AGENDA FOR

HEALTH AND WELLBEING BOARD

Contact: Chloe McCann
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To: All Members of Health and Wellbeing Board

Members : G Little, K Dolton, J Gonda, L Jones, B Barlow, Councillor R Walker, Councillor D Jones, S Taylor, Councillor A Simpson (Chair), S Hashmi, Dr J Schryer, D Lythgoe, Councillor T Tariq, V Hussain and S Downey.

Dear Member/Colleague

Health and Wellbeing Board

You are invited to attend a meeting of the Health and Wellbeing Board which will be held as follows:-

Date:	Wednesday, 20 November 2019
Place:	Meeting Rooms A & B Bury Town Hall
Time:	6.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

Members of the Health and Wellbeing Board are asked to consider whether they have an interest in any of the matters on the Agenda, and if so, to formally declare that interest.

3 PUBLIC QUESTION TIME

Questions are invited from members of the public present at the meeting on any matters for which the Board is responsible.

Approximately 30 minutes will be set aside for Public Question Time, if required.

4 MINUTES OF PREVIOUS MEETING *(Pages 1 - 10)*

The minutes of the meeting held on 21st October 2019 are attached.

Matters Arising: Letter regarding Minimum Unit Price is attached.

5 CHILD DEATH OVERVIEW PANEL ANNUAL REPORT *(Pages 11 - 44)*

Wendy Meston, Consultant in Public Health, Rochdale Borough Council will report at the meeting. Report attached.

6 LOCALITY PLAN REFRESH

Chris Woodhouse Executive Officer Bury Council will report at the meeting.

7 TERMS OF REFERENCE FOR THE BURY SYSTEM BOARD *(Pages 45 - 58)*

Dr Jeff Schryer will report at the meeting. Report attached

8 THE BURY SYSTEM URGENT CARE REVIEW AND RE-DESIGN BRIEF

Nicky Parker, Programme Manager Urgent Care Review will provide members with a verbal update.

9 INTERMEDIATE CARE REVIEW *(Pages 59 - 68)*

Julie Gonda, Interim Director for Communities and Wellbeing will report at the meeting. Report attached.

10 LEARNING DISABILITIES RESPITE REVIEW *(Pages 69 - 76)*

Julie Gonda, Interim Director for Communities and Wellbeing will report at the meeting. Report attached.

11 URGENT BUSINESS

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

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Minutes of: **HEALTH AND WELLBEING BOARD**

Date of Meeting: Monday 21st October 2019

Present: Councillor David Jones, Leader of the Council, Interim Executive Director Communities and Wellbeing, Julie Gonda; Cabinet Member Health and Wellbeing Andrea Simpson (Chair); Councillor Roy Walker, Opposition Member, Health and Wellbeing; Healthwatch Chair, Barbara Barlow; Director of Public Health, L Jones; representing Northern care alliance, Steve Taylor.

Also in attendance:

K. Batt, Independent Chair Bury Safeguarding Board.
Mandy Symes, Head of Adult Safeguarding, Bury Council
Nicky Parker, Programme Manager, Bury CCG
Margaret O'Dwyer, Deputy Chief Officer, Bury CCG
Chris Woodhouse, Executive Officer, Bury Council
Representing K Dolton, Tony Decrop, Assistant Director, Safeguarding.
Julie Gallagher – Democratic Services

Apologies:

Chair, Bury Clinical Commissioning Group, Dr Jeff Schryer);
Geoff Little, Chief Executive
D Lythgoe, Pennine Care NHS Foundation Trust
V Hussain, GMFRS

Public attendance: 1 member of the public was in attendance

HWB. DECLARATIONS OF INTEREST

Councillor Simpson declared a personal interest in all matters under consideration as an employee of the NHS.

HWB. MINUTES OF PREVIOUS MEETING

It was agreed:

The minutes of the meeting held on the 17th July 2019 be approved as a correct record.

HWB. PUBLIC QUESTION TIME

There were no questions from members of the public present at the meeting.

Nb; Further to the published agenda the Chair agreed that the agenda would be re-arranged the Bury System Urgent Care Review and Re-design Brief would be considered first.

HWB. BURY SYSTEM URGENT CARE REVIEW AND RE-DESIGN BRIEF

Margaret O'Dwyer and Nicky Parker, Bury CCG, attended the meeting to provide members with an update of work being undertaken with regards to the Urgent Care Review. The report proposed a number schemes and service reviews for prioritisation and development in 2020-21 based on work undertaken to date and discussions at the Clinical Cabinet and Professional Congress.

Those present were invited to ask questions and the following issues were raised:

Responding to a Member's question the Deputy Chief Executive reported that the proposals will be discussed at a number of fora, there will be opportunities for Elected Members to inform and develop the re-design brief as it progresses. The Programme Manager reported that the urgent care review timeline will be as follows; during November work will be undertaken to ascertain urgent care best practice looking in particular at schemes in neighbouring authorities. A report including details of the urgent care future model will be considered at the Strategic Commissioning Board in December; public consultation will commence in January 2020 with a view to commence implementation in March 2020.

The Chair reported that the current urgent care system is complicated and difficult for patients to navigate. The proposals must include a clear patient pathway and information and communication on when, where and how to access services.

Steve Taylor, representing the Northern Care Alliance reported that it is imperative that the work to redesign the urgent care system is undertaken in conjunction with the intermediate tier review.

The Deputy Chief Officer, Bury CCG reported that the use of technology is critical to the success of this work.

It was agreed:

The Bury System urgent care review and re-design brief will be a standing agenda item.

HWB. ADULT SAFEGUARDING BOARD ANNUAL REPORT

K. Batt, Independent Chair Bury Safeguarding Board and Mandy Symes, Bury Council, attended the meeting to provide members with an overview of the work undertaken in the last twelve months. The Annual Report circulated to members in advance of the meeting provided information in respect of:

- Safeguarding activity
- Greater collaboration
- Details of meetings and work undertaken during 2018/19

- Plans for 2019/2020
- Data in respect of deprivation of liberty orders.

Two key measures were chosen by the Safeguarding Adults Board in order to monitor progress and development. Firstly, "The number of adults being abused is reducing" and secondly "The number of repeat incidents is reducing". With respect to the first measure the numbers have reduced from 413 in 2017/18 to 227, in 2018/19. Of the 442 adults supported via a safeguarding enquiry in 2018/19, 107 also had a safeguarding enquiry within the previous 12 months prior. Compared to 116 in 2017/18.

Those present were invited to ask questions and the following issues were raised:

Members discussed the failure of the Community Rehabilitation Company and the national Probation Service to attend meetings of the Adults Safeguarding Board. The Head of Adult Safeguarding reported that on an operational level staff are very supportive, it is the regional staff that are invited to the Board and they will cover a number of authorities, they will receive the minutes.

Responding to a Member's question, the Head of Adult Safeguarding reported that the PREVENT/CHANNEL programme will support those at risk of radicalisation across all ages. The Assistant Director reported that targeted awareness raising of the Prevent programme has been undertaken in schools. Following any such activity there is always a spike in referrals.

It was agreed:

K. Batt, Independent Chair Bury Safeguarding Board and Mandy Symes, Head of Adult Safeguarding, Bury Council be thanked for their attendance.

HWB. LEARNING FROM THE SERIOUS CASE REVIEW

K. Batt, Independent Chair Bury Safeguarding Board and Mandy Symes, Bury Council, attended the meeting to inform members of the recently undertaken serious case review. The report provided an overview of the incident leading to the review; sudden unexplained death of a child meeting; serious case review, the views of the family and learning from the review.

The Independent Chair reported that there were eight recommendations in the report, the following were of particular relevance to the HWB are as follows;

- The LSCB (now the BISP) should receive assurance from local partners that work to develop a whole system response (service pathway) to childhood obesity.
- The LSCB should receive assurance that local safeguarding partners develop guidance based on research and practice that incorporates Childhood obesity as a potential safeguarding issue.

Members discussed the tragic circumstances that led to the death of the 13 year old resident of the Borough. The Director of Public Health reported that we must ensure that the lessons are learnt and the recommendations from the serious case review are implemented. A whole system approach is needed to tackling

the stigma of obesity, this is not about "nagging" individuals but promoting healthy body image and addressing the increasing problems of obesity in the Borough

It was agreed:

The Board offers condolences to Aiden's family.

HWB. BETTER CARE FUND UPDATE REPORT

Julie Gonda, Interim Executive Director Communities and Wellbeing informed the meeting that the final Better Care Fund 2019-20 Policy Framework and Planning Guidance was published in July 2019. The Interim Executive Director informed the meeting that the BCF 2019/20 is subject to four national conditions:

- Plans must be signed off by the Health and Wellbeing Board (HWB), and by the constituent local authorities (LAs) and CCGs.
- Plans must demonstrate how the area will maintain the level of spending on social care services from the CCG minimum contribution in line with the uplift to the CCG's minimum contribution.
- A specific proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, which may include seven day services and adult social care.
- There must be a clear plan on managing transfers of care, including implementation of the High Impact Change Model for Managing Transfers of Care (HICM). As part of this, all HWBs must adopt the centrally-set expectations for reducing or maintaining rates of delayed transfers of care (DToC) during 2019-20 into their BCF plans

As well as four national metrics; Non-elective admissions (Specific acute); Admissions to residential and care homes; Effectiveness of reablement and Delayed transfers of care.

It was agreed:

- That the Health and Wellbeing Board notes the content of the report.
- That the Bury Health and Wellbeing Board approves the attached Better Care Fund 2019-20 Planning Template for submission to the national Better Care Fund team for assessment.

HWB. LOCALITY PLAN REFRESH AND THE BURY STRATEGY

Chris Woodhouse, Executive Officer provided members with an overview of the locality plan refresh and the bury strategy, the presentation contained the following information:

- Context and approach to delivering the Strategy.
- Details of delivering the locality plan and the target operating model
- GM Draft locality plan framework
- Partnership delivery plans so far.

Members discussed issues in respect of the shared Vision for Bury, how do we deliver this in an integrated way? What has worked well to date across integration, transformation? And what do we need to do differently?

The Chair reported that the development of the strategy must be undertaken with engagement at a neighbourhood level, with good data and intelligence, including neighbourhood profiles informing the process.

Members discussed the Strategy and links with the Locality Plan and agreed that a more coordinated long term vision is required.

It was agreed:

1. Members will be kept updated on the progress and development of the Bury Strategy 2030.
2. The refreshed Locality Plan will be presented at the next meeting of the Health and Wellbeing Board.

HWB. MINIMUM UNIT PRICE FOR ALCOHOL

The Director of Public Health provided members with a verbal update in respect of the development of a minimum unit price for alcohol. Prior to the meeting an accompanying report was circulated to members which included details of research project undertaken by Sheffield University. The model produced gives specific details at individual local authority level on the impact that alcohol pricing has on death rates and hospitalisations as well as economic outcomes for consumers, retailers, government tax revenues and NHS healthcare costs.

For Bury Metropolitan Borough Council, the research suggests that a 50p MUP would mean that:

- the NHS would save £259109 per year,
- alcohol related hospital admissions would fall by 120 per year
- 77 deaths would be avoided over the ensuing 20 year period.
- 176 fewer associated crimes would be committed per year

Those present were invited to ask questions and the following issues were raised:

Members wanted to place on record their support for the introduction of national minimum unit pricing for alcohol.

It was agreed:

That the Health and Wellbeing Board:

- Notes the harms caused to Bury residents and the Bury economy through alcohol
- Note the estimated positive impact on reducing alcohol harm that could be achieved through the introduction of Minimum Unit Price.
- Write a letter to DHSC and the Home Office

- Support a public awareness and engagement exercise
- Lobby to include minimum unit pricing within Greater Manchester Drug and Alcohol Strategy, currently being developed.

HWB. * FOR INFORMATION MANCHESTER PHARMACY NEEDS ASSESSMENT**

Councillor Andrea Simpson– Cabinet Member Health and Wellbeing Chair

(Note: The meeting started at 6pm and finished at 7.50pm)

Sirs

I am writing to you in relation to the Green Paper focussed on prevention recently announced by DoHSC. I am doing so as new evidence based on research by the University of Sheffield has shown that significant harms experienced by Bury Metropolitan Borough Council can be averted by introducing a policy which should be at the forefront of both documents.

Cheap alcohol is at the root of many of the problems both initiatives are attempting to address. The real price of alcohol compared to other goods has fallen dramatically over the past 30 years and this has been most pronounced in shops and supermarkets. It is now possible to buy three litres of white cider containing the equivalent of 22 shots of vodka for around £3.50.

For specific, vulnerable populations, this is associated with an increased risk of harm. The published vision for the Green Paper expressly identifies alcohol as *"…one of the leading causes of ill health and early death."* Additionally, however, those subjected to alcohol-related harm are not only the drinkers themselves but also the many others affected, often innocent bystanders. As you will already be acutely aware, alcohol has been shown to be a contributory factor in child abuse and neglect, domestic violence, family breakdown and crime and disorder, among others. Government figures show that this harm is felt disproportionately in Bury Metropolitan Borough Council and across the North of England generally.

