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MANCHESTER
CITY COUNCIL

Health and Wellbeing Board

Date: Wednesday, 25 January 2023
Time: 10.00 am
Venue: Council Chamber, Level 2, Town Hall Extension

This is a **Revised Supplementary Agenda** containing an additional item of business (Item 9) that was not listed on the original agenda.

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Membership of the Health and Wellbeing Board

Councillor Craig, Leader of the Council (Chair)
Councillor T Robinson, Executive Member for Member for Healthy Manchester and Adult Social Care (MCC)
Councillor Bridges, Executive Member for Children and Schools Services (MCC)
Katy Calvin-Thomas - Manchester Local Care Organisation
Kathy Cowell, Chair, Manchester University NHS Foundation Trust
Bill McCarthy, Chair, Greater Manchester Mental Health NHS Foundation Trust
Mike Wild, Voluntary and Community Sector representative
Vicky Szulist, Chair, Healthwatch
Paul Marshall, Strategic Director of Children's Services
David Regan, Director of Public Health
Bernadette Enright, Director of Adult Social Services
Dr Murugesan Raja Manchester GP Forum
Dr Geeta Wadhwa Manchester GP Board
Dr Doug Jeffrey, Manchester GP Board
Dr Shabbir Ahmad Manchester GP Board (substitute member)
Dr Denis Colligan, Manchester GP Board (substitute member)

Agenda

5.	**Making Manchester Fairer: Tackling Health Inequalities in Manchester 2022-2027** The report of the Deputy Director of Public Health is enclosed.	5 - 16
6.	**Manchester Child Death Overview Panel 2021-22 Annual Report** The report of the Assistant Director of Public Health, Chair of the Manchester Child Death Overview Panel is enclosed.	17 - 56
7.	**Manchester Pharmaceutical Needs Assessment (2023-2026) Final Draft** The report of the Manchester Pharmaceutical Needs Assessment (2023-2026) Final Draft is enclosed.	57 - 66
8.	**Health Protection Board Update** The report of the Assistant Director of Public Health is enclosed.	67 - 74
9.	**Further developments relating to the role of the Health and Wellbeing Board** The report of the Director of Public Health is enclosed.	75 - 78

Information about the Board

The Health and Wellbeing Board brings together those who buy services across the NHS, public health, social care and children's services, elected representatives and representatives from HealthWatch to plan the health and social care services for Manchester. Its role includes:

- encouraging the organisations that arrange for the provision of any health or social care services in Manchester to work in an integrated manner;
- providing advice, assistance or other support in connection with the provision of health or social care services;
- encouraging organisations that arrange for the provision of any health related services to work closely with the Board; and
- encouraging those who arrange for the provision of any health or social care services or any health related services to work closely together.

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Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 25 January 2023

Subject: Making Manchester Fairer: Tackling Health Inequalities in Manchester 2022-2027

Report of: Deputy Director of Public Health

Summary

Making Manchester Fairer: Tackling Health Inequalities in Manchester 2022-27 describes the actions that the city will take to reduce inequalities, with a focus on the social determinants of health. This paper provides a progress update on Making Manchester Fairer and outlines the next steps for the delivery of the Action Plan as a joint programme of work with Manchester's new Anti-Poverty Strategy.

Recommendations

The Board is asked to note progress on the Making Manchester Fairer Action Plan and incorporation of the Anti-Poverty Strategy as a joint programme of work.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	This Action Plan impacts positively on all strategy priority areas
Improving people's mental health and wellbeing	
Bringing people into employment and ensuring good work for all	
Enabling people to keep well and live independently as they grow older	
Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme	
One health and care system – right care, right place, right time	
Self-care	

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

Building Back Fairer – Tackling Health Inequalities in Manchester – Health and Wellbeing Board, 6 July 2022

Making Manchester Fairer, Tackling Health Inequalities in Manchester 2022-2027 – Health Scrutiny Committee, 12 October 2022

Making Manchester Fairer - The Anti-Poverty Strategy 2023-2028 – Economy Scrutiny Committee, 18 January 2023

1.0 Introduction

1.1 In the wake of the COVID-19 Pandemic and cost-of-living crisis, the need to tackle inequalities in the city has rapidly risen up the corporate and political agenda.

1.2 Making Manchester Fairer is our five-year action plan to address health inequalities in the city. The Making Manchester Fairer Action Plan (previously entitled 'Building Back Fairer – Tackling Health Inequalities in Manchester') was endorsed by the Health and Wellbeing Board and Manchester Partnership Board in July 2022 and launched in October 2022.

1.3 Poverty remains a significant and deeply entrenched problem that affects too many of the city's residents. It is complex, driven by many external factors and persists despite the best local efforts to reduce it. A new Anti-Poverty Strategy is expected to be adopted at Executive on 18 January.

1.4 At the same time the cost-of-living crisis is putting immediate pressure on many residents and requires a large-scale and more immediate response.

1.5 These areas of work also require us to strengthen the way we measure and evaluate the success of interventions from both an overall improvement and reducing inequalities perspective. The relationship between these three focuses of work is shown below.

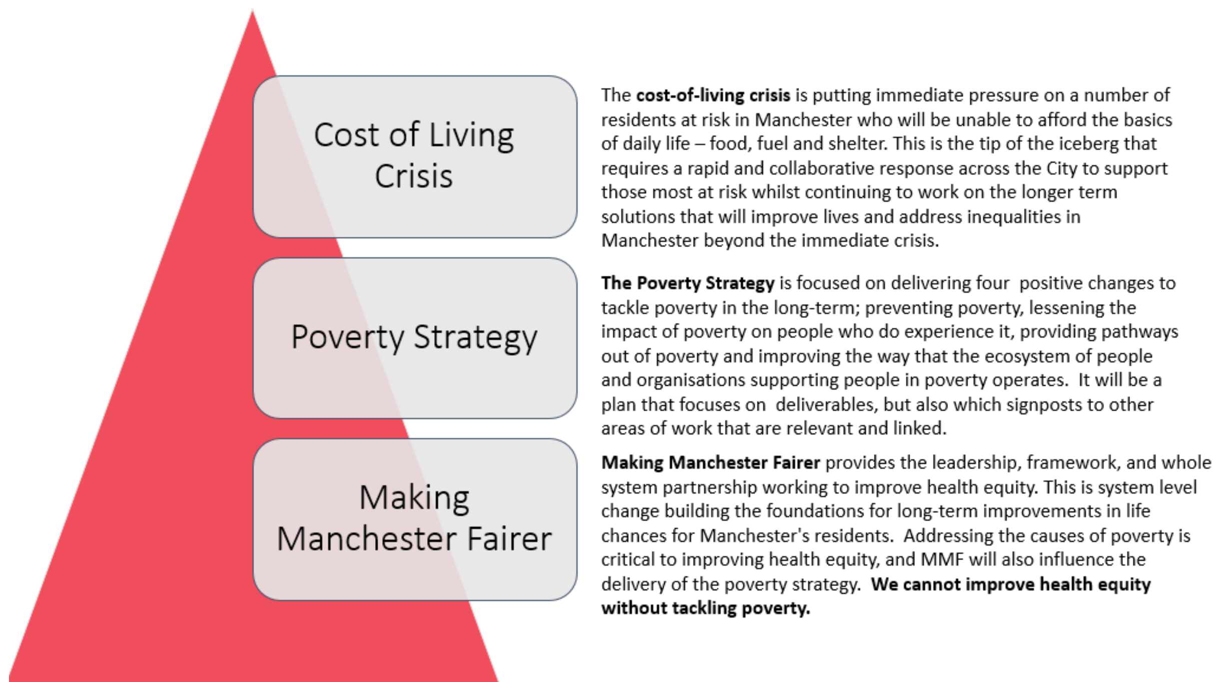

Figure 1: Relationship between Making Manchester Fairer, Poverty Strategy and addressing the Cost-of-Living Crisis

2.0 Integration with Manchester's new Anti-Poverty Strategy

2.1 The new Anti-Poverty strategy has been developed after extensive listening and engagement with people and organisations in Manchester. It has received positive feedback from our partners. The new strategy sets out the themes, priorities and actions for tackling poverty:

Theme 1: Preventing Poverty: The priorities in this theme are about the things that we can do to prevent residents experiencing poverty.

Theme 2: Mitigating Poverty: The priorities in this theme are about trying to make life easier for people who are experiencing poverty and making sure that their basic needs are met.

Theme 3: Pathways out of Poverty: The priority in this theme is about raising people's incomes so they can move out of poverty.

Theme 4: Inclusive and effective delivery: Inclusive and effective delivery is about improving the way that the ecosystem of people and organisations supporting people in poverty operates.

2.2 The Making Manchester Fairer Action Plan recognises that tackling poverty and debt is one of the most significant routes to improving health outcomes in Manchester. Making Manchester Fairer is focused on systems – bringing different parts of the system together to affect change at a systems level. This change is primarily aimed at improving health equity, but because of the activity needed to achieve this, we would also expect to see positive changes in preventing poverty, mitigating poverty and the creation of pathways out of poverty.

2.3 Both Making Manchester Fairer and the Anti-Poverty Strategy have a strong focus on community and resident engagement and involvement; both are grounded in partnership working and collaboration between Manchester's Voluntary and Community Sector organisations and public sector institutions with the support of the city's private sector, including our anchor institutions.

2.4 Given the strength of the relationship and inter-dependency between the two areas of work, proposals to integrate the governance, management and delivery of Making Manchester Fairer with the city's new Anti-Poverty Strategy have been developed and agreed in principle by the former Making Manchester Fairer Task Group, and by the executive members with responsibility for the anti-poverty and health and social care portfolios (Cllrs Joanna Midgely and Thomas Robinson). Work has commenced to bring the two areas of work together, which will maximise the available resource and reduce the risk of duplication.

3.0 Making Manchester Fairer Update

3.1 Following the launch of the action plan in October, the priority has been to establish the workstreams which will form the foundation for the delivery of the plan:

- Governance and Programme Management
- General Communications and Engagement
- Workforce Engagement and Development
- Resident and Community Engagement and Involvement
- Kickstarters and Investment Fund
- Anchor Institutions
- Monitoring
- Evaluation

4.0 Governance and Programme Management

4.1 Meetings with the individual Making Manchester Fairer theme leads commenced in December in order to help establish how, in practice, Making Manchester Fairer can add best value to the actions being delivered under each theme. Work will continue with the leads in early 2023 to map milestones for each of the eight themes of the Action Plan and to develop the programme risk register. A Programme Management Plan will set out the approach to programme governance, risk and issue management, management of dependencies, reporting and monitoring and evaluation.

4.2 Work will be undertaken in the next period to incorporate the Anti-Poverty Strategy as a further additional workstream and establish the arrangements for the planning, management, sequencing and delivery of the actions outlined in the strategy.

4.3 The joint programme of work is being delivered by a programme management team and overseen by a Making Manchester Fairer Task Force. The governance arrangements are summarised below.

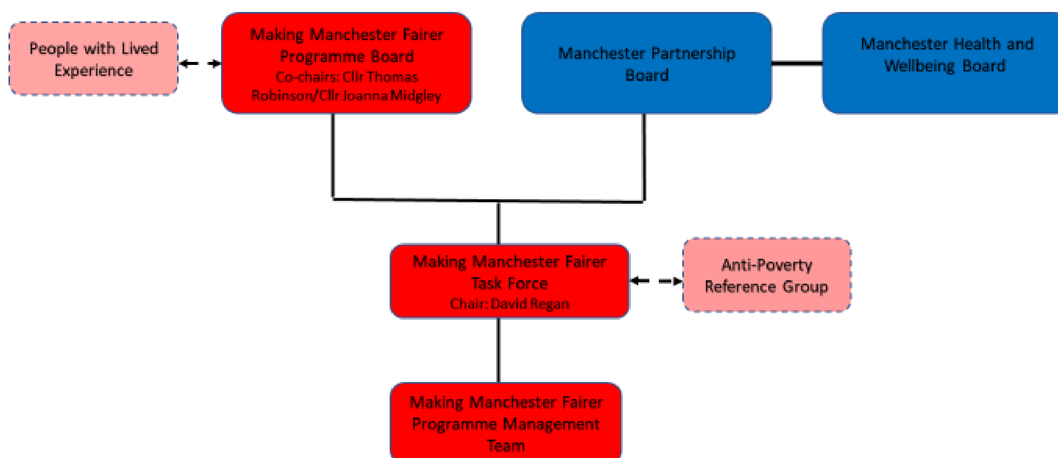

Figure 2: Making Manchester Fairer Programme Governance

4.4 The Making Manchester Fairer Programme Management Team pools existing anti-poverty and Making Manchester Fairer resources and functions as a Programme Management Office to plan and coordinate activity. A temporary Grade 12 Strategic Lead post has been established to add capacity here for three months through the temporary place-based leadership arrangements. This post is critical to the effective delivery of the programme and on 10 January 2023 Manchester City Council's Senior Management Team agreed in principle to resource this post for a further two years.

4.5 The Making Manchester Fairer Task Force is a senior leadership group responsible for the implementation of the Making Manchester Fairer Action Plan themes and workstreams and delivery of the Anti-Poverty Strategy, enabling a joined-up approach to tackling poverty and inequalities.

4.6 The Making Manchester Fairer Programme Board will have strategic oversight of the Making Manchester Fairer Action Plan and Anti-Poverty Strategy. It will set direction, provide challenge, and hold partners to account, supporting high level decision making. It will allocate and monitor the programme budget, monitor high level outcomes and provide assurance that the Making Manchester Fairer principles are upheld and that the programme adds value.

4.7 Work has commenced to establish the Board through a mixture of direct invitations and an expression of interest process. It is anticipated that the Board will have its first meeting following the local elections in May 2023.

5.0 General Communications and Engagement

5.1 During October the Executive Member for Healthy Manchester and Adult Social Care, Cllr Thomas Robinson, facilitated a series of three ‘Policy Panels’ for elected members to hear about the Making Manchester Fairer work from the Director and Deputy Director of Public Health. Policy Panels were also held as part of developing the Anti-Poverty Strategy.

5.2 Presentations about Making Manchester Fairer have been given to the meetings of a number of stakeholder groups, including: Children’s Services, the Manchester Provider Collaborative Board, Youth Matters (supporting young people at the edge of care), a Citywide Primary Care meeting and Manchester Local Care Organisation’s Population Health Management Board.

5.3 The communications team are currently developing a communications strategy for Making Manchester Fairer, including the delivery of the anti-poverty strategy within it.

6.0 Workforce Engagement and Development

6.1 The Making Manchester Fairer Conference was held at Manchester’s Etihad Stadium on 31st October 2022 for the purpose of formally launching the plan to frontline workers, managers and leaders in the organisations and services that make up the Population Health system. Over 200 delegates attended on the day, including colleagues from across the council as well as from the health sector, Voluntary, Community and Social Enterprise sector, housing sector and academia.

6.2 The full day event was opened by Manchester City Council’s Chief Executive Joanne Roney and Council Leader Cllr Bev Craig, and speakers included Professor Sir Michael Marmot, who provided an inspirational keynote speech evidencing the challenges, and Nazir Afzal OBE who focused on the importance of listening to communities and recognising the impact of structural racism and discrimination. The context and key principles of the city’s plan were provided by the Director and Deputy Director of Public Health and delegates were encouraged to begin to explore what the plan would mean for their work in delivering services to communities as part of a breakout session.

6.3 Central to the development of the plan has been the voice of residents and this was reflected throughout the day in the form of specially commissioned short videos and a ‘call to action’ performance piece devised and performed by local young people. Finally, delegates put questions directly to the speakers, who were joined in a panel discussion by Cllr Thomas Robinson, who also closed the conference. An evaluation was conducted of the themes emerging from the breakout session and panel discussions, and this will inform future communications with stakeholders. The main themes are summarised below.

6.4 Evaluation of themes emerging from the conference breakout sessions:

6.4.1 A large number of people identified issues relating to the accessibility of services and assets to support health and wellbeing. These included disadvantage and difference: there were comments about systemic bias and inequalities that affect people's access to care and support. In some cases, the problem was seen to be a lack of understanding on the part of services e.g. a lack of knowledge about who needs help, leading to support not being provided in a way that meets people's needs and information not being provided in a way that people can find and understand it. Lack of trust, stigma associated with accessing services and service complexity were identified as barriers. Transport and digital exclusion (not seen as exclusively an issue of older people) also came up.

6.4.2 The impact of poor housing on health and wellbeing and unaffordable and poor-quality housing was seen as a major problem, particularly with regards to private housing and in the south of the city. It was felt the health sector did not know enough about the housing sector and the city's housing services.

6.4.3The role of poor quality, low paid work and unemployment in ill-health was highlighted, including issues such as low levels of skills and qualifications, training, lack of flexible roles, disincentives of work versus benefits and zero hours contracts.

