to deliver high quality, safe services at the right time and in the right place. We will shape and co-design services to ensure we maximise Trafford's resources.
Chair: Sara Radcliffe
This group is to develop and support the ongoing local system reform in response to the creation of GM ICS. The Board will ensure work is carried out to support the development of the Locality model through the established working groups and linking closely with the Provider Collaborative Board. It has oversight of all working groups, translates policy and guidance and co-ordinates delivery of the work programmes up to the OSB.
Chair: Diane Eaton
The purpose of this group is to oversee the delivery of the programmes of work identified by the Provider Collaborative Board. It will monitor progress and coordinate the priority programmes of work through its direct relationship to the three Strategic Design Groups (SDGs). The Board will ensure connections and interdependencies are made across the SDG's. It will embed a proportionate 'programme risk management approach'. – allowing the partners to mitigate and manage risk successfully but have clear lines to escalate to the Provider Collaborative Board if appropriate.
H&SC System Reform Steering Group
H&SC Delivery Steering Group
Health & Social Care, Delivery & Reform System Connectivity Diagram
Trafford TOGETHER



Summary of changes:

- Provider Collaborative Working Group stood down now the Trafford Provider Collaborative (formerly LCA) has been established
- Clinical and Practitioner Leadership working Group stood down as the Trafford Clinical & Practitioner Senate has been established

Who is in the Team?

1. Commissioning
2. Finance, Governance, Corporate and Contracting
3. PMO and Strategy
4. Nursing
5. Performance and Quality
6. Medical Directorate

July 2022 – Prior to any transformation process enacted by GM ICS

Place Leader

Commissioning
13 FTE

- Urgent Care
- Planned Care
- LTC
- LWAH
- Cancer
- Maternity
- MH
- LD
- Children's

Finance, Contracts & Governance
29.5 FTE

- Finance
- Contracts
- BI
- HR
- Comms
- IT

PMO & Strategy
4 FTE

Shared with Trafford Council

- PMO
- Strategy

Nursing
18 FTE

- Patient Experience
- Individualised Care
- Personalised Care
- IMHaD
- Safeguarding Adults
- Safeguarding Children & LAC

Performance & Quality
13 FTE

Shared with MHCC

- Performance & Quality - MH, Small providers, acute community services
- Primary Care Quality
- Corporate Performance
- Serious Incidents & Patient Safety
- Resilience

Medical Directorate
26 FTE

- Medicines Management
- Primary Care Clinical Advisors

Trafford TOGETHER

Spatial Levels articulation of 6 functions

Function	Spatial level
1. Commissioning	Locality under Place Leader aligned with providers
2. Finance, Governance, Corporate and Contracting	Hub and Spoke Model GM & Locality under Place Leader aligned with providers
3. PMO and Strategy	Locality under Place Leader, aligned with providers
4. Nursing	Hub and Spoke Model GM & Locality Locality alignment for delivery functions
5. Performance and Quality	Hub and Spoke Model GM & Locality Place Leader (Manchester & Trafford)
6. Medical Directorate	Locality under Place Leader, aligned to providers. Locality alignment for delivery functions

Place Leader – Key Characteristics and Duties

Characteristics:

- Advocate for the Trafford patient voice
- Experience of providing leadership across health and care systems
- Experience and understanding of the wider determinants of health
- Strong influencing skills
- Facilitate a culture of collaboration
- Experience of leading within and NHS or other relevant public sector organisation

Duties (Pending publication of national role profile):

- Represent and advocate for Trafford throughout GM governance arrangements (currently JP&DC)
- Provide system leadership and relationship management
- Responsibility for ICB delegations:
- Individually for certain delegated functions
- Via Trafford locality board (One System Board)
- Jointly accountable to the ICB and local authority chief executives
- Management of ICB locality team; locality line management structure TBC
- Lead on local performance management
- Budgetary responsibility for ICB delegated funds and any locality pooling arrangements
- Work with Trafford colleagues to reduce inequalities and unwarranted variation across Trafford
- Question around chairing the Trafford Locality Board (Being discussed on 14th Dec / 12th Jan 22)

Trafford TOGETHER

Critical Factors and Key Next Steps

- Appointment of Chief Executive and Executive Director posts
- Appointment of Place Leader
- GM Operating Model
- Locality Operating Model – Alignment
- Continued Trafford engagement in GM ICS conversations surrounding safeguarding – and other related agendas (Quality) – to shape future arrangements

Questions and Discussion

- What are the opportunities – How can we do things differently to improve our current approach / arrangements?

