TRAFFORD COUNCIL

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

Report Title

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

Purpose

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

Recommendations

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

Contact person for access to background papers and further information:

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Learning from Child Death Reviews

Annual Report of Stockport,

Tameside and Trafford's

Child Death Overview Panel, 2018/2019

Document Control

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

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

- **Helen Gollins, Deputy Director of Public Health (Interim), Trafford Council, and STT CDOP Chair**
- **Shelley Birch, Child Death Overview Panel Manager (Tameside, Trafford and Stockport), Trafford Council.**
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Please send all comments to Shelley Birch, Shelley.birch@tameside.gov.uk.

Executive Summary

1. Introduction

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

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

2. Data protection

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

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

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

Key points from data analysis:

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

4. Recommendations

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

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

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

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

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

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

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

VII. **Health and Wellbeing Boards promote improvements in mental health and resilience by;**
   a. **working with Public Health Directorates to better understand the relationship between self harm and suicide and to ensure services are commissioned that respond to the risks posed from this behaviour.**
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VIII. **Health and Wellbeing Boards to support a reduction in co-sleeping and promote safe sleeping by;**
   a. **working with Public Health Directorates in partnership with Health Visiting and Maternity services to ensure all families receive appropriate safe sleeping interventions.**
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Content

Learning from Child Death Reviews

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

1. Introduction

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3. The Child Death Overview Process

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

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

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

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

4. Implementing Local Learning

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

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

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

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

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

Source: Trafford Public Health, 2019.

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

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

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

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

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

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

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

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

6.i. Data analysis

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

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

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

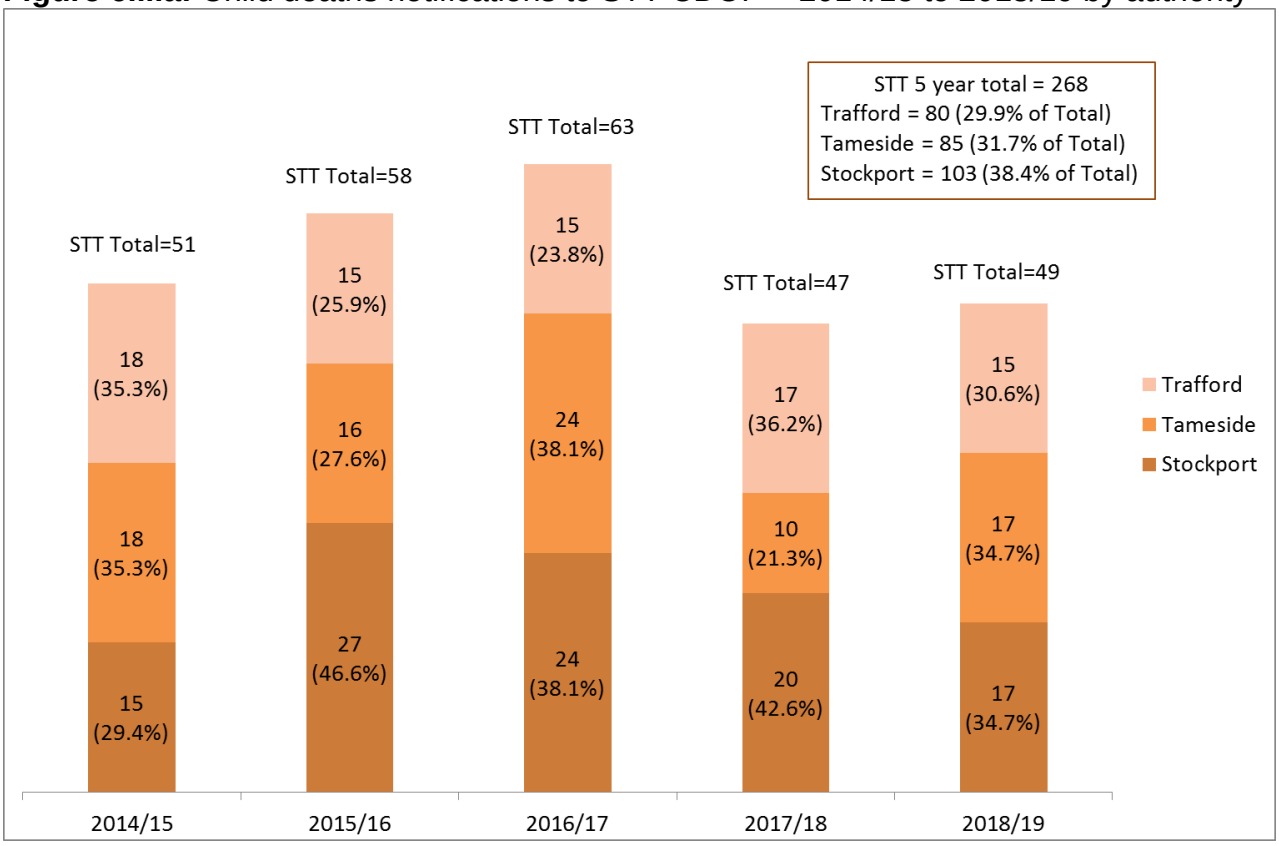
Therefore notifications show epidemiological pattern of deaths for the year under review, whereas closed cases provide intelligence about cases from a range of years.

