



## **Health and Wellbeing Board**

Date: Wednesday, 23 January 2019

Time: 10.00 am

Venue: Council Antechamber - Level 2, Town Hall  
Extension, Manchester, M60 2LA

### **Access to the Council Antechamber**

Public access to the Council Antechamber is on Level 2 of the Town Hall Extension, using the lift or stairs in the lobby of the Mount Street entrance to the Extension. That lobby can also be reached from the St. Peter's Square entrance and from Library Walk. **There is no public access from the Lloyd Street entrances of the Extension.**

### **Filming and broadcast of the meeting**

Meetings of the Health and Wellbeing Board are 'webcast'. These meetings are filmed and broadcast live on the Internet. If you attend this meeting you should be aware that you might be filmed and included in that transmission.

## **Membership of the Health and Wellbeing Board**

Councillor Richard Leese, Leader of the Council (Chair)

Councillor Craig, Executive Member for Adults (MCC)

Councillor Sue Murphy, Executive Member for Public Service Reform (MCC)

Councillor Bridges, Executive Member for Children's Services (MCC)

Dr Ruth Bromley, Chair Manchester Health and Care Commissioning

Dr Denis Colligan, GP Member (North) Manchester Health and Care Commissioning

Dr Murugesan Raja GP Member (Central) Manchester Health and Care  
Commissioning

Kathy Cowell, Chair, Manchester University NHS Foundation Trust

Jim Potter, Chair, Pennine Acute Hospital Trust

Rupert Nichols, Chair, Greater Manchester Mental Health NHS Foundation Trust

Mike Wild, Voluntary and Community Sector representative

Vicky Szulist, Chair, Healthwatch

Dr Tracey Vell, Primary Care representative - Local Medical Committee

Paul Marshall, Strategic Director of Children's Services

David Regan, Director of Public Health

Director of Adult Social Services

Dr Angus Murray-Browne, South Manchester GP federation

Dr Vish Mehra, Central Primary Care Manchester

Dr Amjad Ahmed, Northern Health GP Provider Organisation

## Agenda

- 1. Urgent Business**  
To consider any items which the Chair has agreed to have submitted as urgent.
- 2. Appeals**  
To consider any appeals from the public against refusal to allow inspection of background documents and/or the inclusion of items in the confidential part of the agenda.
- 3. Interests**  
To allow Members an opportunity to [a] declare any personal, prejudicial or disclosable pecuniary interests they might have in any items which appear on this agenda; and [b] record any items from which they are precluded from voting as a result of Council Tax/Council rent arrears; [c] the existence and nature of party whipping arrangements in respect of any item to be considered at this meeting. Members with a personal interest should declare that at the start of the item under consideration. If Members also have a prejudicial or disclosable pecuniary interest they must withdraw from the meeting during the consideration of the item.
- 4. Minutes** 5 - 12  
To approve as a correct record the minutes of the meeting held on 31 October 2018.
- 5. Manchester Local Care Organisation - Update** 13 - 20  
The report of the Chief Executive – Manchester Local Care Organisation is enclosed.
- 6. Clinical Advisory Group - 2018/19 Progress and Priorities for 2019/20** 21 - 28  
The report of the Chair (Clinical Advisory Group) is enclosed.
- 7. Manchester Child Death Overview Panel - Annual Report** 29 - 58  
The report of the Consultant in Public Health/Chair of the Manchester Child Death Overview Panel is enclosed.
- 8. Infant Mortality Strategy** 59 - 82  
The report of the Director of Population Health and Wellbeing is enclosed.
- 9. Operational Local Health Economy Outbreak Plan - Manchester** 83 - 128  
The report of the Director of Population Health and Wellbeing is enclosed.
- 10. Manchester and Greater Manchester Local Industrial Strategies** 129 - 146  
The report of Deputy Chief Executive is enclosed.

11. **Manchester University Hospitals Foundation Trust - One Year Post Merger Report** 147 - 196  
The report of the Single Hospital Service Director is enclosed.

## 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.

The Board wants to consult people as fully as possible before making decisions that affect them. Members of the public do not have a right to speak at meetings but may do so if invited by the Chair. If you have a special interest in an item on the agenda and want to speak, tell the committee officer, who will pass on your request to the Chair. Groups of people will usually be asked to nominate a spokesperson. The Council wants its meetings to be as open as possible but occasionally there will be some confidential business. Brief reasons for confidentiality will be shown on the agenda.

The Council welcomes the filming, recording, public broadcast and use of social media to report on the Committee's meetings by members of the public.

Agenda, reports and minutes of all council committees can be found on the Council's website [www.manchester.gov.uk](http://www.manchester.gov.uk)

Smoking is not allowed in Council buildings.

Joanne Roney OBE  
Chief Executive  
Level 3, Town Hall Extension, Albert Square  
Manchester, M60 2LA

## Further Information

---

For help, advice and information about this meeting please contact the Committee Officer:

Andrew Woods  
Tel: 0161 234 3011  
Email: [a.woods@manchester.gov.uk](mailto:a.woods@manchester.gov.uk)

This agenda was issued on **15 January 2019** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 3, Town Hall Extension (Lloyd Street Elevation), Manchester M60 2LA.



## Health and Wellbeing Board

### Minutes of the meeting held on 31 October 2018

#### Present

Councillor Richard Leese, Leader of the Council (MCC) (Chair)  
 Councillor Bev Craig, Executive Member for Adult Health and Wellbeing (MCC)  
 Councillor Garry Bridges, Executive Member for Children's Services (MCC)  
 Councillor Sue Murphy, Executive Member for Public Service Reform  
 Jim Potter, Chair, Pennine Acute Hospital Trust  
 Kathy Cowell, Chair, Manchester University Hospitals Foundation Trust (MFT)  
 Dr Ruth Bromley, Manchester Health and Care Commissioning  
 Dr Denis Colligan, GP Member (North) Manchester Health and Care Commissioning  
 Dr Murugesan Raja, GP Member Manchester Health and Care Commissioning  
 Neil Walbram, Healthwatch  
 David Regan, Director of Public Health  
 Paul Marshall, Strategic Director of Children's Services  
 Dr Tracey Vell, Primary Care representative – Local Medical Committee

#### Also present

Peter Blythin, Director SHS Programme – Manchester University NHS Foundation Trust  
 Cym D'Souza, Chief Executive - Arawak Walton Housing Association  
 Robin Lawler, Chief Executive, Northwards Housing  
 Sean Duffy, Manchester Housing Providers' Partnership  
 Graham Mellors, Central Manchester GP Federation  
 Julia Shephens-Row, Independent Chair of the Manchester Safeguarding Boards  
 Craig Harris – Executive Director Safeguarding

#### Apologies

Rupert Nichols, Chair, Greater Manchester Mental Health NHS Foundation Trust  
 Vicky Szulist, Chair, Healthwatch  
 Mike Wild, Voluntary and Community Sector representative

#### HWB/18/28 Minutes

#### Decision

To agree the minutes of the meeting of the Health and Wellbeing Board held on 29 August 2018.

#### HWB/18/29 Our Healthier Manchester Single Hospital Service Update

The Board received a report from the Director of Single Hospital Service (SHS) Programme which provided an update on the progress of the SHS. The report referred to delivery of the integration plans and Year Two post-merger plans following the creation of Manchester University NHS Foundation Trust (MFT) and the

current position regarding the proposal for MFT to acquire North Manchester General Hospital (NMGH). The Board also viewed the MFT “Together Care Matters – Our Values” video to demonstrate the ongoing work to engage staff and develop positive culture, values and leadership across the organisation.

The Chair invited questions.

Members commented that the positive benefits provided by a single trust were noticeable and included the positivity and moral of staff to continue to develop and improve care and an increase in efficiency through dealing with a single citywide organisation rather than of a number of trusts.

A member referred to the involvement of Healthwatch and questioned why the number of Quality Impact Assessments (QIA) had increased from a single QIA, as previously reported, to four hundred QIAs.

It was reported that a review of the Single Hospital Service had revealed a large number of QIAs across the Trust. The Trust is committed to equality and diversity and the Integration Steering Group had received a report on the issue which would be shared with Healthwatch.

In welcoming the report, the Chair referred to the partnership of the MFT, Manchester Primary Care Partnership (MPCP) and Manchester Local Care Organisation (MLCO) and the work to move towards a preventative care approach away from hospital and closer to patient’s homes and asked would this be addressed in the next report.

The Board was informed that the report submitted had focussed primarily on the first year of the MFT, however during this period the MFT has provided a lot of support to the work of the MLCO. It was reported that a partnership of MFT, MLCO, the Council and MPCP is working to move the provision of care out of hospital and into patient’s homes. An example of this joint work included the recent discharge of 57 patients over a period of seven weeks who’s stay within hospital had gone over 100 days.

In noting the good progress made with MFT and the improvements in care provision in Wythenshawe and Central Manchester the Chair commented that the progress of the transformation journey had been delayed and it was necessary to accelerate the work in the development of a different approach to care. The point was also made that patient care at NMGH had suffered as a result of the uncertainty around the acquisition and transformation process of NMGH and it was now vital to finalise and agree a strategic case in order to move forward.

The meeting was informed that MFT is working closely with SRFT to accelerate two strategic cases. Further discussions with National Health Service Improvement (NHSI) had been necessary to resolve questions raised on national funding and NHSI options appraisal. This process would help to avoid a delay in completing the strategic case. It was reported that meetings would take place on 9 November with the Transaction Board and 21 November with the NHSI and it was anticipated progress could be made. It was acknowledged that the time taken in this process may be having an impact on the moral of staff at NMGH and staff engagement

meetings had taken place to provide assurance to staff. As part of its involvement in the transformation process, SRFT was working to ensure patient safety is maintained at NMGH and arrangements were in place to promote NMGH to overseas nursing staff and recruit additional nursing staff in the short term.

### **Decisions**

1. To note the report submitted and the comments received.
2. To note the current position of the Single Hospital Programme.

### **HWB/18/30 Children and Adults Safeguarding Boards Annual Reports**

The Board received a report from the Chair of the Manchester Safeguarding Boards, the Strategic Director of Children's Services and the Executive Director of Adult Social Care. The report provided the Annual reports of the Manchester Safe Guarding Adults Board and the Manchester Safeguarding Children's Board for the period April 2017 to March 2018. A copy of the "Trust Your Instinct" booklet was circulated to members.

The report set out the business priorities for 2017/18 that would be shared across the two boards. These included:

- Engagement and Involvement – listening and learning; hearing the voice of children and adults and Making Safeguarding Personal.
- Complex Safeguarding – Domestic Violence and Abuse; Female Genital Mutilation; Sexual Exploitation; Radicalisation; Missing from Care, Home and Education; Organised Crime; Trafficking & Modern Slavery; So-called Honour Based Violence.
- Transitions – Moving from child to adulthood in a safe and positive way.
- Neglect – Ensuring the basic needs of every child are met.
- Neglect - Safeguarding and supporting adults at risk of wilful neglect, acts of omission and self-neglect.

The Board welcomed the report and commented on the help the reports provide to GPs and other frontline roles and the work with communities in helping to identify and report on areas of concern.

### **Decisions**

1. To note the Children and Adults Safeguarding Annual Reports 2017/2018.
2. To request that Health and Wellbeing Board members to consider how the Children and Adults Safeguarding Annual Reports are disseminated and hold to account their organisation with regard to delivering the priorities of both Safeguarding Boards.

## **HWB/18/31 Health and Housing**

The Board received a report from the Director of Population Health and Wellbeing which provided an overview of some of the initiatives and programmes currently underway in Manchester related to housing and health for the purpose of contributing to better outcomes for residents. The Board also received a presentation.

The report provided the basis for a thematic discussion on the challenges and opportunities for a stronger collaborative approach between the organisations represented on the Health and Wellbeing Board registered providers and other key stakeholders.

The Chair invited comments and questions from Board members.

A member welcomed the report and referred to the work being done on age friendly initiatives within the city. Reference was also made to the good work being done within the social housing sector however, it was commented that more focus was needed on work with private rental sector landlords. The Board was informed that a growing number of residents in private rented accommodation were contacting local councillors regarding the condition of their homes and the related health conditions suffered as a consequence of this. The private sector provided accommodation for many of the most vulnerable people in the city and this would usually be low quality accommodation. It was requested that private rental sector accommodation be included within the work programme of the Board.

A member commented on the positive work of health providers to provide mini hubs to support health care for homeless people in view of the significant impact homelessness has on the health of the individual. It was noted that the average life expectancy of a person sleeping rough over time reduces significantly due to resulting ill health (female 43 years and male 47 years). The Board was informed that another area of concern is the number of homeless people living within temporary dispersed accommodation across Manchester, which currently stands at 1900. The poor living conditions of short term private sector accommodation being used in these situations was having a negative impact on the health of those people concerned. The Board was requested to include the impact of homelessness on health within the work programme.

It was reported that the work of Wythenshawe Integrated Neighbourhood Service (WINS) had been successful in the way issues such as health and adult and children's safeguarding had been identified and addressed. Also, training materials had been developed for health workers and twelve homeless health champions were available to provide help and support at the Urban Village Medical Practice. It was noted that the service could be further improved through upskilling by primary care staff within their existing skillsets.

In noting the importance of focussing on the health of homeless people, a member highlighted the need to consider work taking place on an inclusion based primary health care model that included support for before and after periods of homelessness. Reference was made to clusters of poor quality temporary private

rented accommodation that is used to home a significant number of vulnerable people and the need to recognise the impact of health on those living in poor accommodation.

The Chair welcomed the comments and added that Manchester had seen the private rented housing sector triple in size to become the largest provider of accommodation in the city. The Manchester Life initiative had provided high quality accommodation with flexible three-year secure tenancy agreements for social housing. Unfortunately, this was not the case across all of the private sector with the quality of some of the accommodation used being poor quality. Landlords were using older properties to convert into cheap multiple occupancy lets. It was noted that the private rented sector had become a major contributor in the rise of homeless people and families who were unable to pay increased rents and were subsequently evicted. The Board noted that the impact of poor housing on health was as significant as other major causes such as smoking, poor diet and lack of exercise.

The attention of the Board was drawn to the number of diverse Black and Minority Ethnic (BAME) communities in the city who were living in low quality accommodation and were unlikely to be registered with a GP or seek medical care. Further research and work was needed to reach out to those communities in order to provide help and support in accessing medical care and better accommodation.

The Chair also referred to the issue of asthma and respiratory disease and as well as the links to poor housing he also stressed the importance of the impact of poor air quality on health. The Chair requested that raising awareness about Clean Air was a key role for health organisations to stimulate discussion and action across a wider audience.

## **Decisions**

1. To note the report submitted.
2. To request the inclusion of the following topics within the Annual Work Programme:
  - Impact on health caused by poor quality accommodation within the private rental sector and support for vulnerable groups;
  - Impact on health as a consequence of homelessness;
  - Research into the health and housing needs of BAME communities living within Manchester.
3. To request that the topic of Clean Air be added to the agenda for the next meeting of the Board.

## **HWB/18/32 Public Health Approach to Violent Crime**

The Board received a report from the Director of Population Health and Wellbeing which highlighted the success of adopting a public health approach to tackling violent crime. The Board was informed that work in this area, undertaken in Glasgow over

the last decade, had achieved positive outcomes based on a significant reduction in the number of homicides involving a knife.

The report stated that partners in Manchester are keen to explore a similar approach for the city and for the work to be taken forward through a Working Group under the guidance of the Health and Wellbeing Board and Manchester Community Safety Partnership, using existing resources. To ensure the work involves the appropriate people with the expertise the input of the following groups and organisations would be required:

- MHCC Population Health and Wellbeing Team
- NHS Hospital Trust Emergency Department Consultants and Senior Nurses
- Greater Manchester Mental Health Trust Leads
- GP Neighbourhood Leads
- Community Safety Partnership Team
- Greater Manchester Police
- Youth Justice Lead
- Probation Service
- MCC Education and Social Work Leads
- CSE Organisations

### **Decisions**

1. To support the development of proposals to adopt a public health approach to violent crime.
2. To request officers to ensure that key personnel from the organisations represented on the Board input to the proposals.

### **HWB/18/33 Better Care Fund 2018/2019**

The Board received a report from the City Treasurer (Manchester City Council) and the Chief Finance Officer (Manchester Health and Care Commissioning) which provided the Board with an overview of the plan submitted for Better Care Fund 2018/2019 and an update on changes from the guidance released in July 2018.

The Better Care Fund was established by the Government to provide funds to local areas to support the integration of health and social care. Section 75 of the National Health Service 2006 Act gives powers to local authorities and health bodies to establish and maintain pooled funds. Payment from the funds may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed National Health Service (NHS) functions.

### **Decisions**

1. To note the changes to the Delayed Transfers of Care monitoring.

2. To confirm the expenditure plan for 2018/19, as agreed previously at the meeting of the Health and Wellbeing Board held on 30 August 2017.

This page is intentionally left blank



**Manchester Health and Wellbeing Board  
Report for Information**

**Report to:** Manchester Health and Wellbeing Board – 23 January 2019

**Subject:** Manchester Local Care Organisation Update

**Report of:** Michael McCourt, Chief Executive – Manchester Local Care Organisation

---

### **Summary**

This report provides an update on the development of the Manchester Local Care Organisation (MLCO).

### **Recommendations**

The Health and Wellbeing Board are asked to note the contents of this report and specifically the following:

- The significant progress made in the establishment of a Local Care Organisation (LCO) for the City of Manchester initially outlined in the LCO Prospectus and realised from April 2018 through the establishment of the MLCO;
- The signing of the Partnering Agreement by each of the partner organisations of the MLCO; Manchester University NHS Foundation Trust, Manchester City Council, Manchester Primary Care Partnership, Greater Manchester Mental Health NHS Foundation Trust and Manchester Health and Care Commissioning, enabling the MLCO to establish in April 2018;
- The continued progress made in implementing and delivering the New Care Models associated with the Greater Manchester Transformation Fund and Adult Social Care Grant and continued development of Integrated Neighbourhood Team hubs;
- The creation of a co-designed and all-encompassing approach to the MLCO key deliverables for 2018/19 to ensure that it is best placed to meet the needs of communities and neighbourhoods of Manchester in regards to integrated health and social care;
- Approve the proposal to recognise the Manchester LCO Clinical Advisory Group as the clinical and professional leadership group for Manchester reporting to the Manchester Health and Wellbeing Board; and,
- Note the proposed priority of the Clinical Advisory Group to develop a clinical strategy for Manchester and the resourcing required to enable the Group to deliver that.

**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 MLCO will deliver services and support which contributes towards the Health & Wellbeing Boards 7 strategic priorities.
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	

**Contact Officers:**

Name: Tim Griffiths  
 Position: Assistant Director, Corporate Affairs  
 Telephone: 07985 448165  
 E-mail: tim.griffiths@nhs.net

**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.

- GM Strategic Plan – Taking Charge of Our Health and Social Care Manchester;
- Locality Plan – A Healthier Manchester;
- Local Care Organisation Prospectus

## **1. Introduction**

1.1 Further to the establishment of the Manchester Local Care Organisation (MLCO) as a public sector partnership on April 1<sup>st</sup> 2018 through the agreement and signing of a Partnering Agreement this paper provides Health and Wellbeing Board with a further update of progress made across core business areas of MCLO. Scrutiny Committee are advised that this paper builds on the update provided in June 2018.

1.2 The paper provides an overview of the following:

- Integrated Neighbourhood Team Development;
- New Models of Care;
- Winter resilience and system escalation;
- Phase 2; and,
- Clinical Advisory Group.

## **2. Background**

2.1 A key priority of the Our Manchester Strategy is to radically improve health and care outcomes, through public services coming together in new ways to transform and integrate services. This involves putting people at the heart of these joined-up services, a greater focus on preventing illness, helping older people to stay independent for longer, and recognising the importance of work as a health outcome and health as a work outcome. The Locality Plan, “Our Healthier Manchester”, represents the first five years of transformational change needed to deliver this vision.

2.2 Manchester has some of the poorest health outcomes in the country, and there are very significant health inequalities within the city. The Locality Plan aims to overcome the significant financial and capacity challenges facing health and social care in order to reduce these inequalities and to become clinically and financially sustainable.

2.3 The plan sets out the complex, ambitious set of reforms that are needed to integrate services for residents. This included developing a Local Care Organisation for integrating out-of-hospital care, a single hospital service for integrating in-hospital care, and a single commissioning function for health and social care.

2.4 The Locality Plan is fully aligned with the Our Manchester approach to change ways of working. This will mean supporting more residents to become independent and resilient, and better connected to the assets and networks in places and communities. Services will be reformed so that they are built around citizens and communities rather than organisational silos.

## **3. Integrated Neighbourhood Team Leads**

3.1 Integral to the success of the MLCO will neighbourhood working and key to that will be the recruitment of 12 Integrated Neighbourhood Team leads. At the last

HWB the MLCO advised that conversations regarding the development of the 12 integrated neighbourhood teams began in late summer 2017 involving staff side and trade union colleagues.

- 3.2 The arrangements, which are currently being mobilised, include an investment in professional leadership in both health and social care, and will provide opportunities for career development for staff, as well as benefits for the public as outlined below:
- They support integrated working, through developing and enabling neighbourhood-based service delivery models which focus on building relationships with local communities, to better meet their needs;
  - They provide opportunities for career progression for existing staff from both health and social care. The ambition, both now and in the future, is that MLCO roles will attract people from diverse backgrounds, which reflect our communities;
  - The MLCO have strengthened professional leadership capacity across health and social care, with clear lines of professional and management accountability; and
  - The structures support delivery of a consistency of service offer across the city, and the investment in the development of neighbourhood delivery and professional leadership for the next two years will help to create the most successful and sustainable delivery models in the future.
- 3.3 Following a robust consultation period, the MLCO have been actively progressing with an external recruitment process to recruit to 12 INT Lead posts. Following an interview process in November 2018, nine of the 12 posts have been filled. The first three of the Integrated Neighbourhood Team leads have started in post, and it is expected that the remaining leads will start in post in February and March 2019.
- 3.4 In addition to the leadership roles outlined above, the MLCO is also in the process of confirming the rest of the INT leadership quintet. In terms of the GP Leads, it has been agreed that these posts will undertake two sessions a week as part of this role, increasing from the one session a week that is currently in place. All 12 of the GP Leads are in place. Each of the GP Leads will receive a personalised plan and 2 sessions of coaching to support them in this role. It should be noted that the funding for the GP Leads has only been secured on a one-year basis, with the future funding yet to be agreed.
- 3.5 In regards to the rest of the roles, the majority of these have now been recruited to. There are six Mental Health Leads who have been assigned two neighbourhoods each. The 12 Nursing Leads have been confirmed and are in the process of being allocated neighbourhoods and the Social Care Leads recruitment process is currently ongoing.
- 3.6 The NESTA 100-day challenge will launch on 9<sup>th</sup> January with a workshop comprised of senior leaders from across the Manchester system. Between now and 1<sup>st</sup> April the first four neighbourhoods (to be determined) will work with partners within the neighbourhood to create a 100 day plan based on the needs

and priorities that are jointly identified. These plans will be mobilised from 1<sup>st</sup> April.

#### **4. Integrated Neighbourhood Team Hub**

- 4.1 As work to recruit the 12 INT Lead post progresses so does work to ensure that there are appropriate estate solutions in place to accommodate integrated working. The hubs for the Integrated Neighbourhood Teams (INTs) across Manchester continue to be mobilised, which will ensure that staff from across health and social care are physically co-located. The locations of the hubs are as follows:

- Central – Chorlton
- Central – Gorton District Office
- Central – Vallance Centre
- Central – Moss Side Health Centre
- North – Victoria Mill
- North – Cheetham Hill PCC
- North – Cornerstones
- North – Harpurhey District Office
- South – Etrop Court
- South – Burnage
- South – Parkway Green House
- South – Withington Community Hospital

- 4.2 To date estates and IMT work has been completed in six of the hubs (Chorlton, Gorton District Office, Vallance Centre, Burnage, Moss Side Health Centre, and Withington Community Hospital) with health staff operating out of all six of these. Significant progress has been made at the Cornerstones with all significant works being completed.

#### **5. Manchester Community Response**

- 5.1 Manchester Community Response (MCR) is a seven-day service that provides community based intermediate care, reablement and rehabilitation services to patients. These are often older people, after leaving hospital or when they are at risk of being sent to hospital. These services offer an interface between hospitals and where people live, working across the health and social care system. It is an evolution of the highly-effective North Manchester Community Assessment and Support Service. Two component parts of the MCR model are Crisis Response and Discharge 2 Assess services. An update on the mobilisation of these services and some associated activity to date is provided below.

##### Crisis Response

- 5.2 The Crisis Response Team, which supports patients who need urgent support at home, but who do not need to be admitted to hospital. The team accept referrals from North West Ambulance Service (NWAS) and the service is being mobilised across the City.

- 5.3 The team provides urgent assessments and interventions for people who have a health or social care crisis, to support people to remain at home, while the crisis situation is addressed.
- 5.4 The Crisis Response service in Central Manchester went live, 5<sup>th</sup> November 2018. Although implemented ahead of schedule, due to staffing and recruitment issues only the amber pathway element of the service is operational, with the whole service expected to be operational by March 2019. During the first four weeks of operations, the service has had a total of 57 referrals, 41 of which were accepted. This has a direct impact on admission avoidance with 34 of the 41 referrals being cared for in the community. Work is ongoing with the North West Ambulance Service to increase the referrals and usage of this service further.
- 5.5 The Crisis Response service launched in part in South Manchester, 3<sup>rd</sup> December 2018. The community referral element of the model was launched, with there being the aim to operationalise the whole model by March 2019, subject to recruitment. The service is currently operational 7 days a week from 08:30 to 18:30, accepting three out of the four available pathways.

#### Discharge 2 Assess

- 5.6 Discharge 2 Assess (D2A) helps people home from hospital, quickly and safely. The essence of the approach is that the person, once medically optimised, leaves hospital and is assessed for their ongoing needs in their home or other place of residence. The aim is to reduce unnecessary delays in discharge when people could be back at home or in a more appropriate place to receive ongoing assessment, short term interventions and support from community teams. Funding has been provided to design, implement and roll-out D2A across the entire city.
- 5.7 The rollout of Discharge to Assess has commenced in both North and South Manchester. The service commenced in North Manchester in May 2018 and South Manchester in September 2018. Similarly, to other care models, there have been recruitment challenges, which have influenced the roll out of the service. Staff continue to be recruited into the teams to deliver the required capacity as quickly as possible.
- 5.8 In North Manchester, the rollout of the service is complete. By the end of October 2018, the service had supported the discharge of 135 patients through Pathway 1 alone. In contrast in South Manchester, the service is still ramping up. It is planned that the South rollout should be complete by end February 2019.

## **6. High Impact Primary Care**

- 6.1 High Impact Primary Care (HIPC) is being delivered across the City of Manchester with there being a HIPC team based in three neighbourhoods, which span across each of the localities. This service is a vital component of local care organisation models and is supported by international evidence in

terms having a positive impact on population health, specifically for those at high risk of admission to acute and secondary care.

- 6.2 There are numerous patient case studies being collected and shared, demonstrating the quality impact of the service of patient lives. In terms of quantitative activity data, information has been provided below. From an activity perspective, the service is having a demonstrable impact on the cohort of patients, with the cost of emergency activity reducing by 65%. Further 75% of the discharges have had no further emergency activity at all. In addition, the service has met or exceeded its performance targets since they were agreed in October 2018.

## **7. System Resilience and Escalation**

- 7.1 Alongside leading the programmes of work bringing together health and social care services and delivering transformation activity, the MLCO is working with MFT to support local people by working to prevent the need for admission to hospital wherever possible, and getting people home from hospital in a timely and safe manner when they do need hospital care. With support from partners including Manchester City Council and Greater Manchester Mental Health NHS Foundation Trust, there has been an initial period of focussed activity to support people who have faced a long length of stay in hospital.
- 7.2 To date this work has focussed predominantly on the pressures at the Manchester Royal Infirmary with the MLCO senior leadership working closely with colleagues to expedite the movement and discharge of patients from an acute to the most appropriate community setting. As at the end of December 2018, this programme of work led by the MLCO has supported the discharge of 93 patients with an accumulated length of stay of just under 10,000 days. This programme of work, has supported a significant reduction in the average length of stay at the MRI, indicating the impact this is having on acute flow, as well as ensuring that patients are treated in appropriate community settings and home where possible.
- 7.3 Given the relative success of interventions to date MLCO will now increase collaborative work with colleagues at other hospital sites across Manchester to support the discharge for Manchester residents there, as well as broadening the target cohort. In addition to this MLCO is currently mobilising a number of winter schemes. Progress against the delivery of these will be overseen through MLCO governance arrangements, and reported into the Urgent Care Board, which MLCO continues to proactively engage with.

## **8. Phase Two development**

- 8.1 As previously updated the HWB will be aware the MLCO will realise its full potential in a three year phased approach. The majority of services that were transferred in year one were community health services (including North Manchester Community Health Services) and directly provided Adult Social Care.

8.2 Year two will see a range of other services move under the management of MLCO including a host of commissioned services such as Home Care and Residential and Nursing Care. The MLCO are now in the process of developing a range of road maps that will support the development and growth of the organisation to enable it to realise the potential that was outlined in the original prospectus.

## **9. Clinical Advisory Group**

9.1 As previously updated MLCO established a Clinical Advisory Group in 2017/18, and it was subsequently agreed by HWB that the CAG be viewed as a system wide piece of architecture and not solely a piece of MLCO governance. As a result of this it was agreed that convening responsibility pass to Manchester Health and Care Commissioning.

9.2 Following the success of CAG in its first 12 months and the significant levels of support the system have offered to it, a separate Children's Clinical Advisory Group will be established. This will be established as a formal sub-group of CAG.

9.3 A more comprehensive update on CAG is found on the substantive agenda.

## **10. Recommendations**

10.1 Health and Wellbeing Board is asked to note the contents of this report and the progress made to mobilise New Care Models and the work to support system resilience.



**Manchester Health and Wellbeing Board  
Report for Information**

**Report to:** Manchester Health and Wellbeing Board – 23 January 2019

**Subject:** Clinical Advisory Group: 2018/19 progress and priorities for 19/20

**Report of:** Dr. Sohail Munshi, Chair (Clinical Advisory Group).

### Summary

This report provides an update to the Health and Wellbeing Board on the work of the Clinical Advisory Group in 2018/19 and its priorities for 2019/20.

### Recommendations

The Board is asked to note the report, the work of the CAG in 2018/19 and approve the approach that the CAG will take in 2019/20.

### Board Priority(s) Addressed:

<b>Health and Wellbeing Strategy priority</b>	<b>Summary of contribution to the strategy</b>
Getting the youngest people in our communities off to the best start	Children's service representatives are included in the membership of CAG and a children's subgroup will be established in 19/20 aligned to the existing children's governance.
Improving people's mental health and wellbeing	Medical Director of GMMH is a member of the CAG. The Group has considered the extended community model and how partners can support its mobilisation. The Winning Hearts and Minds programme has this as a key driver.
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	The CAG has been aligned to the Manchester Health and Wellbeing Board to ensure that this is a key driver for the development of its priorities.
Self-care	

**Lead board member:**

**Contact Officers:**

Name: Sohail Munshi

Position: Chief Medical Officer, MLCO and Chair of CAG

Telephone:

E-mail: Sohail.munshi@nhs.net

**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 Clinical Advisory Group Terms of Reference.

## Introduction

1. This report provides an update to the Health and Wellbeing Board on the work of the Clinical Advisory Group in 2018/19 and its priorities for 2019/20.

## Background

2. The MLCO established the Clinical Advisory Group in December 2017 to build the connections between clinicians, service and social care professionals across the City. It was intended to work at the interface between primary, community and secondary care services to strengthen relationships.
3. It was established to be a strategic group working across the system not within organisational boundaries, supporting and facilitating the development of clinical, social care and professional relationships across Manchester with a focus on the integration and transformation of health and social care in community, primary, acute and mental health services.
4. Its initial focus was to:
  - align the existing clinical work programmes across the City;
  - determine system wide priorities and opportunities for collaboration and;
  - provide clinical and professional assurance on the safe transfer of services to the LCO in years 1-3.
5. The membership of the group is comprised of clinical and professional leaders in adult and children's services from across the system, MFT, MHCC, LMC, MPCP, LCO, GMMH and PAHT. The terms of reference also include adult social care and the VCSE sector.
6. Following its inception, the CAG agreed that its objectives would be to:
  - Deliver the requisite shifts from hospital to community services in a safe and sustainable manner;
  - Develop and manage the clinical and professional interface between health and social care services within primary, community and secondary care services;
  - Agree and then understand how to incentivise different clinical behaviours to deliver the LCO strategy;
  - Support the development of holistic models of care to address clinical, mental, physical and social wellbeing.
7. The CAG also agreed the priority areas it wanted to focus on during 2018:
  - Prevention;
  - Neighbourhood working;
  - Urgent care;
  - Children's services;
  - Home and residential care;

- Frailty;
- CVD;
- Respiratory;
- Diabetes.

### **Approach and work of the CAG in 2018/19**

8. The first meeting of Clinical Advisory Group was in December 2017, where it agreed its purpose, membership, objectives and priorities for the year.
9. As this was the first meeting of its kind across the City, the Group has spent the first 12 months focused on:
  - Building the foundations for the meeting; consolidating its membership and the governance including the interfaces with existing clinical and professional committees;
  - Undertaking a stocktake of work that is already underway across the City;
  - Connecting the Group to the wider Manchester locality governance to the Health and Wellbeing Board through Transformation Accountability Board.
10. During 2018/19, the Clinical Advisory Group has considered:
  - The population health programme: Winning Hearts and Minds;
  - The Extended Community Model developed by GMMH and its application across community and primary care services;
  - The work led by MFT aligned to the GM HSCP theme 3 work on Cardiology;
  - The approach across the City to enable and support staff to volunteer; as the voice for professional leadership across the locality the CAG wanted to lend more formal support to the Our Manchester approach around volunteering;
  - The Children's Transformation Programme and the operation of children's community services in the City;
  - Community gastroenterology services and options for future developments;
  - The Citywide Respiratory work programme and how the development of community services can be taken forward through partner collaboration
  - The proposed model for Manchester Community Response developed by the MLCO;
  - The operating model for Health Innovation Manchester;
  - The options for a community heart failure service;
11. VCSE representation at the CAG has been facilitated by MACC to ensure the most appropriate representation based on the agenda. Work will continue in 2019/20 with the newly formed VCSE Reference Group to ensure this is more formalised.

12. Through its work in 2018/19, the CAG has taken forward a number of key work streams that will progress in 2019/20.
  - 12.1 Following the consideration of the Children's item and the relationships that have been built in the CAG between clinicians in adults and children's services, the CAG will establish a Children's CAG as a subgroup.
  - 12.2 Following the consideration of the community gastroenterology services, the CAG has commissioned a task and finish group led by clinicians across the City to develop the options for a gastroenterology pathway across the City. This will align the work to review the current community offer, along with the clinical strategy work in MFT. It will take into account the work at GM through the elective hub and be supported by the team at Health Innovation Manchester. The work will commence with a system-wide workshop in February.
  - 12.3 The CAG supported the development of the Manchester Community Response model and as a result of the CAG discussion, clinical support to the mobilisation of the model was identified.
  - 12.4 As a result of a number of the items including Winning Hearts and Minds and the Extended Community model (GMMH), partner organisations were closer aligned to the design and mobilisation of the new models.
  - 12.5 Whilst MHCC and MCC have already established volunteering programmes, the CAG welcomed and endorsed the approach that both have taken and would like to see similar programmes being established in all organisations in the City.
  - 12.6 Following the consideration of the theme 3 Cardiology pathway redesign and Community Heart Failure services, the CAG will aim to prioritise Cardiology and heart failure services in 2019/20 and look to develop the options for a community heart failure service.
  - 12.7 A key priority for 2019/20 will be mobilisation of the work of the Respiratory Steering Group work programme and its alignment to the operating model of the MLCO, including the development of options for a community respiratory model.
13. At the meeting in December, the Group reflected on its work during 18/19 and concluded that:
  - the connections that have been built across the City between clinicians and professionals have been strengthened and the Group has taken a thought leadership approach to its considerations;
  - the focus for 2019/20 should be to build on these foundations, develop its priorities and lead the development of the clinical strategy for the City.

14. In order to build on the work from 18/19, the CAG will develop a set of task and finish groups to take forward the work established in 18/19. In order to do that, it will build on forums and work that are already established and only establish new work streams where they are not already in place.
15. The CAG will use the strategic framework of the Manchester Locality Plan to determine its approach and priorities for 19/20 and will aim to continue to build the connections between clinicians and professionals across the City.

### **Priorities for the CAG in 2019/20**

16. Over the course of 2018 CAG has established that there is a genuine need for citywide clinical oversight of the transformation of the health and social care system. Engagement in the CAG from all agencies has been positive, and it is the only forum in the city that brings together such a diverse range of clinical expertise and perspectives. This ensures transformation proposals are effectively challenged by practitioners from across the system, resulting in a far stronger transformation offer.
17. The building blocks are in place to increase the CAGs impact and influence over the next 12 months. CAG will strengthen its clinical leadership role by focusing three key things:
  - The transformation work being undertaken to address the poor health outcomes suffered by people with long term conditions, notably CVD, Cancer, Respiratory Diseases and Diabetes. CAG will seek to ensure that these proposals take account of prevention measures, including factors and conditions that increase risk, with the ultimate aim of achieving the measures agreed with GM HSCP to reduce preventable deaths in the city related to long term conditions.
  - End-to-end oversight of the shift in service provision from acute to community settings for services provided to people with long term conditions, from the initial case for change through to the evaluation of impact.
  - Continuing to strengthen design and delivery relationships with innovation and delivery partners in the city to achieve the maximum impact from transformation activity. For example, Health Innovation Manchester is now part of the CAG.
18. A Children's CAG will also be established from January 2019, ensuring a specific clinical focus on the needs of children. The Children's CAG will operate as a sub-group of the citywide CAG.
19. Detailed planning for 2019/20 will take place in the first two months of 2019 in partnership with MHCC to determine the priority areas, to ensure CAG can deliver on the three key things listed above. This planning work will then be referenced and reflected in the annual update to the Locality Plan, being led by the Programme Director, Our Healthier Manchester.

20. The role of the CAG will be to ensure that the strategic vision set out by MHCC is deliverable, safe and contributes towards improved outcomes for the residents of Manchester. Following the agreement of the priorities for 19/20, the CAG will work through existing working groups or establish task and finish groups if necessary to ensure that the work programme is agreed and resourced. The CAG has already demonstrated how its approach for 19/20 would operate through:
- 20.1 Respiratory: The CAG in November considered the Respiratory work programme in detail. The proposed service strategy and delivery model were acknowledged and it was agreed that the Manchester Adult Respiratory Steering Group would be the forum through which the CAG could task the development and delivery of the operating model across the system with a focus on developing the opd model.
- 20.2 Urgent Care: The CAG has considered the operational and system flow pressures in Manchester at a few points during 18/19. The cross- system representation has enabled the convening (through the MLCO) of a cross-provider group to develop proposals for how community and primary care services can work together to deliver a different offer. The benefit that the CAG provides is that it is a forum for providers across various disciplines to come together and work through system pressures and develop options for how to resolve them.
21. Further work is to be completed by March 2019 to clarify the relationship of the CAG to the existing clinical and professional groups across the City. A formal relationship has already been established with the MFT Clinical Advisory Committee; the chair of the CAG is formally recognised within the membership of the CAC and provides a regular verbal update. More work is to be done to define the relationship of the CAG to the MHCC Clinical Committee and any other forums that exist partner organisations to ensure the CAG work programme has system wide input on its development and delivery. It is important that the CAG is able to operate effectively with partner governance structures to be able to fulfill its system-wide remit.
22. It has also been agreed by CAG that through the Chief Nurse and Head of Therapies (MLCO) that the therapy professions will be represented in the CAG membership from 2019.

### **Summary**

23. The Manchester Health and Wellbeing Board is asked to note the report, the work of the CAG in 18/19 and approve the approach that the CAG will take in 19/20.

**Sohail Munshi**  
**Chief Medical Officer (MLCO) / Chair of the Manchester Clinical Advisory Group**  
**January 2019**

This page is intentionally left blank



**Manchester Health and Wellbeing Board  
Report for Information**

**Report to:** Manchester Health and Wellbeing Board – 23 January 2019

**Subject:** Manchester Child Death Overview Panel 2017-18 Annual Report

**Report of:** Barry Gillespie, Consultant in Public Health/Chair of the Manchester Child Death Overview Panel

---

**Summary**

The Manchester Child Death Overview Panel (CDOP)- a subgroup of the Manchester Safeguarding Children’s Board- reviews the deaths of children that are normally resident in the area of Manchester City, aged 0 - 17 years of age (excluding stillbirth and legal terminations of pregnancy) in line with Chapter 5 of Working Together to Safeguarding Children 2015. CDOP has a statutory requirement to produce a local annual report based upon cases closed and the findings

**Recommendations**

The Board is asked to note the report and its recommendations.

---

**Board Priority(s) Addressed:**

<b>Health and Wellbeing Strategy priority</b>	<b>Summary of contribution to the strategy</b>
Getting the youngest people in our communities off to the best start	Identification of potential risk factors that are likely to contribute to Manchester’s child death rate and identify action that could be taken to address this.
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	

**Lead board member:**

David Regan- Director of Population Health and Wellbeing, MHCC

**Contact Officer:**

Name: Barry Gillespie  
Position: Consultant in Public Health  
Telephone: 0161 234 3486  
E-mail: b.gillespie@manchester.gov.uk

**Background documents (available for public inspection):**

- Previous CDOP reports;
- Manchester CDOP Annual Report 2016-17;
- GM CDOP Annual Report 2017-18;
- GM CDOP Annual Report 2016-17

available at:

<https://www.manchestersafeguardingboards.co.uk/resource/child-death-overview-panel-cdop-information-practitioners/>

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.

## **Introduction**

1. The 2017/18 Child Death Overview Panel (CDOP) Annual Report is the tenth Manchester CDOP Annual Report. It is a summary of the key issues identified by the CDOP regarding all the deaths reviewed and closed between 1<sup>st</sup> April 2017 and 31<sup>st</sup> March 2018.