- What are the known risks? And how can we mitigate against them?

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Health and Social Care Shadow Joint Planning & Delivery Committee

Date: 22 December 2021

Subject: GM ICS – Implementing the Operating Model

Report of: Sarah Price, Interim Chief Officer on behalf of GMHSCP Core Leadership Group

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PURPOSE OF REPORT:

The Core Group were asked to work with Mike Farrar on making recommendations to JPDC on how to finalise some of the outstanding issues for implementing the GM operating model. The paper emerging from that work is attached.

Importantly, the paper recognises all the work done since the agreement of the operating model in July 2021 and then signals 5 areas (described as integrating processes) that have yet to be resolved. These cover -

- creating a simple narrative
- finalising governance and constitution
- financial flows
- assuring locality structures
- running costs and deployment of CCG/GMHSCP staff

There are detailed recommendations in each of these areas for JPDC to consider. However, it is very easy to get lost in the details and forget that GM is trying to create an ICS that ***transforms*** rather than simply ***manages*** the system (in doing so it will need to consider how it manages the likelihood of a strong expectation from NHS England that the ICS will be an effective system manager arguably first and foremost).

As a consequence, JPDC needs to consider these recommendations in the context of whether these final areas i*n addition* to those already agreed will deliver the transformation that GM committed to in the summer. So, the tests would be:

- Is JPDC confident that with these arrangements GM will now be able deliver the six transformation programmes set out in the operating model? i.e:
    - ✓ have a systematic process for empowering citizens in communities and neighbourhoods

- ✓ will this enable localities and PCNs to reduce unwarranted clinical variation in primary care
- ✓ will this allow locality boards to create place based arrangements that integrate care for those citizens with greatest needs, reduce hospitalisation and help maintain them living independently
- ✓ will this empower providers to coordinate and improve the urgent care response (and meet national standards)
- ✓ will this empower providers to take responsibility for delivering the elective recovery programme within the finite resources available (and meet national standards)
- ✓ will this allow GM to fulfil its potential as a national centre for innovation and specialised care

- And do the arrangements create

  - ✓ the appropriate culture of joint NHS/LA working; clinical and care professional empowerment; joint working with VCSE and citizens
  - ✓ the ability to use existing health and care budgets to better effect and bend non health and care budgets to achieve a health and care dividend

REQUESTS OF JPDC:

The JPDC is asked to:

- Consider the proposals as described in the paper
- Approve the proposals as set out

CONTACT OFFICERS:

Sarah Price
Interim Chief Officer, GM HSCP
sarah.price16@nhs.net

GM ICS - Implementing the Operating Model

Context

Constituent organisations in GM agreed an operating model and governance arrangements in summer 2021 with a view to their implementation by April 2022. GM is committed to implementing a model that is true to

- the **devolution agreement and intrinsic ambition** for improvements in the GM public's health and care
- the **national legislative requirements**
- the **agreed operating principles** (shared priority setting, shared planning, shared stewardship of resources, shared accountability), that also include **clarity and simplicity** of approach in order to enable neighbourhoods, localities, provider collaboratives and GM programmes to operate coherently with a shared mission and purpose. Crucially the implementation of the operating model needs to be focused on **system transformation** not simply a reinvention of system management

The purpose of this paper

- This paper **recognises and identifies the work that has been done since Summer** on building strong component elements of the model and also highlights a number of means by which these components are beginning to work together in a coherent and effective way.

