AGENDA PAPERS FOR

HEALTH AND WELLBEING BOARD

Date: Friday, 15 September 2023

Time: 10.00 a.m.

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

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

1. **ATTENDANCES**

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

2. **DECLARATIONS OF INTEREST**

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

3. **MINUTES** To Follow

To receive and if so determined, to approve as a correct record the Minutes of the meeting held on 14th July 2023.

4. **QUESTIONS FROM THE PUBLIC**

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

5. **APPOINTMENT VICE CHAIR**

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

6. **HOUSING STRATEGY** 1 - 16

To receive a presentation from the Housing and Growth Manager.

7. **LOCALITY PERFORMANCE ASSURANCE FRAMEWORK** 17 - 22

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

8. **SYSTEM WORKING TO ADDRESS HEALTH INEQUALITIES**

To receive a report from the Director of Public Health.

9. **CHILD DEATH OVERVIEW PANEL (CDOP) ANNUAL REPORT** 23 - 54

To receive a report from a Public Health Consultant.

10. **BETTER CARE FUND (BCF)**

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

11. **OPERATIONAL OUTBREAK PLAN** 55 - 88

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

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

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

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

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

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

SARA TODD
Chief Executive

Membership of the Committee

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

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

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

This agenda was issued on **Thursday, 7th September 2023** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall; Talbot Road, Stretford, Manchester, M32 0TH.

WEBCASTING

This meeting will be filmed for live and / or subsequent broadcast on the Council's YouTube channel https://www.youtube.com/channel/UCjwbIOW5x0NSe38sgFU8bKg. The whole of the meeting will be filmed, except where there are confidential or exempt items.

If you make a representation to the meeting, you will be deemed to have consented to being filmed. By entering the body of the Committee Room, you are also consenting to being filmed and to the possible use of those images and sound recordings for webcasting and/or training purposes. If you do not wish to have your image captured or if you have any queries regarding webcasting of meetings, please contact the Democratic Services Officer on the above contact number or email democratic.services@trafford.gov.uk

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

This page is intentionally left blank

TRAFFORD COUNCIL

Trafford Housing Strategy

2024-2029

Health & Wellbeing Board, September 2023

Caroline Siddall – Housing Strategy & Growth Manager

Trafford Housing Strategy

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

Trafford Housing Strategy 2018-2023

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

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

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

Trafford Housing Strategy 2018-2023

The Housing Strategy 2018-2023 had 7 Strategic Priorities:

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

Achievements

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

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

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

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

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

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

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

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

Achievements

The Trafford Housing Need and Demand Assessment 2023 is underway.

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

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

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

Homeless Strategy 2019-2024 produced and launched in 2019.

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

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

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

Housing Strategy 2024 – 2029

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

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

Consultation Survey Findings

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

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

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

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

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

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

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

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

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

Demographic of Respondents

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

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

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

Gender

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

Age

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

Ethnicity

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

Sexual Orientation

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

Disability

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

Housing Circumstances of Respondents

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

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

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

Property Type

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

Tenure

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

Household Makeup

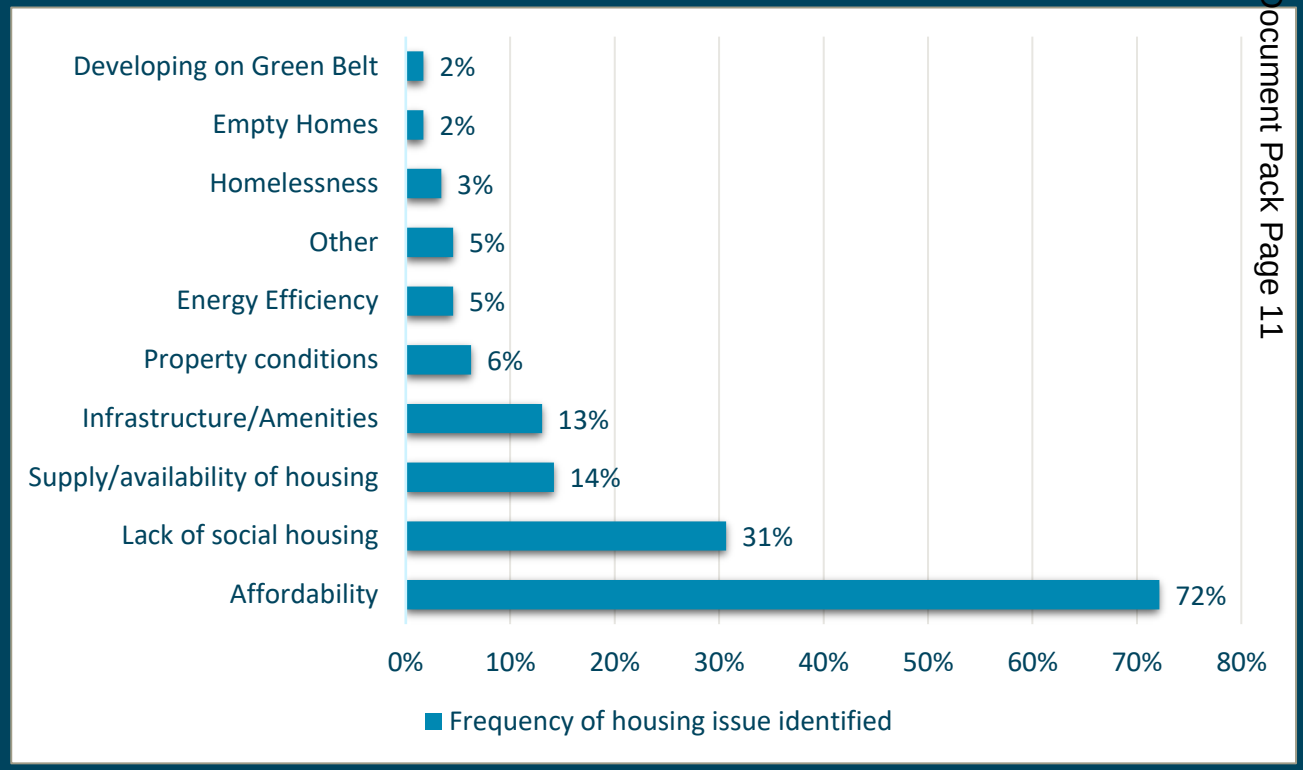
56% living with partner, 25% living alone, 17% living with parents/ family, 1% homeless, 1% living with friends, 1% other