## **Background**

- 2.1 The CDOP Manager, a member of the Manchester Safeguarding Team, works and liaises with a wide range of agencies to gather any relevant information following a reported child death. This will include information about the child, the family and the circumstances of the death to ensure a full picture of relevant clinical and social issues are available for the CDOP to consider.
- 2.2 A key element of our response to each sudden and unexpected death of a child (SUDC) is that we have in place an agreed Greater Manchester (GM) protocol for the rapid assessment of such deaths. A team of senior paediatricians provide cover via an on-call rota (24 hours per day, every day of the year) across GM, working in close collaboration with Greater Manchester Police, Children's Services, GM coroners and primary health care. Nationally this service provision is seen as the "gold standard".
- 2.3 The CDOP reviews all the information at a quarterly meeting and categorises the deaths, based on ten hierarchical categories, and identifies any potentially modifiable factors in the child's death. These modifiable factors (jointly agreed by the four Greater Manchester CDOPs to ensure consistency) are aggregated to identify factors that could reduce the risk of future deaths.
- 2.4 The work of CDOP is also closely linked to the Reducing Infant Mortality Strategy through identifying the key modifiable factors in the population including unsafe sleeping, housing conditions, reducing maternal smoking, and reducing maternal obesity. This Strategy will also be presented to the Health and Wellbeing Board on 23<sup>rd</sup> January 2019.
- 2.5 The 2017/18 CDOP Annual Report, and the 2017/18 GM CDOP and GM Rapid Response Team Annual Reports, were presented to the MSCB meeting in November 2018.

## **Future arrangements**

- 3.1 A new Working Together to Safeguard Children was published in July 2018 and Local Safeguarding Boards are to be replaced with new multi-agency safeguarding arrangements which have to be established by September 2019. Given the robust CDOP system in place in Manchester (and GM) the recommendation is that we will continue with our current system.
- 3.2 Following the transfer of the child death review policy from the Department for Education (DfE) to the Department of Health and Social Care (DHSC) in July

2018 it is recommended that CDOP reports to the Health and Wellbeing via the Children's Board from 2019-20.

# Manchester Child Death Overview Panel

## 2017 – 2018 Annual Report

## CONTENTS

<b>1. Welcome Introduction</b>	<b>2</b>
<b>2. Roles &amp; Responsibilities of The Child Death Overview Panel (CDOP)</b>	<b>3</b>
<b>3. Manchester’s Child Health Profile 2018</b>	<b>4</b>
<b>4. 2017/2018 Child Death Notifications Reported to CDOP</b>	<b>5</b>
<b>5. 2017/2018 Cases Closed by CDOP</b>	<b>6</b>
5.1 A Summary of Cases Closed by CDOP (April 2017 - March 2018)	6
5.2 A Summary of Modifiable Factors Identified in the Review	9
<b>6. CDOP Trends &amp; Emerging Themes</b>	<b>11</b>
6.1 Neonates & Infants Deaths (0 - 364 Days of Life)	11
6.2 Sudden & Unexpected Death in Infancy/Childhood (SUDI/SUDC)	13
6.3 Smoking	15
6.4 Deprivation	16
6.5 Deaths within the Black & Minority Ethnic (BME) Community	17
6.6 Chromosomal, Genetic & Congenital Anomalies	17
6.7 Housing & Living Conditions	18
6.8 Domestic Violence & Abuse	19
6.9 Greater Manchester Rapid Response Team	19
<b>7. 2018/2019 Recommendations to Manchester Safeguarding Children Board</b>	<b>20</b>
<b>8. Acknowledgements</b>	<b>21</b>
<b>9. Appendices</b>	<b>22</b>

## 1. WELCOME & INTRODUCTION

Welcome to the tenth annual report of the Manchester City Child Death Overview Panel (CDOP), reviewing the deaths of children that are normally resident in the area of Manchester City, aged 0 - 17 years of age (excluding stillbirth and legal terminations of pregnancy). In line with Chapter 5 of [Working Together to Safeguarding Children 2015](#) the CDOP has a statutory requirement to produce a local annual report based upon cases closed and the findings. This report bases its analysis on the number of cases closed between 1<sup>st</sup> April 2017 and 31<sup>st</sup> March 2018. The report aims to give some indication of the potential risk factors that are likely to contribute to Manchester's child death rate and suggest action that could be taken to address this.

Year on year the CDOP continues to strengthen the aggregated data to highlight key emerging themes and trends across the city. The Manchester CDOP has expanded its dataset outside the Department for Education (DfE) national requirement to gather additional information such as deprivation, ward, maternal body mass index (BMI), maternal age at time of delivery and breastfeeding. The richness of the data assists in the identification of any potential risk factors antenatally, postnatally and throughout the child's life, with the aim of reducing infant mortality across the City.

The Manchester City Coroner's Office and Register Office continue to provide excellent support in notifying the CDOP of all child deaths. The Manchester City Coroner's Office continues to work closely with the CDOP and provide regular updates at every stage of coronial investigations. This enables the CDOP to close cases in a timely manner and undertake a thorough review of the death.

The four Greater Manchester (GM) CDOPs continue to work together to improve consistency across the CDOPs and to produce an annual GM report. In addition, the GM Rapid Response Team, an on-call team of paediatricians available to attend unexpected child deaths 24 hours a day, 365 days a year, work with the local CDOPs and also produce an annual report. The CDOP continues to supply information and data to support the University of Bristol Learning Disabilities Mortality Review (LeDeR) Programme and The University of Manchester National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH).



**Barry Gillespie**

Consultant in Public Health

Manchester Child Death Overview Panel Chair

## 2. ROLES & RESPONSIBILITIES OF THE CHILD DEATH OVERVIEW PANEL (CDOP)

The CDOP operates in line with the Department for Education statutory guidance [Working Together to Safeguarding Children 2015](#) (Chapter 5: Child Death Reviews) as a Subgroup of the Local Safeguarding Children Board (LSCB). The LSCB functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

- (a) collecting and analysing information about each death with a view to identifying
  - (i) any case giving rise to the need for a review mentioned in regulation 5(1)(e)
  - (ii) any matters of concern affecting the safety and welfare of children in the area of the authority
  - (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area
 and
- (b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

The functions of the CDOP include:

- reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members
- discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family
- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths
- making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible
- identifying patterns or trends in local data and reporting these to the LSCB
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether a Serious Case Review (SCR) is required
- agreeing local procedures for responding to unexpected deaths of children
- co-operation with regional and national initiatives to identify lessons on the prevention of child deaths e.g. National Clinical Outcome Review Programme.



In reviewing the death of each child, the CDOP considers modifiable factors in the family environment, parenting capacity or service provision, and considers 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 aggregated findings from all child deaths inform local strategic planning, including the local Joint Strategic Needs Assessment (JSNA), on how to best safeguard and promote the welfare of children in the area.

### 3. MANCHESTER'S CHILD HEALTH PROFILE 2018

A key tool used in assessing deprivation is the Indices of Deprivation 2015 which ranks Manchester 5<sup>th</sup> out of 326 local authorities in England, 1 being the most deprived area. The Manchester Child Health Profile (2018)<sup>1</sup> provides an annual snapshot of child health in Manchester. Overall, comparing local indicators with England averages, the health and wellbeing of children in Manchester is worse than England. Children and young people aged 0 – 19 years account for 25.6% (138,700) of Manchester's total population. Children aged 0 – 4 years account for 7.2 % (39,200) of the total population.

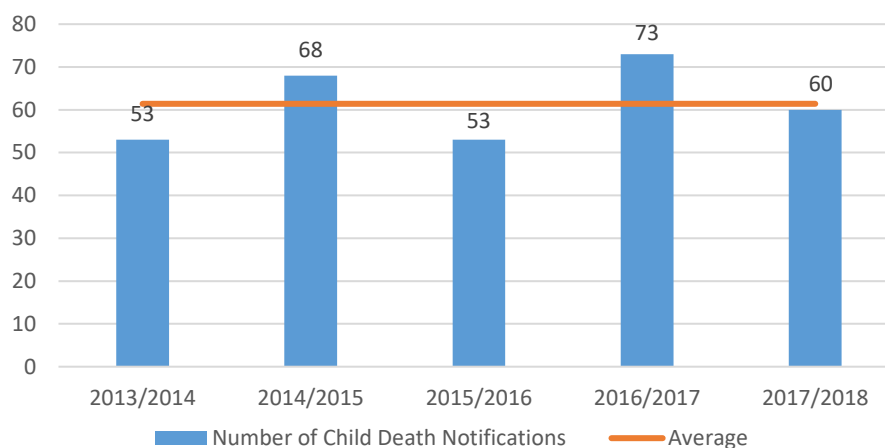
- Life expectancy at birth was recorded as 75.5 for boys and 79.4 for girls, which is lower than the national average (boys 79.5, girls 83.1).
- Manchester's infant mortality rate (6.3 per 1,000 live births) was worse than the England average (3.9 per 1,000 live births) with an average of 50 Manchester infants dying before age 1 each year.
- On average (2014 – 2016), there were 17 child deaths aged 1 – 17 years (16.2 per 100,000 children) which is higher than the England average (11.6 per 100,000 children).
- The Manchester teenage pregnancy rate (0.7) is worse than England (0.8), with 207 girls becoming pregnant in a year.
- 11.6% of women smoke while pregnant which is worse than England (10.7).
- The rate of mothers initiating breastfeeding in Manchester (66.6%) are worse than England (74.5%). By 6 to 8 weeks after birth, 42.4% of mothers are still breastfeeding which is worse than England (44.4%).
- Dental health is worse in Manchester than England (23.3%). 43.0% of 5 year olds have one or more decayed, filled or missing teeth.
- Levels of childhood obesity are worse than England (4-5 years 9.6%, 10-11 years 20%). 11.7% of children in Reception (4-5 years) and 25.4% of children in Year 6 (10-11 years) are obese.
- The rate of child inpatient admissions for mental health conditions at 74.3 per 100,000 is similar to England (81.5 per 100,000). The rate for self-harm at 303.1 per 100,000 is better than England (404.6 per 100,000).
- Manchester has the worst rate of emergency hospital admissions for asthma with a rate of 497.5 per 100,000 children (0 – 18 years) in comparison to the England average 202.8 per 100,000 children.

<sup>1</sup> <https://fingertips.phe.org.uk/profile/health-profiles>

#### 4. 2017/2018 CHILD DEATH NOTIFICATIONS REPORTED TO CDOP

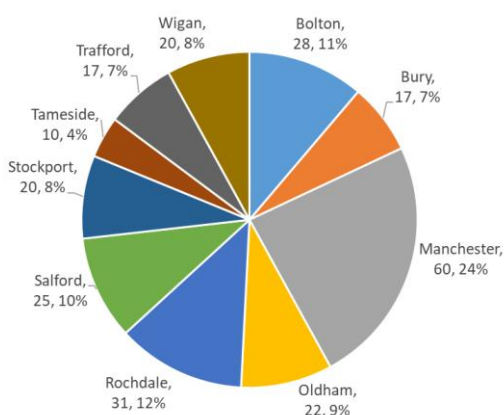
There was a total of 60 child death notifications reported to CDOP from 1<sup>st</sup> April 2017 to 31<sup>st</sup> March 2018. Owing to the Child Death Overview Panel (CDOP) review process, there is a time lapse between a death being reported and the case being discussed and closed at panel. This depends heavily upon the circumstances leading to death and the death being subject to investigations. From 1<sup>st</sup> April 2013 to 31<sup>st</sup> March 2018 there have been a total of 307 child deaths reported to the CDOP. There has been a slight variation in the number of child deaths reported to the panel year on year, with the average number of notifications being 61.4 deaths per year.

**Table/Figure 1: Number of child deaths reported to the Manchester CDOP per year (2013/2018)**



The child population in Manchester rose by over 20% between 2006 and 2016. The latest ONS 2017 mid-year estimates projects Manchester's child population (0 – 17 years) as 121,182, accounting for 22% of the total population (545,501). With a total of 60 child death notifications reported to CDOP during 2017/2018, this would indicate Manchester's overall child death rate as 4.95 per 10,000 children aged 0 – 17 years. A total of 250 deaths were notified to the four Greater Manchester CDOPs in 2017/18, of which 24% of the children resided in Manchester City.

**Table/Figure 2: Number of 2017/2018 child deaths reported to Greater Manchester CDOPs**



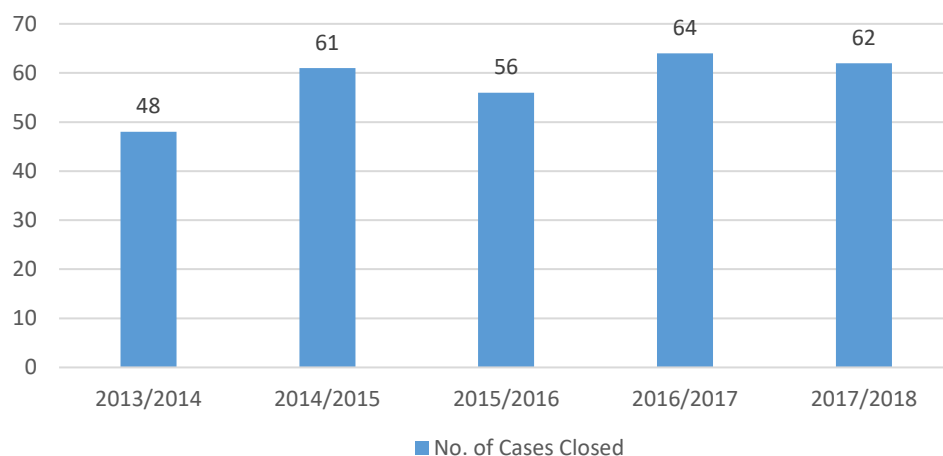
Child Death Overview Panel	No. of child death notifications	
Bolton, Salford, Wigan CDOP	73	29 %
Bury, Oldham & Rochdale CDOP	70	28 %
Manchester CDOP	60	24 %
Stockport, Tameside & Trafford CDOP	47	19 %
Greater Manchester	250	100 %

## 5. 2017/2018 CASES CLOSED BY CDOP

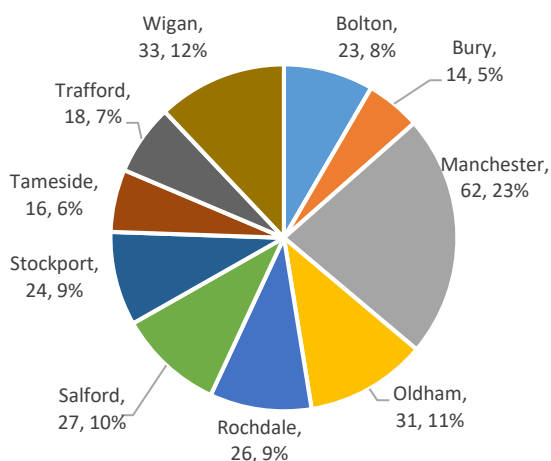
### 5.1 A Summary of Cases Closed by CDOP (April 2017 – March 2018)

This annual report contains data regarding the 62 cases discussed and closed by the CDOP from 1<sup>st</sup> April 2017 to 31<sup>st</sup> March 2018. 33 (53%) of the deaths occurred in 2017/2018 and the remaining 29 (46%) are historical cases where the death occurred prior to 1<sup>st</sup> April 2017. For deaths that occurred during 2017/2018, it would appear that there has been an increase in the number of cases subject to coronial investigations, criminal proceedings and other reviews such as Serious Case Reviews. Depending on the circumstances leading to death and the nature of the death, this impacts on the number of cases closed by the CDOP. To undertake a comprehensive review of the death, the CDOP will not review a case until all investigations have concluded and the necessary reports have been submitted to panel for consideration. Cases that are subject to investigations may remain open for a number of years thus impacting on the timescale of which the CDOP closes the case. There was a total of 274 cases closed across Greater Manchester in 2017/18, 109 (44%) of those notified in the same period.

**Table/Figure 3: Number of death closed by the Manchester CDOP per year (2013/2018)**



**Table/Figure 4: Number of 2017/2018 Greater Manchester CDOP cases closed**



Child Death Overview Panel	No. of cases closed	
Bolton, Salford, Wigan CDOP	83	30 %
Bury, Oldham & Rochdale CDOP	71	26 %
Manchester CDOP	62	23 %
Stockport, Tameside & Trafford CDOP	58	21 %
Greater Manchester	274	100 %

**Table/Figure 5: Cases closed by age at time of death (2017/2018)**

Age Group	No. Cases Closed	
0 - 27 days	25	40 %
28 - 364 days	16	26 %
1 - 4 years	8	13 %
5 -9 years	7	11 %
10 - 14 years	<5	<5 %
15 - 17 years	5	8 %
Total	62	100%

Of the 62 cases closed, 29 (47%) cases were female and 33 (53%) male. 25 (40%) infants were neonatal deaths (babies who died under 28 days of life). A further 16 (26%) died before their first birthday (28 - 364 days), highlighting infants under the age of 1 as the most vulnerable group, accounting for 66% of the cases closed. Of the 25 neonatal deaths, 11 of these had one or more modifiable factors identified in the review that contributed to vulnerability, ill-health or death of the infant.

**Table/Figure 6: Cases closed by ethnicity (2017/2018)**

Ethnic Grouping	No. Cases Closed	
White	23	37 %
Mixed / Multiple ethnic groups	6	10 %
Asian / Asian British	18	29 %
Black / African / Caribbean / Black British	14	23 %
Other ethnic group	<5	<5 %
Total	62	100%

Reviewing the child's ethnicity highlights the largest number of deaths were White children (23, 37%). There was a total of 39 cases closed from the BME community. 29% (18) of these children were of Asian/Asian British heritage and 23% (14) were Black/African/Caribbean/Black British. Breaking the data down into specific BME ethnic groups identifies deaths being most prevalent in the Pakistani (16, 25%) and African (14, 22%) communities.

A total of 41 (66%) deaths were classified as 'expected' (22 of which were neonatal deaths) and 21 (33%) classified as 'unexpected'. An unexpected death is defined as the death of a child which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death.

Of the 62 cases closed, 3 cases were subject to a Serious Case Review. 1 child was subject to a Child Protection Plan at the time of death and 1 child had previously been subject to a Plan prior to death.

The CDOP is responsible for reviewing each child death to categorise the cause of death. This classification is hierarchical, where more than one category could reasonably be applied, the highest up the list is selected (see Appendix 3 description of each category). The CDOP identifies modifiable factors in the review, although categorising a death as modifiable 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:

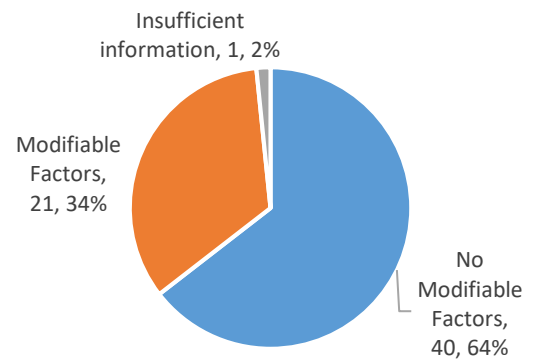
1. **Modifiable factors identified:** *The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths*
2. **No Modifiable factors identified:** *The panel have not identified any potentially modifiable factors in relation to this death*
3. **Inadequate information upon which to make a judgement**

**Table/Figure 7: Greater Manchester CDOP 2017/2018 categorisation of death compared to Manchester 2017/2018 and 2013/2018 5 year snapshot data**

Category of Death		GM 2017/2018 Cases Closed		Manchester 2017/2018 Cases Closed		Manchester 2013/2018 Cases Closed	
1	Deliberately inflicted injury, abuse or neglect	<5	<5 %	-	0 %	<5	<5 %
2	Suicide or deliberate self-inflicted harm	10	4 %	<5	<5 %	<5	<5 %
3	Trauma and other external factors	15	5 %	<5	5 %	11	4 %
4	Malignancy	20	7 %	6	10 %	17	6 %
5	Acute medical or surgical condition	11	4 %	4	6 %	12	4 %
6	Chronic medical condition	16	6 %	3	5 %	15	5 %
7	Chromosomal, genetic and congenital anomalies	67	24 %	19	31 %	84	29 %
8	Perinatal/neonatal event	102	37 %	20	32 %	118	41 %
9	Infection	12	4 %	-	-	<5	<5 %
10	Sudden unexpected, unexplained death	19	7 %	6	10 %	24	8 %
	Inadequate information to make a judgement	-	-	-	-	<5	<5 %
	<b>Total</b>	<b>274</b>	<b>100 %</b>	<b>62</b>	<b>100 %</b>	<b>291</b>	<b>100 %</b>

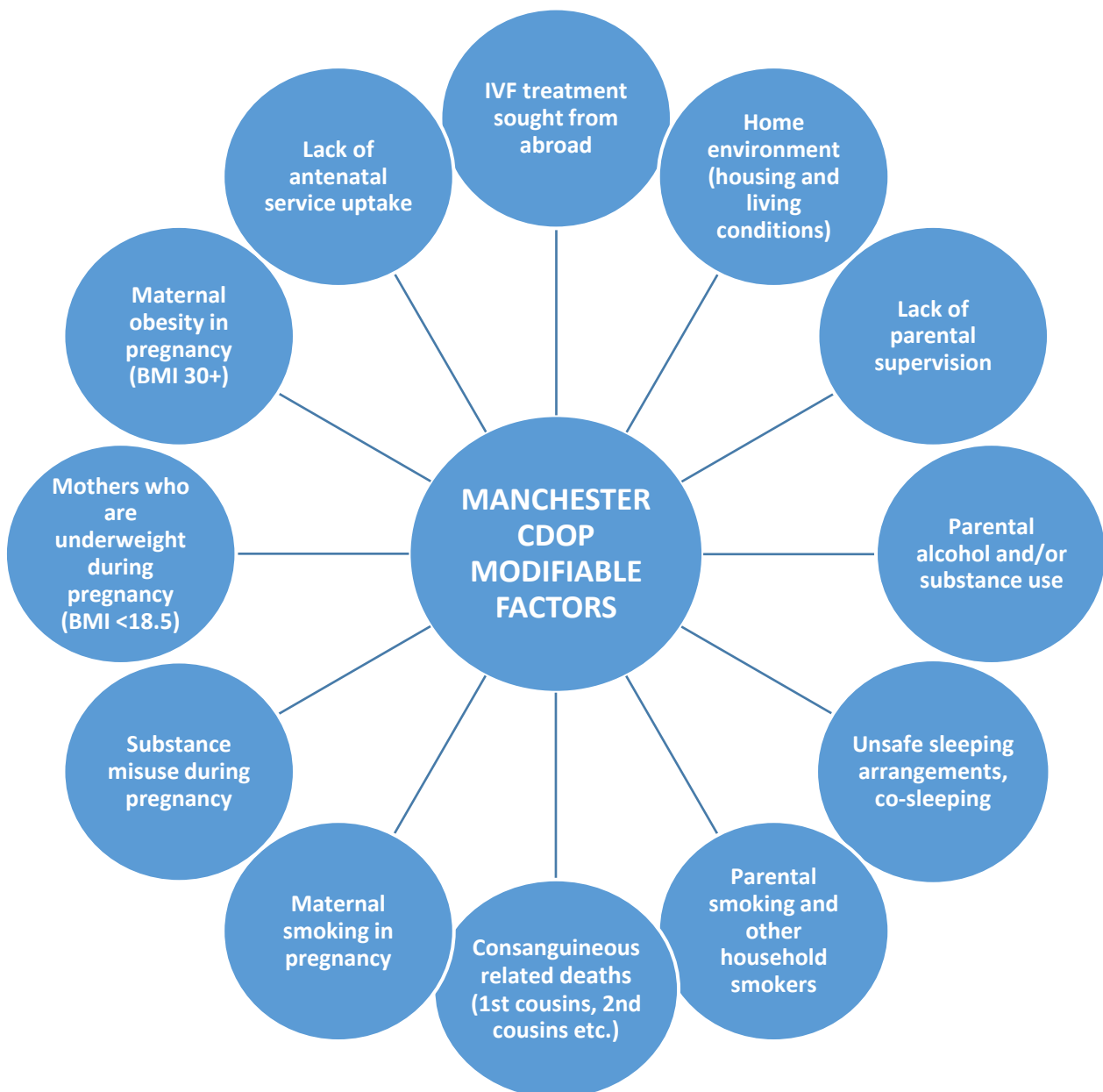
Of the 62 cases, the largest number of deaths were categorised as perinatal/neonatal event (20, 32%) and chromosomal, genetic and congenital anomalies (19, 31%). These categories have remained fairly stable over time across Greater Manchester, with the largest proportions always being classified as resulting from perinatal/neonatal event or from genetic and congenital anomalies. These two categories also had the largest number of modifiable factors identified in the review. There was a total of 21 cases where the CDOP identified modifiable factors, which were recorded in deaths categorised as perinatal/neonatal event (9, 43%), chromosomal, genetic and congenital anomalies (5, 24%), sudden unexpected, unexplained death (19%), acute medical or surgical condition (10%) and trauma and other external factors (5%).

Cases categorised as chromosomal, genetic and congenital anomalies are often expected deaths due to the nature of the child’s condition however, issues within service provision and whether or not families have accessed appropriate genetic counselling can be highlighted as a modifiable factor. The same applies for deaths categorised as a perinatal/neonatal event, as the majority of deaths are expected although there may be a number of risk factors both antenatally and postnatally, which increase the likelihood of infant death.



### 5.2 A Summary of Modifiable Factors Identified in the Review

Of the 62 cases closed, the CDOP identified modifiable factors in 21 (34%) child deaths, where one or multiple risk factors contributed to the vulnerability, ill-health or death of the child:



Of the 21 deaths with modifiable factors, 19 (90%) of the children died before the age of 1, 11 (52%) of which were neonatal deaths (<28 days of life). The most common modifiable factors identified was smoking in pregnancy and maternal obesity (BMI 30+) in pregnancy. Modifiable factors act as multiplier effect, where there are two or more factors present, the vulnerability of the child increases.

Of the 274 cases closed across Greater Manchester in 2017/2018, modifiable factors were identified in 110 (40%) cases. In these 110 cases, 175 modifiable factors were cited; the most common being smoking (in the household or in pregnancy), high BMI of mother, alcohol/substance misuse by parent, access to or uptake of health/care services and unsafe sleeping (in that order). This is an increase from previous years in keeping with the national trend. Greater Manchester is consistently above the national average for modifiable factors identified but this is a somewhat subjective decision so can be hard to compare. The Manchester CDOP continues to review cases in line with the agreed set standard of modifiable factors as developed by the Greater Manchester CDOP Network. To ensure consistency the four CDOPs have developed a standard of identifying modifiable factors when categorising cases:

#### **Modifiable Factors in Perinatal/Neonatal Deaths**

- Maternal smoking in pregnancy
- Maternal Obesity (BMI 30 +)
- Mothers who are Underweight (BMI < 18.5)
- Unbooked pregnancies
- Concealed pregnancies
- Necrotizing Enterocolitis (NEC) where the baby was not fed expressed breast milk

#### **Modifiable Factors in Sudden Unexpected, Unexplained Deaths**

- Unsafe sleeping arrangements (co-sleeping bed/sofa)
- Parental smoking

#### **Modifiable Factors in Consanguineous Related Deaths**

- Where there has been an older sibling who has died or is affected by the same genetic autosomal recessive disorder

## 6. CDOP TRENDS & EMERGING THEMES

### 6.1 Neonates & Infant Deaths (0 – 364 Days of Life)

Of the 62 cases closed, a large proportion of the deaths occurred in the neonatal period (<28 weeks gestation) accounting for 40% (25) of the total child deaths. A further 16 (25%) infants died before their first birthday, highlighting 66% (41) of the total child deaths occurred in the first year of life making children under the age of 1 the most vulnerable age group. Figures were the same for Greater Manchester, with under 1s making up 65% of the cases closed and 45% under 28 days.

**Table/Figure 8: Comparing the impact of gender, ethnicity and deprivation of infants under the age of 1 in Manchester (2017/2018)**

Characteristic		Manchester Infant Deaths Aged 0 - 364 days		* Manchester Child Aged 0 - 4 Population	
Sex	Male	21	51 %	19,685	51 %
	Female	20	49 %	18,779	49 %
Ethnicity	White	15	37 %	17,344	48 %
	Mixed/Multiple ethnic groups	5	12 %	4,038	11 %
	Asian/Asian British	11	27 %	8,237	23 %
	Black/African/Caribbean/Black British	10	24 %	4,952	14 %
	Other ethnic group	-	-	1,842	5 %
Deprivation	Quintile 1 (most deprived)	32	78 %	-	72.1%
	Quintile 2	7	17 %	-	-
	Quintile 3	<5	5 %	-	-
	Quintile 4	-	-	-	-
	Quintile 5 (least deprived)	-	-	-	-

\* Source: Sex: ONS 2017 Mid-year estimates. Ethnicity: ONS 2011 Census. Deprivation: 2015 IMD

Of the 25 neonatal deaths, the majority of infants were born prematurely. Babies born under 24 weeks gestation have a significantly reduced chance of survival. The NHS determines births at the gestation of 37 weeks and over as full term pregnancies. Any delivery under 37 weeks gestation is classified as a premature birth, with those delivered under 26 weeks gestation classified as extremely premature<sup>2</sup>.

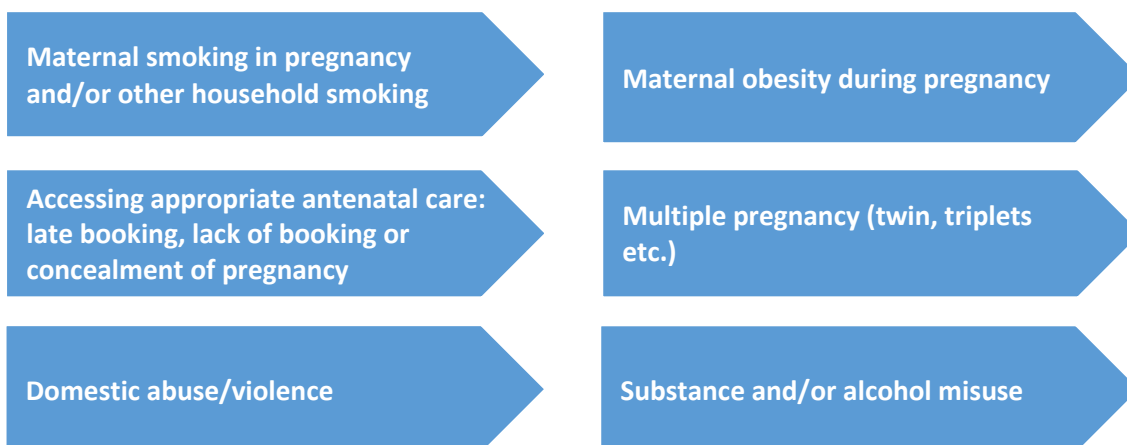
**Table/Figure 9: Neonatal deaths and the gestation at time of delivery (2017/2018)**

Neonatal Deaths (<28 days)	No. Cases Closed	
Extremely Premature (<26 weeks)	14	56 %
Premature (26 weeks to <37 weeks)	4	16 %
Full Term (37+ weeks)	6	24 %
Not Known	1	4 %
Total	25	

<sup>2</sup> <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/premature-early-labour.aspx>



Prematurity can also significantly reduce the infant's birth weight. Low birth weight (less than 2500g) is also a contributing factor for both deaths in infancy and poor health outcomes in later life. Of the 25 neonatal deaths, 19 (76%) infants were born with a low birth weight and 5 (20%) had a birth weight of over 2500 grams (there was 1 death where birth weight was not known). When reviewing infant deaths, a number of contributing risk factors relating to the mother's pregnancy may be relevant such as:



All of these associated factors either increase the risk of prematurity, or that the infant will not be born in the best possible condition.

### Smoking in Pregnancy

Of the 41 infant deaths under the age of 1, 8 (20%) mothers stated that they smoked during pregnancy. A further 7% of mothers stated that they did not smoke in pregnancy but smoked postnatally. In terms of smoking in pregnancy, Manchester has benefitted from major investment from the Greater Manchester Health and Social Care Partnership whereby a gold standard smoking cessation programme is being rolled out across Greater Manchester specifically for women who smoke in pregnancy. This programme is called Baby Clear. Part of the programme is an enhanced model for those women most likely to smoke and those who may find it most difficult to stop. Rolling Baby Clear out across Manchester is challenging for various reasons, but the Tobacco Control Lead of Population Health and Wellbeing Team is working closely with the Greater Manchester Baby Clear Team to achieve a successful roll out.

The Tobacco Control Lead has also initiated a multi-agency workstream, as a Subgroup to the Manchester Tobacco Alliance, which will specifically work on Smoke Free Homes. The ambition is that all children in Manchester will grow up in a smoke free environment. The Manchester Tobacco Alliance, with the backing of the Manchester Health and Wellbeing Board will oversee the programme described in the new Tobacco Plan to ensure that all workstreams are taken forward.

## Maternal Obesity in Pregnancy

Another risk factor is mother's body mass index (BMI) during pregnancy, where mother has a BMI under 18.5 (underweight) or a BMI of 30+ (obese/morbidly obese). Maternal obesity in pregnancy can lead to increased health risks for the mother (e.g. miscarriage, high blood pressure) and the baby (e.g. still-birth and problems such as diabetes and obesity in later life). To ensure consistency, the four Greater Manchester CDOPs have agreed to categorise mothers with a BMI recorded as underweight, obese and morbidly obese as a modifiable factor in deaths that are categorised as perinatal/neonatal event. Of the 20 deaths categorised as a perinatal/neonatal event, the following maternal BMIs were recorded at time of booking:

**Table/Figure 10: Deaths categorised as Perinatal/neonatal event and mothers BMI at time of booking (2017/2018)**

Perinatal/neonatal event: Mothers BMI at Time of Booking	No. Cases Closed	
	Underweight (BMI Under 18.5)	<5
Healthy (BMI 18.5 - 24.9)	6	30%
Overweight (BMI 25 - 29.9)	5	25 %
Obese (BMI 30 - 39.9)	6	30 %
Morbidly Obese (BMI 40+)	<5	10 %
Total	20	100%

There was a total of 8 (40%) mothers with a BMI of 30+ (obese, morbidly obese), of which 5 mothers were aged 30+ at the time of delivery. Whilst figures are small, it would appear that there is an emerging theme in mothers aged 30+ with an increased BMI in comparison to mothers who delivered in their twenties.

Manchester City Council Population, Health and Wellbeing (Public Health) commissions ABL Health to deliver Tier 2 (BMI >25) and Tier 3 (BMI >30) weight management services which pregnant women (18 years and over) who are overweight/obese are eligible to access. Both services include support on healthy eating, increasing physical activity and behaviour change. The Tier 3 service includes psychological therapy and (where appropriate) pharmacotherapy. Midwives can refer pregnant women to the Tier 3 specialist service following the 12th week of pregnancy, and the provider maintains contact until six weeks post birth for onward referral.

## 6.2 Sudden & Unexpected Death in Infancy/Childhood (SUDI/SUDC)

Of the 62 cases closed, 6 (10%) deaths were categorised as a sudden unexpected, unexplained death where the pathological cause of death remains unascertained. There are a number of common risk factors that contribute to sudden and unexpected deaths in infancy (SUDI) such as, unsafe sleeping arrangements, co-sleeping (with adults or other children), overheating, smoking and alcohol/substance misuse. It should be noted that these risks act as multiplier effect where two or more are present. Unsafe sleeping arrangements can also increase risk of overheating which is a contributing factor in a number of SUDI cases. Co-sleeping is particularly dangerous if the

carer has consumed alcohol or ingested substances, which may limit their awareness. Undertaking a 5 year snapshot of cases closed from 1st April 2013 to 31st March 2018, highlights 24 SUDC deaths, 15 (62%) of which had modifiable factors identified in the review which contributed to the vulnerability, ill-health or death of the infant, such as:

- Maternal smoking in pregnancy
- Substance misuse during pregnancy
- Parental smoking and other household smoking
- Unsafe sleeping arrangements, co-sleeping (bed and/or sofa)
- Overheating (temperature of the home)
- Alcohol and/or substance use on the evening of the event
- Home conditions and environment (damp, cluttered)

### Safer Sleeping

The CDOP continues to endorse the Manchester University NHS Foundation Trust Safer Sleeping Practice for Infants message:

***'The safest place for a baby to sleep is on their back, in a Moses basket or cot, in a room with the parent or carer for the first six months (DoH 2009, NICE 2014). This advice is the same for all times of the day and night when the baby is sleeping (Lullaby Trust 2009)'***

Work remains ongoing to raise awareness of the safer sleep messages via MSB training events and the supply of materials from The Lullaby Trust to embed the advice in multi-agency practice. Guidance and further information on how to reduce the risk of SUDI/SUDC is available via the Manchester Safeguarding Board (MSB) website [www.manchestersafeguardingboards.co.uk/resource/safe-sleeping/](http://www.manchestersafeguardingboards.co.uk/resource/safe-sleeping/).

### Infant Feeding

Infants that are breastfed generally experience a lower risk of SUDI but it will not necessarily offset the risk of the factors listed above. The Manchester Infant Feeding Group meet bi-monthly and has membership from the city's CCGs (midwifery, health visitors and other nursing staff) and Population Health and Wellbeing. They have developed an action plan and communications campaigns to target key areas of intervention, including: increase the number of 'breastfeeding-friendly' venues and businesses across the city; ensure groups most in need (e.g. young mothers) are targeted; held an inaugural forum to expand joint working across the city; encourage businesses to have clear and visible breastfeeding policy; influence the education sector; and increase peer support provision. A specialist and peer infant support package recently established for north Manchester secures additional capacity to support more women to continue to breastfeed longer.



### 6.3 Smoking

Household smoking continues to have a negative impact on the general health of children, and it is probable that some of the infant deaths in Manchester may have been prevented if we reduced smoking rates in our population. Smoking remains the main contributing risk factor for child death in Manchester. Of the 21 cases with modifiable factors, smoking was recorded as the key risk factor in 10 (48%) deaths. Maternal smoking in pregnancy and parental smoking in the home environment were highlighted as a key risk factors in deaths categorised as perinatal/neonatal event and sudden unexpected, unexplained death.

Smoking was also a contributing risk factors in deaths categorised as chromosomal, genetic and congenital anomalies and acute medical or surgical condition, where the child had an underlying health condition such as chronic lung disease, respiratory failure, asthma etc. which can be exacerbated by exposure to tobacco smoke. Manchester has the worst rate of asthma related hospital admissions with 497.5 admissions<sup>3</sup> per 100,000 children (under 19 years of age). Children and young people with asthma are at an increased risk of suffering an asthmatic attack when exposed to tobacco smoke and there continues to be links between smoking and asthma related deaths in Manchester.

#### **Manchester Tobacco Control Plan**

Manchester has finalised the new Tobacco Control Plan for 2018/2021. The plan outlines a whole system, multi-agency approach to reducing smoking rates in the city but also preventing children from starting smoking and protecting people of all ages, from the harm associated with exposure to tobacco. There is a major programme of investment and action around Tobacco Control taking place on the Greater Manchester footprint, including major new programmes for women who smoke in pregnancy and patients who receive hospital treatment. The work is the result of the Greater Manchester Tobacco Plan, “Making Smoking History”. The new Manchester plan aligns fully with the Greater Manchester plan whilst localising some of the issues for the city. The Tobacco Control Plan sets out the target of reducing adult smoking prevalence from 21.7% to 15% by 2021 and reducing Smoking at the Time of Delivery (smoking in pregnancy) from 10.6% to 6%.

Reducing smoking in pregnancy and promoting Smoke Free homes have been identified as important priorities for Manchester’s Tobacco Control Plan 2018/2021. Nationally, smoking is highlighted as the single most important modifiable risk factor in pregnancy in terms of preventing infant mortality. We know that children who grow up in homes where adults smoke will be three to four times more likely to smoke as adults. Children may also suffer other health issues if the home is not “smoke free,” meaning that they breathe “secondary” or “environmental” tobacco smoke. As the average adult smoker spends £2000 a year on cigarettes, smoking often increases family

---

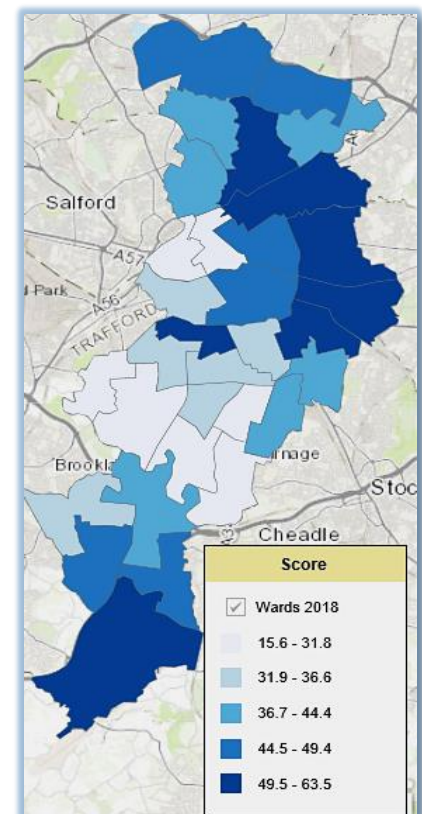
<sup>3</sup> 2015 Public Health England Profile: <https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-overview/data#page/1/gid/1938132992/pat/42/par/R1/ati/102/are/E08000003/iid/10501/age/233/sex/4>

poverty. Clearly, a further benefit of mothers being supported not to smoke in pregnancy is that they will have improved health outcomes themselves.

## 6.4 Deprivation

Deprivation continues to be a strong theme in Manchester child deaths and remains a year on year trend. Of the 62 cases closed, the majority of families resided in areas of deprivation with 51 (82%) families residing in quintile 1 (most deprived) and 9 (15%) families residing in quintile 2. There is a strong correlation with the higher rates of deaths in areas of deprivation across Manchester City and also Greater Manchester. The largest number of deaths occurred where the child/family resided in wards Longsight (6, 10%) and Moston (5, 8%).

28.2% of Manchester children (under 16 year) are living in poverty which is higher than figures across the North West (18.7%) and England (16.8%). 72.1% of Manchester children (under 18 year of age) live in the most deprived 20% of areas nationally (as measured by the 2015 Index of Multiple Deprivation (IMD)). This contrasts with 37% of children in the North West living in the most deprived quintile.



**Table/Figure 11: Comparing gender, ethnicity and deprivation of Manchester and Greater Manchester cases closed (2017/2018)**

Characteristic		Manchester Deaths 0-17 Years		* Manchester Population 0-17 Years		GM Deaths 0-17 Years	
Sex	Male	33	53 %	61,967	51 %	157	58 %
	Female	29	47 %	59,215	49 %	115	42 %
	Indeterminate	-	-	-	-	<5	<5 %
Ethnicity	White	23	37 %	54,842	51 %	156	57 %
	Mixed/Multiple ethnic groups	6	10 %	10,494	10 %	18	7 %
	Asian/Asian British	18	29 %	23,807	22 %	69	25 %
	Black/African/Caribbean/Black British	14	23 %	14,165	13 %	25	9 %
	Other ethnic group	<5	<5 %	4,844	4 %	<5	<5 %
Not Known	-	-	-	-	<5	<5 %	
Deprivation	Quintile 1 (most deprived)	51	82 %	-	72.1%	168	61 %
	Quintile 2	9	15 %	-	-	52	19 %
	Quintile 3	<5	<5 %	-	-	26	9 %
	Quintile 4	-	-	-	-	9	3 %
	Quintile 5 (least deprived)	-	-	-	-	13	5 %
Not Known	-	-	-	-	6	3 %	

\* Source: Sex: ONS 2017 Mid-year estimates. Ethnicity: ONS 2011 Census. Deprivation: 2015 IMD

For Greater Manchester 6 out of the 10 local authorities have higher IMD scores than the North West average, i.e. are more deprived than the average. These local authorities also have a higher proportion of their population living in the most deprived areas of the country than the North West average. Manchester ranks as the most deprived local authority and Trafford the least, with 41% and 3% of their respective populations living in the most deprived areas of the country.