A Minimum Unit Price (MUP) would allow all alcoholic beverages to be priced based on their strength. Stronger drinks, such as high strength white cider and spirits, would have a higher price than their lower-strength alternatives. The research shows that doing so would be more effective in terms of reducing harmful consumption, hospital admissions and preventing alcohol-related deaths than other similar policies. It would have immediate and long-term benefits to health, crime prevention, economic growth and health inequalities. Many people stand to gain from the introduction of MUP – particularly the most vulnerable. In Bury Metropolitan Borough Council alone a 50p MUP would mean:

- the NHS would save £259,109.00 per year,
- alcohol related hospital admissions would fall by 120 per year
- 77 deaths would be avoided over the ensuing 20 year period.
- 176 fewer associated crimes would be committed per year

The vision for the Green Paper makes a specific case for intervention which is *"…targeted and co-ordinated for groups most at risk".* The new research demonstrates that MUP precisely targets those products consumed by people drinking harmful quantities and young drinkers. At the same time, it achieves this without significantly penalising moderate drinkers, including those on low incomes. In fact, it is estimated that moderate drinkers in the most deprived areas in Bury Metropolitan Borough Council would spend just £2.50 more on alcoholic drinks per year under a 50p MUP, a barely noticeable difference.

In light of this new evidence and the potential benefits outlined for residents of Bury Metropolitan Borough Council and the country, I believe the Government should take

the earliest possible opportunity to introduce MUP in England and I urge you to set out plans for its immediate implementation.

The Scottish government recognised the problem and introduced a minimum unit price (MUP) for alcohol over a year ago. Wales are due to do the same. If MUP is not introduced in England, the lives saved, crime cut and money saved across the borders will highlight a serious failure in the Government's duty to protect the health and wellbeing of the English population.

Yours sincerely

Champs Public Health Collaborative

Working together to improve health and wellbeing in Cheshire and Merseyside

The Rt. Hon. (INSERT NAME) MP
House of Commons,
London,
SW1A 0AA

2nd October 2019

Dear (INSERT NAME)

Tackling Cheap Alcohol and Alcohol Harm in our Communities

Colleagues in local authorities across the North of England, together with our Directors of Public Health, have for some time been working on a specific programme focused on tackling cheap alcohol through Minimum Unit Pricing (MUP).

I have recently taken over the lead for this work and, on behalf of the team working on this project, would like to share some information with you about the work we are doing. We hope you will find it useful and informative.

We have recently shared research undertaken by the University of Sheffield with colleagues in every local authority in the North of England. The research outlines the potential local impact of a minimum unit price for alcohol (MUP) on our communities. The model produced gives specific details at individual local authority level on the impact that alcohol pricing has on death rates and hospitalisations as well as economic outcomes for consumers, retailers, government tax revenues and NHS healthcare costs.

We would like to share the following information with you

- A Q&A document addressing this research and wider questions relating to MUP (enclosed)
- a link to the information/data produced by the University of Sheffield for every local authority area in the North of England which provides the opportunity for you to review the evidence/data for the local authority areas within your Constituency:

  https://www.sheffield.ac.uk/scharr/sections/ph/research/alpol/research/minimumunitpricinglocal/assetbank

The evidence shows that a 50p MUP would have immediate and long-term benefits to health, crime prevention, economic growth and health inequalities. Many people stand to gain from the introduction of MUP – particularly the most vulnerable.

The real price of alcohol compared to other goods has fallen dramatically over the past 30 years and this has been most pronounced in shops and supermarkets. It is possible to buy 2.5 litres of white cider containing the equivalent of almost 19 shots of vodka for £3.70. MUP would increase the price of the cheapest, strongest products by setting a floor price based on the amount of alcohol the product contains. The research shows that doing so would be more effective in terms of reducing harmful consumption, hospital admissions and preventing alcohol-related deaths than other similar policies.

We would encourage you to engage with your local authority and local Director of Public Health, if you would like more information on the local evidence/data. If you would like more information on

MUP generally, including the size of the potential national impact and information about how it would affect different communities, businesses and services, we are planning a Parliamentary session at an appropriate time in the next Parliament although the date for this is yet to be confirmed. As soon as that date has been settled, I will be in touch again with an invitation for you to join us to consider the evidence and discuss it with us.

Yours sincerely

David Parr OBE
Chief Executive
Halton Borough Council

Bury Health and Wellbeing Board

Report Title	Child Death Overview Panels and 2018 Annual Report
Meeting Date	
Contact Officer	Wendy Meston , Rochdale Council
HWB Lead	Lesley Jones

1. Executive Summary

Is this report for?	Information ☐	Discussion x	Decision ☐
Purpose of report:		To inform the Board of the findings of the 2018 CDOP Annual Report	
Key Actions:		To note the report and consider the recommendations and any further action for the Locality	
What requirement is there for internal or external communication?		To share the report with the Local Safeguarding Board	
Assurance and tracking process:		*The report has been considered by the Greater Manchester CDOP group*	

2. Introduction / Background

The Bury, Rochdale and Oldham (BRO) CDOP has been set up by Child Death Review (CDR) Partners, the Bury, Oldham and Heywood, Middleton, Rochdale CCG's and Bury, Oldham and Rochdale Council's to review the deaths of children under the requirements of the Children Act, 2004 and Working Together to Safeguard Children, 2018. The tripartite approach covers a population of 641,846. The sector operates within a Greater Manchester (GM) framework for CDOP which includes the production of a GM CDOP Report and development of agreed standards and processes across GM.

Purpose

The purpose of the BRO CDOP is to undertake a review of all child deaths up to the age of 18 years, normally resident in Bury, Oldham and Rochdale/HMR, irrespective of the place of their death. The BRO CDOP will adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018:

https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

The three Councils and the three CCGs have agreed operational arrangements with partners based on the existing model that we have had for some years across Greater Manchester.

3. key issues for the Board to Consider

The Health and Wellbeing Board are asked to note the Child Death Overview Panel Statutory Responsibility and the changes to governance and the transfer of accountability for the Child Death Review Panel reports moving in line with national guidance from Safeguarding Boards to the Health and Wellbeing Boards in Bury, Rochdale and Oldham. The current working arrangements are attached in Appendix 1

The most recent Annual Report (Appendix 2) takes data from the four CDOP panels that cover GM to make observations about causes and modifiable factors in order to inform action to promote child safety and reduce child deaths in GM and the Board are asked to note the report and consider the recommendations

4. Recommendations for action

- That the Health and Wellbeing Board note their responsibility and schedule future Annual reports to be presented to the Board
- That the Board note that arrangements have been put into place to discharge our statutory responsibilities and that this will be subject to further development in 2019/20.
- That the Board seek assurances that plans are in place to address potential modifiable factors including smoking in pregnancy, obesity, drug and alcohol misuse, domestic abuse, safe sleeping, and consanguinity.
- That the Board seek assurances that suicide prevention plans are in place in line with the Greater Manchester Suicide Prevention Strategy
- That the Board seek assurances that good quality services are in place to support families and others affected following the death of a child or young person

5. Financial and legal implications.

6. Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

CONTACT DETAILS:

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Telephone number: 01706 927089

E-mail address: wendy.meston@rochdale.gov.uk

Date: 7th November 2019

Annual Report of Child Deaths in Greater Manchester, 2018/19

Report updated by Leifa Jennings, based on a report by Louise Harding, with data analysis and editing by Jacqui Dorman (Tameside MBC)

October 2019

Contents

1.0 Executive Summary

This is the seventh annual report which reviews the data taken from all four Child Death Overview Panels (CDOPs) across Greater Manchester (GM). This report includes data from closed cases from 1st April 2018 to 31st March 2019.

All under-18 child deaths are referred to a CDOP, and the findings are recorded and used to inform local strategic planning on preventing child death, safeguarding children and improving outcomes. The CDOP does not determine the cause of death; that is carried out by either the medical team or the coroner depending on the circumstances of the death. The CDOP's responsibility is to consider all the information around the child's death, identify potentially modifiable factors, and lessons that can be learned. The outcome of all cases closed by the CDOPs is collected nationally by the Department for Education to build up a picture of child deaths in the UK.

1.1 Key Findings for Greater Manchester

There were a total of 204 closed cases in 2018/19 with 217 notified deaths. The number of closed cases is less than in 2017/18 (274) as is the number of deaths notified (250). The time taken from notification of death to closure was between 31 and 2,328 days, with an average across GM of 297 days.

The large majority of child deaths in GM occurred in the first year of life; 42% of closed cases occurred in the first 28 days and 60% in the first 12 months. This is a reduction from last year, when deaths in infants aged under 1 year accounted for 65% of closed cases, but the main causes of these deaths remain the same. Most were due to events around the time of birth (perinatal or neonatal events), the next most common issue was genetic or congenital conditions.

The older age groups: 1-4, 5-9, 10-14 and 15-17 accounted for 11%, 8%, 10% and 11% of deaths respectively. This does indicate a slightly wider spread of deaths throughout the age groups than in previous years, but the absolute numbers are too small to draw statistical conclusions. Out of all the closed cases in 2018/19, 162 (79%) were classed as 'medical' causes, i.e. acute medical, chromosomal, chronic medical, malignancy, perinatal / neonatal event or infection. Across GM, 82% of neonatal deaths were expected, falling to 45% of infants aged 28-364 days. The pattern is more mixed across the older age groups, but again this could be due to small numbers. However, in children aged 10-14 years, only around 1 in 5 deaths were expected which reflects a greater number of deaths from unexpected causes, such as health-related causes of death and trauma in this age group. This low percentage also reflects the good health of children in this age group, and that those with serious underlying conditions were likely to have died prior to the age of 10.

The ratio of male to female deaths was similar to previous years (60% male, 40% female). However, in contrast to last year, the gender difference is more evident in some older age brackets, rather than infancy. Whilst deaths due to trauma and other external causes usually have a higher ratio of male to female deaths, in 2018/19 these were roughly equal, but numbers were small in this category (7 males and 6 females).

Modifiable factors were identified in 79 closed cases (39%) across GM, which is similar to the findings from 2017/18 (40%). Smoking was still the most common modifiable factor (24 cases), followed by obesity (19). Access to health care or poor care management was the third largest modifiable factor (11) followed by substance misuse (10).

In 199 of the 204 closed cases in 2018/19 the ethnicity of the child was recorded. Of these, 57% were from a white background, which is below the national rate of 63%. Across GM there was a rate of 4.77 deaths per 10,000 in the 0-17 years BME population compared to 2.50 per 10,000 0-17 years among the white population. This marked difference represents a health inequality between the two groups.

Thirty-seven percent of all children under 18 years old across Greater Manchester are within the most deprived quintile. In 2018/19, 62% of deaths occurred in this group, which is similar to 2017/18 (61%). Eighty-two percent of all GM child deaths occurred within the two most deprived quintiles. This remains a significant health inequality.

2.0 Introduction

This is the 7th Annual Report of Child Deaths in Greater Manchester (GM). The current processes for reviewing child deaths were established in 2008 and have continued to develop year on year. This report focuses on the cases that were closed in GM for the year 2018/19 and will include data on the demographics of the cases, duration of reviews, causes of death, and potentially modifiable risk factors. These may vary across local authorities and CDOP areas reflecting the different make-up of populations across GM.

The aim of this report is take data from the four CDOP panels that cover GM and to make observations about causes of death and potentially modifiable risk factors. This would allow an evidence based discussion about how to promote child safety and reduce child deaths in GM.

3.0 Background

In 2004, the Children Act required each local authority to establish a Local Safeguarding Children Board (LCSB) to safeguard and promote the welfare of children in that area. Since 2008 the LCSBs have the statutory responsibility for the child death review process and in 2015 the government published Working Together to Safeguard Children 2015[1] which built on previous reports detailing how each LSCB must ensure that the CDOP carries out a review of the death of any child normally resident in that area. The purpose of the child death review processes is to gather information on how and why children die, look at potentially modifiable factors and try to put in place interventions to reduce future deaths.

[1] http://www.who.int/mediacentre/factsheets/fs178/en/

In GM there are four CDOPs set up to cover the LSCBs of the ten local authorities:

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

As the number of deaths for each area are small, combining the data from the four CDOPs allows for more detailed analysis as well as comparison between different areas of GM. There is well established co-operation between the local authorities in GM and this report is an opportunity to consider how GM as a whole can improve child health and child safeguarding and work together to reduce avoidable child deaths.

As this is the 7th year of the report, there is some limited trend data available.

4.0 Key findings for the UK

Infant, child and adolescent death rates in the UK have declined substantially since the 1980s with a 64% reduction since 1984 in England and Wales[2]. The infant mortality rate in England and Wales was lowest in 2014 (3.6 deaths per 1,000 live births), but increased to 3.9 per 1,000 live births in 2017[2]. Many of the causes and determinants of childhood deaths are potentially preventable[3]. Some areas of improvement are listed below.[4]

- The overall UK childhood mortality rate is higher than in some other Northern European countries.
- The key areas where the UK rates appear to be relatively high are infant deaths and deaths among children and young people who have chronic conditions.
- Injuries are the most frequent cause of death in children after their first year of life, and although unintentional injuries are the most common, the failure to reduce intentional injury and deaths by suicide among young people recently is also a pressing concern.
- Several reports have shown that health services do not always deliver optimal care for children and young people and lives may be lost as a result.
- There are marked social inequalities in death rates.

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[2] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2017

[3] http://www.who.int/mediacentre/factsheets/fs178/en/

[4] **Wolfe I, MacFarlane A, Donkin A, Marmot M, Viner R.** *Why children die: death in infants, children, and young people in the UK - Part A.* London : RCPCH, NCB, BACAPH, May 2014.

5.0 Overview of Greater Manchester population aged under 18 years

Table 1, below, demonstrates the population of children aged under 18 years in each GM borough.

