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MANCHESTER CITY COUNCIL

Health and Wellbeing Board

Date: Wednesday, 26 January 2022
Time: 10.00 am
Venue: Council Chamber, Level 2, Town Hall Extension

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Membership of the Health and Wellbeing Board

Councillor Craig, Leader of the Council (Chair)
Councillor Midgley, Executive Member for Adult, Health and Wellbeing (MCC)
Councillor Bridges, Executive Member for Children and Schools Services (MCC)
Dr Ruth Bromley, Chair Manchester Health and Care Commissioning
Katy Calvin-Thomas - Manchester Local Care Organisation
Kathy Cowell, Chair, Manchester University NHS Foundation 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
Bernadette Enright, Director of Adult Social Services
Dr Murugesan Raja Manchester GP Forum
Dr Geeta Wadhwa Manchester GP Forum
Dr Doug Jeffrey, Manchester GP Forum
Dr Shabbir Ahmad Manchester GP Forum (substitute member)
Dr Denis Colligan, Manchester GP Forum (substitute member)

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 - 10
To approve as a correct record the minutes of the meeting held on 3 November 2021.

5. COVID-19 - Update 11 - 12
The Director of Public Health and the Medical Director, Manchester Health and Care Commissioning, will provide an update.

6. Better Outcomes Better Lives 13 - 28
The report of the Executive Director of Adult Social Services is enclosed.

7. Integrated Care System arrangements and Manchester Locality Plan Refresh 29 - 52
The report of the Deputy Leader (with responsibility for Health and Care), Manchester City Council & Vice Chair, Manchester Health and Care Commissioning is enclosed

8. Child Death Overview Panel (CDOP) Annual Report 53 - 90
The report of the Barry Gillespie, Consultant in Public Health, Chair of the Manchester Child Death Overview Panel 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.

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Agenda, reports and minutes of all council committees can be found on the Council's website 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:

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This agenda was issued on **Tuesday, 18 January 2022** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 2, Town Hall Extension (Library Walk Elevation), Manchester M60 2LA

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Health and Wellbeing Board

Minutes of the meeting held on 3 November 2021

Present:
Councillor Midgley, Executive Member for Adults Health and Wellbeing – In the chair
Councillor Bridges, Executive Member for Children and Schools Services
David Regan, Director of Public Health
Rupert Nichols, Chair, Greater Manchester Mental Health NHS Foundation Trust
Bernadette Enright, Director of Adult Social Services
Paul Marshall, Strategic Director of Children's Services
Dr Murugesan Raja, Manchester GP Forum
Dr Doug Jeffrey, (South) Primary Care Manchester Partnership
Katy Calvin-Thomas, Manchester Local Care Organisation
Dr Denis Colligan, GP Member (North) Manchester Health and Care Commissioning
Kathy Cowell, Chair, Manchester University NHS Foundation Trust

Apologies:
Dr Geeta Wadhwa, GP Member (South) Manchester Health and Care Commissioning
Dr Ruth Bromley, Chair Manchester Health and Care Commissioning
Vicky Szulist, Healthwatch

Also in attendance:
Dr Manisha Kumar, Medical Director, MHCC
Ruth Denton, Our Year Lead
Sam Nicholson, Director, Manchester Climate Change Agency
Owen Boxx, Senior Planning and Policy Manager MHCC

HWB/21/24 Appointment of Chair

Councillor Midgley was appointed Chair for the meeting.

HWB/21/25 Better Care Fund (BCF) return

The Chair informed the Board that an item of urgent business had been agreed to accept the Better Care Fund return report of the Senior Planning Manager, MHCC. The report had been circulated to members of the Board in advance of the meeting.

The report described that NHS England had requested that a BCF return is completed for Manchester which demonstrated the plan to successfully deliver integrated health and social care.

The plan focused on the requirement to reduce long length of stay in acute settings and to provide support for people to remain in the community by having effective discharge pathways and social care provision.

NHS England requested that the plan was approved by the Health and Wellbeing Board prior to being submitted to them by 16 November 2021.

The Chair invited members of the Board to ask questions.

A member of the board referred to arrangement made for patients following their discharge from hospital and asked how a care package would made available if needed.

It was reported that a reablement support package will be applied within the four to six weeks period after leaving hospital.

The Director of Adult Social Services informed the meeting that anyone requiring care as part of a targeted intervention, under the Care Act, would receive an assessment and a care package would then be set up and delivered by home care providers.

Decisions

1. To approve the Better Care Fund return.

2. To approve the narrative return in support of the Better Care Fund plan.

HWB/21/25 Minutes

The minutes of the meeting held on 1 September 2021 were submitted for approval.

Decision

To agree as a correct record, the minutes of the meeting of the Health and Wellbeing Board held on 1 September 2021.

HWB/21/26 Winter Panning: COVID-19 and Flu

The Board received the joint presentation of the Director of Public Health and the Medical Director, Manchester Health and Care Commissioning that described the planned approach to delivering both the COVID-19 and flu vaccination programmes over the coming months. The Board noted that these programmes sat alongside the winter plans of local NHS Trusts and Adult Social Care and the overarching national Autumn/Winter Plan.

The Director of Public Health provided an update on the current data for Manchester at 13 October 2021. Manchester had a rate of 274.9 and was 9 within Greater Manchester and 285 of all local authorities in England. Transmission rates were currently highest within the 11 to 16 years age groups. Reference was made to the rates within the over 60 years age group, that have risen and the importance of continued messaging across the population to take up the offer of the first dose, second dose and the booster vaccine to help prevent hospitalisation. Details were also provided on the impact of covid on secondary care, in particular the number of patients in hospital, those discharged and the impact on staff absences.

The Medical Director, MHCC provided an update on the winter vaccine programme. Details of the first dose, second dose and booster vaccine uptake across Manchester

were provided and it was explained that the vaccine is openly available to encourage wide take up. Work is ongoing to directly notify residents that have not received a first or a second booster vaccine and to invite them to come forward to receive it. Changes to guidance on the provision of the vaccine booster allows the booster to be given before 6 months had past and this was being co-administered with the flu vaccine at the same time to reduce the need for multiple trips. The Board was advised of the timetable and programmes in place to engage with different groups to boost take up of the vaccine that has included various methods of communication to target and engage as widely as possible.

The Chair invited questions and comments from Members of the Board.

A member of the Board referred to the take up rates of the vaccine by the school age children and importance of increasing this and to ensure that schools across the city remain open.

Decision

To note the presentation.

HWB/21/27 Manchester Climate Change Framework 2.0

The Board received the report of the Director, Manchester Climate Change Agency that discussed the evidence of a strong correlation between climate vulnerability and health inequalities; to provide an update on the refresh of the city's Climate Change Framework (Framework 2.0) and to seek guidance on the best way to bring expert advice on Health and Wellbeing into the Framework refresh, both in the short and longer term.

Reference was made to section 4 of the report, that sought support from the Board with the third headline objective on 'health and wellbeing' for setting the right objectives and targets and tracking progress with their implementation. The report set out two proposals for consideration:

a) The Health & Well Being Board itself acts as the independent Advisory Group for the Climate Change Framework's third headline objective.
b) The Health & Well Being Board create a new sub-group of appropriate level members to be the independent Advisory group, which is then overseen by the Board.

The Chair invited questions and comments from Members of the Board.

Members of the Board welcomed the report and referred to the importance of focussing on the impact of climate change on health and making the commitment to the bringing together of the partner agencies to work towards this.

The Director of Public Health proposed that a sub-group be established to help support Climate Change Framework 2.0. The membership of the sub-group would be determined following consultation with partners.

Decisions

The Board agreed to:

1. Note the recent publication of a number of key reports that provide evidence of a strong link between climate vulnerability and health inequality.

2. Provide feedback on the type of indicators that could be adopted to show progress on addressing climate change and health inequalities.

3. Establish a Sub-Group to provide support for the Climate Change Framework 2.0.

HWB/21/28 'Our Year' 2022

The Board received the report and presentation of the Strategic Director of Children and Education Services that discussed the issues and key concerns identified during COVID-19 that must be addressed before they became entrenched and hinder, or even prevent the progress of our children and young people.

The Our Year Lead officer gave an overview and a presentation that described that a citywide approach is required to listening to what children and young people want; and then harness collective resources, support communities to bring more opportunities, training and experiences for the next generation. 'Our Year' 2022 will see partners listening and acting together to create an offer of activities, opportunities and experiences.

From the ongoing work the Board was informed that an expression of interest would be made by Manchester to become part of UNICEF's Child Friendly City and Communities Programme. This would include a number of themes that would be brought to the Health and Wellbeing Board for further work to develop and engage with partners. The engagement of young people had provided valuable data on what is important to young people in the city. These included: family and friends, Education, Environment, Healthy Lives, having fun things to do and feeling included. A calendar of key events is being developed to include key events throughout the year. Members of the Board were invited to be involved in the initiative and to become Active Advocates.

The Chair welcomed the report and in particular, the link to mental and physical health of young people.

Members of the Board were the invited to questions and comment.

Members of the Board noted the enthusiasm and motivation of the young people who had been engaged so far in the process and the richness of the responses they had provided as well as the modesty of some of the requests.

Officers were asked if a fund had been made available and how would the initiative be evaluated to determine how successful the year had been.

It was reported that some funding would be made available for the initiative. Contact had been made with the business sector to help raise support for proposed activities and through other means such as contributing resources via self-funding events, free tickets, mentoring, coaching, donations and work apprenticeships opportunities. The year would be evaluated to measure its success as well as the outcome of the UNICEF Child Friendly City application. Young people will be involved throughout the process and a framework would be developed to measure this through strengthening the voice of young people and how the young people in the city look back at their year.

The Director of Adult Social Services welcomed the initiative and suggested an intergenerational element be included in the initiative that could attract young people to opportunities within the Health and Social Care Sector.

Decisions

The Board;

1. Endorse and promote 'Our Year 2022'. A year to celebrate the successes of Manchester's children and young people and supporting their recovery from the impact of Covid19;

2. Endorse and support Manchester submitting an expression of interest to become part of UNICEF's Child Friendly City and Communities programme; and

3. Promote initiatives/programmes within areas of responsibility that create activities, opportunities and celebrate the success of Manchester's children and young people.

HWB/21/29 Councillor Sir Richard Leese

The Board noted the decision of Councillor Leese to resign from his position of Leader of the Council and Chair of the Board. In acknowledging his involvement in the work of the Health and Wellbeing Board since it was first established, the Board expressed its gratitude to Councillor Leese for the active role he has played in health related matters, especially for his depth of knowledge and awareness of issues being considered and follow up work he has undertaken to ensure Manchester remains in a strong position.

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Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 26 January 2022

Subject: COVID-19 Update

Report of: Director of Public Health

Summary

At the meeting, the Director of Public Health will present an update on the latest COVID-19 data and progress on the implementation of the Manchester Vaccination Programme.

Recommendations

The Board is asked to note the report.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	The ongoing response to the Pandemic impacts on all strategy priority areas and the recovery programmes of all organisations represented on the Board have been affected by the latest Omicron wave.
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 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	
Self-care	

Contact Officers:

Name: David Regan
Position: Director of Public Health
E-mail: david.regan@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.

Manchester City Council
Report for Resolution

Report to: Health and Wellbeing Board – 26 January 2022

Subject: Better Outcomes Better Lives

Report of: Bernie Enright, Executive Director of Adult Social Services

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Summary

Better Outcomes, Better Lives is the adult social care transformation programme. It is a long-term programme of practice-led change, which aims to enable the people of Manchester to achieve better outcomes with the result of less dependence on formal care.

In November 2021, the Health Scrutiny Committee received a substantive update on Better Outcomes Better Lives. This report provides an updated version of that report.

Recommendation

To note the report.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	Better Outcomes Better lives is the ASC transformation programme and is a core part of the ASC delivery of the strategic priorities. The maximising independence workstream is enabling people to keep well and live more independently as they grow older through applying strengths based approaches and person centred care. The whole transformation programme is about ensuring that we put the right care in the right place the right time for people, from getting the front door offer right, maximising the impact of the short term offer and ensuring that if people need long term care, it is at the right level and empowering them.
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	

	The programme is also improving online information to empower people to help themselves as much as appropriate.

Links to the Manchester Health and Social Care Locality Plan

The three pillars to deliver the Manchester Health and Social Care Locality Plan	**Summary of Contribution or link to the Plan**
A single commissioning system ensuring the efficient commissioning of health and care services on a city wide basis with a single line of accountability for the delivery of services	The Responsive Commissioning workstream is focusing on improving the business as usual approach to commissioning in adult social care, to ensure that it responds to people needs.
'One Team' delivering integrated and accessible out of hospital community based health, primary and social care services	
A 'Single Manchester Hospital Service' delivering consistent and complementary arrangements for the delivery of acute services achieving a fully aligned hospital model for the city	

Lead board member:
Councillor Jo Midgley, Deputy Leader with responsibility for Health and Care
Bernie Enright, Executive Director of Adult Social Services

Contact Officers:

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Background documents (available for public inspection):

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

1.0 Introduction

1.1 Better Outcomes Better Lives is the Manchester Local Care Organisation's programme to transform the way that we deliver adult social care so that it meets the needs of our most vulnerable residents and makes best use of the resources that we have.

1.2 Better Outcomes Better Lives began in January 2021, and this is the first report that the Health and Wellbeing Board has received about the programme. Manchester City Council's Health Scrutiny Committee has previously received reports providing detail of the programme and updates, which can be found at the links below:
Link to the March 2021 Health Scrutiny Committee report
Link to the June 2021 Health Scrutiny Committee report
Link to the November 2021 Health Scrutiny Committee report

1.3 This report is an updated version of the November 2021 report that went to Health Scrutiny Committee and provides a detailed overview of the programme and progress against objectives.

2.0 Background

2.1 In 2020, we worked with a consultancy (IMPOWER) to carry out an in-depth analysis of Manchester's adult social care. We reviewed our current practices and how our demand was expected to change over the next few years. We identified significant opportunities to improve practices in order to reduce, prevent and delay demand on services, while also improving outcomes for people in Manchester.

2.2 The Manchester LCO has commissioned IMPOWER to support us to deliver Better Outcomes, Better Lives. The programme builds on IMPOWER's expertise and experience with other local authorities, tailored to the specific strengths and challenges that we have in Manchester. IMPOWER's input into the programme will continue until March 2022.

2.3 The programme is structured around six key workstreams. Four of the workstreams started in January 2021.

- **Maximising independence** – practice led work with teams across the city, embedding strength-based approaches to assessment and review including via 'Communities of Practice' being rolled out across teams
- **Short-term offer to support independence** – building reablement capacity, embedding technology and digitally enabled care and ensuring opportunities to maximise independence through hospital discharge
- **Responsive Commissioning** – ensuring that our commissioning approaches are responsive to need and demand
- **Performance Framework** – embedding a learning and performance approach across the service at all levels

2.4 The programme is key to delivering the savings set out in the 2021/2022 budget agreed by the Council in March 2021. The Better Outcomes Better

Lives trajectory model, agreed in October 2020, has net savings of £6.1m in 2021/2022 and £8.5m in 2022/2023. Work is being finalised as part of budget setting for 2022/23 as to how these savings are apportioned in the budget based on delivery to date.

2.5 The aim of the programme is to build a social care system that starts from people's strengths and puts in place support earlier, so that people can lead more independent lives for longer. Doing this right means that Manchester citizens receive the right support at the right time, based on individual needs, delivered at neighbourhood level by integrated teams.

2.6 The programme will ensure that Adult Social Care in Manchester can be delivered sustainably. It operates alongside other system-wide strategies, like the Manchester Housing Strategy, to make sure that all services across Manchester are working in sync as enablers to support people's independence.

3.0 What will feel different for residents who receive our adult social care services in the future?

3.1 These are our aspirations for what social care will feel like after the Better Outcomes Better Lives programme is complete in 2024:

- Discussions with health and social care staff will be consistent, person-centred and focus on how people would like to live their lives, enabling them to explore different, creative options to do this, including using assistive technology.
- There will be better early help by making the most of all points of contact that people have with health and care, including a better online presence so that people are empowered to help themselves, when appropriate
- More people will be able to do things for themselves and remain in their own homes or have care closer to home so that they can be connected to their communities in a way that is right for them. If leaving hospital, or in need of a step-up of support, an excellent reablement service with technology enabled support throughout it, will be there. This will mean that people will be more likely to be supported at home or in their local neighbourhood in 2024, rather than in residential care.

What will feel different for families and carers?

3.2 The lives of carers and families will be as important as a person in direct receipt of care when discussing support. Carers will be supported to have fulfilling caring experiences in a way that is right for them for as long as possible.

3.3 Through the new Carers Manchester Contact Point (CMCP), carers can expect proactive and flexible support. The CMCP has begun extensive proactive work to identify more carers, including those who need a Carer's Assessment. Strong referral pathways will ensure that Social Workers and the Carers Team work closely with CMCP to deliver improved outcomes to carers such as personalised support and contingency planning, access to a Carer's

Personal Budget, and an improved respite offer to allow Carers regular breaks, with the wider aims of reducing Carer crisis and breakdown.

3.4 Community teams will be supported so that users can access specialist support services, including for learning disability, mental health and autism. Health and care staff will be part of integrated neighbourhood teams across Manchester, so that local support is provided that understands the strengths and needs of local people.

What will feel different for staff?

3.5 Teams will have more freed up capacity to focus on delivering the right support to the right people. Teams will have more confidence in having a conversation with citizens, families and their carers focused on their strengths and practical opportunities, like technology, to living more independent lives.

3.6 Teams will have increased awareness and confidence in community resources in the areas they work, through training and new information links.

3.7 NHS, hospital and social care teams will work more closely together through MLCO. They will also work more closely with colleagues in their neighbourhood, such as district nursing, and with health and care commissioners.

3.8 Practitioners and commissioning will work closer together to ensure that commissioning enables practitioners to identify the most suitable support for people.

3.9 Staff will have more confidence to use and trust data to understand how change is happening. This will support them to be empowered to have the biggest positive impact that they can, as important changes can be prioritised

4.0 Overview of the programme – Key change activities

4.1 The following sections set out the main activities and changes that are taking place within the programme, which will enable us to achieve these aspirations. We have also included some short case studies to illustrate what these changes mean in practice.

5.0 Maximising the independence of residents through improving our social work practice

Strengths-Based Approaches

5.1 We know that there is more we can do in Manchester to support and empower our residents to lead as full and independent lives as possible. In the past, the culture and practices in social work in Manchester have sometimes been risk averse and disempowering for residents. The best practice in social work starts by looking at what a person can do, what they love, and what makes their life good. It then looks at what additional things a

person needs putting in place, to build on that person's strengths. This is called a Strengths-Based Approach.