6.ii. Demographic breakdown of notifications

6.ii.a. Number of notifications

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

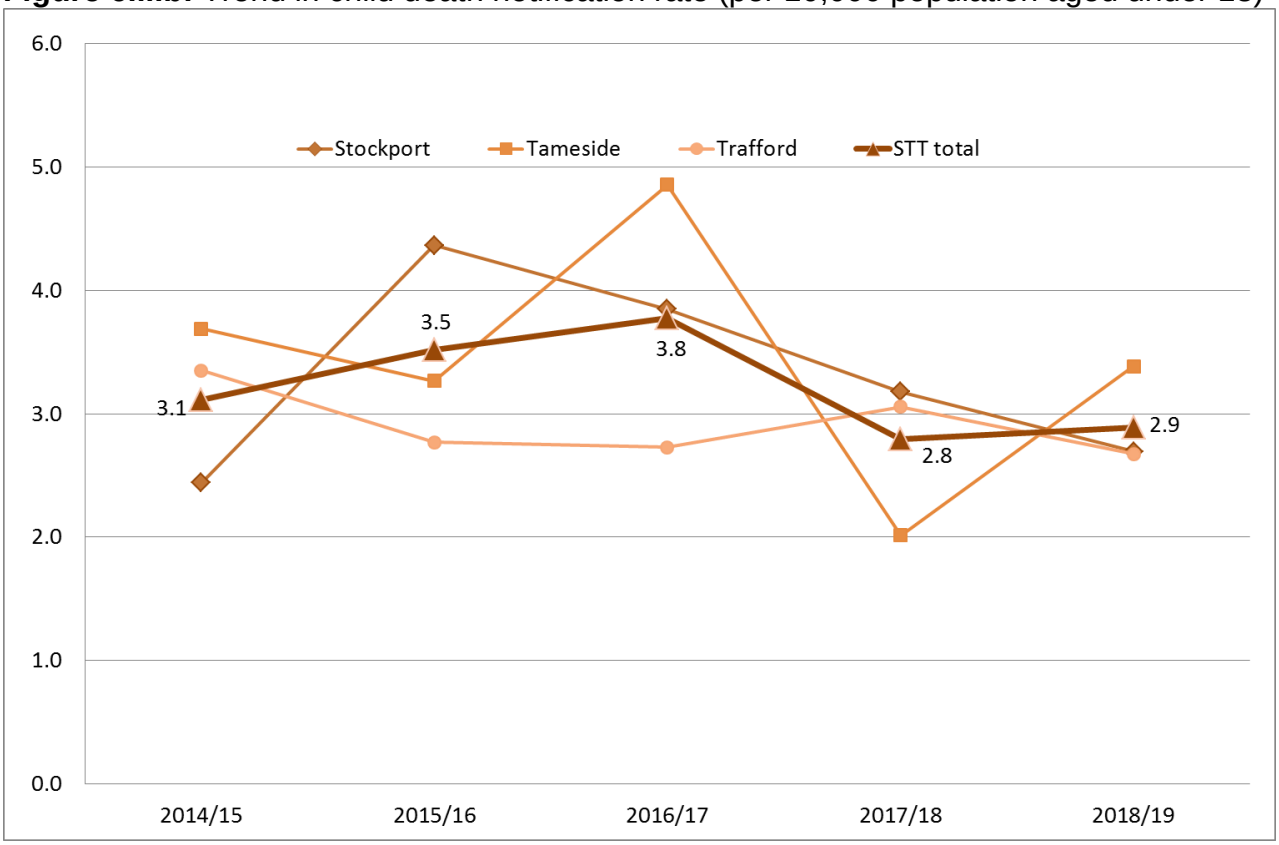
Figure 6.ii.a: Child deaths notifications to STT CDOP – 2014/15 to 2018/19 by authority