6.4.4 Challenges for services in relation to health and wellbeing in the city were raised; current pressures on services were seen to be a significant problem. Funding was identified as an issue. Structural issues came up, particularly the introduction of integrated care bodies which were seen to be increasing complexity. There was a perception of a lack of shared platforms and technology to enable joint working, a lack of knowledge of other organisations and teams and how to collaborate.

6.4.5 The important role played by the Voluntary, Community and Social Enterprise sector in reducing pressures on statutory services was noted, as were the challenges in finding funding, particularly for small organisations that are doing lots of work to keep people well in communities. Pressures on services were seen to generate pressures on workforce: "Groups are working at capacity…staff are tired." But there was a sense of optimism about what people can do: "COVID showed how the city can pull together". A key suggestion was that services should co-operate and collaborate more effectively; the sharing of knowledge and resources was expected to lead to better outcomes than individual efforts. The need to improve workforce development, retention and morale was highlighted.

6.4.6 There were a large number of reflections on funding. Sustainability of funding came up as an issue, with particular focus on the challenge of short-term funding and the inefficiencies this entails. Lack of availability of funding, how funding is allocated, and the transparency of decision-making emerged as themes.

6.4.7 There were a lot of reflections about the involvement of communities in creating health and wellbeing in the city. These included the value of engaging with

communities and individuals, particularly those rarely listened to, and the importance of collaboration and co-production with the local Voluntary, Community and Social Enterprise sector organisations that know local communities.

6.4.8 It was felt that there was a lack of knowledge among staff about how to involve people and a need to change attitudes from seeing people as 'problems' to individuals with issues and assets. Other reflections included the importance of building trust with communities and the importance of listening to the views of children and young people, making involvement accessible to them.

6.4.9 As a topic, working with communities received the most suggestions. It was noted that communities and individuals know their needs and how to meet them better than external organisations – so we need to ask them, particularly those that usually don't get asked. It was suggested that community voices should be embedded into decision-making structures and that collaboration should occur at all levels. The Voluntary, Community and Social Enterprise sector should be seen as equals and strategic partners; collaboration will bring their "rich intelligence" and "best practice" but there is a need to accommodate different working practices. Increased funding for these organisations was proposed by many, given their importance. The community offer for families with a child with special educational needs, designed and developed by parents/carers, was suggested as a model of good practice.

6.4.10 Work has commenced on developing a plan for the wider programme of work around workforce engagement and workforce development.

7.0 Resident and Community Engagement and Involvement

7.1 Work around resident and community involvement is highly dependent upon work being delivered under the 'Communities and Power' theme of the Action Plan. Progress has been made to establish the Communities and Power Forum, which met on 8th December to agree and sign off the group's Terms of Reference.

7.2 During this period the proposal to integrate the planned ongoing resident and community involvement for Making Manchester Fairer with that for the Anti-Poverty Strategy was progressed and work commenced to combine plans for this workstream.

8.0 Kickstarters and Investment Fund

8.1 Two kickstarter schemes have been prioritised for investment for phase 1 of the Making Manchester Fairer Investment Fund of £2m. The schemes are challenged with delivering the MMF plan's principles, improving health equity and also demonstrating an 'invest to save' approach. The schemes prioritised for investment are (i) Improving Health Equity for Children and Young People, and (ii) Early Help for Adults Experiencing Multiple and Complex Disadvantage. The Making Manchester Fairer Investment Sub-Group has

continued to meet during this period to consider and support the development of these business cases.

8.2 The first scheme, Improving Health Equity for Children and Young People, will focus on children, young people and their families who are most affected by health inequalities including those most affected by the cost of living crisis, communities that experience inequalities and young people who are at increased risk of mental ill-health as a result of their lived experiences and/or identity. The scheme is expected to address the widening gap in school readiness for children in early years, through a holistic approach working with schools and families. It will also engage with young people, communities, and wider partners to identify issues in mental wellbeing support and the opportunities for prevention of mental ill-health in order to reduce inequalities.

8.3 The second scheme, Early Help for Adults Experiencing Multiple and Complex Disadvantage, is being delivered in the context of Bringing Services Together for People in Places, and the delivery of multi-agency case management. The target group is adults experiencing multiple barriers to health and wellbeing including homelessness, mental ill health, substance misuse, unemployment. A significant number of this cohort will also have experienced adverse childhood experiences compounding these factors, by growing up in challenging social conditions. The scheme will build on learning from the Changing Futures Pilot and will develop the service design and delivery to expand the programme to ensure that the kickstarter works with cohorts and groups that were missed in the first pilot. In the short-term individuals should see successful engagement with other support services, and improvement in individuals' physical and mental wellbeing. The long-term goal is for individuals to thrive independently within their own communities.

9.0 Anchor Institutions

9.1 Considerable work has been undertaken by Manchester Locality colleagues for NHS GM Integrated Care, working with partners to shape approaches to the role of health and care partners as Anchor institutions. The first stage of a Manchester Locality stocktake, focused on employer and purchasing/ commissioning roles, has concluded.

9.2 An appropriate lead for anchor institutions will be identified to connect anchor institutions to the delivery of the plan and look at the contribution of anchor institutions more broadly. This will build on Manchester's recent success in working with Anchors to become a Real Living Wage City.

10.0 Monitoring

10.1 A Making Manchester Fairer Inequalities Data Development Group has been established to focus on embedding the routine monitoring of inequalities within partner organisations. Work began to identify key indicators to form the basis of an annual 'temperature check' of progress on Making Manchester Fairer and funding was secured from Policy@Manchester to develop a Manchester Measuring Inequalities Toolkit. This toolkit will equip data analysts across the

system with the appropriate skills and techniques for measuring inequalities in their area of work and help policy makers to understand the correct interpretation of these measures.

11.0 Evaluation

11.1 A vacancy within the Public Health Intelligence team was used to create a new Performance and Insight Manager post that will work across the Public Health and City Policy Teams in order to ensure a coordinated approach to evaluating the delivery of the ambitions set out in the Making Manchester Fairer Action Plan and the Anti-Poverty Strategy and ensure that there is a dedicated focus on the evaluation of the programme.

12. Next Steps

12.1 The next steps for the programme will be to:

- Develop an annual programme plan integrating the Making Manchester Fairer and Anti-Poverty work, against which the theme and work stream leads will report.
- Establish the joint programme governance structure as described above.
- Develop a joint communications strategy and a detailed communications plan once the programme's initial milestones have been mapped out. Stakeholders are being encouraged to sign up for monthly e-bulletins and planning is underway to develop content for these.
- Develop more detailed plans for resident and community involvement in the programme governance
- Finalise and approve business cases for priority kickstarter schemes and commence implementation of schemes

13.0 Recommendation

13.1 The Board is asked to note progress on the Making Manchester Fairer Action Plan and incorporation of the Anti-Poverty Strategy as a joint programme of work.

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Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 25 January 2023

Subject: Manchester Child Death Overview Panel 2021-22 Annual Report

Report of: Assistant Director of Public Health, Chair of the Manchester Child Death Overview Panel

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Summary

The Manchester Child Death Overview Panel (CDOP) reviews the deaths of children aged 0-17 years of age (excluding stillbirths and legal terminations of pregnancy), that are normally resident in the area of Manchester City. In line with the Child Death Review: Statutory and Operational Guidance (England) published October 2018, the CDOP has a statutory requirement to produce a local annual report which provides a summary of the key learning and emerging trends arising with the aim of preventing future child deaths.

Recommendations

The Board is asked to:

- note the report and its recommendations

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	Identification of relevant factors and modifiable factors that are likely to have contributed to vulnerability, ill health, or death of children in Manchester and to identify action that could be taken to address this.
Improving people’s mental health and wellbeing	Reviewing social and environment factors which may impact upon the child/young person’s mental health and wellbeing including the mental health issues identified in parents and carers.
Bringing people into employment and ensuring good work for all	
Enabling people to keep well and live independently as they grow older	
Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme	
One health and care system – right care,	

right place, right time	
Self-care	

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Background documents (available for public inspection):
The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

Additional reports are available via the Manchester Safeguarding Partnership CDOP webpage:

https://www.manchestersafeguardingpartnership.co.uk/resource/cdop/

- Manchester Reducing Infant Mortality Strategy (2019-24)
- 2020/2021 Manchester CDOP Annual Report
- National Child Mortality Database (NCMD): Child Death Review Data
- National Child Mortality Database (NCMD): Child Suicide Rates during the COVID-19 Pandemic in England: Real-time Surveillance

1. Introduction

1.1 The 2021-22 Manchester Child Death Overview Panel (CDOP) Annual Report provides a summary of the key factors and modifiable factors for cases closed between 1 April 2021 and 31 March 2022.

1.2 Manchester CDOP, similar to many CDOPs nationwide, has a backlog of cases due to a combination of factors including the implementation of the 2018 Statutory and Operational Guidance (see 7 below) and the pressures on public sector services resulting from the impact of the COVID-19 pandemic. In addition, the complexity of many of the cases in Manchester increase the timescales for closing cases resulting in lower numbers of cases closed in the last two years.

2. Background

2.1 Following the death of a child, the CDOP Coordinator liaises with a wide range of agencies to gather information. This includes information about the child, the family and the circumstances leading to death to ensure a full picture of relevant clinical and social issues are available for consideration at the CDOP.

2.2 The CDOP and Themed Panel (neonatal deaths less than 28 days) meetings are held on a quarterly basis to categorise the cause of death, highlight factors that may have contributed to vulnerability, ill health or death and identify modifiable factors which by means of a locally or nationally achievable intervention, could be modified to reduce the risk of future child deaths

2.3 The work of CDOP is closely linked to the Manchester Reducing Infant Mortality Strategy (2019-2024), within the broader context of the Making Manchester Fairer Plan (2022-27). The CDOP seeks to identify the key modifiable factors in the population such as unsafe sleeping arrangements, housing conditions, reducing maternal smoking, and reducing maternal obesity that can contribute to child deaths.

2.4 A key element of the child death review process is the response to sudden and unexpected deaths in infancy/childhood (SUDI/C) known as a Joint Agency Response (JAR). The Greater Manchester (GM) JAR Team conducts a rapid assessment of such deaths. A team of senior paediatricians provide 24/7 cover 365 days of the year, working in close collaboration with Greater Manchester Police, Children's Services, GM Coroner's Offices, and health services. Nationally this service provision is seen as the "gold standard".

3. Child Death Review Process- national and local arrangements

3.1 The CDOPs national line of accountability transferred from the Department for Education (DfE) to the Department of Health and Social Care (DHSC). Published October 2018, the Child Death Review: Statutory and Operational Guidance (England) sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements

set out in Working Together to Safeguard Children and clarifies how individual professionals and organisations across all sectors involved in the child death review should contribute to reviews. The guidance sets out the process in order to:

- improve the experience of bereaved families, and professionals involved in caring for children
- ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths

3.2 The collation and sharing of the learning from reviews is managed by the National Child Mortality Database (NCMD) using standardised forms. Following the introduction of the NCMD there was an increase in data entry requirements, and a number of changes were made to the national templates used by CDOP to gather information following a child death. To ensure that the CDOP supplies the necessary information to the NCMD Manchester uses the eCDOP system which automatically populates the NCMD.

MANCHESTER CHILD DEATH OVERVIEW PANEL (CDOP)

2021/2022 ANNUAL REPORT

1 April 2021 – 31 March 2022

BARRY GILLESPIE
Assistant Director of Public Health
Chair of the Manchester Child Death Overview Panel

PUBLISHED: JANUARY 2023

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1. WELCOME & INTRODUCTION

This 2021/22 Manchester Child Death Overview Panel (CDOP) Annual Report covers a period that continued to be affected by the COVID-19 pandemic. Following the publication of the HM Government Child Death Review: Statutory and Operational Guidance (England) in October 2018, changes were introduced to build on the interface between the hospital/community led mortality reviews (Child Death Review Meetings (CDRM) and the final CDOP review. The improvements to the revised child death review system have contributed to a reduction in the number of cases being reviewed, and closed, by Manchester CDOP.

During 2021/22 there were 64 child death notifications reported to the Manchester CDOP, with a 5-year average for 2017/22 of 59 notifications per year. A further reduction in the cases reviewed during 2021/22 (27), in comparison to 2020/21 (29), was exacerbated by the impact of COVID-19 across public sector service provision.

The CDOP has a statutory requirement to prepare and publish a local report on:

a) what has been done as a result of the child death review arrangements; and
b) how effective the child death review arrangements are in practice.

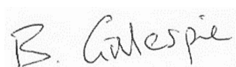
The CDOP Annual Report is produced to advise Child Death Review (CDR) Partners on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process. This report reviews the deaths of children normally resident in Manchester, aged 0-17 years of age (excluding stillbirths and legal terminations of pregnancy) and focuses on the analysis of the number of cases closed between 1 April 2021 to 31 March 2022 (2021/22). Reporting on cases closed provides a full and complete data set, including the outcome of the final CDOP review. The richness of the data and information collated assists in the identification of factors antenatally, postnatally and throughout the child's life. This report aims to highlight relevant factors and modifiable factors that are likely to contribute to Manchester's infant (under one year of age) and child (age 1-17 years) mortality rate.

The Greater Manchester (GM) CDOP Network is made up of the four CDOPs (ten local authorities) across the GM footprint:

- Manchester CDOP
- Bury, Rochdale & Oldham CDOP
- Bolton, Salford & Wigan CDOP
- Tameside, Trafford & Stockport CDOP

The GM CDOP Network focuses on ensuring a consistent GM approach is adopted, with the aim of establishing an efficient child death review process, whilst maintaining the day-to-day business of the CDOP. The Manchester CDOP continues to work closely with neighbouring GM CDOPs to deliver a standardised approach when reviewing child deaths to identify patterns and trends across GM.

I would like to thank those who have contributed to the child death review process including CDOP members, practitioners completing data returns and colleagues that have contributed to the content of this report.



Barry Gillespie
Assistant Director of Public Health
Manchester Child Death Overview Panel Chair

2. THE CHILD DEATH REVIEW PROCESS

In line with Working Together to Safeguard Children (2006)[1], the Child Death Overview Panel (CDOP) became a statutory function from 1 April 2008. Local Safeguarding Children Boards (LSCBs) were tasked with establishing a multi-disciplinary CDOP Subgroup to conduct a review into the death of all children 0-17 years of age, normally resident in their geographical area.

In October 2018, HM Government published the revised Child Death Review: Statutory and Operational Guidance (England)[2] for Clinical Commissioning Groups and Local Authorities as Child Death Review Partners (CDR Partners). CDR Partners are identified as Local Authorities and any Clinical Commissioning Groups for the local area as set out in the Children and Social Work Act 2017[3]. The guidance sets out the full process that follows the death of a child, who is normally resident in England and builds on the statutory requirements set out in Working Together to Safeguard Children (2018)[4]. The revised guidance clarifies how individual professionals and organisations across all sectors, involved in the child death review process, contribute to reviews in order to improve the experience of bereaved families and professionals involved in caring for children.

The publication of the revised guidance prompted significant changes to the way in which child deaths are reviewed. These changes include the expansion of the Department of Health and Social Care (DHSC) CDR dataset, the national templates used to collate information following a child death, the introduction of the Child Death Review Meeting (CDRM) and the implementation of local data management systems (eCDOP) to coincide with the National Child Mortality Database (NCMD).

2.1 DEPARTMENT OF HEALTH AND SOCIAL CARE (DHSC)

The DHSC have amended the data entry fields and national templates[5] used by CDOPs, to collate information following a child death. Year on year, the CDR dataset expands to collate multi-agency information to support CDOPs assess the causes of a child's death as part of the child death review process. Depending on the nature of the death, various templates are used to gather information regarding the circumstances leading to death, any underlying health conditions, the child's social and physical environment and details relating to service provision.

- A. Child death notification form
- B. Child death reporting form
- C. Child death analysis form

Supplementary Reporting Forms:

- Asthma and anaphylaxis
- Cardiac congenital or acquired
- Care pathway
- Chromosomal, genetic, or congenital anomaly excluding cardiac conditions
- Death as a result of fire, burns or electrocution
- Death of a child with an oncology condition
- Death as a result of injuries sustained from a falling object
- Death of a child with a life-limiting condition
- Deaths on a neonatal unit, delivery suite or labour ward
- Diabetic ketoacidosis

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[1] https://webarchive.nationalarchives.gov.uk/20100408113130/http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00060/
[2] https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england
[3] https://www.legislation.gov.uk/ukpga/2017/16/part/1/chapter/2/crossheading/child-death-reviews/enacted
[4] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
[5] Child death reviews: forms for reporting child deaths - GOV.UK (www.gov.uk)

- Drowning
- Epilepsy
- Falls
- Infection
- Poisoning
- Sudden unexpected deaths
- Suicide or self-harm including alcohol or substance abuse
- Trauma or external factors
- Vehicle collisions
- Violent or maltreatment-related deaths

The completed forms help CDOPs collect information regarding child deaths in their area in a consistent way, assess the causes of child deaths to see if there are significant similarities between and recommend how to prevent similar deaths in future. CDOP areas were tasked with implementing arrangements to share the results of local CDRs with the NCMD, as a legal statutory requirement. Prior to the 1 April 2021, the DHSC templates were used by the Manchester CDOP to request child death information. As of the 1 April 2021, data is now captured electronically via the Greater Manchester eCDOP system which falls in line with the NCMD legal requirement, to submit CDR data at a national level.