Table 1: Number of children aged under 18 years in each area of GM and its overseeing CDOP (ONS Data 2018)	
CDOP	**Population Size**
Bolton, Salford & Wigan	**192,624**
Bolton	67,670
Salford	56,566
Wigan	68,388
Stockport, Tameside & Trafford	**169,451**
Stockport	63,141
Tameside	50,223
Trafford	56,087
Bury, Rochdale & Oldham	**155,247**
Bury	43,142
Oldham	59,416
Rochdale	59,416
Manchester	**121,962**
Greater Manchester	**646,011**

Source: ONS 2017

5.1 Ethnicity

We can use ethnicity estimates from the 2011 census and apply these to the 2019 mid-year population estimates for each local authority to tell us the breakdown of the under 18 population by ethnicity. This shows that nine of the local authorities in GM (all except Wigan) have a higher proportion of the population that identify as BME and lower proportion of the population that identify as White British than the North West average. Manchester has the highest percentage BME population and the lowest percentage White British population (see table 2, overleaf).

Table 2: Estimated population by ethnic group for GM local authorities, mid-2018 population data applying 2011 census ethnicity breakdown (source ONS)				
Area	**White British**		**BME**	
Bolton	46,895	69.3%	20,775	30.7%
Bury	34,600	80.2%	8,542	19.8%
Manchester	55,249	45.3%	66,713	54.7%
Oldham	36,125	60.8%	23,291	39.2%
Rochdale	41,056	69.1%	18,360	30.9%
Salford	44,574	78.8%	11,992	21.2%
Stockport	52,975	83.9%	10,166	16.1%
Tameside	41,836	83.3%	8,387	16.7%
Trafford	40,551	72.3%	15,536	27.7%
Wigan	65,447	95.7%	2,941	4.3%
Greater Manchester	459,309	71.1%	186,702	28.9%
North-West	1,309,303	84.3%	243,844	15.7%

Source: ONS 2019

5.2 Index of Multiple Deprivation (IMD)

The Index of Multiple Deprivation (IMD) data has not been updated recently, so the scores from 2015 are still currently used. For GM, 6 out of the 10 local authorities have higher IMD scores than the North West average, i.e. are more deprived than the average. These local authorities also have a higher proportion of their population living in the most deprived areas of the country than the North West average (see table 3). On this measure Manchester ranks as the most deprived local authority in GM with Trafford the least, with 41% and 3% of their respective populations living in the most deprived areas of the country.

Table 3: Average IMD 2015 score and percentage in the most deprived 10% for GM local authorities (source ONS)					
Current Code	**Former Code**	**Area**	**Average IMD 2010 score**	**Average IMD 2015 score**	**% of people in an area in most deprived 10%**
E08000003	00BN	Manchester	41.13	40.51	41%
E08000006	00BR	Salford	34.74	32.95	29%
E08000005	00BQ	Rochdale	33.85	33.68	28%
E08000004	00BP	Oldham	30.41	30.29	23%
E08000001	00BL	Bolton	30.46	28.42	20%
E08000008	00BT	Tameside	29.62	29.38	17%
E08000010	00BW	Wigan	26.01	24.85	14%
E08000002	00BM	Bury	22.23	21.76	10%
E08000007	00BS	Stockport	18.88	19.1	9%
E08000009	00BU	Trafford	17.05	15.38	3%

Source: Local Government and Communities

6.0 2018/19 Reviews by CDOPs

6.1 Closed Cases 2018/19

The four CDOPs in GM completed reviews of 204 child deaths between 1st April 2018 and 31st March 2019. Table 4 below shows the breakdown across GM by local authority and CDOP area.

Bolton, Salford & Wigan CDOP closed the most cases (64) whilst Stockport, Tameside & Trafford CDOP closed the fewest, with 40 closed cases. Looking at individual local authorities (LAs), Manchester closed the most cases (47) with Trafford the fewest (10). The number of closed cases in each area is not the same as the number of deaths that occurred in 2018/19. Of the 2018/19 cases closed, a number of these deaths will have occurred in previous years and it is likely that these were subject to investigation (such as criminal proceedings, or serious case review) which can delay the closure of the case by the CDOP significantly. Some of the deaths notified in 2018/19 will not be closed within that year, therefore the rate of closed cases for 2018/19 has not been calculated as they cannot be interpreted without more information.

Data from Public Health England's (PHE) child health profiles show a small decline in child mortality for GM since 2010. However there is not a clear trend for the whole of GM, with some areas showing a levelling off or an increase. Given the small numbers involved it is impossible to tell whether this is random variation, different data collection methods in different areas or a real effect. Longer term monitoring of the data is needed to establish whether there is an underlying trend.

Table 4: Number and percentage of deaths (cases closed) across GM 2018/19

LA	Total Deaths Closed	Percentage of overall GM deaths (cases closed)	Closed cases per 10,000 populatio
Bolton	33	16%	4.88
Bury	12	6%	2.78
Manchester	47	23%	3.85
Oldham	14	7%	2.36
Rochdale	27	13%	5.12
Salford	16	8%	2.83
Stockport	17	8%	2.69
Tameside	10	5%	1.99
Trafford	13	6%	2.32
Wigan	15	7%	2.19
Greater Manchester	**204**	100%	3.19
Bolton, Salford, Wigan	**64**	31%	3.32
Bury, Oldham & Rochdale	**53**	26%	3.41
Manchester	**47**	23%	3.85
Stockport, Tameside & Trafford	**40**	20%	2.36

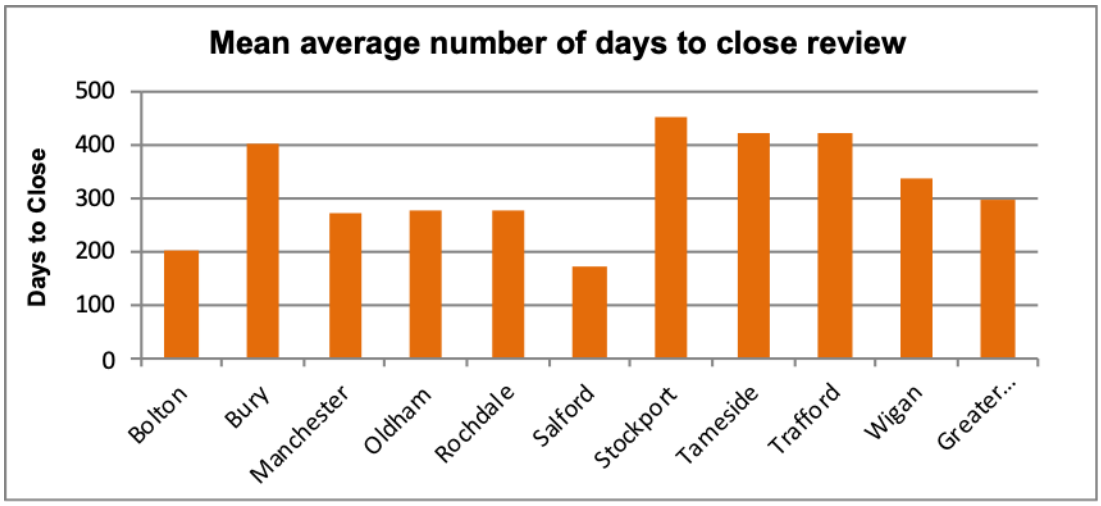
Source: GM CDOPs 2018/19

6.2 Duration of Reviews

The duration of a review is the length of time it takes from the date of notification of death until the review is closed and it is recorded as the number of days. Complex cases that involve agencies such as the Coroner or the Crown Prosecution Service (CPS) will take much longer to close as a CDOP will not review these cases until the relevant authorities have completed their investigations, such as a Serious Case Review (SCR). In these cases it can potentially take years for a case to be closed. There are other factors which can lead to variation in the length of time that different CDOP areas take to review cases; the amount of information that each CDOP requires before opening a review, the speed with which other local agencies notify the CDOP of the death and the time that it takes to gather all the of the relevant information from the external agencies involved.

During 2018/19 Bolton, Salford and Wigan CDOP closed the most cases (64). The longest duration of review was 2,328 days, with the shortest lasting 31 days. The average duration of review for 2018/19 was 297 days across GM.

Chart 1: Mean number of days to close a review (from date of death) by Local Authority (2018/19)



Source: GM CDOPs 2018/19

The different CDOP area is not the only factor that can affect the length of time a review takes. Nationally, it is recognised that cases with potentially modifiable factors, on average, take longer than those without[5] probably because these tend to be more complex cases that can require further investigation.

The cause of death can also effect the duration of the review, so a death involving trauma and other external factors is likely to require more extensive investigation and data collection than a death due to a chronic medical condition which may have been expected.

In 2018/19 the longest average duration of reviews was for Deaths by Suicide or Deliberate Self-harm (248 days), and then Chronic Medical Condition (238 days).

The shortest average duration of review was seen for deaths due to Infections (192 days), and then deaths due to Acute Medical or Surgical Conditions (203 days). This could reflect the fact that deaths in these categories are less likely to involve external agencies, and due to the nature of the deaths,

death certificates may be able to be completed and post-mortem examinations avoided. However, again the absolute numbers are small. All the data on average duration of review by category is summarised in Table 5 below. Categories which include less than 5 cases, and the next smallest category, have been obscured with an asterisk (*).

Table 5: Reviews completed in 2018/19 by duration of review and by category

Category	Closed cases	Average	Minimum days	Maximum days
a. Deliberately inflicted injury, abuse or neglect	*	223	0	2328
b. Suicide or deliberate self-harm	*	248	0	685
c. Trauma and other external factors	13 (6%)	214	0	798
d. Malignancy	16 (8%)	205	0	452
e. Acute medical or surgical condition	14 (7%)	203	0	917
f. Chronic medical condition	8 (4%)	238	0	738
g. Chromosomal, genetic and congenital anomalies	41 (20%)	207	0	562
h. Perinatal / neonatal event	66 (32%)	218	0	1784
i. Infection	17 (8%)	192	0	819
j. Sudden unexpected, unexplained death	20 (9%)	208	0	804

Source: GM CDOPs 2018/19

6.3 Notified Deaths 2018/19

The number of notified deaths across GM decreased in 2018/19 to 217 (from 250 in 2017/18), with Manchester having the highest proportion of these (26%) and Bury having the lowest (6%). Given the wide variation in population size for local authorities across GM it is necessary to adjust these figures to a rate before interpreting them. The rates of child death notifications per 10,000 of the under 18 year old population have been calculated to allow for meaningful comparison across GM.

In 2018/19 Manchester had both the highest crude number of notified deaths and the highest rate at 4.59 deaths per 10,000 <18 population. The next highest rates were seen in Oldham and Tameside with 3.53 and 3.38 deaths per 10,000 under 18 year old population respectively. Trafford had the lowest rate of notified deaths in GM for the second year in a row (2.67 deaths per 10,000 <18 population). It is hard to draw conclusions for the variation in child death rates across GM; it is notable that Manchester is the most deprived local authority in GM and Trafford the least, but the absolute numbers are sufficiently small that any variations could be due to chance.

Table 6: Number, percentage and rate per 10,000 of notified deaths across GM, 2018/19

LA	Total Deaths Notified (number)	Percentage of overall GM deaths	Population 0-17 yrs	Notified cases per 10,000 population
Bolton	22	10%	67,670	3.25
Bury	14	6%	43,142	3.25
Manchester	56	26%	121,962	4.59
Oldham	21	10%	59,416	3.53
Rochdale	17	8%	52,689	3.23
Salford	18	8%	56,566	3.18
Stockport	17	8%	63,141	2.69
Tameside	17	8%	50,223	3.38
Trafford	15	7%	56,087	2.67
Wigan	20	9%	68,388	2.92
Greater Manchester	**217**		639,284	3.39
Bolton, Salford, Wigan	**60**	28%	192,624	3.11
Bury, Oldham & Rochdale	**52**	24%	155,247	3.35
Manchester	**56**	26%	121,962	4.59
Stockport, Tameside & Trafford	**49**	23%	169,451	2.89

Source: GM CDOPs 2018/19

6.4 In-Year Closed Cases (by CDOP)

As previously discussed above, not all cases will be closed in the same year that the death was notified. In GM in 2018/19, 34% of cases were closed in the same year they were notified.

There are also geographical variations between the CDOP areas, in 2018/19 Bolton, Wigan and Salford closed the highest proportion of cases in year (45%) compared to Stockport, Tameside and Trafford which only closed 10% in year.

There is not a clear explanation for these rates of variation, it could be due to the number of cases subject to investigation, differences in how data is recorded in different areas over time, random variation or it might simply reflect how the complexity of the cases reported varies over time and place.

6.5 Causes of death

There are ten nationally defined categories that a CDOP can use when reviewing a death and each case must be assigned to one of these categories. It is a hierarchical list, so if more than one category could reasonably be applied, the highest up on the list should be given.

1. Deliberately inflicted injury, abuse or neglect
2. Suicide or deliberate self-harm
3. Trauma and other external factors
4. Malignancy
5. Acute medical or surgical conditions
6. Chronic medical condition
7. Chromosomal genetic and congenital anomalies
8. Perinatal/neonatal event
9. Infection
10. Sudden unexpected, unexplained death

Having nationally defined categories and standards makes it possible to compare CDOP data from across the country. The chairs and managers of the four GM CDOPs regularly discuss a small number of cases in order to ensure that all of the panels are applying the standards in a consistent way.