6.ii.b. Notification rate

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

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

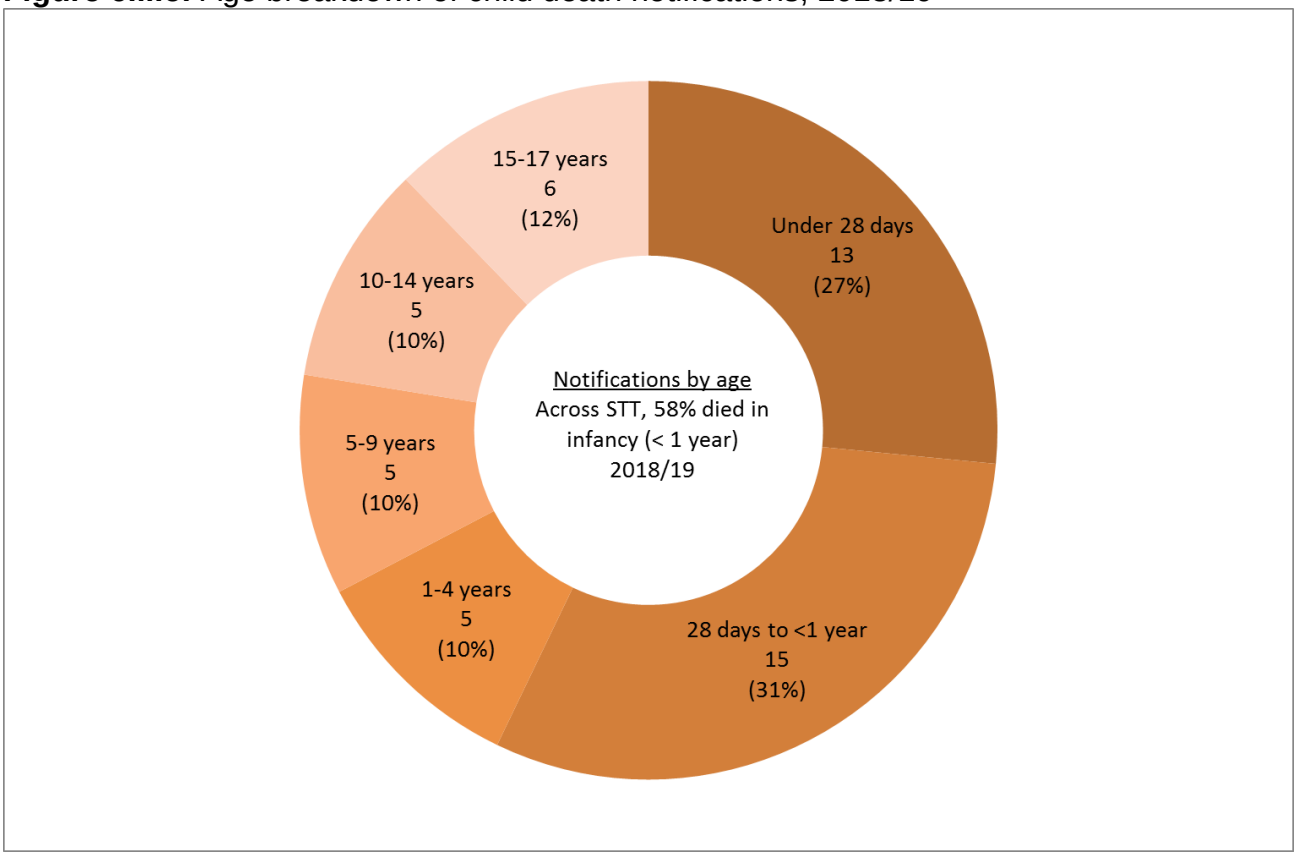


6.ii.c. Age breakdown of notifications