TRAFFORD COUNCIL

Main Housing Issues in Trafford

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

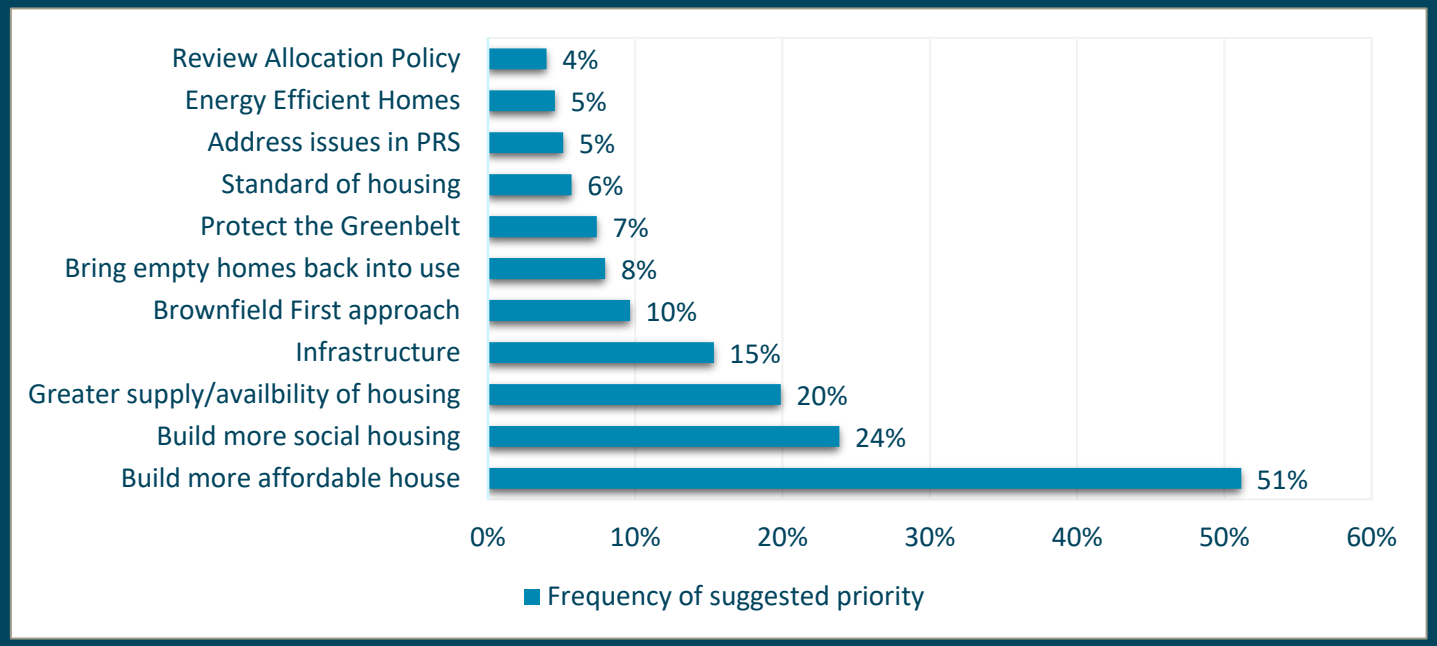
- Poor Infrastructure/insufficient amenities
- Homelessness
- Energy efficiency
- Availability of housing
- Affordability
- Empty homes
- Lack of social housing
- Developing on Greenbelt
- Poor property conditions



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

Suggested Priorities

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



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

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

Listening Session Findings

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

Housing Strategy 2024 – 2029: Draft Strategic Priorities

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

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

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

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

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

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

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

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

Housing Strategy 2024 – 2029

Health & Wellbeing Board Questions

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

TRAFFORD COUNCIL

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

Report Title

Locality Performance Assurance Framework

Purpose

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

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

Recommendations

The Board are asked to:

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

Contact person for access to background papers and further information:

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

1. Introduction

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

2. Background and Context

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

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

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

3. Progress Update

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

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

Table 1:

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

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

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

4. Key Considerations

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

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

5. Recommendations

5.1 The Board are asked to:

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

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

TRAFFORD COUNCIL

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

Report Title

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

Purpose

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

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

Summary

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

Recommendations

The Board is asked to:

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

Recommendations included in the report are:

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

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

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

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

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

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

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

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

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

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

Contact: Kate Shethwood, Consultant in Public Health
Email: kate.shethwood@trafford.gov.uk

This page is intentionally left blank

Learning from Child Death Reviews

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

2021/2022

NHS
Greater Manchester
Integrated care

Tameside Metropolitan Borough

TRAFFORD COUNCIL

STOCKPORT METROPOLITAN BOROUGH COUNCIL

Document Control

Date	Version	Forum/Officer	Purpose	Amendments
26.04.23	1	Eleanor Banister	First draft	Yes
22.06.23	1.1	Ben Fryer	Drafting of recommendations, minor changes	Yes
11.07.23	1.2	Ben Fryer	Re-ordering of recommendations, Addition of Tameside profile	Yes
26.07.23	1.3	Ben Fryer	Addition of Trafford profile	Yes
09.08.23	1.4	Ben Fryer	Feedback from Public Health colleagues across STT	Yes
16.08.23	1.5	Eleanor Banister	Corrected chart labels and page numbering	Yes

Learning from Child Death Reviews: Annual Report of Stockport, Tameside and Trafford's Child Death Overview Panel 2021/2022 has been prepared on behalf of Stockport, Tameside and Trafford Child Death Overview Panel and Stockport, Tameside and Trafford Child Death Review partners by:

- **Ben Fryer, Consultant in Public Health, Stockport Council, and STT CDOP Chair**
- **Eleanor Banister, Public Health Intelligence and Early Intervention and Prevention Lead, Public Health, Stockport Council**
- **Shelley Birch, Child Death Overview Panel Manager (Tameside, Trafford and Stockport), Trafford 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.

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

2. Data protection

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

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

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

Key points from data analysis:

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

4. Recommendations

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

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

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

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

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

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

Contents

Learning from Child Death Reviews

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

1. Introduction

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

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

2. Data protection

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

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

3. The Child Death Overview Process

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

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

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

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

4. Implementing Local Learning

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

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

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

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

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

Source: Trafford Public Health, 2019.