The majority of the 204 cases closed in GM in 2018/19, occurred in early life and resulted from events around the time of birth (perinatal/neonatal event) or from conditions which pre-date birth such as genetic and congenital anomalies. This is consistent with the previous year's findings.

6.5.1 Trend Data

In 2018/19, the greatest proportion of deaths occurred due to a perinatal/neonatal event (category 8) followed by chromosomal genetic and congenital anomalies (category 7).

The number of deaths falling into other individual categories are very small, meaning that there is too much variation from year to year to establish clear trends. The table below demonstrates trends in the category of death from 2013/2013 to 208/2019. Categories with small numbers (between 1 and 5) have been obscured with an asterisk (*). Where only one category has a count of between 1 and 5, the next smallest category during that year has also been obscured.

Table 7: Category of death by number and percentage for 2012/13, 2013/14, 2014/15, 2016/17, 2017/18, 2018/19

Form C Category	2012/2013		2013/2014		2014/2015		2015/2016		2016/2017		2017/18		2018/19	
a. Deliberately inflicted injury, abuse or neglect	*	*	*	*	*	*	0	0%	0	0%	*	*	*	*
b. Suicide or deliberate self-harm	11	4%	*	*	*	*	7	29%	6	3%	*	*	*	*
c. Trauma and other external factors	*	*	10	5%	14	5%	15	63%	16	7%	15	5%	13	6%
d. Malignancy	12	4%	20	9%	18	7%	15	63%	15	6%	20	7%	16	8%
e. Acute medical or surgical condition	16	6%	20	9%	*	*	12	50%	12	5%	11	4%	14	7%
f. Chronic medical condition	11	4%	12	6%	10	4%	11	46%	11	5%	16	6%	8	4%
g. Chromosomal, genetic and congenital anomalies	70	26%	50	23%	68	26%	56	24%	56	24%	67	24%	41	20%
h. Perinatal/neonatal event	97	37%	81	38%	97	37%	78	33%	78	33%	102	37%	66	32%
i. Infection	18	7%	*	*	12	5%	18	75%	18	8%	12	4%	17	8%
j. Sudden unexpected, unexplained death	20	7%	10	5%	19	7%	24	100%	24	10%	19	7%	20	9%

6.5.2 Cause of Death by Ethnicity

All closed cases in GM should have data recorded on their ethnicity. This is classed as either White British or Black and Minority Ethnic (BME). In GM as a whole, for the under 18 year old population, 75% identify as White British and 25% as BME[5].

The small numbers demonstrated in most of the categories prevent meaningful analysis, however, BME groups are over represented in both perinatal / neonatal events and chromosomal / genetic / congenital conditions, with 48% and 51% of deaths in these categories despite having only 25% of the population. The BME data is not further subdivided into different populations so it is not possible to tell if particular communities are more affected by these issues. However, consanguineous marriages are known to increase the risk of congenital abnormalities[7], so it may follow that communities where consanguineous relationships are more likely to take place may suffer a disproportionate burden of these cases. The increased risk of perinatal / neonatal events and chromosomal / genetic / congenital conditions does represent a clear health inequality for the BME population in GM.

6.6 Location of death

For the cases closed in 2018/19, 71% (145) occurred in hospital, this in part will reflect the high proportion of deaths from medical causes. The second most common location of death was the home (20% of cases (41)). There is some variation between local authorities across GM in terms of the proportion of deaths occurring in the home) but the absolute numbers are very small. In the case of deaths in the home, these end to represent either sudden deaths or those in children on an end of life pathway where families choose for their child to die at home.

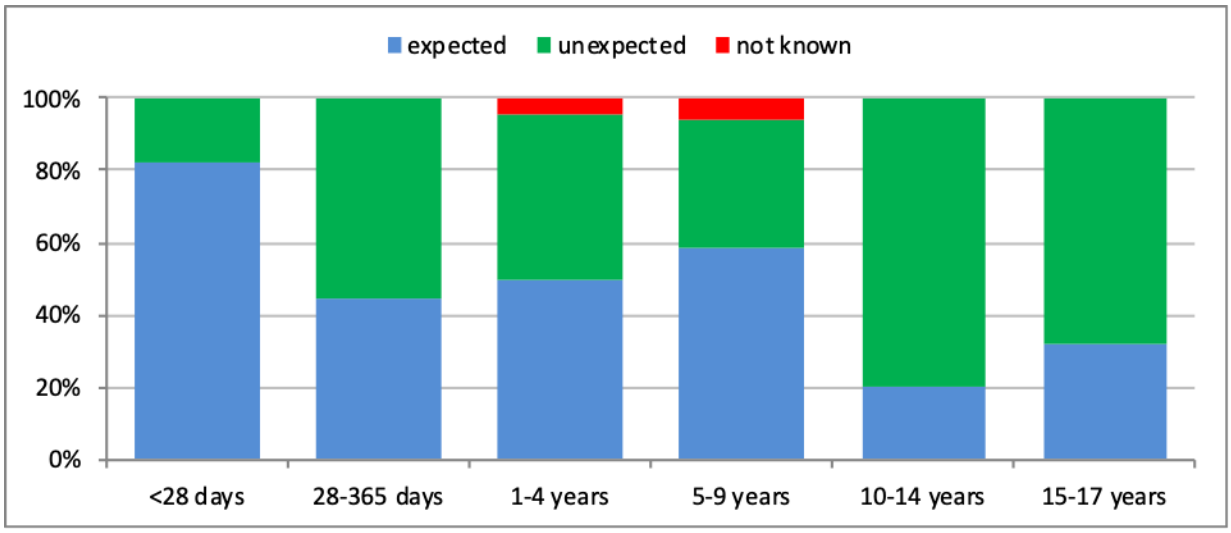
6.7 Expected verses unexpected deaths

Each CDOP will classify cases as either an expected or unexpected death. For 2018/19, 58% of cases were classified as expected, This is in line with the last 5 years, where the overall proportion of deaths categorised as ‘expected’ has remained stable (60-69%).

The proportion of deaths which are expected or unexpected varies across the age bands, with more expected deaths occurring within the neonatal period. This reflects the fact that deaths in the first year of life are often due to the complications of prematurity or from congenital conditions, whereas older children are more likely to be accidental or trauma related and therefore tend to be unexpected. However, in 2018/19 (similar to the year before), there was also a high proportion of expected deaths in the 1-4 year and 5-9 year age categories. It has been suggested that some improvements have been made in medical and social care of children with known life-limiting conditions, meaning more children may survive infancy and live longer. This may increase the overall population of children with these conditions, meaning numbers of deaths could stay the same but rates of death in that population may reduce. It may also lead to a change in the age breakdown of deaths of children with life limiting conditions.

[5] Source: ONS 2015 mid-year estimate and 2011 Census data

Chart 2: Percentage child deaths expected and unexpected by age group 2018/19



Source: GM CDOPs 2018/19

6.8 Potentially modifiable risk factors

In reviewing the death of each child, the CDOP considers factors which are potentially modifiable in a number of different domains (the child, the family and environment, parenting capacity, and service provision). Once identified, the CDOP can consider what action could be taken locally and what action could be taken at a regional or national level to prevent future deaths. The guidance defines potentially preventable child deaths as those in which modifiable factors may have contributed to the death. In line with the Department for Education, the CDOP categorises each case under one of the following:

1. **Modifiable factors identified**
   The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths

2. **No Modifiable factors identified**
   The panel have not identified any potentially modifiable factors in relation to this death

3. **Inadequate information upon which to make a judgement**
   NB this category should be used very rarely.

Nationally, the percentage of reviews which were closed and identified as having modifiable risk factors was 27%[6] in the year ending March 2017 (the most recently published data), which is an increase from 24% in 2014/15.

[6] 4. **Department of Education.** *Child Death Reviews – Year ending March 2017.* London : s.n., 2017

The CDOP analyses any relevant environmental, external, medical or personal factors that may have contributed to the child's death under the following headings.

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

3 - Factors identified that provide a complete and sufficient explanation for the death (This category will no longer exist in the new analysis forms).

Of the 204 cases closed across GM in 2018/19, there were modifiable factors identified in 79 deaths (39%), which is similar to the findings from 2017/18 (40%). There were approximately 89 different issues related to the 79 cases. Smoking was still the largest potentially modifiable factor (24 cases), followed by obesity (19). Access to health care or poor care management was the 3rd largest modifiable factor (11) followed by substance misuse (10).

Table 10, shows the proportion and number of closed cases in each CDOP in which modifiable factors were identified. In all CDOP areas apart from Bolton, Salford and Wigan, the proportion of cases with modifiable factors decreased slightly in 2018/19, which differs to the pattern seen last year where there was a slight increase in all areas. These statistics have to be interpreted with caution due to the small numbers involved.

There is an element of subjectivity in deciding whether modifiable factors are present or not which could explain some of the variation between the four CDOP areas. It is also possible that areas could change their approach over time. The variability seen from year to year in the different areas does not indicate a consistent trend, but the annual data reflects cases closed in that year, this will include deaths occurring over a number of years which could mask any change in approach over time.

Table 8: Percentage and number of child deaths in each CDOP area in which modifiable factors were felt to be present

CDOP Area	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Bolton, Salford and Wigan	39% (34)	28% (13)	26% (17)	38% (21)	34% (23)	35% (29)	44% (28)
Bury, Oldham and Rochdale	21% (15)	30% (17)	25% (20)	22% (16)	41% (21)	46% (33)	40% (21)
Manchester	29% (16)	20% (10)	18% (15)	29% (16)	27% (17)	34% (21)	32% (15)
Stockport, Tameside and Trafford	18% (10)	27% (17)	31% (25)	42% (21)	29% (14)	47% (27)	38% (15)

Source: GM CDOPs 2016/17

Modifiable factors identified by the CDOPs included (in order of frequency):

- Smoking
- Obesity
- Access to appropriate healthcare
- Substance misuse
- Unsafe sleeping
- Safeguarding
- Housing issues / home environment
- Gestational diabetes
- Domestic abuse
- Mental health
- Consanguinity

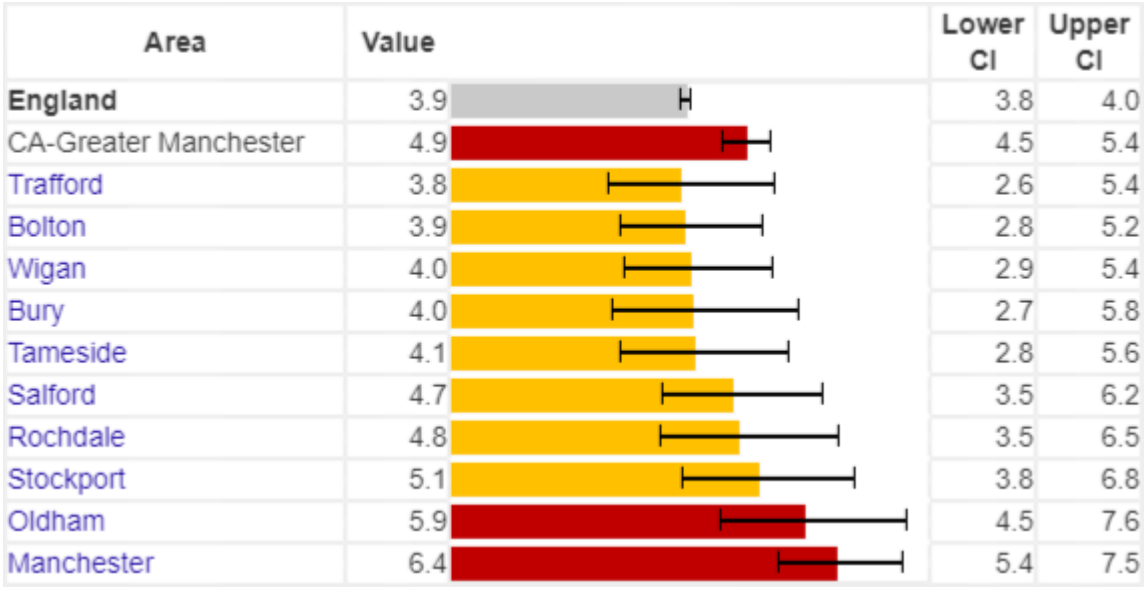
6.9 Neonatal and infant deaths

6.9.1 Infant Mortality Rates

Infant mortality rates are published by the Office for National Statistics, and are available publicly on the Public Health England Fingertips website[7]. These are crude rates, per 1,000 live births, so are likely influenced by population and demographic differences. Due to the small numbers involved, the figures for three years are combined into one. Chart 3 (overleaf) demonstrates the infant mortality rate in each Greater Manchester borough from 2015-2017.

[7] https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/3/gid/1938133228/pat/126/par/E47000001/ati/102/are/E08000008/iid/92196/age/2/sex/4

Chart 3: Infant mortality rate, per 1000 live births, by local authority, 2015-2017 (Source: Fingertips)



Area	Value	Lower CI	Upper CI
England	3.9	3.8	4.0
CA-Greater Manchester	4.9	4.5	5.4
Trafford	3.8	2.6	5.4
Bolton	3.9	2.8	5.2
Wigan	4.0	2.9	5.4
Bury	4.0	2.7	5.8
Tameside	4.1	2.8	5.6
Salford	4.7	3.5	6.2
Rochdale	4.8	3.5	6.5
Stockport	5.1	3.8	6.8
Oldham	5.9	4.5	7.6
Manchester	6.4	5.4	7.5

6.9.2 Overview of CDOP deaths by age

Across GM in 2018/19, 42% of all closed cases were neonates (under 28 days old) and 61% of all closed cases were infants (under 12 months old). This is similar to 2017/18 when the figures were 36% and 62% respectively. In previous years there has only been a small amount of variation in figures reported in the different age groups. The number of deaths is generally expected to reduce as age increases, and in GM the large majority of deaths were seen in the neonatal and infant categories with small numbers for all other ages.