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

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

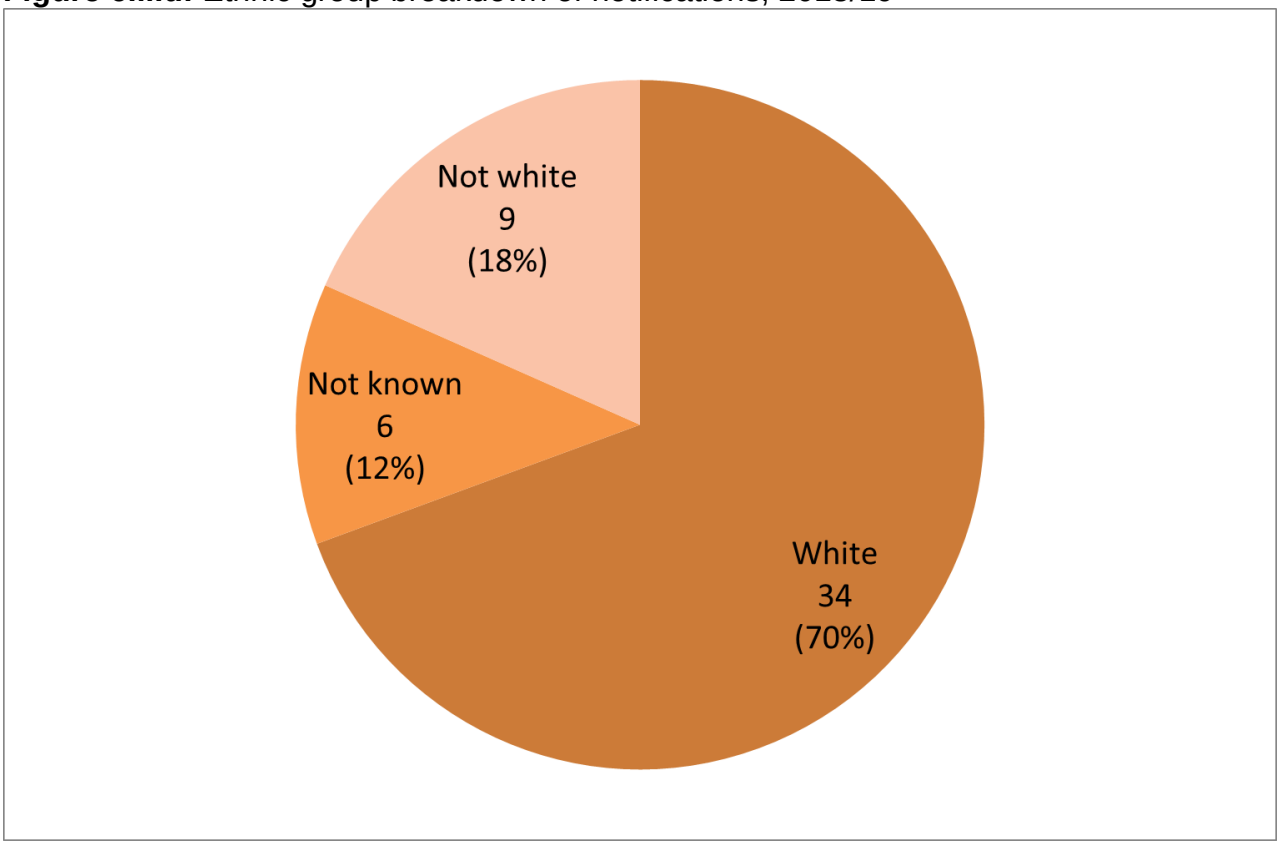
Figure 6.ii.c: Age breakdown of child death notifications; 2018/19