5.2 It has long been recognised that this approach is a better way to practice social work. When social workers and social care assessors work in a strengths based way, the people they work with are happier, healthier, feel more in control and able to make choices. It leads to better outcomes. This way of working is the approach for the future of adult social care assessment and social work in Manchester. Analysis of Manchester's care packages shows that on average, we put in place more care than people really need or want, which costs us more money than necessary. This means that if we improve social work practices we should see packages of care reducing, on average. This should reduce the increases in demand that we would otherwise expect to see. But cost does not drive the decisions the social workers make.

5.3 In Manchester, we first introduced strengths-based practices in 2018, with a focus on training the workforce. This was a really successful training programme, but it revealed that there were things that got in the way of practitioners taking a strength-based approach with residents. Things such as not being able to access the right commissioned provision, not having enough capacity and not knowing what impact the approaches had. So strengths based practices found a home in Better Outcomes, Better Lives, a much larger transformation programme that is, in part, designed to address those barriers that practitioners find get in the way of taking a strengths-based approach.

Case Study – taking a strengths-based approach to a safeguarding concern, to support someone to stay at home

Joint working enabled a man to be safely discharged from hospital back to home when he previously had been unable to manage in his home environment.

Focus on strengths: Prior to his hospital admission, the man had been sofa-sleeping and unable to manage his home environment. While he was in hospital he was referred to safeguarding. The duty safeguarding professionals (a social worker and a physiotherapist) undertook a joint visit to his home and family. The professionals applied a strengths-based approach to the visit. The visit looked beyond the immediate safeguarding concerns and considered his mobility in the home and assessed the wider home environment.

Outcomes: Without an integrated and strengths-based approach by the professionals involved, the citizen would likely have ended up in a placement. Without the joint working the citizen's support would have been caught between health and social care decision making processes.

However because of the strengths-based approach the citizen was safely discharged to his home environment. The physiotherapist continues to provide support and feedback on safeguarding concerns via the physiotherapy care plan

Communities of Practice

5.4 One of the barriers that was identified was a lack of professional support for practitioners to help them implement the improvements they learned about in training. In order to support professional development and reflective practice, we have established Communities of Practice (CoPs). These are weekly meetings, held in teams, which give practitioners a space to learn, reflect, share experiences as well as enable peer support and challenge.

5.5 CoPs started in the south locality, then were rolled out in North and now have been set up in Central. The CoPs that take place in the south are very well established and the facilitators who run them have taken complete ownership. In North they are heading in that direction, and in Central there is more work to do to establish them. The next steps in developing them further is to bring in wider input from health colleagues and the wider system as well as identifying other services which would benefit from having a team CoP.

Communities of Practice Case Study – Reflections and new ways of working

Dave Bradley, Health Development Coordinator and CoP Co-Facilitator

Our Community of Practice meetings started like many others across the city, with the Maximising Independence team being key to setting the tone of these initial meetings. I think both myself and Winifred may have felt a little worried about taking responsibility for them.

During these early days the engagement of the Social Work Team was a little less than enthusiastic, and it was often hard work to get good conversations flowing. Reflecting on this, this scenario was completely normal! Bringing tricky case studies, we are often exposing our potential weaknesses to others.

I decided to ask the Team what would work best for them? Do people find the meetings useful? How would you like to see the meetings develop? This generated some useful conversations and the group decided that we would start to invite partners into the meeting. Initially these were Health focused - Be Well Social Prescribing Team and 93 Wellbeing Centre. Both of these participants added so much value to the meetings and it was at this point the meetings started to become more interactive.

As a further development, Winifred and I decided that the meetings would now become themed. This was discussed with the Team and the focused sessions have been put together based on the predominant themes/ challenges that the team face on a day-to-day basis. Our first session was around finance, debt management and support accessible in the community. We invited Gateway M40 and North Manchester Community Partnership to the meeting to share what they do and how they support people, whilst also informing the team how they can support them to support the people they work with.

Other focused sessions planned for the future include: alcohol and substance abuse: dementia and neuro conditions: work and skills and housing.

Our CoPs still have a focus on strengths-based and reflective conversations; however this now also includes strengthening the knowledge of the team to what support networks and community assets are available to them and Manchester's residents.

Since starting the CoPs I believe that referrals to other agencies have increased, this is predominantly via Be Well but as we bring more agencies in referrals will widen across all partners.

Winifred Laryea, Senior Social Worker and CoP Facilitator continues...

“Team members initially thought CoPs were an addition to their workload. However, over the weeks we have begun to see the benefits. We always engaged in reflective conversations soon after each CoP, and gradually after meeting Dave in person, most team members have lit up with confidence to fully participate! The past few themed weeks have opened a minefield of developing knowledge and relationships with 3rd party services. **The impact is incredibly positive and empowering.**

It's great working with Dave who is very knowledge about services within our community and has links with them. This has contributed hugely to our CoPs.”

What do the Team say?

“Overall CoPs have improved my strength-based conversations and assessments, improved outcomes for service users; and boost my confidence working with complex cases. Thank you so much to the facilitators!”

"They have increased my knowledge on resources in the community to sign-post people to”

“The CoPs sessions have increased my awareness of services available to work with collaboratively to promote strength-bases working. Some interventions are now moving on quicker than before.”

“The community of practice sessions have been beneficial to my strength-based practice in various way. For example, listening to case studies from other professionals has been used as a learning tool on how to improve my own practice.”

Strengths Based Reviews

5.6 Strengths-based reviews help to identify if a person's needs have changed and if the support being provided might need to be altered as a result. In the original evidence base for Better Outcomes Better Lives, Manchester was identified as having significantly more reviews that result in 'no change' than other local authorities who are our statistical neighbours. This presents an opportunity to use strengths-based approaches to undertake reviews to make sure that people have the right support in place. The programme has also

worked with practitioners to develop strengths-based tools to support planning and preparation for review activity, an approach to prioritisation of activity and is monitoring the impact of this work to ensure it supports greater independence and improved outcomes.

Case Study – Person-centred integrated working to prevent an emergency placement of a young adult

A young adult was at risk of admission to a mental health or specialist hospital. Their family unit was at risk of breakdown. The young adult was assaulting mum. The family were receiving separate service offers from health and social care; and the focus of support was on managing the young person's behavioural challenges.

Focus on strengths: The young adult was identified as being at risk of emergency placement or being arrested because of assaults on mum. Community Learning Disability and mental health professionals from Greater Manchester Mental Health (GMMH) and the Clinical Commissioning Group (CCG) discussed the case in a newly established multi-disciplinary meeting.

The multi-disciplinary discussion focused on identifying the least restrictive support option for the young adult. As a result of this discussion, a positive placement search was undertaken. The placement search was centred on identifying a provider who could work positively with the young adult's family and their college. The search was also based on identifying a provider who could support the young adult to achieve SMART targets to improve their wellbeing and reduce behavioural challenges.

Outcomes: A suitable placement was identified and a co-designed plan was put in place, which all parties agreed to (including the family, the provider, and the service professionals). As a result of this the family remain intact and functioning as a unit. The multi-disciplinary team remains active in supporting the young adult. The young adult and the family are moving forward in a positive direction.

6.0 Improving our short term offer

6.1 Another part of the service that the programme focuses on is the short term offer that people receive for temporary, intensive care and support. Some people receive support and then don't need anything further, and some people go on to longer term care. At the moment, we know that too many of the people who receive the short term support go onto longer term care, or larger care packages than they really need. An important part of ensuring that people have the right type and level of care for them is ensuring that when they're in crisis, the support they get helps them and makes things better. There are two main ways in which we are improving this.

Better use of Technology Enabled Care (TEC)

6.2 TEC can enhance someone's experience, give them greater control over their lives and help them keep in touch with loved ones, their community and

professionals. It's a crucial part of supporting people to be as independent as possible. But it needs to be the right kit, for the right person, and people need to know how to use it.

6.3 In Better Outcomes, Better Lives we are investing in making sure we have the right technology for what people need. We are testing different types of technology, so that we have an offer that suits what people need and want.

6.4 We are also supporting the workforce to take a "TEC first" approach. This means that TEC should always be considered when practitioners are making assessments about what support needs to be put in place for a person. We have made a lot of improvements to how we communicate about TEC, to help practitioners think of it in the first instance. We are also improving the process for making requests for TEC to ensure there are no barriers to accessing it for residents.

6.5 The data for November demonstrates a continued upward trend of TEC devices being used as enablers to support individuals to live more independent, and healthier lives, building on their strengths and improving outcomes.

Case Study – Applying an integrated and strengths-based response to manage complex needs

An Occupational Therapist and a Social Worker adopted a strengths-based approach to respond quickly and effectively to a safeguarding concern.

Focus on strengths: The person was identified as being a safeguarding concern because they were living with someone who was a severe hoarder. They have a learning disability and were identified as being vulnerable to abuse and exploitation. They lead a chaotic lifestyle and have previously been in contact with the criminal justice system.

Prior to Better Outcomes Better Lives there would have been separate service responses to the challenges this person was facing. The Learning Disability teams would have only assessed them individually and their health needs would have been managed separately to their social care needs. The issues relating to hoarding would have been managed via a totally separate referral to the Integrated Neighbourhood Team.

However, because of Better Outcomes, Better Lives an occupational therapist (OT) and a social worker undertook a joint visit to identify the best least restrictive option to support the person.

Outcome: As a result of the joint working, a single co-ordinated response was developed. The response involved using TEC to manage the risks the person was facing whilst allowing them to stay in their own home. They continues to receive input from the OT so that they are able to manage the home environment.

Improvements to reablement

6.6 Reablement is way of helping a person remain independent, by giving them the opportunity to relearn or regain some of the skills for daily living that may have been lost as a result of illness, accident or disability. A reablement service may be offered for a limited period in a person's own home and can include personal care, help with activities of daily living, and practical tasks around the home. When reablement goes well for someone, it can help them get back to normal quickly, or adjust to changes in their circumstances. It can also mean that someone doesn't need to have longer term care, or will need a less intensive care package than they otherwise would. This is why we have invested more into our reablement service. This will mean that it is well resourced and available when needed, and our staff are qualified and highly skilled.

6.7 As a result of the improvements we have made, the Reablement service has seen a continued upward trend in community referrals from the Integrated Neighourhood Teams since the programme began.

Testing small scale pilots

6.8 In order to work out the best way of enhancing our use of TEC and maximising our reablement offer, we are testing different ways of working using small scale pilots. If these pilots demonstrate strong evidence that they make a positive difference, we will scale them up, either geographically or with a wider group of people. If they don't demonstrate evidence we will discontinue them. We have a number of small scale pilots in progress or in planning. Three of our key pilots are:

6.9 **Reablement criteria:** To increase the number of people who access Reablement, build relationships and encourage staff to consider people's potential for reablement, we are trialling a new approach through a one-page criteria document. We're currently testing this with Victoria Mill INT.

6.10 **Anywhere Care:** The Anywhere Care device brings together a number of technologies (including falls sensor, GPS monitoring and YourMeds alerts), into one monitoring device which alerts families/carers when triggered. The device is being testing in partnership with the South Discharge to Assess Team, to understand whether it can enable people to be more independent at home post discharge.

6.11 **Occupational Therapy trial:** In Central Locality, Reablement Discharge to Assess (D2A) assessors are identifying people with mobility / personal care / kitchen related needs and delivering joint goal setting with Occupational Therapists from Central Manchester Community Response Team.

Case Study – Joint working between occupational therapy and reablement

The person was discharged on 20/07. At discharge they were assessed as have reduced confidence in relation to mobility, needed full support to wash and dress, and needed support to prepare meals and drinks.

Focusing on strengths: The reablement review officer identified that this person could benefit from occupational therapy input to develop goals which would enable them to be more independent. At a home visit on 22/07 the occupational therapist identified that what mattered to the person was being able to go to bingo in the community three times per week, like they had done before admission.

The reablement review officer devised progressive strengths-based goals which would work towards this main goal. The first set of goals were that after two weeks, the person would be:

- independent and confident with mobility when using the kitchen trolley
- independent with using the shower
- independent with preparing hot drinks and snacks
- independent with ordering shopping online

The reablement review officer and occupational therapist set out tasks for the reablement support workers to enable these outcomes, including to:

- supervise the person when they were using the shower, and only assist if needed
- use a perching stool to enable them to wash and dry independently
- supervise when they prepare a meal and hot drink and only assist if needed, use a kitchen trolley to transport items between kitchen and living room.

Outcomes: When their progress was reviewed on 28/07, they were assessed to be:

- independent with drink/meal preparation.
- independent mobility using walking stick and accessing community.
- still needed support to wash and dry because of having a temporary orthopedic boot

The outcome of the review: care package reduced from 3 calls to once daily. A further review will be needed when the orthopedic boot is removed.

7.0 Improving how and what we commission

7.1 Historically, 'commissioning' has been how we work to arrange and buy services for people who need adult social care in Manchester. In the MLCO, we want commissioning to be much more than that. Effective, strategic, compassionate commissioning will be how we work with system-wide partners to respond to local needs in a truly place-based way.

7.2 Within Better Outcomes, Better Lives, we have developed a Commissioning Plan which sets out how our approach to commissioning will support integration between health and social care services in the coming year. The plan sets out how we will innovate with providers and shape local markets to respond to the short, medium and long-term challenges that we collectively face as we recover from the Covid-19 pandemic. Our approach will help us grapple with an ever complex landscape, where we increasingly recognise that social determinants of health will be crucial not just to social care, but also to health services.

7.3 We have set out eight priorities in the commissioning plan which will help us achieve this:

Putting prevention into practice – Create an environment with more citizen choice and control, with support closer to home that enhances peoples' wellbeing and independence in a way that is right for them
Market development – Plan to support the adults social care market to be innovative, improve outcomes, align to LCO's strategic objectives & ensuring adequate supply of future support
Citizen commissioning – Making sure that commissioners have the tools and knowledge to meaningfully involve residents when developing support models, and to make sure that citizens' voices are heard when things aren't right
Community led commissioning – Creating and using flexible purchasing models for community-led solutions that are more personalised, strengths-based and build resilience
Flagship commissioning activities – Identifying the highest impact projects in adult social care to make them more than the sum of their parts
Building Local Good Practice into Business as Usual – Taking stock of current arrangements to make sure they are the best they can be
Contract management – Driving better outcomes for citizens through robust performance management of existing support delivery, evolution of measuring outcomes and better relationships with providers
Skills for strengths based commissioning – Equipping the commissioning workforce and stakeholders in the widest sense with the knowledge and skills to deliver the commissioning plan priorities

8.0 Better use of data

8.1 Making better use of data is a key part of how Better Outcomes Better Lives is enabling people to work differently. There are two closely linked, but distinct, sides to improving how we use data. The first is how we use data within the programme. We are collecting specific information about what impact the programme is having, what's working and what could work better. The second part is supporting service and teams use data to make better decisions. There are three key tools to enable this, which are currently in varying stages of development.

Learning Logs

8.2 Learning Logs are completed by practitioners when they have carried out an assessment or review. The information they capture includes how the programme has supported them and whether there are gaps in provision. They provide a rich source of information, both quantitative and qualitative, to inform what we need to focus on to support improvement.

Adults Strategic Performance Report (previously Top Level Report)

8.3 The workstream has also developed a high level performance and finance report, which reflects demand, budget trajectories and cost. It is produced by the Council's Performance, Research and Intelligence service, and owned by the Adults Directorate Management Team. The purpose of the Adults Strategic Performance Report is to give an overarching view of performance across the directorate, to:

- provide assurance and visibility
- enable senior leaders to set priorities and actions
- understand the impact of performance and demand measures on spend
- show what impact Better Outcomes, Better Lives interventions are having on business as usual

8.4 The Adults Strategic Performance report is now in regular monthly production and has received very positive feedback from senior leaders in the LCO and Council. It is reviewed on a monthly basis by the MLCO Executive, contributes to the Council's integrated monitoring report and is reported into the MLCO Accountability Board, co-chaired by the Deputy Leader with responsibility for Health and Care. The report will evolve over time to ensure that it remains a useful tool which enables taking decisions and actions that lead to improvement. A number of the metrics included in the report are referred to above.

Team Level Framework

8.5 We want teams to understand and own their own performance and how their actions, behaviours and culture have an impact on measurable outcomes. As set out earlier in the report, there are new approaches, structures and practices being put in place for practitioners and teams. Teams need to be able to understand what tangible difference these practices make. This will reinforce good practice, but also enable managers to tackle poor practice. With this goal in mind, the programme, led by PRI, are working with teams to develop a tool to support this. The tool has been co-designed and adapted to provide only the data that teams need to support constructive improvement. Following extensive engagement to understand needs, a pilot version of the tool has been tested with a team in south locality, and will be rolled out across the city in early 2022.

8.6 We recognise that this using data effectively requires skills and knowledge that are new to some staff, so we will be undertaking a review of skills and providing support and development for those who need it. Our guiding principle is that performance shouldn't be punitive, but constructively support improvement.

9.0 Early Help

9.1 In November 2021, we agreed to commence the Early Help workstream. The purpose of this is to have

- A cohesive initial contact
- An improved online offer which supports independence
- Maximising the community offer

9.2 The Early Help offer, including the Front Door (contact centre), is to be enhanced through a re-focused, strengths based triage supported by improved processes, advice and guidance. This will prevent need, maximise independence and manage demand. It is critical for getting the best outcomes for people. It's also critical for the success of the rest of the programme, to ensure that the service will be sustainable for the future.

9.3 This work is in the early stages of investigation to understand in detail how the system currently works, to test assumptions and identify long term, sustainable solutions as well as some quick wins to enable improvement quickly.

9.4 The number of new contacts that we receive through the contact centre is much higher than we would normally expect to see at this time of year, and are consistently above the three year average. This is likely driven by the Covid-19 pandemic and is putting considerable pressure on our services. The purpose of the Early Help workstream is to ease some of these pressures.

10.0 See and Solve

10.1 The purpose of see and solve will be to address entrenched system barriers that get in the way of practitioners taking decisions which empower residents and build on their strengths. It will use a task and finish methodology to tackle these issues. The programme launched the first see and solve interventions in December, beginning with improving the integrated duty offer in Learning Disabilities South teams.

11.0 Conclusion

11.1 Better Outcomes, Better Lives began in January 2021 and we are now a year into a three year programme. Over the first year of the programme we have progressed at significant pace and achieved a huge amount. Embedding real, sustainable change in how we work across the whole service takes a lot of time. It's an incredibly ambitious transformation programme and there remains a lot to do over the course of the rest of the programme, to deliver what we need to and our staff and residents deserve.

Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 26 January 2022

Subject: Integrated Care System arrangements and Manchester Locality Plan Refresh

Report of: Deputy Leader (with responsibility for Health and Care), Manchester City Council & Vice Chair, Manchester Health and Care Commissioning

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Summary

Part one of the report provides an update on the establishment of a Greater Manchester Integrated Care System/Integrated Care Board and Manchester Locality Board.

Part two of the report provides an update on the refreshed Manchester Locality Plan

Recommendations

The Board is asked to note and comment on this report and to support the refreshed Locality Plan.

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	Parts One and Two of this paper outline how the health and social care system will be organised going forward and the on-going commitment to improve the health and care outcomes for the people of Manchester.
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: Cllr Joanne Midgley MCC & MHCC

Contact Officers:

Name: Ed Dyson
Position: Executive Director of Strategy/Deputy Chief Accountable Officer - MHCC
E-mail: edward.dyson@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.

NHSE ICS guidance documents and the NHSE system oversight framework:

https://www.england.nhs.uk/publication/integrated-care-systems-guidance/
https://www.england.nhs.uk/publication/system-oversight-framework-2021-22/

1. Introduction

This paper updates the Health & Wellbeing Board on the development of Integrated Care Systems (ICS) and the approach to implementation for Greater Manchester and the City of Manchester.

It also includes the refreshed Locality Plan for Manchester, which recommits to the strategic intent to improve the health and care outcomes for the people of Manchester and recognises the significant change in context following the COVID-19 pandemic.

PART ONE

2. Background

2.1 National context

Subject to legislation passing through parliament, Integrated Care Systems (ICS) will be established in England from 1st July 2022. This change was originally planned for 1st April 2022 but has been delayed to allow sufficient time for the legislative process to conclude. ICS will have four aims: -

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

National guidance sets out the core building blocks of an ICS including: -

- **An ICS Partnership**, convened between the ICS Board and Local Authorities as a broad strategic alliance;

- **An ICS NHS Body,** as a statutory NHS organisation, which will deliver the following functions: -

    - Developing a plan to meet the health needs of the population and to ensure NHS services and performance are restored;
    - Allocating resources;
    - Establishing governance arrangements;
    - Arranging for the provision of health services;
    - Leading system implementation of the people plan;
    - Leading system-wide action on data and digital;
    - Working with Councils to invest in local community organisations and infrastructure;
    - Joint work on estates, procurement, supply chain and commercial strategies;
    - Planning for, responding to, and leading recovery from incidents;
    - Functions NHSE/I will be delegating including primary care and appropriate specialised services.

The ICS NHS Body will put necessary governance arrangements in place, including a unitary board (ICB), committees and a scheme of delegation.

The ICS NHS Body may delegate some of these functions to either: -

- **Place based partnerships** between NHS, local councils, VCSE, residents, patients and carers.

- **Provider collaboratives**, bringing NHS providers together across one or more ICSs to secure benefits of working at scale. As a minimum these will cover acute physical and acute mental health services. Some services, such as ambulance services may cover more than one ICS area.

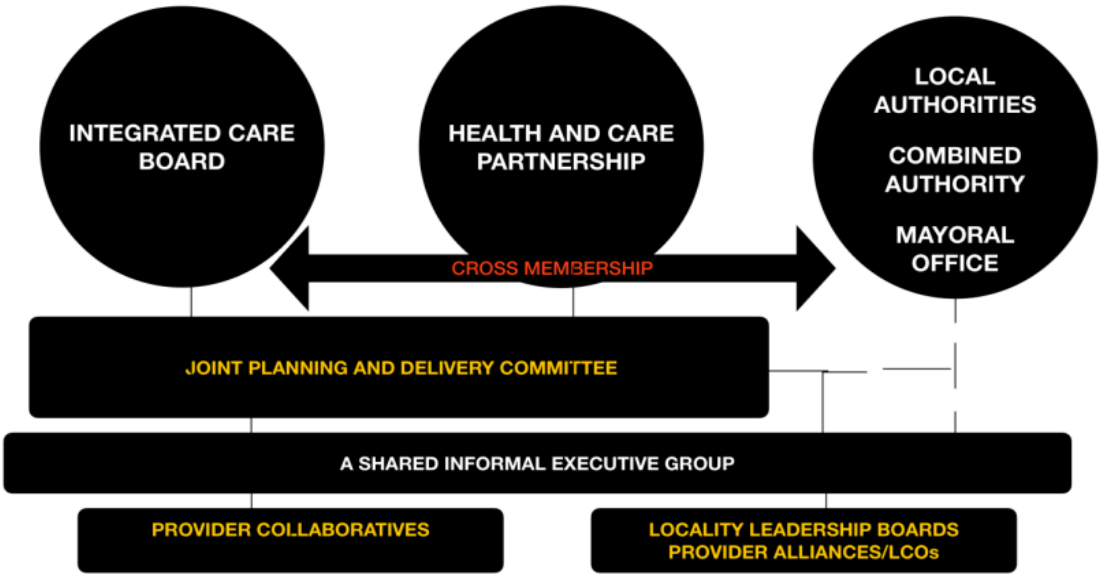
The statutory organisation within this new system will be the Integrated Care Board (ICB). This will take on the functions of Clinical Commissioning Groups (CCGs) which will be disestablished on the 30th June 2022.

2.2 Greater Manchester context

In Greater Manchester this will mean a shift from the Greater Manchester Health & Social Care Partnership (GMHSCP) arrangements to a new Greater Manchester ICS and ICB. Work is underway to prepare for this shift, determining the future role and governance of the GM ICS and ICB and the 10 localities in the new structure.

Sir Richard Leese has been appointed Chair designate of the Greater Manchester ICB along with two non-executive directors. The Chief Executive Officer recruitment is in progress, with a planned interview date in February, and recruitment to the Chief Finance Officer, Medical Director and Chief Nurse roles has also commenced.

The GM ICB will operate within the governance structure shown below:



Work is underway to develop a Greater Manchester operating model. This will include actions focussed on five 'integrating processes'

1. Creation of a simple narrative as to how the new system will work
2. ICB and ICP governance and priority setting
3. Agreeing financial flows and responsibilities
4. Signing off locality leadership arrangements
5. Agreeing running cost allocations and deploying staff within the national HR framework

In addition, there is significant thematic work focussed upon areas such as finance, workforce, digital etc.

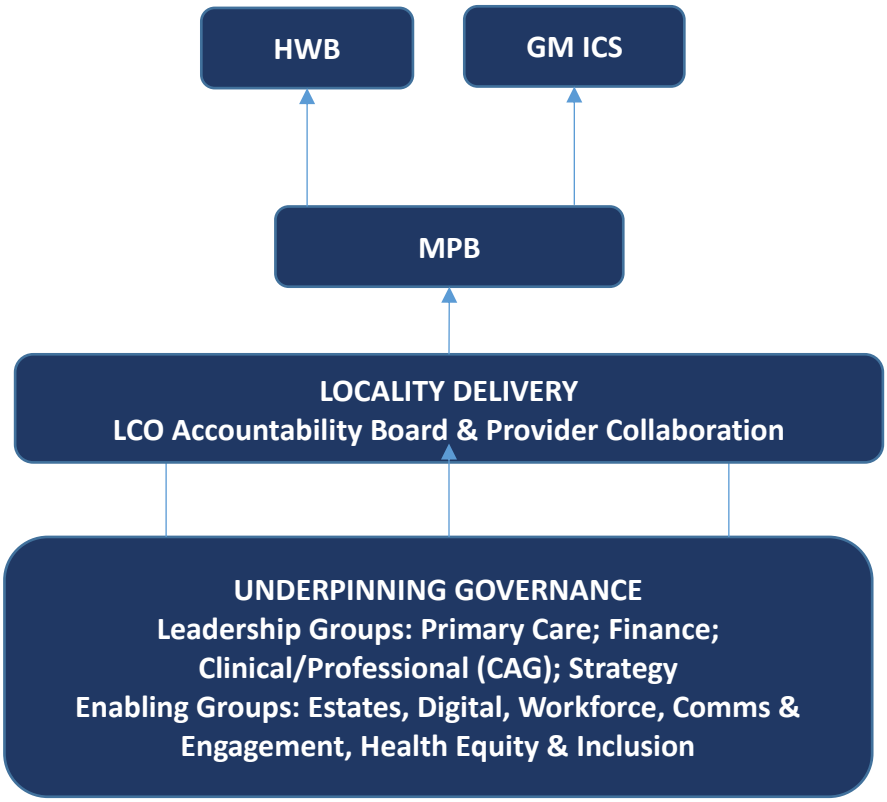
The ten GM localities are each considering this operating model in light of how their own arrangements develop.

3. Manchester Partnership Board (Locality Board)

In response to the national guidance and forthcoming legislative change described above, Manchester's Local Authority and NHS leaders have both contributed to the developing GM ICS and ICB arrangements and worked to develop locality arrangements for the City of Manchester.

The Manchester Partnership Board (MPB) will act as the Locality Board for Manchester, as described in the GM governance model (above) and developing operating model. The MPB succeeds the Transformation Accountability Board, which previously had oversight of Manchester's Locality Plan and associated transformation funding.

It is proposed that MPB functions within the governance model described below:



As the senior leadership forum for health and care within the City, MPB's role will include the Manchester locality health and wellbeing plan, production and implementation; any delegated responsibilities by GM ICB and improving agreed areas of unwarranted variation. It will comprise political, clinical and managerial leadership.

It will be the strategic interface between the NHS and wider public sector strategy in the City, optimising the wider determinants of health and the NHS' contribution to the City strategy.

As described in the diagram above, the Manchester Partnership Board will have the primary line of reporting for Manchester's responsibilities to both the NHS ICB Board and the Manchester Health and Wellbeing Board (HWB), bringing together key partners to plan health & social care services for Manchester.

Work continues to develop an operating model for the Manchester locality that meets the expectations, City strategy, national guidance and complements the emergent GM Operating Model and governance model.

In addition to establishing the set-up arrangements of Manchester within the GM ICS the MPB is also focussing on key City transformation programmes as set out the in locality plan. These include Recovery, North Manchester Strategy and the new Marmot task force work to tackle health inequalities.

PART TWO

4. Our Healthier Manchester: Locality Plan Refresh 2022

The original Locality Plan: Our Healthier Manchester, produced in 2016, set out the ambition to improve health and care outcomes for the people of Manchester within a financially sustainable health and social care system. The initial focus led to a rationalisation of the Manchester system, through the creation of a single commissioning function (SCF), a single hospital service (SHS), and a local care organisation (LCO). The first update to the Locality Plan (April 2018) was set within the context of the city's Our Manchester strategy, shifting the emphasis away from structural change to a focus on Our People, Our Services and Our Outcomes.

A Locality Plan Refresh (November 2019) was produced within the context of a maturing health and social care system, and in response to both the Greater Manchester Health and Social Care Partnership's (GMHSCP) Prospectus (March 2019) and the requirements of the NHS Long Term Plan. It was reflective of key Greater Manchester strategies, including the Greater Manchester Unified Model of Public Services and the Local Industrial Strategy – underpinned by the Greater Manchester Independent Prosperity Review. Turning the 3rd Locality Plan into delivery was, however, interrupted by the advent of the COVID-19 pandemic.

This latest refresh of Manchester's Locality Plan was produced at a time of unprecedented change, recognising that we don't yet know or understand the full impact that this has had on the health and wellbeing of our people. Nevertheless, this

Plan seeks to reaffirm our City's ambition to create a population health approach that puts health at the heart of every policy, improving health and care outcomes for the people of Manchester, whilst recognising that our plans for the future will need to continue to evolve and respond to those changing needs, within a new governance structure.

Like previous refreshes of the strategy, it doesn't change the overall direction but reflects the evolution of our arrangements, the progress made and the shift in context due to the impact of the Covid pandemic. This refresh did not have significant engagement as it was undertaken during the Covid period and quickly in order to give some direction to the recovery phase of the City. We expect a more fundamental refresh, with wider stakeholder engagement to be undertaken in due course.

The Locality Plan Refresh (2022) has been approved by the MPB. It is attached as Appendix A.

5. Recommendation

Health and Wellbeing Board members are asked to: -

i. Note the content of Part One of this report relating to the development of GM and Manchester locality arrangements in response to the Health & Care Bill;

ii. Endorse the proposed governance arrangements for the Manchester Partnership Board, including a primary line of reporting to the Health & Wellbeing Board;

iii. Support the Locality Plan Refresh (2022).

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MANCHESTER LOCALITY PLAN

"Our Healthier Manchester"

2021 REFRESH

V2.0 MPB Approved

CONTENTS

STRATEGIC CONTEXT

The original Locality Plan: Our Healthier Manchester, produced in 2016, set out the ambition to improve health and care outcomes for the people of Manchester within a financially sustainable health and social care system. The initial focus led to a rationalisation of the Manchester system, through the creation of a single commissioning function (SCF), a single hospital service (SHS), and a local care organisation (LCO). The first update to the Locality Plan (April 2018) was set within the context of the city's Our Manchester strategy, shifting the emphasis away from structural change to a focus on Our People, Our Services and Our Outcomes.

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The pandemic has had a major impact on the health and wellbeing of the people of Manchester, as it has impacted people all across the world. We are incredibly grateful for the herculean efforts made by NHS & Council staff, carers and the voluntary, community and social enterprise (VCSE) sector to maintain essential services and support people through such challenging times. What we have learned, however, is that the long-standing inequalities in our City have significantly disadvantaged people further in respect of COVID-19 morbidity and mortality, widening the gap in health outcomes still further. We need to recognise, therefore, that our vision, strategic aims and intended outcomes may still remain true to that original Locality Plan in 2016, but the targets we set for improved health outcomes have become more challenging.

We also need to recognise that the context in which we operate is going to change. The recent Health & Care Bill introduced new measures to promote and enable collaboration and integration in health and care. It also seeks to formalise Integrated Care Systems (ICS) by turning them into statutory bodies, whilst disestablishing Clinical Commissioning Groups (CCGs). In Greater Manchester this will mean a shift from the Greater Manchester Health & Social Care Partnership (GMHSCP) arrangements to a new Greater Manchester ICS. Work is underway to prepare for this shift, determining the future role and governance of the GM ICS and the 10 localities in the new structure. The Manchester health and care system continues to work collaboratively in pursuit of the Locality Plan vision, whilst the new health infrastructure and governance develops (see page 14).

Manchester was ranked as the 6th most deprived Local Authority in England in the 2019 Index of Multiple Deprivation [1], which takes into account factors such as income, housing, education and employment, all of which contribute to people's health and wellbeing. Furthermore, we are operating in the context of a growing and changing population in Manchester. The population is forecast to grow by more than 14% over the next decade, which is the equivalent of 84,900 people. This presents opportunities for the city, but also some challenges in how we plan for the health and care needs of this expanding population.

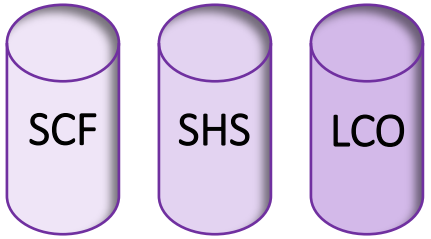
This latest refresh of Manchester's Locality Plan has been produced at a time of unprecedented change and we don't yet know or understand the full impact that this has had on the health and wellbeing of our people. Nevertheless, this Plan seeks to reaffirm our City's ambition to create a population health approach that puts health at the heart of every policy, improving health and care outcomes for the people of Manchester, whilst recognising that our plans for the future will need to continue to evolve and respond to those changing needs, within a new governance structure.

1. To allow comparison between the 317 English local authorities, the deprivation scores of each small area (LSOA) in a district are averaged and then the districts are ranked based on these averages. Manchester ranks as the 6th most deprived local authority on the index of multiple deprivation.

HOW MANCHESTER'S STRATEGY HAS EVOLVED

Manchester's approach to achieving the strategic aims of the Locality Plan has evolved since the first Locality Plan was written in 2016. The graphic below charts this evolution.

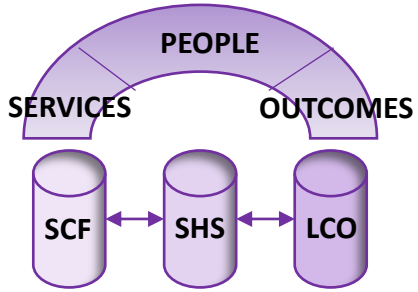
2016
Three Pillars



Laying the foundations

Manchester's first Locality Plan in 2016 emphasised the need to focus efforts on establishing the building blocks for system integration by prioritising structural change. This involved the creation of three new integrated organisations (three pillars): a single commissioning function (SCF); a single hospital service (SHS); and a local care organisation (LCO), plus confirmation of Greater Manchester Mental Health Trust (GMMH) as the provider of integrated mental health and care for the City.

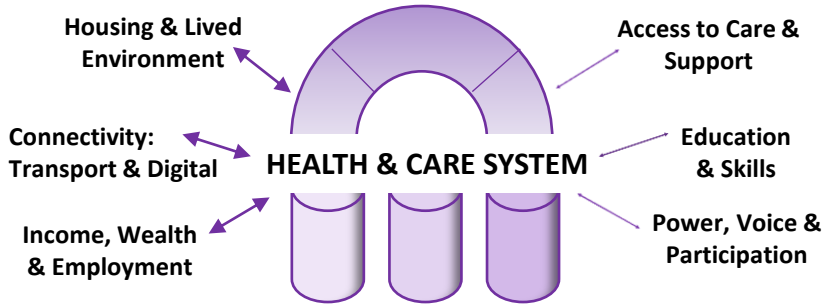
2018
The Rainbow



Focusing on outcomes for people

The second iteration of the Locality Plan in 2018 emphasised the need to switch the focus from structural transformation – the three pillars – to achieving better outcomes for people. A 'Rainbow' graphic was introduced to illustrate the new focus. A number of key milestones were identified up to 2026/27 under the headings: *'Our Services'; 'Our People'; and 'Our Outcomes'.*

2021
System Integration & Collaboration



Build Back Better – Build Back Fairer

Health care is only one of the many factors that impacts on health outcomes and we know that the COVID-19 pandemic has further exacerbated deep-seated inequalities experienced by many in our population. Building on the 2020 Refresh, this plan acknowledges the many challenges that we face, whilst reaffirming our resolve to work collaboratively, as an integrated system, to improve outcomes.