6.9.3 Neonatal and Infant Categorisation of Death (0 – 364 days of life)

There were a total of 123 cases in this age category with around three quarters occurring in the first 28 days of life. The most common causes of death in the neonatal age group were Perinatal/neonatal event followed by Chromosomal, genetic and congenital anomalies and then Infection with 60, 14 and 6 cases respectively. There is however a different pattern of deaths between the two age bands. Unsurprisingly, perinatal/neonatal events was a far more common cause of death in neonates than older infants, with only 5 cases recorded over the age of 28 days. Sudden unexpected, unexplained deaths on the other hand were rare in neonates (<5 cases) but the most common cause of death in babies aged 28-364 days (15 cases).

Overall, congenital anomalies are the second most common cause of death for infants under 1 year old across GM, this reflects the situation for England as a whole. Nationally, congenital anomalies contribute approximately one third of the extra infant deaths experienced by lower socio-economic groups compared with the population as a whole, which is a clear health inequality[8].

[8] **National Perinatal Epidemiology Unit.** The contribution of congenital anomalies to infant mortality . Oxford : University of Oxford, 2010. Inequaliites in Infant Mortality Project Briefing Paper 4.

6.9.3 Gestation

Rates of infant mortality are higher in babies born prematurely compared to those born at term. In the majority of cases the excess deaths occur in the neonatal period, however, improvements in medical care mean that more premature babies are surviving the neonatal period. This has the effect of increasing the number of cases where prematurity is the cause of death recorded in infants up to 1 year old.

The categories of premature birth are:

- Extremely Premature (<26 weeks)
- Premature (26 weeks to <37 weeks)
- Full Term (37+ weeks)

Of the 85 neonatal deaths across GM, 59% (50) were in the extremely premature category with 21% (18) premature and 20% (17) at full term. This is unsurprising as gestational age has a significant effect on a neonate's chance of survival outside the womb and a foetus is not considered viable until after 24 weeks. (Please note, the numbers are not reported at local authority level as they are sufficiently low to be potentially identifiable.)

6.9.4 Low birth weight

Please note that this section refers only to cases closed that occurred when the child was less than 1 year old

Low birth weight (LBW) is recognised risk factor for infant mortality[9]. There are a number of risk factors for LBW including multiple births, smoking and maternal age, as well as gestation at delivery.

Of the infant deaths closed across GM in 2018/19 50% had a birth weight of less than 1500 grams, which is a slightly higher proportion than 2017/18 (47%). However, the data for this year is less complete than last year with no birth weight recorded in 2% of cases.

For the 161 deaths in the under 1 year age group, 69% had a birth weight of less than 2500 grams, which is higher than 2017/18 (63%).

Table 9: Birth weight categories (%)

	<1500g	1500g-2499g	2500g-3999g	4000g+	Not Stated
Greater Manchester	50%	19%	26%	3%	2%

Source: GM CDOPs 2018/19

[9] ONS (2015) Statistical bulletin: Childhood mortality in England and Wales: 2015.

6.10 Socio Demographic Characteristics

6.10.1 Age and Gender

The distribution of male and female child deaths is in line with recent years, with 60% of closed case deaths occurring in males (122) and 40% in females (82).

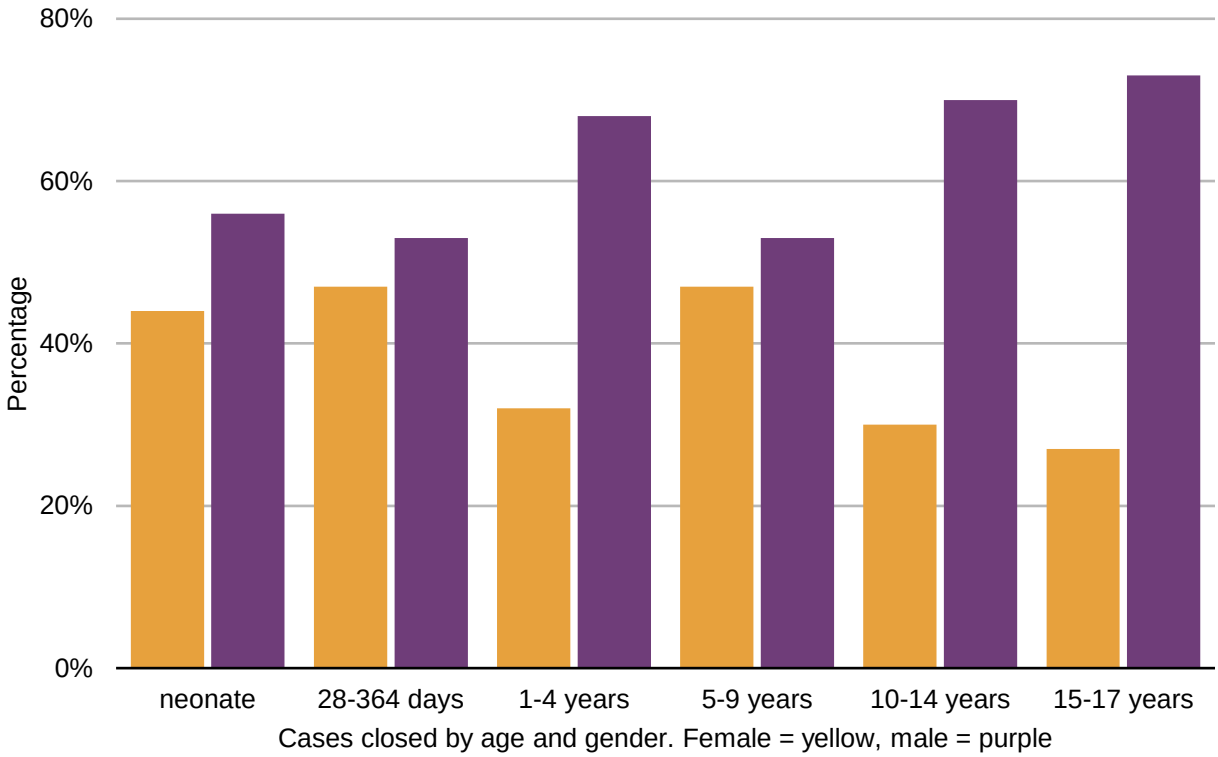
The difference in proportion of male and female deaths is most apparent in the 1-4, 10-14 and 15-17 age groups (see Chart 7). This differs to last year's data, when the gender difference was more pronounced in those aged under 1. Given the small numbers involved, it is possible that this change is due to random variation rather than a changing trend. Continuing to monitor the gender data going forward will be the only way to establish if this year is an anomaly in the longer term trend.

In the 15-17 age group in 2018/19, 38% of deaths in males were categorised as due to suicide or deliberate self-harm, compared to 17% for females in this age group. This is in line with national gender differences in suicide in the UK[10].

Looking at the gender data across local authorities, this pattern continues, as nine areas have more male deaths than female. However, the numbers involved are small.

Chart 4: Cases Closed by Age and Gender

Source: GM CDOPs 2018/19



[10] https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/

Table 10: Number of cases closed by gender by Local Authority 2018/19		
LA	**Males**	**Females**
Bolton	19	14
Bury	*	*
Manchester	26	21
Oldham	8	6
Rochdale	18	9
Salford	10	6
Stockport	10	7
Tameside	*	*
Trafford	6	7
Wigan	*	*
Greater Manchester	**122**	**82**

6.10.2 Ethnicity

Large inequalities in infant mortality rates exist between White and ethnic minority groups in England and Wales[11].

- Caribbean and Pakistani babies are more than twice as likely to die before the age of one as white British or Bangladeshi babies, in part due to a higher prevalence of preterm birth and congenital anomalies, respectively, in these particular groups.
- There is considerable heterogeneity between different ethnic groups in both the causes and the risk factors for infant mortality.
- Explanations for variations in infant mortality between ethnic groups are complex, involving the interplay of deprivation, physiological, behavioural and cultural factors.
- More research is needed in order to identify the pathways that lead to higher risks of infant death among black and other ethnic minority groups.

Nationally, reviews of deaths of children from a white background account for around two thirds of cases[12], which is higher than the proportion across GM in 2018/19, with 57% of in-year closed cases being from a white background. Ethnicity estimates have been calculated by applying total ONS mid-year population estimates for the <18 year old population to the ethnicity rate at the 2011 census for each area. As the estimate is specific to a particular year, the best measure of rates by ethnicity is looking at closed cases where notification was in the same year. This data is displayed in table 11

[11] Gray, R., Headley, J., Oakley, L., Kurinczuk, J. J., Brocklehurst, P. & Hollowell, J. (2009) **Inequalities in infant mortality project briefing paper 3.** Towards an understanding of variations in infant mortality rates between different ethnic groups. Oxford: *National Perinatal Epidemiology Unit.*

[12] **Department of Education.** *Child Death Reviews – Year ending March 2017.* London : s.n., 2017

below, along with the rates per 10,000 to account for varying population sizes. Please note, any potentially small numbers in a local authority area of between 1 and 5 have been labelled with an asterisk (*), to reduce any risk of identification.

This data indicates that 57% of in-year closed cases in 2018/19 were white (similar to previous years) and 43% were from BME populations. The data was reasonably complete, with five cases having no recorded ethnicity data. The proportion of BME cases is slightly higher than the national picture and indicates a substantial over-representation of BME populations in GM as BME groups make up only 25% of the under 18 year old population. Whilst differences in deprivation could account for some of this effect it is also possible that there are separate inequalities related to race such as additional barriers for BME women accessing antenatal care[13].

The inequality varies from area to area, so in Oldham, Trafford, Bolton and Rochdale, the child death rate was much higher amongst populations other than white British for 2018/19. However, this is not consistent year on year. Due to the small numbers involved, even small variations due to chance can make the figures look very different from one year to the next.

Table 11 : Cases closed by Ethnicity where date of notification occurred in year 2018/19

Local Authority	White		BME	
	Number	rate/10,000	Number	rate/10,000
Bolton	11	2.35	21	1.37
Bury	*	*	*	*
Manchester	23	4.19	24	3.34
Oldham	*	*	*	*
Rochdale	10	2.78	15	9.24
Salford	16	3.65	0	0.00
Stockport	*	*	*	*
Tameside	*	*	*	*
Trafford	*	*	*	*
Wigan	15	2.30	0	0.00
Greater Manchester	113	2.50	86	4.77

*Please note there were 5 cases where ethnicity was not recorded

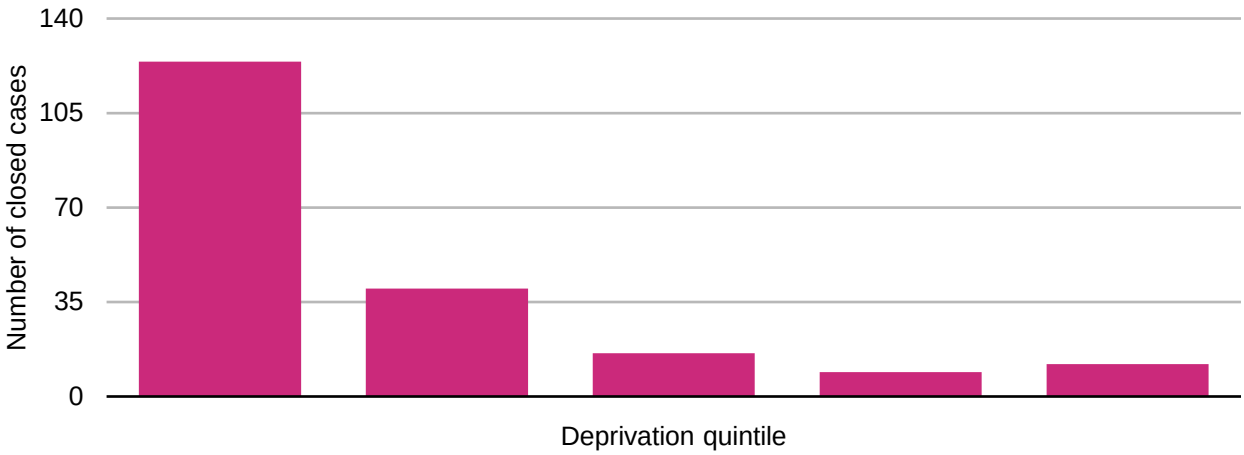
** The total number of deaths used in this table for GM was 199, excluding the 5 not recorded

[13] Hollowell. J, Oakley. L, Vigurs. C, Barnett-Page. E, Kavanagh. J & Oliver S. (2012) Increasing the early initiation of antenatal care by Black and Minority Ethnic women in the UK. Oxford: *National Perinatal Epidemiology Unit.*

6.10.3 Deprivation

The Index of Multiple Deprivation (IMD) is a widely used, area-based score that combines a number of markers to give an overall measure of deprivation. IMD across GM has been previously discussed in section 5.2. In Greater Manchester, 37% of the 0 to 18 population live in the most deprived quintile (quintile 1); in 2018/19, 63% of the child deaths in GM were from this quintile. This is similar to 2017/18, where 61% of child deaths were from this quintile. There is a consistent trend over recent years of higher rates of child deaths in the most deprived groups. Chart 5 shows the number of closed cases by deprivation quintile, demonstrating a much higher risk for those in the most deprived two quintiles.