### **6.5 Deaths within the Black and Minority Ethnicity (BME) Community**

Reviewing the number of child deaths from the BME community, in comparison to the ONS 2011 Census highlights a higher levels of deaths from BME communities which reflects the patterns seen in previous years, although there is year to year fluctuations. Asian/Asian British (18, 29%) and Black/African/Caribbean/Black British (14, 22%) children continue to be overrepresented, in total accounting for 32 (52%) of the 62 cases closed. Overall Manchester's child population is made up of 22% Asian/Asian British and 13% who are of Black/African/Caribbean/Black British heritage.

Breaking the data down into specific BME ethnic groups identifies an overrepresentation in deaths of children who are Pakistani (child deaths 16, 25% / child population 14,465, 13%) and African (child deaths 14, 22% / 9,087, 8%). In previous annual reports the difference between ethnic groups and the causes of death have been noted, particularly for the category chromosomal, genetic and congenital anomalies which, in 2017/2018, accounted for 30% of the total deaths and 50% of the deaths in the Asian/Asian British category.

The same trend is mirrored across Greater Manchester with White British children making up roughly 80% of the GM population but only 52% of the cases closed. The next most common ethnicity of children whose deaths were reviewed are Pakistani (16%) and Black African (8%), who are significantly over-represented compared to the population.

### **6.6 Chromosomal, Genetic & 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 healthy carriers, of a genetic disorder present a 1 in 4 (25%) chance that the child could be affected. 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.

Of the 62 cases closed, there was a total of 11 cases where consanguineous relationships were identified as a contributing factor to vulnerability, ill-health or death of the child. Conditions such as Epidermolysis Bullosa,

Mitochondrial Metabolic Disorder, Polycystic Kidney Disease, Ataxia-telangiectasia, Aicardi-Goutieres Syndrome, Thalassaemia, Complex Congenital Heart Disease and other congenital abnormalities were identified. 10 (91%) children were of Pakistani heritage and 6 (55%) infants died under the age of 1 (most common ward of residence Longsight). A number of the families also suffered from previous child deaths and/or have siblings who are affected by the same autosomal recessive disorder. It would appear that proportion of consanguineous related deaths indicate a link to the overrepresentation of child deaths from the Asian/Asian British community. This was also highlighted across Greater Manchester with just under half of the deaths of Pakistani children closed (20 / 44) being due to chromosomal or genetic anomalies, 16 of which recorded consanguinity as a risk factor.

### **Manchester University NHS Foundation Trust (MFT) Genetic Service**

The Manchester University NHS Foundation Trust (MFT) provides a specialist Genetic Service which is an integrated clinical and laboratory genetics services. The aim of the service is to provide a diagnostic, counselling and support to families with a genetic disorder. Professionals can refer families to the service which offers diagnosis and risk estimation for individuals, pregnancies and the extended family. The service also offers management, support and appropriate information for genetic conditions and offers pre-symptomatic diagnosis. The CDOP reviews factors in relation to service provision, whether the family was referred to the service and if the family engaged to access additional support and counselling. There are health requirements regarding awareness raising amongst professionals and the community about the associated health risks. We need to start a conversation about inherited disorders within communities and raise understanding of genetics in the population, by encouraging conversations on inherited disorders and integrate messages on genetics into mainstream health promotion via the Manchester Infant Mortality Strategy.

## **6.7 Housing & Living Conditions**

Across England 16.8% of children (under the age of 16) are from low income families. This figure is much higher for children residing in Manchester with 28.2% of children being from low income families<sup>4</sup>. While it is difficult to ascribe the cause of death directly to housing and living conditions, it is clear that where housing is inadequate for the needs of families, this can contribute to the risk and the vulnerability of children. Issues such as overcrowding living arrangements and damp home conditions affect the health and wellbeing of those residing in the property. In addition, the levels of hygiene and cleanliness in homes may provide indicators about the quality of care for children living there. Modifiable factors in relation to housing arrangements and living conditions were identified in cases categorised as a sudden unexpected, unexplained death and an acute medical or surgical condition. Risk factors identified included

- damp within in the property
- unsafe sleeping arrangements

---

<sup>4</sup> 2015 Public Health England Profile: <https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-overview/data#page/1/gid/1938132992/pat/42/par/R1/ati/102/are/E08000003/iid/10501/age/233/sex/4>

- smoking in the home environment
- overheating (temperature of the home)
- cluttered living space
- homelessness
- multiple moves/residence in a number of properties
- pets and poor personal hygiene

## 6.8 Domestic Violence & Abuse

The recognition of the extent of domestic violence and abuse and its impact on families and children is a key factor to be considered in addressing neglect and abuse in families with a view to preventing child deaths. There was a total of 10 cases where domestic abuse was known and a further 5 where domestic abuse was previously known. Whilst domestic abuse was noted in these cases there was no record that the incident(s) contributed to vulnerability, ill-health or death of the child.

## 6.9 Greater Manchester Rapid Response Team

Since January 2009 there has been an agreed Greater Manchester protocol for the rapid assessment of each sudden and unexpected death of a child (SUDC). A team of Senior Paediatricians provide cover via an on-call rota (24 hours per day, every day of the year) across Greater Manchester, working in close collaboration with partner agencies such as Greater Manchester Police, Greater Manchester Coroners, Health and Children's Social Care. Between 1st April 2017 – 31 March 2018, the Greater Manchester Rapid Response Service received a total of 56 SUDI referrals, 15 (27%) of which were Manchester children. Of the 60 2017/2018 CDOP child death notifications, 15 were reported to the Rapid Response Service for investigation:

- 5 children were under the age of 1
- 7 children were female and 8 male
- 8 children were White British
- 11 children resided in quintile 1 (most deprived)
- 14 cases remain open pending Coronial investigations, Serious Case Reviews (SCRs) and/or criminal proceedings.

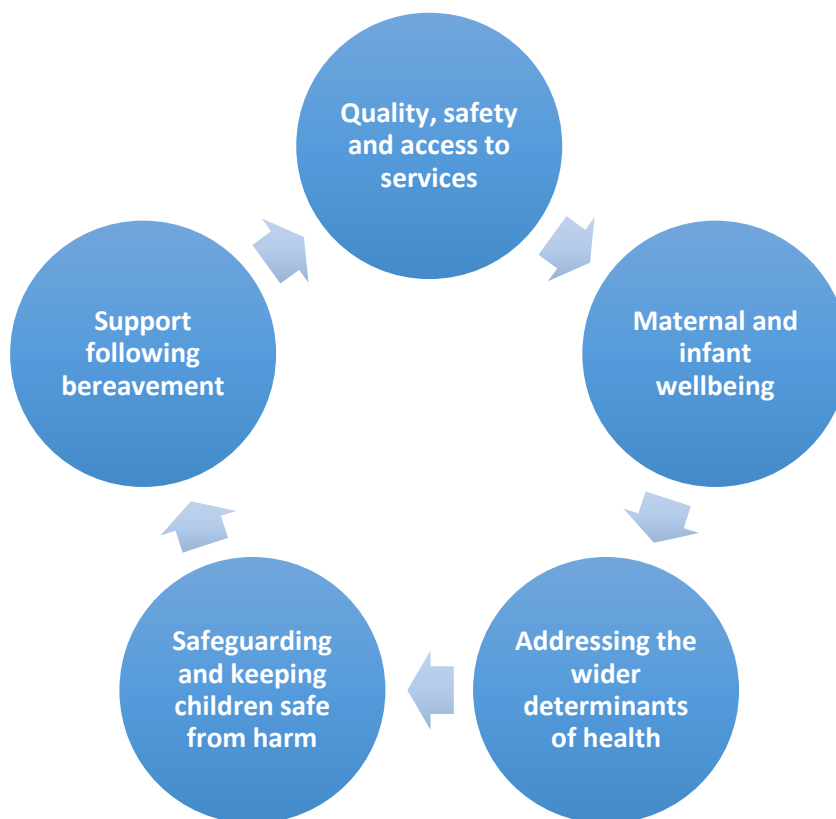
Until the Coroner has ascertained a cause of death the CDOP is unable to confirm if the death was in fact a SUDI. Where the pathological cause of death is either 'sudden infant death syndrome' or 'unascertained', at any age, these deaths are categorised by the CDOP as Sudden unexpected, unexplained death (category 10) excluding Sudden Unexpected Death in Epilepsy (category 5). In line with national data and consistent with findings from previous years, the majority of cases occurred in children under 1 year of age with a peak in children aged between one month and six months of age. There is a second smaller peak in older teenagers who exhibit risk-taking behaviours. The proportion of cases in each age category has stayed relatively constant since 2009.



## 7. 2018/2019 RECOMMENDATIONS TO THE MANCHESTER SAFEGUARDING CHILDREN BOARD (MSCB)

### Recommendation 1: Reducing Infant Mortality Strategy

The Population Health and Wellbeing Team within Manchester Health and Care Commissioning (MHCC) is to lead the development of a collaborative strategy and plan to take action to address infant mortality. Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Reducing infant mortality is a key priority within Manchester's Population Health Plan which will encompass key factors such as:



A steering group is to be established to oversee the development of a new strategy and plans to engage partners in its creation and implementation. The steering group will include partners from services such as Maternity Services, Health Visiting Services, Population Health, Strategic Housing, the CDOP and children's health services commissioning. The CDOP is to support the Population Health and Wellbeing Team in undertaking statistical analysis and highlight the key modifiable factors linked to infant mortality to enable partners to address the wider determinants.

## Recommendation 2: CDOP Messages, Training & Development

As part of the 2016/2017 CDOP Annual Report, the CDOP produced a recommendation for the MSCB to *'develop a training event delivered to frontline practitioners to disseminate emerging themes and CDOP learning. The event will highlight the potential risks to children under the age of one, factors which may contribute to the vulnerability of infants, and will address key intrinsic factors'*.

The CDOP has worked with the Learning and Development Subgroup to progress this recommendation to host the Protecting Vulnerable Babies and Preventing Child Deaths Conference. The event will be held October 2018 to coincide with baby loss awareness week and will include a range of speakers covering subject matters such as sudden and unexpected deaths, abusive head trauma, safe sleeping arrangements and bereavement. The CDOP/MSCB will evaluate the course feedback and consider if the event should be delivered on an annual basis to multi-agency practitioners.

## Recommendation 3: CDOP Newsletter & Communication

The CDOP is to produce a quarterly newsletter containing seasonal safety messages, aimed at parents, carers and members of the public, to raise awareness of the emerging CDOP trends. The newsletter will provide advice and information regarding services available with the aim of preventing future deaths of children and young people. This will be made available (size A4 leaflet format and A3 poster format) for CDOP members to disseminate within their agency and encourage staff to promote the use of the newsletter with service users and display in public waiting areas. The newsletter will also be made available via the Manchester Safeguarding Board website.

Alongside the newsletter, the CDOP is to continue the distribution of The Lullaby Trust Safer Sleep advice, to partners via CDOP members and MSB training events. The CDOP will establish links with the Serious Case Review Subgroup and provide quarterly updates on how work is progressing to reduce duplication and ensure consistency.

## 8. ACKNOWLEDGEMENTS

Thanks are due to everyone who has contributed to this work including those on the review panel, those completing the data returns and those that have advised/contributed to the content of this report.

### **Barry Gillespie**

Consultant in Public Health, Chair of the Manchester CDOP  
Manchester Population Health and Wellbeing Team  
Manchester Health and Care Commissioning

### **Stephanie Davern**

Child Death Overview Panel Co-ordinator  
Manchester Safeguarding Boards

## 9. APPENDICES

### Appendix 1: CDOP Membership

Name	Position	Agency / Department
Barry Gillespie	CDOP Chair, Consultant in Public Health	Manchester Health and Care Commissioning
Allison Jones	HM Senior Coroners Officer and Paediatric Coroners Officer	Manchester City Coroner's Office
Catherine Atkins	Project Officer	Manchester City Council, Strategic Housing
Chris Navin	Specialist Midwife, Rainbow Clinic (Bereavement)	Manchester Foundation Trust, Wythenshawe Hospital
Ethna Dillon	Head of Services / Lead for Early Help & Prevention	MFT Vulnerable Baby Service/Health Visiting South, Safeguarding
Joanna Heath	Designated Nurse Safeguarding Children	Manchester Health and Care Commissioning
Lis Meates	Advanced Nurse Practitioner	Children's Community Palliative Care Team
Lizzy Dierckx	SUDC Lead for Greater Manchester	Manchester Foundation Trust, Rapid Response Team
Louise Burcham	Specialist Midwife, Safeguarding	Manchester Foundation Trust, Wythenshawe Hospital
Maria Slater	General Manager	Child Adolescent Mental Health Services
Maria Strickleton	Safeguarding & Quality Assurance Manager	Manchester City Council, Social Care
Ngozi Edi-Osagie	Consultant Neonatologist	Manchester Foundation Trust
Rebecca Boyce	Detective Chief Inspector	Greater Manchester Police
Ruth Denton	Safeguarding Lead for Early Years	Education
Sarah Doran	Strategic Lead Children and Young People	Manchester Health and Care Commissioning
Suzy Emsden	Consultant	NWTS Intensive Care Paediatric Transport Service
Tina Moors	Postnatal Unit Ward Manager	Manchester Foundation Trust, Wythenshawe Hospital

## Appendix 2: 2017/2018 CDOP Attendance

Agency	June 2017	September 2017	December 2017	March 2018
CDOP Chair, Public Health	✓	✓	✓	✓
Manchester City Coroner's Office	X	✓	X	X
Manchester City Council, Housing	✓	X	✓	✓
Wythenshawe Hospital, Midwifery	X	X	X	X
Vulnerable Baby Service/Health Visiting	X	✓	X	✓
Children's Community Palliative Care Team	-	-	-	✓
Rapid Response Service	✓	✓	✓	✓
Wythenshawe Hospital, Safeguarding Team	X	✓	✓	X
CAMHS	X	X	X	✓
Manchester City Council, Social Care	X	✓	X	X
CCG, Citywide Safeguarding Team	✓	✓	✓	X
Early Years, Education	X	X	✓	✓
Intensive Care Paediatric Transport Service	✓	X	X	✓
Wythenshawe Hospital, Postnatal Unit	X	✓	X	X
Greater Manchester Police	✓	✓	✓	✓

✓ In attendance

X Apologies or did not attend

## Appendix 3: Categorisation of Death

The CDOP categorises the likely/cause of death using the following schema. This classification is hierarchical, where more than one category could reasonably be applied, the highest up the list is marked:

- 1 Deliberately inflicted injury, abuse or neglect**  
This includes suffocation, shaking injury, knifing, shooting, poisoning and 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**  
This includes isolated head injury, other or multiple trauma, burn injury, drowning, and unintentional self-poisoning in pre-school children, anaphylaxis and other extrinsic factors. Excludes deliberately inflicted injury, abuse or neglect. (Category 1).
- 4 Malignancy**  
Solid tumours, leukaemias and 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**  
Trisomy's, 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, 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).

This page is intentionally left blank

**Manchester Health and Wellbeing Board  
Report for Resolution**

**Report to:** Manchester Health and Wellbeing Board – 23 January 2019

**Subject:** Reducing Infant Mortality Strategy

**Report of:** Director of Population Health and Wellbeing

---

### Summary

This report provides information on current trends, patterns and risk factors associated with infant mortality in Manchester. It highlights a concerning picture of infant mortality rates increasing since 2011-13 following a long period of year on year reductions.

The report also presents the final draft for approval, of the five year multi agency strategy to reduce infant mortality and support those affected by baby loss. The strategy contributes to the Manchester Population Health Plan “First 1000 days” priority. The draft strategy was presented to the Manchester Children and Young People Scrutiny Committee on 8 January 2019, which gave its full support to the objectives and actions contained in the strategy

### Recommendations

The Board is asked to:

- Note the report;
- Approve the Strategy.

### 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	Being in good health is essential for our children and young people in enabling them to achieve their full potential in transition to adulthood. A healthy start in life is fundamental to our young people being able to contribute to the city and will improve their life chances. Action to reduce infant mortality will have positive health benefits for families who would have been affected and the wider community.
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	

**Contact Officers:**

Name: David Regan  
Position: Director of Population Health and Wellbeing  
Telephone: 0161 234 5595  
E-mail: d.regan@manchester.gov.uk

Name: Sarah Doran  
Position: Strategic Lead, Children & Young People's Population Health  
Telephone: 0161 234 3742  
E-mail: s.doran@manchester.gov.uk

Name: Christine Raiswell  
Position: Programme Lead, Children & Young People's Population Health  
Telephone: 0161 234 4268  
E-mail: c.raiswell@manchester.gov.uk

**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.

The Population Health Plan can be found at [www.manchester.gov.uk/healthplan](http://www.manchester.gov.uk/healthplan)

Manchester Child Health Overview Panel (CDOP) Annual Report 2017/18  
<https://www.manchestersafeguardingboards.co.uk/wp-content/uploads/2017/07/2017-2018-Manchester-CDOP-Annual-Report-FINAL.pdf>



## 1. Introduction

- 1.1. This report provides information about infant mortality and outlines our proposed strategy to reduce the number of infant deaths in Manchester.
- 1.2. Infant mortality is an indicator of the overall health of a population. It reflects the relationship between the causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Reducing infant mortality is key element of the Manchester Population Health Plan First 1000 Days priority.

## 2. Definitions

- 2.1. Infant mortality is defined as deaths that occur in the first year of a child's life. The infant mortality rate is the number of deaths at ages under 1 per 1,000 live births. Stillbirths are not normally counted as infant deaths and are not included in the calculation of the infant mortality rate. Some of the factors that contribute to a stillbirth may also be contributing factors in infant deaths.
- 2.2. Infant deaths can be divided into three broad stages, each with a different set of risk factors and determinants:
  - Deaths under 7 days of life (perinatal mortality)
  - Deaths to infants aged under 28 days (neonatal mortality)
  - Deaths to infants aged 28 days to 1 year (post-neonatal mortality)

## 3. Data sources and limitations

- 3.1. There are three main sources of data and information on infant deaths in the UK:
  - Vital Statistics i.e. information supplied when infant deaths are certified and registered as part of the civil registration process. This is a legal requirement and the information that is collected is prescribed in the relevant legislation. The data collected through this process is managed by the Office for National Statistics (ONS) and is usually reported based on the local authority within which the deceased was usually resident at the time of death.
  - Child Death Overview Panels (CDOP) collect and review information about each child death in a local area in order to build a picture of emerging themes and patterns and inform local strategic planning on how to best safeguard and reduce harm and promote better outcomes for children in the future. Each CDOP collects data in a common format and also submits information to the Department for Education on an annual basis to inform the national picture.
  - Surveillance reporting systems, notably the Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) system. MBRRACE is part of the national Maternal, Newborn and Infant Clinical

Outcome Review Programme, the aim of which is to provide robust national information about the causes of maternal deaths, stillbirths and infant deaths and support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services across the UK.

- 3.2. The information collected by each of these sources is different. For example, the restrictions on the data collected as part of the deaths registration process means that the ONS dataset contains limited information on key risk factors, such as ethnic group, mother's country of birth, maternal lifestyles and family circumstances. However, data on some of these factors is collected as part of the CDOP process. Used together, the ONS and CDOP data provide a rich and powerful picture of infant deaths in Manchester.
- 3.3. The CDOP Annual Report for Manchester for the period 2017-18 will also be presented to the Health and Wellbeing Board on 23 January 2019 to help set the context for this report and the strategy.

#### 4. Trends and patterns of infant deaths in Manchester

##### 4.1. Infant Mortality rates

Figure 1 shows the infant mortality rate for Manchester is 6.4 per 1,000 compared to 3.9 per 1,000 England 2015-17. Manchester has the fourth worst infant mortality rate in England.

Figure 1: Infant mortality rate for Manchester compared to England 2015-17

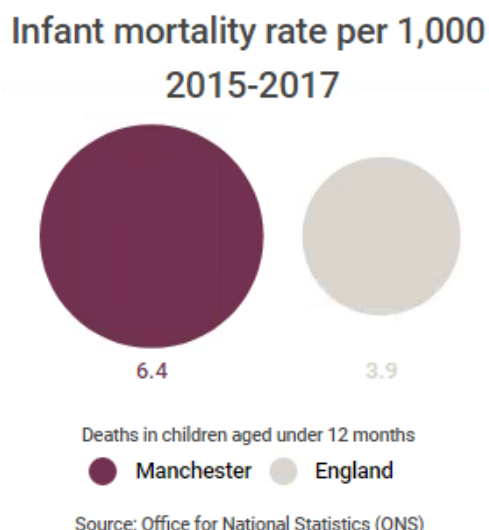
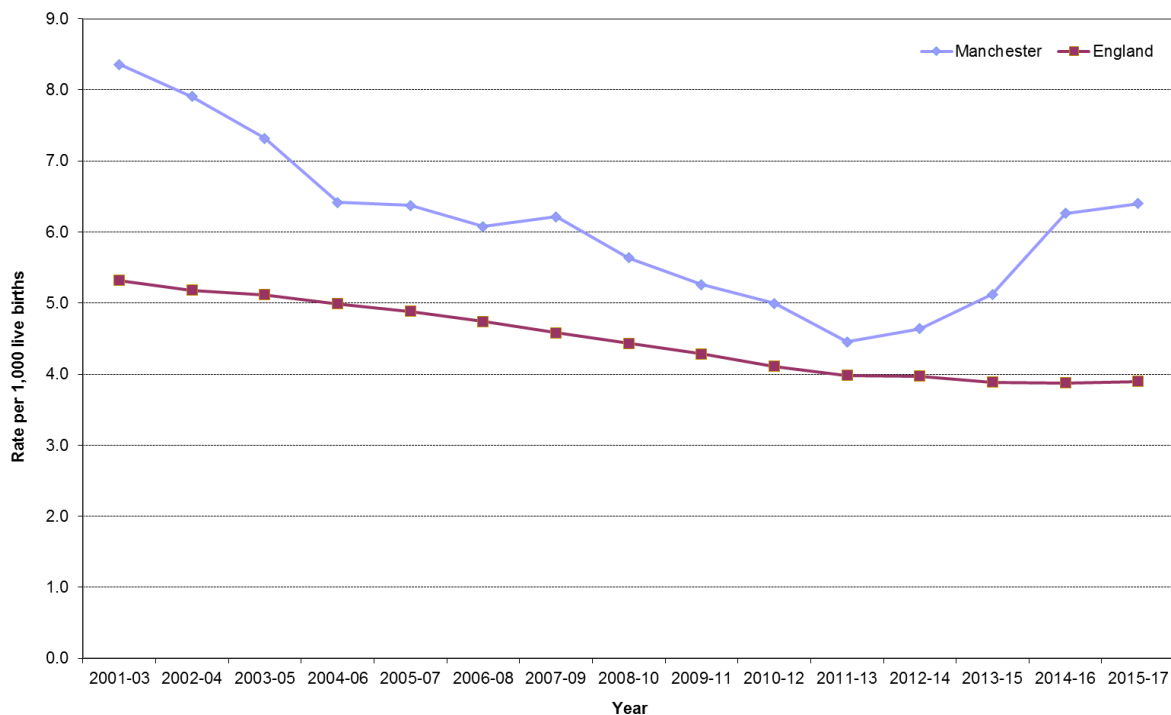


Figure 2: Infant mortality rate 2001-3 to 2015-17 in Manchester and England



- 4.2. The infant mortality rate in Manchester has fallen substantially since the early 1900s. This is due, in part, to general improvements in healthcare combined with specific improvements in midwifery and neonatal intensive care. Between 1999-2001 and 2015-17, the infant mortality rate in Manchester fell from 9.2 per 1,000 live births to 6.4 deaths per 1,000 live births - a 30% fall in the infant mortality rate over this period (see Figure 2).
- 4.3. Although in Manchester the infant mortality rate remains low in historical terms, the data shows that the rate of infant deaths has started to increase again. The number of infant deaths rose from 108 in 2011-13 to 151 in 2015-17 - an increase of 39.8%. In contrast the number of live births over this period has remained relatively stable.
- 4.4. Data from ONS provides a more detailed insight into the recent increase in the number of infant deaths in Manchester (see table 1 below).

Table 1: Number of infant deaths in Manchester 2012-2017 by stage of death

Year	Stage of death		
	Neonatal	Non-neonatal	Total deaths
2012	25	6	31
2013	22	12	34
2014	32	15	47
2015	28	14	42
2016	51	11	62
2017	41	7	48
<b>Total</b>	<b>198</b>	<b>65</b>	<b>263</b>

- 4.5. The table shows that there was an unusually large increase in the number of infant deaths in 2016 compared with 2015, particularly among deaths occurring in the neonatal period (>28 days), and that this reduced in 2017 but remained above the numbers seen in 2015. Overall, around a third (35%) of infant deaths occur very shortly after birth (less than 1 day) with a further 21% occurring within the child's first week of life. The figures indicate that the increase in infant deaths observed leading up to 2016 has now started to reduce.
- 4.6. CDOP discussed and closed a total of 62 child deaths during 2017/18. Of these 40% were neonatal deaths (babies who dies under 28 days of life) and a further 25% died before their first birthday. Of the neonatal deaths 72% were born prematurely (56% were extremely premature <26 weeks) and 76% were born with a low birth weight. Further detail is provided in the CDOP Annual Report.
- 4.7. Infant deaths by residence

In the period from 2013 to 2017, three of the neighbourhoods, based on the previous ward boundaries in Manchester, stand out by virtue of having higher numbers of infant deaths. These are (in order of the number of deaths), Higher Blackley, Harpurhey and Charlestown, Ardwick and Longsight, and Gorton and Levenshulme. In terms of the rate per 1,000 children aged 0 years, the Neighbourhood that stands out as having the highest rate is Ardwick and Longsight and the Neighbourhood with the lowest rate is Fallowfield and Withington.

Table 2: Number, rate and percentage of child deaths in Manchester by neighbourhood

<b>Neighbourhood</b>	<b>Number of deaths 2013-17</b>	<b>% of all deaths</b>	<b>Rate per 1,000 (MYE 2015)</b>
Higher Blackley, Harpurhey and Charlestown	31	13.4%	7.5
Ardwick and Longsight	29	12.5%	11.5
Gorton and Levenshulme	28	12.1%	5.4
Miles Platting, Newton Heath, Moston and City Centre	23	9.9%	7.5
Cheetham and Crumpsall	22	9.5%	5.5
Didsbury, Burnage and Chorlton Park	21	9.1%	5.1
Ancoats, Clayton and Bradford	18	7.8%	6.1

Moss Side, Hulme and Rusholme	17	7.3%	4.3
Wythenshawe	14	6.0%	3.7
Chorlton, Whalley Range and Fallowfield	13	5.6%	4.6
Wythenshawe and Northenden	12	5.2%	5.1
Fallowfield and Withington	<5	2.0%	2.9
<b>Total (rounded to nearest 5)</b>	<b>235</b>	<b>100%</b>	<b>5.8</b>

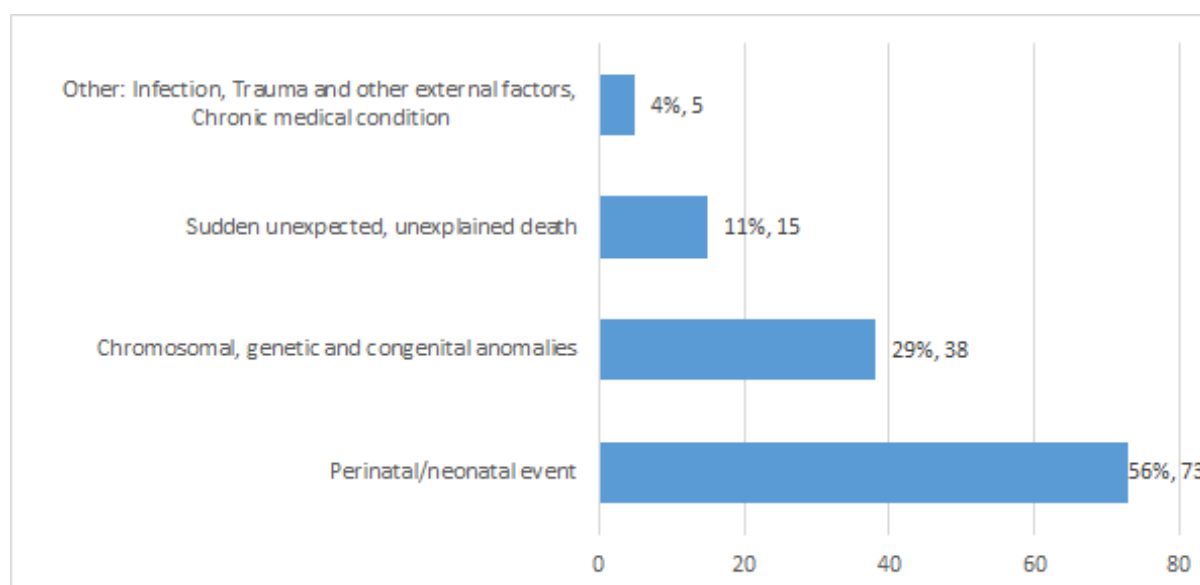
## 5. Causes and underlying factors of infant deaths

5.1. When discussing and closing a case at panel, in line with the Department for Education requirement, the CDOP must categorise the nature of the death and the preventability to:

- evaluate information about the child's death;
- identify lessons to be learnt and gain an understanding of child deaths at a national level.

Of the 131 cases closed between April 2015 and March 2018, the CDOP categorised the deaths as follows:

Figure 3: Categorisation of deaths Manchester CDOP cases closed April 2015 - March 2018



- 5.2. The CDOP categorised just over half (56%) as a perinatal (under 7 days) / neonatal (under 28 days) event. 29% of cases were categorised as chromosomal, genetic and congenital anomalies. For these anomalies deaths are often expected due to the nature of the child's condition, however issues within service provision and whether or not families have accessed genetic counselling can be highlighted as a modifiable factor. For a small number of cases categorised as genetic, chromosomal or congenital parents stated that they were in a consanguineous relationship (1st or 2nd cousins) which increases the risk of inherited autosomal recessive disorders.
- 5.3. For deaths categorised as a perinatal / neonatal event, the majority of deaths are expected although there may be a number of risk factors both antenatally and postnatally which increase the likelihood of an infant death.
- 5.4. CDOP reviews age of mother when considering cases. Table 3 below shows maternal age for all perinatal / neonatal deaths for cases closed between 2015 / 18. There were no deaths of infants to teenage mothers recorded among cases reviewed during this period, although national research indicates infants of teenage mothers are at increased risk. This shows that the additional support offered to teenage parents in Manchester has a protective factor. The largest group were mothers ages 30-34 although this reflects the greatest number of births in this group. The highest rate of infant deaths occurred where mothers were 40+.

Table 3: Maternal age of mother - Manchester CDOP cases closed 2015-2018

<b>Age of mother</b>	<b>No. of infant deaths</b>	<b>% of infant deaths</b>	<b>Births 2015/17</b>	<b>Rate per 1,000 births</b>
Mothers Aged under 20	0	0%	731	0.0
Mothers Aged 20 - 24	15	21%	3,623	4.1
Mothers Aged 25 - 29	15	21%	6,854	2.2
<b>Mothers Aged 30 - 34</b>	<b>25</b>	<b>34%</b>	<b>7,093</b>	3.5
Mothers Aged 35 - 39	10	14%	4,166	2.4
Mothers Aged 40+	8	11%	997	<b>8.0</b>

- 5.5. The ethnicity of the mother or the child are not collected at the time of registering a birth or death and, therefore, it is not possible to produce an ethnic breakdown of infant deaths using the data provided by ONS. However, national data shows that of babies with known gestational age, babies born in the White Other ethnic group (White Irish and any other White background) had the lowest infant mortality rate. In contrast, Pakistani and Black African babies had the highest infant mortality rates.
- 5.6. Ethnicity is collected as part of the CDOP process. Table 4 below shows infant deaths reported to CDOP 2015/2018

Table 4: Ethnic groups - Manchester CDOP cases closed 2015-2018

<b>Ethnic Groups</b>	<b>No. of infant deaths</b>	<b>% of infant deaths</b>	<b>2011 census data (under 5s)</b>	<b>Primary Schools roll data January 2018</b>
White	49	40%	67%	42%
Black/African/Caribbean/Black British	31	25%	9%	17%
Asian or Asian British	30	25%	17%	22%
Mixed/ multiple ethnic groups	12	10%		9%
Other ethnic group	0	0%		
<b>Total</b>	<b>122</b>	<b>100%</b>		

- 5.7. These deaths have been considered alongside census data and primary school roll data. This suggests that deaths amongst Black/African/Caribbean/Black British and Asian or Asian British ethnic groups were more likely to die under the age of 1 compared with what might be expected, in line with ethnic distribution of the Manchester child population.
- 5.8. In part, this can be linked to the fact that the prevalence of some lifestyle factors known to increase the risk of infant mortality are higher in certain ethnic groups. For example, the prevalence of obesity is known to be higher among

women of Black Caribbean, Black African and Pakistani origin compared with other ethnic groups. It may also be the case that BME women are accessing maternity services less frequently (and later in their pregnancy) due to previous experiences and uncertain awareness of important prenatal testing.

- 5.9. Infant deaths are linked to deprivation. For cases closed at CDOP during 2017/18, 78% occurred where residence was in the most deprived quintile. A similar pattern has been seen over a number of years.
- 5.10. A number of the perinatal/neonatal deaths reviewed by the CDOP were recorded as being multiple pregnancies (i.e. twins or triplets). Some of the multiple pregnancies also resulted in miscarriages and stillbirths.
- 5.11. The CDOP also noted that in some cases the mother had sought IVF treatment, a number of whom had travelled abroad for treatment. Issues were highlighted by the CDOP regarding 3 or more eggs being implanted, putting both the mother and baby at increased risk of complications during pregnancy and childbirth and having a lower birth weight.
- 5.12. Maternal obesity during pregnancy can lead to increased health risks for mother and baby. For perinatal / neonatal cases closed by CDOP 2015-18, 34% of mothers had a Body Mass Index (BMI) of 30+ at time of booking (obese, morbidly obese) a further 37% (27) of mothers were overweight (BMI between 25 - 29.9). Maternal obesity more prevalent in mothers aged 30+
- 5.13. Smoking in pregnancy is the single biggest risk factor for infant mortality. Of the 41 infant deaths closed by CDOP in 2017/18, 20% of mothers stated that they smoked during pregnancy. A further 7% stated that they did not smoke in pregnancy but smoked postnatally.
- 5.14. As well as risk factors there are a number of protective factors against infant deaths. These include vaccinations (including flu vaccination for pregnant women), breastfeeding and safe sleeping practices (putting babies to sleep on their backs in a separate cot or moses basket in the same room as parents)<sup>1</sup>

## 6. **Modifiable factors**

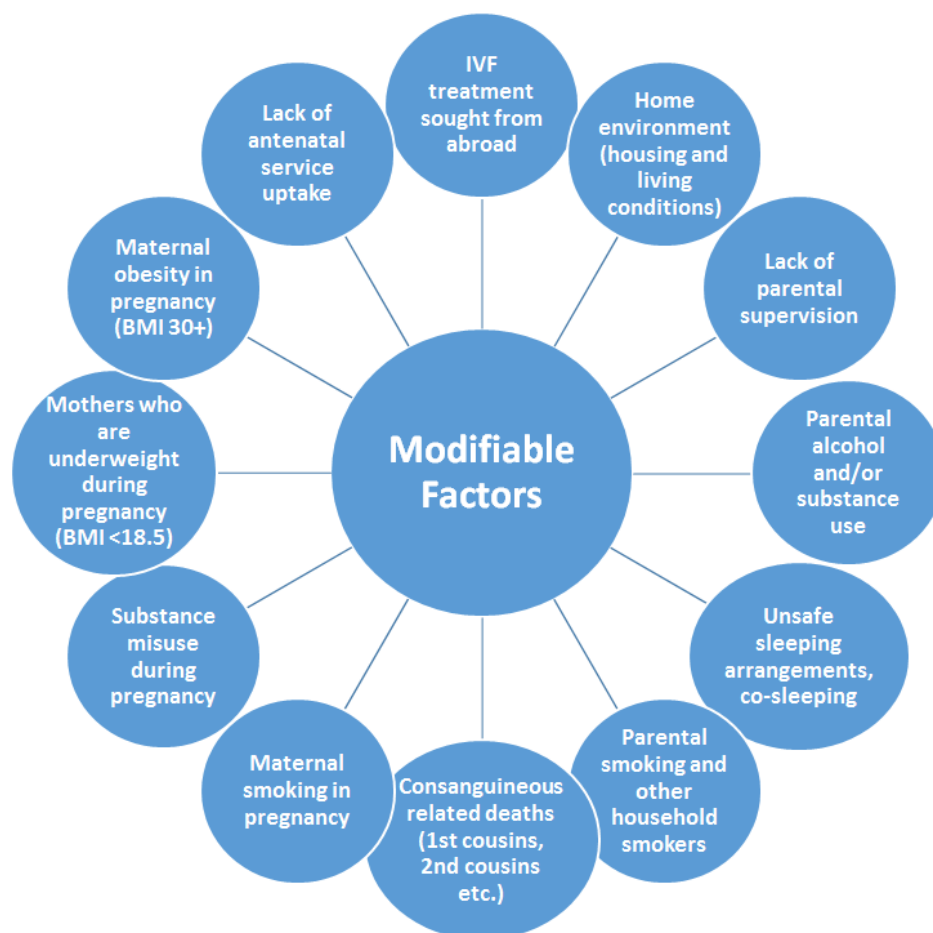
- 6.1. Figure 4 below summarises the range of modifiable / risk factors identified in infant deaths in Manchester. All of these factors can either increase the risk of prematurity, or that the infant will not be born in the best possible condition or make sudden infant death syndrome more likely. It is identified that modifiable factors occur in around one third of infant deaths. Modifiable factors act as a multiplier effect, where there are two or more factors present, the vulnerability of the child increases.

---

<sup>1</sup> <https://www.lullabytrust.org.uk/safer-sleep-advice/>



Figure 4: Modifiable risks factors identified in infant deaths in Manchester



## 7. About the strategy for reducing infant mortality

- 7.1. In order to try to reverse the trends in infant mortality rates in Manchester and ensure that those who experience baby loss get the support they need, a multi-agency strategy has been drafted and is attached as Annex 1. The work to develop the strategy has been led by the Population Health and Wellbeing Team with a steering group who will oversee the implementation of the strategy. The steering group includes key partners with a role to play in the delivery of the strategy and influencing others including maternity services, health visiting services, strategic housing, early help, early years, CDOP, safeguarding and the VCSE
- 7.2. The development of the strategy has included the following elements to ensure it reflects local and national evidence and the experiences of professionals and families:
- Analysis of trends, data and research relating to infant mortality locally and nationally including CDOP annual reports, North West Sector Led Improvement Project on Infant Mortality 2016, Maternity Experiences in North Manchester Research.

- Establishment of a steering group to oversee the writing of the strategy and support its implementation in the coming months and years.
- Two multi agency workshops to engage a wider range of partners and gather ideas and expertise
- Specialist meetings on key issues including genetics and bereavement support
- Consultation with delegates attending the Manchester Preventing Infant Deaths Conference in October 2018

7.3. There is already a strong network of organisations and programmes in the city focused on supporting healthy pregnancy and the first years of a baby's life. The approach of the strategy will be to embed priorities in the provision of quality services. It will also support current and developing work programmes and to test and implement new approaches to improving the health and wellbeing of mothers and infants.

7.4. Our Reducing Infant Mortality Strategy will span five years from 2019 to 2024 to allow time for longer term outcomes to be realised. Reducing infant mortality is a complex picture of interrelated factors including the wider determinants of health. Whilst we have described and simplified the strategy under themes and objectives, it is recognised that this belies the complicated system wide nature of this important priority.

## **8. Next steps**

- 8.1. Following approval, the strategy will be published and launched in early March and disseminated to key boards and groups.
- 8.2. A partnership steering group comprising of partners who developed the strategy will oversee the delivery and provide regular updates to Children and Young People Scrutiny Committee, MSCB, the Children's Board and Health and Wellbeing Board.

## **9. Conclusion and recommendations**

- 9.1 The City Council and partners represented on the Health and Wellbeing Board are extremely concerned by the recent rise in infant mortality. The Strategy is a clear indication of our collective commitment to ensure that we reverse the recent rise in infant mortality and by co-ordinating efforts across the city we are confident that we can start to see a downward trend once again.
- 9.3 The Board is asked to:
- Note the report;
  - Approve the Strategy.

## Manchester Reducing Infant Mortality Strategy (Final Draft)

### 1. Introduction

#### 1.1 Our aim

We want to reduce the rates of infant mortality in Manchester, improve the physical and mental health and wellbeing of pregnant women and babies and provide compassionate support to families who are bereaved following the loss of a baby.

#### 1.2 Our approach

In order to have the greatest impact we have identified ten principles which will underpin our priorities and programmes and the way we deliver services.

##### 1) Providing system wide leadership and coordination

Chaired by the Population Health and Wellbeing Team, the 'Reducing Infant Mortality Steering Group' will oversee the delivery of the strategy, regularly report progress to Children's Board, Children's Safeguarding Board and Health and Wellbeing Board and act as champions for this agenda across services and networks in the city. System wide leadership will come through key partners in the city who are in a position to support maternal and infant health and wellbeing. Reducing infant mortality is everyone's business and partners will consider how different settings and services can contribute and develop their own delivery plans.

##### 2) Commissioning services to support infant mortality strategy

We will ensure that the commissioning of existing and future services supports our reducing infant mortality strategy.

##### 3) Providing high quality and safe services

Providing high quality and safe services is crucial to reducing infant mortality. This applies not just to maternity and specialist services such as Neonatal Units but to other services that support the health and wellbeing of pregnant women, mothers and infants such as Stop Smoking Services, Perinatal Mental Health Services, and Weight Management Services.

##### 4) Raising awareness and knowledge of mums / partners / family about issues impacting on maternal and infant health and wellbeing.

Increasing health and wellbeing knowledge and literacy about keeping mothers and babies healthy and safe is a core feature cutting across the priority themes of our strategy. We will look for opportunities to educate families through resources, campaigns, training and strengths-based conversations.

5) Ensuring the wider workforce is equipped and knowledgeable

We will ensure that training / education needs relating to reducing infant mortality are reflected in workforce development plans and that key messages are developed and disseminated.

6) Targeting the most vulnerable and at risk to reduce health inequalities

As well as working universally we will target those most vulnerable to the risk factors. For example, people in poor quality or unsuitable accommodation, refugees and asylum seekers or with no recourse to public funds, teenage parents and other communities.