We also recognise that the Locality Plan doesn't exist in isolation. It sits alongside the Manchester Population Health Plan (2018-2027) as a primary strategy driving improved health and care outcomes, and together they form the health & care element of the overall city strategy: **Our Manchester.**

STRATEGIC AIMS & PRIORITIES

OUR HEALTHIER MANCHESTER

Manchester's Locality Plan has five Strategic Aims, outlined in the graphic below. Progress is tracked against a range of indicators in the Locality Plan Outcomes Framework, with the key intended outcomes included below. The Manchester Partnership Board (the City's newly formed senior leadership forum for integrated health and care) has identified eight key priorities that will contribute to the achievement of these strategic aims. The priorities and associated work programmes are explained in more depth in Annex 1.

STRATEGIC AIMS	KEY INTENDED OUTCOMES	NOTABLE PROGRESS/CHANGES
 **Improve the health and wellbeing of people in Manchester**	➢ Narrow the life expectancy gap between the city's residents ➢ Improved health & well-being – social care quality of life ➢ Reduction in preventable deaths (all causes).	↓ Under 75 Mortality Rate from causes of death considered preventable *
 **Strengthen the social determinants of health and promote healthy lifestyles**	➢ Reduction in smoking prevalence to 15% or lower by 2021 ➢ Increase in the number of children who are school ready ➢ Reduction in residents who are out of work due to an underlying health condition/disability.	↓ A sustained decease in smoking prevalence **
 **Ensure services are safe, equitable and of a high standard with less variation**	➢ All providers have a CQC rating of good or above ➢ All national and local quality standards are met.	↑ Percentage of GP practices, Nursing and Care Homes CQC rated good or above **
 **Enable people and communities to be active partners in their health and wellbeing**	➢ Increase the level of knowledge and confidence that people have in managing their own health.	↑ People feeling in control of their daily life, and feeling safe and secure (pre-COVID-19) **
 **Achieve a sustainable system**	➢ Achievement of financial balance across the system ➢ Achievement of constitutional and statutory targets ➢ Developing a sustainable workforce.	↑ Number of people and the length of time waiting for elective care, diagnostic tests and cancer treatment. **

MANCHESTER PARTNERSHIP BOARD PRIORITIES

1. Health infrastructure developments as a driver of economic regeneration
2. Covid response and recovery
3. Reduce inequalities
4. Supercharging the MLCO
5. Major transformation programmes
6. Development of Greater Manchester ICS and Manchester Local System arrangements
7. Refresh of key City strategies
8. Development of a short and long term approach to resource allocation

***Indicators relating to data available for period 2017/19 **Indicators relating to data available over the period 2019/21**

SYSTEM CHALLENGES – CURRENT & EMERGING

OUR HEALTHIER MANCHESTER

The Manchester Partnership Board priorities outlined on the previous page also take account of the need to address the challenges Manchester's health and care system is currently facing, many of which have been exacerbated by COVID-19. A selection of pressing system challenges related to standards, access and quality of care have been grouped into 'operational', 'financial' and 'workforce', and are detailed below. In addition to these challenges, the next few pages identify the challenges, and emerging approaches, associated with population health, health equity and the wider determinants of health.

Key system OPERATIONAL challenges

Acute and Mental Health system pressures

- The acute health care system continues to experience operational pressures as a result of the national pandemic that is impacting on delivery of NHS constitutional targets for Manchester patients. Safety is being prioritised across emergency, urgent and elective pathways and system-wide improvement programmes are in place to support recovery (MPB priority 2). It is envisaged that progress will be made in reducing elective backlogs over the coming months, however this will be incremental and in the context of wider pressures. Specific operational challenges include:
- **Impact of COVID-19 on long waits:** COVID-19 has had a profound impact on the shape and size of the waiting list at MFT. The overall waiting list size at the end of June 2021 was 141,545 with 14,706 patients waiting over 52 weeks.
- **Urgent Care:** As a result of high demand and the continued need to split estate and flow to meet infection prevention and control requirements the number of breaches to the 4 hour A&E standard has been significantly high across all sites.
- **Cancer:** Delivery against the 62-day referral to treatment standard has been challenged throughout the pandemic. Reducing the number of patients waiting for cancer treatment is a key priority with good progress being made across all hospital sites in Manchester.
- **Mental Health:** Mental Health Services in Manchester have experienced extreme pressure with increased demand being seen in a number of service areas; Manchester Community Mental Health Teams have experienced sustained, higher levels of demand that are above pre-COVID-19 rates, delayed transfers of care remain challenging, and there has been a rise in demand for inpatient beds resulting in an increase in patients being placed out of area.

Primary care

- The COVID-19 pandemic has led to unprecedented change in the way General Practice works. The continued provision of services throughout the pandemic combined with the rapid implementation of digital and triage first models of care and the increasing demands for the delivery of the largest vaccination programme in history is seeing General Practice endure one of the most challenging periods in its history.
- A combination of reduced staffing levels in primary care due to sickness and self-isolation, coupled with increasingly complex patients presenting who did not access care throughout the pandemic is presenting significant operational challenges.
- The primary care quality, recovery and resilience scheme (PCQRRS) is focusing on restoring service provision, preparing for future waves of the pandemic, and supporting reform and recovery. It will support the recovery, boost the resilience of our primary care workforce and fund time to ensure quality is embedded in recovery across Manchester General Practice to meet the needs of our diverse communities.

Social Care

- There are real challenges being experienced in the care home and home care markets particularly in relation to staffing capacity which will potentially be exacerbated by the mandated vaccinations for care home workers – a risk which is being managed closely. In home care in particular workforce capacity is a national issue which continues to create challenges locally in both the community and in supporting hospital flow.

Community

- High levels of COVID-19 related sickness/vacancies are leading to challenges in the delivery of community services, where both activity levels and complexity are greater now than pre-pandemic, at a time when community staff are also supporting the COVID-19 vaccination programme.

SYSTEM CHALLENGES – CURRENT & EMERGING

OUR HEALTHIER MANCHESTER

Key system FINANCIAL challenges

The current financial landscape is very different to those which previous locality plans have been based upon. In response to the global pandemic the health and care financial regimes have been changed to allow greater focus on the response to the crisis, targeted resources to critical areas and now as we emerge – focus on recovery. Arrangements for the coming years in respect of the level of financial autonomy and national requirements post pandemic are still awaiting clarification, including the outcome and scope of the spending review for Local Authorities. What will be of particular focus for Manchester is the transition to the ICS arrangements and how this will impact the funding flows between a Greater Manchester and a locality level.

We are aware of significant national pressures on resources and likely efficiency targets. Greater Manchester and Manchester health and care systems are currently spending significantly more than previously notified allocations. The Manchester system will need to identify issues arising from non recurrent funding and prioritise future funding in line with the delivery of the locality plan.

Finance system leaders are working in partnership to ensure that Manchester is able to respond in a coordinated and agile manner to address the challenges outlined above.

CASE STUDY – DIGITAL PRIMARY CARE

The COVID-19 pandemic has accelerated previous plans to build a different relationship between patients and primary care. Alongside the face to face appointments that remain important to many people and for many conditions, an increasing number of patients are now able to use digital technology to access and interact with primary care. We have found that for some patients, digital access has revolutionised their experience of GP care, whereas others preferred the traditional system. Knowing that digital is not better for everyone means that digital inclusion is now a key priority going forward. We now have the challenge of embedding the benefits that digital working provides, whilst ensuring that patient experience and digital inclusion are improved for all.

Key system WORKFORCE challenges

Previous iterations of the Locality Plan have recognised the need for our health and care system to work collaboratively ***'to make Health and Care in Manchester the best place to work',*** with priorities set around: Recruitment, Retention and progression; Equality, Inclusion and Social Value; Health and Wellbeing; Workforce Development; Workforce Planning; and the development of a Workforce Operating Model.

Our strategic intent is unchanged, however, we need to recognise the impact that the pandemic has had on our workforce. The demands placed upon our people in the last 18 months were unprecedented and we know that they are exhausted and need to recover. We recognise, therefore, that supporting staff health and wellbeing will be crucially important if we are to continue to support the health and care needs of our population effectively.

We also know that the pandemic has disproportionately affected people in our population who experience racial inequality which includes our staff. We have, therefore, renewed our commitment to creating a culture where people can develop and thrive in a compassionate and inclusive environment that addresses systemic and structural inequalities. We want our health and care system to be representative of the people we serve, celebrating diversity.

CASE STUDY – SHARED CARE RECORD

The rollout of the Greater Manchester Care Record (GMCR) was rapidly accelerated due to the COVID-19 pandemic, as technological and information governance barriers were addressed, allowing patient information sharing across GM regardless of organisation or geography. This meant, for the first time, those providing care had access to a wider range of health and care data from organisations across the whole of Greater Manchester.
When the vaccination programme began in December 2020 Manchester developed an innovative solution to utilise data from the GMCR, including a suite of resources to understand vaccination coverage by multiple population groups. These resources were used to identify and reduce vaccination inequalities in BAME groups through targeted interventions.
Vaccination data, coupled with the development of a re-identification tool, has supported vaccination sites to identify and target patients that may have been otherwise missed.

SYSTEM CHALLENGES – LONG-STANDING

OUR HEALTHIER MANCHESTER

Health Equity & Wider Determinants

Manchester has entrenched health inequalities dating back for generations. The City has amongst the worst health inequalities in the country and also experiences wide variation between different communities within the City itself. The wider determinants of health such as employment and education also have worse outcomes than the country as a whole. The Manchester Population Health Plan (2018–2027) details these inequalities.

COVID-19 has had a profound impact upon the population's health. It has impacted disproportionately on different communities within our City, largely exacerbated by existing inequalities experienced across different ethnic groups and areas of deprivation. For example, life expectancy has reduced and instances of life limiting illnesses have increased. This comes on top of the recent Marmot report 'Build Back Fairer', which identified that mortality was already double in areas of highest deprivation, nationally, compared with the least. Our response to the pandemic has mitigated some of this differential but we expect to see greater variation in health outcomes across the City and compared to the rest of the country. Some of this variation is evident now; some we know will emerge in the future and some impacts may, as yet, remain unknown.

Reducing Health Inequalities

We recognise the need for continuous improvement in addressing inequalities and promoting inclusion and, in support of this, Manchester has identified seven priority actions: -

- Improved demographic data collection;
- Community research to inform service delivery;
- Improved access, experience and outcomes;
- Culturally competent workforce risk assessment;
- Culturally competent education and prevention;
- Targeted culturally competent health promotion and disease prevention;
- Ensure recovery plans reduce inequalities caused by wider determinants.

Manchester has put these priority actions into practice throughout the pandemic. COVID-19 Health Equity Manchester (CHEM) was set up to address the disproportionate effects that COVID-19 has had on specific population groups in Manchester including: communities that experience racial inequality; disabled people and Inclusion Health groups. A number of Sounding Boards (see panel) were developed to build insight and inform action planning. These included, for example, changes to how our vaccine delivery occurred e.g. pop up sites in different locations and community leaders engaging directly with their communities to encourage uptake.

As part of the Population Health Recovery framework, the CHEM approach and infrastructure will be built on to address a broader health and wellbeing remit and support the implementation of the Locality Plan.

How we work – Sounding Boards

COVID-19 HEALTH EQUITY MANCHESTER

Sounding Boards have been set up to help CHEM address the needs of Communities that Experience Racial Inequality*

They are a forum to discuss ideas and proposed activities to deliver CHEM's objectives, and act as "critical friends" to the Strategic Group.

The main functions of the Sounding Boards are to

- Bring together a group of people that can act as a voice for their communities
- Give the communities they represent a voice in the development and delivery of CHEM's programme of work
- Identify and share what the priority issues and concerns are for the communities they represent
- Share their views on how statutory sector initiatives and activities might inadvertently impact adversely on different communities and provide potential solutions

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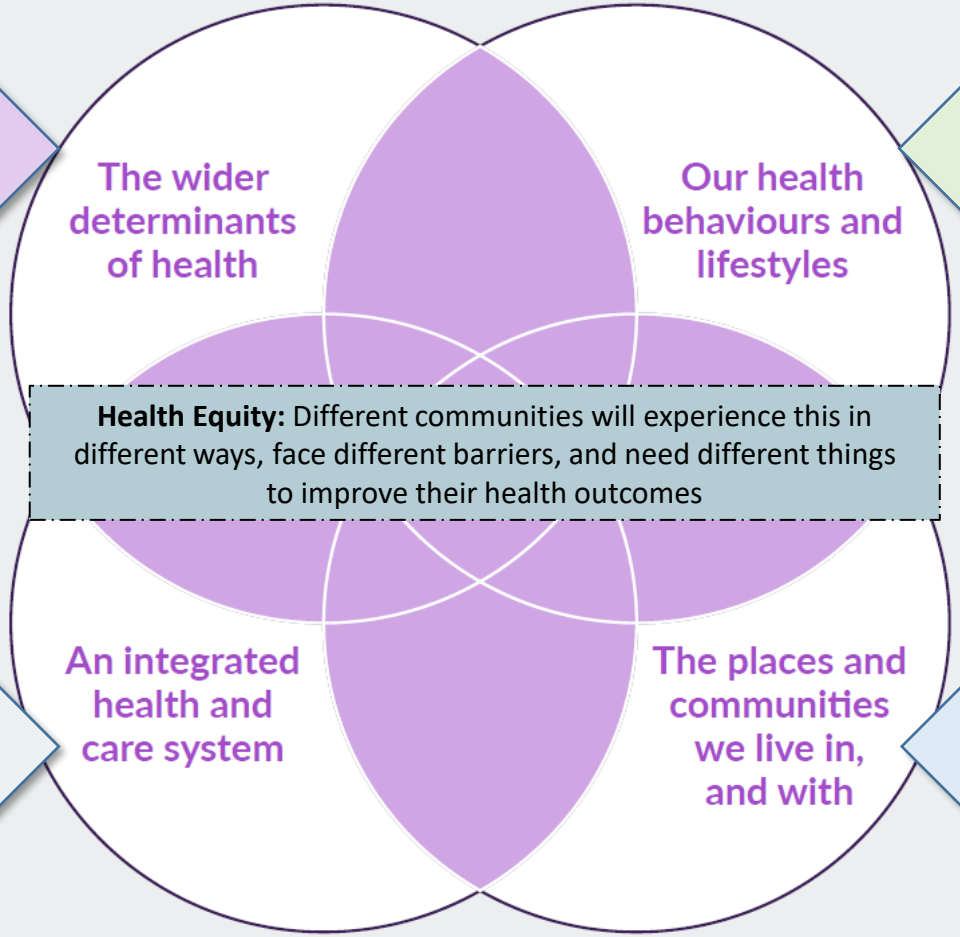
*including people who experience xenophobia or experience disadvantage because of their migrancy status

A POPULATION HEALTH APPROACH TO ADDRESSING OUR CHALLENGES *OUR HEALTHIER MANCHESTER*

The Manchester Population Health Plan (2018–2027) is at the heart of our long-term plan to tackle Manchester's entrenched health inequalities, outlined on the previous pages. The plan for the city will requires a whole system, all-age approach as depicted in the framework below; with a strengthened approach to health equity in response to the systemic inequalities for certain communities highlighted by the COVID-19 pandemic. Collaborative delivery of this framework will involve all system partners. Each of the four components of this framework is described in more detail on the following slides, including relevant case studies.

- **Income, wealth, poverty**
- **Housing**
- **Education and work**
- **Transport**
- **Leisure**
- **Environment, climate**

- **Mental wellbeing**
- **Physical wellbeing (activity, food)**
- **Alcohol, drugs, smoking**
- **Sexual health**



Health Equity: Different communities will experience this in different ways, face different barriers, and need different things to improve their health outcomes

- **Multi-agency teams**
- **Person-centred care**
- **Community-centred care**
- **Strengths-based approaches**
- **Trauma-responsive approaches**

- **Team around the neighbourhood**
- **Local environment**
- **Social and community networks**
- **Communication and engagement**
- **Developing assets**

THE WIDER DETERMINANTS OF HEALTH

In order to have maximum impact, the partners in the City will need to work as a collective system on the activities that address the social determinants of health for people at an individual and community level, ensuring every resident has the opportunity for better health and support.

The City Council as part of its civic leadership role is ideally placed to harness the collective strengths of organisations and sectors across the city to address the wider determinants of health. It is proposed that, under the Health and Wellbeing Board, the Director of Public Health will establish and lead a focused Task Group to respond to the recent Marmot Report with a clear action plan relating to the wider determinants. This work will feed into the refresh of the Manchester Population Health Plan from April 2022.

Manchester has a number of complimentary strategies that are interdependent, all of which will positively impact upon the wider determinants of health, as illustrated below.

Wider determinants of health	Strategies to address
Housing and lived environment	Manchester Housing and Residential Growth Strategy
Education and skills	Manchester Children and Young People's Plan; Work and Skills Strategy
Power, voice and participation	The Our Manchester approach
Income, wealth and employment	Powering Recovery; Our Manchester Industrial Strategy for inclusive growth
Connectivity: (transport and digital	Greater Manchester Transport Strategy 2040; Manchester Digital Strategy
Access to Care and Support	MLCO Operating Plan; Better Outcomes Better Lives (Adult Social Care transformation); Bringing Services Together for People in Places

CASE STUDY – INCLUSIVE GROWTH

North Manchester is embarking on a transformation period of major investment, with a total value of £4.5bn over the next 15-20 years.

Victoria North - £4bn residential led redevelopment of 7 districts from the edge of the city centre and up through the Irk Valley. This will create green space and some 15,000 new homes for around 35,000 people

The Manchester College - £140m transformation programme, including a new £93m campus on the southern edge of North Manchester. This industry Excellence Academy will be designed and delivered with leading employers.