2.2 CHILD DEATH REVIEW MEETING (CDRM)

The Child Death Review Meeting (CDRM) is a multi-professional meeting where all matters relating to an individual child death are discussed by the professionals directly involved in the care of the child during life and any investigation after death. The nature of the meeting varies according to the circumstances of the child's death and the practitioners involved. The CDRM can take place in the form of a final case discussion following a Joint Agency Response (JAR); a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit; a hospital-based mortality review meeting following the death of a child in a paediatric intensive care unit; or similar case discussion.

In all cases, the aims of the CDRM are:

- to review the background history, treatment, and outcomes of investigations, to determine, as far as is possible, the likely cause of death.
- to ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment, and service delivery.
- to describe any learning arising from the death and, where appropriate, to identify any actions that should be taken by any of the organisations involved to improve the safety or welfare of children or the child death review process.
- to review the support provided to the family and to ensure that the family are provided with:
    - the outcomes of any investigation into their child's death.
    - a plain English explanation of why their child died (accepting that sometimes this is not possible even after investigations have been undertaken) and any learning from the review meeting.
- to ensure that the CDOP and, where appropriate, the Coroner is informed of the outcomes of any investigation into the child's death; and
- to review the support provided to staff involved in the care of the child.

Information, reports, and notes of the CDRM are shared with the appropriate CDOP.

2.3 CHILD DEATH OVERVIEW PANEL (CDOP)

CDR Partners have a legal responsibility to ensure that the deaths of children normally resident in their area are reviewed. This function is carried out by the Child Death Overview Panel (CDOP) to ensure that a review is undertaken for all infant/child deaths age 0-17 years, excluding babies who are stillborn, late foetal loss and planned terminations of pregnancy carried out within the law.

In reviewing the death of each child, the CDOP considers relevant factor and modifiable factors in the family environment, parenting capacity and service provision. The CDOP identifies what action could be taken locally, regionally or at a national level with the aim of preventing child deaths and to improve the health and safety of children and young people.

The functions of the CDOP are:

- to collect and collate information about each child death, seeking relevant information from professionals.
- to analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths.
- to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety, and well-being of children.
- to notify the Child Safeguarding Practice Review Panel (CSPR) and Local Safeguarding Partnership (LSP) when it suspects that a child may have been abused or neglected.
- to notify the Medical Examiner and the Doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction.
- to provide specified data to the National Child Mortality Database (NCMD).
- to produce an annual report for child death review partners on local patterns and trends in child deaths, 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.

The Manchester CDOP membership is made up of senior multi-agency professionals who have knowledge and expertise in fields such as public health, children's social care, paediatrics, police, education etc. The panel consists of representation from a range of organisations who can make a valuable contribution when undertaking a child death review. Each professional provides information and advice to enable a thorough review and analysis, with the aim of identifying relevant factors, modifiable factors, and emerging themes.

The purpose of a review and analysis is to identify any matters relating to the death(s), that are relevant to the welfare of children in the area or to public health and safety, to consider whether action should be taken. The aim of the child death review process is to ensure that information is systematically captured for every death to enable learning and prevent future deaths. The CDOP publishes an annual report which provides an overview of local patterns and trends.

2.4 MANCHESTER CDOP THEMED PANEL MEETINGS

Some child deaths are reviewed at a Themed Panel to discuss a particular cause or group of causes. The Manchester CDOP holds Themed Panel meetings to review perinatal/neonatal deaths (<28 days of life) and infant deaths (under 1 year of age), where the infant was never discharged from hospital. Such arrangements allow for the attendance of appropriate professional experts including the Manchester University NHS Foundation Trust Consultant Neonatologist and Designated Doctor for Child Death, to

inform discussions and allow easier identification of themes. Deaths reviewed at the Themed Panel are pre-screened to highlight any relevant factors and/or modifiable factors during the antenatal/postnatal period, focusing on issues relating to service provision.

2.5 LEARNING DISABILITIES MORTALITY REVIEW (LeDeR) PROGRAMME

Once the Manchester CDOP is notified of the death of a child aged 4-17 years who has learning disabilities or is very likely to have learning disabilities but not yet had a formal assessment for this, information is shared, and the death is reported to the Learning Disabilities Mortality Review (LeDeR) Programme. The Manchester CDOP reports deaths to LeDeR via the online referral form and provides core information about the child which is submitted to the LeDeR Local Area Contact.

Once all investigations have concluded and sufficient information has been collated to ensure the CDOP can undertake a comprehensive review, the Manchester CDOP invites the LeDeR representative to attend the panel meeting at which the death is reviewed. During the CDOP meeting, the LeDeR Local Area Contact may offer advice and expertise about learning disabilities (if appropriate) and ensure that the CDOP provides sufficient core data to support the LeDeR Programme. Once the Manchester CDOP has conducted a review, documentation is submitted to the LeDeR Local Area Contact. This includes the final Analysis Form which highlights the:

- common contributory factors leading to deaths
- factors that may have contributed to the vulnerability, ill health or death of the child
- modifiable factors that may reduce the risk of future child deaths
- learning points and issues identified in the review
- recommendations and actions that may inform and support local, regional or national learning

2.6 GREATER MANCHESTER eCDOP

The software company QES placed a bid for the national tender and was appointed as technical providers to develop and host the NCMD. QES developed a supporting CDOP case management and reporting system known as eCDOP. The eCDOP system operates in line with the statutory guidance to assist CDOPs and ensure compliance. The system is known for improving efficiencies throughout the multi-agency information gathering process.

The eCDOP system automatically transfers multi-agency data at each relevant stage of the process into the NCMD therefore reducing the duplication of data entry. Over 1000 data entry fields auto-populate directly into the NCMD which significantly reduces double data entry and prevents local CDOPs having to do update NCMD records manually. The information is then used to analyse data nationally to improve learning and implement strategic improvements in healthcare for children in England, with the overall goal to reduce infant/child mortality.

The four Greater Manchester (GM) CDOPs adopted a collaborative approach and agreed to purchase an eCDOP system that would support the ten GM local authorities. The system went live on 1 April 2021, therefore all child death notifications must be reported electronically via the GM eCDOP system[6], in line with the statutory requirement to notify the CDOP of all child deaths aged 0-17 years of age, within 24 hours (or the next working day) of the child's death.

[6] https://www.manchestersafeguardingpartnership.co.uk/resource/cdop/

2.7 NATIONAL CHILD MORTALITY DATABASE (NCMD)

The National Child Mortality Database (NCMD) is a repository of data relating to all child deaths in England. The NCMD was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and is delivered by the University of Bristol, in collaboration with the University of Oxford, University College London (UCL) Partners and the software company QES. The NCMD enables more detailed analysis and interpretation of all data arising from the child death review process, to ensure that lessons are learned, that learning is widely shared and that actions are taken locally and nationally, to reduce child mortality. The introduction of the NCMD aims to learn lessons that could lead to changes to improve outcomes for children.

As of the 1 April 2019, it became a statutory requirement that CDOPs across England submit data via the NCMD. For every child death, CDR Partners must ensure that:

1. A notification form is completed and sent to the CDOP secretariat or equivalent immediately after the death of a child
2. The details on the notification form are entered onto the NCMD within 24 hours of receipt of the form by the CDOP secretariat or equivalent
3. The CDOP gathers information from all agencies that were involved with the child during their life or after death through completion of a reporting form
4. The CDOP secretariat identifies the most appropriate agency to complete the relevant supplementary reporting forms, depending on the cause of death, and request for that agency to complete the relevant forms
5. When completed, reporting forms and supplementary reporting forms are returned to the CDOP secretariat or equivalent, and information is entered onto the NCMD
6. A local CDRM is convened, to include all professionals that were involved with the child during their life or after death
7. Anonymous versions of the completed CDOP templates (notification form, reporting form, supplementary reporting forms and draft analysis form) are presented to the CDOP, to conduct an independent review of the death
8. Following the CDOP review, the details are entered on the final analysis form and data is submitted to the NCMD.

3. MANCHESTER'S DEMOGRAPHICS

3.1 INDICES OF DEPRIVATION 2019

A key tool used in assessing deprivation is the Indices of Deprivation 2019 that combines data from across seven domains of deprivation to produce an overall relative measure of deprivation:

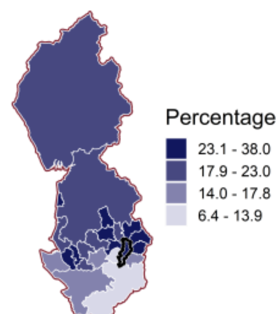
- Income: Measures the proportion of the population experiencing deprivation relating to low income
- Employment: Measures the proportion of the working age population in an area involuntarily excluded from the labour market
- Health Deprivation and Disability: Measures the risk of premature death and the impairment of quality of life through poor physical or mental health
- Education, Skills Training: Measures the lack of attainment and skills in the local population
- Crime: Measures the risk of personal and material victimisation at local level
- Barriers to Housing and Services: Measures the physical and financial accessibility of housing and local services
- Living Environment: Measures the quality of both the indoor and outdoor local environment

Each small area in England is ranked from 1 (most deprived) to 32,844 (least deprived)[7]. According to the 2019 Index of Multiple Deprivation (IMD), as an average score, Manchester ranks 6 out of 326 local authorities in England, 1 being the most deprived.

3.2 MANCHESTER'S CHILD HEALTH PROFILE 2021

The Manchester Child Health Profile 2022 provides a snapshot of child health across the City. Overall, comparing local indicators with England averages, the health and wellbeing of children in Manchester is worse than that of England. According to the ONS population estimate for mid-2021, children and young people aged 0-19 years account for 26.7% (140,047) of Manchester's total population. Children aged 0-4 years account for 6.2 (33,932) of the total population of the city. Manchester's infant mortality rate of 6.1 per 1,000 live births (2018-20), is worse than the England rate of 3.9, with an average of 44 infants dying before the age of one each year. This is same as the previous years (2017-19). Manchester's child mortality rate (2018-20) of 13.5 deaths per 100,000 children aged 1-17 years is worse than the England rate of 10.3, with an average of 15 child deaths each year. This is a decrease in comparison to previous years (2017-19) where the standardised rate of death was 16.2 per 100,000 children, with an average of 19 child deaths (aged 1-17 years) each year. 35.5% of Manchester children under 16 years of age are living in poverty in comparison to the England average of 27% (2020/21).

Diagram 1: Map of the North-West with Manchester outlined, showing the relative levels of children living in poverty



[7] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

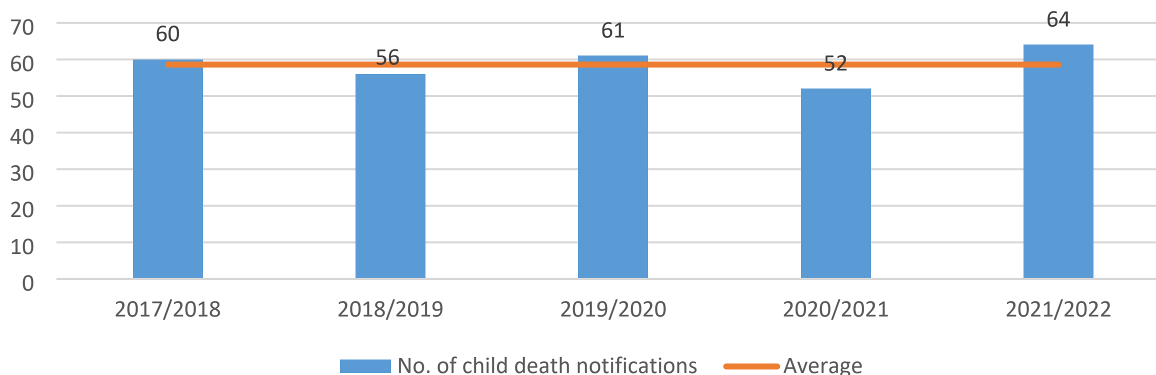
4. CHILD DEATH NOTIFICATIONS REPORTED TO THE CHILD DEATH OVERVIEW PANEL

There were 64 child death notifications reported to the Manchester CDOP from 1 April 2021 to 31 March 2022 (2021/22). At the end of the CDOP reporting year (31 March 2022) there was a total of 125 cases that remained open pending a CDOP review, 61 of which were historical child death notifications where the death occurred prior to 1 April 2021 and the remaining 64 where the death occurred during 2021/22 period.

From 1 April 2017 to 31 March 2022 there were 293 child deaths reported to the Manchester CDOP. There has been a variation in the number of child deaths reported year on year, with an average of 58.6 notifications per year.

The latest Office of National Statistics (ONS) population estimate for mid-2021 suggests that there are 176,602 children aged 0-17 years living in Manchester. This is equivalent to 23.0% of the total resident population of the city (549,853). With a total of 64 child death notifications reported to the Manchester CDOP during the period 2021/22, this would indicate that Manchester's overall child death rate is 36.2 deaths per 100,000 children (aged 0-17 years), which is a lower than the comparable rate for 2020/21 of 52.1 child deaths per 100,000 population.

Diagram 2: Number of child deaths reported to the Manchester CDOP per CDOP year (2017/22)



Across the three-year period (2019/22), Manchester CDOP has received a total of 177 deaths. In 2019/20, 62 notifications were received and 85% were reviewed. In 2020/21, 51 notifications were received and 14% were reviewed. In 2021/22, 64 notifications were received with all pending a review. The total percentage of cases reviewed over this period has been 33%[8].

Diagram 3: Number of child deaths reviewed by year of death to the Manchester CDOP (2019/22)

Number of deaths notified by year of death				Total
Year	2019/20	2020/21	2021/22	
Deaths	62	51	64	**177**
% Reviewed	85%	14%	0%	**33%**

This is partly due to the publication of the revised guidance having a significant impact in terms of the operational aspects of the CDR process and the development of the new arrangements for CDOPs

[8] NCMD Regional Report North-West Data up to 31st March 2022

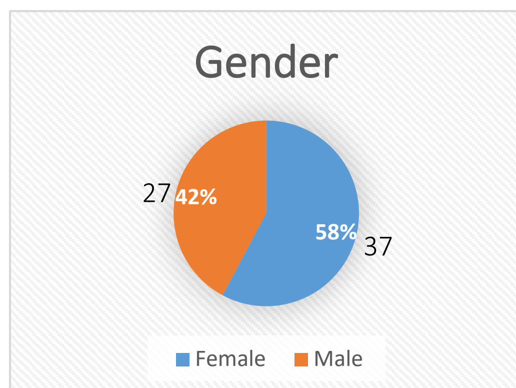
locally, which is far more complex in comparisons to previous requirements. This has resulted in an increase in case management functions, to ensure statutory requirements are adhered to.

There is a time lapse between a death being reported to the CDOP and the case being discussed and closed at panel. This depends heavily upon the circumstances leading to death, pending CDRMs and, for deaths subject to one or more forms of investigation, the CDOP must await the conclusion before conducting a review. Deaths subject to multiple investigations such as internal agency reviews, coronial investigations, criminal proceedings, and child safeguarding practice reviews, can take years before all have concluded and sufficient information is submitted to CDOP.

4.1 AGE, GENDER & ETHNICITY

Of the 64 cases notified, 37 (58%) children were female and 27 (42%) were male. 27 (42%) of the infants were neonatal deaths (<28 days). A further 17 (27%) deaths occurred before the first year of life (28-364 days), accounting for a total of 69% (44) of cases closed.