7) Working at a neighbourhood level to tailor programmes of work to the needs of the population and supporting local assets

We will work at neighbourhood level to ensure that approaches are co-produced with communities and reflect local needs and concerns and draw on local assets.

8) Thinking 'family' in everything we do

Rather than just focusing on mothers, we will 'Think Family' in our services and approaches and ensure that messages are targeted to wider family - fathers, partners, older siblings and grandparents. Evidence has shown that issues relating to safe sleeping, accidental injuries, abusive head trauma, smoking can occur where infants are in the care of those other than mums.

9) Safeguarding children and keeping them safe from harm

Good safeguarding practices should underpin all work with families and children and will contribute to efforts to reduce infant mortality.

10) Learning and evaluation - from Serious Case Reviews (SCRs), CDOP and national data.

We will ensure that of focus and priorities are informed in a dynamic way by learning from national and local research, CDOP and serious case reviews. We will evaluate the effectiveness of our approach and monitor performance.

## **2.0 Priority themes, objectives and actions**

- 2.1 We have set out actions to reduce infant mortality, improve maternal and infant health and support those bereaved under five priority themes. We recognise the complexity and interrelatedness of work required and we will co-ordinate activities across all the key objectives.

1. Quality, safety and access to services	
OBJECTIVES	ACTIONS
Increase engagement with antenatal services and promote the benefits of antenatal care	<ul style="list-style-type: none"> <li>● Increase awareness of the benefits of antenatal care starting from preconception, for example through open days and roadshows in Children's Centres ('under one roof')</li> <li>● Increase early booking and attendance into antenatal care, for example researching new ways of booking sessions - including use of IT</li> <li>● Find out where and how antenatal health education is delivered, identify gaps and develop a targeted approach</li> <li>● Maximise opportunities to deliver key communications when antenatal services are delivered, such as providing information on flu vaccinations.</li> <li>● Ensure appropriate assessment of mother and child where there is a concealed / denied pregnancy to ensure any additional needs are identified</li> <li>● Explore the feasibility of a 'Pregnancy Circle' pilot in different neighbourhoods linked to GP practices - local antenatal groups that include health care, education, peer support and building social networks.</li> </ul>
Appropriate assessment and referral during pregnancy and support during birth	<ul style="list-style-type: none"> <li>● Investigate feasibility of implementing the Saving Babies Lives Care Bundle across all hospitals</li> <li>● Ensure National Institute of Clinical and Health Excellence (NICE) guidelines and Greater Manchester (GM) maternity spec are implemented</li> <li>● Consider the contribution of specialist midwives to ensure the most vulnerable get continuity of care e.g. refugees and asylum seekers, women with no recourse to public funds.</li> <li>● Ensure transient and traveller population receive consistency of care and don't miss out on important messages such as safe sleeping for example through Early Help Assessment. This will include providing information in different languages.</li> <li>● Ensure swift and appropriate referral to weight management, stop smoking services and genetics services</li> </ul>
Improving take up of flu vaccinations for pregnant women	<ul style="list-style-type: none"> <li>● Ensure more health professionals in contact with pregnant women are able to promote the importance of and administer flu vaccinations.</li> </ul>

Genetic counselling / genetic literacy for individuals and communities with a need	<ul style="list-style-type: none"> <li>• Swift referral and clear pathways for genetic counselling where family history is identified</li> <li>• Training for midwives and obstetricians to improve knowledge of genetics and consanguinity</li> <li>• Pilot a place based community focused genetic literacy project</li> <li>• Explore how genetic literacy can be taught in schools</li> </ul>
Improving access to IVF and Raising awareness about IVF treatment outside UK	<ul style="list-style-type: none"> <li>• We will work with the Human Fertilisation and Embryology Authority to develop and disseminate key messages about risks of IVF abroad to the public. We will also communicate to health care professionals working with women looking into IVF to ensure that women have an informed choice</li> <li>• We will find out more about the experiences of women who have sought IVF treatment abroad</li> </ul>
<b>2. Maternal and infant wellbeing</b>	
<b>OBJECTIVES</b>	<b>ACTIONS</b>
Supporting women to stop smoking and promote 'smoke free homes'	<ul style="list-style-type: none"> <li>• We will implement the Baby Clear programme across Manchester to support smoke free pregnancies</li> <li>• We will actively promote stop smoking services to women and their families.</li> <li>• We will support staff to have conversations about smoke free homes with clear, constructive and supportive messages and communications</li> </ul>
Supporting maternal mental health and wellbeing	<ul style="list-style-type: none"> <li>• We will build on the success of services offered in south and central parts of Manchester and increase access to specialist perinatal mental health support</li> <li>• We will investigate ways to reduce social isolation in new mums and dads / partners</li> <li>• We will embed the "Manchester University Hospitals NHS Trust (MFT) Health Visiting Service Perinatal and Infant mental health Pathway" with leadership from specialist Health Visitor.</li> </ul>
Reducing maternal obesity and improving nutrition	<ul style="list-style-type: none"> <li>• We will take a fresh look at maternal obesity through a dedicated task group focusing on prevention and earlier intervention</li> <li>• We will raise awareness of the importance of healthy weight for a healthy pregnancy</li> <li>• We will ensure that maternal obesity is treated as a priority and that referrals to appropriate services take place as early as possible, at family planning and</li> </ul>

	<p>booking stages, for example. This will involve training more health professionals to confidently identify, provide consistent advice and refer where required.</p>
Encouraging and supporting breastfeeding	<ul style="list-style-type: none"> <li>• We will build on the strength of the successful breast pump loan scheme and expand across the city</li> <li>• We will take a collaborative approach to breastfeeding and nutrition, ensuring the benefits of breastfeeding and maternal Body Mass Index (BMI) are understood.</li> <li>• We will ensure that conversations about infant feeding decisions take place as early as possible with consistent advice provided by all health professionals to ensure women are able to make an informed choice.</li> <li>• We will explore options for increasing the provision of peer support.</li> </ul>
Alcohol and substance misuse support in pregnancy and postnatally	<ul style="list-style-type: none"> <li>• We will ensure that available alcohol and substance misuse services are communicated more effectively to health professionals and other relevant agencies to help improve referral pathways.</li> <li>• We will ensure that health professionals are vigilant to safeguarding risks associated with drug and alcohol use</li> </ul>
3. Addressing the wider determinants of health	
OBJECTIVES	ACTIONS
Support efforts to reduce and mitigate against poverty (the most important determinant of a child's health)	<ul style="list-style-type: none"> <li>• We will make sure that services and organisations that can help people are properly promoted.</li> <li>• We will continue to highlight the links between deprivation and infant mortality</li> <li>• We will produce guidelines on what the basics are that a new baby needs and work with charities and community organisations to ensure the most vulnerable are able to access them.</li> </ul>
Housing - focus on the private rented sector to ensure housing is safe and warm and meets basic standards for mother and baby	<ul style="list-style-type: none"> <li>• We will work with housing sector bodies to influence provision - particularly in the private rented sector.</li> <li>• We will devise a set of minimum housing standards for a mother and baby (covering safe sleeping, safe appliances, warm and dry etc.)</li> <li>• We will ensure everyone working with families has up to date knowledge about housing options and feasible actions</li> </ul>
Identifying and	<ul style="list-style-type: none"> <li>• All professionals working with a family to consider</li> </ul>

addressing inappropriate environments	<p>housing conditions including overcrowding during assessments</p> <ul style="list-style-type: none"> <li>● We will work with partners, such as GPs and Early Help team, to help identify families who may be living in overcrowded or unsuitable homes.</li> <li>● We will ensure that agencies working with families understand the mental health impacts associated with moving (and the lack of choice that can occur) and living in temporary accommodation.</li> </ul>
Working with Homeless Families Services to support vulnerable mothers and infants	<ul style="list-style-type: none"> <li>● We will agree a set of standards required for safe temporary accommodation and support their implementation</li> <li>● We will ensure families have the basics for safe sleeping and breastfeeding in temporary accommodation.</li> </ul>
4. Safeguarding and keeping children safe from harm	
OBJECTIVES	ACTIONS
Continuing to educate on safe sleeping and supporting those most vulnerable with additional help	<ul style="list-style-type: none"> <li>● We will continue to work with partners to educate and promote clear messages and consistent messages on safe sleeping. This will include visuals and leaflets to aid required training.</li> <li>● We will instigate targeted work with vulnerable families at risk from alcohol and drug use.</li> <li>● We will produce specific guidance for families in temporary accommodation to ensure safe sleeping standards are met for the most vulnerable.</li> <li>● We will target messages to the wider family, not just parents, as incidents often happen when babies are away from home</li> </ul>
Helping parents to keep a safe home environment	<ul style="list-style-type: none"> <li>● We will work with families in poor living conditions to support them to make improvements recognising issues that may impact on this such as poverty, mental health problems, drug and alcohol use</li> </ul>
Preventing unintentional injuries (e.g. scolds and falls)	<ul style="list-style-type: none"> <li>● Improve the flow of information between Accident &amp; Emergency and Health Visitors following an accident</li> <li>● We will work with partners who enter people's home to increase awareness of potential accidents and raise awareness amongst families as a means of their prevention.</li> <li>● We will work with partners to understand and share amongst agencies potential patterns of injuries.</li> </ul>



	<ul style="list-style-type: none"> <li>We will support the development and delivery of the emerging Child Accident Prevention strategy for Manchester.</li> </ul>
Reducing the damage of abusive head trauma	<ul style="list-style-type: none"> <li>Implement the 'ICON' Programme to reduce abusive head trauma across the city (see description below).</li> </ul>
Supporting pregnant women / mums experiencing domestic abuse	<ul style="list-style-type: none"> <li>Continued support for specialist maternity Independent Domestic Violence Adviser (IDVA) services to support pregnant women experiencing domestic abuse</li> <li>We will ensure that investigating potential signs of domestic abuse forms part of health care assessments as standard</li> <li>We will strengthen links to organisations who provide essential basic items for babies and children to women in need</li> </ul>
5. Providing support to those bereaved and affected by baby loss	
<b>OBJECTIVES</b>	<b>ACTIONS</b>
A system-wide approach to making things as easy as possible for bereaved families	<ul style="list-style-type: none"> <li>We will train more staff across our partnership in bereavement care and support.</li> <li>We will work with partners, such as death registrations, to ensure support is provided to those in need.</li> <li>We will ensure staff are equipped provide support during antenatal period to help reduce anxiety for those who have previously lost children.</li> <li>We will offer support to extended family and siblings.</li> <li>We will work with local groups so that bereavement support can continue in the community.</li> <li>We will promote Baby Loss Awareness week during October every year.</li> </ul>
Increase knowledge about bereavement services to improve signposting	<ul style="list-style-type: none"> <li>We will build on the positive work from partners in Manchester and will work together to compile a directory of services to which agencies across the city can signpost.</li> </ul>
Strengthening pathways to ensure people who have had a loss get enhanced support for the next	<ul style="list-style-type: none"> <li>We will work with families to improve the way that information is shared between services.</li> </ul>

pregnancy	
Increasing the skills and confidence of wider workforce to talk about bereavement	<ul style="list-style-type: none"> <li>• We will disseminate a training and awareness resource available to organisations and businesses across the city to improve understanding, support and signposting outside of clinical settings.</li> </ul>
Minimum standards of care for bereavement support	<ul style="list-style-type: none"> <li>• We will strengthen the work already taking place across the city and work with partners to develop standards for use across agencies</li> <li>• Work with employers to develop guidance on supporting employees following baby loss</li> </ul>

### 3.0 Where are we now?

3.1 As already described, the prevention of infant mortality is delivered through key statutory health and social care services e.g. Maternity Services, Neonatal Units, Health Visiting, Children's Social Care as well as wider public and voluntary services and society as a whole. There are also a number of established and emerging programmes/services directly supporting this strategy – four are highlighted below.

#### 1) Vulnerable Babies Service (see case study, Appendix 1)

This service, provided by MFT was established in 2004 to address rising numbers of sudden infant deaths. It provides targeted case planning to meet the needs of individual families, involving them in their package of support. The service works with and takes referrals from all professionals and volunteers who work with parents and babies. It facilitates a multi-agency approach so that families do not have to keep repeating their story and to improve communication between professionals.

The criteria for referrals are:

- Substance misuse which raises concerns around safe and consistent parenting and/or has the potential to place the baby at risk
- A previous unexplained death of a child in the family
- A violent criminal history against a child, partner or animals
- Parents who have experienced a difficult childhood
- Late booking for antenatal care (no proof of care before 22 weeks gestation) plus movement in to Manchester or poor engagement with antenatal care
- A previous child not living with a parent
- Homelessness/transient lifestyle/inappropriate housing **plus** any one of the following: mental illness, domestic abuse, drug/substance user (including alcohol), contact with the probation service or criminal justice team (including drug treatment and testing orders), hearing impaired.

- Other Additional Needs that may impact upon ability to parent

## **2) Midwifery Domestic Abuse Support (MiDASS) / Pathway: Specialist IDVA support based in maternity services**

In recognition of the increased risk of domestic abuse during pregnancy (30% starts in pregnancy and existing abuse may get worse), a specialist Independent Domestic Violence Adviser (IDVA) service is located in Maternity Services of the three Manchester hospitals (St Mary's, Wythenshawe, North Manchester General Hospital). The service offers training and advice to midwives and provides individual support to women experiencing violence.

## **3) Baby Clear Programme**

Baby Clear is a key part of the Greater Manchester Strategy to make smoking history. The programme is being implemented across GM in three phases:

- Cluster one: Rochdale, Bury, Oldham and North Manchester (Pennine) (in delivery phase)
- Cluster two: Bolton, Salford
- Cluster three: Tameside, Manchester (MFT) and Trafford (target start date for MFT by March 2019)

The overall aim of the programme is to reach a target of no more than 6% of women smoking at delivery in any locality by 2021 *and ultimately for no woman to smoke during her pregnancy*. Key programme elements are Carbon Monoxide (CO) monitoring of all pregnant women at booking (all midwives specially trained), referral to specialist stop smoking support within 24 hours for ongoing support to quit and risk perception interview for those who have not quit at the first scan.

## **4) ICON Programme**

ICON is a new programme based on research of programmes in Canada and North America to address the damage of abusive head trauma through a simple four point message delivered by health professionals through strength based conversations to parents.

**I**= Infant Crying is normal and it will stop

**C**= Comfort methods can sometime soothe the baby and the crying will stop

**O**= it's OK to walk away if you have checked the baby is safe and the crying will stop

**N**= Never ever shake or hurt a baby.

The programme has been piloted in South Manchester and dependant on endorsement by the Manchester Safeguarding Children Board (MSCB) in January will be expanded to all babies in Manchester.

This page is intentionally left blank

## **Case Study of pregnant mother with complex needs and indicators of risk for infant mortality**

Mary completed an Early Help Assessment (EHA) with the midwife at her booking appointment. She had a 5 year old boy who has significant behaviour problems, some health issues and poor school attendance at previous school. Mary had recently ended a relationship with a violent partner who had been prosecuted and a Multi-Agency Risk Assessment Conference (MARAC) assessment been carried out.

Mary had completed a 14 week course with the Child and Parents Service (CAPS) on parenting. Mary had recently been rehoused to a new area where she did not know anyone or have any local support. Mary had recently been diagnosed with bipolar disorder and started medication. Mary had a BMI of 29 at booking and was trying to cut down on smoking.

Mary was happy for organisations to have joint meetings together managed by Specialist Baby Case Planning. The EHA was forwarded to Vulnerable Baby Service in order to assess, plan, deliver and review the actions from plans put in place for the family. Meetings were arranged at the 5 year old's new school. 3 meetings were held involving Mary, Health Visitor, Psychology, Housing Trust, Midwife, Early Help and teaching staff. With the extensive support available Mary was able to fully engage in all appointments and therapeutic relationships provided, which led to positive outcomes for her and her children.

Mary benefitted from the medication for her mental health condition and worked effectively with the agencies who monitor and support this. Mary's weight was maintained and she had an elective caesarean section to deliver a healthy baby girl. Mary cut down on smoking and is working towards stopping with a re-referral into support.

Mary's 5 year old has 94.1% school attendance. Mary is continuing to work on having a responsive relationship with school and using an email address to keep up to date. Her son is making some small steps in progress and bespoke interventions continue, for improvements in behaviour. His oral health is being addressed and appointments for his eyes and management of glasses with school is done in partnership. He has been discharged from hospital for asthma which is now controlled. His father has not asked for contact with him.

Mary's baby daughter is thriving and mum has bonded well with her. They have ongoing support from the health visiting service. Mary's risk of abuse is significantly reduced and the perpetrator does not know where she is living. Mary is aware of actions she must take if she perceives any threat in the future. The housing situation is good and the family have settled well in the new area.

Mary is very happy with the progress she has made and the support she has received to achieve this. Universal services will continue to be available to the family and work with her to maintain her success and develop further opportunities for them in the future.

This page is intentionally left blank

**Manchester Health and Wellbeing Board  
Report for Resolution**

**Report to:** Manchester Health and Wellbeing Board – 23 January 2019

**Subject:** Operational Local Health Economy Outbreak Plan - Manchester

**Report of:** David Regan, Director of Population Health and Wellbeing

---

**Summary**

The Greater Manchester Multi-Agency Outbreak Plan sets out the response arrangements of emergency responders to an outbreak of infectious disease within Greater Manchester that requires multi agency coordination. The plan is owned by the Greater Manchester Resilience Development Group on behalf of the Greater Manchester Resilience Forum and is authorised by the Greater Manchester Resilience Forum and the Local Health Resilience Partnership.

In addition to the Greater Manchester Multi-Agency Outbreak Plan, each local health and care economy has been asked to produce a local Operational Outbreak Plan to clarify local arrangements in the event of outbreak situations.

Our Operational Local Health Economy Outbreak Plan for Manchester has been developed in partnership with all organisations who may be involved in the event of an outbreak and has been tested and validated through real outbreak scenarios that we have dealt with in the past 12 months.

**Recommendation**

The Board is asked to approve the Operational Local Health Economy Outbreak Plan for Manchester.

---

**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 Outbreak Plan ensures that Manchester has the appropriate response arrangements to any outbreak of infectious diseases which will mitigate against health related harms across the life course
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	
-----------	--

**Contact Officers:**

Name: Sarah Doran  
Position: Strategic Lead, Population Health and Wellbeing, Manchester Health and Care Commissioning (MHCC)  
Telephone: 0161 234 3742  
E-mail: s.doran@manchester.gov.uk

Name: Leasa Benson  
Position: Clinic Lead Health Protection - Community Infection Control Team, MHCC  
Telephone: 0161 234 1724  
E-mail: l.benson@manchester.gov.uk

**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 Greater Manchester Multi-Agency Outbreak Plan sets out the response arrangements of emergency responders to an outbreak of infectious disease within Greater Manchester that requires multi agency coordination. The plan is owned by the Greater Manchester Resilience Development Group on behalf of the Greater Manchester Resilience Forum and is authorised by the Greater Manchester Resilience Forum and the Local Health Resilience Partnership.
- 1.2 In addition to the Greater Manchester Multi-Agency Outbreak Plan, each local health and care economy has been asked to produce a local Operational Outbreak Plan to clarify local arrangements in the event of outbreak situations.

## **2. Background**

- 2.1 In July 2017, the Greater Manchester Resilience Forum and Local Health Resilience Partnership approved the updated Greater Manchester Multi-Agency Outbreak Plan, including appendices on Legionella and HCID (High Consequence Infectious Diseases). The plan sets out the strategic principles for outbreak management in Greater Manchester, including the roles and responsibilities of key organisations.
- 2.2 The AGMA Civil Contingencies Resilience Unit facilitated a multi-agency group in creating a complimentary Operational Local Health and Care Economy Outbreak Plan Template. This operational tool was designed to assist with diagnostics and planning in relation to local outbreak management.
- 2.3 Building on audit of Local Health Protection Arrangements Questionnaire, all Greater Manchester Health and Wellbeing Boards were recommended to ensure local completion of the outbreak plan template. This would ensure clear agreement and documentation of local plans and systems in response to commonly occurring outbreaks, for example, influenza outbreaks in a care home setting.

## **3. Operational Local Health Economy Outbreak Plan for Manchester**

- 3.1 In line with the Local Health Resilience Partnership recommendation, a true multi-agency document that reflects resilient local arrangements to support robust local outbreak response has been developed. The Operational Local Health Economy Outbreak Plan for Manchester includes input from the following:
  - Director of Public Health for Manchester, Manchester Health and Care Commissioning
  - Health Economy Resilience Group (HERG) chairs & members
  - Community Infection Control Team, Manchester Health and Care Commissioning
  - Environmental Health Department, Manchester City Council
  - TB Team, Manchester University NHS Foundation Trust
  - Manchester Local Care Organisation

- NHS Manchester Clinical Commissioning Group (MHCC)
- Greater Manchester Health Protection Team, Public Health England

With support from:

- Health Protection Confederation representatives
- AGMA Civil Contingencies Resilience Unit (CCRU)

- 3.2 The Operational Local Health Economy Outbreak Plan for Manchester has been developed in partnership with all organisations who may be involved in the event of an outbreak and has been tested and validated through real outbreak scenarios that we have dealt with in the past 12 months.
- 3.3 The Manchester plan was approved at the Health Economy Resilience Group (HERG) on 29th November 2018. All local health economies have been asked by the AGMA CCRU to ensure that the Plan secures final approval from the local Health and Wellbeing Board.



# Operational Local Health Economy Outbreak Plan

**Manchester**  
**January 2019**

Final Draft

**Foreword:**

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

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

**Signed (after Health and Wellbeing Board approval)**

.....  
[Local DPH]

## Contents

<b>PART 1: AIM, OBJECTIVES and scope OF THE PLAN</b> .....	<b>5</b>
1.1 Aim of the Plan .....	5
1.2 Objectives of the Plan .....	5
1.3 Primary Objectives .....	5
1.4 Secondary Objectives .....	5
1.5 Command & Control .....	6
1.6 Declaration of an outbreak .....	6
1.7 Investigation and Control of Outbreaks .....	7
1.7 Communications .....	7
1.8 End of the Outbreak .....	8
1.9.1 Scope / Context of the Plan .....	8
1.9.2 Complementary Guidance and Documentation .....	8
1.9.3 National Guidance .....	8
1.9.4 Greater Manchester Guidance .....	8
<b>PART 2: KEY ASPECTS OF OUTBREAK MANAGEMENT</b> .....	<b>10</b>
2.1 Detection and Coordination .....	10
2.2 Investigations Roles and Responsibilities .....	11
2.3 Control Measures .....	13
2.4 Communications - Roles and Responsibilities .....	14
2.5 Funding Arrangements .....	15
<b>PART 3: LOCAL OPERATIONAL ARRANGEMENTS FOR SPECIFIC TYPES OF OUTBREAKS REQUIRING AN OCT</b> .....	<b>16</b>
3a. Arrangements for an outbreak of Influenza like illness (ILI) in a care home .....	17
3b. Arrangements for investigating complex TB incidents .....	18
3c. Arrangements for investigating and controlling blood-borne viruses (BBV) .....	19
3d. Case/s meningococcal disease in a nursery, school or college .....	20
3e. Hepatitis A outbreak /cases in a school or childcare setting .....	21
3f. Investigating outbreaks in a hard to reach population (e.g. measles at a traveller's site/Hep A in Homeless/NFA) .....	23
<b>PART 4: LOCAL OPERATIONAL ARRANGEMENTS FOR SPECIFIC TYPES OF OUTBREAKS NOT REQUIRING AN OCT</b> .....	<b>25</b>
4a. Outbreak situations NOT requiring an OCT .....	26
<b>Appendices 1: Stocks of Laboratory Testing Kits, Medication, and Other Equipment</b> .....	<b>30</b>

**Appendices 2: Potential Outbreak Settings or Sources..... 31**  
**Appendices 3: Common Pathogens ..... 32**  
**Appendices 4: Common Outbreak Scenarios and Challenges..... 33**  
**Appendices 5: Teleconference Details and Protocol ..... 37**  
**Appendices 6: Key Contacts..... 38**

DRAFT

## **PART 1: AIM, OBJECTIVES and scope OF THE PLAN**

### **1.1 Aim of the Plan**

This document has been developed to supplement the “Greater Manchester Outbreak Plan” at a Manchester level ensuring the right people are contacted at the right time to ensure that the borough is resilient and can respond appropriately to outbreaks. It focuses on the most likely outbreak scenarios and provides the contact details should an outbreak control team need to be called, and an immediate response made by health and social care partners across the borough.

It has been designed to ensure that an appropriate lead from each organisation is contacted as they will know which member of their service will need to be called, and is therefore output/effect focused e.g. identifying clinical staff to provide antibiotics to a large number of school children both in and out of normal working hours.

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

### **1.2 Objectives of the Plan**

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

### **1.3 Primary Objectives**

- The primary objective in the management of an outbreak is to protect public health by identifying the source of an outbreak and implementing necessary control measures to prevent further spread or recurrence of the infection. This should be underpinned by a risk assessment, with regular re-assessment of the risk.
- The protection of public health takes priority over all other considerations, and this must be understood by all members of the Outbreak Control Team (OCT).

### **1.4 Secondary Objectives**

- Responsibility for managing outbreaks is shared by all the organisations who are members of the OCT. This responsibility includes the provision of sufficient financial and other resources necessary to bring the outbreak to a successful conclusion.
- The great majority of incidents and outbreaks are dealt with as part of normal service provision, and may not impact greatly on routine services or require an OCT to be convened.
- On occasion, outbreaks are of such magnitude that there may be significant implications for routine services and additional resources are required. In this instance the Director of Public Health (DPH) may declare a major outbreak / incident and therefore the major incident plans of organisations affected will be invoked as appropriate.

### 1.5 Command & Control

- In the event that Public Health England (PHE) call an OCT, Manchester's DPH and members of the Manchester Community Infection Control /Health Protection Team (CICT) will participate in that group along with any key services such as Environmental Health.
- It is likely that OCT will be supplemented by a Local Co-ordination Team (LCT), established by the Manchester CICT; the purpose of this group is to co-ordinate necessary actions and feedback into the OCT.

### 1.6 Declaration of an outbreak

- In the case of complex or unusual infections/situations an outbreak will be declared and led by PHE. An OCT will be convened by PHE and attended by key staff across the health economy.
- The Manchester CICT may be contacted by a variety of sources to report an outbreak, typically these include; PHE, nursing/care home staff, schools/nurseries, Adult Social Care, Infection Prevention & Control from an NHS Trust, Microbiology/virology or Environmental Health Officers.
- It is usual that locally confined smaller outbreaks (such as Norovirus, HCAs & Influenza) will be recognised and declared by the CICT, with the response being led locally..
- Following the recognition and declaration of an outbreak, if needed, PHE will make a decision regarding the need and urgency to convene an OCT , this decision should be guided by risk assessment
- There are many minor outbreaks and clusters of disease that occur within Manchester every year that are managed satisfactorily without the need to convene an OCT. For example an OCT will not normally be necessary to support the management of confirmed or suspected viral gastroenteritis in a nursing home, school, or similar setting. Not convening an OCT does not necessarily mean that there will be no public health actions required.
- The DPH will lead the local response to an outbreak within Manchester, this may, however, be delegated to the Clinical Lead Health Protection other appropriate member of the CICT/Health Protection Team.



- Terms of reference should be agreed upon at the first meeting of the OCT & should be reviewed at regular intervals.
- When a decision has been made not to declare an outbreak or establish an OCT, the DPH/Clinical Lead Health Protection should be informed at appropriate intervals to determine if the formal declaration of an outbreak or convening of an OCT is subsequently required<sup>1</sup>. This may involve consulting with the other parties to assist with on-going surveillance.
- A suggested list of OCT members can be found in Annex 6: this is not an exhaustive list and depending on the nature of the outbreak representation from additional organisations may be required.

### **1.7 Investigation and Control of Outbreaks**

- Control measures should be documented with clear timescales for implementation and responsibility.
- A case definition should be agreed and reviewed as required during the investigation.
- Basic descriptive epidemiology is essential and should be reviewed at the OCT.
- Legal powers relating to the investigation of food poisoning outbreaks are vested in Local Authorities. If, during the investigation, it is determined that the outbreak is related to food then the management of this would be handed over to the Environmental Health Team and PHE.

### **1.7 Communications**

- The communications response will depend on the nature of the incident/outbreak and the outcome of OCT discussions if an OCT is convened.
- Smaller contained outbreaks(if not related to environmental health issues): Mon-Fri, The CICT will send out Daily Community Outbreak reports to all partner organisations such as e.g MFT and PAHT, NWAS, social care etc. If educational establishments are affected MCC Education Directorate, Comms and Health and Safety will be informed.
- Larger outbreaks with OCT: It is expected that the OCT will identify & nominate which agency will lead the media response at the outset of the outbreak, usually PHE will develop a holding press statement which will be shared with partner Comms Teams.
- The Communications Teams are the lead for communications within MCC/MHCC and in the event of an outbreak/incident, and they would produce communications/information for the public in conjunction with advice from PHE. Social Media will be used in accordance with existing MCC/MHCC policies.

## 1.8 End of the Outbreak

- The CICT will decide when outbreaks of a smaller, contained nature (that are not likely to escalate to significant, major emergency status), are over. The CICT Team will make a statement to this effect via the Outbreak Summary email will be based on an ongoing risk assessment and considered when:
  - There is no longer a risk to public health that requires further investigation or management of control measures.
  - The number of cases has declined.
  - The probable source has been identified and is no longer a risk/infectious.
- Any lessons learnt and recommendations will be discussed at the debrief. If relevant information will be disseminated to the HPG and refinements to practice considered for implementation where appropriate.

### 1.9.1 Scope / Context of the Plan

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

### 1.9.2 Complementary Guidance and Documentation

#### 1.9.3 National Guidance

- [Communicable Disease Outbreak Management: Operational Guidance 2014](#)
- [PHE guidelines on the management of outbreaks of Influenza Like Illness \(ILI\) in care homes 2017](#)
- [Health Protection in schools and other childcare facilities](#)
- [Health and Social Care Act 2008: Code of practice on the prevention and control of infections](#)
- [PHE Health Protection A-Z guidance and information](#)
- [PHE IM Influenza PGD](#)

#### 1.9.4 Greater Manchester Guidance

##### **Roles in an outbreak (see appendix C of GM Multi-Agency outbreak plan)**

- Role of the DPH
- Role of CICN
- Role of CCG/COO
- Role of the Environment Health Officer
- Role of NHS/Mental Health/Community Trust
- Role of LCO to be defined
- Role of PHE consultant/nurse and labs

**GM Outbreaks general including Legionnaires**

- GM Multi-Agency Outbreak Plan (including Legionnaires Disease and High Consequence Infectious Disease)

**Influenza**

- Joint Flu SOP
- PHE Influenza-Like Illness in a Care Home
- PHE Flu brief for GM LHRP
- PHE NW Flu Resource Pack for Care Homes
- Flu Guidelines for GMMMG
- Template AV for staff
- GM Care Home Joint SOP
- Influenza-like Illness/Influenza cases and outbreaks associated with educational settings guidance letter PHE 2017

**Manchester local outbreak documentation**

- Local Outbreak forms
- CICT Notification of Outbreak Form
- Management of outbreaks in CH flowchart 2017
- Deep Cleaning Guidance 2017
- Outbreak Procedure November 2015
- CICT daily outbreak reporting summary form

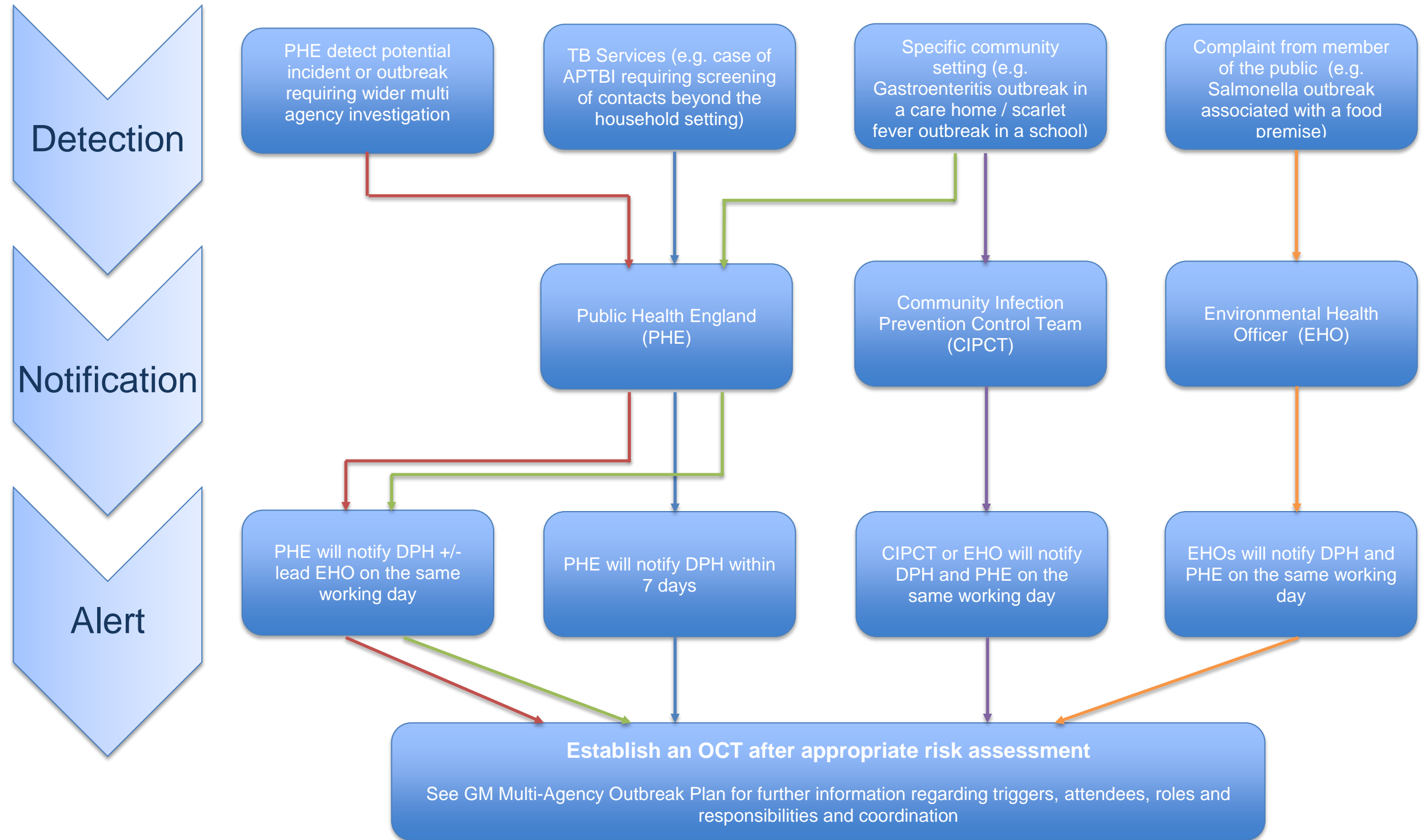
**Influenza**

- Influenza outbreak – GM Care Homes Toolkit
- ILI – Outbreak Questionnaire
- Manchester Swabbing and Antiviral procedure for FLU /ILI
- Director on-call flowchart for antivirals

## PART 2: KEY ASPECTS OF OUTBREAK MANAGEMENT

### 2.1 Detection and Coordination

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



## 2.2 Investigations Roles and Responsibilities

	Response activity	Potential responder(s)		Considerations, comments or potential issues
		In hours (9-5)	Out of hours	
<b>Investigation</b>  (NB. Any setting where staff affected have access to Occupational Health, the investigation will be delivered through them)	Questionnaires / Interviews/Consent	PHE 0344 2250562 option 3	PHE 0151 434 4819	If notifiable (except sexual health clinics). Support from CICT where appropriate 0161 234 1724
		Hospital IPC team	Hospital IPC team	For Acute Trust incidents MFT Oxford Rd 0161 276 4042 Wythenshawe site 0161 291 2632 NMGH 0161 720 2935
		EHO Tel: 0161 234 5004 (internal: 34853) Fax: 0161 274 7309	PHE	Legionella/Food/Environmental/Gastrointestinal (food related) Compliance and Enforcement - Environmental Health/Food Hygiene Sue Brown or Tim Birch
		LCO Children's Services –School Imms team	PHE	Consent to immunisation forms: Schools/Children: Contact: LCO School Immunisation Leads Contact details in contact list.
Sampling <b>All samples MUST be correctly labelled and have ILOG where needed</b>	Respiratory samples (e.g. swabbing)	NHS Provider/Nursing Home Staff/GP/School Imms Team Go To Doc	PHE/Go To Doc	Clinical sampling will be undertaken by: Nursing Home Residents: staff if in a nursing home Nursing Home Team if in South of the City, Residential Care: District Nurses belonging to LCO in each Neighbourhood if a Residential home. GP Uni/over 18: Option:Go to Doc Nursery/Under 5 years: Option 1: LCO School Imms or Option 2: Go To Doc Those not registered with GP e.g Homeless/Rough sleepers Option 1: GP option 2: GTD (dependant on outbreak)  <b>Flu:</b> Flu Kits are held across the city in 3 areas for DN's to access and identified Care homes across the city for other care homes to access. (see attached swabbing and antiviral procedure). The CICT also hold a pack. Further stocks can be accessed via PHE lab. Clare Ward. See list of contacts at the end of the doc. Other swabs held by PHE Lab.
	Faecal (GI outbreak)	PHE/GP /EHO	PHE/ EHO emergency out of hours: 07887916848	PHE may notify EHO and CICT of outbreak, Samples posted back to PHE labs currently. PHE in discussion with EHO about changes in protocol to EHO managing sample collection and delivery to labs (as of Oct 2018).  If more than 2 cases unconnected – to see GP GP may be asked to obtain samples depending on organism. E.g. Clostridium difficile
	Faecal (GI outbreak in a care home)	Care /Care Home Staff/ GP	Care home staff/OOH	Initial sampling taken by care home on GP instructions or with advice from CICT. CICT coordinate outbreak response and advise the home. CICT may contact PHE or EHO for advice. Care home staff take samples.

		Oral fluid (e.g. Hep A outbreak)	GP/NHS Provider/LCO/GTD	N/A	Risk assessment and contact tracing undertaken by PHE Self-administered arranged by PHE. If wider community outbreak : e.g. School/nursery : option 1: School nursing team option 2: GTD Care Home: Care home nurses/NH team/GP University: Go to Doc Commercial Premises: PHE/CICT may support staff self sampling GP-Urban Village for Rough sleepers
		Urine test	PHE/GP/Care Home	N/A	If legionella: Care Home – Care Home Staff on request by PHE Primary care: GP
		Environmental (e.g. food / water)	Environmental Health Officers / HSE	PHE	e.g. Legionella/cryptosporidium? Where EH are the enforcing authority then EHO should be able to undertake sampling For certain premises or complex sampling e.g legionella linked to cooling towers EHO may need to discuss with HSE /and or use Bureau Veritas. 0161 446 4600
		Blood test	NHS provider/GP	N/A	e.g Phlebotomy services for adults and children – NHS trust to clarify community service/or possible commissioning of GTD -SLA
		TB skin test	TB nurses	N/A	e.g Mantoux/IGRA testing 0161 276 1234 extension 64387. Christine Bell is the lead nurse.
		Scabies (clinical assessment)	GP/Dermatologist	N/A	Most cases treated based on clinical assessment by GP or referral to dermatologist without testing. Advice from CICT if outbreaks. Follow NICE Scabies Guidance
		Mass blood tests (e.g. IGRA testing) for TB	TB Nurses MFT	N/A	0161 276 1234 extension 64387. TB service lead nurse.
		Mass X-Ray (incl. mobile x-ray)	NHSE/PHE/TB nurses	N/A	When/if required coordinated by MFT TB team as above
		Sexually Transmitted Infections	NHS Trust Sexual Health Clinic/GP	N/A	Sexual Health Services in MFT would respond to the outbreak. Public Health Commissioning manager- sexual Health MHCC would be contacted in regard to response & communicate with partner services. 0161 234 3358
	Transport to lab	Local lab transport system		EHO via PHE system	GP routine samples in-hours. EHO would liaise with Manchester Public Health Lab for posting of samples.
		PHE Postal		N/A	e.g measles on individual cases. PHE packs have paid return envelope.
		Hand deliver			Care home flu swab samples Flu swabs - Care Homes transport to lab and can have taxi organised via MHCC, CICT member of staff to drop off swabs.

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

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

2.3 Control Measures

	Response activity	Potential responder(s)		Considerations, comments or potential issues
		In hours (9-5)	Out of hours	
<b>Control</b>	Advice on infection, prevention & control measures	MHCC Community Infection Prevention Control 0161 234 1724 EHO Tel: 0161 234 5004 (internal: 34853) PHE 0345 225 0562 opt 3	PHE 0151 434 4819	9am-5pm The CICT have a main number with all CICT Nurses mobile numbers on voice mail, should the main number not be manned. PHE may also provide some infection control information and advice if related to a specific notifiable disease not routinely dealt with by CICT or if unusual situation EHO for commercial food premises/preparation
	Exclusion advice	CICT /PHE	PHE	Using national PHE guidelines and advice. Would depend on the outbreak
	Enforcement of control measures	Local Authority(Proper officer) with PHE support	Local Authority with PHE support	Tim Birch – Proper Office EH Part 2a Order
	Treatment and Prophylaxis  (including immunoglobulin, vaccines, antivirals, antibiotics and anti-toxins)	Trust Pharmacy – order vaccines CCG Medicines Optimisation – order vaccines/coordinate delivery May use Immform PHE may order direct in some circumstances/use own stocks-antivirals/vaccines PGDs to be available from Trust for imms team/DNs From SIT for primary care/Use of PSD	PHE to order vaccines in specific cases Trust pharmacy/CCG	There may be vaccine manufacturing shortages or ordering issues, ordering at short notice in some unusual outbreaks. – PHE to advise/support if vaccination recommended by them

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

Control measures usually include:

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

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

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

- EHOs: IPC advice for cases/contacts of GI illness + enforcement powers
- CICTs: IPC advice and monitoring for community settings
- GPs: prescribing of Rx and PEP
- School nurses: delivery of PEP (e.g. vaccination) in a school setting



- NHS community providers (e.g. DNs): delivery of PEP in community settings (excluding schools) e.g. traveller site, university, care home...