6.ii.d. Ethnicity breakdown of notifications

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

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

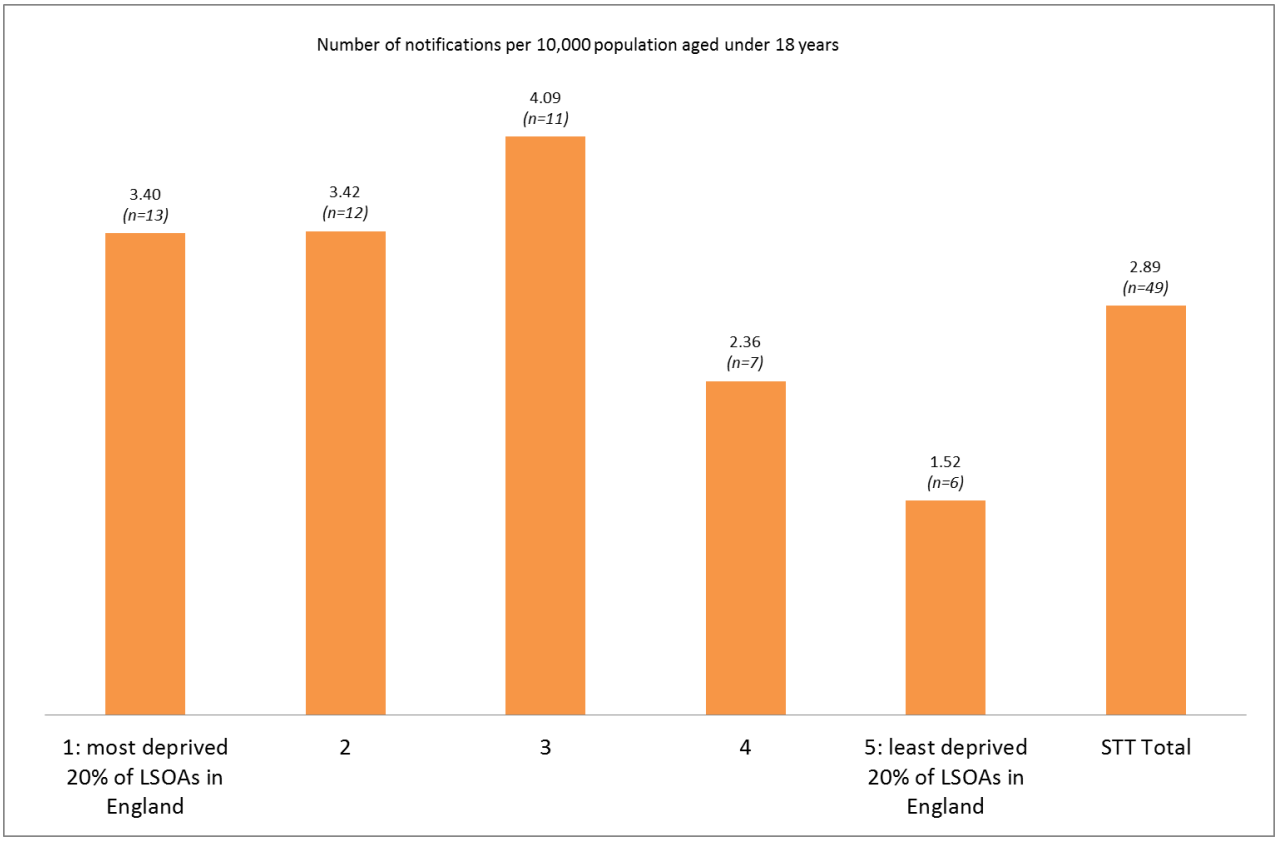


6.ii.e. Deprivation breakdown of notifications

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

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

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



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

6.iii.a. Number of closed cases

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

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

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

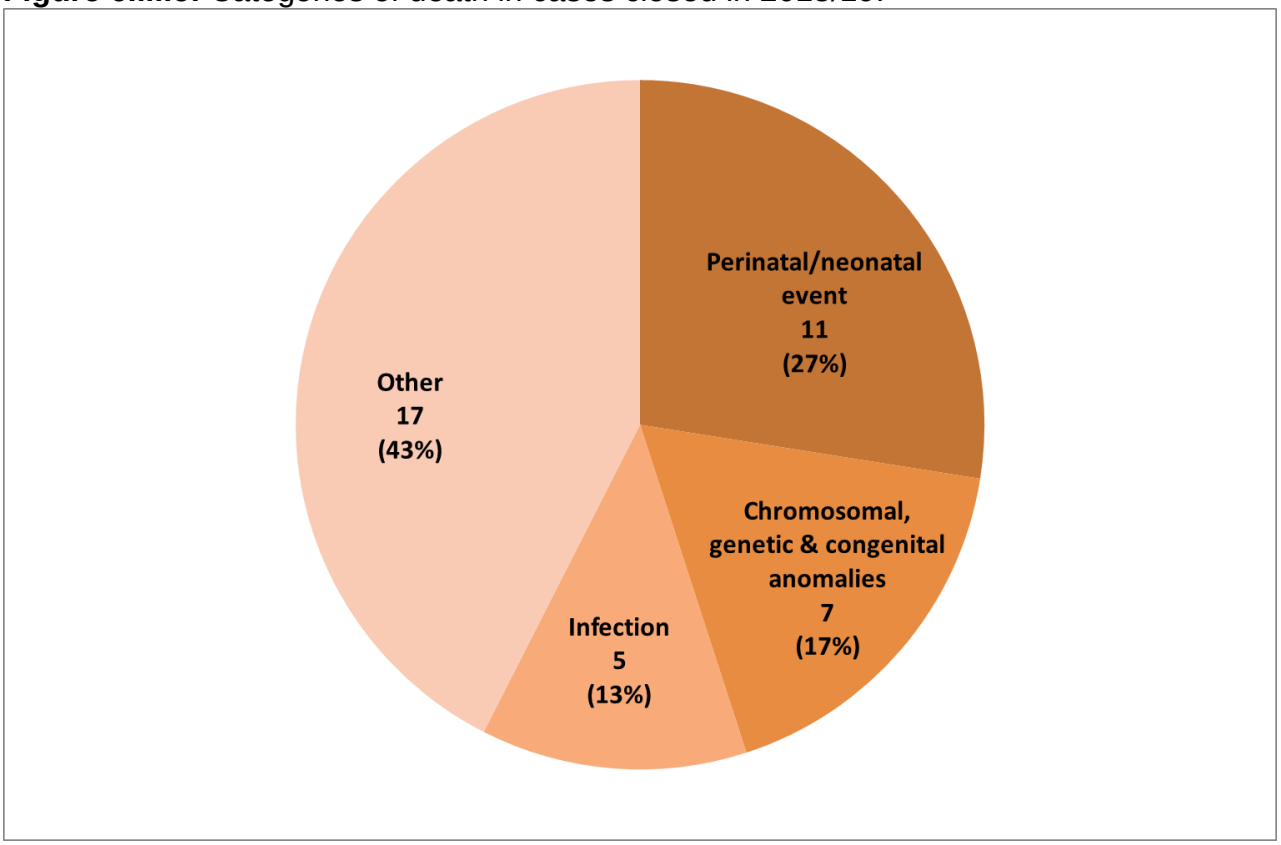
6.iii.b Birthweight and gestation

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

6.iii.c. Categories of death

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