Park House Mental Health Unit - £72m, 150-bed adult mental health inpatient facility. This will greatly improve the quality of care for patients in the best therapeutic environment possible

BENEFITS

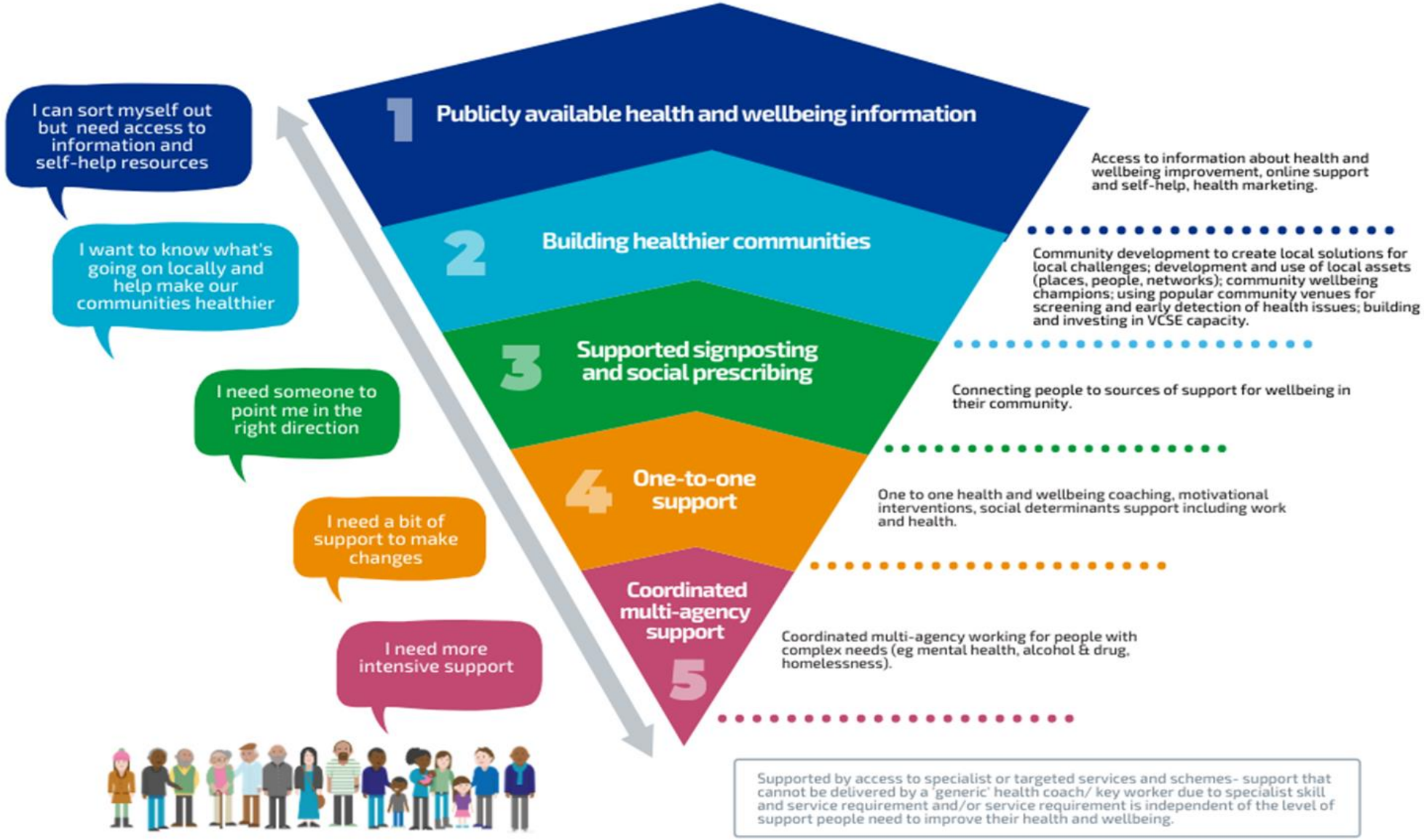
- Boosting life expectancy of North Manchester residents by 1.3 years
- Creation of 15,000 good quality, affordable, low-carbon homes
- Diversification of housing choice and tenure
- GDV of £4.5bn with investment in the local economy
- Good-quality skills, training and employment opportunities
- Better connected and more liveable neighbourhoods
- Improved digital connectivity and infrastructure

Manchester City Council is bringing ALMO Northwards Housing back in-house, facilitating the retrofit of approximately 13,000 homes in North Manchester

North Manchester General Hospital - £350m redevelopment. This will include a sustainable health campus with integrated health and social care facilities, new homes, access to better education and training, and a new centre for healthy ageing.

HEALTH BEHAVIOURS & LIFESTYLES – WELLBEING MODEL

Manchester's Wellbeing Model outlined in the graphic below provides the delivery framework for services and approaches to improving outcomes for Manchester's residents based on the level of support people need to look after their own health and wellbeing.



AN INTEGRATED HEALTH AND CARE SYSTEM

Bringing Services Together - Team Around the Neighbourhood

We recognise that the health and wellbeing of residents and the demand for health and social care services are significantly dependent on the contribution of other public services. INTs are one part of the neighbourhood approach across the City, supporting residents to be independent and well. Local authority, Police and Housing services also work on neighbourhood footprints, linking in with INTs. We call this joint working across the public sector "Team Around the Neighbourhood", which is part of the Bringing Services Together. initiative set up to coordinate and co-produce solutions.

Manchester City Council Neighbourhoods

Greater Manchester Police

Health and Social Care

Bringing Services Together for People in Places

- Governance, footprints and plans
- Workforce, relationships and place-based working
- Understanding people and places

Services for Children - locality model

Housing Providers

CASE STUDY – HEALTH EQUITY

The Manchester COVID-19 Vaccination Programme followed a 'whole-system', three stage approach to addressing barriers to vaccination uptake amongst communities experiencing entrenched health inequalities:

Access: increasing capacity and opportunities to be vaccinated, improving the ways in which people can access these opportunities, and removing barriers that make it difficult for people to get their vaccine;

Information: provision of tailored, targeted and culturally competent information about COVID and vaccination with bespoke use of the "3Ms" as appropriate for the target audience (Message, Messenger, Media);

Motivation: activities that create conditions for people to want the vaccine, and build trust and confidence in the vaccine.

Bespoke offers and pop up clinics were offered at a range of venues targeted at people experiencing barriers to vaccination.

- Deaf institute;
- Homeless offer including hostels;
- Care homes/wider care homes and housebound offer;
- Supermarkets/local community venues;
- Schools/colleges and university offers.

THE PLACES AND COMMUNITIES WE LIVE IN AND WITH

OUR HEALTHIER MANCHESTER

Community health & care services in Manchester are delivered through the Manchester Local Care Organisation's 12 Integrated Neighbourhood Teams (INTs) operating on neighbourhood footprints, alongside Manchester's 14 Primary Care Networks (PCNS).

About INTs

- The Core Neighbourhood Team is consistent across all 12 neighbourhoods;
- They are a multi-agency, multi-disciplinary team (MDT) working closely together whilst maintaining links to relevant employers/professions;
- The Voluntary, Community & Social Enterprise (VCSE) sector plays an important role in multi-agency working including MDT involvement in neighbourhoods and co-opted leadership roles in some areas;
- Each team is co-located in their neighbourhood, to support multi-disciplinary meetings and co-working;
- The teams adopt a strengths/asset-based approach underpinned by Manchester's Wellbeing model, focusing on prevention and cognisant of the impact of the wider determinants of health.

The Core Neighbourhood Team

- **INT Lead**
- **Adult Community Nursing lead**
- **Adult Social Care Lead**
- **Adult Mental Health Lead**
- **GP Lead,** linking to GP practices in the neighbourhood and Primary Care Networks
- **Health Development Coordinator**
- **Care Navigator**
- **VCSE representation** from the neighbourhood

CASE STUDY – POPULATION HEALTH MANAGEMENT (DIABETES)

Working in partnership with Primary Care Networks (PCNs), Manchester Local Care organisation (MLCO) is piloting a data enabled approach to improve health and care outcomes in neighbourhoods.

Alongside local knowledge and insight, there is now a real focus on using data to agree local priorities and action plans for improving health and wellbeing in local communities. This approach has identified a need to radically improve outcomes for people living with type 2 diabetes in the Chorlton, Whalley Range and Fallowfield neighbourhood.

It is expected that this approach will create an early opportunity to demonstrate how using the local health and care system's shared capacity differently can lead to improved outcomes for disadvantaged parts of the population, as well as reducing costs.

Below is a summary of the pilot's objectives -

- Provide a proof of concept of a data enabled health improvement project in a neighbourhood.
- Develop a clear understanding of the data analysis skills, competencies and activities required to support this type of project, including the data requirements and data gaps that may currently exist.
- Demonstrate to the Manchester Partnership Board (MPB) that a sustainable reduction in hospital activity is achievable through local actions by services, people and communities working together in a neighbourhood.
- Demonstrate that by using data analysis alongside neighbourhood partnership working that entrenched health inequalities can be effectively tackled and reduced.
- Creating a data enabled approach and methodology which is replicable as part of the health improvement and reform function of MLCO.

HOW WE ARE ORGANISED - SYSTEM ARCHITECTURE

OUR HEALTHIER MANCHESTER

Manchester's Health & Care system governance is evolving, in response to the establishment of the GM ICS. Emerging responsibilities are detailed below, and supporting infrastructure (resources and assets) are being identified.

Manchester Partnership Board (MPB)

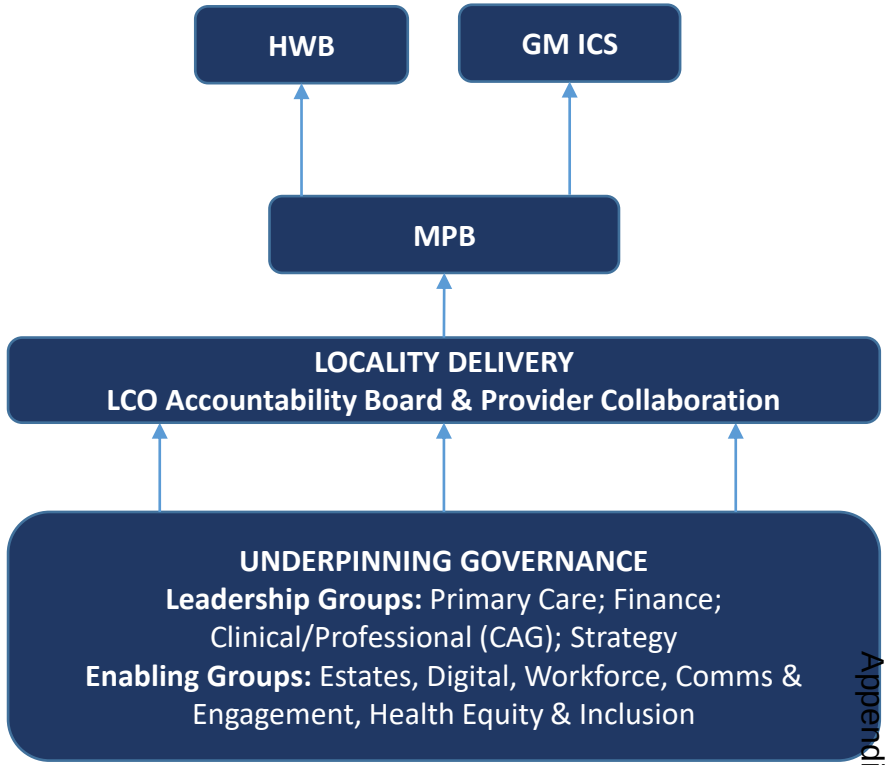
- MPB is the senior leadership forum for health and care within the City. Its role will include: setting strategy; agreeing system transformation priorities; high level resource allocation; strategic engagement with partners; and a potential assurance role for the GM ICS. It will comprise political, clinical and managerial leadership.
- It will receive delegated responsibilities, powers and budgets for specific responsibilities (to be determined but expected to have an emphasis on care delivered out of hospital). The Partnership Board will have 'sight' and influence over the full locality budget for health, care and public health;
- The MPB will be the strategic interface between the NHS and wider public sector strategy in the City, optimising the wider determinants of health and the NHS' contribution to the City strategy.
- The Partnership Board will have the primary line of reporting for Manchester's responsibilities to both the NHS ICS Board and the Manchester Health and Wellbeing Board (HWB), bringing together key partners to plan health & social care services for Manchester.

Manchester Provider Collaboration (MPC)

- The MPC approach is still in development, but it is being built from a strong base of provider collaboration that already takes place between/across statutory and non-statutory organisations, providing health & care services at neighbourhood, locality and city-wide levels every day;
- Manchester providers will work individually and collectively to deliver integrated, safe and effective services; shifting care upstream, reducing demand on acute and long term care. Care will be organised at a neighbourhood level so that it is well connected to local people, communities and assets and health and care teams will work at an operational level with other public sector front line teams to ensure a holistic offer to residents.

Underpinning governance

- The MPB and MPC will be supported by wider governance arrangements working at a system level;
- The Primary Care Forum will act as a conduit to primary care within the locality and GM ICS primary care functions;
- The finance, clinical/professional (Clinical Advisory Group) and strategy leadership groups will work individually and collectively to support direction setting and the transformation agenda;
- Enabling groups including workforce, estates, digital, communications & engagement and health equity and inclusion will wrap support around system priorities.



ANNEX 1 - KEY PRIORITIES AND WORK PROGRAMMES (1)

OUR HEALTHIER MANCHESTER

Priorities	Work Programmes	Description
1.**Health infrastructure developments as a driver of economic regeneration**	New NMGH	Secure the investment for the redevelopment of the North Manchester General Hospital (NMGH) site, through the New NMGH Transformation Programme.
	New Park House	Developing the full business case and plans to redevelop the New Park House mental health facility on the NMGH site .
	Wythenshawe Master Plan	Developing the case for investment for the redevelopment of the Wythenshawe Hospital site by building on the Strategic Regeneration Framework (SRF) .
2.Covid response and recovery	Recovery Framework - M&T Community Cell	The framework sets out how health, as a major sector within the city, and a significant presence within communities, will contribute to the wider city recovery. This will support MPB to gain a full picture of progress & tailor strategic direction to determine its transformation priorities.
	MLCO Recovery and Reform	Re-establishing and reforming community services to meet the increased and changing needs of our residents and the new context in which we find ourselves as a result of the COVID-19 pandemic. Covers 1) urgent care, 2) alignment of management responsibilities, 3) adult nursing, 4) therapy services, and 5) end of life and palliative care
	MFT Recovery programme	Initially largely focused on returning activity levels to the new normal, these four programmes are also rethinking how activity is best delivered in the future and the COVID-19 pandemic has acted as a natural catalyst for rapid change. Covers 1) elective care, 2) outpatients, 3) urgent and emergency care, and 4) community diagnostic hubs.
3.Reduce inequalities	Reducing inequalities	Focused on addressing health inequalities and a commitment to put into practice the Marmot 2020 report's recommendations by working across all public services in our city region to ensure that policies, approaches and resources are geared towards creating a fairer, more equal society.
4.Supercharging MLCO	MLCO Transitions Board	MLCO led programme with all partners represented to deliver plans to 'supercharge' MLCO by April 2022. Includes 1) embedding a Population Health Management (PHM) approach, 2) development of neighbourhood model ((work with Primary Care Networks (PCNs) and Greater Manchester Mental Health NHS Foundation Trust)), 3) development of deployed commissioning and contracting functions, 4) bolstering of corporate functions, and 5) development of people and culture (HR) and organisational development (OD).
5.Major transformation programmes	Bringing Services Together for People in Places (BST)	A multi-partner programme of work that will help to provide a space and mechanism for collaboration between services and partners to develop new ways of working, join up individual service offers and reduce duplication.
	Neighbourhood Development	Continue the work to integrate services at the INT level and the extent to which they are joined up around residents/patients. Creating opportunities to support residents to prevent ill health, be independent, in control, and connected to their communities.

ANNEX 1 KEY PRIORITIES AND WORK PROGRAMMES (2)

Priorities	Work programmes	Description
	MH Transformation programme	A refocusing of mental health priorities following publication of the Mental Health Long Term Plan and a shift in priorities as a result of the impacts of COVID-19.
	Better Outcomes Better Lives	MLCO's transformation programme for Adult Social Care. The programme is structured around six key workstreams – 1) maximising independence, 2) providing early help, 3) short term offers to support independence, 4) transforming community and specialist teams, 5) responsive commissioning, and 6) performance framework.
	North Manchester Strategy	Implementation of the NM Strategy with a focus on placemaking and partnerships; regeneration, economic and social impact, service transformation, and progression of the wider site / campus redevelopment under the Strategic Regeneration Framework
	Adults LTC	System wide review and service model design for the management and provision of Long Term Condition (LTC) services across the whole health and care pathway. Covering 1) respiratory, 2) vascular, 3) long COVID, and 4) community diagnostic hubs.
	Children and Young People	Delivering services that meet the health needs of children and young people, and support them and their parents and carers in managing those health needs. Includes 1) virtual ward and LTC, 2) Special Education Needs and Disabilities (SEND), 3) Transitions, 4) think family (community hubs), and 5) year of the child 2022.
6.**Development of Greater Manchester ICS and Manchester local system arrangements**	MPB engine room	Development of the system infrastructure required to support the activities to integrate care and improve population health driven by commissioners and providers collaborating at a locality level.
	Influencing the GM ICS	Influencing the blueprint for developing the GM ICS. Reviewing spatial levels to determine what future work is undertaken at what level (e.g. GM vs locality level).
7.**Refresh of key city strategies**	Our Manchester Strategy	Refreshed strategy (taking into account the impacts of COVID-19) that provides aspiration and resets priorities to ensure Manchester can achieve its aim of being a top-flight world class city by 2025, with equality, inclusion and sustainability at its centre.
	Population Health Plan	Taking into account the impacts of COVID-19, the development of the refresh of the population health plan for 2022 moving towards a new individual, communities and heath equity approach
	Locality Plan	Refresh and reset of the Manchester Locality plan to describe how the health and social care system in Manchester will be transformed with improved health and wellbeing, high quality services, a balanced budget and making the most of the many strengths we already have. This will be in the context of a post pandemic world & new NHS ICS legislative changes.
8.**Development of a short and long term approach to resource allocation**	H2 Planning	Setting a financial plan for Q3 & Q4. Given that national guidance is expected to predominantly outline a rollover of H1 arrangements with a further savings requirement, the greater work might be planning for 2022/23.

Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 26 January 2022

Subject: Manchester Child Death Overview Panel 2020-21 Annual Report

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

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Summary

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

Recommendations

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

Board Priority(s) Addressed:

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

right place, right time	
Self-care	

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

Additional reports are available via the MSP CDOP webpage:

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

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

Introduction

1. The 2020-21 Manchester Child Death Overview Panel (CDOP) Annual Report provides a summary of the key factors and modifiable factors for cases closed between 1 April 2020 and 31 March 2021.

Background

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

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

4. The work of CDOP is closely linked to the Manchester Reducing Infant Mortality Strategy (2019-2024), within the broader context of First 1000 Days Priority of the Manchester Population Health Plan (2018-2027). The CDOP seeks to identify the key modifiable factors in the population such as unsafe sleeping arrangements, housing conditions, reducing maternal smoking, and reducing maternal obesity that can contribute to child deaths.