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

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

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

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

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

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

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

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

6.i. Data analysis

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

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

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

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

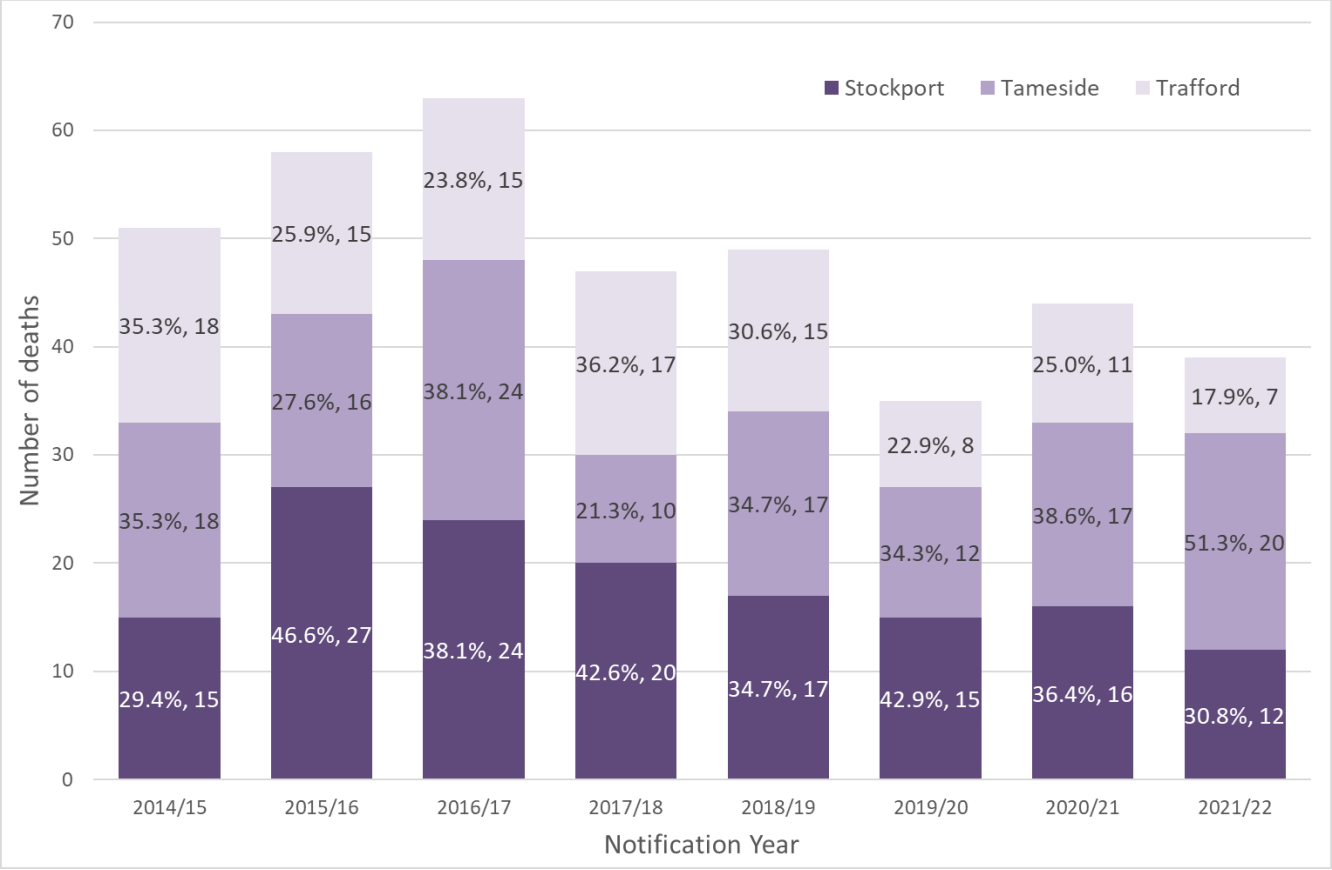
6.ii. Demographic breakdown of notifications