- It provides further clarity on implementing the operating model and **we recommend actions on five integrating processes** that are essential for the GM system to capitalise on these components and deliver its aims and objectives -

1. Creating a simple narrative as to how this new system will work
2. Finalising ICB and ICP governance and priority setting
3. Agreeing Financial Flows and Responsibilities
4. Signing off Locality Leadership Arrangements
5. Agreeing Running Cost Allocations and deploying staff within the national HR framework

- **It recommends how the operating model should be initiated and delivered in the next twelve months** with the direction of travel clear for the 3-5 years.

What has been achieved since Summer 2021

Established Component Elements

A number of key components elements were agreed and developed throughout year since the operating model was signed off -

GM has agreed and now has strong platform of governance that is consistent with the ethos of partnership.

GM has created a clear expectation and framework within which the 10 localities have developed their approach to place based working. There is further work to be done on the balance of consistency and local variability of approach (see point 4 of the integrating functions)

GM has created the opportunity of intelligent deployment of resources by previously establishing, and now consolidating, country leading collaborative approaches in specialist, secondary, primary,

mental and physical health services through PFB and PCB, VCSE and neighbourhood working, with sector led, system wide development work on adult and children's social care

GM has built a platform for establishing strong neighbourhood working, with a formal GM wide Accord with the VCSE and national exemplars of working with citizens as assets in localities (eg Wigan)

GM has, at its disposal, country leading assets designed to accelerate innovation in Life Sciences, Digital and wider Technologies through MAHSC and Health Innovation Manchester that : facilitate and build on the strengths of GM academic institutions; create the potential for commercial partnerships; and provide the route for transforming services

GM has established a strong commitment to and platform for excellent HR management and OD as part of its work on individual and organisational transition.

Established Integrating Processes

GM has established an Integrated Partnership Board that sits centrally between the ICB and Local Authorities, the Combined Authority and the Mayor's Office

GM has established a single new Joint Planning and Delivery Committee that supports these structures to work in an integrated manner in practice (replacing a number of joint commissioning and GMGSCP structures)

GM and Localities are beginning to appoint leaders to the key posts within the structures at GM level (eg ICS/ICB Chair); Locality level (Place based leaders); Provider Collaboratives (Chairs and Managing Directors)

GM has established a core executive leadership group, bringing together the executive leaders of its component elements that represent all levels in the new system to enable joined up implementation of the new operating model

GM has completed an extensive exercise to identify the appropriate spatial level for planning and delivering integrated services (GM, multi locality, locality and neighbourhood/PCN(s))

Required Further Integrating Processes

Whilst progress has been made on building the component elements and beginning to put in place some integrating processes that will bind the components in a coherent operating model, there is more work needed. There are 5 areas that we believe need agreement to develop further -

1) ***Creating a simple narrative as to how this new system will work*** (see draft in the box below)

- All GM constituent organisations are committed to achieving better health, better standards of care, financial sustainability and reduced inequalities
- Our approach to do this requires us to receive and allocate NHS resources provided by the Government and align these with resources raised locally through our Local Authorities (including for non health and care spend)
- The new Integrated Care Board and Integrated Partnership Board will be responsible for considering the full range of these resources and setting a strategy and priorities for how these resources, when seen together, can be used to deliver it. This will be informed by the legitimate priorities set by national Government, the legitimate local priorities set by Local Government on behalf of GM residents, and the priorities set by the GM Mayor