Diagram 4: Cases notified to Manchester CDOP by gender and age at time of death (2021/22)



Age	Notified Cases[9]	
0-27 days	27	42%
28-354 days	17	27%
1-4 years	5	8%
5-9 years	<5	3%
10-14 years	5	8%
15-17 years	8	12%
Total	64	100%

Diagram 5: Cases notified to Manchester CDOP by ethnic grouping (2021/22)

Ethnicity	Notified Cases	
Asian or Asian British	23	36%
Black or Black British	11	17%
Mixed	7	11%
Other ethnic group	7	11%
White	16	25%
Total	64	100%

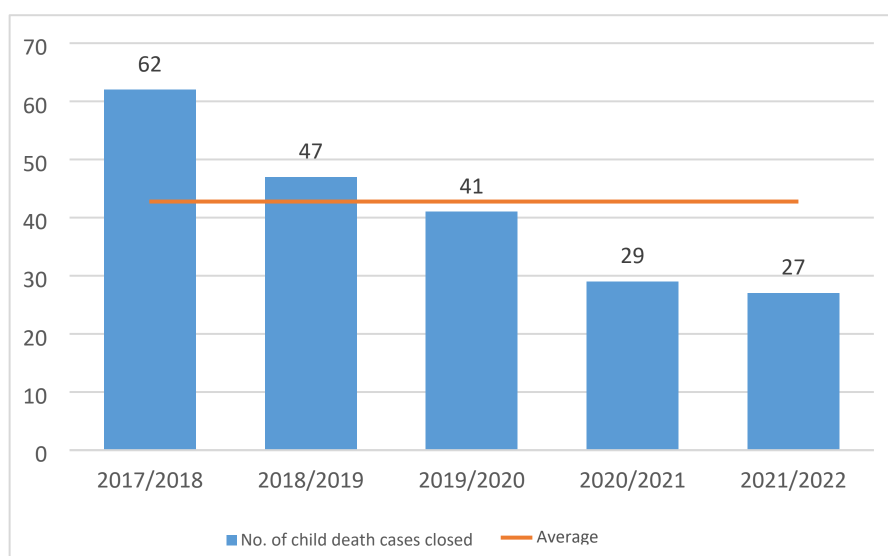
The ethnic breakdown of deaths follows the pattern of previous years with children who were Asian or Asian British (23, 36%) or White (16, 25%) being the groups experiencing the highest number of child deaths.

[9] Suppression of data to anonymise statistics: Personal data where the value is less than 5 has been removed (<5/1)

5. CASES CLOSED BY THE CHILD DEATH OVERVIEW PANEL (CDOP)

Once the CDRM has taken place, all investigations have concluded and sufficient information has been collated, the CDOP holds the final multi-disciplinary review. Examining deaths using the data of cases discussed and closed at panel, provides a full dataset to conduct analysis. This annual report focuses on data relating to the 27 cases discussed and closed by the CDOP from 1 April 2021 to 31 March 2022 (2021/22). Of the 27 cases closed during 2021/22, all were historical cases, where the death occurred prior to 1 April 2021.

Diagram 6: Number of cases closed by the Manchester CDOP per CDOP year (2017/22)



Following the publication of the revised Child Death Review: Statutory and Operational Guidance (England), it was anticipated that the CDOP would see a decrease in the number of closed cases per year due to additional national requirements. The national changes have drastically impacted upon the level of data as requested by the DHSC, the time taken to process case information and documentation during the CDOP review.

In previous years, the Manchester CDOP conducted timely reviews for expected child deaths, where the death was anticipated within 24 hours due to natural causes such as extreme prematurity and life limiting conditions. The Manchester CDOP operates in line with the current guidance, which stipulates that a CDOP review should not take place until the CDRM has concluded and information is shared for discussion at panel. Whilst the Manchester CDOP welcomes the new standardised approach to CDRMs, this impacts heavily on the timescale in which the panel undertakes a review, therefore resulting in fewer cases closed.

Information submitted following a CDRM is detailed and extremely useful in supporting the Manchester CDOP carry out a thorough review of the death. The CDOP utilises CDRM reports, assessing the care provided, to highlight any issues in relation to service provision such as, the identification of illness, assessment, investigations and diagnosis; treatment or healthcare management; communication or teamwork within or between agencies; and organisational or systemic issues. The Manchester CDOP identifies relevant factors including underlying staffing issues, equipment, work environment, education and training requirements and documents positive aspects of service delivery to record examples of excellent care.

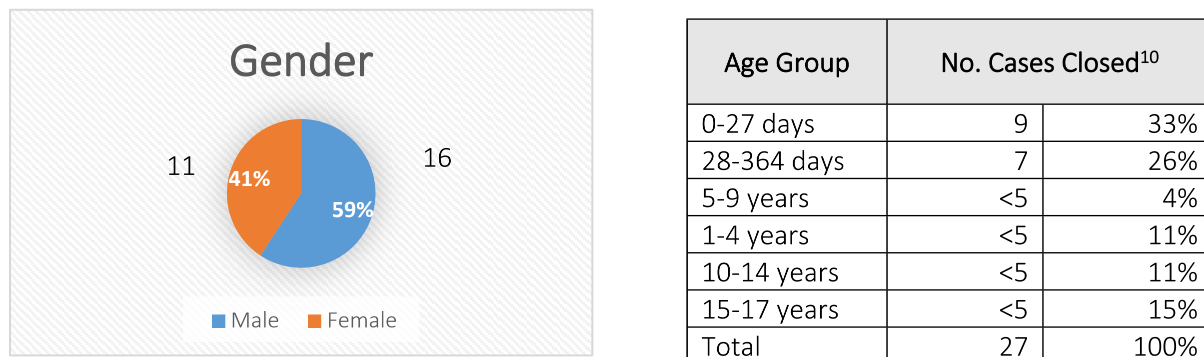
Whilst the number of child deaths reported to the Manchester CDOP varies year on year the average number has been around 60 deaths per year (2017/22 average is 58.6 notifications per year), it is anticipated that the panel will continue to see a reduction in the number of cases closed over the coming years. It has been recognised by the NCMD programme team that the interface between the CDRM and CDOP process will impact the timescale of completed reviews due to operational aspects of the revised child death review process. The circumstances leading to death and the nature of the death also impact upon the number of cases closed by the CDOP. Deaths where the cause appears to be unnatural, sudden, and unexpected can be subject to multiple investigations that can remain ongoing for several years, which impacts on the timeliness of the CDOP review.

6. A SUMMARY OF 2021/22 CASES CLOSED

6.1 AGE, GENDER & ETHNICITY

Of the 27 cases closed, 11 (41%) children were female and 16 (59%) male. 9 (33%) of the infants were neonatal deaths (<28 days). A further 7 (26%) deaths occurred before the first year of life (28-364 days), accounting for a total of 59% (16) of cases closed. Of the 16 infant deaths (0-364 days), 6 (37.5%) had one or more modifiable factors identified in the review (see section 6.2).

Diagram 7: Manchester CDOP cases closed by gender and age at time of death (2021/22)



Age Group	No. Cases Closed[10]	
0-27 days	9	33%
28-364 days	7	26%
5-9 years	<5	4%
1-4 years	<5	11%
10-14 years	<5	11%
15-17 years	<5	15%
Total	27	100%

Year on year, infants under the age of one account for the majority of cases with modifiable factors, with the most common factors occurring in the antenatal period such as maternal smoking in pregnancy.

Diagram 8: Manchester CDOP cases closed by ethnic grouping (2021/22)

Ethnicity	No. Cases Closed	
Asian or Asian British	10	37%
Black or Black British	6	22%
Mixed	<5	4%
Other ethnic group	<5	7%
White	8	30%
Total	27	100%

The largest number of cases closed were recorded in children who were White (13, 45%) and Asian or Asian British (9, 31%). Breaking the data down further into specific ethnicities identifies the largest number of cases closed were children of English/Welsh/Scottish/Northern Irish/British heritage (10, 34%) and children from the Pakistani community (6, 21%). Comparing this data with 2020/21, the largest number of deaths was also recorded in children who were White (13, 45%)- English/Welsh/Scottish/Northern Irish/British heritage (10, 34%)- and Asian/Asian British children (9, 31%)- Pakistani community (6, 21%).

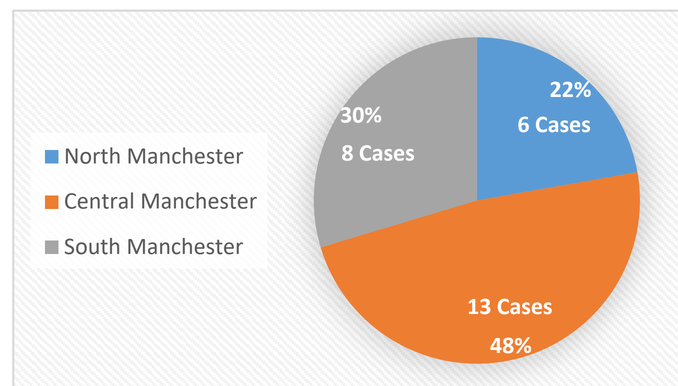
[10] Suppression of data to anonymise statistics: Personal data where the value is less than 5 has been removed (<5/1)

6.2 AREA OF RESIDENCE & DEPRIVATION

The 2019 Index of Multiple Deprivation (IMD) ranked Manchester as 6 out of 326 local authorities in England (where 1 is the most deprived). 33.6% of children (under 16 years of age) in Manchester are living in poverty (2018/19) which is higher than the North-West (23.0%) and England (18.4%)[11]. The number of children (under 16 years of age) residing in relative low-income families have increased from 27.1%, 29,510 (2016) to 33%, 37,373 (2018/19). In 2020/21, the rate of households with dependent children owed a duty under the Homelessness Reduction Act in Manchester (25.4 per 1,000 households with at least one dependent child) is more than double the rate for England as a whole (11.6 per 1,000).

Within GM, Manchester has the highest proportion of residents (43%) residing in the most deprived 10% of neighbours in England[12]. Across GM, 6 of the 10 local authorities have a higher proportion of their population living in the most deprived areas of the country in comparison to the North-West average, with Manchester being the most deprived local authority. All GM local authorities but Trafford have deprivation scores above the national average. This emphasises that deprivation remains a significant public health concern and demonstrates a significant correlation between poverty and child death.

Diagram 9: Area of residence for closed cases by the Manchester CDOP (2021/22)



Of the 27 cases closed, the majority of children resided in areas of deprivation with 81% (22) of families residing in quintile 1 (most deprived). Of the 27 cases closed, 48% (13) of the children resided in Central Manchester[13]. Breaking the data down into neighbourhoods identifies Longsight having the largest number of deaths, accounting for 26% (7) of the 27 cases closed. Year on year, there continues to be a strong correlation with the higher rate of deaths in areas of deprivation where the Lower Layer Super Output Area (LSOA) are deemed most deprived.

The social deprivation and the increased risk of child death has been highlighted at a national level the publication of the NCMD Child Mortality and Social Deprivation Report[14]. The report analyses data for children who died during 2019/20 in England and identifies a clear association between the risk of child death and the level of deprivation (for all categories of death except cancer). More specifically, *the report* states that over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived – which translates to over 700 fewer children dying per year in England.

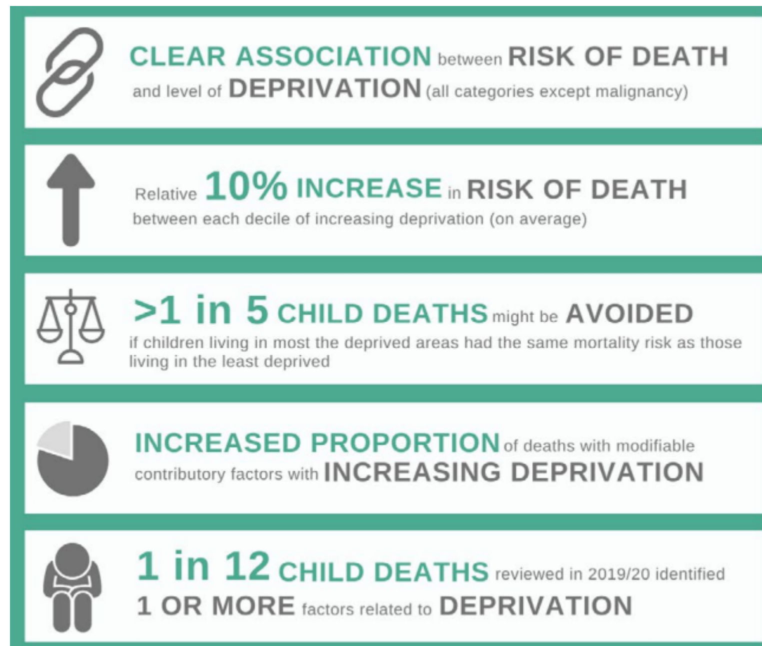
[11] https://fingertips.phe.org.uk/profile/child-health-profiles

[12] https://secure.manchester.gov.uk/downloads/download/414/research_and_intelligence_population_publications_deprivation

[13] https://www.manchesterlco.org/howwework

[14] https://www.ncmd.info/2021/05/13/dep-report-2021/

Diagram 10: NCMD Child Mortality & Social Deprivation Key Findings (2019/20)



The most common age at death was less than 1 year (63%) and more boys than girls died (56.5% vs 43.5%), while the majority of children who died lived in urban areas (87.8%). It was determined that child mortality increased as deprivation increased. More specifically, on average, there was a 10% increase in the risk of death between each decile of increasing deprivation. A total of 2,738 child deaths were reviewed during 2019/2020 by CDOPs in England. Analysis of the data highlights the proportion of deaths with modifiable factors increased with increasing deprivation (factors relating to the social environment were the most common). While, overall, at least 1 in 12 of all child deaths reviewed had one or more factors related to deprivation identified.

The report documented the work of the Manchester CDOP as an exemplar case study, to highlight the value of CDOPs in influencing changes in local and regional policies. The report praised Manchester services and initiatives such as the Manchester reducing infant mortality strategy (2019/24), Vulnerable Babies Service, Baby Clear Programme and ICON Programme.

Professor Sir Michael Marmot FRCP, Director, UCL Institute of Health Equity UCL Dept of Epidemiology and Public Health:

'The harrowing accounts of child loss both illustrate how the causation works and where intervention might have saved lives. The illustration that such intervention is possible is another strength. For example, the Manchester Reducing Infant Mortality Strategy has five priority themes: quality of services, maternal and infant wellbeing, addressing the wider determinants of health, keeping children safe from harm, and providing support for those bereaved by baby loss.'

6.3 RELEVANT FACTORS & MODIFIABLE FACTORS

Information is collated using the Department of Health and Social Care (DHSC) national CDOP reporting forms[15]. Completed forms are presented during the CDOP meeting to assess the death. As part of the child death review process, the CDOP is responsible for analysing information to determine the categorisation of death (see appendix 2), relevant factors and modifiable factors.

Information is collated and categorised using the four domains:

Domain A: Factors intrinsic to the child:

Factors in the child (and in neonatal deaths, in the pregnancy) relating to the child's age, gender and ethnicity; any pre-existing medical conditions, developmental or behavioural issues or disability, and for neonatal deaths, the mother's health and wellbeing.

Domain B: Factors in social environment including family and parenting capacity:

Factors in family structure and functioning and any wider family health issues; provision of basic care (safety, emotional warmth; stimulation; guidance and boundaries; stability); engagement with health services (including antenatal care where relevant); employment and income; social integration and support; nursery/preschool or school environment.

Domain C: Factors in the physical environment:

Factors relating to the physical environment the child was in at the time of the event leading to death, and for neonatal deaths, the mother's environment during pregnancy including poor quality housing; overcrowding; environmental conditions; home or neighbourhood safety; as well as known hazards contributing to common childhood injuries (e.g. burns, falls, road traffic collisions)

Domain D: Factors in Service Provision:

Factors in relation to service provision or uptake including any issues relating to identification of illness, assessment, investigations and diagnosis; treatment or healthcare management; communication or teamwork within or between agencies; and organisational or systemic issues. Consider underlying staff factors, task factors, equipment, and work environment, education and training, and team factors.

For each of the four domains, the Manchester CDOP determines the level of relevance (0-2) for each factor, relating to the registered cause of death and to inform learning of lessons at a local, regional, and national level. The categories are:

0 Information not available

1 No factors identified, or factors identified but are unlikely to have contributed to the death

2 Factors identified that may have contributed to vulnerability, ill health, or death

[15] https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths

As part of the review, the CDOP is responsible for identifying modifiable factors, although categorising a death as having modifiable factors does not necessarily mean the CDOP regards the death in question as preventable, but that there may be emerging trends which could reduce the risk of future child deaths:

Modifiable factors identified: The review has identified one or more factors across any domain which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths

No modifiable factors identified: The review did not identify any modifiable factors

Inadequate information upon which to make a judgement: The review was unable to identify if any modifiable factors were present.

Diagram 11: Categorisation of death for cases closed by the Manchester CDOP (2021/22)

Categorisation of Death	No. Cases Closed	
Acute Medical and Surgical Condition	<5	7%
Chromosomal, genetic and congenital anomalies	5	19%
Deliberately inflicted injury, abuse or neglect	<5	4%
Infection	<5	7%
Malignancy	<5	4%
Perinatal/neonatal event	9	33%
Sudden unexpected, unexplained death	<5	15%
Suicide or deliberate self-harm	<5	7%
Trauma and other external factors	<5	4%
Total	27	100%

Although the number of cases closed (27) is small the largest number of deaths were categorised as chromosomal, genetic and congenital anomalies (5, 19%) and perinatal/neonatal event (9, 33%) reflecting a pattern experienced in previous years.