6.ii.a. Number of notifications

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

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

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

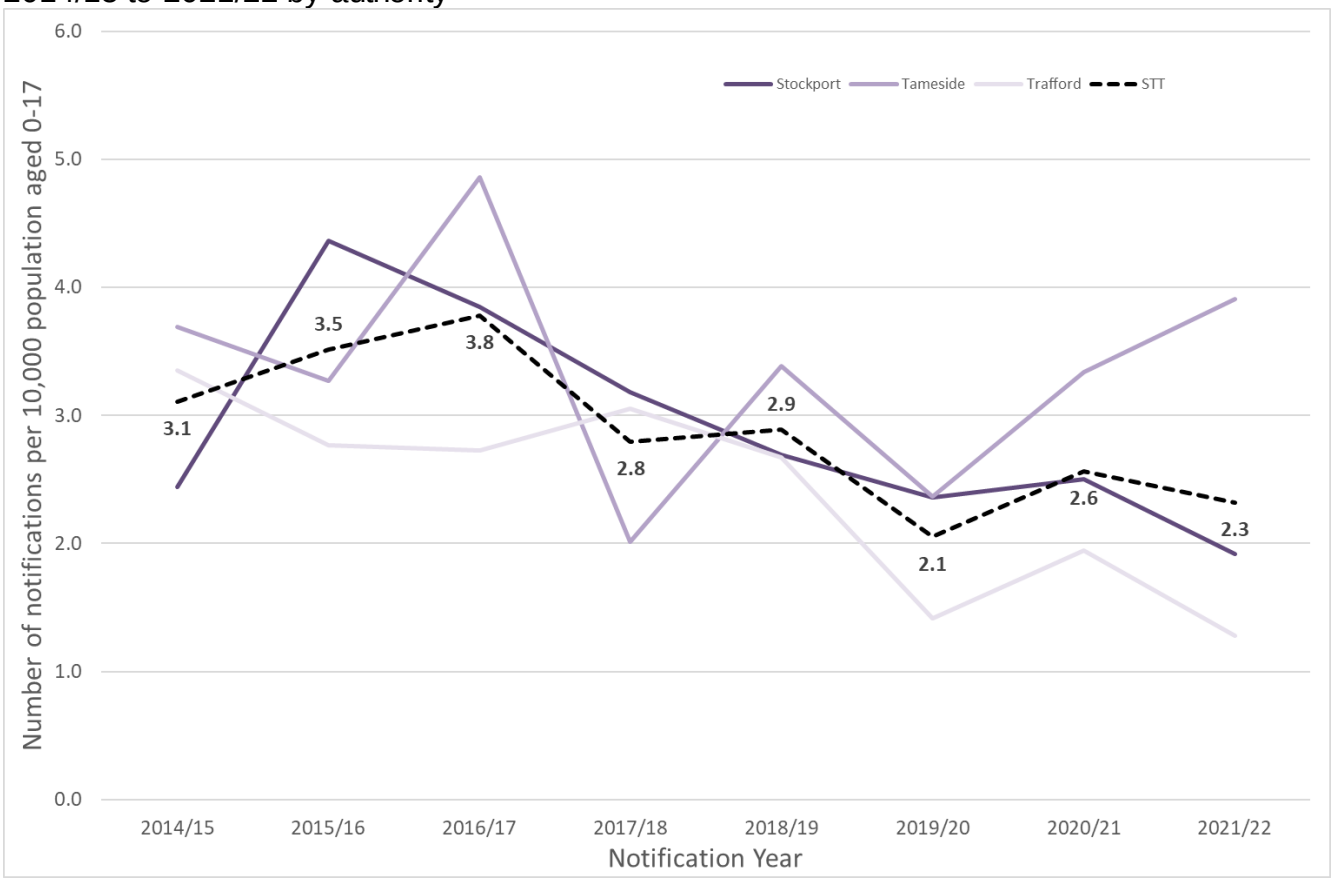


6.ii.b. Notification rate

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

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

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



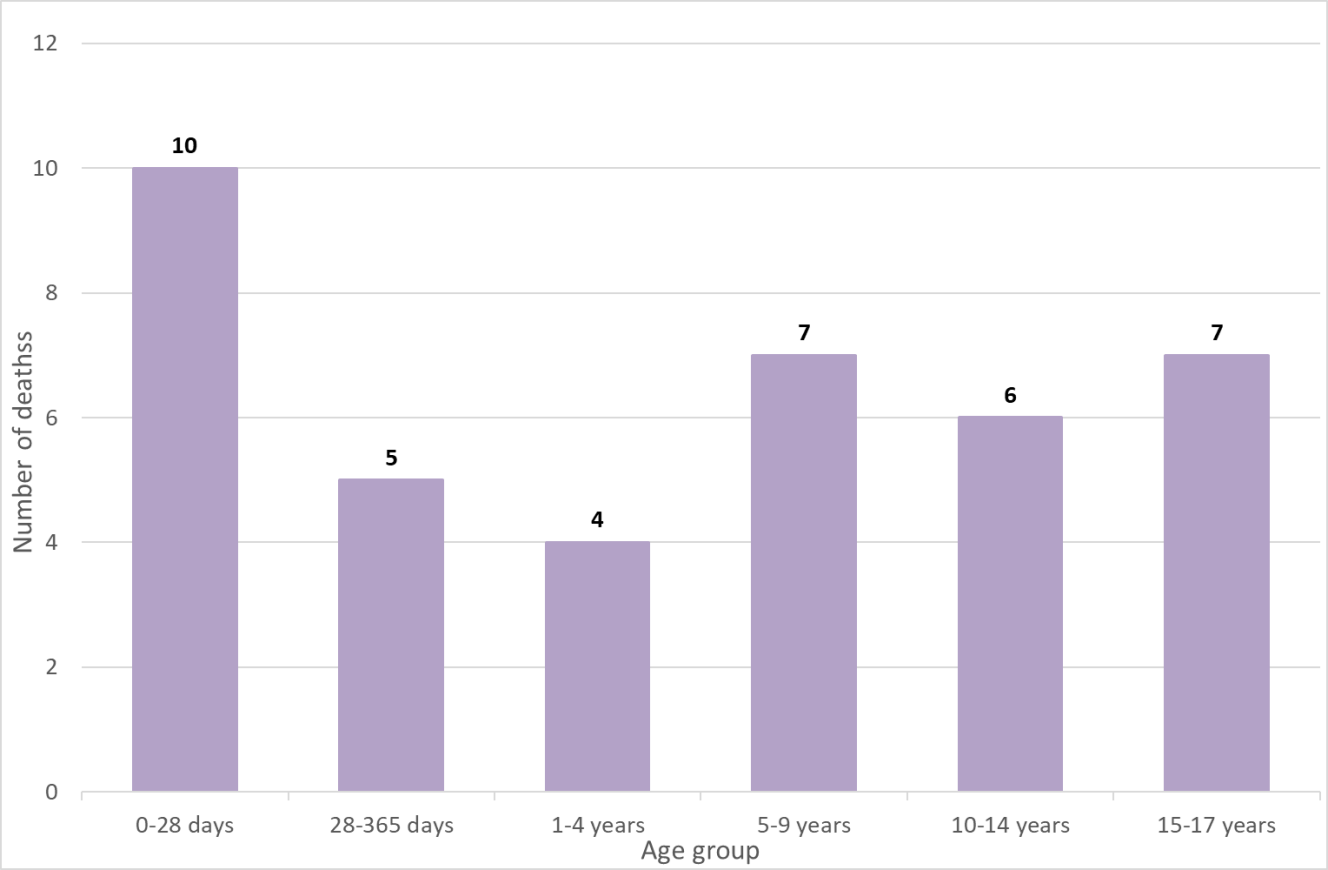
6.ii.c. Age breakdown of notifications

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

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

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

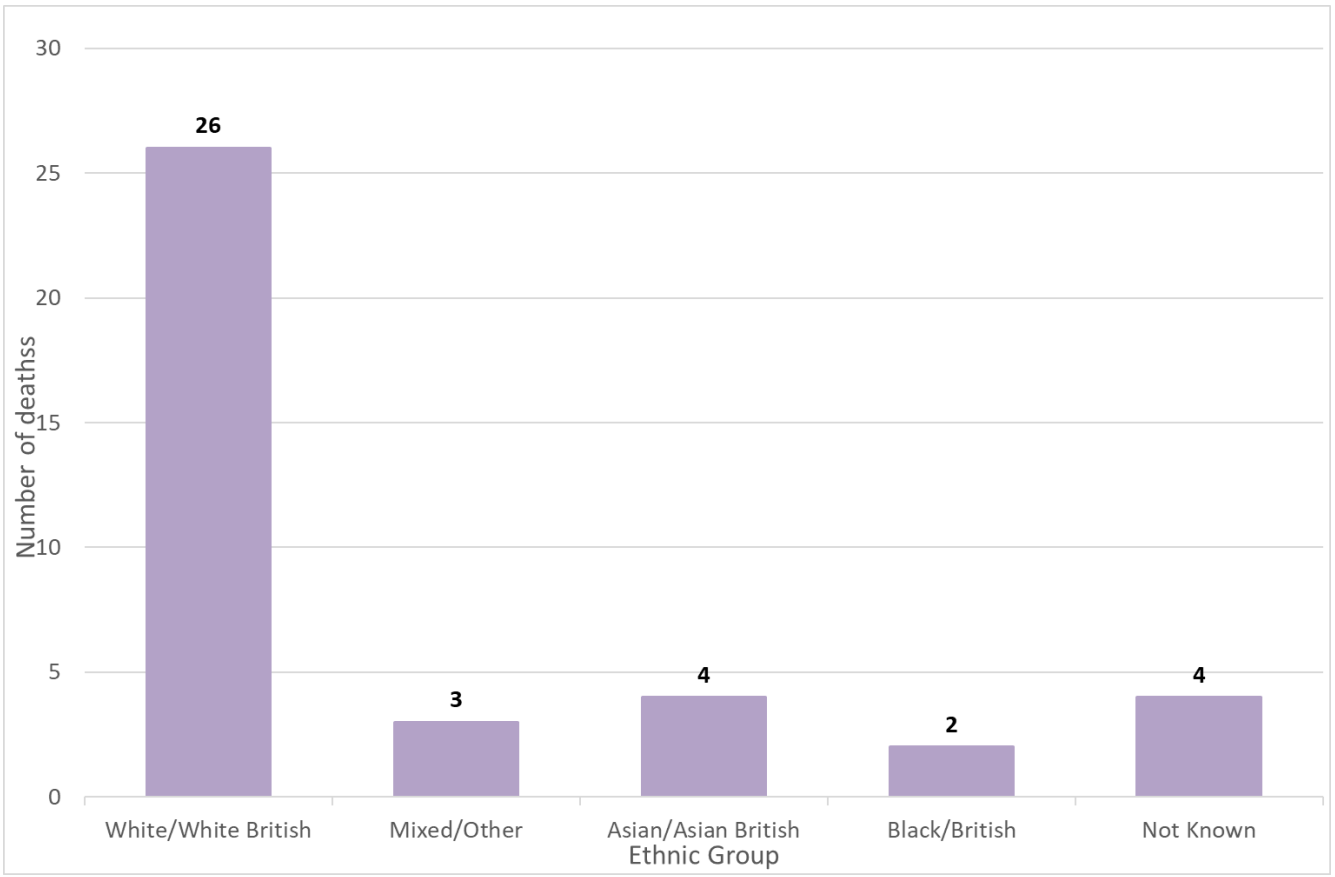
Figure 6.ii.c: Age breakdown of child death notifications 2021/22