- The new Joint Planning and Delivery Committee will be formally responsible, acting in support of the ICB, to ensure the delivery of this strategy and its impact on the GM overall objectives
- NHS Funding will flow from the ICB directly to NHS Trusts for locally agreed and GM wide programmes - the latter, having been advised by PFB who are taking on responsibility on behalf of GM ICS to coordinate and ensure the delivery of a programme of specialised services, elective care recovery, pathway transformation (eg MH and cancer), and coordination of urgent care
- NHS Funding will also flow from the ICB to the 10 GM localities where Locality Boards will have the ability to align or pool this with LA funding, prior to them a) setting the Locality priorities including the delivery of their contribution to the GM wide objectives, b) allocating the resources to their local provider collaborations/alliances, who will join up service delivery, and c) delegating responsibilities for how these resources will be overseen and stewarded at neighbourhood level with local communities and PCNs working together.
- This activity will be coordinated between localities and the ICB through the appointment of a single place based lead (who will have joint employment and accountability status with the ICB and with a LA or Trust)
- Finally, NHS funding will also flow to primary care practices and to PCNs in line with the national contract agreements. They will receive guaranteed funding levels, but will undertake to work through Locality Boards to align this spending with local and GM priorities and objectives. They also have flexibility to agree or maintain local incentive funding for achieving objectives. The ICB will be advised by PCB/GPB in this task and at local level by GP Boards working in support of Locality Boards,
- Some NHS and LA funding will be retained or deployed at GM level and spent by GM ICS, PFB or PCB. This will be largely associated with enabling functions such as system governance, data and digital, labour market and people, innovation support, performance improvement etc
- Wherever funding is held or banked within the system, every organisation is committed to the key principle of joint stewardship in order to help speed the processes of service transformation, productivity improvement and efficiency
- These processes will require a) joint planning and joint working at each level (in line with the operating principles) - overseen by the JPDC, b) informed allocation of resource (people and money) to enable each component part to deliver its contribution, c) bold, radical and collective leadership to tackle long standing issues such as health inequalities

2) Finalising ICB membership, delegation, constitution and relationship to priority setting process

Membership

Whereas there is flexibility in the ICS operating model and the ICP governance structure, the ICB structure itself needs to be consistent with the legislation including a number of specified mandatory elements. GM needs therefore to agree the membership, constitution, including delegations and the relationship with the ICP Board.

We recommend that the GM ICB begins simply by meeting the specified mandatory roles in terms of membership but this is reviewed in 6 months time to ensure that it is providing a governance approach capable of delivering on both national and GM objectives, operating model and culture

In relation to the membership of the ICP, we are aware that initial proposed membership arrangements have been subject to question (in particular the importance of securing clear

input from VCSE and from the voice of citizens) and so recommend a short review of those to be completed by the end of January 2022.

Chairing

The proposed chairing arrangements for the ICB and ICP (and the JPDC that serves them) have been considered in light of the need to have

- continuity of thought and direction
- confidence of the GM stakeholders
- the principles of good governance at their heart

This has led to a proposal that

a) Individual chairs for the ICB and the ICP with the JPDC being jointly chaired by the two Chairs
b) The ICB Chair is the vice chair of the ICP; and the ICP chair is in attendance at meetings of the ICB
c) The ICB is appointed through the national process set out by the NHS (as was the case); and the ICP Chair is the health and social care portfolio holder of the Combined Authority, and appointed by the Mayor

We recommend that this approach is now formally adopted within the GM ICS governance structure

Constitution and Governance Handbook

In terms of the Constitution that the ICS is required to establish, this will set out the core legal requirements but a Governance Handbook will sit along side this and will describe the component elements of the system that relate to GM's chosen operating model and process. This will provide a more comprehensive and understandable explanation of the ICS which would foster more transparency and openness to the GM public. It will also allow any changes that GM wishes to make to its approach to be enacted swiftly within the need for national recourse and permissions, as it 'learns by doing' in the coming period.

We recommend that the ICB constitution mirrors the national constitution with a commitment expressed in the Governance Handbook that it will operate in manner consistent with the GM operating model and principles, and will have full regards to the strategy and priority setting process of the ICP, and the role we have established for a JDPC, (which does not feature in the national model constitution).

We recommend that the ICB adopts a scheme of delegation allowing it to delegate budgets to localities and to providers on behalf of Collaboratives.

We recommend that the Governance Handbook should describe the crucial role of the JDPC as it holds responsibility for overseeing GM level activity and coordinating locality and multi locality working. It will also advise and oversee the option of establishing effective joint committees with localities, and with providers/provider collaboratives and be a driver and assurer of joint stewardship within the system and across GM functions.