## 2.4 Communications - Roles and Responsibilities

	Response activity		Potential responder(s)		Considerations, comments or potential issues
			In hours (9-5)	Out of hours	
<b>Communications</b>	To public	Setting specific advice letters (eg businesses, care homes)	OCT: MCC/MHCC/EHO/PHE	PHE	Dependent on topic and setting. Template letter provided by PHE for Infectious Diseases Template letter provided by PHE/EHO for food related or Environmental
		Update NHS 111	PHE	PHE	PHE Comms Team
		Helpline	MCC/MHCC	MCC/MHCC	Script and algorithm provided by PHE for any LA comms via the Contact Centre. This would need to be pre-agreed.
		Websites / social media	PHE/MCC/MHCC	MCC/MHCC	Comms Lead for PHE/MHCC/MCC
		Door to door	MCC/MHCC/PHE	MCC/MHCC/PHE	Need would have to be clearly identified and resourced.
	To health partners	Briefings / sitreps from OCT	PHE/MHCC – Comms & PCC	PHE/MHCC – Comms & PCC	see list of contacts for community cases in appendix
		Other relevant groups	Responsibility of each agency	Responsibility of each agency	
	To the media		Coordinated by PHE/MHCC/MCC via OCT	PHE/MHCC/MCC via OCT	Include all partner agencies in discussion of key comms messages
	To Elected Members / Committees e.g. Health and Wellbeing Boards		DPH	DPH MHCC oncall director	David Regan Director of Population Health and Wellbeing/director of Public Health
	Internal briefs		MHCC/MCC	MHCC/MCC	MHCC Comms lead 0161 765 4004 communicationsmanchester@nhs.net Senior Communications Manager 07976883111 MCC Comms 0161 234 3166 communications@manchester.gov.uk

## 2.5 Funding arrangements

	Response activity		Potential responder(s)		Considerations, comments or potential issues
			In hours (9-5)	Out of hours	
<b>Funding arrangements</b>	Vaccination session arrangement and provision by LCO Immunisation Team		Response by NHS Trust	N/A	Response to outbreak to be undertaken. Funding agreed after event.
	Obtaining vaccines from Immform or other sources		NHS Trust CCG		
	Vaccination and prophylaxis activity		GPs/GTD		LCS
	Legionella Testing D+V sampling (specific outbreaks/cases)		EHO		Specific situations identified by PHE/EHO
	Immunisation/Prophylaxis for under 5 years and over 18 years/Uni		GTD/GPs		LCS



## OFFICIAL SENSITIVE

## 2.5 Funding Arrangements

Guiding principles:

- Protection of human health takes priority over funding challenges/financial discussions
- Where a local arrangement is in place re delivery of a certain aspect of the response (e.g. delivering an immunisation session in a school setting): partners must actively:
  - Involve key decision makers from the relevant agency to formally approve the agreement (i.e. do not assume that the organisation will do it)
  - Consider whether activity should be absorbed in existing contracts or whether additional funding is required and if so, which commissioner will sort this.
- Key commissioners in Manchester health economy include:
  - MHCC (CCG and MCC commissioners combined), which commissions: Primary care and acute and community/social care providers
  - LA PH, which commission public health services (school nurses and HVs) –
  - GM Health and Social Care Partnership (GMHSCP), Dentists and GPs which are jointly commission with CCG
  - Specialist Commissioning commissioned by the CCG
  - LA Environmental Health

**CCG Medicines Optimisation: A Locally Commissioned Service Specification has been developed and agreed for use with GPs including OOH in case of outbreak responses for antiviral treatment/prophylaxis and vaccination.**

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

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

**NB:** In the event of a BBV incident/outbreak occurring in Manchester, CICT/Health Protection Team will act as a facilitator, providing the link between PHE and various parts of Manchester Health Economy (these will vary according to location of outbreak and who is involved). The CICT/Health Protection Team will also act as a point of contact for individuals seeking advice

DRAFT

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

	Response Activity		Responders		Considerations
			In hours	Out of hours	
Investigations	<b>Detection/Alerting</b>	<ul style="list-style-type: none"> <li>Two or more residents or staff suffering from ILI</li> <li>CICT alerted by home, PHE alerted by CICT</li> <li>ILI Outbreak proforma completed/ilog obtained</li> <li>Outbreak summary sent to relevant groups</li> <li>Daily (Mon-Fri) call to home for update</li> <li>Home has PHE out of hours tel number</li> <li>Alert trust of any admissions/Trust to alert CICT of any positive cases from CH</li> </ul>	<b>Support</b> Manchester CICT/ Health Protection Team  <b>Samples</b> DNs/LCO Nursing Service if Care Home Nurses in Nursing home	<ul style="list-style-type: none"> <li>PHE</li> <li>GTD</li> <li>Director on-call MHCC</li> </ul>	
	<b>Sampling and prophylaxis (see Manchester swabbing and antiviral doc for details)</b>	<ul style="list-style-type: none"> <li>Nose and throat swabs to be obtained from 5 most recent symptomatic people</li> <li>Swabs delivered to MRI lab by care home staff. Taxi ordered by CICT paid on account</li> </ul>			
Control	<b>Advice IPC</b>	<ul style="list-style-type: none"> <li>Increased hand and respiratory hygiene measures advised</li> <li>Home/Unit closed to admissions (restricted visitors)</li> <li>Affected residents isolated until 5 days post symptoms</li> <li>Affected staff excluded for 5 days</li> <li>Deep clean before reopening</li> </ul>	CICT  <b>Antivirals</b> GP: Med Opt advise Stocks in 3 pharmacies	<ul style="list-style-type: none"> <li>PHE</li> <li>GTD via LCS</li> </ul>	<ul style="list-style-type: none"> <li>Residents may be difficult to isolate, e.g dementia patients may wander</li> <li>Cohort nurse (where possible) to avoid full closure of home</li> </ul>
	<b>Treatment/Prophylaxis</b>	<ul style="list-style-type: none"> <li>PHE called to discuss management</li> <li>Antiviral treatment/prophylaxis prescribed and administered dependant on lab results</li> <li>Antivirals: CICT contact Med Opt to contact all GPs and advise</li> <li>Home collect px and medications</li> </ul>			
Comms	<b>To care home</b>	<ul style="list-style-type: none"> <li>Advice letters/emails/outbreak info pack</li> </ul>	<ul style="list-style-type: none"> <li>CICT</li> </ul>	N/A	

	Response Activity		Responders		Considerations
			In hours	Out of hours	
	To health partners	<ul style="list-style-type: none"> <li>Outbreak email*</li> </ul>	<ul style="list-style-type: none"> <li>CICT</li> </ul>		
	To media	<ul style="list-style-type: none"> <li>Coordinate by PHE via OCT if needed</li> </ul>	<ul style="list-style-type: none"> <li>PHE/MHCC comms</li> </ul>		

### 3b. Arrangements for investigating complex TB incidents

	Response Activity		Responders		Considerations
			In hours	Out of hours	
<b>Investigations</b>	<b>Detection/Alerting</b>	<ul style="list-style-type: none"> <li>Notifiable disease</li> <li>PHE/CICT alerted about a case/s by MFT TB team</li> <li>MFT TB team Identify contacts of infected individuals</li> <li>OCT</li> </ul>	<ul style="list-style-type: none"> <li>PHE</li> <li>MFT TB Team</li> <li>MHCC/CICT</li> </ul>	PHE	TB lead advises mass xray unlikely
	<b>Sampling</b>	<ul style="list-style-type: none"> <li>Screen contacts/people in affected area (MFT chest clinic)</li> <li>Large scale screening if needed</li> <li>Mantoux testing</li> <li>Interferon testing</li> <li>Mass x-ray (including mobile x-ray)</li> </ul>	<ul style="list-style-type: none"> <li>MFT TB Team</li> <li>LCO school nurses for support</li> </ul>		
<b>Control</b>	<b>Advice IPC</b>	<ul style="list-style-type: none"> <li>Isolation? (need for Part2a)</li> <li>Hygiene measures</li> <li>Provide advice/reassurance to worried individuals</li> </ul>	<ul style="list-style-type: none"> <li>PHE</li> <li>MFT TB services</li> <li>CCG</li> <li>Tim Birch</li> </ul>	PHE (if necessary)	<ul style="list-style-type: none"> <li>Prescribing</li> <li>Sourcing</li> <li>Individuals not complying with treatment due to complex social needs (e.g. homeless)</li> <li>Need for Part 2 a.</li> </ul>
	<b>Treatment/Prophylaxis</b>	<ul style="list-style-type: none"> <li>Mass vaccinations – BCG</li> <li>TB antimicrobial therapy – individual prescriptions from Consultant</li> <li>Latent infections?</li> <li></li> </ul>	<ul style="list-style-type: none"> <li>EHO (part 2a) if person needs to be detained for MDRTB</li> </ul>		

	Response Activity		Responders		Considerations
			In hours	Out of hours	
<b>Comms</b>	<b>To public</b>	<ul style="list-style-type: none"> <li>Advice letters</li> <li>Update NHS 111, helpline, social media</li> </ul>	<ul style="list-style-type: none"> <li>PHE/MHCC comms</li> <li>PHE comms</li> </ul>	<ul style="list-style-type: none"> <li>PHE</li> </ul>	
	<b>To health/LA partners</b>	<ul style="list-style-type: none"> <li>Outbreak email*</li> <li>Letter via Primary Care at CCG to GPs</li> </ul>			
	<b>To media</b>	Coordinate by PHE via OCT			

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

	Response Activity		Responders		Considerations
			In hours	Out of hours	
<b>Investigations</b>	<b>Detection/Alerting</b>	<ul style="list-style-type: none"> <li>PHE investigate/questionnaire contact tracing</li> <li>CICT notified when unusual numbers or cluster of cases</li> </ul>	<ul style="list-style-type: none"> <li>PHE</li> <li>CICT</li> <li>MFT</li> <li>MRI</li> <li>Virology laboratory</li> <li>GPs</li> </ul>	PHE  NIL	
	<b>Sampling</b>	<ul style="list-style-type: none"> <li>Blood samples for virology</li> <li>Screening of contacts</li> <li>Screen for multiple BBVs</li> </ul>			
<b>Control</b>	<b>Advice IPC</b>	<ul style="list-style-type: none"> <li>Explain routes of transmission</li> <li>Hygiene measures</li> </ul>	<ul style="list-style-type: none"> <li>PHE</li> <li>CICT</li> <li>General Practice</li> <li>Cons Microbiologist</li> </ul>	PHE	<b>Vaccine</b> Community outbreak to be obtained from immform/? PHE stock/Trust
	<b>Treatment/Prophylaxis</b>	<ul style="list-style-type: none"> <li>Sexual health clinic to provide to MSM etc</li> <li>PEP treatment for close contacts</li> <li>Vaccinations for close contacts and</li> </ul>			

	Response Activity		Responders		Considerations
			In hours	Out of hours	
		other contacts (dependant on virus)			
Comms	To public	<ul style="list-style-type: none"> <li>Advice letters</li> <li>Update NHS 111, helpline, social media</li> </ul>	<ul style="list-style-type: none"> <li>PHE</li> <li>CICT</li> </ul>		
	To health/LA partners	<ul style="list-style-type: none"> <li>Outbreak email*</li> <li>Via CCG Primary Care to GPs</li> </ul>			
	To media	Coordinate by PHE via OCT			

### 3d. Case/s meningococcal disease in a nursery, school or college

	Response Activity		Responders		Considerations
			In hours	Out of hours	
Investigations	Detection/Alerting	<ul style="list-style-type: none"> <li>Meningococcal case notified to PHE from lab/trust</li> <li>PHE notify DPH inc CICT</li> <li>Identify close contacts - PHE</li> </ul>	PHE	PHE	
	Sampling	<ul style="list-style-type: none"> <li>No screening needed, but highlight symptoms and importance of urgent medical attention</li> <li>Hospitalisation of anyone displaying symptoms</li> </ul>			
Control	Advice IPC	<ul style="list-style-type: none"> <li>Highlight symptoms and importance of urgent medical attention</li> </ul>	PHE CICT Student Health	PHE	<ul style="list-style-type: none"> <li>Prescribing</li> <li>Sourcing</li> </ul>

	Response Activity		Responders		Considerations
			In hours	Out of hours	
	<b>Treatment/Prophylaxis</b>	<ul style="list-style-type: none"> <li>Prophylactic antibiotics for close contacts</li> <li>Check vaccination status of rest of school/college – offer vaccination for unimmunised</li> </ul>	<b>Nursery:</b> Opt 1: Imms Team Opt 2: GTD <b>School:</b> LCO Imms Team <b>Uni/College:</b> GTD		
<b>Comms</b>	<b>To public</b>	<ul style="list-style-type: none"> <li>Advice letters</li> <li>Update NHS 111, helpline, social media</li> </ul>	PHE		
	<b>To health/Uni partners</b>	<ul style="list-style-type: none"> <li>Outbreak email*</li> <li></li> </ul>	PHE/CICT		
	<b>To media</b>	Coordinate and led by PHE via OCT	PHE/MHCC/MC C		

**3e. Hepatitis A outbreak /cases in a school or childcare setting**

	Response Activity		Responders		Considerations
			In hours	Out of hours	
<b>Investigations</b>	<b>Detection/Alerting</b>	<ul style="list-style-type: none"> <li>Notifiable disease</li> <li>PHE notified by lab Contact tracing</li> <li>CICT notified of case(s)</li> <li>Identify close contacts</li> <li>Identify source</li> </ul>	<ul style="list-style-type: none"> <li>PHE SIT &amp; HP</li> <li>CICT</li> <li>School nurses</li> </ul>	PHE	

	Response Activity		Responders		Considerations
			In hours	Out of hours	
	<b>Sampling</b>	<ul style="list-style-type: none"> <li>Blood samples from all contacts for Hep A testing – students/staff/household</li> <li>Oral saliva sampling</li> </ul>	<ul style="list-style-type: none"> <li>GP</li> </ul>		
<b>Control</b>	<b>Advice IPC</b>	<ul style="list-style-type: none"> <li>Increased hand hygiene, extra measures for close contacts</li> <li>Environmental Assessment of toilets and hand washing facilities</li> </ul>	<ul style="list-style-type: none"> <li>PHE SIT &amp; HP</li> <li>CICT</li> </ul>		<ul style="list-style-type: none"> <li>Availability of sufficient vaccine</li> <li>Ensure vaccinations are given in a timely manner</li> <li>2<sup>nd</sup> vaccination to consider</li> </ul>
	<b>Treatment/Prophylaxis</b>	<ul style="list-style-type: none"> <li>No treatment available</li> <li>Immunoglobulin therapy for household contacts</li> <li>Vaccinate contacts</li> </ul>	<ul style="list-style-type: none"> <li>School nurses</li> <li>GPs</li> <li>Intrahealth</li> <li>CCG meds management</li> </ul>		
<b>Comms</b>	<b>To public</b>	<ul style="list-style-type: none"> <li>Advice letters to schools/households</li> </ul>			
	<b>To health/LA partners</b>	<ul style="list-style-type: none"> <li>Outbreak email*</li> <li>CCG primary care letter to GPs</li> </ul>			
	<b>To media</b>	Coordinate and led by PHE via OCT			



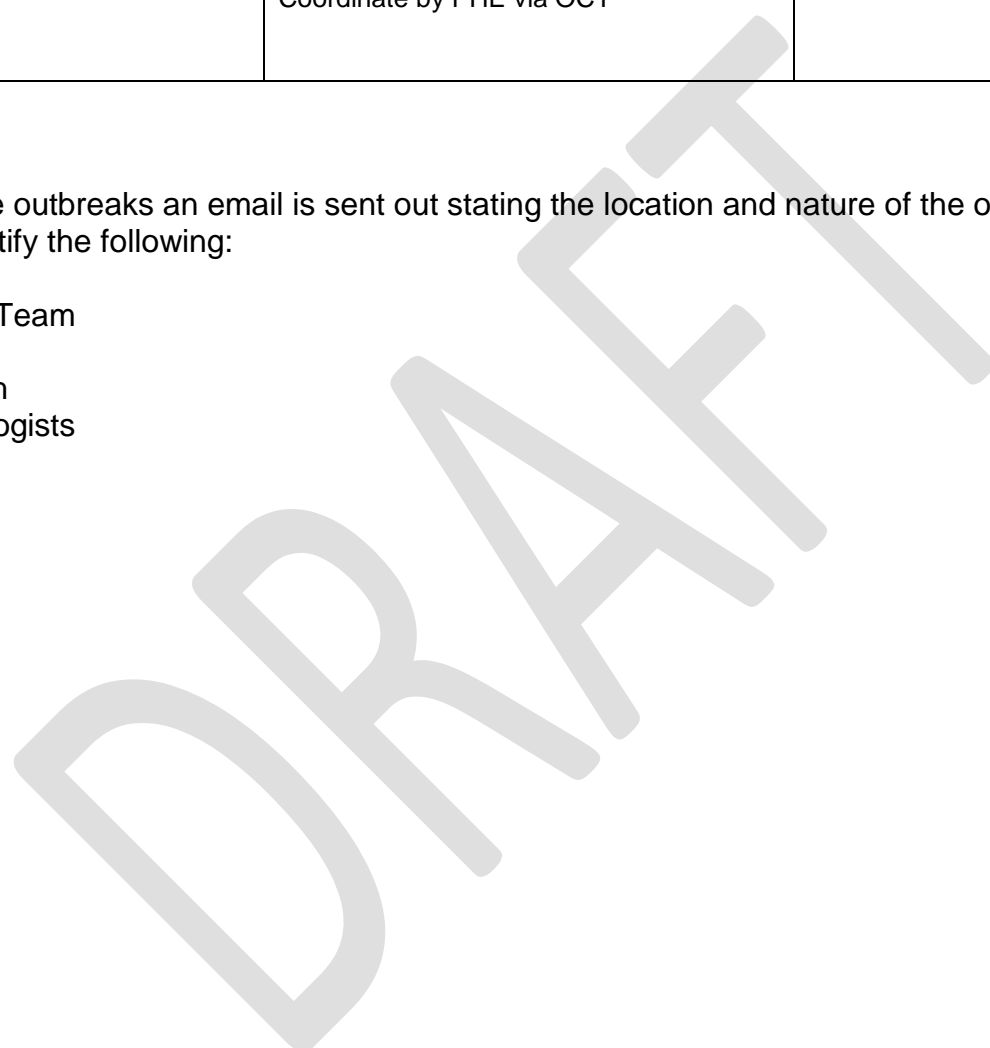
**3f. Investigating outbreaks in a hard to reach population (e.g. measles at a traveller’s site/Hep A in Homeless/NFA)**

	Response Activity		Responders		Considerations
			In hours	Out of hours	
<b>Investigations</b>	<b>Detection/Alerting</b>	<ul style="list-style-type: none"> <li>• Notifiable disease</li> <li>• PHE/CICT notified of case(s)</li> <li>• PHE Identify close contacts</li> <li>• Identify source</li> </ul>	PHE	PHE	Use of LCS
	<b>Sampling</b>	Provision of test kits/specific swabs if required	PHE lab GPs/Identified GP practice e.g Urban village	GTD	
<b>Control</b>	<b>Advice IPC IPC activity</b>	Provision of advice to specific services e.g Homeless services/ teams, cleansing services, drug services, 3 <sup>rd</sup> sector	CICT PHE EHO LA specific teams Health and safety	<b>PHE Health and Safety (LA)</b>	
	<b>Treatment/Prophylaxis</b>	Advice from PHE Mass vaccination onsite Vaccination via Primary care services	Identified GP practice e.g Urban Village Community Nursing Team/TB nurses		
<b>Comms</b>	<b>To public</b>	<ul style="list-style-type: none"> <li>• Advice letters to key groups</li> <li>• Direct information to key groups from Outreach workers and 3<sup>rd</sup> sector</li> </ul>			
	<b>To health/LA partners</b>	<ul style="list-style-type: none"> <li>• Outbreak email*</li> <li>• OCT</li> <li>• Via CCG primary care Messages to GPs re increasing vaccine uptake / bringing forward routine vaccinations</li> <li>• Targeting schools with low uptake</li> </ul>			

	Response Activity		Responders		Considerations
			In hours	Out of hours	
	To media	Coordinate by PHE via OCT			

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

- Infection Prevention Team
- Adult Social Care
- Environmental Health
- Consultant Microbiologists
- Councillors
- Schools
- DPH



## OFFICIAL SENSITIVE

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

- Investigating & controlling outbreaks of viral gastroenteritis in schools/nurseries
- Investigating & controlling outbreaks of viral gastroenteritis in care homes
- Investigating & controlling outbreaks of respiratory disease in care homes (excluding seasonal ILI-covered in part 3a)
- Investigating an outbreak of a HCAI

Some outbreaks although not requiring an OCT will be discussed with PHE e.g. respiratory outbreaks in care settings

4a. Outbreak situations NOT requiring an OCT

Outbreak Situation	Detection/Alerting	Response	Control	Treatment/Prop hylaxis	Documents
<p><b>Viral gastroenteritis in schools/nurseries</b></p>	<p>CICT contacted by school/nursery/other source when 2+ cases are noted</p>	<ul style="list-style-type: none"> <li>• Phone call between school &amp; CICT to discuss symptoms and numbers of affected staff &amp; students.</li> <li>• CICT daily contact updates with school via phone</li> <li>• Outbreak form details added to outbreak spreadsheet daily.</li> <li>• Stool sample to collect by school nurse supported by the HP Nurse.</li> </ul>	<ul style="list-style-type: none"> <li>• Ill pupils &amp; staff to stay home for 48hours post last symptoms</li> <li>• Outbreak email sent out daily*</li> <li>• Notify LA Education Directorate and Health and Safety</li> <li>• Extra hygiene measures advised</li> <li>• Deep clean of school 48 hours after last symptoms</li> </ul>	<p>Unnecessary in most cases</p>	

Outbreak Situation	Detection/Alerting	Response	Control	Treatment/Prop hylaxis	Documents
<p><b>Viral gastroenteritis in nursing/care homes</b></p>	<p>CICT contacted by home/other source when 2+ cases are noted</p>	<p>Phone call between home &amp; CICT to discuss symptoms and numbers of affected staff &amp; residents</p> <p>Home contacts MRI lab for Ilog number</p> <p>CICT contact home daily during the outbreak (mon-fri) for update. Can contact PHE OOH</p> <p>Outbreak details added to daily outbreak summary sheet</p> <p>Home to take stool samples (type 5-7) from affected residents and sent to laboratory (see outbreak Management doc)</p>	<ul style="list-style-type: none"> <li>• Ill residents isolated for 48hours post symptoms</li> <li>• Ill staff excluded for 48 hours post symptoms</li> <li>• Closure to admissions, avoid unnecessary appointments and restrict visitors until 48 hours post symptoms</li> <li>• Extra hygiene measures advised</li> <li>• Deep clean before reopening (48 hours after last symptoms)</li> <li>• Outbreak summary email updated and sent out daily*</li> </ul>	<p>Unnecessary in most cases</p>	

Outbreak Situation	Detection/Alerting	Response	Control	Treatment/Prop hylaxis	Documents
<p><b>Respiratory illness in nursing/care homes</b> (Not seasonal Influenza – see part 3a)</p>	<p>CICT contacted by home/other source when 2+ cases are noted</p> <p>CICT alert PHE to alert of cases and discuss approach</p>	<ul style="list-style-type: none"> <li>• Phone call between home &amp; CICT to discuss symptoms and numbers of affected staff &amp; residents</li> <li>• CICT email outbreak form to Care Home to be completed and emailed to HP team on daily basis</li> <li>• Outbreak form details added to outbreak spreadsheet daily</li> <li>• CICT Obtain Ilog number</li> <li>• Arrange for swabs, Urine and sputum samples if needed s to be taken from affected people, and sent to laboratory (see outbreak management doc) arrange with DNs for this for care homes</li> </ul>	<p>Depends on cause?</p> <ul style="list-style-type: none"> <li>• Ill residents &amp; staff to stay home for 5 days post last symptoms</li> <li>• Outbreak summary email sent out daily*</li> <li>• Isolation where possible, respiratory hygiene measures advised</li> <li>• Deep clean of home before reopening, must be 5 days after last symptoms</li> </ul>	<ul style="list-style-type: none"> <li>• Resident’s GP to clinically assess and prescribe</li> </ul>	<p>PHE ILI national document</p>

Outbreak Situation	Detection/Alerting	Response	Control	Treatment/Prop hylaxis	Documents
<p><b>An outbreak of a HCAI</b></p>	<p>CICT contacted by processing laboratory or another source e.g IPN at NHS Trust, GP</p> <p><b>NB May need PHE involvement in certain situations</b></p>	<ul style="list-style-type: none"> <li>• Outbreak form to be completed</li> <li>• Excel spreadsheet updated</li> <li>• I log number to be obtained by CICT</li> <li>• Sampling as required or as advised by PHE e.g. stool,swabs</li> </ul>	<p>Dependent on causal organism</p> <ul style="list-style-type: none"> <li>• MRSA</li> <li>• PVL</li> <li>• ESBL</li> <li>• C.diff</li> <li>• CPE</li> </ul> <p>See relevant protocol document</p>	<p>Antibiotic treatment or decolonisation if needed.</p> <p>See relevant protocol document</p>	<p>Outbreak spreadsheet</p>

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

- Infection Prevention Teams : MFT, NCA, GMMHSCT
- Adult Social Care
- Education and Early Years (when appropriate)
- NW Ambulance Service
- Environmental Health
- Consultant Microbiologists
- PHE
- LCO key contacts

## APPENDICES

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

Type of Stock (e.g. swabs, tubes etc.)	Where Located	Quantity	Arrangements for Access
Antivirals	<p>Three pharmacies</p> <ul style="list-style-type: none"> <li>• <b>Lloyds (Sainsbury's) Fallowfield:</b></li> <li>• <b>Everest Pharmacy- 1117b Withington Rd</b></li> <li>• <b>Lloyds Sainsbury's Heaton Park:</b></li> </ul> <p>PHE contingency stock in Salford Royal.</p>		<p>Pharmacies via prescription via Med management- Kenny Li/Heather Bury</p> <p>PHE stock access via PHE GM Team</p>
Swab kits for influenza Measles	<p>PHE Lab hold main stock</p> <p>Manchester: List of care homes and DNs GPs</p>	PHE –Lab	See Manchester swabbing procedure contact Clare Ward at MRI for replacement swab kits
Vaccines	Immform urgent order	Depends on size of outbreak	Order via immform web site. Local SIT Team may be able to expedite when needed. PHE
Stool sample pots	PHE GP EHO		No stock in care homes for early response to outbreak samples EHO currently in discussion with PHE around potting samples GP



## OFFICIAL SENSITIVE

**Appendices 2: Potential Outbreak Settings or Sources**

These are examples of community settings sometimes associated with outbreaks

- Care homes: nursing, residential, intermediate, mixed etc.
- Schools / Colleges
- Nurseries / Child minders / Play centres
- University / student accommodation
- Food outlets
- Petting farms
- Swimming pools / water activity parks
- Dental practices
- Community health care settings (GP practices, Integrated Care centres etc.)
- Prisons / Detention Centres
- Workplaces
- Ports / airports
- Hotels
- Leisure Centres
- Travellers Sites
- Private camp sites / holiday parks
- Community Hospitals
- Hostels
- Tattoo Parlours

### Appendices 3: Common Pathogens

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

The full list of notifiable diseases is available [here](#):

- Influenza
- Norovirus
- Scabies
- Tuberculosis
- Clostridium difficile
- PVL positive MR(S)SA
- Invasive Group A Streptococcal infection
- E Coli O157
- Hepatitis A
- Meningitis
- Pertussis
- Legionnaires Disease
- Measles

DRAFT

**Appendices 4: Common Outbreak Scenarios and Challenges**

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

Outbreak Scenario	Recommended response	Usual partners providing the local response (provider + commissioner)	Common challenges for consideration	OOH response required?	Comments
Seasonal influenza outbreak in a care home	See GM SOP document and Manchester Swabbing and antiviral procedure Manchester LCS	CICT District Nurses GPs Got to Doc		Yes (09:00 -20:00 ...not overnight)	
Outbreak of iGAS in a care home	-screening (lab testing) of residents and staff -Treatment of cases - GP, decolonisation of carriers -GP, surveillance of contacts – PHE/CICT -IPC measures potentially including home closure - CICT	-PHE 0344 225 0562 opt 3 CICT – give infection control advice -Lab: local/PHE -Care home -CCG meds Opt	Treatment of residents who are cases by their GP For prophylaxis for other residents use LCS Screening - would depend if they are residential or nursing. Staff would be directed to their GP if no appropriate Occupational Health provider. Go To Doc or LCO or own staff if Nursing home	Treatment of residents – OOH GP  PHE for advice to home/GP on cases	CICT would take advice from PHE and monitor home for any symptomatic cases
Hepatitis A case with suspected	-vaccination +/--HN1g for contacts: households / School (pupils/staff)	-School nurses -CCG meds management	-ensuring GPs vaccinate household contacts in a timely manner	No	NOTE: also consider scenario where outbreak evolves

Outbreak Scenario	Recommended response	Usual partners providing the local response (provider + commissioner)	Common challenges for consideration	OOH response required?	Comments
source in a primary school	<ul style="list-style-type: none"> <li>IPC measures for individual cases and contacts</li> </ul>	(sourcing of vaccine etc.) <ul style="list-style-type: none"> <li>GPs</li> <li>CICNs</li> <li>Labs: PHE/local</li> </ul>	<ul style="list-style-type: none"> <li>Delivering a mass vaccination session in a school (logistics, obtaining consent, language barriers, vaccine supply, prescription/PGD, governance, recording uptake etc.)</li> <li>catch-up arrangements for those who missed school session</li> </ul>		to a large community outbreak  LCO/GTD
Two or more cases of meningococcal disease in a nursery, school, college or university setting	<ul style="list-style-type: none"> <li>delivery of mass prophylaxis for contacts: antibiotics +/- vaccine</li> </ul>	<ul style="list-style-type: none"> <li>CICNs</li> <li>School nurses/imms team</li> <li>Student health services</li> <li>GPs</li> <li>Local trust</li> </ul>	As for any mass treatment session: <ul style="list-style-type: none"> <li>Sourcing (local stock?)</li> <li>Prescribing (GP/Hospital)</li> <li>Delivery</li> </ul>		LCO/GTD
TB incident with a large number of contacts (e.g. university)	<ul style="list-style-type: none"> <li>MFT TB service-testing of a large number of contacts</li> <li>Treatment of latent infections where appropriate</li> </ul>	<ul style="list-style-type: none"> <li>TB services</li> </ul>	Hospital Trust – MFT TB services	No	NOTE: within TB response, consider issue of preparedness for residents not complying with Rx with complex social needs (e.g. no access to public resources)

Outbreak Scenario	Recommended response	Usual partners providing the local response (provider + commissioner)	Common challenges for consideration	OOH response required?	Comments
GI outbreak linked to a food premise, swimming pool or petting farm	<ul style="list-style-type: none"> <li>rapid investigation of potential source in setting: reviewing records, inspection, +/- environmental sampling</li> <li>faecal sampling for cases</li> <li>setting-based control measures (e.g. food hygiene advice): recommendation/enforcement</li> <li>case-based control measures (exclusion etc)</li> </ul>	<ul style="list-style-type: none"> <li>EHOs</li> <li>Lab: local/PHE</li> </ul>	<ul style="list-style-type: none"> <li>What is the process for obtaining faecal samples</li> </ul>	Yes EHO	Oncall EHO/PHE
Large community outbreak of measles	Potentially: <ul style="list-style-type: none"> <li>information gathering from large number of cases</li> <li>setting-specific (e.g. school) mass vaccination sessions</li> <li>local vaccine catch-up campaign</li> </ul>	<ul style="list-style-type: none"> <li>CICNs</li> <li>lab: PHE</li> <li>School nurses</li> <li>GPs</li> </ul>	<ul style="list-style-type: none"> <li>delivering mass vaccination session in school (see Hep A example), including identifying eligible target group based on CHIS</li> </ul>		
Hard to reach populations: <ul style="list-style-type: none"> <li>Homeless</li> <li>Traveller sites</li> </ul> Example outbreaks: measles, TB, iGAS	Investigations: <ul style="list-style-type: none"> <li>Blood samples, skin swabs, respiratory samples.</li> </ul> Control measures: <ul style="list-style-type: none"> <li>IPC advice, medication (Rx/PEP)</li> </ul>	<ul style="list-style-type: none"> <li>CICNs</li> <li>Liaison teams</li> <li>DNs/HVs</li> </ul>	Urban village practice have dealt with recent incident in Rough sleepers.	Not usually	

## Notification of Cases of infectious disease in Trusts to CICT

Trusts to ring CICT directly and notify. CICT will liaise with PHE.

DRAFT

## OFFICIAL SENSITIVE

**Appendices 5: Teleconference Details and Protocol**

Dial-in number:

Chairperson Passcode:

Participant Passcode:

For further information: [BT Conference User Guide](#)

In order for a teleconference to run smoothly, participants must follow certain rules of etiquette while on the call.

**Conference call etiquette- Chair**

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

**Conference call etiquette – Participants**

- The 'mute' button should be used at all times unless you are speaking to the conference this avoids any back ground noise pollution
- Callers should treat a conference call like any other meeting.
- Choose a location with little background noise
- Select a phone with the handset attached. Mobile or cordless phones often add annoying static to the call.
- If you do have to use a mobile phone in a car, please park up and turn off the radio and engine to reduce background noise when speaking.
- If calling individually try to avoid using speakerphone as this can lead to excess background noise and may reduce the quality of your call.
- Be sure to keep your mobile phone turned off or at least a few feet away from the telephone you are using as it can create a 'hum' when active.
- Make a list of any issues you need to raise and note where they can slot into the agenda.
- Introduce yourself when speaking.
- Take care not to rustle paper, type or make a noise that might disturb the call when your line is open.
- Speak clearly and pause frequently when delivering complicated material.

**Appendices 6: Key Contacts**

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

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>Public Health England</b>	Caroline Rumble Consultant for Manchester
<i>Phone(s)</i>	<i>Email</i>
Between 9-5 hours 0344 225 0562 opt 3 Out of Hours 0151 434 4819	gmanchPU@phe.gov.uk

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>Director of Public Health/Director Population Health and Wellbeing</b>	David Regan
<i>Phone(s)</i>	<i>Email</i>
0161 234 3981 Mobile: 07770 981699	d.regan@manchester.gov.uk

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>Public Health Consultant Health Protection</b>	Not in place
<i>Phone(s)</i>	<i>Email</i>

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>Community Infection Control Team (MHCC)</b>	Clinical Lead/Specialist Nurses
<i>Phone(s)</i>	<i>Email</i>
0161 234 1724	cict@manchester.gov.uk

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>Manchester University Foundation Trust IPC</b>	Assistant Chief Nurse IPC and Tissue Viability: Julie Cawthorn Lead Nurse: Sue Jones
<i>Phone(s)</i>	<i>Email</i>
0161 276 6042	

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>MFT/ PHE labs</b>	
<i>Phone(s)</i>	<i>Email</i>
0161 276 8854 choose from options	

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>MFT TB Team</b>	Christine Bell – Lead Nurse
<i>Phone(s)</i>	<i>Email</i>
TB Nurse Specialists: extensions 0161 276 1234 - 64387, 15034, 11893, 67964, 67963	



<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>North Manchester General Hospital IPC</b>	Infection Prevention and Control
<i>Phone(s)</i>	<i>Email</i>
0161 720 2935	

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>MHCC Medicines Optimisation</b>	Kenny Li Deputy Director and Head of Medicines Optimisation  Heather Bury Locality Lead Pharmacist- Practice Based Medicines Optimisation Team
<i>Phone(s)</i>	<i>Email</i>
Kenny Li 07976655833 or 07867860787  Heather Bury 0161 219 9417/Mobile: 07968622688	<a href="mailto:Kenny.li@nhs.net">Kenny.li@nhs.net</a> <a href="mailto:hbury@nhs.net">hbury@nhs.net</a>

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>MHCC Primary Care Senior Commissioning Manager</b>	Sue Lock Senior Commissioning Manager
<i>Phone(s)</i>	<i>Email</i>
0161 219 9426 07970 297866	<a href="mailto:susan.lock@nhs.net">susan.lock@nhs.net</a>

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>MCC EHO</b>	Managers: Sue Brown or Tim Birch
<i>Phone(s)</i>	<i>Email</i>
0161 234 5004 (internal: 34853) EHO emergency out of hours: 07887916848	

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>LCO: School Health Imms and Screening Team- Team Lead</b>	Julie Bowden
<i>Phone(s)</i>	<i>Email</i>
0161 209 9952  Mobile no: 07964244190	<a href="mailto:julie.bowden@mft.nhs.uk">julie.bowden@mft.nhs.uk</a>

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>LCO: Clinical Head - School Health Service Children's Community Services</b>	Sam Shaw
<i>Phone(s)</i>	<i>Email</i>
Tel: 0161 202 8794 Mobile: 07870 381381	<a href="mailto:sam.shaw@mft.nhs.uk">sam.shaw@mft.nhs.uk</a>

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>LCO: Children's Community Services Lead Manager School Nursing   Healthy Schools   Child Accident Prevention   Orthoptic Service</b>	Claire Duggan
<i>Phone(s)</i>	<i>Email</i>
Tel:0161 946 8274 Mob:07870275360 Fax: 0161 946 9427	<a href="mailto:claire.duggan@mft.nhs.uk">claire.duggan@mft.nhs.uk</a>

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>PHE Screening and Imms Team</b>	
<i>Phone(s)</i>	<i>Email</i>
0113 825 5178	

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>MHCC Acting Head of Nursing</b>	Carolina Ciliento
<i>Phone(s)</i>	<i>Email</i>
Administration: 0161 765 4726 mobile: 07779 546663	<a href="mailto:carolina.ciliento@nhs.net">carolina.ciliento@nhs.net</a>

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>MHCC lean Nurse</b>	Joanne Oakes
<i>Phone(s)</i>	<i>Email</i>
0161 765 4710   07980 944073	<a href="mailto:j.oakes@nhs.net">j.oakes@nhs.net</a>

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>MHCC Senior Coms Manager</b>	Ruth Edwards
<i>Phone(s)</i>	<i>Email</i>
07976883111	<a href="mailto:ruth.edwards7@nhs.net">ruth.edwards7@nhs.net</a>

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>MCC Pest Control</b>	
<i>Phone(s)</i>	<i>Email</i>
0161 234 5004	

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>LCO: Chief Nurse and Prof Lead</b>	Ian Trodden
<i>Phone(s)</i>	<i>Email</i>
07768565002	<a href="mailto:i.trodden@nhs.net">i.trodden@nhs.net</a>

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>LCO: Dep Director Nursing</b>	<b>Lorraine Ganley</b>
<i>Phone(s)</i>	<i>Email</i>
	<a href="mailto:l.ganley@mft.nhs.uk">l.ganley@mft.nhs.uk</a>

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>MCC Risk and Resilience Lead</b>	Kimberley Hart
<i>Phone(s)</i>	<i>Email</i>
Tel: 0161 234 3313 Internal Tel: 800 33313 Mobile No: 07899 664 614 Fax: 0161 274 7002	k.hart@manchester.gov.uk k.hart@manchester.gcsx.gov.uk

<i>Organisation/title/department</i>	<i>Name/comment</i>
<b>Internal Audit and Risk Management Corporate Services Manchester City Council</b>	<b>Simon Gardiner Health and Safety Manager</b>
<i>Phone(s)</i>	<i>Email</i>
Tel 0161 234 5260 Internal Tel 801 35260 Health and Safety Duty Line 0161 234 1897 Mobile Tel 07810 557 473 Fax 0161 276 7615	s.gardiner@manchester.gov.uk

This page is intentionally left blank

**Manchester Health and Wellbeing Board  
Report for Information**

**Report to:** Health and Wellbeing Board – 23 January 2019

**Subject:** Manchester and Greater Manchester Local Industrial Strategies

**Report of:** Sara Todd, Deputy Chief Executive

---

**Summary**

The report provides an update on the development of the Manchester and Greater Manchester Local Industrial Strategies and their respective engagement approaches. The Strategies will support the delivery of the Our Manchester Strategy and the Greater Manchester Strategy by setting out a set of priorities which will deliver a more inclusive city and city region.

**Recommendations**

The Board are invited to comment on the approaches being developed in Manchester and Greater Manchester and the links between the two pieces of work.

The Board are also invited to suggest the most significant issues or topics they feel need to be addressed by the two Strategies. The views of the Board will form an important part of the overall consultation process.

---

**Wards Affected:** All

---

**Board Priority(s) Addressed:**

<b>Health and Wellbeing Strategy priority</b>	<b>Summary of contribution to the strategy</b>
Getting the youngest people in our communities off to the best start	
Improving people's mental health and wellbeing	
Bringing people into employment and ensuring good work for all	The Manchester LIS will set out Manchester's Strategy for delivering inclusive growth for the city.
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	

**Contact Officers:**

Name: David Houlston  
Position: Strategic Lead, Policy and Strategy  
Telephone: 0161 234 1541  
Email: d.houlston@manchester.gov.uk

Name: Victoria Clarke  
Position: Strategic Lead, Reform  
Telephone: 0161 234 3640  
Email: v.clark@manchester.gov.uk

**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.

*Working to Deliver Inclusive Growth in Manchester*, Economy Scrutiny Committee (July 2017)

*Inclusive Growth Commission: Making our Economy Work for Everyone*, Inclusive Growth Commission, RSA (March 2017)

*Patterns of Poverty in Greater Manchester's Neighbourhoods*, Inclusive Growth Analysis Unit (May 2017)

## 1.0 Introduction

- 1.1 The Council's Economy Scrutiny Committee received a report in July 2017 titled '*Working to Deliver Inclusive Growth in Manchester*'. This report set out the findings of the Royal Society of Art's (RSA) Inclusive Growth Commission, the work of the Inclusive Growth Analysis Unit and summarised some of the existing activity in the city which was contributing to delivering inclusive growth. The report also set out a number of challenges facing the city including; low skills, low wages, part-time employment and productivity. The '*2018 State of the City Report*' provides the latest performance data in relation to the city and also highlights skills, outcomes for over 50's, the proportion of residents being paid the real living wage and transitioning to a zero carbon city as challenges for the city.
- 1.2 Following the 2017 report, consideration was given to whether or not a new strategy or delivery plan was required to enable Manchester's economy to become more inclusive. The publication of the UK Government's Industrial Strategy in late 2017 provided an opportunity to align Manchester's work with national and city region activity.
- 1.3 The Manchester Local Industrial Strategy (LIS) will support the delivery of the Our Manchester Strategy by producing a delivery plan that will help to create a more inclusive economy. The Strategy will be aligned to both the existing UK Government Industrial Strategy and also the Greater Manchester Local Industrial Strategy (GM LIS) which is also currently under development. Further information about the GM LIS is provided under section 4 of this report.
- 1.4 Manchester has a number of major economic assets which contribute to the city region and regional economy such as the city centre and Manchester Airport. The GM LIS will need to reflect the importance of these assets and the contribution they make to the city region, as well as some of the major infrastructure improvements which are required to support future growth such as High Speed 2, Northern Powerhouse Rail, Metrolink expansion, improvements to the motorway network and the roll out of full fibre.
- 1.5 The Manchester Strategy will provide a much more granular level of detail about the city and will contain specific suggestions about how productivity can be improved by focussing on the demand side of the economy, as well as better connecting residents to economic opportunities. There are clear links to existing programmes of work including the ambitions to become a zero carbon city, the Work and Skills Strategy, the development of a Digital Strategy for the city and transport infrastructure. Further information about the scope of the Manchester and GM Strategies is provided in the accompanying presentation (see appendix 1).