6.ii.d. Ethnicity breakdown of notifications

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

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

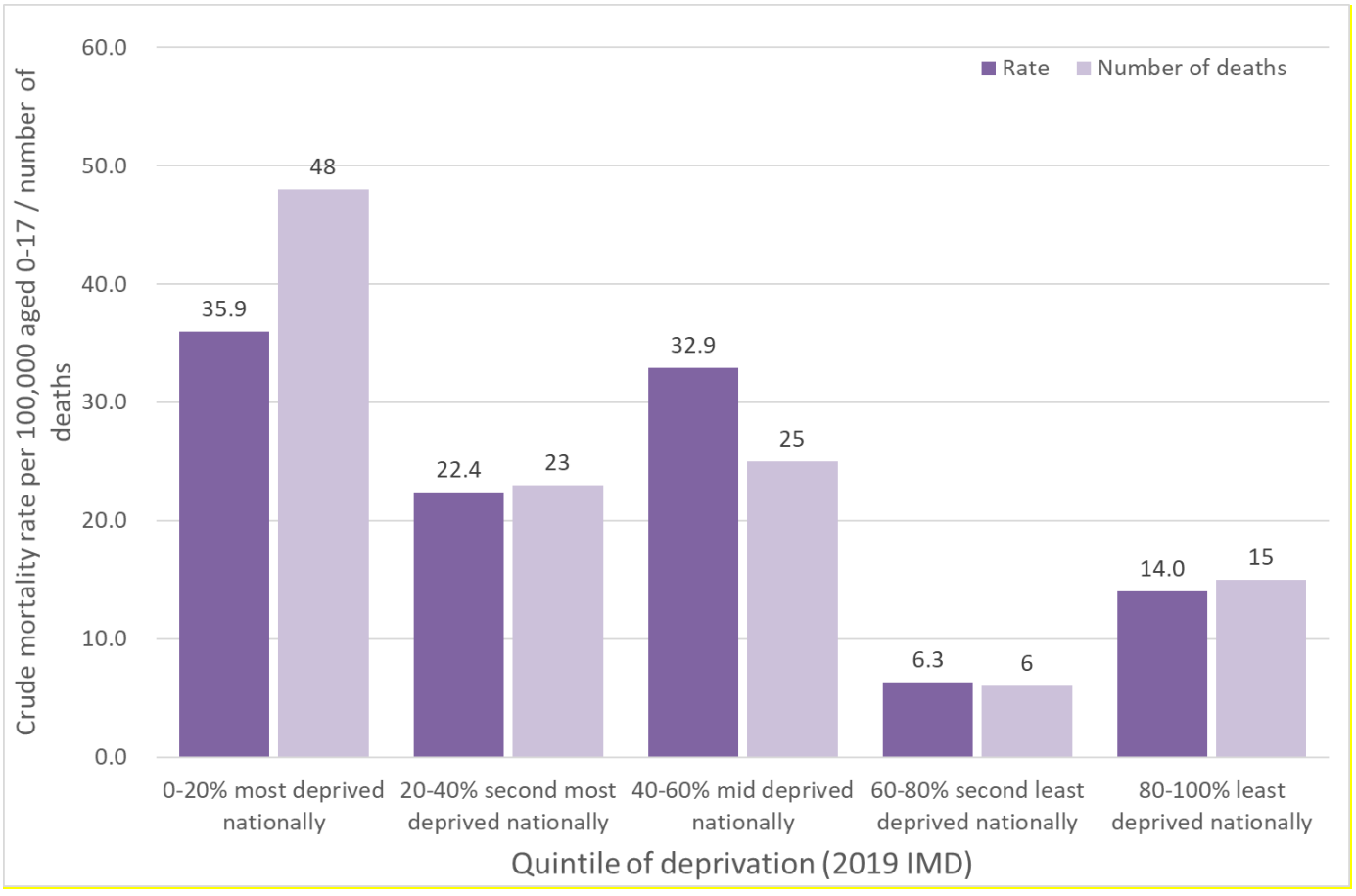


6.ii.e. Deprivation breakdown of notifications

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

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

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



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

6.iii.a. Number of closed cases

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

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

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

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

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

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

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

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

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