The JDPCs role is crucial in ensuring coherence of the new model with its component elements and we recommend that it establishes a clear joint planning process that joins up the spatial levels and informs the allocation of resources (finance and staffing) across neighbourhoods, localities, collaboratives and GM enabling programmes)

We recommend that the Governance Handbook formally recognises the role of PFB, PCB, and the VSCE Accord in advising the ICB, ICP and JPDC on strategy, priorities, operational requirements, in line with their responsibilities to steer, coordinate and in some cases deliver key agreed programmes of work in support of their clinical strategies

We recommend that the Governance Handbook also formally identifies the commitment to create a clinically and care professionally driven and empowering culture as a key element of the GM system operating model.

Finally we recommend that the Governance Handbook sets out the basis upon which there will be a clear route for public engagement, through establishing precisely the GM commitment to open meetings and published minutes

3) Agreeing Financial Flows and Responsibilities

We are clear that it will be mission critical in order to achieve our shared objectives that we have aligned financial incentives

Ongoing work since the summer undertaken by the FAC supported by a core financial officers team on financial flows will be brought together with NHS Planning Guidance and work on spatial levels to recommend how flows will work. It is essential that this is finalised urgently and signed off it GM is to be able to pursue our objectives and make sure the next financial year (2022/23) is the starting point for the new approach we wish to take.

We recommend that JPDC oversee allocations into the system for the next financial year taking account of the priorities and strategy set by ICP and agreed ultimately by ICB. This will include them taking into account the work on spatial levels, balancing the need for simplicity with the key forward principle of joint stewardship to facilitate transformation

Looking at this in some detail, we need as a system to be very clear as to how the different funding streams in national and GM previous arrangements will flow in the new ICS from the ICB for the NHS and from LAs for locally raised revenue. So taking these in turn -

Simplicity

We recommend that money previously committed through the specialised commissioning route (ie funding for those highly <u>specialised tertiary services</u> that deliver extremely rare, complex or innovative treatments, concentrated largely at MUFT, Christie, MH Trusts and SRFT) are simply distributed directly to the relevant Trusts

We recommend that <u>money previously distributed through the NHS CCGs would be allocated by the ICB in two main streams</u>

a) Directly to Trusts as ***a single allocation to each for NHS work they do*** locally (in hospital and in community) and as informed through the programmes where PFB, in some cases working with partners, are leading the planning; and through discussion at the locality board (see joint stewardship principles). This will avoid a retrograde step of disintegrating budgets that have previously been integrated allocations for community, diagnostic and in hospital care, and which in many areas are also subject already to joint stewardship arrangement through s75 arrangements

b) To Localities, for money spent with non NHS Trusts (NB in Bolton for example, this sum may be around £150m of their previous allocation) which would be routed through a joint committee (ICB/LA) or lead provider option; money would then be allocated from there to individual care providers or via a lead provider. At this stage, using the role of Locality Leadership Boards, money available locally by LAs eg for social care or public health could be pooled via s75 or

aligned virtually to achieve a virtual place based budget. NHS Trusts and GPs/PCNs would also be expected to discuss the optimal utilisation of the money they had received directly from the ICB in this forum. This allows the simplicity of allocating and accounting to be married with the important ambition for service transformation

On the specific question of primary care core service funding we recommend this being allocated directly to practices and PCNs based on the national contract formula and conditions. But there is work in train with PCB working with local GP representatives to determine how money that was previously directed locally through co-commissioning routes (eg Local Enhanced Services) should be distributed into practices (NB it is also clear that NHSE are taking an active role in considering the next steps for these services, which they currently formally commission or co-commission) .

One option for example may be for this to be included in the locality allocation but with a view that the objectives associated with this local money are advised by the local GP Board and crucially with a ***minimum*** level of expenditure guaranteed to be spent through practices. Any agreement on the ***quantum*** within a minimum baseline however will need to take account of the current variation of local schemes across GM eg Salford's additional, non GMS, financial commitment to their quality scheme, where our understanding is that colleagues locally would clearly wish this to be protected and guaranteed.

There is a need to finalise and agree swiftly the route and level of *allocation* into the primary care sector. CFOs, and for primary care, PCB, should make clear recommendations for JDPC decision on this by the end of January. There is also an immediate need for JDPC to work in parallel with them on whether the GM system adopts a single model or allows variability depending on the preference of each locality.