## 2.0 Manchester LIS Engagement Approach

- 2.1 A wide ranging listening exercise with young people, residents, workers and businesses across the city has been developed using the *Our Manchester* principles. Staff from a number of Council services including: City Policy; Reform and Innovation; Work and Skills; and Communications were involved in this work which was completed between October 2018 and the end of December 2018. The approximate reach is as follows:
- 500 face-to-face conversations with residents across the city in different neighbourhoods;
  - 110 online resident survey responses generated via social media posts;
  - 200 face-to-face engagements with young people at a Youth Council event, 9 secondary schools (including 4 Special Education Needs schools) and an event with Uprising;
  - 170 conversations and survey responses from businesses and organisations
  - 25 Voluntary Community Sector responses
- 2.2 This engagement has provided a large volume of qualitative information which is currently being analysed to help inform citywide and neighbourhood actions to address the fundamental issues of low pay and productivity. A range of important quantitative data will also be analysed to help create the evidence base that will underpin the Strategy. This includes:
- Review of Greater Manchester evidence base which will be published in early 2019;
  - State of the City and Economy Dashboard;
  - Other sources of data such as the ONS Annual Survey of Hours and Earning and Labour Insight.
- 2.3 The draft timeline for the development of the Strategy is included in the table below. The ambition is to align the development of the Strategy to the GM LIS mean producing a draft by March 2019 with formal adoption of the final Strategy during summer 2019.

**Table 1: Manchester Local Industrial Strategy timeline**

<b>Task</b>	<b>Date</b>
Discussion at Economy Scrutiny Committee	10 October 2018
Consultation Phase 1	October – December 2018
Workshop with Our Manchester Forum	11 December 2018
Analysis of consultation results and GM evidence base	January 2019
Consultation Phase 2 and engagement with key boards and stakeholders on draft Strategy	Late January-February 2019
Draft Strategy to Economy Scrutiny Committee	6 March 2019
Final Strategy to Executive for adoption	Summer 2019



### **3.0 National Industrial Strategy**

- 3.1 The UK Government published their Industrial Strategy *'Building a Britain fit for the Future'* in November 2017 which aims to create an economy that boosts productivity and earning power. The Strategy is structured around five foundations of productivity (Ideas, People, Business Environment, Infrastructure and Place) – and four grand challenges (Ageing Society, Digital/Artificial Intelligence, Clean Growth, and Future of Mobility). The Strategy also lists a number of funding streams, some of which are new and some of which have already been announced.
- 3.2 The Strategy includes a commitment to work with Combined Authorities and Local Enterprise Partnerships (LEPs) to develop Local Industrial Strategies with the first being published by March 2019. These will be evidence based, long term plans which identify local strengths and challenges, future opportunities and the action needed to boost productivity, earning power and competitiveness. They will be used to direct local funding and also any national programmes.

### **4.0 Greater Manchester Local Industrial Strategy**

- 4.1 The 2017 Autumn Budget agreement between the GMCA and HM Government (HMG) committed them to jointly developing a GM LIS which will reflect the main themes of the national Industrial Strategy, but also take a place-based approach that builds on the area's unique strengths and ensures all people in Greater Manchester can contribute to, and benefit from, enhanced productivity, earnings and economic growth.
- 4.2 Discussions with local authority Leaders, LEP members and other stakeholders confirmed that the ambition should be to develop a focused strategy which progresses the growth and reform agenda, aligned to the refreshed Greater Manchester Strategy. These discussions have also identified stakeholder views that skills needs to be a central element of the GM LIS and that, ultimately, the success of the GM LIS will be critically linked to our ability to have more influence and control over the skills system than is currently the case.
- 4.3 The intention is that the GM LIS will be:
- developed so that it provides a long-term vision that sets out the opportunities to grow the economy and reform public services to 2030 and beyond;
  - informed by a robust evidence base, and focused on a select number of priority actions, to capitalise on Greater Manchester's strengths and address the challenges it faces to raise skills levels and improve productivity and earning power;
  - a collaborative effort, co-designed and jointly owned by Government, local leaders, business, the community, voluntary and social enterprise (CVSE) sector and citizens.

- 4.4 Working in collaboration with the Cities & Local Growth Unit, who are leading the development of local industrial strategies in Whitehall, the initial tranche of work has focused on two workstreams:
- Agreeing the approach to developing the GM LIS; and
  - Initiating the evidence base development work.
- 4.5 A robust and credible evidence base will be critical to make the case for what needs to be done to deliver growth for Greater Manchester and its residents. It will also be critical to ensure the buy-in from all government departments.
- 4.6 Greater Manchester already has a strong evidence-base (including the Manchester Independent Economic Review (MIER), the Northern Powerhouse Independent Economic Review, the Science and Innovation Audit, and the deep dive analysis, which provides a very solid platform on which to build. However, to enable the GM LIS process to genuinely drive forward the next phase of devolution and partnership working with Government, it was agreed that there was a need to build on this evidence and co-produce additional analysis with HMG.
- 4.7 The Greater Manchester Independent Prosperity Review was established during 2018 with the following panel members:
- Diane Coyle (Chair) – (Bennett Professor of Public Policy, University of Cambridge);
  - Professor Ed Glaeser (Professor of Economics at Harvard University);
  - Stephanie Flanders (Head of Bloomberg Economics);
  - Professor Henry Overman (Professor of Economic Geography at the London School of Economics);
  - Professor Mariana Mazzucato (Professor in the Economics of Innovation at University College London);
  - Darra Singh (Government & Public Sector Lead at Ernst & Young).
- 4.8 The panel identified a select number of research commissions to support the GM LIS. These are as follows:
- **Audit of Productivity:** This will aim to provide a finer-grained understanding of the barriers and enablers of productivity in different parts of Greater Manchester. It will build on the research piece undertaken recently by the GMCA on the economic role of the regional centre and look at agglomeration effects and clusters/specialisms across the city region.
  - **Education and Skills Transitions:** This will analyse the role of different parts of the education and skills system (early years, primary and secondary school outcomes, Further Education, Higher Education and skills within the labour market) in contributing to labour market outcomes. It will review the ‘transitions’ between different parts of the system and assess the extent to which failures at key transition points

impact on individual outcomes. It will seek to set out the role of local and national actors in delivering improved skills performance.

- **Low Productivity Sector Review:** This will analyse in more granular detail the long tail of low productivity firms within Greater Manchester. Case studies of major sectors will be undertaken, including adult social care (taking into account the devolved commissioning powers which Greater Manchester has within this sector). The report will focus on how productivity could be raised in these sectors, including through greater technology adoption and diffusion.
- **Supply Chain and Trade Analysis:** Recognising that this is a challenging area to explore in a short timescale, there is an identified need to better understand Greater Manchester's supply chain and trade linkages nationally and internationally. Work will be undertaken to explore what new datasets and analytical techniques are available which can give a better understanding of Greater Manchester's supply chain and trading linkages.
- **Innovation Ecosystem:** Aligned with the work to refresh the information in the Greater Manchester and East Cheshire Science and Innovation Audit (particularly to expand the coverage of private sector assets), this research will analyse the interrelationships between public and private innovation in Greater Manchester. It will look to fill gaps in understanding of private sector innovation through the use of innovative data techniques.
- **Infrastructure:** This study will analyse the infrastructure needs of Greater Manchester to raise productivity, including looking at current funding and investment models and the potential for new approaches to unlock additional investment in infrastructure.

4.9 The findings of the Review will be available in January 2019 and will be published in February 2019.

## 5.0 Recommendations

5.1 The Board are invited to comment on the approaches being developed in Manchester and Greater Manchester and the links between the two pieces of work.

5.2 The Board are also invited to suggest the most significant issues or topics they feel need to be addressed by the two Strategies. The views of the Board will form an important part of the overall consultation process.

This page is intentionally left blank

# Appendix 1: Developing Manchester's Industrial Strategy

Health and Wellbeing Board  
23<sup>rd</sup> January 2019

# Contents

1. Scope - purpose and rationale for local Industrial Strategy development
2. Context - National Industrial Strategy
3. Context - Greater Manchester Local Industrial Strategy
4. Manchester engagement

## 1. Scope - purpose and rationale (1)

The Our Manchester Strategy sets the vision for Manchester to be in the top flight of world-class cities by 2025, when the city will:

- Have a competitive, dynamic and sustainable economy that draws on our distinctive strengths in science, advanced manufacturing, culture, and creative and digital business – cultivating and encouraging new ideas
- Possess highly skilled, enterprising and industrious people
- Be connected, internationally and within the UK
- Play its full part in limiting the impacts of climate change
- Be a place where residents from all backgrounds feel safe, can aspire, succeed and live well
- Be clean, attractive, culturally rich, outward-looking and welcoming.

Manchester's Industrial Strategy will support the delivery of this vision by producing a delivery plan focused on **People, Place** and **Growth**. This approach puts people at the centre of growth, with the Strategy acting as our main responsibility for creating more **inclusive growth** in the city.

## ○ Scope - purpose and rationale (2)

- Alignment to GM Local Industrial Strategy and the national Industrial Strategy, expressing our position and responsibilities to promote and drive inclusive growth in the conurbation core.
- Clarify where Manchester can contribute to the GM strategy in particular the unique roles of the City Centre and the Airport and our contribution to the Northern Powerhouse.
- Develop with partners how we use the 4 Grand Challenges to find ways to increase our productivity.
- Provide a rationale to inform the city's spatial plan.

This work will inevitably touch upon a number of existing programmes of work (e.g. work and skills initiatives, reform programmes, planned transport investment) but will add value by focusing on what more needs to be done to ensure all residents can contribute to and benefit from enhanced productivity.



## 2. National Industrial Strategy

The Government have recently published a national Industrial Strategy – outlined below. Manchester is developing a local Industrial Strategy using the national framework underpinned by an ambition around inclusive growth.

The White Paper sets out an ambition to create an economy that boosts productivity and earning power throughout the UK around the “**5 foundations of productivity**”

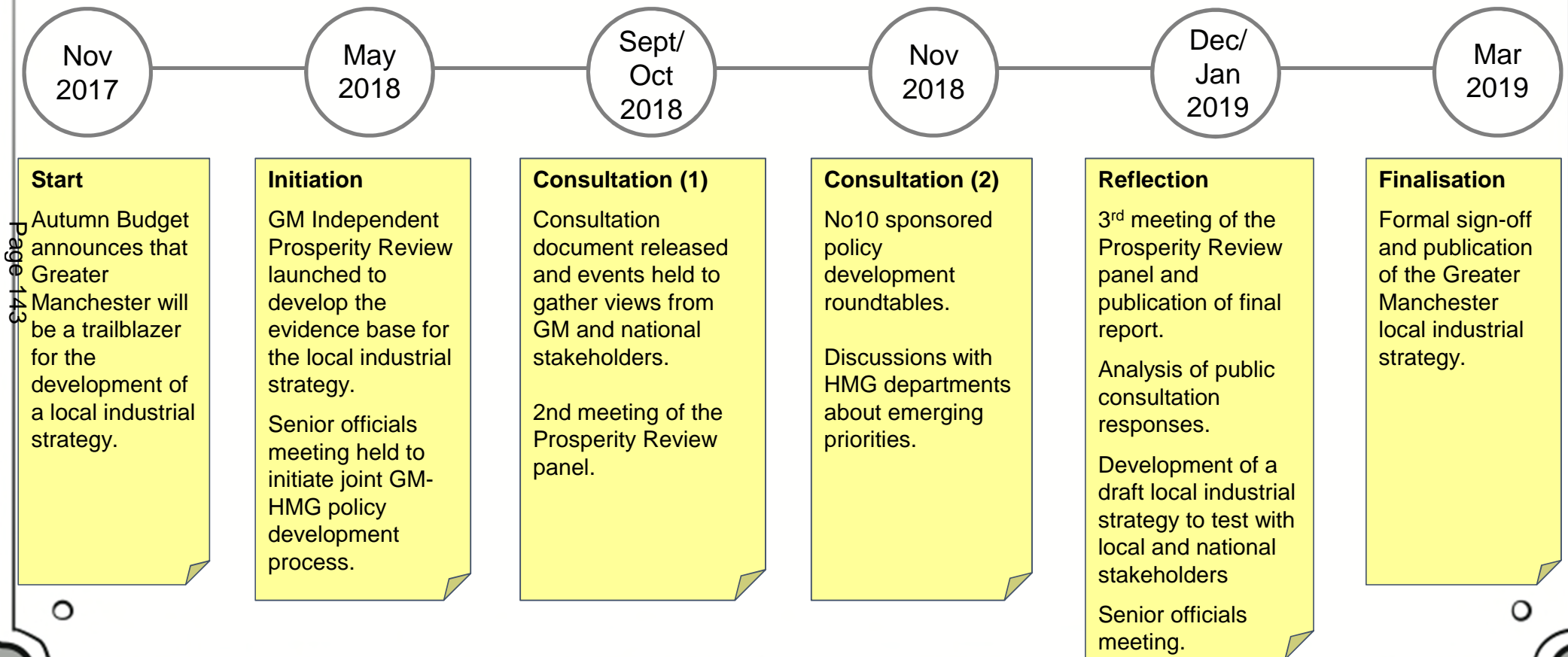
It also sets out **Grand Challenges** to put the future of the UK at the forefront of the industries of the future












### 3. Greater Manchester Local Industrial Strategy

- GM Local Industrial Strategy will reflect main themes of the national Industrial Strategy – but will take a place-based approach building on the region’s unique existing strengths.
- Will be a broad strategy to progress the GM growth and reform agenda, aligned to the GM Strategy, through focusing on the 5 Foundations of Productivity and 4 Grand Challenges
- Working in collaboration with the Cities and Local Growth Unit, including engagement with other government departments (DfE, DHSC, DCMS)
- Independent Advisory Panel established, who have identified a number of recommended research commissions
- Panel leading a GM Independent Prosperity Review to refresh the evidence base – final results available January 2019; agreed final strategy March 2019
- Co-design / co-production approach

# Greater Manchester LIS key milestones



# GM LIS Research Programme

<b>Baseline</b>	<b>Evidence stocktake</b> Baseline report covering progress since the Manchester Independent Economic Review (MIER) and summarising GM's existing evidence base across the five foundations of productivity.		<b>Progress with devolution</b> Update of progress on the implementation of GM's devolution deals, highlighting key achievements and barriers.	
<b>New commissions</b>	<b>Audit of Productivity</b> Developing our understanding of labour productivity performance in GM; the factors that determine that performance; and identifying possible policy responses to the issues identified.		<b>Low productivity</b> Developing GM's evidence base on the contribution of low productivity firms and sectors to the overall productivity challenge in the city region; and to identify possible policy responses.	
	<b>Supply chain and trade linkages</b> Understanding the inter-connections between sectors and firms; the way economic shocks are transmitted through supply chain connections; and the strength of the city region's trade linkages		<b>Infrastructure</b> Reviewing the infrastructure needs of Greater Manchester (GM) to raise productivity, including the potential for new approaches to unlock additional investment	
	<b>Education and Skills Transitions</b> Reviewing the role of the education and skills system in GM; how individuals pass through key transition points; and what can be done to help young people progress in life and work		<b>Global competitiveness and innovation</b> Assessing GM's future sources of competitiveness, understanding the innovation synergies which are emerging between sectors and firms. Exploring how to address gaps in GM's innovation ecosystem.	
<b>Recommendations</b>	<b>Reviewers' Report</b> On the basis of the research undertaken, the report will set out the key findings and Panel's recommendations as to how the GM Local Industrial Strategy should be developed			

## ○ 4. Manchester engagement

A wide ranging listening exercise with residents, workers and businesses across the city has been undertaken using the **Our Manchester principles**.

Approximate reach:

- 500 face-to-face conversations with residents across the city in different neighbourhoods;
- 110 online resident survey responses generated via social media posts;
- 200 face-to-face engagements with young people at a Youth Council event, 9 secondary schools (including 4 Special Education Needs schools) and an event with Uprising;
- 170 conversations and survey responses from businesses and organisations
- 25 Voluntary Community Sector responses

A full analysis is currently underway to inform the development of the Strategy with a first draft being produced by March 2019

This page is intentionally left blank

**Manchester Health and Wellbeing Board  
Report for Information**

**Report to:** Manchester Health and Wellbeing Board – 23 January 2019

**Subject:** Manchester University NHS Foundation Trust (MFT) One Year Post Merger Report

**Report of:** Peter Blythin, Single Hospital Service Director

---

### Summary

This report provides the Board with a final copy of MFT's One Year Post Merger Report. The Report captures some of the key achievements and lessons learned in the first year of operation for the new organisation.

### Recommendations

The Board is asked to note the contents of MFT's One Year Post Merger Report and the continued good progress with Integration.

---

### 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	
Improving people's mental health and wellbeing	
Bringing people into employment and ensuring good work for all	A Single Hospital Service Programme will optimise the provision of healthcare services to young people across Manchester and so minimise any adverse effects.
Enabling people to keep well and live independently as they grow older	A Single Hospital Service will ensure effective standardisation of hospital services in Manchester so that residents are able to access the best and most appropriate healthcare, regardless of where they live.
Turning around 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	The Single Hospital Service will help to facilitate development and implementation of the most appropriate care provision.
Self-care	

**Lead board member:** Kathy Cowell – Chair, MFT

**Contact Officers:**

Name: Peter Blythin

Position: Director, Single Hospital Service Programme (MFT)

Telephone: 0161 701 0190

E-mail: Peter.Blythin@mft.nhs.uk

**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.

None



## **Introduction**

1. The purpose of this paper is to provide a copy of the Manchester University NHS Foundation Trust (MFT) One Year Post-Merger Report (Annex A) to the Health and Wellbeing Board.

## **Background**

2. The Health and Wellbeing Board has received regular updates on the progression of the Single Hospital Service Programme including video briefings, presentations and written reports.
3. The attached One Year Post-Merger Report is a consolidation of the achievements, challenges and reflections from the first year of MFT, incorporating and building on the case studies and integration examples that have been previously submitted to the Board.

## **Content Summary of the One Year Post-Merger Report**

4. The One Year Post-Merger Report captures and celebrates some of the key achievements and benefits that colleagues have delivered in the first year of operation of MFT.
5. The Report also outlines the new organisational structure including the scope and scale of services MFT provides before setting out the vision and values that have been collaboratively developed with staff.
6. Additionally, the Report details the initial priorities of the new Trust and the dedicated focus MFT gave to ensuring that services remained safe and stable for patients.
7. Finally, the Report also reflects on the lessons learned from the merger process and outlines MFT's ambition to continue to integrate services and improve the provision of healthcare for the population it serves.

## **Recommendation**

8. The Manchester Health and Wellbeing Board is asked to receive the attached One Year Post-Merger Report and note the good progress that continues with integration.

This page is intentionally left blank



Manchester University  
NHS Foundation Trust

# One Year Post-Merger Report

## November 2018



# Contents

<b>Foreword</b>	<b>3</b>
<b>Executive Summary</b>	<b>4</b>
<b>Key Messages</b>	<b>5</b>
<b>1 Introduction to Manchester University NHS Foundation Trust</b>	<b>6</b>
<b>2 The Creation of Manchester University NHS Foundation Trust</b>	<b>10</b>
<b>3 First Priorities Post-Merger</b>	<b>13</b>
<b>4 Establishment of Leadership and Organisational Structure</b>	<b>15</b>
<b>5 Establishing Robust Governance and Assurance Arrangements</b>	<b>21</b>
<b>6 Developing MFT's Service Strategy</b>	<b>25</b>
<b>7 Planning for Major Clinical Transformation</b>	<b>27</b>
<b>8 Delivering Benefits in Year One Post-merger</b>	<b>29</b>
<b>9 Lessons Learned</b>	<b>40</b>
<b>10 Conclusion</b>	<b>46</b>

## Foreword

Manchester University NHS Foundation Trust (MFT) was launched on 1st October 2017. The new organisation brought together a group of nine hospitals plus community services, providing a once in a lifetime opportunity to deliver even better services for the people of Manchester, Trafford and beyond.

Our first priority was to keep services running safely and smoothly. On day one, patients saw little change apart from the new name and new lanyards for staff. We wanted to minimise disruption to maintain stability for staff and ensure patient safety.

We quickly started detailed planning to maximise the opportunities to improve services for patients and address the health inequalities that exist in the City of Manchester, Trafford and the wider communities we serve. We started to deliver changes steadily and we are pleased to see some major improvements for patients being delivered already. Behind the scenes significant work has also taken place to consolidate the systems, policies and processes that support the day-to-day operation of a major organisation.

Designing and embedding new governance and leadership structures was a key component of our early work. It took a great deal of effort and support from staff and, as a result, we now have an

organisational structure that is fit for purpose. This means we can press on to finalise the service strategy which will support more fundamental transformation over the coming years. This is exciting work which will continue to involve staff from across our nine hospitals and community services, along with partner organisations.

All this work has taken place against a challenging backdrop. Like other NHS Trusts, we face increasing demand on our services, workforce challenges and financial pressures. Despite this headwind our staff have continued to deliver outstanding care whilst also developing single services and delivering early transformation. We would like to thank them for their unrelenting efforts and support in establishing MFT, and for the steps they have taken to maintain and improve services for patients.

We look forward to continuing the development of MFT, and remain excited about the potential for us to reduce variation in care so that all patients can get the same standard of service no matter where they are in MFT. Together we can achieve an international reputation and exceed all expectations across care provision, education and training, and research and innovation for the benefit of patients.



*Kathy Cowell*

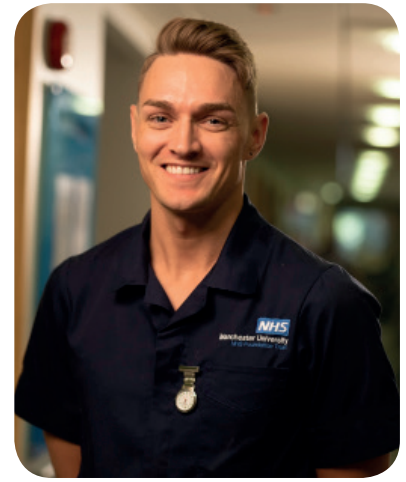
**Kathy Cowell OBE DL**  
Chairman



*Sir Michael Deegan*

**Sir Michael Deegan CBE**  
Chief Executive

## Executive Summary



Manchester University NHS Foundation Trust was created through the merger of Central Manchester NHS Foundation (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM) on 1st October 2017.

This One Year Post-Merger Report provides an overview of the Trust's establishment and first year of operation. It outlines the new organisational structure including the scope and scale of services it provides before setting out the vision and values that have been collaboratively developed with staff. It explains the initial priorities of the organisation, including the primary objectives of maintaining stability and continuing to deliver core activities safely.

The Report explains that a new organisation structure has been established comprising both traditional hierarchies and new networks that run across the breadth of the organisation. It outlines how the Trust's formal governance arrangements have been set up and how the Hospital, Managed Clinical Services and Clinical Standards Groups function and interact. It also confirms that despite the significant levels of change staff engagement to date has remained strong.

The Report confirms that the main driver for the creation of MFT was the opportunity to deliver significant patient benefits across the full range of services offered. These span improvements in patient safety, clinical quality and outcomes, to improvements in the experience of patients, carers and their families. It explains how the Trust is developing its overarching service strategy, setting out a long term vision that will shape how services are provided in the future. This service strategy work will inform the delivery of significant service transformation over the coming years.

**"The overriding reason for the merger was to create single hospital services for the people in Manchester and Trafford and, to make sure every person using our hospitals and community services receives the same excellent experience and quality of care, no matter where they live or where they access care. During our first year we have seen many examples of staff working together to improve standards of care for patients and their families."**

Professor Cheryl Lenney, Chief Nurse

The Report outlines that delivery of patient benefits has commenced with major improvements already evidenced in services ranging from lithotripsy and urgent gynaecology services to the better management of patients suffering a fractured neck of femur. Across the organisation staff have been working to develop single services that build on the strengths of the predecessor organisations. This work has been underpinned by efforts to consolidate systems, processes and policies in support services, such as IT, finance, HR and workforce.

The creation of MFT and subsequent work to fully establish the organisation has been a significant undertaking. The Trust has learnt useful lessons during this process and these are set out in the Report. This learning will go on to inform MFT's future work, including the proposed acquisition of North Manchester General Hospital. It is hoped that other NHS organisations will also be able to benefit from this learning.



## Key Messages

The value of having a credible, robust and adaptable Post-Transaction Integration Plan (PTIP) cannot be overstated. The PTIP provided the Group Board of Directors and external scrutineers with a framework to assess progress and gain assurance about the merger. More importantly it afforded staff, clinical leaders, managers and transformation teams a framework against which to operate from day one of the merger.

Having a dedicated Single Hospital Service/ Integration Team avoided the deployment of external consultancy and enabled delivery of the PTIP as a local product recognised and owned by staff. It also provided a resource to coordinate post-merger work including the transition from merger change processes to business as usual linked to portfolios of individual Group Executive Directors and Hospital and Managed Clinical Services Chief Executives.

Communicating and engaging with staff was crucial throughout the merger. Staff were central to the planning and delivery of the merger work and the subsequent development of the Vision and Values of the new Trust. Despite the significant level of change that has taken place staff engagement remains strong.

The establishment of an Integration Steering Group with active involvement of Group Executive Directors has been critical in driving change, tracking patient benefits and planning for Year Two of the merger.

The new organisational structure and governance arrangements were well planned pre-merger and established relatively quickly. Combining hierarchy and certain reporting arrangements with defined structures offered clear lines of accountability without stifling innovation, agility and flexibility. Matrix working has, and continues to be, encouraged.

A key element of post-merger work has been the consolidation of systems, processes and policies on a priority basis to ensure MFT operates as a single entity. This work is complex and will continue to receive attention as part of the PTIP work stream.

As planned, the development of the Trust's long term service strategy is well underway with strong engagement from across the organisation and with relevant partners.

The focus for the first year was on ensuring as much stability for staff as possible as well as protecting patient safety during a time of significant change. In essence it was a deliberate policy to maintain business continuity and avoid any unnecessary disruption to pre-merger working practices.

During the establishment of MFT and in its first year of operation important lessons have been learnt. These will be carefully considered to optimise future work.

"The creation of the new Trust was always going to be a fantastic opportunity to bring together the clinical strengths of our two predecessor organisations, and build on them to provide even better care to our patients. Both in the lead up to the merger and since, clinical engagement has been at the heart of the work to bring about benefits for patients; and I'm sure that's a major factor in achieving the successes we've already delivered."

Miss Toli Onon, Joint Medical Director

# 1 Introduction to Manchester University NHS Foundation Trust

MFT was created on the 1st October 2017 following the merger of CMFT and UHSM. It is one of the largest acute Trusts in England, employing over 20,000 staff. The Trust is responsible for running a group of nine hospitals across six distinct geographical locations and for hosting the Manchester Local Care Organisation:



In **Manchester City Centre** on the Oxford Road Campus care is delivered from the Manchester Royal Infirmary and four specialist hospitals: Saint Mary's Hospital, Royal Manchester Children's Hospital; Manchester Royal Eye Hospital; the University Dental Hospital of Manchester.

In **South Manchester** care is provided from Wythenshawe

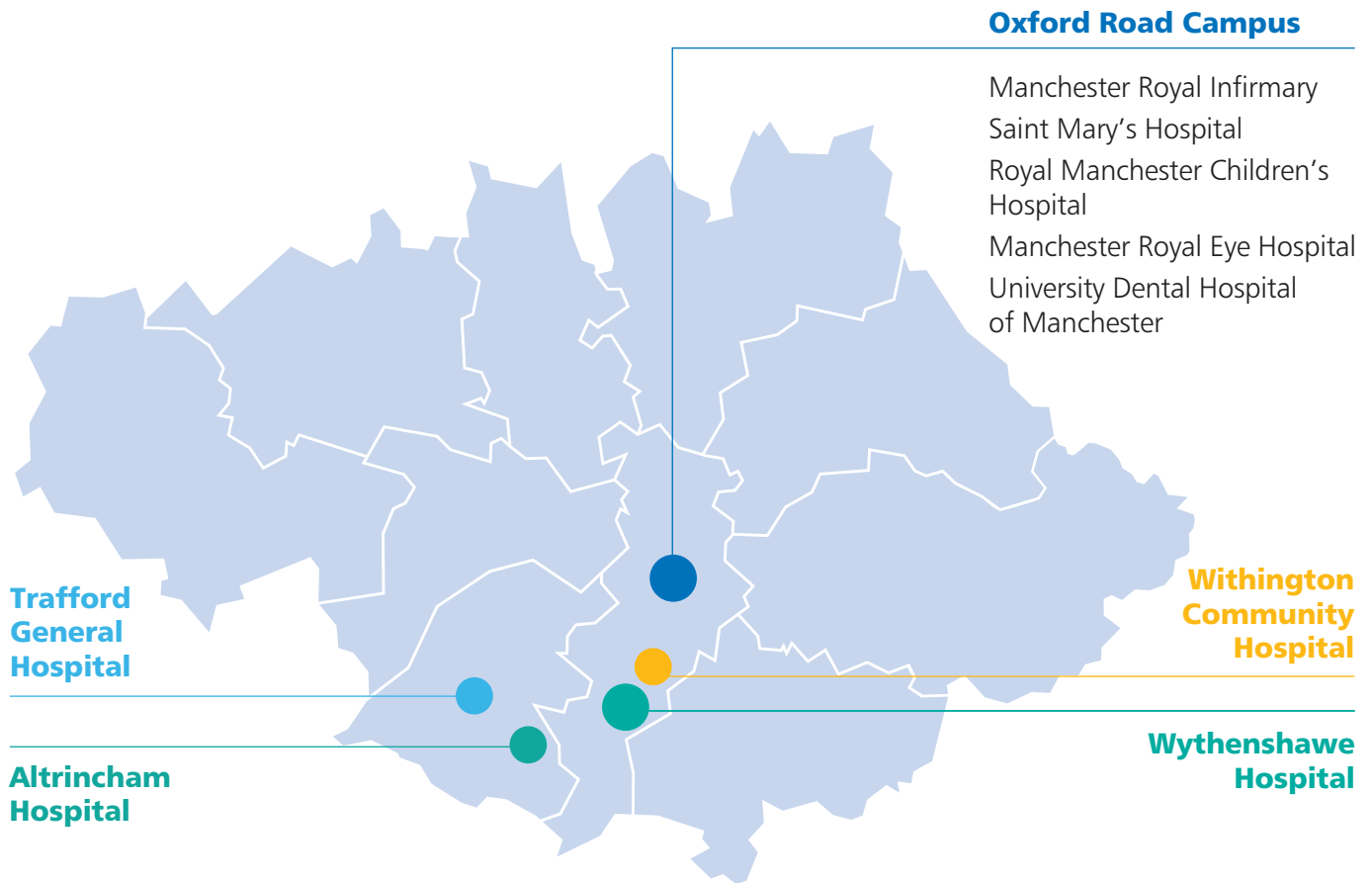
Hospital and Withington Community Hospital.

In **Trafford** services are delivered from Trafford General Hospital and from Altrincham Hospital.

MFT hosts the Manchester Local Care Organisation which is responsible for delivering integrated **out-of-hospital care** across the City of





**Figure 1: Manchester University NHS Foundation Trust**

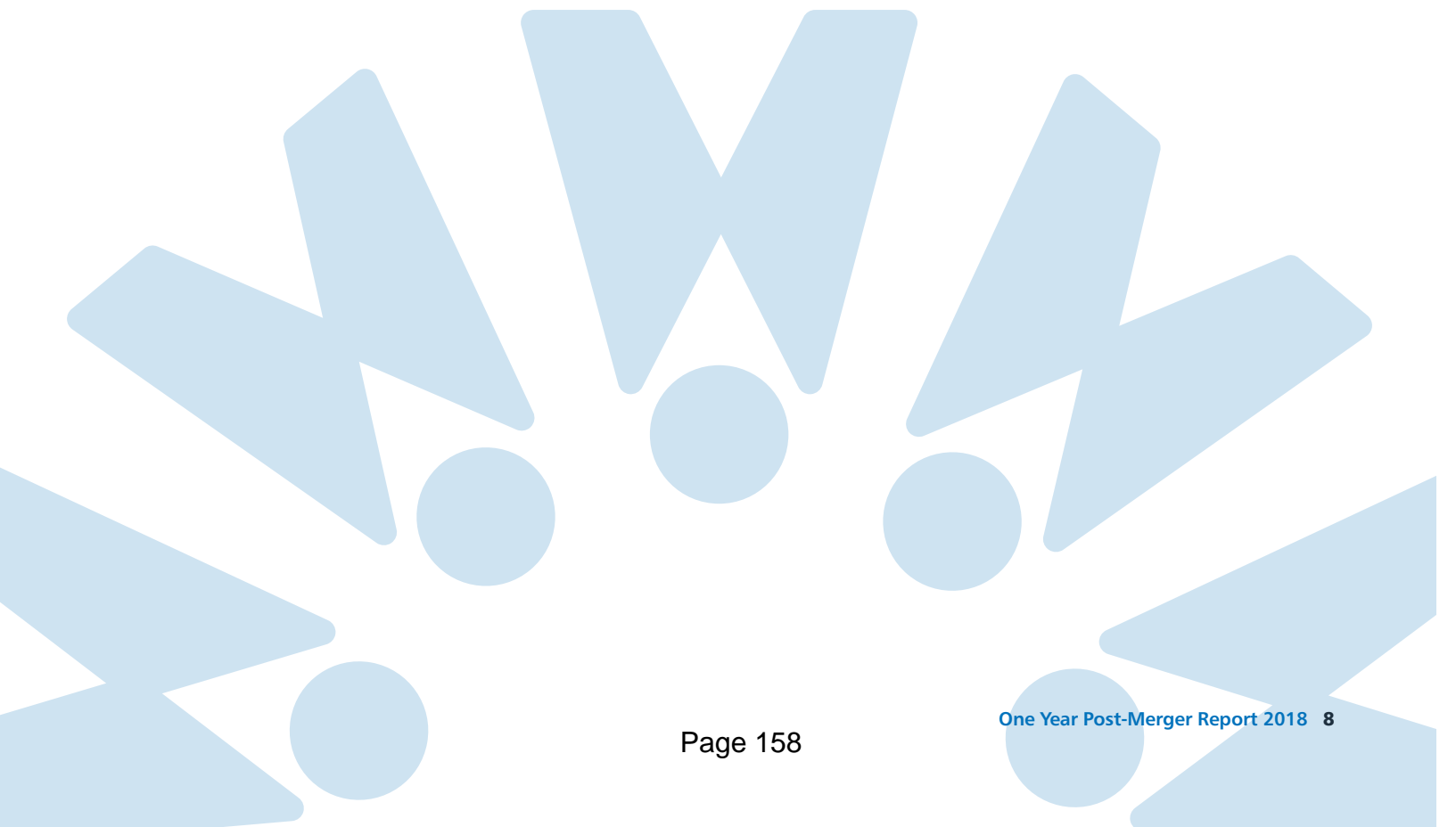
Whilst they operate as distinct hospitals, Saint Mary's Hospital, the Royal Manchester Children's Hospital, the Manchester Royal Eye Hospital, and the University Dental Hospital of Manchester have also been established as Managed Clinical Services. The hospital services use their in depth expertise to deliver and manage specific clinical services across the Trust. In addition, a dedicated Managed Clinical Service for Clinical and Scientific Support Services has been established and operates across the Trust. This arrangement ensures consistency of clinical standards, guidelines and pathways across the breadth of the organisation.

The Trust is the largest and one of the most diverse acute and community hospital groups in the country,

which despite its size is strongly rooted in the local communities it serves. It provides district general hospital services to a population of approximately 750,000 local people. It is also a major provider of tertiary and quaternary services across Greater Manchester and the wider North West region in areas including Vascular, Cardiac, Respiratory, Urology, Renal, Burns/Plastic Surgery, Cancer, Paediatrics, Women's Services, Ophthalmology, Breast Surgery and Genomic Medicine. The Trust is also the largest provider of specialised services in the country, providing 88 specialised services and 9 highly specialised services.

<p><b>The Trust employs over 20,000 staff</b></p> 	<p><b>The Trust attends to more than 1,725,000 out-patients per year</b></p> 
<p><b>The Trust has an annual turnover of almost £1.6 billion</b></p> 	<p><b>The Trust delivers over 13,000 babies and carries out in excess of 189,000 operations/procedures per year</b></p>
<p><b>The Trust sees around 405,000 patients in its Accident &amp; Emergency Departments per year</b></p> 	<p><b>The Trust has approximately 2,500 inpatient beds</b></p> 
<p><b>The Trust's research portfolio is the largest in the North West</b></p> 	<p><b>The Trust has the largest number of undergraduates and clinical staff in training in the North West</b></p>

MFT is a major academic research centre and education provider. This clustering of clinical services with life sciences and academia enables the Trust to deliver cutting edge care to patients.





## Manchester Local Care Organisation

Leading local care, improving lives in Manchester, with you

Whilst the creation of MFT was progressing, the Manchester Local Care Organisation (MLCO) was also being established. The Manchester LCO is a partnership between the City Council, Commissioners and providers, including MFT, with responsibility for the delivery of out-of-hospital care and improved community-based health services aimed at preventing illness and caring for people closer to home.

In March 2017, Manchester Health and Care Commissioning (MHCC) invited bids for the award of a single contract for the provision of health and care services across the neighbourhoods and communities of Manchester, through a Local Care Organisation (LCO). The prospectus stipulated that a single provider would be awarded a single contract by commissioners. A range of possible organisational models were reviewed, to establish which model could deliver the objectives and ambition of the LCO. Although a single contract for the delivery of the LCO services was not possible, partners including MFT agreed to develop a legally binding ten-year Partnering Agreement, which commits all parties (MFT, MHCC, Manchester City Council, Manchester Primary Care Partnership and Greater Manchester Mental Health NHS Foundation Trust) to the delivery of the LCO agenda and the transformation of out of hospital services.

The Partnering Agreement was formally signed by all Partners in March 2018, coming into effect on 1st April 2018, and in doing so establishing MLCO. MLCO is a virtual organisation responsible for the delivery of a range of services including community health services, and adult social care. As the organisation develops over an agreed three year phased approach, the range of services that will be delivered through MLCO will grow to include Mental Health and Primary Care.

MLCO continues to develop the Integrated Neighbourhood Team hubs, and the creation of a co-designed and all-encompassing approach to the MLCO. Key deliverables for 2018/19 and beyond will ensure that it is best placed to meet the needs of communities and neighbourhoods of Manchester in regards to integrated health and social care.

The benefits delivered through the Manchester LCO include improved health outcomes, improving people's experience of care, local people being independent and able to self-care, better integrated care, better use of resources, fewer permanent admissions into residential/nursing care and fewer people needing hospital-based care. Alongside progressing integration of the two predecessor Trusts, MFT is also working hard to support the establishment of MLCO.

This large and complex organisation has been in operation for just over twelve months. Although still in its infancy, MFT has already achieved a great deal. This report has been produced to explain some of these achievements and to celebrate the progress that has been made during its first year, including the improvements that have been delivered for patients and staff.

## 2 The Creation of Manchester University NHS Foundation Trust

### Single Hospital Service Review

The principle of significantly changing the way that hospital and community services are provided in Manchester was first established late in 2015, in the Manchester Locality Plan.

This work was led by MHCC in collaboration with the Manchester Health and Wellbeing Board. It commenced in response to the challenges faced by health and social care providers, and set out an ambitious programme of work made up of three 'pillars' and called the Manchester Locality Plan:

- A Single Hospital Service for Manchester;
- A local care organisation that delivers integrated, accessible, out-of-hospital health and care services across Manchester; and
- A single commissioning system for health and social care services across the citywide footprint.

The Manchester Locality Plan was endorsed by all local stakeholders across the city and supported by Trafford Council.

**"The creation of a Single Hospital Service is a key strand of the Manchester Locality Plan, along with the Single Commissioning Function and Local Care Organisation, and was a complex undertaking. The two Trusts achieved this within a year, working in partnership with organisations in the locality. This was a vital step towards ending health inequalities in our city to make sure everyone gets the same quality of care, no matter where they live."**

Ian Williamson, Chief Responsible Officer,  
Manchester Health and Care Commissioning

To commence the Single Hospital Service element of this work the 'Single Hospital Service Review' was commissioned in 2016. This work, independently led by Sir Jonathan Michael, sought to consider the benefits that might be accrued by hospital services in Manchester working more closely together and to identify the optimal organisational form required to deliver these improvements. At the time of the Review there were three hospital service providers in Manchester: CMFT, UHSM, and North Manchester



General Hospital (NMGH) – part of Pennine Acute NHS Hospitals Trust (PAHT). All three were included in the review process.

The first stage of the review acknowledged the significant challenges that were facing health and social care providers in Manchester. The review found that hospital care was fragmented and that there was an unacceptable variation across the City in the provision and quality of care provided. The review also identified that although duplication, and even triplication, existed across the city in some clinical services, in other specialties patients were struggling to access healthcare appropriate to their needs. Workforce challenges facing hospital providers, exacerbated by the imperative to move to more even service provision across the seven days of the week, were also highlighted as a key issue. In line with NHS services nationally, increasing financial and operational difficulties were also acknowledged.

The development of a Single Hospital Service was identified as a key mechanism to address these issues. To identify the potential benefits of a Single Hospital Service the review focussed its attention on eight specialty areas and engaged clinicians to identify specific improvements that could be delivered by closer co-operation of clinical teams. This work was extrapolated and expanded to include contributions from colleagues working in research, training, finance and back office support services.

The process resulted in the identification of a series of high level benefits that cover a range of areas including quality of care, patient experience and financial/operational efficiency. The full list of potential benefits that were identified is shown in Table 1.

**Table 1: High level benefits identified in the Sir Jonathan Michael Review<sup>1</sup>**

Category	Benefits
<b>Quality of Care</b>	<ul style="list-style-type: none"> <li>• Reduce variation in the effectiveness of care</li> <li>• Reduce variation in the safety of care</li> <li>• Develop appropriately specialised clinicians and reduce variation in the access to specialist care, equipment and technologies</li> </ul>
<b>Patient Experience</b>	<ul style="list-style-type: none"> <li>• Provide more co-ordinated care across the city (and reduce fragmentation)</li> <li>• Enhance the work of the Local Care Organisation to transfer care closer to home</li> <li>• Improve patient access and choice</li> <li>• Improve access to services and reduce duplication (and thus unnecessary trips to hospital)</li> </ul>
<b>Workforce</b>	<ul style="list-style-type: none"> <li>• Improve the recruitment and retention of a high quality and appropriately skilled workforce</li> <li>• Support the requirement to provide a seven day service</li> <li>• Reduce the reliance on bank and locum/agency staff</li> <li>• Support teams to meet the needs of current and future demand for services</li> </ul>
<b>Financial and Operational Efficiency</b>	<ul style="list-style-type: none"> <li>• Reduce costs in supplies and services (including drug costs)</li> <li>• Reduce staff costs through improvement in productivity and changes in skill mix</li> <li>• Limit future capital outlay and ongoing fixed costs assets</li> <li>• Improve operational performance</li> </ul>
<b>Research and Innovation</b>	<ul style="list-style-type: none"> <li>• Increase research activity and income</li> <li>• Create a single point of entry to all clinical trials thereby improving access</li> <li>• Ensure new research and best practice guidelines are implemented consistently to improve services</li> </ul>
<b>Education and Training</b>	<ul style="list-style-type: none"> <li>• Optimise curriculum delivery, clinical exposure and reduce the variability in the student and trainee experience</li> <li>• Widen student and trainee exposure to different clinical environments</li> <li>• Enhance the reputation of Manchester as a place to come to be trained and to work</li> </ul>

<sup>1</sup>City of Manchester Single Hospital Service Review Stage One Report; April 2016.