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

Child Death Review Process- national and local arrangements

6. The CDOPs national line of accountability transferred from the Department for Education (DfE) to the Department of Health and Social Care (DHSC). Published October 2018, the Child Death Review: Statutory and Operational Guidance (England) sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in Working Together to Safeguard Children and clarifies how individual professionals and organisations across all sectors involved in the child death review should contribute to reviews. The guidance sets out the process in order to:

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

7. The collation and sharing of the learning from reviews is managed by the National Child Mortality Database (NCMD) through the use of standardised forms. Following the introduction of the NCMD, there was an increase in data entry requirements and a number of changes were made to the national templates used by CDOP to gather information following a child death. To ensure that the CDOP supplies the necessary information to the NCMD, the four GM CDOP areas took a collaborative approach to purchasing the eCDOP system. The eCDOP system went live on 1 April 2021 and now automatically populates the NCMD.

MANCHESTER CHILD DEATH OVERVIEW PANEL (CDOP)

2020/2021 ANNUAL REPORT

1 April 2020 – 31 March 2021

Barry Gillespie, Consultant in Public Health
Chair of the Manchester Child Death Overview Panel

Published: TBC

Manchester Safeguarding Partnership

CONTENTS

1. WELCOME & INTRODUCTION

Welcome to the 2020/21 Manchester Child Death Overview Panel (CDOP) Annual Report which covers a period dominated by the COVID-19 pandemic, that affected society and service provision in a way never before encountered. Following the publication of the HM Government Child Death Review: Statutory and Operational Guidance (England) in October 2018, changes were introduced to build on the interface between the hospital/community led mortality reviews (Child Death Mortality Reviews (CDRM)) and the final CDOP review. The improvements to the revised child death review process, aim to deliver a joined up whole system approach. However, the impact of these changes resulted in a reduction in the number of cases reviewed by the CDOP. During 2020/21 there were 52 child death notifications reported to the Manchester CDOP, with a 5-year average for 2016/21 of 60 notifications per year. A further reduction in the cases reviewed during 2020/21 (29) in comparison to 2019/20 (41), was exacerbated by the impact of COVID-19 across public sector service provision.

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

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

The CDOP Annual Report is produced to advise Child Death Review (CDR) Partners on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process. This report reviews the deaths of children normally resident in the area of Manchester, aged 0-17 years of age (excluding stillbirths and legal terminations of pregnancy) and focuses on the analysis of the number of cases closed between 1 April 2020 to 31 March 2021 (2020/21). Reporting on cases closed provides a full and complete data set, including the outcome of the final CDOP review. The richness of the data and information collated assists in the identification of factors antenatally, postnatally and throughout the child's life. This report aims to highlight relevant factors and modifiable factors that are likely to contribute to Manchester's infant (under one year of age) and child (age 1-17 years) mortality rate.

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

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

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

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

Barry Gillespie
Consultant in Public Health
Manchester Child Death Overview Panel Chair

2. THE CHILD DEATH REVIEW PROCESS

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

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

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

2.1 DEPARTMENT OF HEALTH AND SOCIAL CARE (DHSC)

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

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

Supplementary Reporting Forms:

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

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

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

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

2.2 CHILD DEATH REVIEW MEETING (CDRM)

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

In all cases, the aims of the CDRM are:

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

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

2.3 CHILD DEATH OVERVIEW PANEL (CDOP)

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

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

The functions of the CDOP are:

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

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

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

2.4 MANCHESTER CDOP THEMED PANEL MEETINGS

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

University NHS Foundation Trust Consultant Neonatologist and Designated Doctor for Child Death, to inform discussions and allow easier identification of themes. Deaths reviewed at the Themed Panel are pre-screened to highlight any relevant factors and/or modifiable factors during the antenatal/postnatal period, focusing on issues relating to service provision.

2.5 LEARNING DISABILITIES MORTALITY REVIEW (LeDeR) PROGRAMME

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

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

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

2.6 GREATER MANCHESTER eCDOP

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

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

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

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

2.7 NATIONAL CHILD MORTALITY DATABASE (NCMD)

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

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

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

3. MANCHESTER'S DEMOGRAPHICS

3.1 INDICES OF DEPRIVATION 2019

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

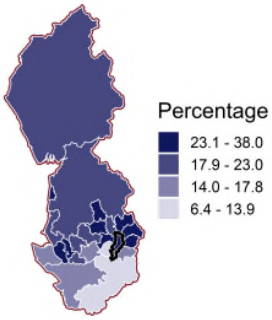
- Income: Measures the proportion of the population experiencing deprivation relating to low income
- Employment: Measures the proportion of the working age population in an area involuntarily excluded from the labour market
- Health Deprivation and Disability: Measures the risk of premature death and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

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

3.2 MANCHESTER'S CHILD HEALTH PROFILE 2021

The Manchester Child Health Profile 2021[8] provides an annual snapshot of child health across the City. Overall, comparing local indicators with England averages, the health and wellbeing of children in Manchester is worse than England. Children and young people aged 0-19 years account for 25.5% (140,900) of Manchester's total population. Children aged 0-4 years account for 6.7% (37,100) of the total population. Manchester's infant mortality rate of 6.1 per 1,000 live births (2017/19), is worse than the England rate of 3.9, with an average of 45 infants dying before the age of one each year. This is a slight decrease in comparison to previous years (2016/18) where the standardised rate was recorded as 6.4 per 1,000 live births, with an average of 48 infant deaths before the age of one. Manchester's child mortality rate (2017/19) of 16.2 per 100,000 children (aged 1-17 years), is worse than the England rate of 10.8, with an average of 19 child deaths each year. This is a slight decrease in comparison to previous years (2016/18) where the standardised rate was recorded as 18.4 per 100,000 children, with an average of 21 child deaths (aged 1-17 years) each year. 33.6% of Manchester children under 16 years of age are living in poverty in comparison to the England average of 18.4% (2018/19).

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



[7] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019
[8] https://fingertips.phe.org.uk/profile/child-health-profiles

4. CHILD DEATH NOTIFICATIONS REPORTED TO THE CHILD DEATH OVERVIEW PANEL (CDOP)

There were 52 child death notifications reported to the Manchester CDOP from 1 April 2020 to 31 March 2021 (2020/21). At the end of the CDOP reporting year (31 March 2021) there was a total of 89 cases that remained open pending a CDOP review, 39 of which were historical child death notifications where the death occurred prior to 1 April 2020 and the remaining 50 where the death occurred during 2020/21 period.

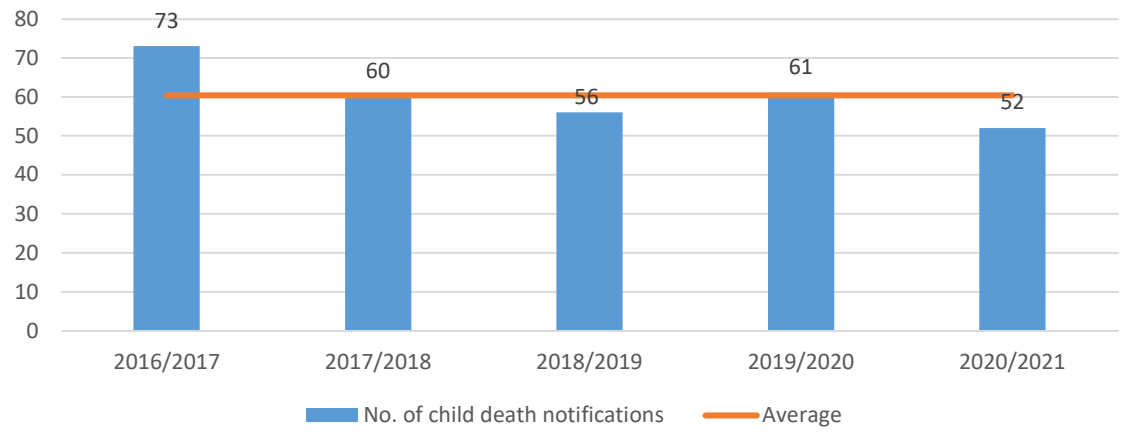
The publication of the revised guidance has had a significant impact in terms of the operational aspects of the CDR process and the development of the new arrangements for CDOPs locally, which is far more complex in comparisons to previous requirements. This has resulted in an increase in case management functions, to ensure statutory requirements are adhered to.

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

From 1 April 2016 to 31 March 2021 there were 302 child deaths reported to the Manchester CDOP. There has been a variation in the number of child deaths reported year on year, with an average of 60.4 notifications per year.

The latest Office of National Statistics (ONS) 2019 mid-year estimates[9] projects Manchester's child population (0-17 years) as 122,914, accounting for 22% of Manchester's total population (552,858). With a total of 52 child death notifications reported to the Manchester CDOP during the period 2020/21, this would indicate Manchester's overall child death rate as 4.23 deaths per 10,000 children (aged 0-17 years) which is a slight decrease in comparison to the rate of 4.96, as recorded for 2019/20.

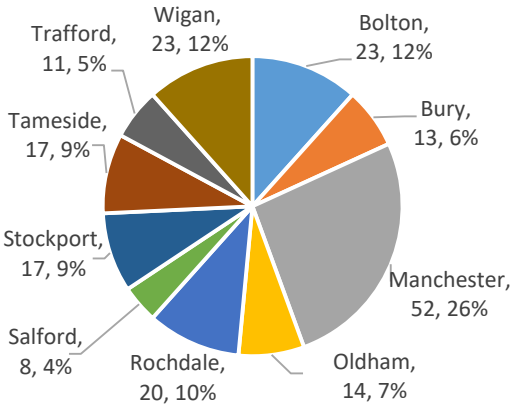
Diagram 2: Number of child deaths reported to the Manchester CDOP per CDOP year (2016/21)



9 https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

A total of 198 deaths were reported to the four GM CDOPs during 2020/21, of which 26% of the children resided in Manchester City. This is an 18% (42) decrease in GM child deaths, in comparison to the 240 deaths notifications during 2019/20. Since child death records began in the 1980s, there has been a steady reduction in the rate of child death.

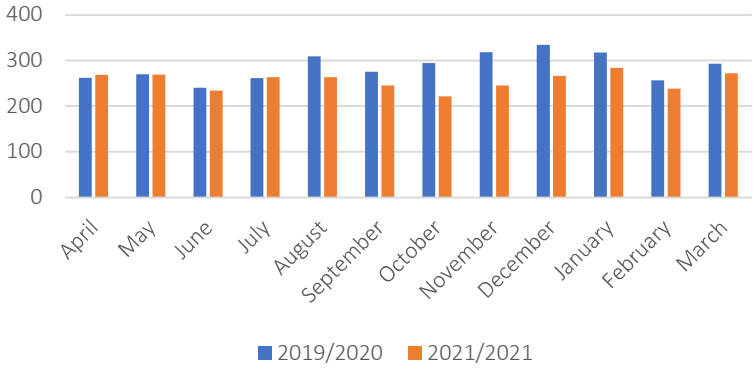
Diagram 3: Number of child deaths reported to GM CDOPs (2020/21)



GM Child Death Overview Panels	No. of child death notifications	
Bolton, Salford & Wigan CDOP	54	27%
Bury, Rochdale & Oldham CDOP	47	24%
Manchester CDOP	52	26%
Tameside, Trafford & Stockport CDOP	45	23%
Total	198	100%

The NCMD Child Death Review Data: Year ending 31 March 2021[10] provides an overview of the national CDR data. The NCMD was notified of 3,068 child deaths in England during 2020/21. In the same period, 2,575 child deaths, some of which occurred during the period or before, were reviewed in detail by local CDOP areas. The data release also covers the first year of the COVID-19 pandemic and shows that an estimated 25 children are likely to have died of COVID-19 infection between 1 March 2020 and 28 February 2021.

Diagram 4: Child death notifications across England, reported to the NCMD, by month (2019/21)



Year of notification to NCMD	* No. of child death notifications
2019/2020	3,429
2020/2021	3,068
Total	6,497

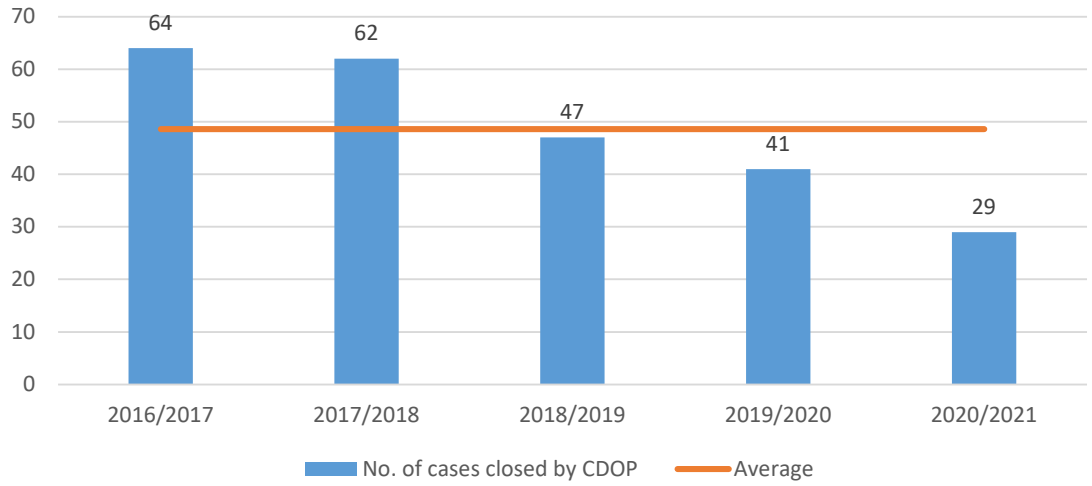
* *Data source: NCMD Child Death Review Data: Year ending 31 March 2021*

[10] https://www.ncmd.info/2021/11/11/child-death-data-release-2021/

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

Once the CDRM has taken place, all investigations have concluded and sufficient information has been collated, the CDOP holds the final multi-disciplinary review. Examining deaths using the data of cases discussed and closed at panel, provides a full dataset to conduct analysis. This annual report focuses on data relating to the 29 cases discussed and closed by the CDOP from 1 April 2020 to 31 March 2021 (2020/21). Of the 29 cases closed during 2020/21, 4 (14%) deaths occurred during the same period and the remaining 25 (86%) are historical cases, where the death occurred prior to 1 April 2020. From 1 April 2016 to 31 March 2021, the Manchester CDOP closed a total of 243 cases. Year on year, there has been variations in the number of cases closed by the Manchester CDOP, with an average of 48.6 cases closed per year.

Diagram 5: Number of cases closed by the Manchester CDOP per CDOP year (2016/21)



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

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

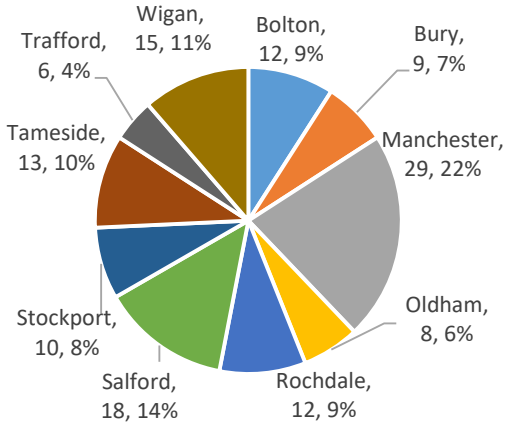
Information submitted following a CDRM is detailed and extremely useful in supporting the Manchester CDOP carry out a thorough review of the death. The CDOP utilises CDRM reports, assessing the care provided, to highlight any issues in relation to service provision such as, the identification of illness,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

education and training requirements and documents positive aspects of service delivery to record examples of excellent care.

Whilst the number of child deaths reported to the Manchester CDOP has slightly decreased in comparison to 2019/20 (average of 60.4 notifications per year), it is anticipated that the panel will continue to see a reduction in the number of cases closed over the coming years. It has been recognised by the NCMD programme team that the interface between the CDRM and CDOP process will impact the timescale of completed reviews due to operational aspects of the revised child death review process. The circumstances leading to death and the nature of the death also impact upon the number of cases closed by the CDOP. Deaths where the cause appears to be unnatural, sudden, and unexpected can be subject to multiple investigations that can remain ongoing for a number of years, which impacts on the timeliness of the CDOP review. To undertake a comprehensive review, the Manchester CDOP will await the conclusion of all investigations and once finalised, request copies of reports that document the outcome for consideration at the panel meeting.

The four GM CDOPs discussed and closed 132 cases during the 2020/21 period. This is a significant fall in the number of cases closed in comparison to previous years which reflects the impact of the changes to the national child death review process.

Diagram 6: Number of cases closed by GM CDOPs (2020/21)

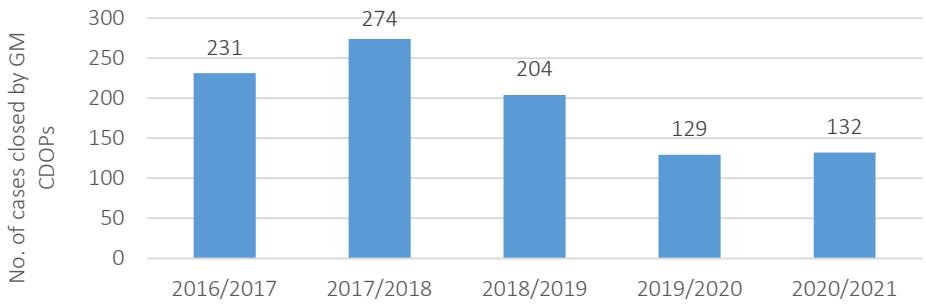


GM Child Death Overview Panels	* No. of case closed	
Bolton, Salford & Wigan CDOP	45	34%
Bury, Rochdale & Oldham CDOP	29	22%
Manchester CDOP	29	22%
Tameside, Trafford & Stockport CDOP	29	22%
Total	132	100%

** Data source: NCMD Quarter 4 2020/21 Monitoring Report*

Owing to changes to the child death review process and additional national requirements, there has been a decrease in the number of closed cases. Overall, there has also been a reduction in the number of child death notifications reported locally, across the GM footprint and nationally.

Diagram 7: Number of cases closed by GM CDOPs (2016/21)



6. A SUMMARY OF 2020/21 CASES CLOSED

6.1 AGE, GENDER & ETHNICITY

Of the 29 cases closed, 13 (45%) children were female and 16 (55%) male. 12 (41%) of the infants were neonatal deaths (<28 days). A further 8 (28%) deaths occurred before the first year of life (28-364 days), accounting for a total of 69% (20) of cases closed. Of the 20 infant deaths (0-364 days), 8 (38%) had one or more modifiable factors identified in the review (see section 6.3).