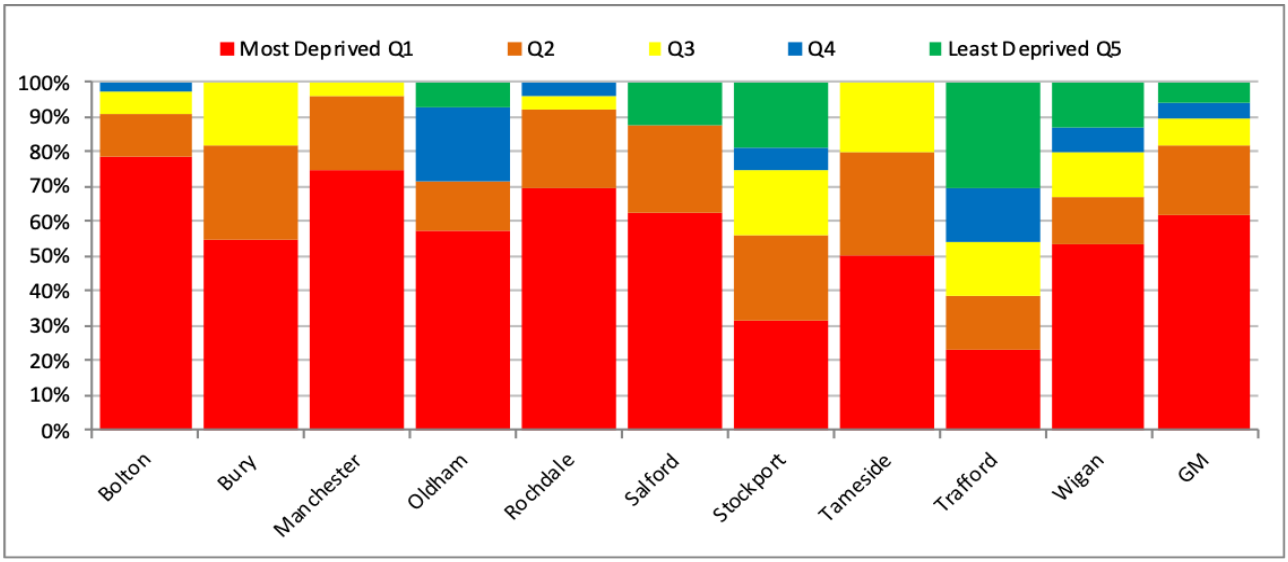
Chart 5: Number of cases closed by deprivation quintile 2018/19



Source: GM CDOPs 2018/19 & IMD 2015

Chart 6 below shows the average IMD score for each local authority and the number of closed cases. There is some variation but, generally, local authorities with higher (more deprived) IMD scores have higher numbers of closed cases. As this data is not adjusted for the different population sizes of these areas it can only show a potential correlation between deprivation and child mortality.

Chart 6: Proportion of closed cases 2018/19 and deprivation quintile by Local Authority



Source: GM CDOPs 2018/19 and IMD 2015

6.11 Smoking status of the mother

Whilst smoking is always hazardous to health, it is associated with worse outcomes in pregnancy for mother and child. These were described by the Royal College of Physicians[14] as an increased risk of complications in labour, as well as an increased risk of miscarriage, still birth, low birth-weight and sudden unexpected death in infancy. Maternal smoking is also estimated to increase infant mortality by approximately 40%[15].

Public Health England (PHE) uses smoking at time of delivery (SATOD) as a national measure to record rates of smoking in pregnancy. The most up to date figures available for this measure are from 2017/18[16] and show an average SATOD for England of 10.8% and 12.6% for Greater Manchester. The figures for GM show that 7 out of 10 local authorities are above the England average. This shows that smoking in pregnancy is a considerable problem for GM. Two of the areas in GM under the national average were the least deprived local authorities, Trafford and Stockport, which recorded rates of 6.7% and 10% respectively. This reflects that tobacco use is strongly linked to deprivation and constitutes another health inequality. However Manchester also had a rate of 10.7, which was just under the England average.

For 2018/19 smoking was deemed to be relevant in 23 closed cases for infants under the age of one year. This appears to be a decrease from 38 in 2017/18. The proportion of cases in which smoking was a factor ranges from 0-50% across the ten local authorities, demonstrating huge inter-borough variation, but the absolute numbers are small only ranging from 0-6.

6.12 Raised Body Mass Index

Maternal obesity is known to be associated with worse pregnancy outcomes and higher rates of stillbirth[17]. Maternal obesity is also strongly associated with socioeconomic deprivation, so mothers in more deprived groups are more at risk of these negative outcomes. Since 2015/16 data on maternal BMI has been collected for all cases where the child was aged less than 1 year old, and it was agreed that a BMI of over 30 should be considered as a modifiable factor in cases categorised as perinatal / neonatal deaths.

In 2018/19 there were 19 cases where maternal obesity was identified as a modifiable factor, this was second only to smoking (24) as a leading modifiable factor in GM. This is a decrease from 2017/18 where obesity was identified as a modifiable factor in 39 cases, but similar to the data in 2016/17. Given that there are rising rates of obesity nationally and across GM, it is important that this data continues to be gathered in future years so that the trend can be monitored. As with maternal smoking data, CDOPs should promote data collection requirements among front line professionals to try and capture as much health-related data as possible.

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[14] J R Coll Physicians Lond. **1992** Oct;26(4):352-6. **Smoking and the young**

[15] NICE Guidance PH26 (2010) Smoking: stopping in pregnancy and after childbirth. https://www.nice.org.uk/guidance/ph26/chapter/2-public-health-need-and-practice

[16] http://fingertips.phe.org.uk/search/smoking

[17] Maternal obesity in the UK: findings from a national project (2010) UK. Centre for Maternal and Child Enquiries

6.13 Other factors

6.13.1 Consanguinity

From 2015/16 it was agreed that to standardize recording between different CDOPs, consanguinity would be considered as a modifiable factor if a second child was born with genetic anomalies to consanguineous parents. In 2018/19, consanguinity was recorded as a modifiable factor in a small number of cases (<5), which was a decrease from last year (3%) and a decrease from 2017/18 (4%).

This is a sensitive and complex topic because some cultures have higher rates of marriage amongst relatives than others. It can be argued that different cultural attitudes to screening and termination of pregnancy may affect the rates of congenital anomalies[18,19], however given that not all of the conditions that the NHS screens for are fatal conditions (e.g. Down syndrome) this is unlikely to provide a full explanation of the difference. Some groups, such as women who are born outside of the UK, may experience additional barriers to accessing antenatal care and education and so may miss out on measures such as folic acid supplementation which can reduce the risk of some defects.

Parents from all social groups require genetic counselling services to be widely available for couples with a family history or past history of pregnancy affected by congenital anomalies[20] so that they have the information and support they need to plan their families.

6.13.2 Parental Alcohol/Drug Use

Alcohol and/or drug use by parents was identified as a potentially modifiable factor in just under 5% of cases (10) which is the same as last year (13). Although not always a direct risk factor, parental drug or alcohol use is associated (although not proven to be causal) with higher rates of sudden unexplained deaths in childhood and co-sleeping.

6.13.3 Co-sleeping

Co-sleeping was identified as a potentially modifiable factor in just under 4% of closed cases (8) across GM in 2018/19. This is a similar proportion of cases to last year (4%) however, co-sleeping persistently appears as a key modifiable factor in the years since this report began even if the numbers are small. This suggests that more parental education around safe sleeping for babies would be helpful to ensure that the key messages are understood and acted upon.

6.13.4 Domestic Violence

In GM, domestic violence and abuse was deemed a relevant modifiable risk factor in a small number of closed cases (<5) for 2018/19. This is similar to previous years. However, it is difficult to draw conclusions around trends with such small numbers.

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[18] Hawkins, A., Stenzel, A., Taylor, J., Chock, V. & Hudgins, L. (2012) Variables Influencing Pregnancy Termination Following Prenatal Diagnosis of Fetal Chromosome Abnormalities. *Journal of Genetic Counselling.* 22(2) pp. 238-248

[19] Gil, M., Giunta, G., Macalli, E., Poon, L. & Nicolaides, K. (2015) UK NHS pilot study on cell-free DNA testing in screening for fetal trisomies: factors affecting uptake. *Ultrasound in Obstetrics and Gynecology.* 45(1) pp. 67-73. DOI: 10.1002/uog.14683

[20] **National Perinatal Epidemiology Unit.** The contribution of congenital anomalies to infant mortality . Oxford : University of Oxford, 2010. Inequaliites in Infant Mortality Project Briefing Paper 4.

6.13.5 Access to Appropriate Healthcare

Access to appropriate healthcare includes a wide range of factors relating to the mother or child receiving appropriate medical and maternity care. This can include factors such as parents being unable or unwilling to seek medical help when advised, as well as failings within the system such as medical errors or factors around service provision. Access to appropriate healthcare was identified as a modifiable factor in 5% of cases (11) for 2018/19, which was similar to the numbers in 2017/18 (14).

7.0 Discussion and Conclusions

This report focuses on the cases reviewed and closed by CDOPs during 2018/19. The number of cases notified in 2018/19 is referred to but full details are only available to analyse for cases that have been closed. As the overall number of child deaths for GM is small compared to the size of population (204 closed cases for the whole of GM), all of the analysis has to be treated with some caution as variation between areas or over time may be due to chance.

Whilst the absolute numbers are small, each child's death represents many years of potential life lost and a huge loss to the family and community involved. There is a need to ensure that all those affected have access to timely and appropriate support services, including specific provision for bereaved children.

Both the number of closed cases and the number of notified cases have decreased slightly in 2018/19 compared to those from the year before. There is not a clear trend in the number of child deaths across GM over the last few years as the small variations seen from year to year can be explained by chance.

The large majority of child deaths in GM occurred in the first year of life; 42% of closed cases occurred in the first 28 days and 60% in the first 12 months. This is a decrease on last year, when deaths in infants aged under 1 year accounted for 65% of closed cases, but the main causes of these deaths remain the same. Most were due to events around the time of birth, perinatal or neonatal events, with the next most common issue being genetic or congenital conditions, which would have been present from before birth.

The older age groups: 1-4, 5-9, 10-14 and 15-17 account for 11%, 8%, 10% and 11% of deaths respectively, which does indicate a slightly wider spread of deaths throughout the age groups than in previous years, but the absolute numbers are too small to draw conclusions. From all the closed cases in 2018/19, most deaths (79%) were classed as 'medical' causes, i.e. acute medical, chromosomal, chronic medical, malignancy, perinatal / neonatal event or infection. Across GM 82% of neonatal deaths were expected, falling to 45% of infants aged 28-364 days. However, in children aged 10-14 years, only a small number of deaths were expected which reflects a greater number of deaths from unexpected causes, such as health-related causes of death and trauma in this age group. Overall, 79% of closed cases were attributed to medical causes. The high proportion of deaths relating to the child's health mean that the provision of high quality maternity and paediatric care across all the local authorities is essential and work needs to ensure services work together. Access to appropriate healthcare was listed as a modifiable factor in 11 of the closed cases from 2018/19 but this figure was higher in 2017/18 and should be considered, as deprived or vulnerable groups are likely to face greater barriers to accessing care.

The proportion of cases where potentially modifiable factors were identified has continued to remain above the national average, at 39% in Greater Manchester. Whilst potentially modifiable factors are not often directly causal, they reflect factors in the child's situation that make poorer health outcomes more likely and reducing potentially modifiable factors, such as parental smoking, for the population as a whole would be likely to reduce child mortality. This is why it is important to identify the factors associated with higher rates of childhood deaths, to try and reduce their prevalence in the population.

8.0 Recommendations

The following should be considered by each CDOP panel and the Public Health lead for children's health. A coordinated GM response is recommended:

1. This report means that there are now seven sets of data and analysis which are available to review and combine into an aggregate report. This should help to identify trends, and having larger numbers to work with should reduce the impact of random error in the data. This will be a large piece of work and will need greater resources than for the stand alone annual report, but it should be possible to identify a group of public health registrars to carry out this work.

2. Health inequalities in the distribution of child deaths remain a concern. The BME population remains at increased risk of childhood mortality and the proportion of deaths in the most deprived groups is consistently high. Although data is now being collected for more BME subgroups by CDOP panels, meaningful analysis may take several years as the small numbers involved would mean that aggregate will be required. However, further analysis on these subgroups should be conducted as it may help to identify further patterns and areas for intervention.

3. A higher proportion of deaths occurred in males (60%) compared to females (40%). Although the age at which this disparity was most apparent has changed since 2017/18, possibly due to the small numbers of cases involved, this may require further investigation. Suicide prevention, especially in males age 15-17, should be a public health and CDOP priority.

4. As in previous years, smoking remains a key modifiable factor for child deaths across GM, with the proportion of cases where smoking is identified as a relevant factor higher than the rate of smoking in pregnancy. This has been recognised in the Greater Manchester Population Health Plan which is putting in place a GM evidence-based approach to reducing smoking, particularly in pregnancy. CDOP data and action plans should be linked to this and allow an opportunity to review the impact of smoking on deaths through the in depth CDOP review process. Work to reduce smoking prevalence across Greater Manchester should continue.

5. GM CDOPs should consider any emerging evidence from other areas and from international research to identify any risk factors which have not received the focus that others have, including areas for future data collection and analysis. In particular, it may be worthwhile recording the relevance (1,2,3) for factors which are not (yet) on the national data analysis proforma but which CDOPs currently record, such as physical health or learning disability.