This process should also propose, for agreement, funding for any programmes of work that need to be undertaken at GM level on behalf of the system. In this case, funding would need to flow predominantly from running cost budgets (see section below)

Joint stewardship

Whatever is ultimately agreed on any or all the allocation routes , ***the principle of joint stewardship is absolutely fundamental to the transformation of services .*** This, we know to be necessary to achieve our quadruple aim.

So we recommend that whatever arrangements are proposed and adopted for distribution of resources to fund previously NHSE/CCG/LA commissioned Health and Care services, there has to be the principle of joint stewardship applied to how the money is *deployed* and this should be built in as a condition of any allocation.

These conditions could be as follows -

1) money going directly to Trusts through the ICB directly must be 'brought to the table' to identify how that resource, when added to money sitting with other Trusts, organisations or sectors, can be used collectively to achieve maximum productivity, necessary cost saving and contribute most effectively to achieving the quadruple aim

2) Money going directly to Trusts for specialised care and those other hospital based programmes (eg elective care), that are subject to the shared planning and strategy set by Trusts through PFB, would be subject to joint stewardship through the PFB governance arrangements; and for wider services (eg urgent care, MH, cancer) through PFB working with partners under the specific governance process they establish to coordinate services

3) money going via locality joint committees, locally agreed lead providers or LA commissioned services would be required to adhere to the same principle as in 1) above (this allows for locally raised revenues for social care and public health programmes to be subject also to joint stewardship)

4) money for general practice should achieve the minimum guaranteed level (ie must meet previous levels of CCG based expenditure going into GMS services) and for core services go directly to the practices but should be 'brought to the table' for alignment and agreement about the requirements attached to any money out with global sum, QoF payments and DES payments (to ensure consistency with locally set priorities and objectives). There are a variety of local models in play in this regard, and local GP Board, where present, should propose the approach for any local alignment including protection of schemes that may add additional resources to the sector from non - GMS monies (eg local quality incentive schemes)

5) money for wider primary care practitioners should follow the same principle as for general practice with guaranteed sums and consistency with national agreements

Efficiency, Inequalities, and Review

We are conscious that there is likely to be pressure to generate efficiency across all budgets (including running costs - see next section). Allocations will need to balance technical efficiencies in each organisation with the need to secure allocative efficiencies by working more creatively. **We recommend that the finance community identify the level of efficiency required and JPDC commission a short piece of work to inform the distribution of the efficiency goals to be achieved in each organisation, Collaborative and Locality**

We recommend that all resources are allocated mindful of the GM objective to reduce health inequalities which may mean a gradual shifting of money to those individuals, communities and localities with greatest need.

We recommend that these arrangements would govern the starting point for the new system but, with the exception of maintaining the core principle of joint stewardship, be seen as the basis upon which longer term thinking on a more radical financial and service transformation strategy should be based, with this work starting in the new year.

4) ***Signing off Locality Leadership***

There is an important balance to strike between consistency of approach in each of the ten localities and the recognition that each has differing characteristics and history of joint working. The operating model set out some core expectations of having -

- A Locality Board (that can deliver accountability for decisions and budgets at place level) and includes LA political leaders/portfolio holders, and care providers (primary care, MH, social care and acute hospital care) as an integral element of the governance
- A "place based lead" (jointly accountable person to localities and to GM ICS for health and care) - recognising this may be subject to further national policy
- An accountability agreement between partners in the locality and GM ICS
- A mechanism for the priorities to be decided together in the locality and a process for determining consequent financial flows to providers or provider alliances
- A system of clinical and professional advisory input
- An articulated relationship with their local Health and Well Being Board (the detail of which would be determined locally)

As we have a clear commitment to ensure the system is up and running to begin formally in April 2022, **we recommend that JPDC sets up a process where it has sight of the arrangements**

for each locality and the facility to run a process of check and challenge that would ensure all localities are fit for purpose. This would be appropriate given that each locality is represented on this Committee and can bring the advantage of peer review to the process, rather than this being a top down approach. (Should any locality require or ask for support, this would be arranged by the JDPC).