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

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

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

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

6.iii.c Place of death of closed cases

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

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

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

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

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

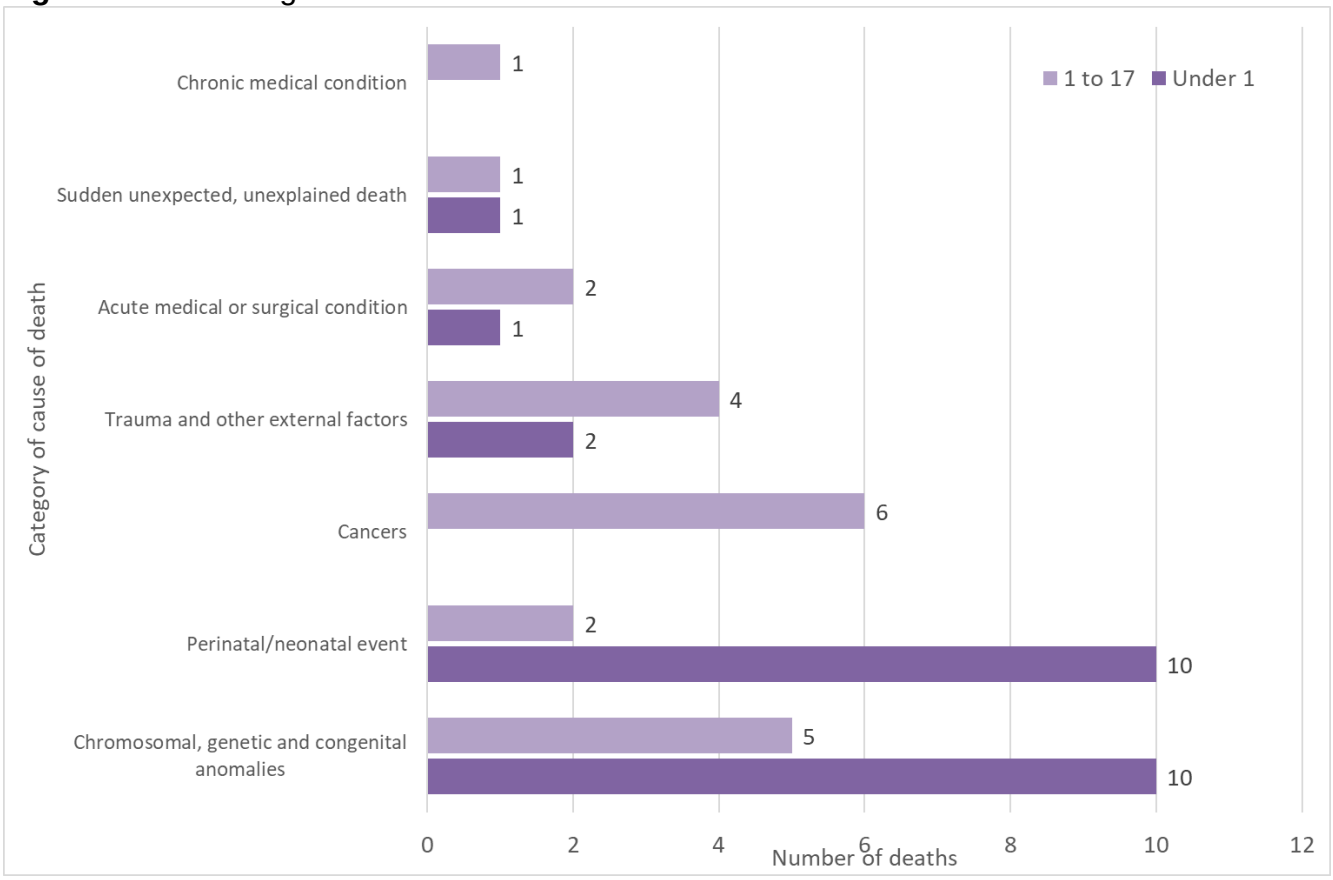
6.iii.d. Categories of cause of death

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

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

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

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



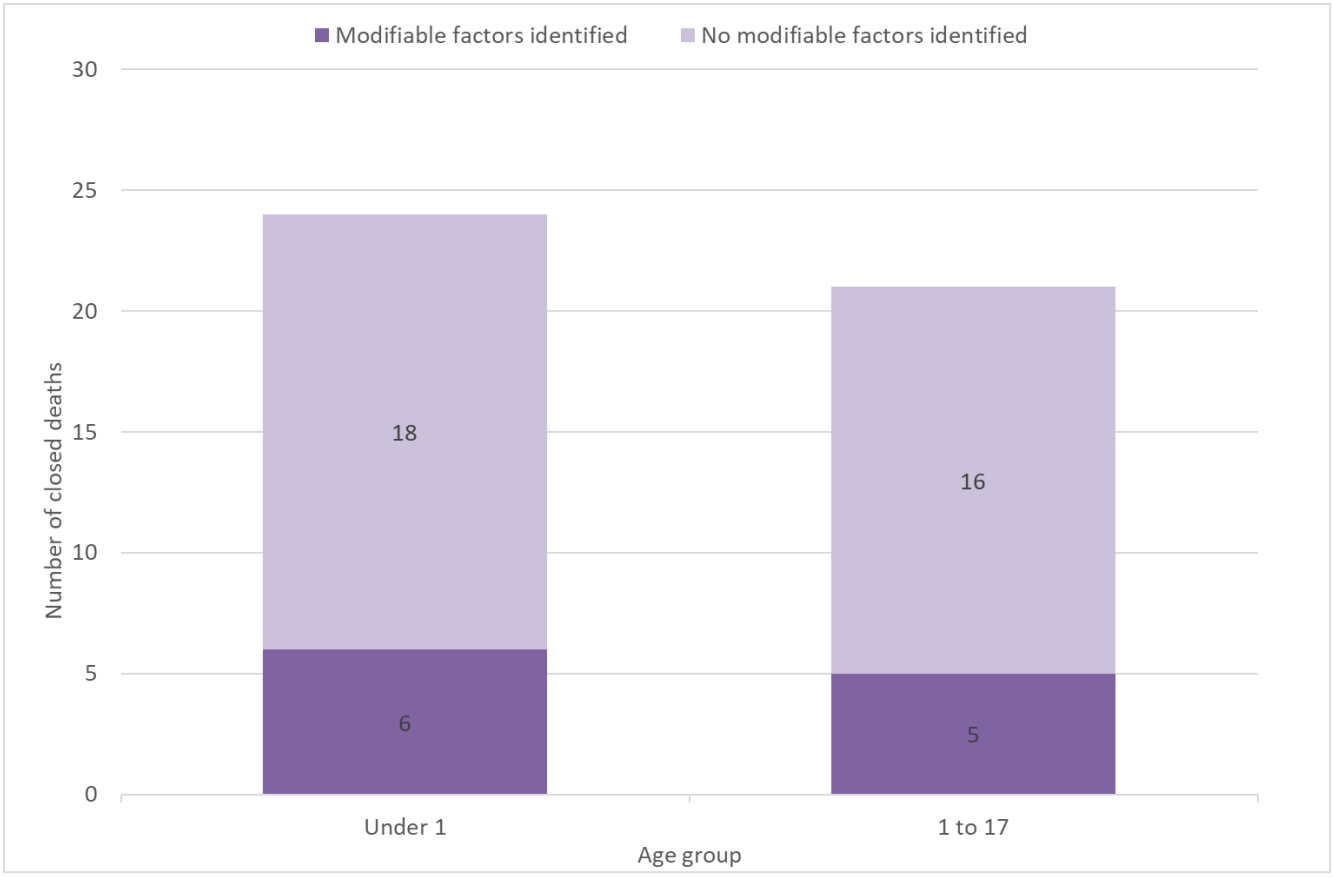
6.iii.e. Modifiable factors

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

Present modifiable factors included:

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

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

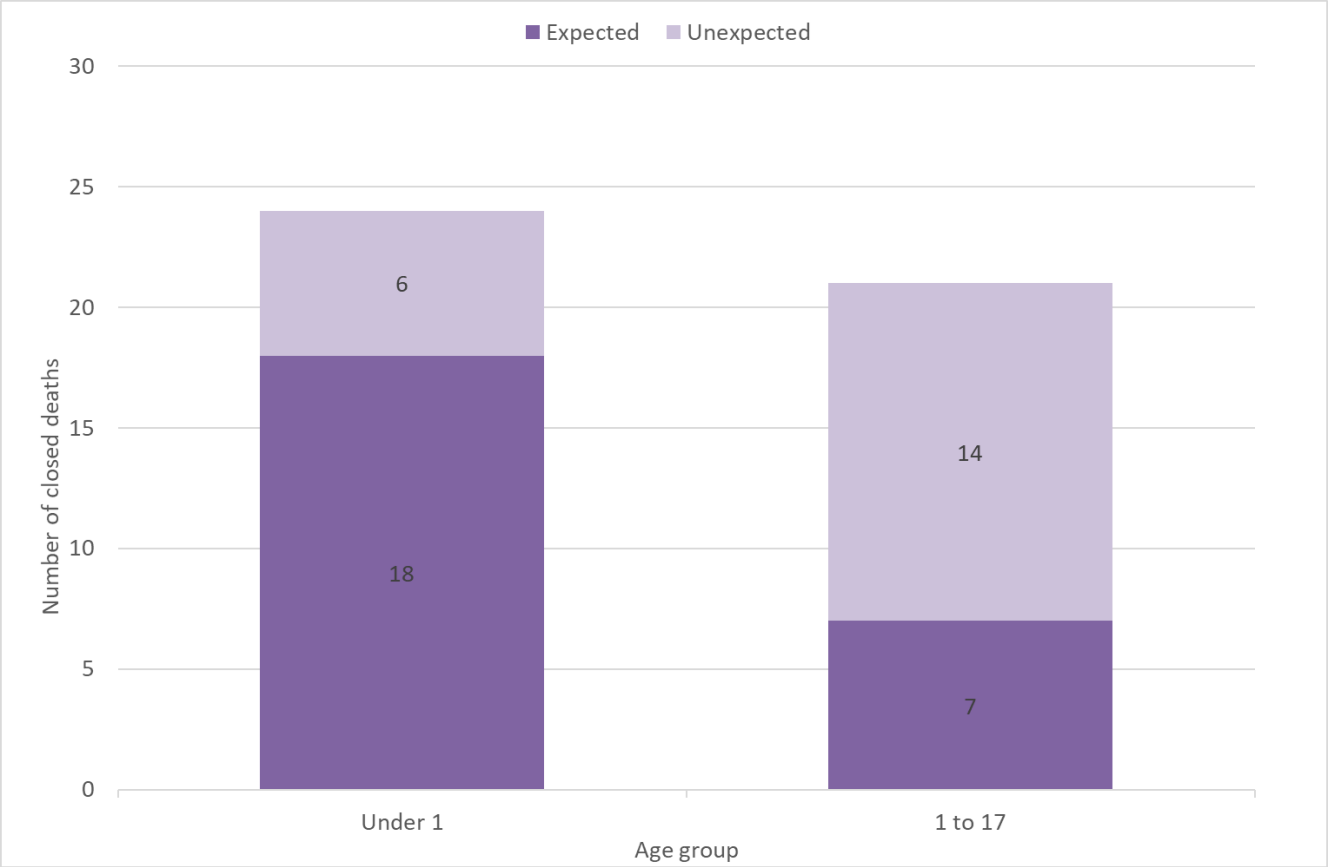


6.iii.f. Expected deaths

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

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

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



7. Recommendations

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

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

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

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

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

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

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

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

9. Summary

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

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

Appendix A: CDOP Responsibilities and Operational Arrangements

Ai: Child Death Overview Panel Responsibilities

CDOP responsibilities are:

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

Aii: Child Death Overview Panel Operational Arrangements

CDOP will;

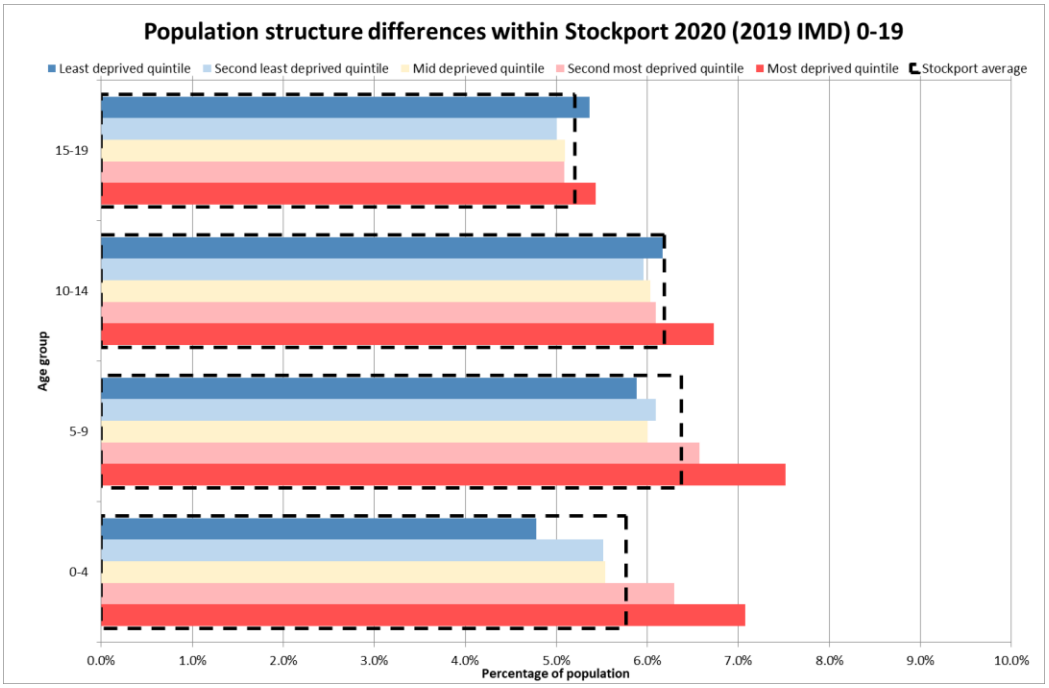
- meet quarterly to enable the deaths of children to be discussed in a timely manner and within the statutory timeframe of six months. Exceptions are where there is a current criminal or coronial investigation.
- ensure that effective rapid response arrangements for sudden deaths are in place, to enable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

Appendix B: Borough Child Profiles

i: Stockport

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

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



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

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

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

Borough Priorities

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

ii: Tameside

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

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

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

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

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

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

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

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

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

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

iii: Trafford

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

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

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

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

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

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

10. References

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

Operational Local Health Economy Outbreak Plan

Trafford
June 2023

V15 [REVIEW DATE: 16/06/23]

Document Control

Document title:	Operational Local Health Economy Outbreak Plan: Trafford
Document status:	Sent for authorisation
Document version:	Version 15
Document date:	June 2023
Document author(s): *(Name, Title)*	Template: Karl Astbury, AGMA Civil Contingencies and Resilience Unit Business Partner
Document owner(s): *(Name/organisation)*	Template: GM Local Health Resilience Partnership / Greater Manchester Resilience Forum Borough Plan: Helen Gollins, Local Director of Public Health / NHS Trafford ICB