The majority of child deaths are due to medical causes which encompass multiple categories of death including acute medical or surgical, chronic medical, chromosomal, perinatal/neonatal event, malignancy and infection. Small numbers were attributable to non-medical causes including trauma, deliberate harm/abuse/neglect, suicide/self-harm and sudden unexpected/unexplained death.

Diagram 12: Frequency of relevant associated factors in closed cases by the Manchester CDOP (2021/22)

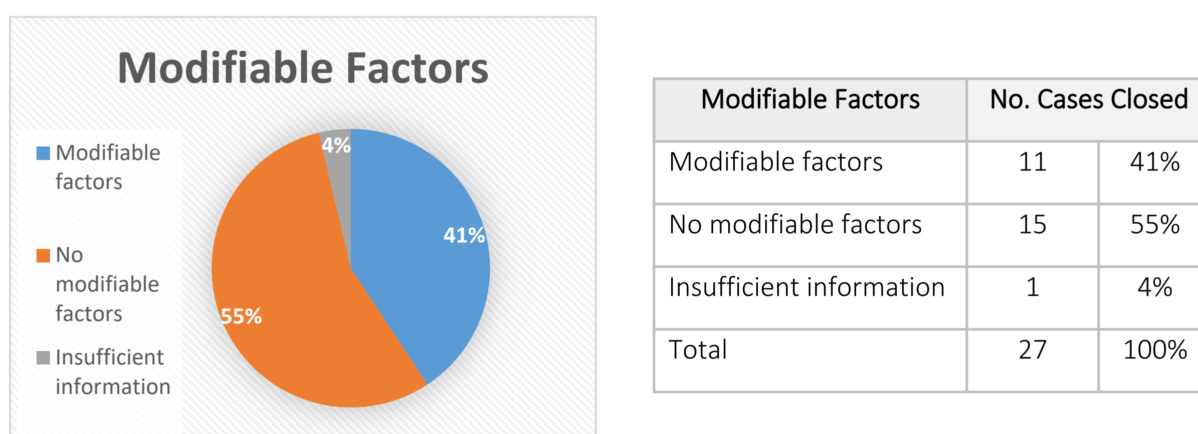
Factors identified that may have contributed to vulnerability, ill-health or death (2)	No. of factors categorised as a relevance of 2[16]
Factors intrinsic to the child	
Acute/Sudden onset illness	16
Epilepsy	<5
Other chronic illness	7
Learning disabilities	<5
Motor impairment	<5
Sensory impairment	<5
Other disability or impairment	5
Emotional/behavioural/mental health condition in the child	<5
Alcohol/substance misuse by the child	<5
Domain B: Factors in social environment including family and parenting capacity	
Maternal Obesity	<5
Emotional/behavioural/mental/physical health condition in a parent or carer	9
Alcohol/substance misuse by a parent/carer	<5
Smoking by the parent/carer in household	<5
Smoking by the mother during pregnancy	<5
Domestic violence	<5
Co-sleeping	<5
Bullying	<5
Gang/knife crime	<5
Poor parenting/supervision	<5
Child abuse/neglect	<5
Social services intervention	5
Income deprivation	<5
Asylum seeker	<5
Late Booking/Concealed Pregnancy	<5
Lack of engagement with services	5
Domain C: Factors in the physical environment	
Housing	<5
Homelessness	<5
Poor condition of house	<5
Widespread use of drugs	<5
Unsafe sleeping arrangements	<5
Domain D: Factors in Service Provision	
Access to health care	<5
Prior medical intervention	<5
Prior surgical intervention	<5
Delay in assessment	<5
Lack of communication between agencies	<5

[16] Suppression of data to anonymise statistics: Personal data where the value is less than 5 has been removed (<5/-)

There may be factors present, although not deemed relevant to the child's cause of death. These are categorised as a relevance of 1. Some cases present no modifiable factors but have multiple relevant factors that may have contributed to vulnerability, ill-health or death of the child such as parental alcohol/substance use and housing conditions and therefore categorised as a relevance of 2. For example, natural causes of death categorised as chromosomal, genetic, and congenital anomalies, where the child was known to have an autosomal recessive disorder, may not display any modifiable factors but there may have multiple factors as a relevance of 2. Where there are multiple modifiable factors and relevance 2 factors present, the vulnerability of the child increases.

The Manchester CDOP identified one or more modifiable factors in 11 (41%) cases which is higher than the England average of 34% (as recorded by the NCMD). The highest number of modifiable factors were recorded in deaths categorised as a perinatal/neonatal event (<5).

Diagram 13: Modifiable factors identified in cases closed by the Manchester CDOP (2021/22)



Modifiable Factors	No. Cases Closed	
Modifiable factors	11	41%
No modifiable factors	15	55%
Insufficient information	1	4%
Total	27	100%

Year on year, deaths categorised as a perinatal/neonatal event continue to have the largest number of modifiable factors identified in the review. Modifiable factors in perinatal/neonatal deaths mostly relate to antenatal maternal health and wellbeing, which can lead to poor outcomes for both mother and infant such as maternal smoking in pregnancy and maternal obesity in pregnancy. Factors also include engagement with health services in accessing antenatal care, social and environmental conditions during pregnancy.

Of the 27 cases closed, the Manchester CDOP identified modifiable factors in 11 (41%) deaths. These are factors where local or nationally achievable intervention could be modified to potentially reduce the risk of future child deaths. Of the 11 deaths with modifiable factors, 5 (46%) children died before the age of 1, <5 (27%) of which were during the neonatal period.

Some deaths feature multiple modifiable factors which vary depending on the circumstances leading to death and the cause of death ascertained. For example, deaths categorised as a perinatal/neonatal event, may exhibit more than one modifiable factor such as maternal smoking in pregnancy, maternal obesity in pregnancy and lack of antenatal care service uptake. Modifiable factors act as multiplier effect, increasing the child's vulnerability where multiple factors are present.

Diagram 14: Modifiable factors identified in cases closed by the Manchester CDOP and the CDOPs in the Northwest region (2019/22)

Year of Review	2019-20			2020-2021			2021-2022		
CDOP	Number of reviews	Modifiable factors identified	%	Number of reviews	Modifiable factors identified	%	Number of reviews	Modifiable factors identified	%
Manchester	41	15	37%	29	9	31%	27	11	41%
Northwest	367	164	45%	318	136	43%	341	138	40%

Across the three-year period (2019/22), Manchester CDOP has reviewed a total of 97 deaths. In 2019/20, 41 deaths were reviewed and 37% had modifiable factors identified. This contributed to the Northwest regional total of 367 deaths reviewed, 45% of which had modifiable factors identified. In 2020/21, 29 deaths were reviewed and 31% had modifiable factors identified. This contributed to the Northwest regional total of 318 deaths reviewed, 43% of which had modifiable factors identified. In 2021/22, 27 deaths were reviewed and 41% had modifiable factors identified. This contributed to the Northwest regional total of 341 deaths reviewed, 40% of which had modifiable factors identified.

Though attempts have been made to standardise the process of identifying and categorising modifiable factors, it is often a subjective matter which is decided on a case-by-case basis. The GM CDOPs continue to conduct reviews in line with an agreed GM set standard of modifiable factors, as developed by the GM CDOP Network. The standard ensures consistency across the four GM CDOPs when undertaking reviews and identifying modifiable factors.

Diagram 15: Manchester CDOP Modifiable Factors 2021/22

* Smoking continues to the most common modifiable factor identified by the Manchester CDOP with maternal smoking in pregnancy and household smoking a factor in deaths categorised as a perinatal/neonatal event and sudden unexpected, unexplained death. Maternal obesity, where mother has a raised body mass index (BMI) of 30+ during pregnancy is also a modifiable factor in perinatal/neonatal deaths, as is maternal alcohol and/or substance use during pregnancy. Multiple modifiable factors were also identified (antenatally and postnatally) in sudden unexpected, unexplained deaths the most common being unsafe sleeping arrangements including parental alcohol and/or substance use. There were also 5 cases which showed issues within service provision as a modifiable factor, specifically delay in assessment, lack of communications between agencies and the impact of COVID-19 restrictions.

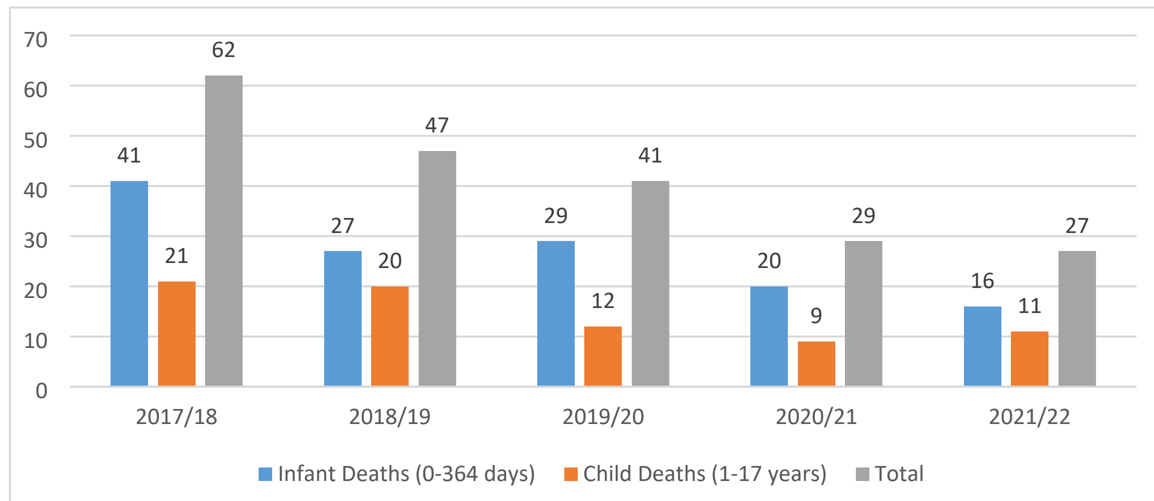
Though the numbers involved are relatively small, it emphasises that factors relating to smoking remain key modifiable factors for infant and child deaths. Despite ongoing efforts to reduce the rate of smoking, this continues to influence in the death of children and remains a steady modifiable factor. Further, the link between smoking and obesity strongly correlates with deprivation, meaning they represent a significant health inequality.

6.4 INFANT DEATHS (0-364 DAYS OF LIFE)

Of the 27 cases closed (2021/2022), a large proportion of the deaths occurred in the neonatal period (<28 days of life) accounting for 37% (10) of the total cases closed.

A further 6 (22%) infants died before the age of one (28-364 days of life), highlighting 59% (16) of the deaths occurring in the first year of life. This remains to be a year-on-year trend highlighting infants under the age of one as the most vulnerable age group.

Diagram 16: Manchester CDOP cases closed by age at time of death (2017/22)



Of the 15 infant deaths, a large proportion of the deaths were categorised as a perinatal/neonatal event and chromosomal, genetic, and congenital anomalies. Of the 10 deaths categorised as a perinatal/neonatal event, all infants were delivered prematurely, with prematurity featuring as the registered cause of death. Many infant deaths were anticipated due to the death ultimately being related to perinatal/neonatal events and chromosomal, genetic, and congenital anomalies. This reflects those deaths in the first year of life are often due to the complications of prematurity or from underlying health conditions.

Babies are considered viable at around 24 weeks' gestation, meaning it's possible for them to survive at this stage. Infants delivered under 24 weeks' gestation, have a significantly reduced chance of survival. The World Health Organization (WHO)[17] defines preterm birth as babies born alive before 37 weeks of pregnancy are completed, with sub-categories of preterm birth based on gestational age:

- extremely preterm (less than 28 weeks)
- very preterm (28 to 32 weeks)
- moderate to late preterm (32 to 37 weeks)

Of 15 infant deaths, 8 (53%) babies were delivered preterm (<37 weeks). Babies born before full term (<37 weeks) are vulnerable to health problems associated with prematurity. The earlier in the pregnancy a baby is born, the more vulnerable they are. Preterm birth occurs for a variety of reasons. Most preterm births happen spontaneously, but some are due to early induction of labour or caesarean birth, whether for medical or non-medical reasons. Common causes of preterm birth include multiple pregnancies, infections, and chronic conditions such as diabetes, high blood pressure and genetic influence.
Around 8 out of 100 babies are born prematurely[18]. Using the World Health Organisation (WHO) preterm birth sub-categorises, highlights 33% (7) of the preterm infants (7) were born extremely

[17] https://www.who.int/news-room/fact-sheets/detail/preterm-birth
[18] www.nhs.uk/conditions/pregnancy-and-baby/premature-early-labour

preterm (<28 weeks). Twins and triplets are often born prematurely with an average delivery date for twins at 37 weeks and 33 weeks' gestation for triplets. There were a number of infant deaths <5) recorded as a twin pregnancy some of which also resulted in a late foetal loss (<24 weeks' gestation) or stillbirth (>24 weeks) although, in line with Child Death Review: Statutory and Operational Guidance (England), stillbirths and late foetal loss are not subject to CDOP reviews.

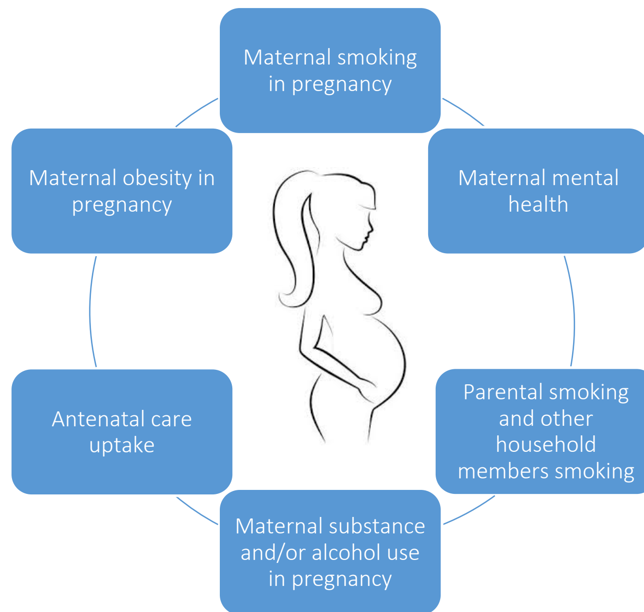
Low birth weight is defined by the WHO[19] as weight at birth less than 2500 g (5.5 lb). Low birth weight continues to be a significant health problem and is associated with a range of both short- and long-term consequences. Low birth weight is complex and includes preterm neonates, small for gestational age neonates at term and the overlap between these two situations. Typically, both preterm and small for gestational age neonates, have the worst outcomes.

The Royal College of Obstetricians and Gynaecologists[20] defines small for gestational age to an infant born with a birth weight less than the 10th centile[21]. Historically small for gestational age at birth has been defined using population centiles. The use of centiles is customised for maternal characteristics (maternal height, weight, parity, and ethnic group) as well as gestational age at delivery and infant sex, identifies small babies at higher risk of morbidity and mortality than those identified by population centiles. Of the 20 infant deaths, 18 (90%) had a birth weight of less than 2500 grams, 16 of which were preterm deliveries (<37 weeks' gestation).

Whilst prematurity impacts the infant's birth weight, low birth weight is also influenced by maternal lifestyle such as smoking and wider maternal health including pre-eclampsia. When reviewing infant deaths, the Manchester CDOP identifies modifiable factors and relevant factors during pregnancy that increase the risk to both mother and baby. These factors may also contribute to an early onset of labour, leading to poorer outcomes. All the associated factors act as a multiplier effect increasing the risk of prematurity, or that the infant may not be born in the best possible condition.

Diagram 17: Modifiable factors and/or relevant factors identified in infant death cases closed by the Manchester CDOP (2021/22)

[19] www.who.int/nutrition/publications/globaltargets2025_policybrief_lbw/en/
[20] www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf
[21] www.rcpch.ac.uk/resources/uk-who-growth-charts-neonatal-infant-close-monitoring-nicm



6.5 MATERNAL OBESITY IN PREGNANCY

A modifiable and relevant factor highlighted by the Manchester CDOP is mother's raised body mass index (BMI) during pregnancy. Significant activity has been undertaken by Population Health to reduce obesity across the city following the launch of the five-year Healthy Weight Strategy[3] in 2021 The strategy advocates a population-wide, all-age, whole system approach which begins with pregnant women and babies. The strategy advocates equipping health professionals with the resources to begin sensitive conversations about weight in pregnancy, increasing breastfeeding and making healthy choices in weaning with infants. Delivering on the healthy weight outcomes in maternity services and early years is a key outcome for the City's Start Well Board. Manchester City Council was one of only two authorities nationally to participate in a Public Health England pilot project in 2019/20, in which a maternal obesity resource was created for the benefit of Midwives and Health Visitors. After pandemic disruption, this resource has since been made available to a variety of health professional teams and partners across the city.