Diagram 8: Manchester CDOP cases closed by gender and age at time of death (2020/21)

Age Group	No. Cases Closed[11]	
0-27 days	12	41%
28-364 days	8	28%
1-4 years	<5	-
5-9 years	<5	-
10-14 years	<5	-
15-17 years	<5	-
Total	29	100%

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

Diagram 9: Manchester CDOP cases closed by ethnic grouping (2020/21)

Ethnic Grouping	No. Cases Closed	
Asian or Asian British	9	31%
Black or Black British	<5	-
Mixed	<5	-
Other ethnic group	<5	-
Unknown	<5	-
White	13	45%
Total	29	100%

The largest number of cases closed were recorded in children who were White (13, 45%) and Asian or Asian British (9, 31%). Breaking the data down further into specific ethnicities identifies the largest number of cases closed were children of English/Welsh/Scottish/Northern Irish/British heritage (10, 34%) and child from the Pakistani community (6, 21%). In the previous year 2019/2020, the largest number of deaths was also recorded in children who were White (15, 37%) of English/Welsh/Scottish/Northern Irish/British heritage (12, 29%) and Asian/Asian British children (15, 37%) from the Pakistani community (11, 27%).

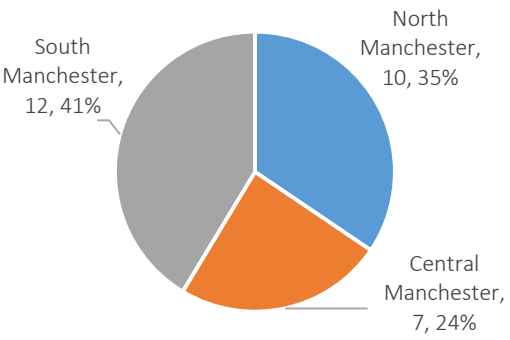
[11] Suppression of data to anonymise statistics: Personal data where the value is less than 5 has been removed (<5/-)

6.2 AREA OF RESIDENCE & DEPRIVATION

The 2019 Index of Multiple Deprivation (IMD), ranked Manchester as 6 out of 326 local authorities in England (where 1 is the most deprived). 33.6% of children (under 16 years of age) in Manchester are living in poverty (2018/19) which is higher than the North West (23.0%) and England (18.4%)[12]. The number of children (under 16 years of age) residing in relative low-income families have increased from 27.1%, 29,510 (2016) to 33%, 37,373 (2018/19). The rate of households with children who are homeless or at risk of homelessness, is higher in Manchester (29.2), in comparison to the England average (14.9) (2019/20).

Within GM, Manchester has the highest proportion of residents (43%) residing in the most deprived 10% of neighbours in England[13]. Across GM, 6 of the 10 local authorities have a higher proportion of their population living in the most deprived areas of the country in comparison to the North West average, with Manchester being the most deprived local authority. All GM local authorities but Trafford have deprivation scores above the national average. This emphasises that deprivation remains a significant public health concern and demonstrates a significant correlation between poverty and child death.

Diagram 10: Area of residence for closed cases by the Manchester CDOP (2020/21)



Of the 29 cases closed, the majority of children resided in areas of deprivation with 83% (24) of families residing in quintile 1 (most deprived). Of the 29 cases closed, 41% (12) of the children resided in south Manchester[14]. Breaking the data down into neighbourhoods identifies Baguley and Cheetham and as having the largest number of deaths, jointing accounting for 28% (8) of the 29 cases closed. Year on year, there continues to be a strong correlation with the higher rate of deaths in areas of deprivation where the Lower Layer Super Output Area (LSOA) are deemed most deprived.

The social deprivation and the increased risk of child death has been highlighted at a national level following the publication of the NCMD Child Mortality and Social Deprivation Report[15]. The report analyses data for children who died during 2019/20 in England and identifies a clear association between the risk of child death and the level of deprivation (for all categories of death except cancer). More specifically, *the report* states that over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived – which translates to over 700 fewer children dying per year in England.

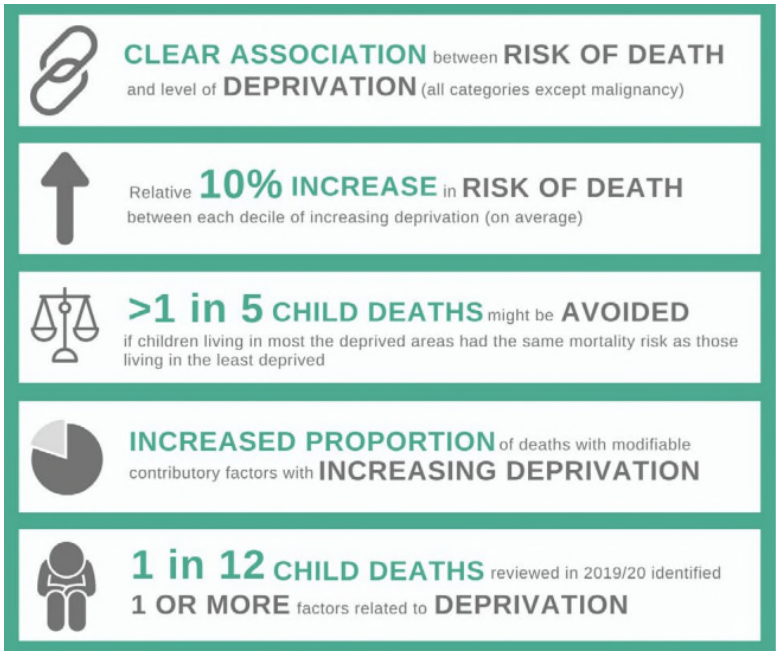
[12] https://fingertips.phe.org.uk/profile/child-health-profiles

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

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

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

Diagram 11: NCMD Child Mortality & Social Deprivation Key Findings (2019/20)



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

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

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

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

6.3 RELEVANT FACTORS & MODIFIABLE FACTORS

Information is collated using the Department of Health and Social Care (DHSC) national CDOP reporting forms[16]. Completed forms are presented during the CDOP meeting to assess the death. As part of the child death review process, the CDOP is responsible for analysing information to determine the categorisation of death (see appendix 2), relevant factors and modifiable factors.

Information is collated and categorised using the four domains:

Domain A: Factors intrinsic to the child:

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

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

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

Domain C: Factors in the physical environment:

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

Domain D: Factors in Service Provision:

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

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

0 Information not available

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

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

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

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

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

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

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

Diagram 12: Categorisation of death for cases closed by the Manchester CDOP, GM CDOPs and CDOPs across England (2020/21)

Category of Death		Manchester 2020/2021 Cases Closed[17]		GM 2020/2021 Cases Closed		England 2020/2021 Cases Closed	
1	Deliberately inflicted injury, abuse, or neglect	<5	-	<5	-	51	2%
2	Suicide or deliberate self-inflicted harm	<5	-	<5	-	98	4%
3	Trauma and other external factors	<5	-	7	5%	116	5%
4	Malignancy	<5	-	7	5%	220	9%
5	Acute medical or surgical condition	<5	-	8	6%	132	5%
6	Chronic medical condition	<5	-	8	6%	140	5%
7	Chromosomal, genetic, and congenital anomalies	9	31%	34	26%	625	24%
8	Perinatal/neonatal event	8	28%	41	31%	859	33%
9	Infection	<5	-	10	8%	135	5%
10	Sudden unexpected, unexplained death	<5	-	11	8%	198	8%
	Not known	<5	-	<5	-	<5	-
	Total	29	100%	132	100%	2574	100%

Of the 29 cases closed by the Manchester CDOP, the largest number of deaths were categorised as chromosomal, genetic and congenital anomalies (9, 31%) and perinatal/neonatal event (8, 28%). Year on year, both categorises account for the largest proportion of child deaths and have remained stable overtime, as is the case across the GM CDOPs.

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

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

There has been a consistent GM pattern in the categories of death over a number of years. Perinatal/neonatal events and deaths due to chromosomal, genetic and congenital anomalies remain, by far, the two main causes of death accounting for over half of all closed cases by the Manchester CDOP, GM CDOPs and CDOPs across England.

Diagram 13: Frequency of relevant associated factors in closed cases by the Manchester CDOP (2020/21)

Factors identified that may have contributed to vulnerability, ill-health or death (2)	No. of factors categorised as a relevance of 2[18]
Factors intrinsic to the child	
Acute/Sudden onset illness	24
Asthma	<5
Epilepsy	<5
Diabetes	<5
Other chronic illness	10
Learning disabilities	<5
Motor impairment	<5
Sensory impairment	<5
Other disability or impairment	5
Emotional/behavioural/mental health condition in the child	<5
Allergies	<5
Alcohol/substance misuse by the child	<5
Domain B: Factors in social environment including family and parenting capacity	
Emotional/behavioural/mental/physical health condition in a parent or carer	9
Alcohol/substance misuse by a parent/carer	5
Smoking by the parent/carer in household	<5
Smoking by the mother during pregnancy	<5
Domestic violence	<5
Co-sleeping	<5
Bullying	<5
Gang/knife crime	<5
Pets/animal assault	<5
Consanguinity	<5
Poor parenting/supervision	<5
Child abuse/neglect	<5
Domain C: Factors in the physical environment	
Housing	<5
Domain D: Factors in Service Provision	
Access to health care	<5
Prior medical intervention	<5
Prior surgical intervention	<5

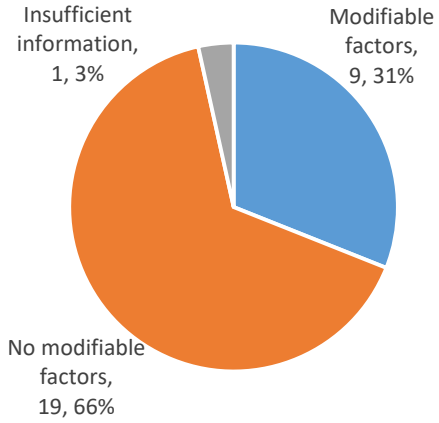
There may be factors present, although not deemed relevant to the child's cause of death. These are categorised as a relevance of 1. Some cases present no modifiable factors but have multiple relevant factors that may have contributed to vulnerability, ill-health or death of the child such as parental

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

alcohol/substance use and housing conditions and therefore categorised as a relevance of 2. For example, natural causes of death categorised as chromosomal, genetic, and congenital anomalies, where the child was known to have an autosomal recessive disorder, may not display any modifiable factors but there may have multiple factors as a relevance of 2. Where there are multiple modifiable factors and relevance 2 factors present, the vulnerability of the child increases.

The Manchester CDOP identified one or more modifiable factors in 9 (31%) cases which is lower than the England average of 34% (as recorded by the NCMD). The highest number of modifiable factors were recorded in deaths categorised as a perinatal/neonatal event (<5) and sudden unexpected, unexplained death (<5).

Diagram 14: Modifiable factors identified in cases closed by the Manchester CDOP (2020/21)



Modifiable Factors	No. Cases Closed	
Modifiable factors	9	31%
No modifiable factors	19	66%
Insufficient information	1	3%
Total	29	100%

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

Diagram 15: Modifiable factors identified in cases closed by the Manchester CDOP, GM CDOPs, NW CDOPs and CDOPs across England (2020/21)

CDOP Area(s)	Modifiable Factors		No modifiable factors		Insufficient information	
Manchester	9	31%	19	66%	1	3%
Greater Manchester	57	43%	74	56%	1	1%
North West	136	43%	*	*	*	*
England	882	34%	*	*	*	*

Manchester % cases with modifiable factors
31%

GM % cases with modifiable factors
43%

England % cases with modifablefactors
34%

Modifiable factors were present in 57, 43% of the GM CDOPs 2020/2021 cases closed, 56% having no modifiable factors and 1% having insufficient information to make a judgment. The 2020/2021 national data, as provided by the NCMD, records modifiable factors present in 34% of cases closed by CDOPs across England. The highest number of GM CDOPs modifiable factors were recorded in deaths categorised as a perinatal/neonatal event (19, 33%) and sudden unexpected, unexplained death (11, 19%).

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

Of the 29 cases closed, the Manchester CDOP identified modifiable factors in 9 (31%) deaths. These are factors where local or nationally achievable intervention could be modified to potentially reduce the risk of future child deaths. Of the 9 deaths with modifiable factors, 8 (89%) children died before the age of 1, 5 of which were during the neonatal period.

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

Diagram 16: Modifiable factors identified in cases closed by the Manchester CDOP (2020/21)

* Smoking continues to the most common modifiable factor identified by the Manchester CDOP with maternal smoking in pregnancy and household smoking a factor in deaths categorised as a perinatal/neonatal event and sudden unexpected, unexplained death. Maternal obesity, where mother has a raised body mass index (BMI) of 30+ during pregnancy is also a modifiable factor in perinatal/neonatal deaths, as is maternal alcohol and/or substance use during pregnancy. Multiple modifiable factors were also identified (antenatally and postnatally) in sudden unexpected, unexplained deaths the most common being unsafe sleeping arrangements including parental alcohol and/or substance use.

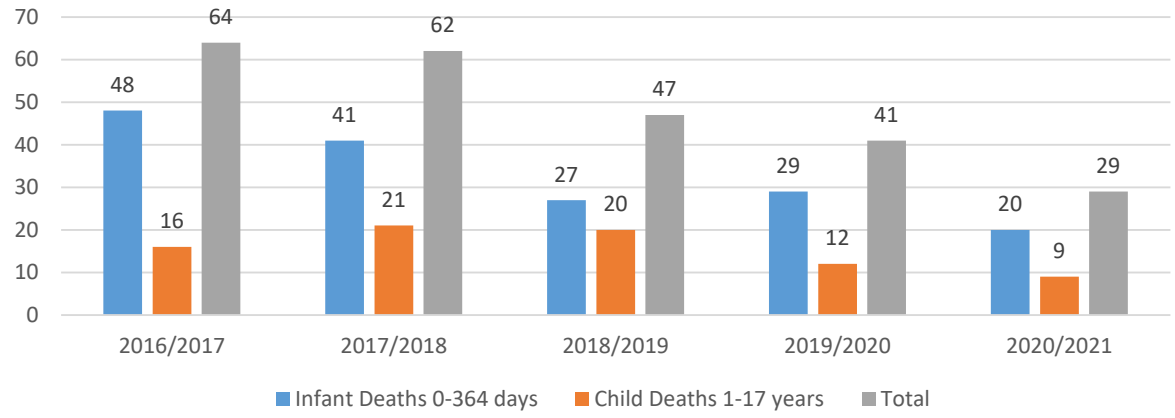
Though the numbers involved are relatively small, it emphasises that factors relating to smoking remain key modifiable factors for infant and child deaths. Despite ongoing efforts to reduce the rate of smoking, this continues to influence in the death of children and remains a steady modifiable factor.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

6.4 INFANT DEATHS (0-364 DAYS OF LIFE)

Of the 29 cases closed (2020/2021), a large proportion of the deaths occurred in the neonatal period (<28 days of life) accounting for 41% (12) of the total cases closed.

A further 8 (28%) infants died before the age of one (28-364 days of life), highlighting 69% (20) of the deaths occurring in the first year of life. This remains to be a year on year trend, as is the case across GM CDOPs (91, 69%), highlighting infants under the age of one as the most vulnerable age group.

Diagram 17: Manchester CDOP cases closed by age at time of death (2016/21)



Of the 20 infant deaths, a large proportion of the deaths were categorised as a perinatal/neonatal event and chromosomal, genetic, and congenital anomalies. Of the 8 deaths categorised as a perinatal/neonatal event, all infants were delivered prematurely, with prematurity featuring as the registered cause of death. Many infant deaths were anticipated due to the death ultimately being related to perinatal/neonatal events and chromosomal, genetic and congenital anomalies. This reflects that deaths in the first year of life are often due to the complications of prematurity or from underlying health conditions.

Babies are considered viable at around 24 weeks' gestation, meaning it's possible for them to survive at this stage. Infants delivered under 24 weeks' gestation, have a significantly reduced chance of

survival. The World Health Organization (WHO)[19] defines preterm birth as babies born alive before 37 weeks of pregnancy are completed, with sub-categories of preterm birth based on gestational age:

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

Of 20 infant deaths, 17 (85%) babies were delivered preterm (<37 weeks). Babies born before full term (<37 weeks) are vulnerable to health problems associated with prematurity. The earlier in the pregnancy a baby is born, the more vulnerable they are. Preterm birth occurs for a variety of reasons. Most preterm births happen spontaneously, but some are due to early induction of labour or caesarean birth, whether for medical or non-medical reasons. Common causes of preterm birth include multiple pregnancies, infections and chronic conditions such as diabetes, high blood pressure and genetic influence.

Around 8 out of 100 babies are born prematurely[20]. Using the WHO preterm birth sub-categorises, highlights 33% (7) of the preterm infants (7) were born extremely preterm (<28 weeks). Twins and triplets are often born prematurely with an average delivery date for twins at 37 weeks and 33 weeks' gestation for triplets. There were a number of infant deaths <5) recorded as a twin pregnancy some of which also resulted in a late foetal loss (<24 weeks' gestation) or stillbirth (>24 weeks) although, in line with Child Death Review: Statutory and Operational Guidance (England), stillbirths and late foetal loss are not subject to CDOP reviews.

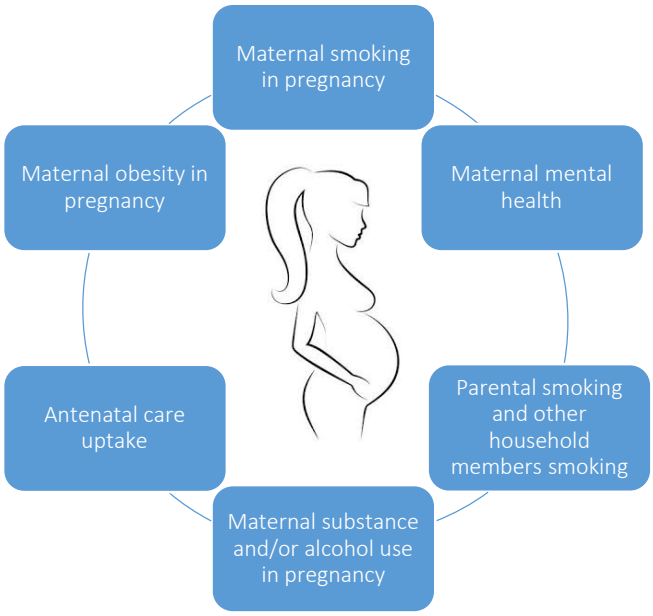
Low birth weight is defined by the WHO[21] as weight at birth less than 2500 g (5.5 lb). Low birth weight continues to be a significant health problem and is associated with a range of both short- and long-term consequences. Low birth weight is complex and includes preterm neonates, small for gestational age neonates at term and the overlap between these two situations. Typically, both preterm and small for gestational age neonates, have the worst outcomes.