The above recommendations should be followed up at the next GM CDOP panel meeting and CDOP panels and public health leads should continue to conduct reviews and monitor the number of child death notifications.

Appendix 1: Summary of Gender, Ethnicity and Deprivation Data for 2018/19

Characteristic	Number of child deaths for Greater Manchester 2018/19	Greater Manchester <18 year old Population (%)
Sex		
Male	122 (60%)	51%
Female	82 (40%)	49%
Undetermined	0 (0%)	
Ethnicity		
Asian/Asian British	52 (25%)	White (72%)
Black/Black British	17 (8%)	BME (29%)
White British	109 (53%)	
Other/mixed	22 (10%)	
No data	<5 (<5%)	
Deprivation		Approximately 20% of the GM population live in the most deprived 10% quintiles
1 (most deprived)	124 (62%)	
2	40 (20%)	
3	16 (8%)	
4	9 (4%)	
5 (least deprived)	12 (6%)	
No data	<5 (<5%)	

Appendix 2: Population and number of cases closed by CDOP panel (2012/2013 - 2018/19)

Area	0-17 population 2016	Number of cases closed in 2012/13	Number of cases closed in 2013/14	Number of cases closed in 2014/15	Number of cases closed in 2015/16	Number of cases closed in 2016/17	Number of cases closed in 2017/18	Number of cases closed in 2018/19
Manchester CDOP	**119,825**	**56**	**49**	**61**	**56**	**64**	**62**	**47**
Bury, Oldham & Rochdale CDOP	**153,144**	**72**	**57**	**81**	**74**	**48**	**71**	**53**
Bury	42,879	20	13	17	17	11	14	12
Oldham	58,802	25	20	28	28	24	31	14
Rochdale	51,463	27	24	36	29	13	26	27
Bolton, Salford & Wigan CDOP	**189,634**	**88**	**48**	**66**	**56**	**68**	**83**	**64**
Bolton	66,918	43	17	20	12	23	23	33
Salford	54,881	27	12	19	23	21	27	16
Wigan	67,835	18	19	27	21	24	33	15
Stockport, Tameside & Trafford	**166,675**	**52**	**62**	**54**	**50**	**48**	**58**	**40**
Stockport	62,372	18	18	14	20	21	24	17
Tameside	49,349	16	15	25	14	16	16	10
Trafford	54,954	18	29	15	16	11	18	13
Greater Manchester	**629,278**	**268**	**216**	**262**	**236**	**228**	**274**	**204**

Bury Health and Wellbeing Board

Report Title	Bury System Board-Terms of Reference
Meeting Date	20th November 2019
Contact Officer	Margaret O'Dwyer, Director of Commissioning and Business Delivery
HWB Lead	Cllr Andrea Simpson, Deputy Leader, Cabinet Member for Health and Wellbeing

1. Executive Summary

Is this report for?	Information ☐	Discussion ☐	Decision ☒

Purpose of report:	To present the Terms of Reference for the Bury System Board for approval.
Key Actions:	Approve the Terms of Reference
What requirement is there for internal or external communication?	None
Assurance and tracking process:	The Bury System Board considered the Terms of Reference at their meeting on the 16th October 2019.

2. Introduction / Background

1. Introduction

1.1 The Transformation governance arrangements have recently been reviewed by the OCO and LCO which has resulted in the Bury Health and Social Care Transformation Board being replaced by a Bury System Board from October 2019.

1.2 The Bury System Board brings together key Partners across the Bury system with the intent to collaborate to bring about system wide change to achieve clinical and financial sustainability. The agreed goal will be to improve the life chances for the Bury population, by maximising the use of the 'Bury Pound'. The impact on Partners in respect to Bury decisions which change the current delivery of services and flow of resources will be recognised to ensure there continues to be a stable delivery system in Bury to achieve improvements to the health and well-being of our population.

1.3 The core functions of the Board are to:

i) ensure overall clinical and financial sustainability of the Bury Health and Social Care system within a context of reducing resources.
ii) provide system leadership to enable the transformation of health and social care in Bury at the same time as addressing significant service pressures.
iii) deliver a balanced health and social care system, which closes the financial gap

2.0 Governance arrangements

2.1 In line with existing governance and accountability arrangements, there is a need to ensure that the Terms of Reference for the Bury System Board are approved by the Health and Wellbeing Board and are reviewed on an annual basis (Please see Governance Structure at Appendix 1).

2.2 The Terms of Reference for the Bury System Board were considered at the System Board meeting on the 16th October 2019 and are recommended to the Health and Wellbeing Board.

2.3 A copy of the Terms of Reference are included at Appendix 2 of the report.

3. key issues for the Board to Consider

- The Terms of Reference reflect the existing governance arrangements in place.

- The Terms of Reference will be reviewed again in November 2020 in line with OCO/LCO governance structures. It was agreed that this date would be brought forward if required.

4. Recommendations for action

- That the Health and Wellbeing Board approve the revised Terms of Reference for the Bury System Board

5. Financial and legal implications.

If necessary please seek advice from the Council Monitoring Officer Jayne Hammond (J.M.Hammond@bury.gov.uk) or Section 151 Officer Mike Woodhead (Mike.Woodhead@nhs.net).

- None

6. Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

- None

CONTACT DETAILS:

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Date: 12th November 2019

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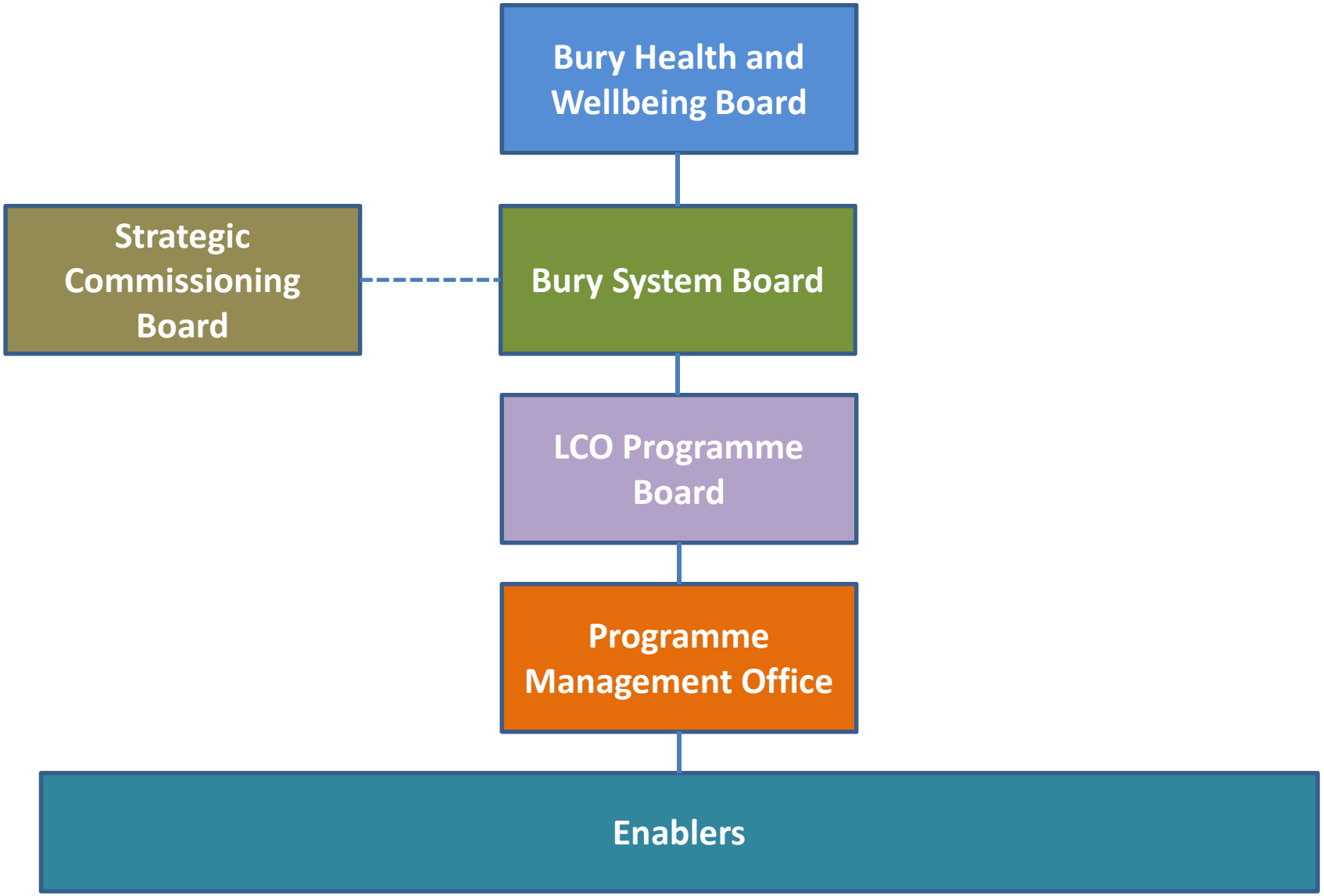
Transformation Governance



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NHS
Bury
Clinical Commissioning Group

F I N A L D R A F T

TERMS OF REFERENCE
BURY SYSTEM BOARD

Terms of Reference Document Control Sheet

MEETING	Bury System Board
ESTABLISHED BY/REPORTING TO:	
AUTHOR	Margaret O'Dwyer
REVIEW	November 2020.
ASSOCIATED DOCUMENTS	
RELATED COMMITTEES/GROUPS	

Document Control	
Document Name	Bury System Board Terms of Reference
File Name	
Version/Revision Number	Final Draft

Version Control

Version Ref	Amendment	Date Approved

1.0 Purpose

Bury refreshed Locality Plan set within the context of wider Public Sector Reforms reaffirms a vision to enable people to be active participants in their own well-being, to build thriving communities and to reduce demand for statutory services. There is recognition that system wide transformation is requested to support delivery of this vision at the same time as addressing significant pressures which challenge the on-going delivery of safe and sustainable services.

The System Board brings together key Partners across the Bury system with the intent to collaborate to bring about system wide change to achieve clinical and financial sustainability. The agreed goal will be to improve the life chances for the Bury population, by maximising the use of the 'Bury Pound'. The impact on Partners in respect to Bury decisions which change the current delivery of services and flow of resources will be recognised to ensure there continues to be a stable delivery system in Bury to achieve improvements to the health and well-being of our population.

2.0 Functions

The core functions of the Board will be:

i) To ensure overall clinical and financial sustainability of the Bury Health and Social Care system within a context of reducing resources.
ii) To provide system leadership to enable the transformation of health and social care in Bury at the same time as addressing significant service pressures.
iii) To deliver a balanced health and social care system, which closes the financial gap.

3.0 Objectives

i) To continue to oversee implementation of the Transformation Plans and receive progress reports which demonstrate impact and evidence that they remain within resources designated to them via the Greater Manchester Transformation Fund.
ii) To receive reports from the Health and Care Recovery Board, the Outcomes and Performance Group, the Local Care Organisation (LCO) Board, and the Transformation Fund Oversight Group (TFOG) which identifying areas for escalation for which the Board, working as a whole system, will agree solutions.
iii) To agree transformation plans and oversee implementation of a joint change programme between Bury and the Northern Care Alliance.
iv) To provide strategic direction and have oversight for the implementation of major service reviews, such as Urgent Care, which have the potential to impact on one or more Partners across the Bury system.
v) To consider and agree the future model of the LCO from April 2020, confirming the architecture required for the Alliance of Partners, the services within scope of the LCO and its resourcing.
vi) To agree the outcomes expected of the LCO delivery vehicle and the proxy metrics which provide assurance that improvements and progress are being made; and to receive regular reports to demonstrate this.
vii) To consider the outcomes required from community services now working within an integrated health and care delivery system; and to agree a procurement timeline and milestones to enable these services to be fully commissioned by July 2021.
viii) To oversee the on-going development of the One Commissioning Organisation; and to agree a trajectory to become true strategic commissioners; to agree the conditions and trajectory under which operational commissioning would be devolved to the LCO.
ix) To ensure that local people are considered and their views are taken into account

when the Board makes decisions about health and social care.

x) To provide a forum for partner agencies to negotiate solutions to any problems or conflicts.

xi) To model the cultural shift and new organisational behaviours which will underpin transformation and problem solving, working for the betterment of the Bury population and not to serve organisational self interest (see Appendix 1).

xii) To ensure the existence of an agreed coherent, system wide Programme approach to all aspects of the Board's agreed work plan.

xiii) To identify, mitigate and manage risks across services, captured through a Risk Register which is regularly reviewed.

xiv) To agree a Forward Plan for the Board which will identify regular items, future reports and key decisions to be made.

4.0 Delegated Authority

As a successor body to the Transformation Programme Board, the System Board will have authority to agree deployment of the remaining Transformation Funds in line with the Board's objectives to steer the whole Programme to fully mobilise and achieve designated outcomes.

5.0 Membership

5.1 Chair Bury CCG
Accountable Officer CCG/Chief Executive Bury Council
Chief Finance Officer, Bury CCG and Council
Clinical Directors (x2), Bury CCG
Director of Commissioning and Business Delivery, Bury CCG

Leader/Deputy Leader – Bury Council
Executive Director (Communities and Well-Being), Bury Council
Executive Director (Children, Young People and Culture), Bury Council

Chair, Bury LCO
Chief Officer, Bury LCO
Medical Director, Bury LCO
Director of Transformation and Delivery, Bury LCO
Director of Finance, Bury LCO
2x Board Members, LCO (1 to include Board Member for Mental Health?)
Chief Officer, Bury and Rochdale Care Organisation, on behalf of the NCA

Briefed Deputies with delegated authority to act as permitted to cover unavoidable absences. The Board Secretary is to be notified before the meeting if a Member intends to send a Deputy.