Research was recently undertaken by MCRactive to identify physical activity opportunities available to pregnant women with raised BMI's, which highlighted a lack of provision for pregnant women regardless of BMI status. In response, a multi-agency group was established, which sought to map out current physical activity provisions and engage with pregnant women and new mums to identify the barriers to accessing physical activity. A survey of 237 pregnant women / new mums highlighted only 17% of women were aware of the current physical activity guidance during pregnancy and as a new

mum, and barriers to accessing activities included time, cost, a lack of energy and difficulty finding suitable activities. As a result of the project and survey findings, there have been significant outcomes to increase the maternal offer, including a specific web page for active mums detailing physical activity for pregnant women, a twelve month pilot of aqua natal activities at three Leisure Centres, training for Children's Centre Staff to deliver Baby Yoga and the creation of an educational video 'The truth about being physically active during pregnancy and as a new mum - YouTube

https://www.mcractive.com/activity/activemumsclubmanchester

A dedicated Council Officer role in Public Health has been created to facilitate delivery of the Healthy Weight Strategy and increased access to commissioned services at a neighbourhood level, including partnership working between midwifery and weight management services. A social prescribing service for pregnant women who have a BMI of 28 and over, offers a voucher to access a free local weight loss group. A specialist service is also available for pregnant woman with a BMI of 35 or above, to encourage lifelong change by supporting pregnant women achieving a healthier lifestyle through education and personalised goal setting. Both programmes offer advice and support on nutrition, lifestyle, and behaviour change to enable women to be healthy throughout their pregnancy and beyond. Both services provide advice on nutrition in relation to breastfeeding and complementary feeding. Midwives can refer pregnant women into the tier three service from 12 weeks gestation which includes psychological therapy and, where appropriate, pharmacotherapy.

For most adults, an ideal BMI is in the 18.5 to 24.9 range (healthy weight range). The NHS defines the BMI categories[1] as:

- below 18.5 - underweight
- between 18.5 and 24.9 - healthy weight range
- between 25 and 29.9 - overweight range
- between 30 and 39.9 - obese weight range
- 40 and over - severely obese weight range

Being overweight increases the risk of complications for pregnant women and baby[2]. The higher a woman's BMI, the higher the chance of complications. Problems for baby can include being born prematurely and an increased risk of stillbirth (from an overall risk of 1 in 200 in the UK to 1 in 100 if mother has a BMI of 30 or more).

The increasing chances are in relation to:

- miscarriage - the overall chance of miscarriage under 12 weeks is 1 in 5 (20%); for women with a BMI over 30, the chance is 1 in 4 (25%)
- gestational diabetes - women with a BMI of 30 or above, are 3 times more likely to develop gestational diabetes than women who have a BMI below 25
- high blood pressure and pre-eclampsia - women with a BMI of 30 or above at the beginning of their pregnancy, have a chance of pre-eclampsia which is 2 to 4 times higher than that of women who have a BMI below 25
- blood clots - all pregnant women have a higher chance of blood clots compared to women who are not pregnant, for women with a BMI of 25 or above, the chance is increased further
- the baby's shoulder becoming "stuck" during labour (sometimes called shoulder dystocia)
- heavier bleeding than normal after the birth (post-partum haemorrhage)
- having a baby weighing more than 4kg (8lb 14oz) - the overall chance of this for women with a BMI of 20 to 30 is 7 in 100 (7%); for women with a BMI of above 30, the chance is doubled to 14 in 100 (14%)

- women are also more likely to need an instrumental delivery (forceps or ventouse), or an emergency caesarean section

Deaths categorised as a perinatal/neonatal event, where mothers BMI in pregnancy is recorded as underweight (BMI <18.5) or obese (BMI 30+), are deemed a modifiable factor by the Manchester CDOP. Obesity in the general population has increased, with factors such as Covid lockdown and cost of living being a contributor. Maternal obesity in pregnancy continues to be a relevant factor and features as a modifiable factor for Manchester, and across GM, in deaths categorised as a perinatal/neonatal event.

Infants born to women who begin pregnancy obese have a higher risk of premature death than children born to mothers at a healthy weight. Children who are obese at reception age are more likely to become overweight or obese adults and have shorter life expectancy.

In 2018, Manchester Population Health established a Healthy Weight Team in response to the rising levels of severe obesity and a Serious Case Review where a 13-year-old child died from a heart condition exacerbated by morbid obesity. The team puts the needs of children and families first, providing innovative, evidence-based intervention, and its work is now part of Manchester's Healthy Weight Strategy 2020–25. The team won the national *Nursing Times 'Public Health Nursing Team of the Year Award'* in December 2021. Manchester's Director of Public Health presented to the Coroners Court in January 2022 to demonstrate the measures Manchester had put in place and the work undertaken by numerous partners following the Serious Case Review, to reduce childhood obesity.

In 2023, Manchester will launch the Manchester *Food Active! Healthy Weight Declaration.* This is a city-wide pledge signed by City-Leaders to emphasize and give leverage to our commitment to enabling residents to live healthy, physically active lives, and reduce obesity.

6.6 SMOKING

Smoking continues to have a negative impact on the general health of children and remains a key modifiable factor for child deaths in Manchester. Depending on the nature of the death, the CDOP collates information regarding the smoking status of the child and during the antenatal period, maternal smoking in pregnancy and household members to monitor women who are exposed to harmful effects of environmental tobacco smoke during pregnancy.

Smoking in pregnancy has well recognised detrimental effects for the growth and development of baby and the health of the mother. Smoking during pregnancy can cause serious pregnancy related health problems including complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy (SUDI). Maternal smoking in pregnancy and/or parental household smoking was the most common occurring modifiable factor which the Manchester CDOP deemed a significant relevant factor in relation to the child's cause of death. Having a smoke free pregnancy, smoke free population generally and smoke free homes is the best way of protecting babies and children.

The National Tobacco Control Plan[1] includes an ambition to reduce smoking in pregnancy to 6% by the end of 2022, which is measured at the time of giving birth. The new National Tobacco Plan has been delayed and so we are currently working to the same target, not withstanding the fact, that the government has set an overarching target to reduce adult smoking prevalence nationally to under 5% by 2030 and recently updated.

Whilst not directly linked, it's obvious that smoking in pregnancy and the number of babies and children living in smoke free homes is a function of adult smoking prevalence. It is therefore encouraging to note that recently published government data suggest a reduction in adult smoking prevalence in Manchester from 21.4% in 2020 to 16.8% in 2021 (95% CI 13.1% - 20.5%). This puts

Manchester 4th out of the 10 local authorities in GM (see below) and 14th in the list of Counties and Unitary Authorities in England. The prevalence rate in Manchester is still significantly higher than the rate for England as a whole (13.0%). However, the gap between Manchester and England has been halved from 7.6 percentage points in 2020 to 3.8% percentage points in 2021

However, we do have to be mindful that smoking in prevalence is higher in some groups within Manchester. We know that at adults from a routine or manual occupation living in Manchester are over three times more likely to report that they were a current smoker compared with adults with another occupations and women and children from these cohorts may be at higher risk of other maternal health inequalities.

However, as part of a comprehensive and concerted approach to smoking in pregnancy across Manchester and the city region, latest SATOD figures for 2021/22 show that SATOD in the city is 8.9% versus a national average of 9.1%. However, we cannot be complacent because 8.9% remains high and those women who do smoke may well have other vulnerabilities.

The Manchester Population Health Plan priority 'The first 1000 days of a child's life' focuses on this area of work and is further addressed by the Manchester Tobacco Plan[3] and the Manchester Reducing Infant Mortality Plan.

Since in the introduction of the Greater Manchester Smokefree pregnancy programme in Manchester and Bolton 2018, all maternity services across Greater Manchester have adopted this approach. This has been seen as a exemplar work programme and highlighted as best practice as part of NHS England Long Term Plan and Saving Babies' Lives Care Bundle Element 1, which both aim to reduce smoking in pregnancy. The national ambition is that all maternity services offer a 'in-house' midwifery-led stop smoking service that offers – behaviour change interventions and treatment that can include the provision of NRT and vaping equipment. Manchester (as part of Greater Manchester NHS Integrated Commissioning Service) have enhanced this offer by including the provision of a financial incentive scheme to support those who would find it hardest to quit. The programme also includes a hard-hitting motivational interview following the first scan to all those who do not initially engage. The programme also supports significant others who can quit themselves and/or support the pregnant person to quit.

From 2022, Manchester Public Health has funded the Smoking in Pregnancy service above to provide free vaping devices to pregnant smokers, where those people felt that they would be more likely to "quit" with a vaping device rather than other forms of Nicotine Replacement Therapy (NRT). The Public Health Team also continued to fund NRT for pregnant smokers who lived in the city of Manchester or had a Manchester GP.

Pregnancy and Other Forms of Tobacco Use:

The Smoking in Pregnancy Service report that they see a significant number of women who also report using Cannabis (which is mixed with tobacco) whilst pregnant or being exposed to smoked Cannabis. The legal status of Cannabis may prevent accurate reporting. The service take a non-judgmental approach in order to encourage disclosure. Women who smoke Cannabis while pregnant are treated on the same pathway, with NRT/ vaping devices, as other smokers but are also referred to the Drug and Alcohol Specialist Midwives.

We also believe that a very small number of women may smoke Shisha when pregnant, or be exposed to Shisha smoke. Awareness of the harms associated with Shisha (in relation to its tobacco content) are not always fully understood and we believe that some Shisha smokers do not think of this activity as smoking. The Public Health team have therefore asked the Smoking in Pregnancy service to ask about "use" of Shisha when asking about use of other forms of tobacco.

Addressing smoking during pregnancy alone is not enough. Manchester aspires to reduce adult smoking rates (which remain higher than national averages), so that women are not smoking when they become pregnant. Furthermore, for women to remain smoke free after they give birth, in order to protect the baby from environmental tobacco smoke in the home and to protect future pregnancies. Manchester now has a citywide, community stop smoking service called, "Be Smoke Free". This service is a nurse led service, which offers free and direct provision of combination pharmacotherapy, Electronic Cigarettes and twelve week's psychological and motivational support in line with NICE guidance. This service treats any smoker aged 12 and over if they live in Manchester or have a Manchester GP.

Whilst Manchester has specialist services, it is essential that all professionals who work with pregnant women and families, understand the importance of women giving up smoking and smoke free homes. Be Smoke Free have designed training in how to deliver "Very Brief Advice" (VBAs) about smoking and we would like to encourage a Make Every Contact Count (MECC) as a multi-agency approach.

6.7 SUDDEN & UNEXPECTED DEATH IN INFANCY/CHILDHOOD (SUDI/SUDC)

Deaths categorised as a sudden unexpected, unexplained death where the pathological cause of death was recorded as either 'sudden infant death syndrome (SIDS)' or remains 'unascertained', continue to feature multiple modifiable factors relating to forms of unsafe sleeping arrangements. Unsafe sleeping arrangements such as co-sleeping, are particularly dangerous if the parent/carer has consumed alcohol or ingested substances, which may limit their awareness. Other known risk factors include co-sleeping with babies born prematurely or those with a low birth weight, overheating, covering baby's face or head while sleeping, loose bedding and falling asleep with baby on a sofa or in an armchair.

In deaths categorised as sudden unexpected, unexplained death, the Manchester CDOP highlighted several modifiable factors identified including:

- Maternal alcohol use in pregnancy
- Maternal substance use in pregnancy
- Maternal smoking in pregnancy
- Parental smoking and/or other household smokers
- Unsafe sleeping arrangements
- Co-sleeping
- Baby placed to sleep on a soft surface (parental bed)
- Parental alcohol use
- Parental substance use

The Manchester CDOP also highlighted several relevant factors (relevance 2) which may have contributed to the vulnerability, ill-health or death of the infant such as parental mental health issues, housing conditions, domestic abuse, poor parenting/supervision, and child abuse/neglect. It should be noted that factors (in the antenatal and/or postnatal period) act as multiplier effect, where there is more than one present this increases the vulnerability of the child

The Manchester CDOP continues to raise awareness of safer sleep messages via quarterly newsletters[22] to embed safer sleep advice into multi-agency practice. The Manchester CDOP promotes consistent safe sleep advice, published by the Manchester Local Care Organisation Safer Sleeping Practice for Infants[23].

[22] https://www.manchestersafeguardingpartnership.co.uk/resource/cdop/
[23] https://www.manchestersafeguardingpartnership.co.uk/resource/safe-sleeping/

The Manchester Reducing Infant Mortality Strategy Steering (RIMS) Group regrouped, with a new lead, during 2021-22, after a short break during the pandemic. Safe Sleeping remained one of the core agenda items. The RIMS had previously established a Safer Sleep Task and Finish Group, to review local safer sleep messages and look at methods to deliver consistent advice within the community. Led by the Manchester Public Health Team the group was made up of multi-agency professionals including Manchester City Council Communications and Marketing and the Manchester Local Care Organisation, with representation from the Health Visiting Service and Care of Next Infant (CONI) Programme. The group agreed to develop an accessible Manchester safer sleep video containing useful tips for parents and carers on how to create a safer sleep environment. This video was in infographic form meaning that it was not language dependent. These materials continued to be used during 2021/22.

In early 2022, the Public Health Team have funded "baby thermometers" which are now given to all new mums. These thermometers can be used to ensure that the room a baby sleeps in is the correct temperature and has a Quick Response (QR) code on the back, leading to safe sleep advice.

6.8 GREATER MANCHESTER RAPID RESPONSE (JOINT AGENCY RESPONSE)

The Greater Manchester Rapid Response Team was established in January 2009, to provide a rapid assessment of each sudden and unexpected death of an infant or child. The team is made up of Senior Paediatricians who provide a 24/7 on-call service across GM, working in close collaboration with partner agencies such as Greater Manchester Police (GMP), the GM Coroners, Health and Children's Social Care.

Following changes to the national guidance, the service falls under the remit of a CDRM and is now known as a Joint Agency Response (JAR). Revisions to the national guidance meant that it was longer a statutory requirement to investigate all sudden and unexpected deaths with a 'Rapid Response' Team. Instead, a JAR should occur in a more limited number of circumstances. The new guidance was discussed with the commissioners for the GM Rapid Response Service who requested that the on-call team continue to respond at the point of a child's death. It was agreed that there should not be a narrowing of the inclusion criteria for such a response, and that the on-call team continue to respond to all deaths that were not anticipated as a significant possibility 24 hours prior to the death, or when the collapse that precipitated death was similarly unexpected (as defined in the Working Together to Safeguard Children 2008). The decision to see the same cohort of children was strongly approved by the Steering Group, the GM CDOP Chairs, and the local Coroners.

An ongoing challenge to the service has been maintaining the on-call rota, as doctors have moved on to new posts or retired. There continues to be a national shortage of Paediatricians, and this has been reflected in difficulties recruiting into vacant posts. Despite the challenges, increased used of virtual meetings has had a very positive impact on attendance at both initial meetings and CDRMs.

Deaths subject to the JAR process usually remain open to the CDOP for a longer period due to pending coronial investigations. Until the Coroner has ascertained a cause of death, the CDOP is unable to confirm if the death was in fact a sudden and unexpected death in infancy (SUDI)/childhood (SUDC). Where the pathological cause of death is recorded as 'sudden infant death syndrome' or 'unascertained', at any age, these deaths are categorised by the Manchester CDOP as a sudden unexpected, unexplained death (excluding sudden unexpected death in epilepsy).

The GM JAR Lead continues to be an integral part of the Manchester CDOP, attending panel meetings to interpret medical terminology and supporting the implementation of the Child Death Review: Statutory and Operational Guidance (England).

6.9 CHROMOSOMAL, GENETIC & CONGENITAL ANOMALIES

Of the 27 cases closed, <5 deaths were categorised as chromosomal, genetic and congenital anomalies, all of which were infant deaths (0-364 days of life) and <5 children recorded Asian/Asian British. The Manchester CDOP continues to determine the relevance of consanguinity in deaths categorised as chromosomal, genetic and congenital anomalies. Consanguinity refers to a relationship in which a couple are blood relatives, for example first cousins, second cousins etc. Consanguinity increases the risk of genetic disorders known as autosomal recessive disorders. Parents who are both unaffected healthy carriers of a genetic disorder present a 1 in 4 (25%) chance that the child could be affected and a 50% chance that the child could be a healthy carrier with no sign of the disorder but could pass the unusual gene on to the next generation. Unrelated parents have a 2% risk of having a child with a severe abnormality, whilst parents who are first cousins have a 5% risk and second cousins have a 3% risk. However, couples that are more closely related, such as a family with a history of cousin marriages going back generations, will have a higher risk of having a child with autosomal recessive disorders.