The Royal College of Obstetricians and Gynaecologists[22] defines small for gestational age to an infant born with a birth weight less than the 10th centile[23]. Historically small for gestational age at birth has been defined using population centiles. The use of centiles is customised for maternal characteristics (maternal height, weight, parity, and ethnic group) as well as gestational age at delivery and infant sex, identifies small babies at higher risk of morbidity and mortality than those identified by population centiles. Of the 20 infant deaths, 18 (90%) had a birth weight of less than 2500 grams, 16 of which were preterm deliveries (<37 weeks' gestation).

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

[19] https://www.who.int/news-room/fact-sheets/detail/preterm-birth
[20] www.nhs.uk/conditions/pregnancy-and-baby/premature-early-labour
[21] www.who.int/nutrition/publications/globaltargets2025_policybrief_lbw/en/
[22] www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf
[23] www.rcpch.ac.uk/resources/uk-who-growth-charts-neonatal-infant-close-monitoring-nicm

Diagram 18: Modifiable factors and/or relevant factors identified in infant death cases closed by the Manchester CDOP (2020/21)



6.5 MATERNAL OBESITY IN PREGNANCY

A modifiable and relevant factor highlighted by the Manchester CDOP is mother's raised body mass index (BMI) during pregnancy. For most adults, an ideal BMI is in the 18.5 to 24.9 range (healthy weight range). The NHS defines the BMI categories[24] as:

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

Being overweight increases the risk of complications for pregnant women and baby[25]. The higher a woman's BMI, the higher the chance of complications. Problems for baby can include being born prematurely and an increased risk of stillbirth (from an overall risk of 1 in 200 in the UK to 1 in 100 if mother has a BMI of 30 or more).

The increasing chances are in relation to:

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

[24] https://www.nhs.uk/conditions/obesity/
[25] https://www.nhs.uk/conditions/pregnancy-and-baby/overweight-pregnant/

- having a baby weighing more than 4kg (8lb 14oz) - the overall chance of this for women with a BMI of 20 to 30 is 7 in 100 (7%); for women with a BMI of above 30, the chance is doubled to 14 in 100 (14%)
- women are also more likely to need an instrumental delivery (forceps or ventouse), or an emergency caesarean section

Deaths categorised as a perinatal/neonatal event, where mothers BMI in pregnancy is recorded as underweight (BMI <18.5) or obese (BMI 30+), are deemed a modifiable factor by the Manchester CDOP. Maternal obesity in pregnancy continues to be a relevant factor and features as a modifiable factor for Manchester, and across GM, in deaths categorised as a perinatal/neonatal event.

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

The Healthy Weight Team was established in September 2018 in response to the rising levels of severe obesity and following a Serious Case Review where a 13-year-old child died from a heart condition exacerbated by morbid obesity. The team puts the needs of children and families first, providing innovative, evidence-based intervention, and its work is now part of Manchester's Healthy Weight Strategy 2020–25. The Manchester Population Health Team launched the five-year Healthy Weight Strategy[26] in 2021. The strategy advocates a whole system approach which begins with pregnant women and babies. The strategy advocates equipping health professionals with the resources to begin sensitive conversations about weight in pregnancy, increasing breastfeeding and making healthy choices in weaning with infants. Delivering on the healthy weight outcomes in maternity services and early years is a key outcome for the City's Start Well Board.
Manchester has received national COVID-19 recovery funding to support tier two weight management provision. This has reduced the eligibility criteria to allow more residents access to local support. The two tiers of weight management provision are commissioned by the Manchester Population Health Team, for women aged 16 years and over.

A social prescribing service for pregnant women who have a BMI of 28 and over, offers a voucher to access a free local weight loss group. A specialist service is also available for pregnant woman with a BMI of 35 or above, to encourage lifelong change by supporting pregnant women achieving a healthier lifestyle through education and personalised goal setting. Both programmes offer advice and support on nutrition, lifestyle, and behaviour change to enable women to be healthy throughout their pregnancy and beyond. Both services provide advice on nutrition in relation to breastfeeding and complementary feeding. Midwives can refer pregnant women into the tier three service from 12 weeks gestation which includes psychological therapy and, where appropriate, pharmacotherapy.

The Manchester Healthy Weight Nurse Team successfully won the national 'Nursing Times Public Health Nursing Award 2021'[27] for their work supporting families referred to the specialist service, supporting overweight and obese children, to achieve healthier lifestyle and improve life chances.

Emma Schneider, Project Lead for the Manchester Healthy Weight Team, said: *"Winning this award and for the Healthy Weight Team to be recognised at such a prestigious event was an absolute career highlight! I feel so lucky to work with the most passionate, knowledgeable, caring, and dedicated team you will ever find, and who make me proud every day."*

[26] https://www.manchester.gov.uk/downloads/download/7356/manchester_healthy_weight_strategy
[27] https://www.nursingtimes.net/news/leadership-news/winners-of-the-2021-nursing-times-awards-revealed-28-10-2021/

6.6 SMOKING

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

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

The National Tobacco Control Plan[28] includes an ambition to reduce smoking in pregnancy to 6% by the end of 2022, which is measured at the time of giving birth. The national average for SATOD is 9.6% and in Manchester, the smoking at time of delivery (SATOD) rate has been falling in recent years (8.9%). However, we cannot be complacent because 8.9% remains high and those women who do smoke may well have other vulnerabilities.

The Manchester Population Health Plan[29] priority 'The first 1000 days of a child's life' focuses on this area of work and is further addressed by the Manchester Tobacco Plan[30] and the Manchester Reducing Infant Mortality Plan[31]. Since 2018, Manchester has had an 'in maternity' Smoking in Pregnancy Service which is delivered by Manchester University NHS Foundation Trust. This programme has been rolled out across GM according to a broadly similar model, based on NICE guidance. This means that all women who smoke while pregnant are offered free Nicotine Replacement Therapy (NRT) and motivational support for the duration of their pregnancy and just beyond. Most pregnant smokers in Manchester qualify for an Incentive Scheme too. This scheme, which "rewards" women who stay smoke free with shopping vouchers, is administered by the GM Health and Social Care Partnership. The effectiveness of this approach is being studied as part of an ongoing Randomised Control Trial.

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

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

[28] https://www.gov.uk/government/publications/tobacco-control-plan-delivery-plan-2017-to-2022
[29] https://www.manchester.gov.uk/healthplan
[30] https://www.manchester.gov.uk/downloads/download/6971/smoke_free_manchester
[31] https://www.manchester.gov.uk/downloads/download/7002/reducing_infant_mortality_strategy

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

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

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

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

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

The Manchester CDOP continues to raise awareness of safer sleep messages via quarterly newsletters[32] to embed safer sleep advice into multi-agency practice. The Manchester CDOP promotes consistent safe sleep advice, published by the Manchester Local Care Organisation Safer Sleeping Practice for Infants[33]:

'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. This advice is the same for all times of the day and night when the baby is sleeping'

The Manchester Vulnerable Baby Service (VBS) is an integral service in delivering safe sleep messages to the community. The Manchester VBS was established with the aim of reducing the risks of sudden and unexpected death in infancy (SUDI) across the City. The service facilitates multi-agency case planning meetings for any unborn babies and infants under one year of age, who are considered to be vulnerable as defined by the referral criteria. Any practitioner can refer into the service if the family meets the criteria. In each case, the assessment of need and liaison with partners continues and is carried out by the VBS staff. The VBS continues to play a public health role in preventative measures, leading on safe sleeping policies across the City and strategically informing practice to improve outcomes for infants.

[32] https://www.manchestersafeguardingpartnership.co.uk/resource/cdop/
[33] https://www.manchestersafeguardingpartnership.co.uk/resource/safe-sleeping/

The Manchester Reducing Infant Mortality Strategy Steering Group established a Safer Sleep Task and Finish Group, to review local safer sleep messages and look at methods to deliver consistent advice within the community. Led by the Manchester Population Health Team, the group was made up of multi-agency professionals including Manchester City Council Communications and Marketing and the Manchester Local Care Organisation, with representation from the Health Visiting Service and Care of Next Infant (CONI) Programme. The group agreed to develop a Manchester safer sleep video containing useful tips for parents and carers on how to create a safer sleep environment. Across Manchester, there are up to 200 different languages spoken in the adult population therefore, the safer sleep animation aims to deliver key messages visually using simple graphics, which can be understood and readily available to all viewers. The 'Creating a safe sleep environment for your baby'[34] was published during The Lullaby Trust Safer Sleep Week 2021 and promotes the 'Be Cot Safe' message of:

'Be aware of your baby's sleep environment for every sleep, every where, every time.'

The video was published via YouTube and made available to professionals, parents, and carers to reduce the risk of sudden infant death syndrome (SIDS). Every baby born in Manchester, receives a free thermometer which also features Be Cot Safe advice to reduce the risk SIDS.

6.8 A MANCHESTER CASE STUDY

The death of an infant aged 6 months was reported to the Manchester CDOP by the responding on call GM Joint Agency Response (JAR) Paediatrician. As a sudden and unexpected death in the community, a referral was made to the GM JAR to conduct a rapid response review. A multi-agency strategy meeting was held involving services directly involved with the family, for professionals to work collaboratively and share information.

Mother booked the pregnancy at 14 weeks gestation and it was noted that there were several missed antenatal appointments. Mother and father were known to be smokers. The infant was born full term, with a low birth weight which was recorded as the 2nd centile[35] at the time of delivery.

Mother had been caring for the infant prior to death and awoke the following morning, to find the infant unresponsive. Ambulance services arrived on the scene and paramedics conducted cardiopulmonary resuscitation (CPR) before transferring the infant to the local Paediatric Emergency Department (PED). On arrival to PED, resuscitation attempts were continued but unsuccessful. There were some discrepancies surrounding the account provided, before the infant's collapse, particularly regarding the final place of sleep. On the night of the infant's death, the infant took feeds as usual and slept next to her mother on a double bed. The following morning, mother awoke to find the child lifeless.

Once all investigations concluded, the Manchester CDOP conducted the final review which highlighted multiple relevant factors and modifiable factors which were deemed may have contributed to vulnerability, ill health, or death of the child. The key modifiable factors included:

- Unsafe sleeping arrangements
- Baby placed on a soft surface to sleep, on the parental bed, with a large feather duvet

[34] https://www.youtube.com/watch?v=eUwbFKID_6c&t=6s

[35] https://www.nhs.uk/conditions/baby/babys-development/height-weight-and-reviews/baby-height-and-weight/

- High risk of co-sleeping in parental bed
- Parental smoking
- Parental substance use on the day of the infant's death
- Evidence of parental substance use in the bedroom shared by parent and the infant
- Smoking within the household and evidence of smoking in the bedroom
- Poor living conditions and unsuitable home environment

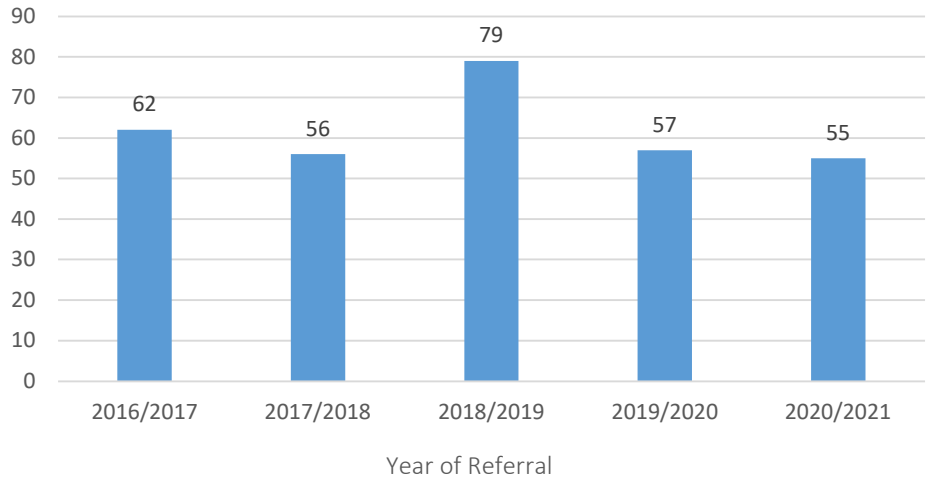
6.9 GREATER MANCHESTER RAPID RESPONSE (JOINT AGENCY RESPONSE)

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

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

In total, 766 child death referrals have been made to the GM JAR since 1st January 2009. There has been year on year fluctuation in the numbers of cases referred to the Rapid Response Service, but there continues to be a mean of 1.2 cases referred each week. Between 1 April 2020 - 31 March 2021, the GM JAR received 55 child death referrals.

Diagram 19: Number of child death referrals to the GM JAR (2016/21)



Most cases (32%) occurred in infants under one year of age, with a peak incidence in infants aged between one month to six months of age (26%). There is a second peak in teenagers who exhibit risk-taking behaviours. The proportion of cases in each age category has stayed relatively constant since 2009, although during 2020/2021 there was a further rise from 2019/2020, in the number of 16-17-

year-old deaths (20%). This appears to map onto an increase in the number of deaths by apparent suicide, but numbers are too small to allow statistical analysis.

An ongoing challenge to the service has been maintaining the on-call rota, as doctors have moved on to new posts or retired. This has been compounded by COVID-19 related illness. There continues to be a national shortage of Paediatricians and this has been reflected in difficulties recruiting into vacant posts. COVID-19 has had a significant impact during 2020/2021 and preserving home visits whenever it is safe to do so, has been a real achievement, as a key part of the JAR function. Despite the challenges, increased used of virtual meetings has had a very positive impact on attendance at both initial meetings and CDRMs.

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

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

6.10 CHROMOSOMAL, GENETIC & CONGENITAL ANOMALIES

Of the 29 cases closed, 9 deaths were categorised as chromosomal, genetic and congenital anomalies, all of which were infant deaths (0-364 days of life) and 5 children recorded Asian/Asian British. The Manchester CDOP continues to determine the relevance of consanguinity in deaths categorised as chromosomal, genetic and congenital anomalies. Consanguinity refers to a relationship in which a couple are blood relatives, for example first cousins, second cousins etc. Consanguinity increases the risk of genetic disorders known as autosomal recessive disorders. Parents who are both unaffected healthy carriers of a genetic disorder present a 1 in 4 (25%) chance that the child could be affected and a 50% chance that the child could be a healthy carrier with no sign of the disorder but could pass the unusual gene on to the next generation. Unrelated parents have a 2% risk of having a child with a severe abnormality, whilst parents who are first cousins have a 5% risk and second cousins have a 3% risk. However, couples that are more closely related, such as a family with a history of cousin marriages going back generations, will have a higher risk of having a child with autosomal recessive disorders.

The Manchester University NHS Foundation Trust (MFT) provides one of the largest and most comprehensive multi-disciplinary clinical genetics units in UK and Europe providing integrated clinical and laboratory genetics services[36]. The aim of the regional genetic service is to provide a diagnostic, counselling and support service to individuals and their families with a genetic disorder affecting any body system at any age.

Practitioners can make referrals to the service for a number of reasons including:

- organisation of specialist prenatal diagnosis for a known familial genetic disorder
- diagnosis and counselling on diagnosis of foetal abnormality either on genetic testing or ultrasound
- investigation and diagnosis of congenital abnormality
- investigation and diagnosis of abnormalities of growth or development in childhood
- diagnosis of a metabolic disorder

[36] https://www.mangen.co.uk/

- diagnosis if a possible genetic disease, including eye, renal, cardiac and neurological disorders with known or possible genetic basis
- strong family history of cancer
- concern regarding personal or family history of a genetic disease
- access testing of family members for carrier status for single gene (mendelian disorders) including presymptomatic or predictive gene testing when indicated.

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

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

As part of the Manchester Reducing Infant Mortality Strategy 2019-2024[37], work remains ongoing to raise awareness of the genetic service and how practitioners can make referrals. This includes information about autosomal recessive disorders, to increase the knowledge and understanding of genetics in the population.

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

7. ACKNOWLEDGEMENTS

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

The Manchester CDOP remains continually thankful for the support from the Manchester Child Health Department, Manchester City Coroner's Office, Manchester City Register Office, and Manchester University NHS Foundation Trust (MFT) in supplying the necessary information required to conducted a thorough CDOP review.

[37] https://secure.manchester.gov.uk/downloads/download/7002/reducing_infant_mortality_strategy

8. 2020/21 MANCHESTER CDOP RECOMMENDATIONS

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

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

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

RECOMMENDATION 1: The Manchester CDOP is to liaise with MFT clinicians and senior management, to request the completion of the DHSC C. Analysis Form during CDRMs. The draft CDRM C. Analysis Form is to be shared with the appropriate CDOP (based on area of residence) to affirm the findings documented by the CDRM.

GREATER MANCHESTER eCDOP

Following the implementation of the National Child Mortality Database (NCMD) on 1 April 2019, CDOPs had a statutory requirement to submit data collated using the national CDOP templates, to the NCMD web portal. This includes large quantities of data being inputted into the NCMD from all reporting forms, supplementary reporting forms and analysis forms which has drastically increased the Manchester CDOP workload and neighbouring GM CDOP areas. The NCMD requirement for CDOPs to provide live notifications for all child deaths and a full dataset for all cases closed, has resulted in a significant increase in the Manchester CDOPs operational aspects and administrative functions, when processing cases.

The four GM CDOPs took a collaborative approach to developing a system to support all ten of the GM local authorities. The GM eCDOP system[38] allows professionals to report child deaths electronically via a web-based link, to notify the CDOP of all child deaths aged 0-17 years of age, within 24 hours (or the next working day) of the child's death.

RECOMMENDATION 2: As of the 1 April 2021, all child death notifications are to be reported electronically via the GM eCDOP. Email notifications and paper-based documentation will no longer be accepted by the GM CDOP areas. Professionals involved must complete an eCDOP A. Notification Form with as such information as possible, within 24 hours (or the next working day) of the child's death. The Manchester CDOP Co-ordinator is to process each A. Notification Form and generate requests to complete the B. Reporting Form, including Supplementary Forms, via the GM eCDOP system.

[38] https://www.ecdop.co.uk/GMCDOPS/live/public

9. APPENDICES

APPENDIX 1: MANCHESTER CDOP MEMBERSHIP

The Manchester CDOP membership includes:

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

APPENDIX 2: C. ANALYSIS PROFOMA CATEGORISATION OF DEATH

1. Deliberately inflicted injury, abuse or neglect

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

2. Suicide or deliberate self-inflicted harm

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

3. Trauma and other external factors, including medical/surgical complications/error

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

4. Malignancy

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

5. Acute medical or surgical condition

For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.

6. Chronic medical condition

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

7. Chromosomal, genetic and congenital anomalies

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

8. Perinatal/neonatal event

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

9. Infection

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

10.Sudden unexpected, unexplained death

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