We recommend that this process is completed by the end of January 2022

On the specific point of the appointment of a place based lead we are aware of the need to make appointments to enable the ICB to function. As such **we recommend moving forward with a joint Locality/GM appointment process as per the current timeframe but making any appointments provisional subject to any emerging approaches associated with national guidance once clear.**

We believe that these appointments have a clear specific purpose of enabling the interaction between the ICB and the localities and so the principles of ***joint Locality and GM employment and accountability*** are fundamental to ensuring that the role of place based lead contributes effectively to the development of place based working and GM system wide working***. Successful appointments will allow for the effective delegation of budgets into place with appropriate accountability, when needed, back into the ICB***

Once appointed the place based lead would also be able to take responsibility for defining the locality posts that are needed within their defined running costs envelope

On the issue of staffing from the deployment of staff from CCGs we cover this in point 5 below.

5) Agreeing running cost allocations and redeploying staff (displaced by the abolition of CCGs) within the national HR framework

In order for the operating model to work, there must be a recognition that for a number of key functions there will be work to be undertaken that is over and above the single organisation operational and planning roles that are already in the system.

We believe that this must be resourced properly but equally ***we also know that to support our achievement of financial stability there is considerable scope for efficiency in the running cost envelope as we bring a large number of organisations together***. Clearly in the short term we must be cognisant of the employment commitment but over time we would wish to see running costs released to support more front line care and service delivery.

In order to treat staff fairly and the get the new system motoring, **we would recommend early decisions on the initial distribution of the running cost envelope to the component elements of the system, based on the work that the core CFO group is leading. (NB A separate paper is being worked up for JPDC along side this paper).**

In time we should ask each organisation individually and then working in concert, to make plans as to how safe and effective running cost reductions would be made to contribute over time to efficiencies and additional front line resources.

We recognise that this is tied intrinsically into people and posts and so needs intelligent thought and sensitive transparent and fair management. Any deployment of existing staff must be undertaken in line with the national HR framework and commitments given to staff through that route. This will mean maintenance of roles in transferring into the ICB in April but appropriate consultation with people on any changes down stream in the usual approved manner.

In order to start this process, **we are aware that the work being undertaken on behalf of the system by FAC needs to be considered urgently with agreement to follow swiftly. If that is**

not possible then we recommend that the default starting point for running cost allocations is the current distribution of budgets within the localities (based on previous CCG budgets) but that this is reduced proportionately to allocate running costs to provider collaboratives and GM programmes that JPDC agree should be maintained at this spatial level.

Any budgets agreed for provider collaboratives and GM programmes will need to differentiate between cash and staff (in the latter case, staff may be employed and paid for directly through the ICB but deployed, subject to due consultation, in support of the provider collaborative work).

As the new system is likely to have a more distributed leadership approach within the system, we believe there will be scope over time, and subject to consultation with staff, to reallocate resources held at GMHSCP into budgets held or steered by the component elements of the system.

We would also recommend that the GMICS applies its mind creatively to how it can attract inward investment (eg through life sciences and HIM commercial partnerships) and also in partnership with VCSE to create roles that enable differing employment and voluntary roles within the system as a means to improving social mobility for example.

Initiating the Operating Model and Arrangements

We believe that time is of the essence and we would like clear decisions to be made on our recommendations at the JDPC in December, wherever possible. This will allow for

- staff deployment and running cost budget assumptions to be finalised quickly in the new year
- Locality leadership boards to be agreed via the check and challenge process by the end of January and to begin operating in earnest
- Place based leads to be identified
- ICB and ICP to meet in shadow form
- the GMICS to plan for transformation and change in 2022/23 so that there is no loss of a further year due to organisational change
- the Constitution to be established (without decisions, this will not be possible within the expected timeframe).

We recognise that some of our recommendations are designed to get the new system up and running and these will need to be reviewed as the new system begins and then beds in.

We do not believe there will be a need for a fundamental overhaul of our arrangements but we recommend an informal review of the ICB and ICP membership arrangements early in 2022 with an operating model review undertaken in Summer, to make any adjustments necessary.

MF on behalf of the Core Leadership Group,

November 2021

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