The Manchester University NHS Foundation Trust (MFT) provides one of the largest and most comprehensive multi-disciplinary clinical genetics units in UK and Europe providing integrated clinical and laboratory genetics services[24]. The aim of the regional genetic service is to provide a diagnostic, counselling and support service to individuals and their families with a genetic disorder affecting any body system at any age.

Practitioners can make referrals to the service for several reasons including:

- organisation of specialist prenatal diagnosis for a known familial genetic disorder
- diagnosis and counselling on diagnosis of foetal abnormality either on genetic testing or ultrasound
- investigation and diagnosis of congenital abnormality
- investigation and diagnosis of abnormalities of growth or development in childhood
- diagnosis of a metabolic disorder
- diagnosis if a possible genetic disease, including eye, renal, cardiac and neurological disorders with known or possible genetic basis
- strong family history of cancer
- concern regarding personal or family history of a genetic disease
- access testing of family members for carrier status for single gene (mendelian disorders) including presymptomatic or predictive gene testing when indicated.

The specialist genetic service which is an integrated clinical and laboratory genetics service, aims to provide diagnostic, counselling and support to families with a genetic disorder. The service also offers management, support and appropriate information for genetic conditions and offers pre-symptomatic diagnosis.

The Manchester CDOP works with the Specialist Geneticist to request information to review factors in relation to service provision. The Manchester CDOP reviews whether a referral to the genetic service was made and if the family engaged, to access additional support and counselling. There are health requirements regarding awareness raising amongst both practitioners and the community about the associated health factors and services available that can provide advice and support.

As part of the Manchester Reducing Infant Mortality Strategy 2019-2024[25], work remains ongoing to raise awareness of the genetic service and how practitioners can make referrals. This includes

[24] https://www.mangen.co.uk/
[25] https://secure.manchester.gov.uk/downloads/download/7002/reducing_infant_mortality_strategy

information about autosomal recessive disorders, to increase the knowledge and understanding of genetics in the population.

The Health Visiting Teams deliver a universal screening service which is key in in the identification and referral of congenital anomalies found in infants and children. Data from the Manchester CDOP highlighted clusters and hotspot wards cross the City, where infant deaths and factors relating to consanguineous relationships were identified. Close relative (consanguineous) marriage has recognised benefits for couples and families. However, this pattern is linked to an increased risk of genetic disorders. The Health Visiting Teams in these localities have been provided with specialist genetic literacy training, so that they can explore potential indicators in the community and refer families to genetic services, for individual assessment, genetic testing, and discussions regarding support available. This is a new speciality within the Health Visiting Teams and supports an improved understanding of how genetics is expected to impact positively on mortality and morbidly in the City.

7. 2021/22 MANCHESTER CDOP RECOMMENDATIONS

CHILD DEATH REVIEW MEETINGS (CDRM): DRAFT C. ANALYSIS FORMS

The publication of the Child Death Review: Statutory and Operational Guidance (England) documents significant changes to the child death review process including the introduction of the CDRMs. Colleagues at Manchester University NHS Foundation Trust (MFT) have been extremely supportive of the new national requirements and continue to submit CDRM documentation to the Manchester CDOP. Forms of hospital CDRMs include Perinatal Mortality Review Tool (PMRT) reports, Neonatal Intensive Care Unit (NICU) Mortality Reviews, Paediatric Intensive Care Unit (PICU) Morality Reviews and High-

Level Investigation (HLI) Reports, all of which provide useful information to enable the Manchester CDOP conduct a thorough review.

MFT has taken a proactive approach to conducting CDRMs across multiple departments including Obstetrics, Neonatology, Paediatrics and Adult Wards. Senior management and lead clinicians have embedded policies and practice, to meet the national statutory requirements in all areas of MFT including the implementation of the 'Procedure for CDRMs for child deaths occurring in non-paediatric areas of MFT'.

RECOMMENDATION 1: The Manchester CDOP will continue to work with MFT clinicians and senior management to ensure the draft CDRM C. Analysis Form is shared with the appropriate CDOP (based on area of residence) in a timely fashion to affirm the findings documented by the CDRM. This will allow cases to be fully discussed and closed at CDOP contributing to the collation of data to influence policies and practice aimed at reducing future child deaths.

GREATER MANCHESTER CDOP WORKFORCE

There has been a strong history of working together as a GM CDOP Network, including the GM SUDC clinician, to ensure consistency of approach across GM. However, there has been an increasing concern about the resilience of local systems which are viewed as a significant risk. The current CDOP workforce arrangements are fragmented with limited resilience with no consistency between job role, banding, terms and conditions, and responsibilities for the CDOP managers/co-ordinators.

For example, if one of the local managers/co-ordinators (total GM WTE= 3.3) is off sick, on leave, or leaves their post, there is no immediate cover to support with notifications and process. This lack of resilience and support for the workforce creates high levels of stress and anxiety which impacts on wellbeing. Furthermore, during busy periods managing workload can be difficult as notifications need to be prioritised over other work.

It is proposed to develop a single GM CDOP system and team that manages the death notifications, information collation, panel processes and outputs for each of the four-locality based CDOPs and thematic panels. This will increase resilience, contribute to the streamlining of systems, and provide added value to the current GM public health and children's system through a coordinated approach. The adoption of eCDOP notification system across the GM CDOPs in 2020 will support and enable a newly established team to work across a GM footprint.

RECOMMENDATION 2: Manchester CDOP works with the other 3 GM CDOPs, GM Association of Directors of Public Health, and the broader integrated care system leadership- involving specialist human resource and finance expertise- to initiate a change programme to create a sustainable and flexible workforce model hosted by an appropriate organisation within GM.

8. APPENDICES

APPENDIX 1: MANCHESTER CDOP MEMBERSHIP

The Manchester CDOP membership includes:

1. Manchester CDOP Chair, Assistant Director of Public Health - Manchester Health and Care Commissioning, Manchester Population Health Team
2. Manchester CDOP Lay Representative, Therapy Services Team Leader - The Gaddum Centre

3. Deputy First Officer/Deputy Service Manager and Senior Paediatric Coroners Officer - Manchester City Coroner's Office *(ad hoc member)*
4. Detective Chief Inspector - Greater Manchester Police
5. Project Officer - Manchester City Council, Strategic Housing
6. Programme Lead - Manchester Health and Care Commissioning, Manchester Population Health Team
7. Head of Service Children's Community Nursing Team - Children's Community Palliative Care Team (STAR Team)
8. Senior Officer for QA of Safeguarding in Schools - Manchester City Council, Education
9. Head of Services Vulnerable Baby Service, Health Visiting South and Lead for Early Help and Prevention Manchester University NHS Foundation Trust Vulnerable Baby Service and Health Visiting Service - Manchester Local Care Organisation
10. Designated Nurse Safeguarding Children/Specialist Nurse Safeguarding Children - Manchester Health and Care Commissioning
11. Named Nurse for Safeguarding Children - Greater Manchester Mental Health Foundation Trust
12. Safeguarding and Quality Assurance Team Manager - Manchester Children's Social Care
13. Community Paediatrician, Designated Doctor for Child Death, GM Joint Agency Response Lead - Manchester University NHS Foundation Trust
14. General Manager - Child Adolescent Mental Health Services (CAMHS) *(ad hoc member)*
15. Bereavement Midwife - Manchester University NHS Foundation Trust, Saint Mary's Hospital
16. Consultant in Paediatric Emergency Medicine, Group Associate Medical Director - Manchester University NHS Foundation Trust
17. Consultant Paediatric Intensivist - North-West and North Wales Paediatric Transport Service Intensive Care Paediatric Transport Service
18. Clinical Nurse Lead- Learning Disabilities, Learning Disabilities Mortality Review (LeDeR) Programme - Manchester Health and Care Commissioning *(ad hoc member)*

APPENDIX 2: C. ANALYSIS PROFOMA CATEGORISATION OF DEATH

1. Deliberately inflicted injury, abuse, or neglect

This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also, deaths from war, terrorism, or other mass violence; includes severe neglect leading to death.

2. Suicide or deliberate self-inflicted harm

This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.

3. Trauma and other external factors, including medical/surgical complications/error
This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. Excludes Deliberately inflected injury, abuse, or neglect. (category 1).

4. Malignancy
Solid tumours, leukaemia's & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.

5. Acute medical or surgical condition
For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.

6. Chronic medical condition
For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause.

7. Chromosomal, genetic, and congenital anomalies
Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.

8. Perinatal/neonatal event
Death ultimately related to perinatal events, e.g., sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause and includes congenital or early-onset bacterial infection (onset in the first postnatal week).

9. Infection
Any primary infection (i.e., not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.

10. Sudden unexpected, unexplained death
Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).

9. ACKNOWLEDGEMENTS

Thanks are due to Manchester CDOP and Themed Panel multi-agency members of their attendance and commitment, and colleagues in the Manchester Public Health Team who have contributed to the content of this annual report.

The Manchester CDOP remains continually thankful for the support from the Manchester Child Health Department, Manchester City Coroner's Office, Manchester City Register Office, and Manchester

University NHS Foundation Trust (MFT) in supplying the necessary information required to conducted a thorough CDOP review.

Finally, thanks to Stephanie Davern, the former CDOP Co-ordinator who has gained a promotion within the Public Health Team, for all her work in recent years and to Eesha Naeem, the newly appointed CDOP Co-ordinator.

Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 25 January 2023

Subject: Manchester Pharmaceutical Needs Assessment (2023-2026) Final Draft

Report of: Director of Public Health

Summary

The provision of pharmaceutical services falls under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. The regulations cover the production of this Pharmaceutical Needs Assessment (PNA). The responsibility for producing the PNA is that of the local Health and Wellbeing Board (HWB).

The PNA steering group has been leading the development of the next PNA for 2023-2026 on behalf of the HWB Board. The regulations state that the HWB must undertake a consultation on the content of the PNA and it must run for minimum of 60 days. The HWB agreed to the commencement of the consultation in July 2022. This report includes the Executive Summary (Appendix 1) of the final draft of the PNA. The full final draft of the Manchester PNA can be accessed via the web link below.

https://www.manchester.gov.uk/pna

Recommendations

The Board is asked to:

1. Approve the final report for publication.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	The PNA ensures that the provision of pharmaceutical services meet the needs of Manchester residents across the life course. It ensures that there is appropriate access to pharmaceutical services for Manchester residents and allows residents to receive appropriate advice and treatment for self-care.
Improving people's mental health and wellbeing	
Bringing people into employment and ensuring good work for all	
Enabling people to keep well and live independently as they grow older	
Turning round the lives of troubled	

families as part of the Confident and Achieving Manchester programme	
One health and care system – right care, right place, right time	
Self-care	

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy, please contact one of the contact officers above.

Manchester Pharmaceutical Needs Assessment 2020

Report on the PNA consultation process to the Manchester Health & Wellbeing Board on 6 July 2022

1. Introduction

1.1 The Health and Social Care Act 2012 transferred responsibility to develop and update the Pharmaceutical Needs Assessment (PNA) from Manchester Primary Care Trust to Manchester Health and Wellbeing Board (HWB). NHS England has responsibility for the application process and the management of pharmacies compliance with their terms of service. The PNA informs the application and decision-making process, however, NHS England have the responsibility for approving or rejecting new applications.

1.2 The provision of pharmaceutical services falls under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. The regulations cover the production of the PNA, the application and decision-making process for opening pharmacies, and details the term of services for pharmacies, dispensing appliance contractors and dispensing doctors.

1.3 The PNA looks specifically at the current provision of pharmaceutical services in Manchester. It determines whether these pharmaceutical services meet the needs of the population and will:

- be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractors, or applications from existing pharmaceutical provides to change their regulatory requirements.

- help work with providers to target services to the areas where they are needed.

- inform interested parties of the PNA and enable collaborative work to plan, develop, and deliver pharmaceutical service for the residents of Manchester.

- help inform commissioning decisions by local commissioning bodies

2. Background

2.1 The PNA has been produced using a standard methodology in accordance with the requirements set out in regulations 3-9 Schedule 1 of the NHS (Pharmaceutical and Local Pharmaceutical Service) Regulations 2013.

2.2 The views of a wide range of stakeholders were sought to identify local health needs and priorities, and to inform the future commissioning of pharmaceutical services in Manchester.

3. Other Developments

3.1 Since the publication of the last Manchester PNA (2020) the city has experienced, and continues to experience, the impacts of the COVID-19 pandemic alongside a significant health and social care services change programme, whilst continuing to implement the Manchester Locality Plan. In

addition, the national cost of living crisis is expected to exacerbate the effects of deprivation experienced by many communities across Manchester.

3.2 The impact of the COVID-19 pandemic on Manchester has included damaging longer-term economic, social and health effects which are expected to further impact on health and widen inequalities and to be compounded for people from Black, Asian and Minority Ethnic (BAME) groups, disabled people, older people, women and those on low incomes. In turn, these effects are likely to be further compounded for those living in low-income areas.

Following the publication of Professor Sir Michael Marmot's "Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives" in June 2021, Manchester gave a commitment to consider the recommendations and develop a local response.

Making Manchester Fairer- Tackling Health Inequalities in Manchester 2022-27 describes the actions Manchester will take to reduce health inequalities through greater collaboration between multi-agency and cross sectoral partnerships over the next 5 years in response to the Marmot Review for Greater Manchester, and the specific needs of Manchester's residents in light of the COVID-19 pandemic.

The plan identifies eight areas of action:

1. Giving children and young people the best start in life
2. Lifting low-income households out of poverty and debt
3. Cutting unemployment and creating good jobs
4. Preventing illness and early death from big killers- heart disease, lung disease, diabetes, and cancer
5. Improving housing and creating safe, warm and affordable homes
6. Improving our environment and surroundings in the areas where we live, transport, and tackling climate change
7. Fighting systemic and structural discrimination and racism
8. Strengthening community power and social connections

3.3 Integrated Care Systems (ICS) were established in sub regions of England from 01 July 2022. This now means that the ten Clinical Commissioning Groups in Greater Manchester (GM) no longer exist and have integrated to become the Greater Manchester Integrated Care (GMIC) Partnership.

The ICS has four aims:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

There is a designated Place Based Lead (PBL) for each local authority area and in Manchester this is the Chief Executive of the City Council. There will

also be a Locality Board and Provider Collaborative in each area, and these are now both established in Manchester.

3.4 The development of the Manchester Local Care Organisation (MLCO)- a partnership organisation comprised of Manchester University NHS Foundation Trust (MFT), Greater Manchester Mental Health NHS Trust (GMMH), Manchester City Council (MCC), and the Manchester Primary Care Partnership- established in 2018 has continued. The MLCO is based on 12 neighbourhoods across the city, bringing local teams together as Integrated Neighbourhood Teams (INT), so care is planned and delivered in a seamless way. The delivery of this is based upon utilising and working in partnership with the assets in neighbourhoods, such as pharmacies, that are the most accessible and frequently visited source of healthcare.

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APPENDIX 1

Executive Summary

1.1 Introduction

From 01 April 2013, Manchester Health and Wellbeing Board (HWB) has had a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services for the population in its area, referred to as a 'pharmaceutical needs assessment' (PNA).

The PNA aims to identify whether current pharmaceutical service provision meets the needs of the population. The PNA considers whether there are any gaps to service delivery.

The PNA may be used to inform commissioners, such as local authorities (LA) and the NHS, including Integrated Care Boards (from 01 July 2022) of the current provision of pharmaceutical services and where there are any gaps in relation to the local health priorities. Where such gaps are not met by NHS England (NHSE), these gaps may then be considered by those organisations.

The PNA will be used by NHSE in its determination as to whether to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended ('the 2013 Regulations'). The relevant NHSE Local Offices (LO) will then review the application and decide if there is a need for a new pharmacy in the proposed location. When making the decision NHSE is required to refer to the local PNA.

The City of Manchester covers an area of approximately 116 square kilometres (11,600 hectares) with a population of 586,100, giving a density of 51 persons per hectare. This is based on the Manchester City Council Forecasting Model (MCCFM) data for 2021.

Manchester is a city of change, the birthplace of the industrial revolution, and the powerhouse of the north-west region. The city boasts several key drivers that help sustain the economic growth of the area. These include its world-class universities, a knowledge-based economy, a thriving city centre, a skilled workforce, and Manchester International Airport.

Despite this, Manchester has a higher rate of unemployment and the percentage of the population aged 16+ claiming unemployment benefit is higher (5.8%) when compared to the England national average (3.7%) as of October 2022. Manchester also has some of the poorest health in England, and within its boundaries, people die younger and experience higher levels of illness in some parts of the city than others.