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



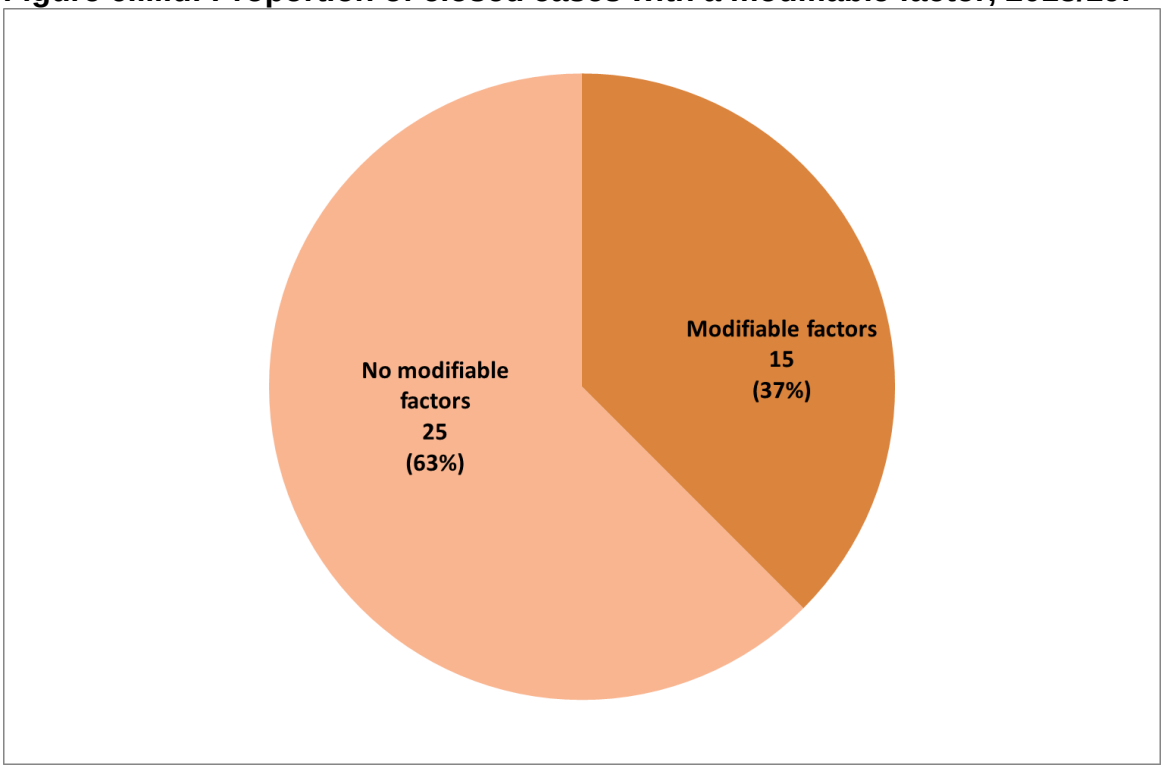
6.iii.d. Modifiable factors

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

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

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

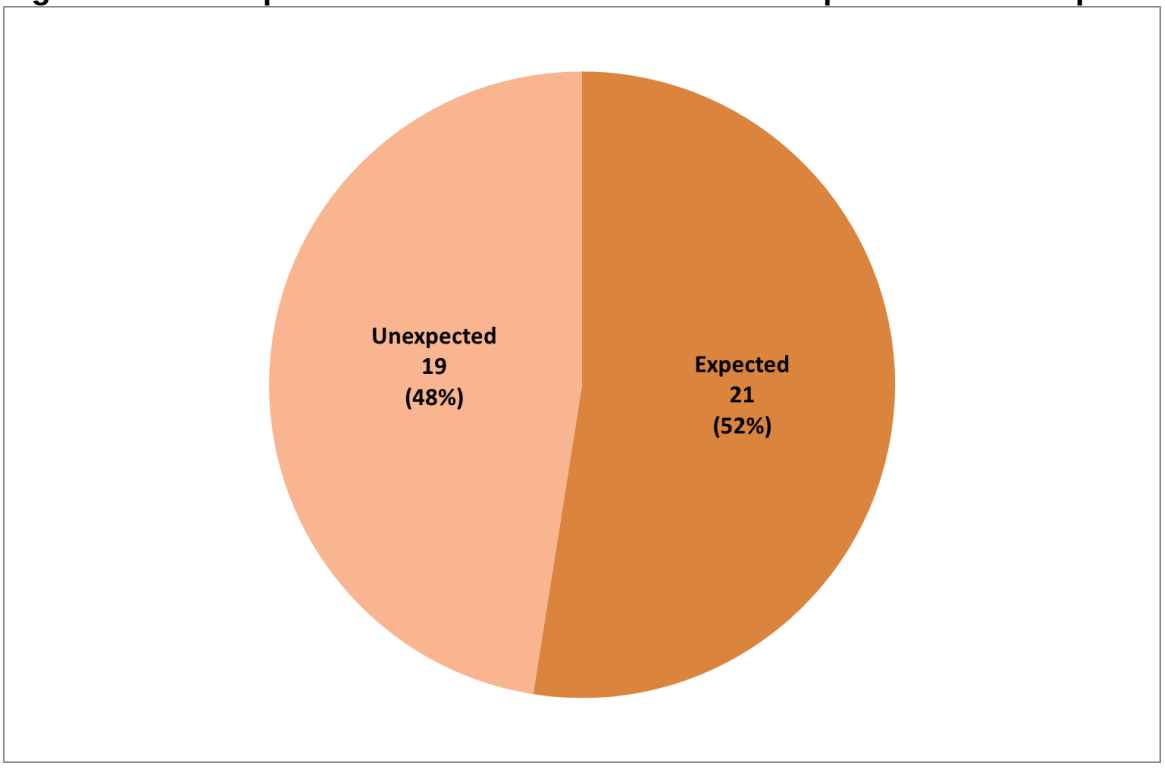
Figure 6.iii.d: Proportion of closed cases with a modifiable factor, 2018/19.



6.iii.e. Expected deaths

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

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



7. Recommendations

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

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

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

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

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

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

V. **Health and Wellbeing Boards to improve the outcomes of babies by;**
   a. **working with maternity services to deliver safe, evidence based healthy weight interventions, so that when a women books with the service and she is recorded as not being a healthy weight she is supported to maintain or if safe to do so support her to reduce her BMI.**
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VII. **Health and Wellbeing Board promote improvements in mental health and resilience by;**
   a. **working with Public Health Directorates to better understand the relationship between self harm and suicide and to ensure services are commissioned that respond to the risks posed from this behaviour.**
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and Young People are included in the work programme and that this is cascaded to localities.