Change History

Version	Date	Status	Notes
0.01	15-09-21	Initial draft	Following 1st Planning Group meeting
11.00	08-02-23	Addition	Added Glossary of Terms and Annex 7 & 8
11.00	12-02-23	Amendment	Update to Part 3 to include other communicable diseases and tables added
11.00	28-02-23	Amendment	Removed CCG & PHE references
12:00	28-04-23	Amendment	Updated following SME comments
13.00	15-05-23	Amendment	Update of DPH
14.00	22-05-23	Amendment	Updated following further SME comments
15:00	16-06-23	Sent	Document sent for approval

Approval

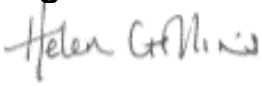
Approving group/body: FOR BOROUGH PLAN	Approval date
Local Health Protection Group	
HERG (for awareness)	
Local DPH	28.2.23
UKHSA North West	03.05.23

Foreword:

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

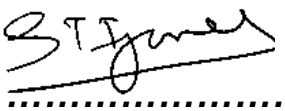
This plan has been developed to ensure clarity on operational roles and responsibilities for each responding organisation in the event of an outbreak. It is intended to act as a companion to the GM Multi-agency Outbreak Plan, providing operational detail helping responders quickly provide an effective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

Signed



Helen Gollins, Director of Public Health

Signed



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

CONTENTS

Table of Contents

Glossary of Terms

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

PART 1: AIM, OBJECTIVES and scope OF THE PLAN

1.1 Aim of the Plan

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

1.2 Objectives of the Plan

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

1.3 Scope / Context of the Plan

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

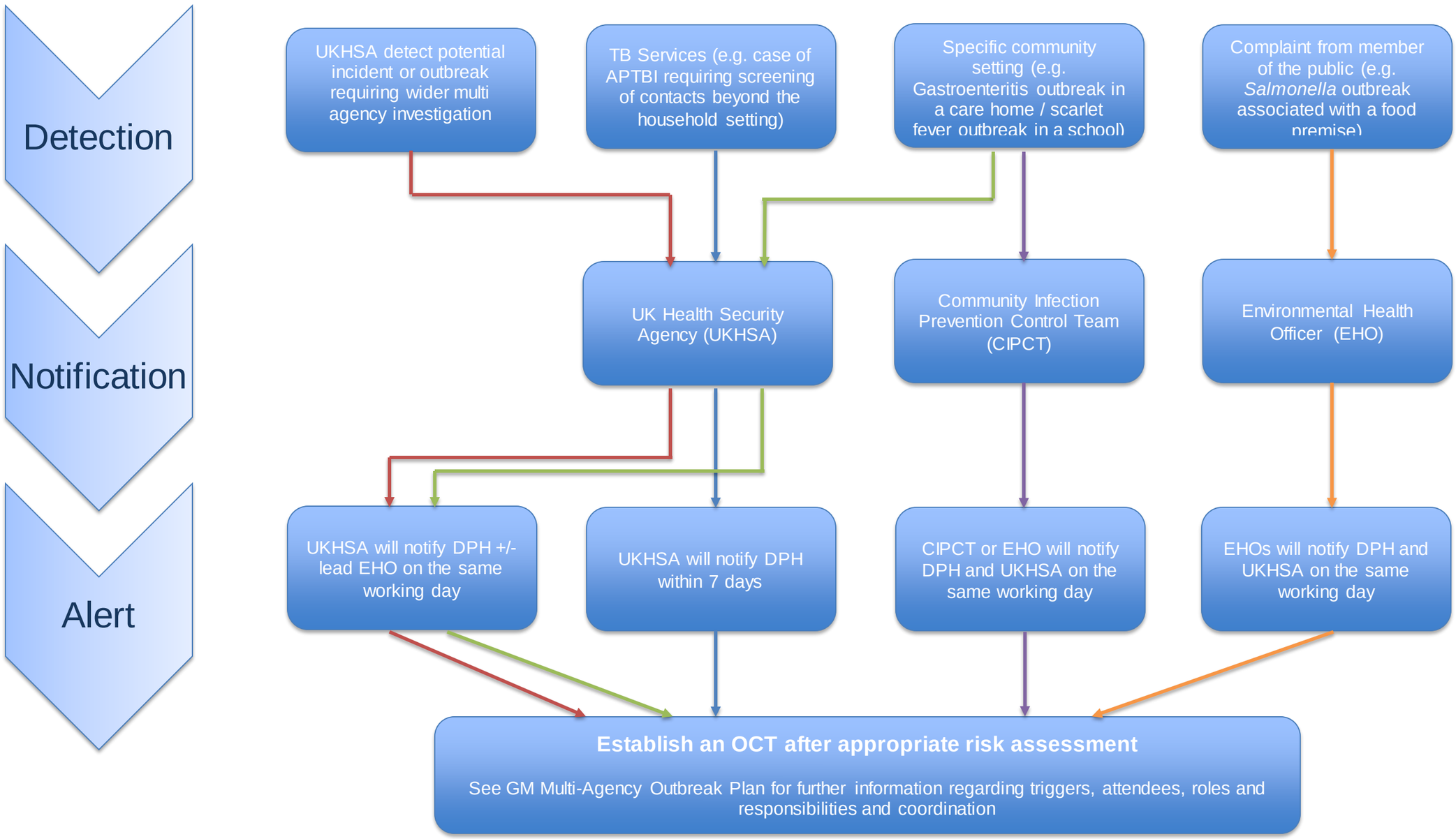
1.4 Complementary Guidance and Documentation

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

PART 2: KEY ASPECTS OF OUTBREAK MANAGEMENT

2.1 Detection and Coordination

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



2.2 Investigations

Investigation Roles and Responsibilities:

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

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

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

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

2.3 Control Measures

Control: Roles and Responsibilities

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

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

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

Control measures usually include:

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

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

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

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

2.4 Communications

Communications: Roles and Responsibilities

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

2.5 Funding Arrangements

Guiding principles:

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

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

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

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

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

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

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

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

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

3b. Arrangements for investigating complex TB incidents

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

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

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

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

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

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

	To media	Coordinate by UKHSA via OCT			

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

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

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

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

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

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

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

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

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

Care homes

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

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

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

APPENDICES

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

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

Annex 2: Potential Outbreak Settings or Sources

These are examples of community settings sometimes associated with outbreaks

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

Annex 3: Common Pathogens

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

The full list of notifiable diseases is available here:

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

Annex 4: Common Outbreak Scenarios and Challenges

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

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

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

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

Annex 5: Teleconference Details and Protocol

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

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

Conference call etiquette- Chair

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

Conference call etiquette – Participants

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

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

Annex 6: Key Contacts

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

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

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

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

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

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

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

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

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

Annex 7: OCT Members List

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

Annex 8: OCT Agenda Template

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

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

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

4. Declarations of Conflicts of Interest

5. Duty of Candour

5. Items Not on the Agenda

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

7. Risk Management/Control Measures

8. Further Investigation

9. Communications

10. Any Other Business

11. Recommendation List with timescale and allocated responsibility

12. Date and time of next meeting

This page is intentionally left blank