1.2 How the assessment was undertaken

This PNA describes the needs for the population of Manchester. The PNA includes information on:

- Pharmacies in Manchester and the services they currently provide, including dispensing, providing advice on health, medicines reviews and local public health services, such as smoking cessation, sexual health and support for drug users
- Other local pharmaceutical type services, including dispensing appliance contractors (DAC)
- Relevant maps relating to Manchester and providers of pharmaceutical services in the HWB area
- Services in neighbouring HWB areas that may affect the need for services in Manchester
- Potential gaps in provision that could be met by providing more pharmacy services, or through opening more pharmacies, and likely future needs.

The HWB established a steering group to lead a comprehensive engagement process to inform the development of the PNA. The group undertook a public survey of the Manchester population and sought information from pharmacies, Manchester City Council (MCC), Manchester Integrated Care Partnership (ICP), and NHSE.

1.3 Overview of current pharmaceutical services

Manchester currently has 127 pharmacies providing a range of essential services, advanced services, enhanced services, and locally commissioned services on behalf of MCC, Manchester ICP and NHSE.

Of those pharmacies, 18 are 100-hour pharmacies and 10 are distance selling or wholly mail order (internet) pharmacies.

There are three DACs who provide access to dispensing and services associated with appliances for some patients. In addition to this, DACs offer their services remotely and deliver products across huge footprints both regionally and nationally.

Therefore, it is worth noting that there are currently 8 DACs in Greater Manchester (this figure includes the three local to Manchester) that serve the whole of Greater Manchester and beyond.

The PNA contractor survey received response from 27 Manchester community pharmacies.

The PNA public questionnaire received 91 responses from the public via digital methods of collection.

The PNA has not, to date, identified any existing gaps in pharmaceutical services. This is clearly demonstrated by the following points:

- Manchester has 23 pharmacies per 100,000 population, which is higher than the Greater Manchester and England averages
- Manchester has more prescription items dispensed per pharmacy per month than the Greater Manchester and England average
- The majority of residents live within one mile of a pharmacy

- The majority of residents can access a pharmacy within 15 minutes, either by walking, public transport or driving
- The number, location and distribution of pharmacies across the city of Manchester
- Over 84% of patients surveyed have a preferred pharmacy that they use regularly
- Over 71% of patients surveyed are aware there are pharmacies in Manchester that open early mornings, late nights and weekends
- Manchester has a choice of pharmacies which are open a range of times including early mornings, evenings and weekends
- 82% of patients surveyed are satisfied with the opening hours of their pharmacy
- Manchester pharmacies offer a range of pharmaceutical services to meet the requirements of the population

1.4 Consultation

The PNA process requires a minimum 60-day statutory consultation period to take place. This will ensure pharmaceutical providers and services, which support the population, are recognised. Manchester's HWB consultation was conducted between Monday 05 September and Friday 04 November 2022 (see section 2.1 for list of consultees).

1.5 Conclusions

Taking into account the totality of the information available, the HWB considered the location, number, distribution and choice of pharmacies covering the whole of Manchester's HWB area that provide essential and advanced services during the standard core hours to meet the needs of the population.

The HWB has not received any significant information to conclude otherwise or any future specified circumstance that would alter that conclusion within the lifetime of this PNA.

Based on the information available at the time of developing this PNA, no current gaps have been identified:

- In the need for essential service provision during and outside of normal working hours
- In the provision of advanced or enhanced services
- In the need for pharmaceutical services in specified future circumstances
- In essential services that if provided either now or in the future would secure improvements, or better access, to essential services
- In the need for advanced services that if provided either now or in the future would secure improvements, or better access, to advanced services
- In respect of securing improvements, or better access, to other NHS services either now or in specified future circumstances have been identified

Results from both the public and contractor surveys indicate that further collaboration is required working with Manchester ICP, MCC, primary care, NHSE and Local Pharmacy Committee (LPC) stakeholders in order to promote the range of community pharmacy services available to the public and primary care. The HWB also recognise that collaboration with pharmacy contractors is required to understand the capability and capacity to provide existing and future services, commissioned both locally and nationally.

Not all changes to pharmaceutical services will result in a change to the need for services. Where required, the HWB will issue supplementary statements to update the PNA as changes take place to the provision of services locally.

Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 25 January 2023

Subject: Health Protection Board Update

Report of: Assistant Director of Public Health

Summary

The Manchester Health Protection Board is a statutory group, chaired by the Director of Public Health, that reports to the Manchester Health and Wellbeing Board. To ensure that the city responded effectively to the COVID-19 pandemic, the Health Protection Board was replaced by the COVID-19 Task Group during 2020 to 2022. The Manchester Health Protection Board was re-established in June 2022 and has a broader remit, which includes COVID-19. The Health Protection Board also includes agenda items covering health services, emergency preparedness, resilience and response and Greater Manchester and Manchester City Council Resilience Forum feedback. This report gives an update on the responsibilities of the Health Protection Board and highlights some of the current issues raised at the last meeting in December 2022.

Recommendations

The Board is asked to: Note the report

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	Health protection prevention and response work is essential and underpins our ability to deliver all health and wellbeing strategy priorities. The Health Protection Board provides assurance and governance of health protection work in the city to the Health and Wellbeing Board.
Improving people's mental health and wellbeing	
Bringing people into employment and ensuring good work for all	
Enabling people to keep well and live independently as they grow older	
Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme	
One health and care system – right care, right place, right time	
Self-care	

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy, please contact one of the contact officers above.

1. Introduction

1.1 The Manchester Health Protection Board is a statutory group, chaired by the Director of Public Health, that reports to the Manchester Health and Wellbeing Board.

1.2 To ensure that the city responded effectively to the COVID-19 pandemic, the Health Protection Board was replaced by the COVID-19 Task Group during 2020 to 2022. The Manchester Health Protection Board was re-established in June 2022 and has a broader remit, which includes COVID-19. The Health Protection Board also includes agenda items covering health services, emergency preparedness, resilience and response and Greater Manchester and Manchester City Council Resilience Forum feedback.

1.3 This report gives an update on the responsibilities of the Health Protection Board and highlights some of the current issues raised at the last meeting in December 2022.

2. Background

2.1 The Health Protection Board supports partnership working on health protection and assists the Director of Public Health to discharge his statutory responsibility for ensuring oversight of health protection in Manchester, and in providing a strategic challenge to health protection plans and arrangements produced by partner organisations.

2.2 The Health Protection Board meets quarterly and reports to the Manchester Health and Wellbeing Board to give assurance that robust plans and arrangements are in place and will draw to the attention of the Board any matter of concern in this context.

2.3 Health protection topics covered by the Health Protection Board include, but are not restricted to:

- Prevention and Control of infectious diseases in the community
- Mandatory Healthcare associated infections surveillance and reporting
- Vaccine preventable diseases and immunisation programmes
- Screening programmes
- Influenza
- COVID-19
- Tuberculosis (TB)
- Prevention of infections related to oral health
- Blood borne viruses
- Sexually transmitted infections, including HIV
- Environmental hazards, including air quality
- Health protection emergency response/incident management

2.4 To further strengthen partnership working, from December 2022 the Health Protection Board also incorporates agenda items around health service emergency preparedness, resilience and response that were part of the Health Economy Resilience Group that has now stood down. It is important for the Health Protection Board to interface with the new Greater Manchester Integrated Care Board arrangements for emergency planning as well as the established locality structures. The Board also receives feedback from the Greater Manchester and Manchester City Council's Resilience Forums.

3. Key responsibilities of the Health Protection Board

3.1 Key responsibilities of the Health Protection Board include:

- Providing assurance to the Health and Wellbeing Board that effective local arrangements are in place for the prevention, detection, control, response and preparedness on health protection issues in Manchester.
- Highlighting concerns about significant health protection issues and the appropriateness of health protection arrangements in Manchester, raising any concerns with key organisations and escalating if necessary to the Health and Wellbeing Board or relevant Chief Executives
- Providing an expert view on any health protection concerns on which the Health and Wellbeing Board request advice.
- Monitoring a 'health protection dashboard' to assess local performance in addressing the key health protection issues in Manchester
- Responding to issues identified by partners concerning health protection and working together as a system to find and support resolution
- Reviewing and signing-off the local outbreak plan
- Making recommendations as to health protection issues that should be included in the local Joint Strategic Needs Assessment
- Considering the lessons found from any serious incidents or outbreaks and to expect that learning from such incidents is embedded in future working practices
- Supporting member organisations to fulfil their legal duties under the Civil Contingencies Act, helping them meet requirements for Emergency Preparedness, Resilience & Response (EPRR) (for example, as set out in the NHS Core Standards for EPRR) and further shared understanding of EPRR risks as well as joint working to mitigate/prepare for such risks.

4. Health Protection Board membership

4.1 The Health Protection Board is chaired by the Director of Public Health. Organisations with representatives on the board include Manchester City Council, UK Health Security Agency, NHS Greater Manchester Integrated Care, Manchester University NHS Foundation Trust, Manchester Local Care Organisation and Greater Manchester Mental Health. Representatives from other organisations, including voluntary sector organisations, are invited to the

meetings to contribute to topics of discussion. A list of Board members can be found in the Appendix below.

5. Health Protection Board Subgroups

5.1 The Manchester Health Protection Steering Group meets bimonthly and reports into the Health Protection Board. The Board also receives updates from the Greater Manchester Local Health Resilience Partnership (LHRP), Greater Manchester Resilience Forum and Manchester City Council Resilience Forum.

5.2 Other groups feeding information into the Health Protection Board include vaccination programme working groups, Greater Manchester TB Collaborative, Manchester AMR (Antimicrobial Resistance) Group and other time limited groups as needed.

6. Feedback from Health Protection Board December 2022

6.1 The Health Protection Board agenda covers the following areas:

- Overall situation update
- Emergency Preparedness, Resilience and Response (EPRR)
- Wider Health Protection Issues
- Focussed discussion

6.2 Overall situation update - The last meeting was held on 13th December 2022. Health protection issues highlighted were the increasing cases of COVID-19 and influenza and increasing number of education settings with respiratory infections, including Group A Streptococcus and scarlet fever. Group A Streptococcus situations were adding pressure on health and education systems and on the local community health protection team as well as the UKHSA (UK Health Security Agency). The Board were made aware of new Greater Manchester antibiotic stock management database, organised by NHS Greater Manchester Integrated Care to support access to antibiotics. The Board also discussed the management of infectious disease outbreaks within asylum seeker accommodation and the related work to ensure antibiotics and outbreak vaccination were available where needed. Positive news that Mpox cases in the city have been steadily decreasing with vaccination still offered to at risk residents.

6.3 Emergency preparedness, resilience and response – The Board received updates from the Greater Manchester Local Health Resilience Partnership (LHRP), the Greater Manchester Resilience Forum and the Manchester City Council Resilience Forum. Emergency preparedness procedures in the Manchester locality are being updated and the Manchester city centre evacuation plan has been updated. Discussions were held on planned industrial action involving nurses and North West Ambulance Service and information shared on the incident management team set up to oversee this.

The Board discussed winter and cold weather pressures on health services and were made aware of planning for potential rota power cuts. Feedback was given to the Board on two exercises that partners engaged in to test local systems. Exercise Boreas focused on winter pressures in health and social care services and Exercise Mitchell related to a situation involving hazardous materials.

6.4 Wider health protection issues – The Board discussed a variety of topics relating to wider health protection issues including work around mould and damp to encourage more people in private rented sector to report poor housing conditions. Work around outbreaks includes the establishment of a task group to ensure there is a more robust system in place for vaccination outbreak response in the city. The Board was made aware of the increasing workload relating to health protection issues in the asylum seeker hotels and there was escalation of funding issues for managing antibiotics and vaccination for outbreaks in the hotels.

6.5 Focused discussion **–** The focused discussion at the December meeting was on Tuberculosis (TB). Issues escalated to the Board included the lack of funding and staff capacity for undertaking latent TB screening in asylum seeker hotels and the risks relating to this. The Board acknowledged the need for a co-ordinated Greater Manchester approach and funding needed for this through a business case to NHS Greater Manchester Integrated Care. The Board was also made aware of the risks relating to the lack of funding in place for housing support for homeless people with TB with no recourse to public funds while they undergo TB treatment. It was a requirement of Clinical Commissioning Groups to provide this funding and a new system for funding needs to be set up through NHS Greater Manchester Integrated Care as soon as possible. The Director of Public Health has agreed to support the progression of both aspects of this work with senior leads in NHS Greater Manchester Integrated Care.

7. Next steps

7.1 The Health and Wellbeing Board will receive regular updates on health protection and the Health Protection Board.

7.2 The local outbreak plan is reviewed annually and will be shared with the Health and Wellbeing Board for sign off.

8. Appendix

8.1 Membership of Manchester Health Protection Board includes:

- Manchester City Council – Public Health
    - Director of Public Health (Chair)
    - Assistant Director of Public Health – Lead for Health Protection (Vice Chair)
    - Strategic Lead Health Protection

- Lead Nurse Health Protection
- Deputy Lead Nurse Health Protection
- Strategic Commissioning Manager
- Strategic Lead Senior Responsible Officer Vaccination Programmes
- Public Health Specialist (Health Intelligence)

* Manchester City Council
    - Head of Compliance Enforcement and Community Safety and Chair of MCC (Manchester City Council) Resilience Forum
    - Neighbourhood Manager (Environmental Health \Trading Standards and Housing)
    - Head of Strategic Communications

* UK Health Security Agency
    - Consultant in Health Protection

* NHS Greater Manchester Integrated Care – Manchester Locality
    - Associate Director of Planning
    - Associate Medical Director

* NHS Greater Manchester Integrated Care
    - Senior Resilience Manager
    - Greater Manchester Screening and Immunisation Team Lead

* Manchester University NHS Foundation Trust (MFT)
    - Assistant Chief Nurse IPC (Infection Prevention and Control)
    - Consultant in Infectious Diseases and Tropical Medicine
    - Deputy Group Director of Operations

* Manchester Local Care Organisation
    - Director of Nursing

* Greater Manchester Mental Health
    - Interim Associate Director of Operations

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Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 25 January 2023

Subject: Further developments relating to the role of the Health and Wellbeing Board

Report of: Director of Public Health

Summary

Following the review last year and the agreed reset of the role and function of the Board in November 2022, this report provides a further update on changes to the membership and chairing of the Board. It also provides a progress report on the ongoing work to establish the Manchester Partnership Board as a sub-committee of the Greater Manchester Integrated Care Board (ICB).

Recommendations

The Board is asked to:

1) Note the report;
2) Agree to the further changes to the membership and chairing of the Board

Our Manchester Outcomes Framework

Manchester Strategy outcomes	Summary of how this report aligns to the OMS/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	The Board adopted the Our Manchester outcomes Framework in November 2022 and going forward all Board reports will reflect how plans and strategies contribute to these outcomes.
A highly skilled city: world class and home grown talent sustaining the city's economic success	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

Contact Officers:

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Position: Director of Public Health
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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

1. Background

1.1 The establishment of Integrated Care Systems (ICS) on 1 July 2022 required a further review of the role and operation of the Manchester Health and Wellbeing Board. Whilst the ICS statutory guidance confirmed the continued role of the Board in relation to the JSNA and Joint Health and Wellbeing Strategy, there was a recognition of the need to ensure there a clearly defined role for the Manchester HWB distinct from the Manchester Partnership Board.

1.2 The delegated responsibilities that the Manchester Partnership Board will receive from the NHS GM ICB and the formal governance arrangements required are still being progressed. It is expected that this work will be completed by the end of February 2023.

2. Membership

2.1 At the November 2022 Board the membership of the Board was agreed as follows:

Manchester City Council	Leader (Chair) Executive Member for Healthy Manchester and Social Care (Deputy Chair) Executive Member for Early Years, Children and Young People
Manchester City Council	Director of Public Health
Manchester City Council	Director of Adult Social Care
Manchester City Council	Director of Children's Services
Manchester NHS Foundation Trust	Chair
Greater Manchester NHS Mental Health Trust	Chair
Manchester Local Care Organisation	Chief Executive
NHS Greater Manchester Integrated Care	Place Lead/Deputy Place Based Lead
Manchester Healthwatch	Chair
Manchester VCSE	Chief Executive, Manchester Alliance Community Care
Manchester GP Board	Three representatives covering North, Central and South Manchester

2.2 It is now proposed that the Executive Member for Healthy Manchester and Social Care assumes the role of Chair of the Health and Wellbeing Board as the Leader of the Council will chair the Manchester Partnership Board when it becomes a formal sub committee of the ICB.

2.3 Furthermore, the Deputy Executive Member for Healthy Manchester and Social Care will join the Health and Wellbeing Board as a member.

2.4 Since the November Board meeting Bill McCarthy has been appointed as Chair of Greater Manchester Mental Health Trust and Tom Hinchcliffe has taken up post as the permanent Deputy Place Based Lead and both will become members of the Board.

3. Recommendations

3.1 The Board is asked to:

1) Note the report;
2) Agree to the further changes to the membership and chairing of the Board

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