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

c. working with Public Health Directorates in partnership with Health Visiting and Maternity services to ensure all families receive appropriate safe sleeping interventions.

d. working with Public Health in partnership with Health Visiting colleagues to implement a safe sleeping awareness campaign to all front line services that are in contact with families with infants.

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

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

9. Summary

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

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

Appendix A: CDOP Responsibilities and Operational Arrangements

Ai: Child Death Overview Panel Responsibilities

CDOP responsibilities are:

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

Aii: Child Death Overview Panel Operational Arrangements

CDOP will;

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

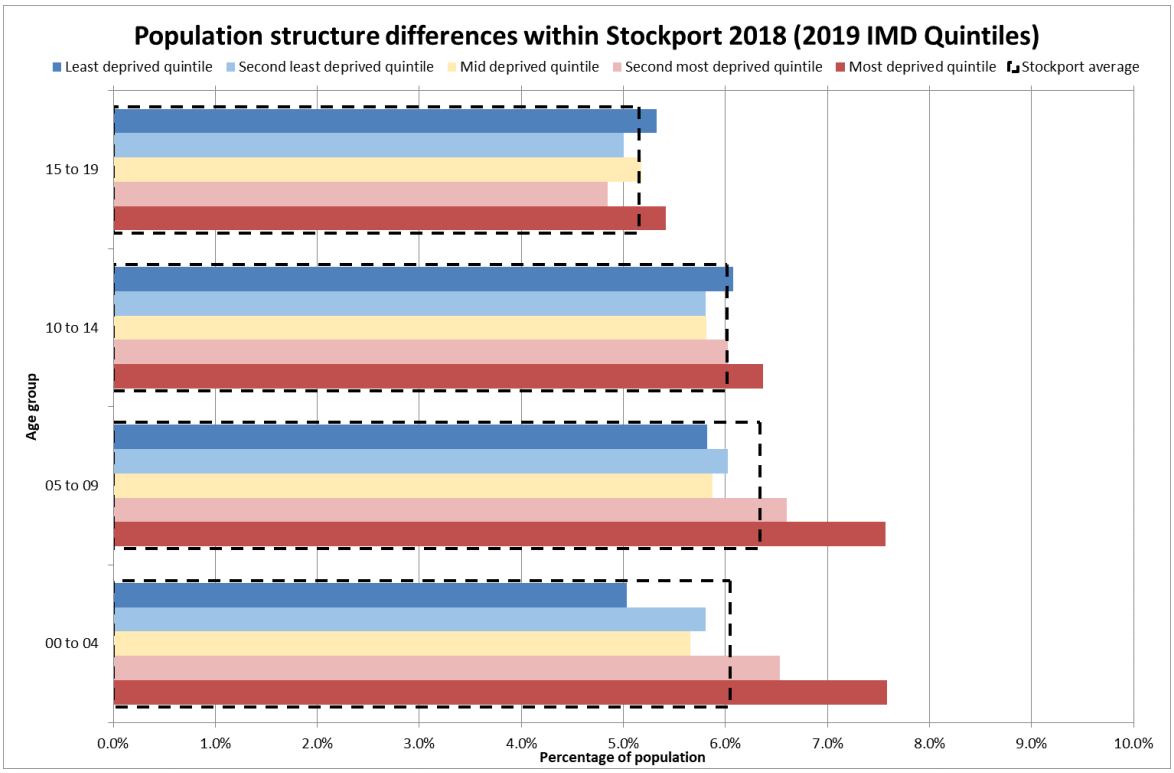
The full description of local CDOP arrangements for Stockport, Tameside and Trafford can be found here:
www.traffordccg.nhs.uk/docs/Publications/STT-CDOP-implementation-plan-June-2019.pdf

Appendix B: Borough Child Profiles

i: Stockport

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

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



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

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

Stockport JSNA

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

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

Borough Priorities

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

ii: Tameside

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

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

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

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

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

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

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

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

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

Please find more information here: child-health-profiles

iii: Trafford

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

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

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

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

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

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

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

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

10. References

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