Given the scale of the potential benefits, the second stage of the review considered the options for changing the governance and leadership arrangements for hospital services in Manchester to achieve the identified benefits as rapidly and effectively as possible. This process recommended that the most effective organisational approach to delivering benefits would be through the creation of a single new hospital provider, encompassing the existing hospitals (CMFT, UHSM and NMGH) located within the City of Manchester.

The findings of the review were fully supported by all local stakeholders including the three acute Trusts, local commissioners, civic leaders across the city, civic leaders at Trafford Council and Manchester's Health and Wellbeing Board.

**"The creation of Manchester Foundation Trust was a crucial step in the development of a Single Hospital Service for the City of Manchester and our devolved health and care model for Greater Manchester. By UHSM and CMFT bringing together their assets, skills and specialisms, we now have an organisation which is greater than the sum of its parts, of national and global significance. Already we are seeing the impact in terms of improvements to clinical services, enhanced career opportunities and a richer research and development offer."**

Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership

(NHS I) and the CMA. A key component of this work was the development of a PTIP which set out the tasks required to successfully merge CMFT and UHSM, and start to deliver the Single Hospital Service patient benefits, by Day One, Day 100, Year One and Years 2-5.

MFT remains committed to the principal of a Single Hospital Service in the City of Manchester and has started work to enable NMGH to join the Trust. This work is expected to conclude between 1st October 2019 and 1st April 2020 and is being overseen by the Greater Manchester Health and Social Care Partnership. The transfer of NMGH into MFT will truly allow the full range of benefits, outlined in the Single Hospital Service Review, to be delivered to all residents across the City of Manchester, and beyond.



## Creating MFT

To fulfil the recommendations of the Single Hospital Service Review it was decided to first merge the two Foundation Trusts in the expectation that the resulting single Foundation Trust would later acquire NMGH from Pennine Acute NHS Hospitals Trust.

Work started in the Autumn of 2016 to merge CMFT and UHSM. A programme team was established and appropriate governance mechanisms were arranged to ensure elements of process, including Competition and Markets Authority (CMA) submissions, the development of a Business Case, Due Diligence and legal mechanisms were completed.

This work was undertaken in twelve months and obtained clearance from both NHS Improvement



### 3 First Priorities Post-Merger

Although merging two large acute NHS Foundation Trusts to create MFT was a relatively unique undertaking, there have been a number of examples of hospitals integrating. These integrations have achieved varying success, and MFT has sought to learn lessons from elsewhere to avoid the problems that similar projects have experienced. Some of the key issues that NHS I advises merging Trusts to consider are:

- Setting a realistic timeframe for delivering change.
- Engaging with stakeholders.
- Balancing merger implementation and maintaining core activities.
- Embedding a common culture.
- Establishing effective management across multiple sites.

Taking these issues into account, MFT deliberately placed an emphasis on the need to maintain stability throughout the process of merger and immediately after. The PTIP, developed in advance of the merger, intentionally minimised the number of changes that would take place on Day One of the new organisation. This allowed a focus on the basics of constantly and consistently delivering patient safety, patient experience and high quality care. MFT delivered this against the challenging backdrop of unprecedented winter pressure nationally which resulted in considerable demand on urgent and emergency services.

**“The important thing to achieve was to ensure patients and staff felt safe on day one of the merger. Having an integration plan meant we could do that. We deliberately did not plan for major changes in the first year but we did deliver some early benefits.”**

Julia Bridgewater, Group Chief Operating Officer

Throughout the merger and integration UHSM and CMFT, and subsequently MFT, ensured that existing staff, including those at NMGH, were central to the planning and delivery of the merger work. There was a conscious decision to limit reliance on external management consultants. This has ensured that knowledge has been retained and embedded within

the organisation, and that work was undertaken with an in depth understanding and appreciation of the predecessor organisations, including their underlying cultures, strengths and weaknesses.

This measured and steady approach ensured that the new organisation maintained its focus on the delivery of safe and high quality services for patients, whilst also undertaking the significant work required to create a new organisation. The focus on stability and delivering core activities, while steadily implementing the integration required when two organisations come together, has persisted.

In preparation for Day One, significant work was undertaken by support services to provide the essentials to create a new MFT identity. All staff were sent a welcome letter and provided with a new lanyard and badge holder. Although CMFT and UHSM email addresses continued to work, each staff member was provided with a new MFT email address. This helped to promote the sense that staff from both predecessor organisations were now part of a single entity and working together.

Alongside these more visible changes, critical work was undertaken to enable the organisation to operate successfully as a single entity. The majority of this work was overseen by a Corporate Integration Steering Group, chaired by the Deputy Chief Executive, and a Clinical Risk and Governance Steering Group, chaired by the Chief Nurse.

The integration plans for the first 100 days largely focussed on the need to put in place firm and robust organisational structures, including a new Council of Governors, a substantive Group Board of Directors and Hospital/Managed Clinical Service leadership teams. In addition work commenced to consolidate systems, processes and policies and to implement a small number of clinical improvement schemes. Preparation was also undertaken to support the Trust’s first Care Quality Commission (CQC) inspection.

The work to consolidate systems, processes and policies has been significant. Immediate work was undertaken to enable cross site working and to support effective management and reporting across the Trust. This included merging the Electronic Staff Records, implementing a single ledger, integration of the Annual Planning Process and development of a single risk management system.

Alongside delivering this change, corporate services began to consolidate into single teams working across MFT, bringing together the teams from the two predecessor organisations. This has involved over 1000 members of staff. Due to the scope and scale of the services, and the pressure to simultaneously support wider changes within the organisation, this work has been carefully paced. The restructures that have been completed to date have delivered financial savings of five percent. It is planned that similar savings will be delivered across the services that remain to be consolidated.

Collectively these early changes began to give the new organisation a sense of identity that staff could relate to and feel part of. To promote this further one of the first priorities was the development of MFT's vision and values as part of a major organisational development programme with staff. Developing these early with staff, patients and partners was essential to supporting the development of the organisation's culture and setting the direction of travel on which the foundations of success would be built. These are set out in Figure 2.

**Figure 2: MFT's Vision and Values**

## Our Vision

Our vision is to improve the health and quality of life of our diverse population by building an organisation that:

- **Excels in quality, safety, patient experience, research, innovation and teaching**
- **Attracts, develops and retains great people**
- **Is recognised internationally as a leading healthcare provider**

## Our Values

**Together Care Matters**

**Everyone Matters**

**Working Together**

**Dignity and Care**

**Open and Honest**



<https://mft.nhs.uk/the-trust/our-vision-and-values/>

Staff quickly engaged in this work and related strongly to the vision and values. This has been clearly demonstrated through the regular staff surveys undertaken by the Trust. For example, in Quarter 2 of 2018/19, 89% of MFT staff reported that they were aware of the Trust values.

This significant change work has been delivered carefully without distracting MFT from its core purpose; to excel in quality, safety and patient experience. MFT recognises the valuable contribution that all staff have made following the merger. Whilst the organisation has been committed to ensuring all employees are kept informed and engaged regarding

the integration process, much of the success of MFT's first year is because of the hard work, commitment and dedication of MFT staff. Teams have seized the opportunity that the merger provided and have been working to ensure that the benefits of a Single Hospital Service are delivered. Some examples of the excellent work that has been undertaken following the creation of MFT are outlined in Chapter 8.

The creation of MFT was a ground breaking process that has yet to be repeated elsewhere in the country. The remainder of this document sets out some of the key achievements that have been delivered by MFT during its first year.



## 4 Establishment of Leadership and Organisational Structure

In order to deliver services safely and effectively, MFT prioritised the establishment of a robust organisational structure and new leadership teams. Given the scale of the organisation this was critical to ensuring a strong and continued focus on delivering safe care for patients. In addition to being a new organisation, MFT was formally and legally constituted as a 'Group'. This required a new design of Executive oversight and leadership.

### Trust Membership Base

As a new NHS Foundation Trust, MFT required a new membership base. In order to establish the membership in a timely manner it was formed from the existing CMFT and UHSM membership base. Members were contacted and advised that they would automatically become members of the new Trust unless they actively opted-out. A small number of staff chose to opt-out. The remaining 42,000 members formed the initial membership of the new Trust. Work has since been undertaken to recruit more participants and to refine the involvement, ensuring that it is representative of the population served by MFT.

### Council of Governors

As a new NHS Foundation Trust, MFT also had to meet a statutory requirement to have a new Council of Governors. Immediately after authorisation of the new Trust on 1st October 2017, the MFT Public and Staff Governor election process was instigated. The elections concluded in November 2017 and the results were announced at a Special Members Meeting in December 2017. A new Lead Governor was elected and this appointment was confirmed at the inaugural meeting of the MFT Council of Governors on 20th December 2017. Since then significant work has been undertaken to plan and deliver training and development for the new Council of Governors.



### Group Board of Directors

Prior to the merger of UHSM and CMFT an Interim Group Board of Directors was established in line with the requirements set out in the NHS I Transaction Guidance. This Interim Board remained in operation after the merger to provide stability and continuity. The substantive Group Board of Directors was confirmed and became operational on 20th December 2017 following a robust selection process which included external assessment.

### Design of the Organisational Structure

Alongside the establishment of the high level organisational leadership, implementation of the new organisational structure commenced. To ensure that every member of staff was clear about their own accountability the default position was that pre-merger accountability arrangements would stand and no overnight changes were made for Day One of the new organisation except in exceptional circumstances.

The leadership team carefully designed the new structure, taking into consideration learning from other hospital groups, both nationally and internationally. Some of the organisations reviewed favoured a vertical structure, where hospitals and accountability were the focus, ensuring operational grip. Contrastingly, other organisations favoured a horizontal structure where clinical synergies and pathways were the main focus. Notably, each organisation stated they would have focused on the opposite approach if they went through the process again.

Considering this learning, MFT designed a structure that starts with the delivery of clear, vertical operational grip to ensure patient safety and maintain clear accountability. This is achieved through the management of the Hospital Sites and Managed Clinical Services as operational units, each with their own Chief Executive and leadership team. These operational units are overseen by the Group Chief Operating Officer with Chief Executives reporting to the Group Chief Executive.

The achievement of clinical synergies is being delivered through the establishment of Managed Clinical Services and Clinical Standards Group functions. The Clinical Standards Groups bring

together a multi-disciplinary group of subject experts and supporting professionals to enable clinical staff to apply best practice and standardisation across the Trust. In addition, Education and Research runs through the whole structure.

Through this comprehensive approach, the new organisational structure facilitates clinical service delivery against evidence-based standards of practice, combining site specific management with the management and ongoing development and change of clinical services across sites. This dual approach is beginning to give the organisation flexibility and agility despite its size. As the horizontal functions and networks mature it is envisaged that they will provide challenge and will enable the organisation to continually adapt and change.

## Detailed Organisational Structure

Breaking down the structure in greater detail, MFT has eight operational units; five of these are described as Managed Clinical Services, two are hospitals and one is the hosted Manchester Local Care Organisation. Of the five Managed Clinical Services, four are associated with a distinct physical site, whilst one manages services across multiple sites. The five Managed Clinical Services are accountable for the delivery and management of a defined group of clinical services taking place on any site within MFT. Their role includes the operation of Clinical Standards Groups for their areas of specialty, setting clinical standards and developing evidence-based guidelines and pathways across the Trust. This arrangement is described in Table 2.

**Table 2: Managed Clinical Services**

Managed Clinical Service	Services	Clinical standards development function
Clinical & Scientific Services (CSS)	Anaesthesia, Critical Care, Pathology, Radiology et al	Yes
Manchester Royal Eye Hospital (MREH)	Adult & Paediatric Ophthalmology	Yes
Royal Manchester Children's Hospital (RMCH)	Children's Services	Yes
Saint Mary's Hospital (SMH)	Women's Services & Neonatology	Yes
University Dental Hospital of Manchester (UDH)	Dental Surgery & Oral Medicine	Yes

The other two operational units are the hospital sites of Manchester Royal Infirmary (MRI) on the Oxford Road campus, and the multiple hospital sites of Wythenshawe, Trafford General, Withington and Altrincham Hospitals (WTWA) managed by the senior leadership team based out of Wythenshawe

Hospital. The two operational units of MRI and WTWA each deliver many clinical services to adults which they share in common, such as Emergency Medicine, Urology and Cardiac Surgery, but which are operationally managed independently by each site. This arrangement is described in Table 3.

**Table 3: Hospital Sites**

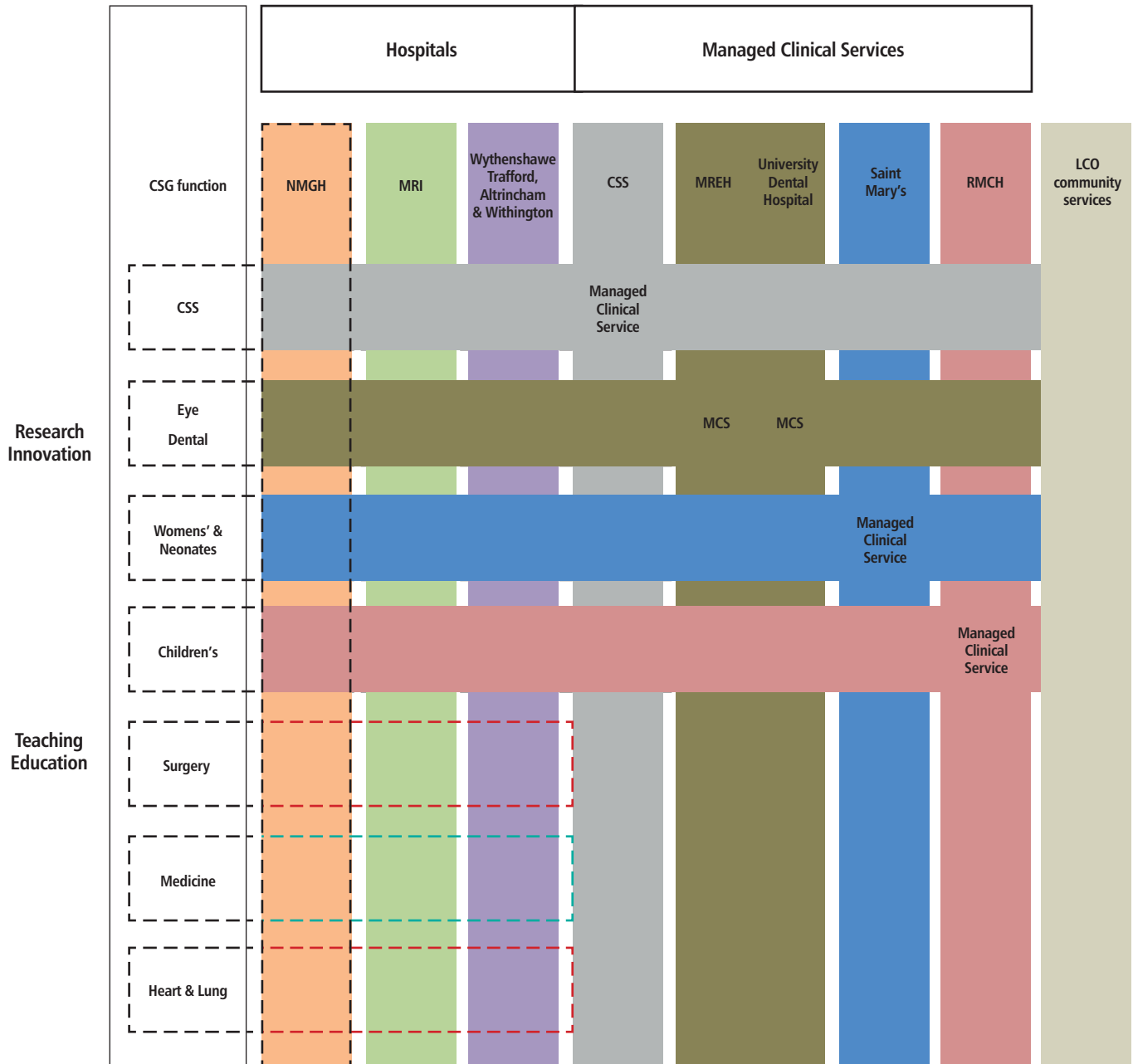
Hospital Site	Services include:	Clinical standards development function within hospital site
Manchester Royal Infirmary (MRI)	Adult Medical & Surgical Services including Cardiac & Respiratory	No
Wythenshawe, Trafford, Withington & Altrincham (WTWA)	Adult Medical & Surgical Services including Cardiac & Respiratory	No

The organisation structure also takes into account the Manchester Local Care Organisation (LCO) and provision of community services. MFT is a key partner in the LCO that is providing integrated out-of-hospital care in the city of Manchester. Services provided incorporate community nursing, community therapy

services, intermediate care and enablement, and some community-facing general hospital services.

The overall organisational structure of MFT is illustrated in Figure 3, including NMGH which is planned to join the Trust in the near future.

**Figure 3: Diagram of MFT Organisational Structure**



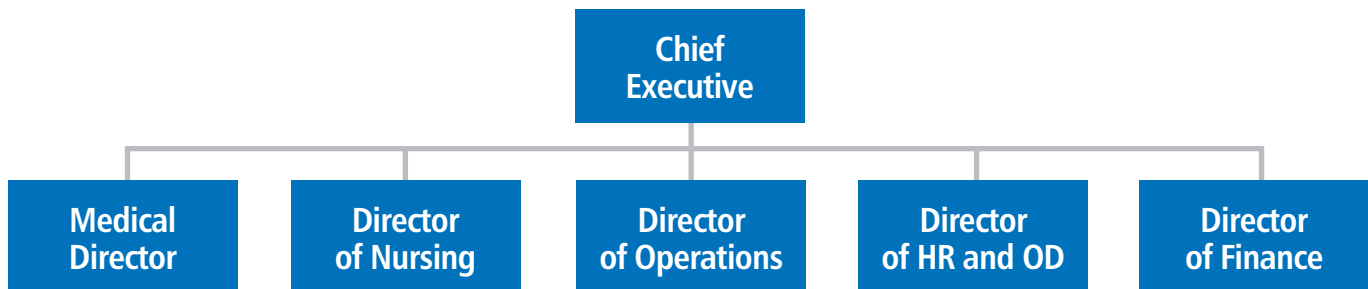
NMGH is planned to join the Trust in the near future.

### Organisational Leadership

Based on the new organisational structure, implementation of the senior leadership arrangements started immediately after the Trust was established. This was undertaken in a planned, staged approach to limit disruption to services, but at sufficient pace to ensure that the structure was in place by April 2018.

The Hospital and Managed Clinical Service leadership teams are central to maintaining patient safety and

clear accountability. It was therefore decided that they would be recruited as early as possible through rigorous internal and external recruitment processes. Each Hospital and Managed Clinical Service has its own Medical Director, Director of Nursing, Director of Operations, Director of Finance and Director of HR and Organisational Development. These senior leadership teams are each led by a Chief Executive.

**Figure 4: MFT Hospital and Managed Clinical Service Organisational Structure**

The appointment of leaders in the Group Corporate functions followed the establishment of the substantive Group Board of Directors. Each Group Executive Director developed the structures for their own directorates, and formal consultation on these changes started in January 2018. The review and alignment of Group Corporate functions has been undertaken in a phased approach, based on an assessment of priority to minimise disruption, reduce risk and ensure business continuity.

Throughout the recruitment of the organisational leadership there was a strong focus on consistency in both the design of structures, roles and pay, and also in the approach to the process of managing change and recruitment. This ensured transparency and equity of access for all individuals. The process was overseen by the Group Executive Director Team.

**“We made a conscious decision to maintain a clear focus on continuing to deliver stable services during Year 1, while also starting the work required to integrate our hospitals and community services. I’m so proud of what we have achieved so far. Now we will build on this, sharing our many strengths to deliver consistent, high quality care for all.”**

Sir Michael Deegan, Group Chief Executive

In addition to the establishment of the Hospital and Managed Clinical Service leadership teams, the leadership of the three standalone Clinical Standards Groups was appointed to during March 2018.

The Clinical Standards Group leads are medically-qualified consultants who provide clinical leadership and expertise to oversee a set of clinical standards. For example, the Surgery Clinical Standards Group Lead sets standards relating to Adult Surgery including General Surgery, Oral and Maxillofacial Surgery, Otolaryngology, Burns and Plastics, Trauma and Orthopaedics, Urology and Vascular Surgery; but excluding Cardiothoracic and Heart/Lung Transplant Surgery (which would fall under the Heart and Lung CSG), and excluding Paediatric Surgical specialties (whose standards will be monitored and developed by the RMCH Managed Clinical Service).

In undertaking their roles the Clinical Standards Group Leads are expected to foster high levels of clinical involvement and joint working, underpinned by a culture of integrity to reach the best outcomes for patients.







Freedom to speak up

## Freedom to Speak Up Guardian and Champions

The Trust also appointed a Freedom to Speak Up Guardian and Freedom to Speak Up Champions across all hospital sites and Managed Clinical Services to support staff, students and patients to raise concerns. The Champions act as a local resource to support staff who raise concerns. They work continuously to improve safety and quality for patients, carers and families, as well as enhancing the work experience for staff.

"I know how to speak up safely at MFT"



MFT Freedom to Speak Up Guardian David Cain

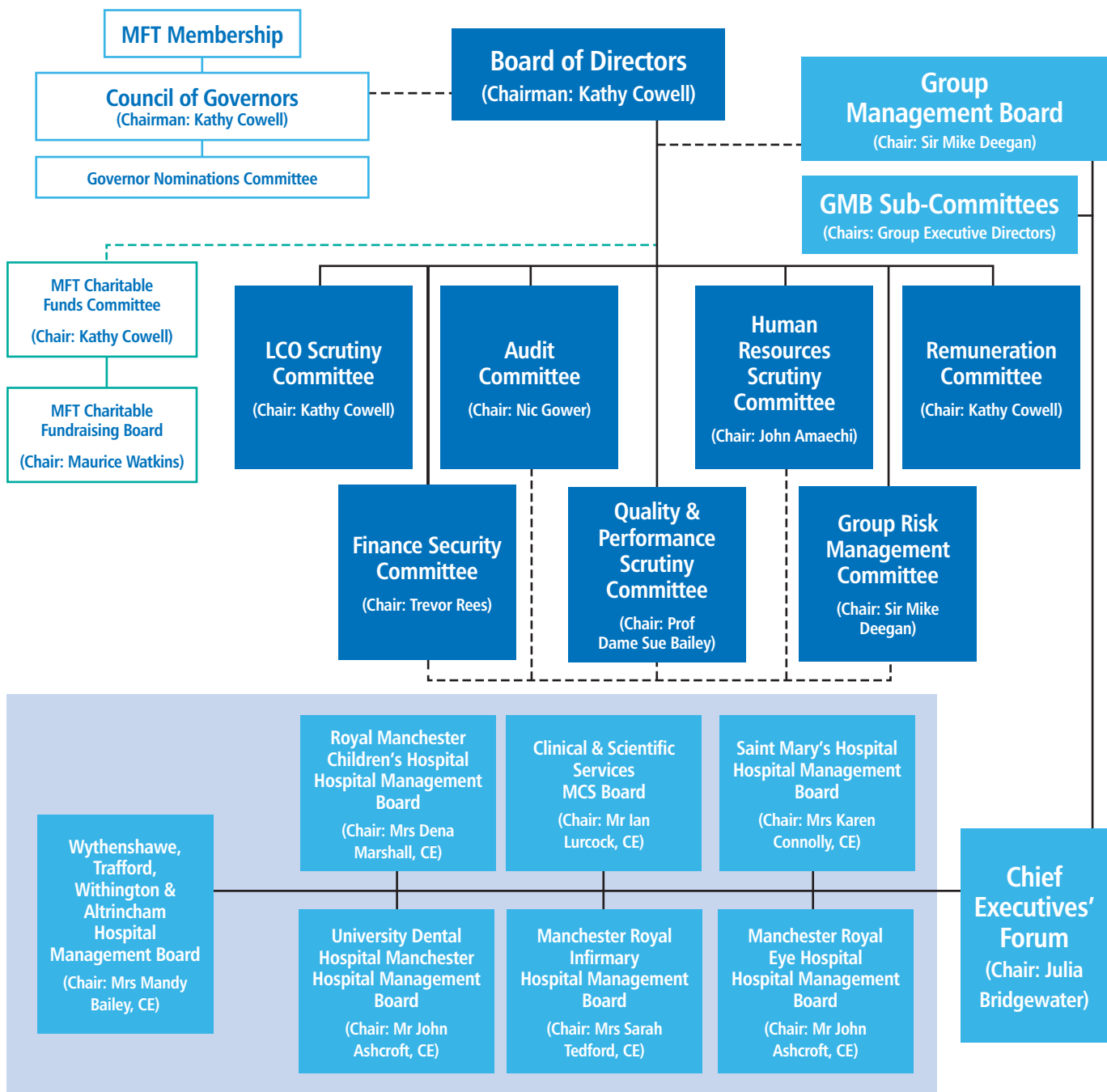
# 5 Establishing Robust Governance and Assurance Arrangements

As a new NHS Foundation Trust, MFT needed to establish its Board Sub-Committee structure and a new design of Executive Director oversight and leadership appropriate to its constitution as a Group. The governance structure and assurance arrangements to support the Board of Directors have been established over the course of the Trust’s first year.

## Board Sub-Committees

Board Sub-Committees chaired by the Non-Executive Directors and the Group Chief Executive were established in October 2017, providing oversight of the full breadth of MFT’s clinical and non-clinical activities. The Board Sub-Committee structure is illustrated in Figure 5.

**Figure 5: Board Sub-Committee Structure**



## Accountability Oversight Framework

The Accountability Oversight Framework (AOF) underpins how the Hospitals and Managed Clinical Services function and interact with the Group Executive Directors. The AOF contributes to the overarching Board Governance Framework. The key purposes of the AOF are to:

- Provide a fair and transparent means of understanding performance across the Group;
- Identify areas of good and poor performance; and
- Enable Group Executives to direct Group resources to support improvement in areas of greatest need.

The AOF records monthly performance across a wide range of metrics. This provides visibility to the Group Executives on performance trends, providing early warning signs where performance is off track. Focussed discussions are held with Hospitals and Managed Clinical Services to agree remedial actions.

## Single Operating Model

Each Hospital and Managed Clinical Service leadership team is responsible for establishing effective governance and accountability to ensure successful operational delivery and achievement of the metrics set out in the AOF. To support this the Trust introduced a Single Operating Model.

The Hospital and Managed Clinical Service Management Boards have established governance structures that mirror the corporate governance structure. The Management Boards are responsible for the oversight and delivery of performance. They are underpinned by a number of sub-groups focussed on the day-to-day management of performance against key business areas. To gain assurance a performance review process is undertaken with individual service lines to ensure consistency from 'Ward to Board' with input from the Clinical Standards Groups, where appropriate.

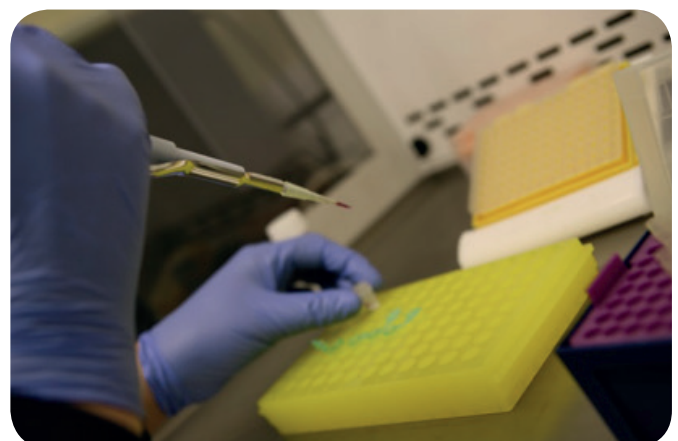
## Clinical Standards Groups

To ensure that the Clinical Standards Groups are embedded across the Trust, the Clinical Standards Group Leads and Managed Clinical Service Medical Directors are members of the Group Management Board, Clinical Advisory Committee and Quality

& Safety Committee. They also share corporate responsibility for the implementation of agreed Board decisions.

The Clinical Advisory Committee, chaired by the Group Joint Medical Directors, provides oversight and assurance of the Clinical Standards Groups' work programmes. This ensures that all hospital and Managed Clinical Service Chief Executives are sighted on their priorities and activities, and that any changes instigated are planned and delivered without unintended consequences on day-to-day operations.

The output of the Clinical Standards Groups is scrutinised by the Quality and Performance Scrutiny Committee and any risks identified are reported to the Group Risk Management Committee; both are sub-committees of the Group Board of Directors.





## Hospital and Managed Clinical Service Reviews

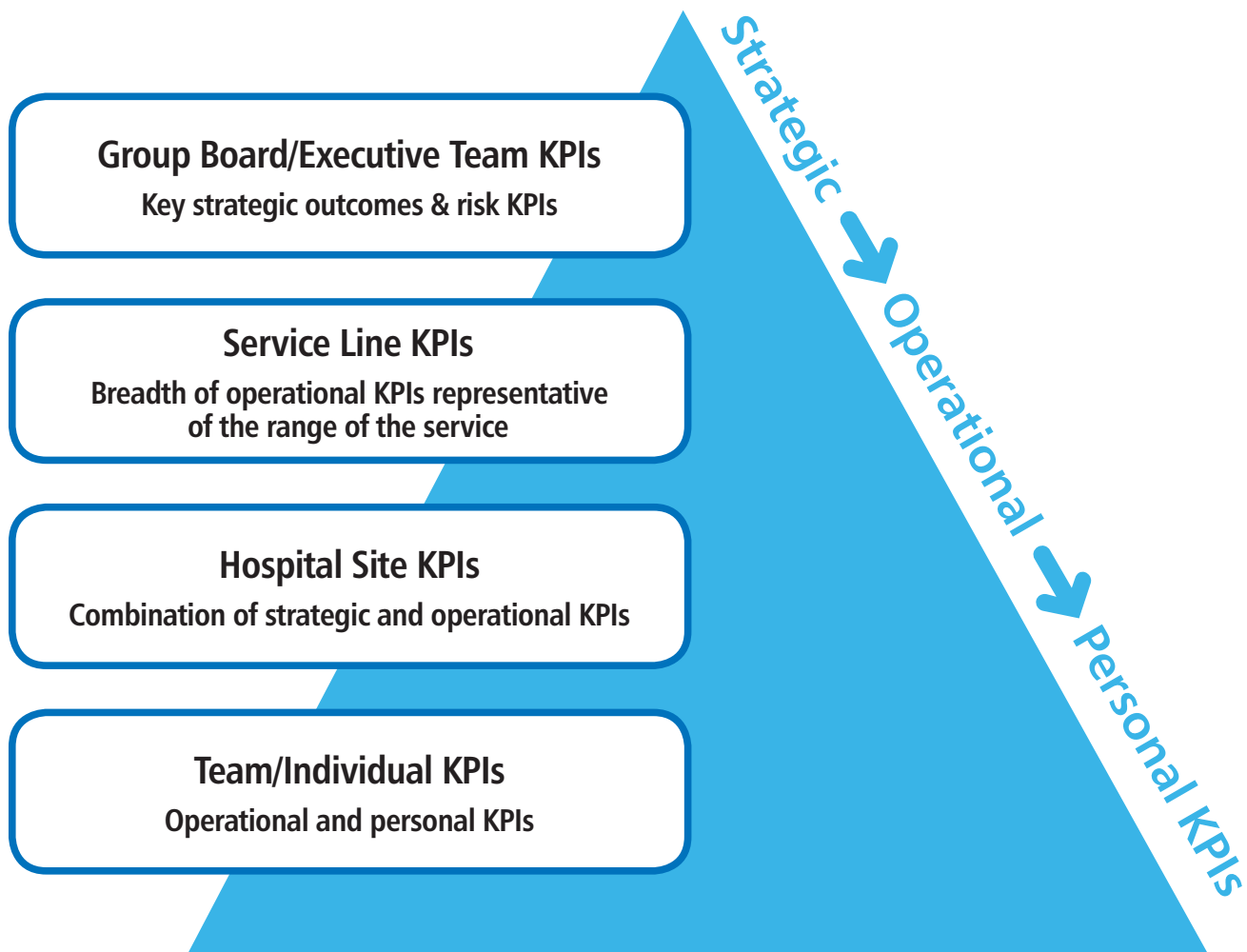
Each Hospital and Managed Clinical Service has regular reviews every six months, chaired by the Group Chief Executive. These reviews focus on the operational unit's strategic vision, and the key issues and challenges being faced in achieving this. They provide an opportunity for a broad and in-depth discussion about issues such as:

- Leadership and governance, including objectives, priorities and risks
- Strategy and business planning
- Quality, safety and patient experience
- Workforce
- Finance
- Communications and Engagement

## Group Executive Directors' Appraisals and Mid-Year Reviews

The formal governance mechanisms and clear lines of accountability and assurance are underpinned by regular staff appraisals. Annual appraisals and mid-year reviews are used to set and review clear, measurable objectives for Group Executive Directors which are then cascaded through the organisation, ensuring that all staff have clarity of purpose and accountability. The connection between Group Executive Director and Executive Team objectives is illustrated in Figure 6.

**Figure 6: Cascade of Group Executive Director Objectives**



## External Governance

The establishment of MFT is supported by funding from the Greater Manchester Transformation Fund. The funding was secured through a composite bid that encompassed the full spectrum of health and care transformation activities in the Manchester Locality Plan.

The overarching governance arrangement for this funding is through an Investment Agreement between the Greater Manchester Health and Social Care Partnership and the Manchester system. Within Manchester a more detailed Investment Agreement has been established to manage the partnership working arrangements and the flow of resources.

The Investment Agreement with the Greater Manchester Health and Social Care Partnership required the agreement of a set of high-level indicators to allow the progress and success of integration activities to be assessed. These indicators were agreed in early 2018 and include financial and non-financial metrics. Ongoing monitoring of

these metrics is undertaken and they are reported to the Manchester Health and Care Commissioning performance team on a quarterly basis and then through to the Greater Manchester Health and Social Care Partnership. In addition to the reporting of metrics, MFT has met Manchester Health and Care Commissioning and the Greater Manchester Health and Social Care Partnership to provide a broader overview of the integration and transformation work being undertaken.

Each month the Greater Manchester Health and Social Care Partnership arranges a Performance and Delivery meeting to hold commissioners to account for delivery against the Greater Manchester transformation schemes and key performance metrics. MFT's Group Chief Operating Officer is one of the two provider representatives on this Board.

NHS I is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. They continue to hold MFT to account for delivery of the merger integration through their normal assurance processes.



## Improvement

## 6 Developing MFT's Service Strategy

On the establishment of MFT, there was no overarching service strategy that provided a comprehensive overview of the Trust's services and how they would be developed in the future. The Trust's Strategy Team has therefore been working closely with clinical leaders and stakeholders to develop a full service strategy.

The Trust's strategy is being developed at two levels:

- **Group Service Strategy:** Outlining MFT's long term vision for existing clinical areas, setting out potential new clinical areas to develop, and, outlining linkages across people, research, education and service strategies.
- **Clinical Service Strategies:** Service level plans covering configuration of services across the Hospital Sites, vision for how the service will operate and develop over the next 5-10 years, potential new service provision to develop and recommendations to address specific long standing issues.

The work is supported by clinical leads and overseen by the Group Service Strategy Committee.

The Group Service Strategy has been developed internally through wide engagement across the Trust and externally with key stakeholders. Executive and Corporate Directors, Hospital leadership teams and Clinical Standards Group Leads have informed the starting position. It has been further developed through discussion with external stakeholders including commissioners, Health Innovation Manchester and those involved in the Greater Manchester transformation work. Wider engagement with the Trust's workforce, the Council of Governors and other key groups within the Trust has then further shaped its development.

The content of the Clinical Service Strategies is being developed by Clinical Working Groups, and, due to the scale of the work it has been split into three waves. Each Clinical Working Group includes a Clinical Lead, representatives from all of the constituent specialties, sub-specialties and co-dependent services and representatives from external organisations, principally commissioners and Local Care Organisations. Staff from across the organisation, including over 150 doctors, nurses and allied healthcare professionals, have been engaged in the process.

**"The two Trusts that joined to form Manchester University NHS Foundation Trust had many excellent services. The merger has given us the opportunity to bring clinical teams together to develop service strategies that best serve the city of Manchester and beyond. In this way, the merger will continue to deliver benefits for many years to come."**

Darren Banks, Group Director of Strategy

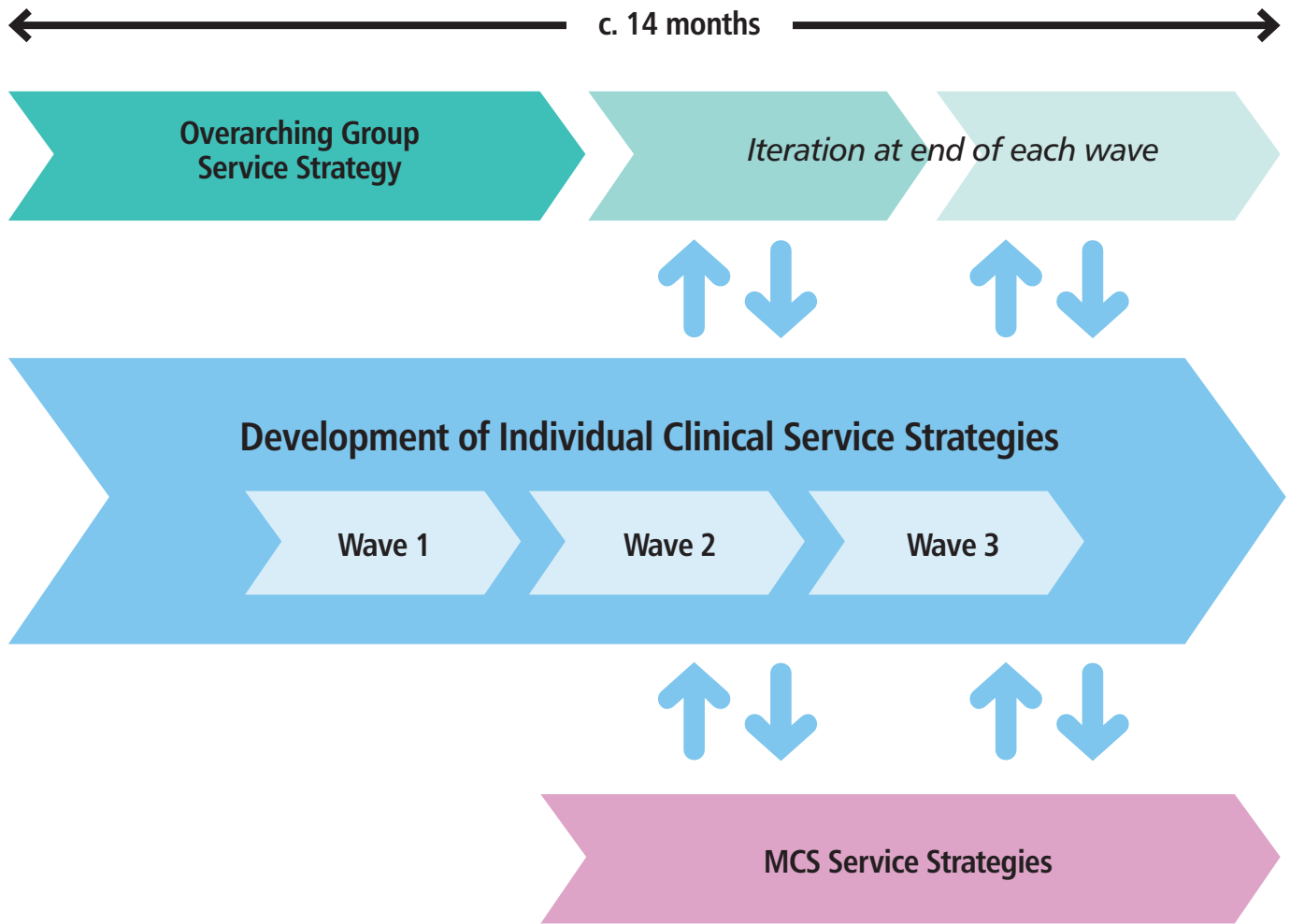
The Strategy Team has ensured that the strategy development aligns with wider work in the health and social care economy. The aims of the Manchester Locality Plan and those of Trafford have been reflected in a set of principles that have been used to frame the work. Decisions that have already been taken, for example by NHS England or within Greater Manchester, have been considered 'fixed points' and Manchester and Trafford commissioners have been engaged on an on-going basis.

The Service Strategy work is also accounting for NMGH as a future member of the Trust. Each Clinical Lead has considered how their vision for the service would change if NMGH joined the Trust. This has been informed by meetings with groups of NMGH clinicians.

The development of the Service Strategy has proven to be a large and complex task and will take approximately fourteen months to complete (illustrated in Figure 7). Development will continue until April/May 2019 with drafts being iterated during this time.



**Figure 7: MFT Service Strategy Development Process**



Any significant service changes that are proposed will be taken to commissioners and the public for consultation. Once completed, the maintenance and development of the clinical service strategies will be the responsibility of the Clinical Standards Groups and Managed Clinical Services. Alignment across clinical

service strategies as they develop will be maintained through the Group Service Strategy Committee which includes all three Clinical Standards Group leads and the Medical Directors and Chief Executives of the Hospitals and Managed Clinical Services.

## 7 Planning for Major Clinical Transformation

The primary driver for the establishment of MFT was the delivery of significant benefits for patients. These benefits were set out in the Sir Jonathan Michael Review and in documentation required prior to the merger, such as the Patient Benefits Case submitted to the CMA.

To support effective and timely delivery of these benefits, MFT's Transformation Team established an Operations and Transformation Steering Group. This Group leads the planning and delivery of the programme of clinical integration, including the twenty seven work streams representing the clinical services that have developed integration plans to deliver the patient benefits described in the Patient Benefits Case and the Full Business Case.

Prior to the merger, the Operations and Transformation Steering Group developed a high level project timeline, work stream integration plans and quality impact assessments. It also identified benefits and developed non-financial KPIs. The project plans were uploaded on to a programme monitoring system called Wave to enable regular highlight reporting and robust assurance of project delivery.

The integration projects and work streams differ in scale, scope and complexity and this was taken into account in the planning and delivery. Following the establishment of the new MFT operating model it was necessary to adapt the approach to integration to ensure it worked effectively.

The senior team responsible for the delivery of the integration portfolio mapped the work streams onto a matrix which assessed whether each work stream was strategic or tactical, and, complex or simple. This approach determined whether changes were led and delivered by the clinical directorates themselves, the Hospitals or Managed Clinical Services (with or without Group support) or whether the changes must be led by the Group (complex, strategic projects).

Where an integration work stream was classified as 'complex, strategic' a Programme Board was established. Meeting monthly, chaired by a Group Executive Director and attended by senior clinicians and managers from each site, the Programme Boards are the vehicles driving the integration work across these areas. Programme Boards are now in place for general surgery, urology, cardiac and trauma and orthopaedics.

The Transformation Team has supported the delivery of patient benefits across all of the integration areas. Opportunities for improvement have come from clinical teams from each site working together to understand each other's services. This has been enhanced through use of comparable information and national benchmarks such as 'Getting It Right First Time' and 'the Model Hospital'.

Although improvements for patients are already being delivered, a number of the major clinical benefits that were outlined during the merger process will be facilitated by structural changes that are being decided through the development of Clinical Service Strategies. An Integration Steering Group, chaired by the Director – Single Hospital Service, has maintained oversight of the two areas of work to ensure that any adverse impact of each area of work upon the other is mitigated as far as possible and that the delivery of patient benefits can progress as quickly as possible. Alongside this, both work streams acknowledge the operational pressures across the Trust and aim to ensure that any service plans seek to improve operational efficiency where possible.

Organisational Development tools and techniques have been used to support the teams going through the integration work. Prior to the merger both predecessor organisations engaged in, and collaborated on, a significant programme of work to build on the best of what both Trusts did, and to align and further develop the culture and capabilities of people to lead and manage change.

In November 2017 the Interim Board of Directors approved a Leadership and Culture Strategy for the newly formed Trust. The strategy describes the kind of leadership and culture MFT needs to further build and sustain high quality care and high performance. It is a key enabler for implementing the integration plans and outlines the guidance and plans for developing the cultural conditions needed for a compassionate, inclusive and continuously improving culture.

As part of this strategy there are three core organisation development interventions in place to support teams to successfully integrate:



## High Performing Team Development

Team Leaders are supported by a coach and guided through the foundations of effective team working using an online tool called the 'Affina Team Journey' in order to increase effectiveness, improve the team's ability to manage change and continuously improve. The programme aims to embed positive structures, processes and interpersonal behaviours into team working. The programme includes nine stages of evidence-based assessment tools, with automated on-line reporting, and briefings for development activities, taking between 4-6 months for a team leader to implement. The Team Journey approach is being used for teams leading strategic and system challenges as part of integration and transformation, and bespoke Organisational Development support continues to be offered for teams without a defined team leader or with complex issues.



*MFT Ward Accreditation Assessment winners*

## Leadership Development

To successfully implement the Group model and integration, MFT leadership must have the right balance of technical knowledge, skills and backgrounds and be appropriately qualified to discharge their roles effectively. This includes setting strategy, monitoring and managing performance and nurturing continuous quality improvement.

Leaders must also demonstrate a commitment to our values, building positive relationships and trust at all levels, and have opportunities to access a range of leadership and management development opportunities.

Leadership programmes to support those managing change have been refreshed and further developed, including the continued delivery of a Newly Appointed Consultant programme and a new Clinical Leadership Programme. The latter is aimed at experienced Consultants leading key Clinical areas. The programmes support participants to deliver a change or transformation project or team development work during the ten month programme.

In addition, bespoke development has been delivered for the Group Board, Governors and Hospital and Managed Clinical Service leadership teams.

## Improvement Skills

Staff at all levels of the organisation have access to a range of development programmes aimed at accelerating change and developing a culture of continuous improvement. With programmes available at Foundation, Champion, Practitioner and Expert levels, the Organisational Development and Transformation programmes aim to build confidence and capability to deliver change across the organisation and target areas that are leading integration and key enabling change programmes such as the development of an Electronic Patient Record Services. Teams have had the opportunity to learn from each other where one site is doing something well or in an innovative way or to collaborate and pool resources to provide more responsive care.

## 8 Delivering Benefits in Year One Post-Merger

The Single Hospital Service review identified a range of high level benefits that would be delivered from the creation of a Single Hospital Service for the City of Manchester (see Table 1). During the Trust's first year, clinical and corporate teams have started to implement changes to processes and services with the aim of delivering the best care possible for patients. The benefits realised so far have been categorised under the key themes identified in the review. Many of the benefits envisaged by Sir Jonathan Michael will be delivered over an extended timeframe and long term plans are in place to ensure that these programmes of work will be realised.

### Quality of Care

Quality is defined as having three dimensions: safety, clinical effectiveness and patient experience. These must be present to provide a high quality service.

The Trust's Quality and Safety Strategy 2018-2021 was agreed by the Group Board of Directors in July 2018 and sets out a commitment to provide quality of care that matters to patients and their families as well as caring for the wellbeing of staff. As teams start to work together the Trust has been able to capitalise on the sharing of experience

and knowledge allowing new and different ways of working. Early examples of improvements to reduce variation across hospitals, enhance clinical effectiveness and strengthen services are starting to become a reality. This includes opportunities for sharing specialist equipment and technologies and ensuring patients have access to the most appropriate clinicians for their care. The Transformation Strategy was approved by the Interim Board pre-merger to enable the delivery of patient benefits to start immediately.

### Lithotripsy Service

**Patients needing kidney stone removal wait no longer than 4 weeks. Before the merger, patients waited 6 weeks or more.**

Patients in need of Kidney stone removal now have quicker access to non-invasive lithotripsy treatment following the introduction of a combined lithotripsy service between the MRI and Wythenshawe Hospital. Lithotripsy

uses ultrasound to shatter kidney stones, avoiding the need for potentially more invasive treatments. Following the merger, MRI patients in need of kidney stone removal now have the choice of elective treatment at Wythenshawe Hospital if an earlier appointment becomes available or the location is more convenient. For many patients this means faster and more convenient care and reduced waiting times. It also ensures that the Lithotripsy service at Wythenshawe is better utilised.





## Imaging

Since the merger, Imaging and Nuclear Medicine colleagues across sites are working together to combine protocols and procedures to ensure consistent standards are being met across all areas of work. An accountability and oversight framework has been introduced to manage turnaround times for scan reports across hospitals, reducing the time that patients are waiting to receive their results. Plans are now being developed to offer patients' access to scans at a different site if one hospital has reached capacity or if this is closer to their home

or workplace. A shared on-call rota to deliver increased staff coverage throughout the week is also being put into place. The service is also working towards Imaging Services Accreditation Standard (ISAS).

**“When a hospital gains this accreditation, patients can be assured of a first class imaging service and staff benefit from working in a service that meets the gold standard.”**

Catherine Walsh, Divisional Director of Imaging

## Patient Experience

Providing high quality, safe and compassionate care to patients and their families is the heart of what we do every day. Patient experience means putting the patient at the heart of everything, delivering timely access to services, and offering treatment and care that is compassionate, dignified and respectful wherever it is provided.

Improving the experience for patients, carers and their families is one of the Trust's strategic aims. This will be delivered by enhancing access to services, providing patient choice and ensuring a consistency in the quality and delivery of care across hospitals. One of the first service improvements aimed at reducing variation and improving access and choice for patients involved the Trust's Urgent Gynaecology Surgery service.





## Urgent Gynaecology Surgery

Women who need surgery after a miscarriage are getting faster treatment in less than 2.5 days on average instead of 4 before the merger.

An additional dedicated urgent gynaecological list has been introduced at Wythenshawe Hospital as a result of the merger to create MFT. Before the merger patients who needed surgery for an urgent gynaecological condition were added to a general theatre list with the possibility that their operation could be delayed due to emergency cases. Women initially treated at Wythenshawe can now choose to join the surgical list at St Mary's and women treated at St Mary's have the choice of going to Wythenshawe to have their pre-op appointment and surgery. This will ensure that surgery is not delayed; there

is a reduced risk of any condition worsening and quicker and more convenient treatment for patients. This has been made possible by dedicated teams at both sites working together to reorganise surgical waiting lists, allowing access to quicker and more convenient care for patients.

**“By introducing a dedicated list at Wythenshawe, we have been able to offer greater choice for patients and reduce the chance of surgery being postponed. I’m proud that our teams have worked together across sites to introduce this extra list as they know it will be better for our patients.”**

Mr Theo Manias, Consultant Obstetrician and Gynaecologist at Wythenshawe Hospital

## Fractured Neck of Femur Service

An improved rehabilitation pathway has been developed by Therapy and Nursing teams for Trafford residents following the recent merger. Patients receiving Fractured Neck of Femur surgery at Wythenshawe hospital sites, who meet set criteria, are now able to be transferred to Trafford General Hospital to receive rehabilitation as well as the medical care they need. Patients can recover in a specialist environment closer to home and this enables

better outcomes, shorter lengths of stay in hospital and improved patient experience. Staff are able to prioritise patients and provide personalised care. The teams are continuing to work together to review the pathway with the aim of increasing the number of patients accessing the rehabilitation service at Trafford General Hospital. This pathway change was an early product of the merger.



## Workforce

Securing the workforce required to deliver high quality services remains an ongoing challenge across the NHS and there continues to be a focus on reducing reliance of locum and agency staff. The retention of the Trust's hard working and skilled employees, and the attraction of new employees, is vital to ensure the delivery of excellent patient-focussed quality care across the new organisation. The merger presents significant opportunities for the recruitment and retention of a range of staff including medical, nursing and specialist clinical staff, and is a key focus for the new organisation. The creation of MFT enables revised patient pathways to be developed leading to:

- The creation of new roles.
- The integration of teams.
- The ability to provide enhanced cover out of hours.
- The creation of single integrated staff rotas.
- The opportunity for staff to sub-specialise.

**"It is a real credit to our staff that they engaged so positively with the merger process at a time when for many their own future was uncertain. I'm extremely proud that our staff continued to put patients first during this time of change and are now working hard to realise the benefits of the merger for patients. Our staff are our greatest asset and we want to make MFT an even better place to work, with opportunities for people to develop to their full potential and become the best at what they do."**

Margot Johnson, Group Director of Workforce and Organisational Development

**"I am pleased to say the Trade Unions were encouraged at the outset to be involved with the merger plans. We had a group which met regularly and the Single Hospital Service Team worked with the Staff Side Committee to ensure we were involved and kept informed. During the first year of the organisation, I am very proud of the hard work our staff have accomplished during a period of change, which has been really exemplary."**

Peggy Byrom, Legacy CMFT Staffside Chair

**"We've worked hard on a partnership Management of Change document as a process to assist people to move through the change. This has irrefutably been a difficult, complex and sometimes anxiety invoking experience for staff. This being recognised, we have put in place supportive mechanisms within this process. Credit should go to everyone involved for pulling together to make this work and improve services for patients."**

Kate Sobczak, Legacy UHSM Staffside Chair

## Joint Recruitment Programme

Following the merger, MFT is currently leading a programme of work across all Manchester hospitals to develop a single attraction strategy for consultant medical staff that will support service development and integration plans. This is illustrated by the recent recruitment of eleven new Consultant Obstetricians and Gynaecologists who recently joined the Saint Mary's Hospital clinical team. These new posts will be based across Saint Mary's Hospital, Wythenshawe Hospital and North Manchester General Hospital. The posts were advertised jointly with North Manchester General Hospital to support recruitment issues. The eleven consultant posts will enable some specialist services to be extended across all three hospitals,

ensuring equity of access to these services for women across Manchester; providing specialist care 'closer to home' and streamlining the referral pathways. The recruitment programme is now being extended to other roles and services across MFT.

**"Candidates were attracted by the breath of roles available, the professional development opportunities on offer at such a large Trust, and our popular Consultant Development Programme."**

Dr Sarah Vause, Medical Director, St Marys Hospital

## Supporting Staff – Employee Assistance Programme

In order to retain the Trust's dedicated staff, it is vital for them to feel supported in every area of their lives. Following the creation of MFT, a 24/7 assistance programme has been rolled out across all nine hospitals, offering support with any issues MFT's employees are facing. Services were developed to provide staff with improved and enhanced support for work related or personal issues following a review of employee health and wellbeing services that took place prior to the creation of the new Trust. The Employee Assistance Programme (EAP) is available to everyone and offers a 24-hour support service that includes confidential advice, counselling services and access to an online information portal. There has been

positive feedback throughout the Trust with staff actively seeking support for a wide range of personal and work related issues during the first year of operation. These issues include family problems, financial information, personal health and bereavement.

**"Staff members who have used the confidential service have found it really helpful. Knowing that my staff can get immediate advice and support is a real comfort to me as a manager."**

Michelle Hampson, Clinical Coordinator, Manchester Centre for Genomic Medicine





## Financial and Operational Efficiency

The national focus on improving efficiency and productivity across the NHS requires taking local action to deliver financial and operational efficiency and this remains a priority for all NHS organisations. MFT continues to work hard to deliver savings through the delivery of a Cost Improvement Programme with the aim of improving efficiency, reducing waste and at the same time improving quality and safety. The formation of a new organisation provides an opportunity for increased focus for reducing unwarranted variations in every area of the hospital – reducing costs in supplies, reducing staff costs through a reduction in agency spend and by improving operational performance.

### Integration Savings

Bringing together the two legacy Trusts has provided additional opportunities for efficiency benefits through the integration of clinical and corporate teams and services. In the first 12 months of operation, five focus areas have been identified based on the opportunity for financial savings from economies of scale and synergies and from using more efficient processes and working methods.

### Clinical Support Service Integration schemes:

The integration of Clinical Support Service across hospital sites, providing opportunities for combined contracts, cost reductions and service efficiencies. For example, work to change the Medical Equipment Service will deliver significant savings in 2018/19.

**Pay harmonisation schemes:** The harmonisation of pay and benefits structure for ensuring equitable remuneration and conditions across sites.

**Corporate savings:** The integration of the Corporate Services division including the review of team structures and removal of service duplication to deliver a 5% cost reduction.

**Pharmacy Carter Plans:** Cost savings identified through medicine management; reducing the cost of medicines, electronic prescribing and improved administration as identified in Lord Carter Review.

**Workforce transformation:** Working with third party suppliers to reduce agency and locum costs; improving the efficiency of internal systems and processes; on-going work across sites with rota harmonisation and cross site working.

The merger also provides an opportunity for a more cohesive approach to the procurement process. The joint procurement of services across hospital sites are reducing costs and increasing value for money through better negotiation power and identification of single suppliers. As an example, the Trauma and Orthopaedic Programme Board has reported significant savings from joint procurement projects across a number of sub-specialities. Forecast cost savings have already been agreed during the first year of operation across the Trauma and Orthopaedic service amounting to approximately £200,000.



## Informatics Systems and Processes

Since the merger and establishment of MFT, work has commenced to improve quality and efficiency in the hospitals through the establishment of coordinated Informatics systems and processes and the use of digital technology to reduce variation across hospital sites. The informatics team at MFT has implemented a number of systems to create a suite of tools enabling teams to work collaboratively across sites, assist with clinical decision-making and improve operational efficiencies. Examples include:

- The Hive, providing web-based access to operational reports with its repository underpinned by the new MFT data warehouse.
- Lync, a set of desktop tools including WiFi access, video calling service, and instant messaging supporting cross-site collaboration, remote working and reduced travel time between hospital sites.
- A single transition network, enabling corporate and clinical services to run efficiently and safely since the establishment of MFT.

The Informatics Team have also concluded a review of the EPR Systems that are currently in use across the new Trust. It was important to agree early the way forward for the future EPR. In January 2018, it was approved that the new Trust would procure an EPR / PAS through an open Procurement process.

**“This is an exciting time as we help the trust realise the clinical benefits identified as part of becoming a Single Hospital Service by harmonising clinical systems across the new organisation. The EPR decision was a significant step forward on our digital journey which will support us achieving the vision of becoming “A world class academic teaching organisation.”**

Alison Dailly, Group Chief Informatics Officer

## Medical Workforce Improvements

One of the workforce benefits highlighted by the recent merger was an opportunity to reduce reliance on agency and locum staff. Since the merger, MFT has committed to reduce expenditure on this element of the workforce budget, not only to save the Trust money but also to improve the opportunities for employees. Two new systems have been implemented that are improving the way the Trust manages its agency spend:

**TempRE:** An online system providing locums with an online user friendly system covering all elements of their assignments and a centralised repository of contracts, payslips and timesheets. The system allows medical workforce to liaise with locums directly, reducing spend on agency fees.

**Medic online:** An e-rostering phone app is helping Junior Doctors and Consultants at Wythenshawe Hospital to manage shift cover and annual leave more easily. The system allows potential gaps in shifts to be identified and managed. As a result of the merger this system is being rolled out across all MFT hospital



sites, supporting a better work-life balance for Junior Doctors and Consultants and improved recruitment and retention across the Trust.

**“Making sure we have enough doctors to cover rotas through the week can be challenging and time consuming. The app means managers and rota coordinators can see potential gaps and book agency staff in advance meaning a more competitive rate, knowledge of shift coverage and the delivery of patient care.”**

Christine Tudor, Medical Staffing Manager



## Research and Innovation

Research and Innovation allows MFT to improve the health and quality of life of patients. By combining the research and clinical strengths of the legacy Trust's, MFT will be able to develop and evaluate new treatments and technologies to achieve this ambition. Research and innovation programmes influence advances in medical care on regional, national and international levels, working collaboratively with academic partners and industry to deliver the next generation of treatments and technologies.

The merger to create MFT provides a number of exciting opportunities:

- Improved access to research, leading to better participant recruitment and improved patient outcomes;
- Accelerated adoption of research and innovation into routine clinical practice;
- A driver to leverage additional research income; and
- A more effective and efficient service for companies wanting to trial new tests, medicines and devices.

The opportunities for expanding and improving research and utilising innovation are starting to be realised as a direct response to the formation of MFT.

### Life Sciences Industrial Strategy

The Government's Life Sciences Industrial Strategy brings the NHS together with government and industry to create new jobs and economic growth across the UK as well as aiming to improve care for patients.

Citylabs and Medipark, joint ventures between industry and the legacy organisations, provided an opportunity for health and medical technology

business to grow and co-create new health products in collaboration with the NHS and academia. The creation of MFT has enabled these ventures to come together creating a ground breaking community of industry, clinicians and academic partners to nurture commercial success and provide new products and services for patients. It is attracting major international biotech companies to locate at the Oxford Road campus, creating a world-leading 'precision medicine campus'.

The integration of Medipark and Citylabs ensures that investment into future developments is supported by strong business demand, creating compelling and sustainable economic opportunities, and a more efficient and effective service for companies wanting to trial new tests, medicines and devices.

**"The scale of the new organisation, our links to local universities, and the potential to improve the health of the populations that we serve, creates a unique opportunity. As the largest Trust in the UK, we now have huge potential to dramatically increase the amount of funding we introduce into the system for research and innovation to improve the health of patients across Manchester, Greater Manchester and the North West."**

Professor Bob Pearson, Former Joint Medical Director MFT, Strategic Clinical Adviser on Academic Health Science, Honorary MAHSC Clinical Professor, University of Manchester



## Single Unified Approach to Research Studies

The Research and Innovation Division is creating a single unified process for the set-up of new research studies and trials across the organisation. The first part of this process was to adopt R-Peak as a common research project management system. This has played a vital role in streamlining and unifying the management of research studies across the various research centres within the Trust. Information is securely

held on a central server allowing better communication and reduced duplication and ensuring that data is input, captured and coded in the same way. This has dramatically improved performance reporting to NIHR, the NHS research governing body. During Q4 2017/18, MFT initiated 94.9% of all studies to time and target, a dramatic increase from the legacy Trusts.

## Intensive Care Unit (ICU) Research Trial

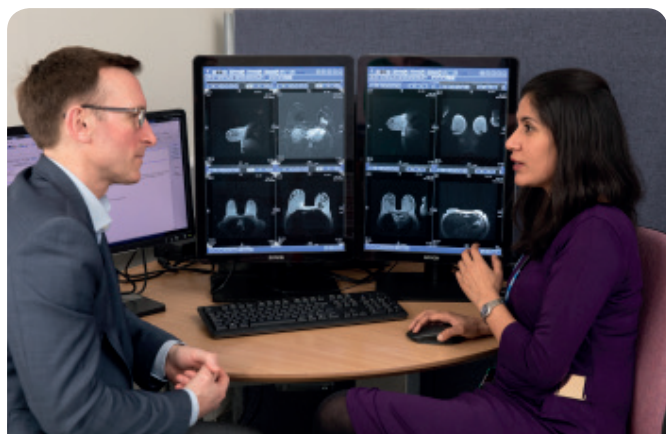


Patients participating in clinical trials are starting to benefit from sharing resources across sites following the creation of MFT. In one example, a patient was recruited to a complex ICU trial at MRI, assessing the use of a respiratory dialysis machine to remove partial CO<sub>2</sub> whilst on a ventilator. Due to the nature of ICU, there are often multiple patients recruited to a research study that require a new dialysis kit for each patient and this is not always available if multiple

patients are recruited at the same time. Working together, the MRI and Wythenshawe ICU research teams and sponsor of the study looked into how they could share kit and transport across sites. This meant the patient had access to the latest treatment pathway as soon as possible and the study did not encounter any delay.

**“This process was made much easier because of the merger, which has enhanced our relationship with Wythenshawe. The patient was subsequently transferred to Wythenshawe for long term ventilation needs, where colleagues were able to continue to collect data and obtain the patient’s regained capacity consent, ensuring safety and high quality data.”**

Richard Clarke, Senior Clinical Research Nurse



## Education and Training

Education and training are regarded as an essential part of the NHS not only to deliver excellence but to ensure that the NHS is responsive to changes in patient needs across healthcare. The Trust's vision is to widen access and exposure to education and training for staff and students, with the aim of

delivering high quality care for all patients. The formation of MFT has provided an opportunity to improve career development opportunities, offer a choice of work locations and provide rotations to gain skills and experience thereby promoting a positive staff experience.

### Educators' Development Programme

Traditionally, a number of courses had been developed to support educators within medical education by the education teams at the Wythenshawe and Oxford road sites. An educator's conference had also been developed on the Oxford Road site.

Following the merger, irrespective of location within the Trust, medical staff are now able to access an increasing number of educational sessions at either site, offering a greater choice of sessions. Regular updates are issued as new courses become available.



### Neonatal Rotation Initiative

As a result of the merger a neonatal nursing rotation initiative has been established, giving nursing staffing from Wythenshawe Hospital and St Mary's Hospital an opportunity to work across the different services within MFT. The Neonatal service at the Oxford Road Campus is a level 3 service, looking after acutely ill and preterm babies that need the highest levels of intensive care. Conditions are often life-threatening with babies requiring constant close monitoring and support. The unit at Wythenshawe Hospital is a level 2 service providing short term intensive care and high dependency care. The service has a community focus and excels in patient experience feedback. Following the merger, rotations between the newborn services provided at both hospitals were offered to staff. Offering rotations allows staff to experience different working environments and opportunities to advance their learning and training. Staff at Wythenshawe Hospital are able to increase intensive care skills and gain exposure



to surgical care. Staff from St Mary's are able to understand how other neonatal units function and increase their managerial skills.

**"This initiative has increased opportunities and choices for staff, which in turn makes them feel valued. A joint competency package was developed to identify individual needs and ensure that staff realised what they wanted to achieve."**

Kath Eaton, Lead Nurse for Newborn Services



## Mary Seacole Programme

MFT has been approved as a host organisation for the Mary Seacole Programme following the merger. The Trust was selected due to its increased size, capacity and commitment to providing excellent health leadership development. The programme is designed for first-time leaders in healthcare or those aspiring to their first formal leadership role, and is developed and run by the NHS Leadership Academy. Being part of the programme

enhances the reputation of the Trust as a place to train and work in Greater Manchester and offers employees access to a nationally recognised qualification. The programme is locally-tailored to offer training across all partnership organisations in Greater Manchester. 70 participants have completed the course since the merger with another 47 registered until December 2018.

## Libraries Service

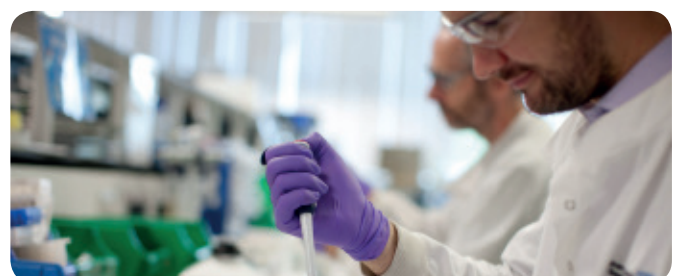
Following the recent merger, MFT staff and students now have extended access to books, online journals and study areas. Access to online resources has expanded and new facilities have been provided at Trafford Hospital, the Oxford

Road campus and Wythenshawe Hospital. This includes work pods with integrated device chargers, access to new PCs and new furniture to enhance the learning environment for students.

## Emergent Benefits

There have been a number of emergent benefits that have also been realised as a result of the merger. These are benefits that were not identified in the original benefit plans for the merger, and have emerged during the design and implementation of new ways of working across the Trust. Opportunities for these types of benefits are continually being explored and demonstrate additional value to the creation of MFT. Early examples include:

- **Fellowship programme:** The combined Trauma and Orthopaedic service is leveraging its size and scope to create a fellowship programme.
- **MFT Frailty Standards:** A set of standards for the care of frail patients have been agreed that cross all MFT sites and services.
- **Shared capacity for trauma surgery:** At times of high demand for trauma surgery and longer waiting times at MRI, some patients have been transferred to Wythenshawe Hospital for their surgery.
- **Gynaecology Multi-Disciplinary Teams:** Cross site endometriosis and urogynaecology Multi-Disciplinary Teams have been established, improving patient access to specialists and increased capacity across MFT.
- **Gynaecology shared elective capacity:** Over 100 elective patients have chosen to transfer their care from St Mary's to Wythenshawe where they will be seen more quickly.
- **Fractured neck of femur improvements:** The implementation of a shared approach to fractured neck of femur governance has led to improvements in key metrics at Wythenshawe Hospital and MRI.
- **Urgent care recruitment:** A joint recruitment programme to fill specialist urgent care roles is being carried out across the Trust.
- **Microbiology centralisation:** The Microbiology lab will be centralised from Wythenshawe into a new, state of the art, facility at Oxford Road with associated benefits.



## 9 Lessons Learned

A number of important lessons have been learnt through the merger process and during the new Trust's first year of operation. It is important to appraise both the strengths and the challenges although, inevitably, it is more useful to reflect on areas where the process could be improved. Lessons learnt will continue to be used to inform programme decisions and to improve the arrangements put in place for any future transactions.

### Areas of Strength

Some of the key strengths of how the merger was undertaken, and how the new Trust has operated in its first year are as follows:

#### Strategic issues

The Single Hospital Service Review and the reports produced by Sir Jonathan Michael provided a very firm strategic basis for the merger programme, with a clear vision that was widely understood and accepted. The key messages from the original review have been sustained throughout the process and are still relevant now.

The Single Hospital Service Programme arose out of the requirements of the Manchester Commissioners and the Manchester Locality Plan, but the overall approach is also completely consistent with the GM "Taking Charge" strategy, including the emphasis on collaborative working within and across health and social care systems. The merger (and the planned acquisition of NMGH) are creating an organisation which will be a more effective vehicle for delivering key aspects of the GM strategy, particularly in Themes 3 and 4.

#### Engagement and involvement

A significant amount of time and effort was expended on involving and engaging key constituencies in the process, most importantly the engagement with senior clinical staff throughout the two Trusts. In particular, clinicians with dedicated Clinical Lead roles were identified and a standing Clinical Advisory Group was put in place. These arrangements proved to be invaluable in the run in to the merger and the early period post-merger, and have been a strong influence on how the "business as usual" operation of the new organisation has been developed.

Importantly time was also committed to engaging with staff side. A local partnership forum was established specifically to engage with staff representative colleagues and Full Time Officers in a proactive way on Single Hospital Service matters. This forum took a partnership approach to agree processes in relation to consultation, management of change and integration, and development of terms

and conditions for new starters from day one of MFT. These arrangements continued until December 2017 when the new Joint Negotiating and Consultative Committee was established.

The clarity of the strategic approach has also facilitated effective stakeholder engagement, and the new organisation has been fortunate to benefit from positive relationships with its main Commissioners and other partners throughout Greater Manchester. Detailed stakeholder mapping from the early stages of the programme was an essential part of optimising relationships, understanding, and support for the merger.

**"The Chair and Chief Officer of Healthwatch Manchester were interviewed as part of the CMA review of the merger between CMFT and UHSM and we have maintained a constructive dialogue with the SHS leads from an early stage. The move to a Single Hospital Service is welcomed by Healthwatch Manchester. We are monitoring the impact of this initiative closely on local people with particular regard to those patients with protected characteristics."**

Neil Walbran, Chief Officer, Healthwatch Manchester



*The programme team included five clinical leads from UHSM and CMFT*



**Neil Davidson**

**SHS Clinical Lead  
Medical Consultant**

Cardiologist/Deputy  
Medical Director, UHSM



**Ngozi Edi-Osagi**

**SHS Clinical Lead  
Medical Consultant**

Neonatalologist/Associate  
Medical Director, CMFT



**Debra Armstrong**

**SHS Clinical Lead  
Nursing**

Deputy Director of  
Nursing (Quality), CMFT



**Caron Crumbleholme**

**SHS Clinical Lead  
Nursing**

Head of Nursing  
(Scheduled Care), UHSM



**Lesley Coates**

**SHS Clinical Lead  
AHP**

Head of Nutrition and  
Dietetics, UHSM

### **Leadership and Organisational Development**

The new organisation prioritised the establishment of experienced and effective senior leadership teams for each of the Hospitals and Managed Clinical Services. The new leadership teams included experienced individuals from the two predecessor organisations, along with key appointments of senior leaders from elsewhere.

The relationship between the Group management and the Hospital leadership teams was given very careful consideration prior to the transaction date, but it has continued to be a subject for active consideration throughout the first year of operation. In particular, the Accountability Oversight Framework (AOF) and the associated review processes have been evolved and iterated in this time, and it is likely that they will continue to be developed and refined. This is an entirely health process that is helping the Trust to ensure that the Group and each of its constituent elements can operate as effectively as possible.

There has been a clear and sustained emphasis on cultural work and organisational development. This commenced from the audits of organisational culture that were undertaken prior to the merger and has been maintained through the organisational change processes, the development of the new statement of behaviours and values, and other key OD activities. Cultural differences are known to be a key risk issue in organisational mergers, and the time and effort put into developing a positive approach has been beneficial.

### **Planning and review**

NHS I now places much greater emphasis on PTIP in its assurance processes, and this perhaps creates a risk that PTIP will be seen simply as something that is required to negotiate an external process, rather than being of primary importance in managing the organisational merger. The two Trusts always took the development of the PTIP very seriously, and invested a lot of time and effort in developing multiple iterations, so that the document remains relevant and up to date. Three iterations were developed in the run in to the merger, and a fourth version following the first 100 days. The fifth iteration is being developed following completion of the first year of operation. Board members have been closely involved in the development of PTIP, and there have been regular progress reports at Board level throughout the merger process. This has meant that PTIP has continued to be the central function in guiding MFT's management of its integration agenda.

The merger process has been subject to a number of external audit processes, from the original Reporting Accountant Reports, through to follow-ups on PTIP and on how the new organisation performs against the Well Led framework. These processes have helped to maintain the standard of the integration work in the merger, from planning through to implementation, and although the audit outcomes have always been positive there has also been something to learn from each exercise.

### **Programme management and resourcing**

In the process of preparing for the merger, the SHS programme team was set up to have a semi-independent role, working between the two merging Trusts. In particular, the SHS Director was clearly understood to be independent, and had sufficient seniority to join the Executive Team and Board meetings at both Trusts. This was of great benefit in fostering confidence in the two Trusts as to the fairness of the process, and allowed more rapid progress to be made.

The use of external support, for example from the major consultancies, was deliberately kept to an absolute minimum, and was focused on areas where specialist skills were required, rather than just additional capacity. This approach means that there

is far better ownership, and buy-in to the integration process, and that continuity and organisational memory are maintained. In essence, the people involved in diagnosing the challenges and developing the integration plans are the same people who then take responsibility for implementation. This has been balanced with sufficient external due diligence and audit work to provide adequate assurance on the information being reported at Group Board-level.

The dedicated resourcing that the programme was able to access from the GM Transformation Fund to support the transaction process and the integration and transformation activities over the first twelve months of operation has been essential to the delivery of the planned benefits.

## **Areas for Improvement**

### **Programme management**

The programme management arrangements for the merger have generally been successful. The two Trusts were fortunate to be able to benefit from resourcing from the GM Transformation Funds, and this allowed for the establishment of a dedicated programme team, with a very experienced and independent senior leader. The team also able to second in key players from within the two Trusts, and this produced a positive blend of local knowledge, established relationships and balanced involvement. The governance processes operated by the programme team were also well organised and effective, as were the communication and engagement activities. The merged Trust has been able to keep together a programme team including many of the key individuals from the merger process, and this group is now managing the process to acquire North Manchester General Hospital. It is expected that the Trust will continue to be able to fund this function from GM Transformation Fund monies. If the Trust were to become involved in a further transaction after the completion of the Manchester Single Hospital Service programme, careful thought would need to be given to how to fund and establish a programme team with the relevant capacity and capabilities.

The scale and complexity of the programme made it inherently difficult to manage, and this was particularly true of the Post Transaction Integration Plan, where there were a very significant number of different activities that had to be monitored and

managed, and a changing programme of work that was updated with each iteration of PTIP. To support the management of this process, the Trusts agreed to deploy a programme management tool (Wave). The functionality of Wave has proved to be very useful, and it is now used to support all of the new Trust's integration and transformation activities. There was a problem, however, with the initial implementation process. The need for a structured programme management tool was not recognised until the PTIP was quite well developed, and many of the Day One plans were being implemented. As such, the Single Hospital Service Programme Team and IM&T had to support the implementation of the package at a time when the planning and implementation agenda was already very busy, and sometimes plans that had already been recorded in other formats had to be re-keyed.

Wave has been used extensively and actively in managing the integration process, and over the long term, there is no doubt that it has been beneficial to have a structured programme management tool in place. However, it is likely that the benefits would have been greater, and the disadvantages reduced, if there had been an earlier realisation that a system of this sort would be required.

### **Working with external agencies**

The merger process required the two Trusts to work in close collaboration with a number of external





## Working with the Councils of Governors

The level of work required with the two Councils of Governors (CoGs) exceeded the original plans and expectations. The process started positively, but as the merger programme developed it became apparent that the interests and needs of the two CoGs were quite different i.e. “one size” did not fit all. There would have been a benefit in preparing a more detailed plan from an earlier stage, including more analysis and testing of the different requirements of the two groups.

At some points there was significant challenging back from the Governors and, while this is not a problem in itself, it did demonstrate that more preparation and support was needed. The intensity of the engagement with the CoGs was stepped-up in the middle of the process, in recognition of the

scale of the task, and the fact that not all of the Governors were in the same place. Working closely with the two Board Secretaries was very beneficial, and it was helpful that the Programme Team had its own governance lead to facilitate these processes. The position reached with the CoGs at the end of the process was very positive, but more preparation at an earlier stage would have been advantageous.

**“Governors were actively listened to and every effort was made to help us understand the formal transaction processes. The Single Hospital Team arranged independent legal advice so that we fully understood our role at the point a vote on the merger was taken.”**

Geraldine Thompson, MFT Lead Governor

agencies, but particularly the CMA and NHS I. Much of the interaction with the CMA was facilitated through the Economic Advisors (Aldwych Partners) and the Trust was fortunate to have such effective and expert support. The relationship and interactions with the CMA proved to be unproblematic throughout the process. The CMA’s working arrangements were clear and easy to understand, and the CMA team seemed to be highly responsive, and gave meaningful feedback in a timely manner. As such, although there was no pre-existing relationship, the Trusts quickly developed a high degree of confidence that the CMA team would operate effectively and efficiently in line with their guidance.

Engagement with NHS I proved to be more problematic. Throughout the merger process, the NHS I Transaction Guidance was in a state of flux, with revisions to the guidance repeatedly

being promised, but not delivered. The role of the competition team was not always as clear as it could have been. The process for critiquing the Patient Benefits Case was slow and cumbersome. The issues raised by the competition team did not always seem well informed, and there were often lengthy delays in getting responses.

The two Trusts invested a significant amount of time and energy in managing relationships with external agencies, and this proved to be essential in making sure the merger progressed on the planned timescale.

### **Working in a novel transaction environment**

The transaction was a true merger between two existing acute Foundation Trusts. There had only been one previous merger in the NHS, with all the other transactions being acquisitions, so the two Trusts

were exploring new territory in pursuing a merger. The significant additional challenge that comes with a merger is that both of the predecessor organisations cease to exist, and so there is no constitution, senior leadership, governance arrangements or operational processes that can automatically be carried forward to the new organisation.

To address this situation, the two Trusts had to agree ways to work collaboratively in the run in to the merger, including the creation of the Interim Board, and the integration plans had to set some very rapid timescales for putting in place the new governance arrangements. There also had to be some careful judgements made about how legacy operational process could be maintained until such time as new integrated arrangements could be implemented.

All of the experience of the transaction and the first year of operation indicates that a merger was the only way to create an effective new organisation: the merged Trust is significantly different in size, scope and culture from either of its predecessor, and entirely governance arrangements and organisational structure would always have been necessary to make it function properly.

Further transactions that the Trust may be involved in are likely to be acquisitions rather than mergers, so the risk of encountering this problem again is limited. Having said that, the learning from this experience is that:

- Mergers are intrinsically more complex than acquisitions, requiring expert legal and economic advice.
- Undertaking novel processes inevitably takes more time, effort and care than following a “well-trodden path”.
- The right transaction mechanism is the one that produces the right sort of post-transaction organisation.
- The engagement of Governors is critical to the smooth management of a merger of two NHS Foundation Trusts.

### **Describing merger benefits**

The process that the two Trusts went through to deliver the merger included extended and detailed engagement with the CMA. To ensure clearance from the CMA to proceed with the merger, there was a requirement to develop a Patient Benefits Case, and this attempted to quantify what the CMA would recognise

as “Relevant Customer Benefits” (RCBs). In large part, NHS I accepted that it could depend on the CMA’s assessment of patient benefits, so the Patient Benefit Case became the principal description of the merger benefits, and a lot of time and resource was put into evidencing these benefits robustly.

In many ways, this was beneficial, in that it ensured that a high priority was attached to patient benefits, and some of these were described in considerable detail. However, there may have been an effect whereby the focus on this benefit area was at the expense of detailed work on other areas, such as finance. It was always recognised that there would be financial benefits associated with the merger. These were not deemed to involve the delivery of productivity improvements beyond the scope of what the two Trusts would have been seeking to achieve absent the merger, but it was argued that the merged organisation would have greater confidence about delivering the productivity improvement objectives determined through the normal NHS processes, for example, tariff deflation, particularly over the longer term.

The fact that there was less emphasis on describing the detail of financial benefits in the pre-merger phase has meant that in tracking the delivery of integration plans in the first year of operation it has been difficult to link these back to business as usual financial planning processes.

### **Strategy development**

The predecessor organisations had strategic intentions of one sort or another that predated the merger, but during the period running up to the merger it was no longer appropriate to update or develop these. It was always clear that, when the new organisation commenced operation, there would be some elements of strategic thinking that could be continued from the previous organisations. Similarly, there would be some themes that arose out of the objectives of merger itself, for example, developing single services, minimising variation, and learning from the best services in the Trust. However, there was also an explicit understanding that there would be a need to develop a comprehensive new strategy for the new organisation, and this has been a consistent feature in all of the iterations of PTIP.

The initial intention was that the new strategy should be developed by March 2018 i.e. within six months of the creation of MFT, but in practice the process has

taken longer to deliver. Prior to the commencement of the Service Strategy Programme it was determined that:

- the strategy development work should be focused on a long-term time frame i.e. five to ten years
- in order to expedite the delivery of the quality and financial benefits the strategy development work should be supported by specialist external resources which involved a procurement process to identify and secure the correct support
- the scope of the strategy development work was too extensive to undertake it as one exercise, and so it was broken down into three “waves”, with some services being considered earlier and others later.

In combination, these effects have meant that the timeframe for the completion of the new strategy will be circa 12 months following commencement in May 2018. Work to realise the merger benefits has continued to be progressed through the Trust’s Transformation Programme, and those services where reconfiguration was likely to be required were planned in to the early waves of the strategy programme. For services where a major reconfiguration is envisaged, the strategic planning process may be followed by a lengthy implementation timescale, and this may mean that some merger benefits take longer to deliver than would originally have been expected.

It was recognised that the service strategy should, as far as possible, take account of the incorporation of North Manchester General in to MFT. This is being achieved by asking the clinical leads to consider scenarios with and without NMGH for any significant service change. It must be recognised that this has

introduced further uncertainty into the process.

Any further transactions that the Trust is involved in are unlikely to require a wholesale redevelopment of strategic thinking on this scale, so the risks of encountering this problem again are limited. Having said that, the learning from this experience is as follows:

- to begin to consider how the long term strategy work can be effected at as early a stage as possible
- to give careful consideration to the lead time and resource requirements for an exercise of this scale and scope
- to identify any benefits that rely on the completion of the development of a long-term strategy at an early stage and plan accordingly.

This would minimise the risk of tensions between the pressure for rapid implementation of transformational change, and the need for all service change proposals to be developed in the context of a clear and comprehensive long-term strategy.

## In Summary

Many elements of the merger programme have progressed well and, overall, the merger process has managed the key risks effectively, and has delivered the planned benefits for the first year of operation. However, there are always lessons to be learnt in major projects of this sort, and the issues identified above should be used to improve the arrangements put in place for any similar future exercise.



## 10 Conclusion



MFT was established as a new organisation on 1st October 2017. Since then significant work has been undertaken to transition and integrate the two predecessor organisations, slowly and carefully evolving the new organisation to one that has the right culture from the start, and that maintains a focus on patient safety, patient experience and high quality care.

The Trust intends to build one of the best healthcare systems in the world, underpinned by a clear understanding of the needs of the people it serves and a commitment to the skilled and dedicated

people that work within it. Significant transformation will be carefully delivered over the coming years as MFT fully implements its developing service strategy and NMGH is integrated into the organisation.

The work undertaken to date, and future plans that have been made, have been achieved with the continued support of organisations in the City of Manchester and Greater Manchester, including the Greater Manchester Health and Social Care Partnership, Manchester City Council, Trafford Council and commissioners.

**“I have been very impressed by our teams’ enthusiasm and receptiveness to new ways of doing things during our first year as Manchester University NHS Foundation Trust – and would like to thank everyone for their contribution. I look forward to continuing to work with staff and partner organisations to further develop our world class staff and services to benefit patients.”**

Kathy Cowell OBE DL, Chairman