The Board shall be entitled to invite other managers or subject matter experts, with the Chair's permission, to attend for specific items to support the Board's decision making.

5.2 Chair

As leader for the Bury system, the Chair shall be either the Chair of the CCG or Leader of the Council/Deputy Leader of the Council. The Chair will rotate on a monthly basis with either party deputising for the other. In the event that neither can attend the CCG Accountable Officer/Council Chief Executive shall take the Chair.

5.3 Voting

The expectation is that decisions will normally be arrived at by consensus. If a vote is required, it will be weighted as follows:

2 votes for the OCO (excluding the Chair)
2 votes for the LCO

In the event of a tie, the Chair of the meeting will have a casting vote.

5.4 Quoracy

The meeting shall be quorate when there is a minimum of 7 Members consisting of:

i) An OCO Chair
ii) Two Members of the LCO
iii) Two Members of the OCO (not including the Chair?)
iv) One Clinical representative (who is not included in the OCO or LCO representatives at ii) and iii) above).
v) One Finance representative (who is not included in the OCO or LCO representatives at ii) and iii) above).

5.5 Frequency

The Board shall meet monthly with meeting dates circulated in advance for each financial year.

6.0 Accountability and Reporting

The Bury System Board is accountable to Partner organisations represented on the System Board.

The Bury System Board will report on key decisions to the Strategic Commissioning Board, the LCO Board, and the Health and Wellbeing Board.

7.0 Conduct of Meetings

7.1 The agenda and supporting papers will be sent out 5 working days in advance. Reports must be received by the Board Secretary in line with published deadlines.

7.2 The Board will be supported by a Board Secretary from the OCO who will be responsible for the production of minutes, action logs and decision tracking and maintenance of a formal record.

7.3 Presenters of reports can expect Board members to have read their papers and should keep to a short summary which outlines the purpose and key issues.

7.4 At the start of each meeting, the Chair will invite Board Members to declare all interests in relation to the current agenda and any conflicts of interest which may have arisen since the previous meeting.

7.5 The Chair shall decide, taking advice as required, on the materiality of each conflict and whether the conflicted party should participate in the discussion and/or vote, if one is required. The decision shall be documented in the minutes together with their reason.

7.6 Behaviours

The expected behaviours of Board Members shall be as set out at Annex 1. The key features are that we will have honesty, openness and trust at the heart of our discussions. We will play to our collective strengths with a “can do” attitude.

Disagreements will be resolved in a courteous manner with challenges managed in a mature way without blame. Recognising that we will get things wrong, we will develop a reflective culture, learn from our mistakes and most importantly work as a system to improve outcomes for our population.

8.0 Review

These Terms of Reference shall be reviewed annually, with the first annual review at November 2020.

Annex 1

Proposed principles for new ways of working between the LCO and the OCO for 2019/20

Introduction

This paper intends to outline to the System Board, the principles by which the LCO and OCO will abide, in its joint working in 2019/20 and beyond. These principles have been developed in collaboration with OCO and LCO Board members.

Our ambition

1. Our ambition for commissioning and providing services in a different way across Bury, is to improve the outcomes for our population of Bury and reduce inequalities, which will be understood at a population, system, function and service level , as is appropriate. The outcomes we measure will be developed in collaboration with our population, and with the strong involvement of the voluntary sector, building from our Team Bury single outcomes framework.

Our principles

2. Contracts for 19/20 will be rolled over from 18/19 as is, unless there is a good rationale for changes to be made, with a detailed service development plan agreed to align existing specifications and KPI's moving to an outcome based approach.

Our approach

3. Being light on meetings, but with a key focus on communication and relationships to ensure there are no surprises for either party.

4. Being quick to make decisions especially in relation to developing services, correcting shortcomings and faults and seizing opportunities. We wish to reduce the burden of assurance to take a more strategic approach, be more impactful and reduce the costs of administration and provision.

5. Delivery of the LCO will be assured in an integrated way across the domains of population health outcomes, performance, quality, user and staff experience and finance. We aim to improve the effectiveness of our system, by ensuring that interfaces between services are harmonious and optimised. We aim to devolve decision making as close to citizens and patients,as is appropriate, seeking greater opportunities for the involvement of our population. We aim to shift the balance of activity from and acute and residential services to community provision.

6. Being nimble to react to the decisions made at Greater Manchester regarding the commissioning of services at a GM level, and influencing GM with regard to the opportunities which exist from managing the market / procurement at a GM level.

7. Honesty, openness and trust in our discussions, which are focused on the people we serve. We aim to take to take a positive approach, playing to the strengths of both of our teams. We will always look for opportunities for change and implement solutions quickly, rather than focus on the reasons why things can't be done or changed. .Any disagreements will be stated transparently and courteously, with both parties committing themselves to resolve disagreements in a constructive & collaborative manner.

8. Promoting thinking and working differently, and supporting our teams to do the same. The LCO will be creative and innovative, and therefore will try some things that don't work. If the LCO is not doing this, we have the wrong model in the LCO. We will work together to manage these challenges together in a mature adult way without blame. We should encourage and welcome mistakes, so long as we collectively extract the learning from failures. We will develop a reflective, evaluative and learning culture across the Borough.

Our processes

9. A single dialogue will take place between the OCO and LCO for the purposes of monitoring in 2019/20 of Bury specific NHS services, and for contract negotiations in 20/21, to support the commissioning of outcomes for the population of Bury. For 20/21, we will look to include the broader spectrum of local authority commissioned services and CCG services commissioned from the third and voluntary sector, which may have not at present been included within the ' in scope ' conversations.

10. We recognise that detailed functional and service level reporting will be necessary in some circumstances to meet local, GM and national requirements. However, where this is required, commissioning resources will need to be deployed to where commissioning activities are taking place. We have a requirement to reduce the overall management costs in the economy, as part of establishing the new arrangements, however we recognise that this transition will take a period of time. Where possible, we will aim to use a single agreed dataset across parties , to build trust and reduce workload across organisations.

11. We recognise that separate negotiations will need to continue for PCFT MH specialist services, and the NCA at this point in time, due to the historic nature of the negotiation and monitoring of these contracts. That said, some of the outcomes regulated through NES arrangements, will also need to be included within the local Bury LCO/OCO conversation e.g. NEL admission rates. We will remain focused on the place rather than organisational self-interest. When the OCO and individual providers in particular, come under pressure from the regional and national NHS system to deliver to national performance targets, we will respond together to meet those requirements, in a way that focused on the people and place of Bury.

12. Where the OCO would wish the LCO to take on commissioning responsibilities on its behalf, the OCO will ask the LCO to formally identify a lead partner to take on these responsibilities. Communications to affected parties will be jointly agreed between the LCO and the OCO. As a principle, it will be assumed that the LCO as an entity takes on the responsibility of redesigning services which are defined as ' in scope', unless there is an alternative procurement process required, which will defined by the OCO, as and when required.

Kath Wynne-Jones
Interim LCO Executive
29th March 2019

Dr. Jeffrey Schryer
CCG Clinical Chair
29th March 2019

Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	04 November 2019	**Action**	Consider
Item No	9c	**Confidential / Freedom of Information Status**	No
Title	Commissioning review - Intermediate Care		
Presented By	Julie Gonda, Interim Executive Director of Communities and Wellbeing		
Author	Julie Gonda, Interim Executive Director of Communities and Wellbeing		
Clinical Lead	Howard Hughes, Clinical Director		
Council Lead	-		

Executive Summary

A savings proposal and financial update report was submitted to the CCG Governing Body meeting on the 28th August 2019.

The report proposed a number of schemes and service reviews for prioritisation and development in 2020-21 which was based on the work undertaken to date and discussions at the Clinical Cabinet and Professional Congress. It can be noted that savings targets have been attributed to these reviews in line with service redesign and delivery of value for money principles.

Attached is a copy of a scoping paper that has been developed in order to take forward the Bury system Intermediate Care review and rebalance.

The paper includes further details in relation to:

- Review objectives;
- Services in scope;
- Proposed project teams;
- Project sub structure;
- Required outputs;
- Key local reviews to be considered;
- Governance;
  - Key Inter-relationships;
  - Risks; and
- Engagement.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Note this report;
- Support progression of the proposal to business case for future consideration by Strategic Commissioning Board.

Links to Strategic Objectives/Corporate Plan	Yes
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	No
Add details here.	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☒	No	☐	N/A	☐
Are there any legal implications?	Yes	☒	No	☐	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☒
How do proposals align with Health & Wellbeing Strategy?	See attached brief					
How do proposals align with Locality Plan?	See attached brief					
How do proposals align with the Commissioning Strategy?	See attached brief					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?	See attached brief					
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?	N/A					
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐

Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☒	N/A	☐
Additional details	The equality Impact Assessment will be developed as part of the project – this will be an iterative document					

Governance and Reporting		
Meeting	**Date**	**Outcome**

Bury System Intermediate Care Review and Rebalance - Brief

1. Review Objectives

1.1 Rebalance Intermediate Care Services to -

- Align our services to Best Practice and Evidence;
- Deliver services efficiently and remove waste;
- Deliver Value for Money;
- Protect high quality estate;
- Improve experience;
- Increase the activity delivered;
- Extend the reach of our services;
- Deliver £2.6m savings from current spend by April 2020;
- Redesign to simplify service offer and pathways;
- Extend service areas/provision of Rapid Response service;
- Improve effectiveness and user experience.

2. Services in-scope of review:

- Bealey Community Hospital;
- Killelea Intermediate Care Unit;
- Reablement Home Support Service;
- Discharge to Assess beds;
- Short Stay residential care beds at Elmhurst and Spurr House;
- Integrated Discharge Services – Fairfield General Hospital (FGH), North Manchester General Hospital (NMGH) and Out of Borough.

3. Roles and Responsibilities

a) Senior Responsible Officer
- J. Gonda Executive Director Communities and Wellbeing

b) Project Team
- A. Crook Assistant Director Adult Social Care Operations
- L. Darley Director of Service Transformation
- D. Hawley Intermediate Tier Lead
- K. Sowden Managing Director Persona
- H Hughes Clinical Lead

c) Extended Support Team:
- Analytics – Sandy Firth
- Workforce – Caroline Beirne
- Finance – Mui Wan, Velma Livesey, Sue Hargreaves
- Commissioning – David Latham, Kirstin Lee
- Estates – to be identified
- Programme support – to be identified from LCO
- IT – to be identified

4. Outputs

4.1 A high-level outline service description and timeline for delivery and implementation will be delivered for the next Strategic Commissioning Board in December for implementation from April 2020 onwards.

- Benchmarking clearly illustrates that Bury is too reliant on bed-based services delivering too much of its activity in Bealeys, Killelea and its Discharge to Assess Beds. In addition, activity that would best be provided in an intermediate care setting is going to other short stay beds not set up for this purpose. This rebalance will see the location of where intermediate care is delivered focused more on people's own homes rather than beds and where beds are used they will be delivered in locations that are the most cost effective whilst delivering the best outcomes and experience;

- This rebalance will see clear activity expectations for our newly enhanced Intermediate Care at Home and Rapid Response services set and with it an increase in support to our urgent care system;

- In addition, a robust model for Integrated Discharge will be delivered to cover FGH, NMGH and our residents in out of Borough hospitals;

- Aspirational capacity levels required to deliver system balance will also be identified to compliment the Greater Manchester Adult Social Care Transformation programme of the same name.

5. Key Local Reviews to be considered:

- North of England Commissioning Support Unit System Balance Review – September 2019.

6. Governance

- The outcome of this review to report to the Strategic Commissioning Board.

7. Key Interdependency - Relationships

- Intermediate Tier Transformation Programme;
- Urgent Care Review;
- Review of Operating Model for Integrated Neighbourhood Teams.

8. Risks

8.1 There are several common risks with the delivery of schemes including: -

- Ensuring that all decisions including gateway decisions are made robustly based on clear and accurate information/ evidence;
- Ensure that changes to services are managed safely;

- The requirement to maintain pace to ensure that outcomes are delivered as soon as safely possible;
- The time over which organisational culture and public behaviour change takes to embed is not in line with the time required to become financially sustainable;
- There could be qualitative and quantitative unintended consequences;
- Some commissioning decisions required in the short term may not be in line with long term aims;
- Reconfiguration of services is likely to generate stranded costs that the system will need to bear in the short to medium term.

9. Stakeholder Engagement

9.1 It is critical that we work effectively with all stakeholders to ensure that service developments and changes are delivered safely, 'right first time' and at pace. This is achieved by having all stakeholders involved and contributing to the delivery of schemes through multi-disciplinary and multi-organisation scheme delivery teams.

9.2 Due to the complex nature of services, the risk of unintended consequences and the large web of interdependencies, an agile approach to delivering change will be adopted with clear gateways where:

- progress can be assessed;
- decisions to continue can be made;
- necessary changes to the approach can be made;
- communication about progress can be shared with stakeholders;
- impact assessments can be revisited as required.

9.3 A process will be agreed, and the progress will be monitored through the Health and Care Recovery Board (which reports to the Joint Executive Team) with regular updates to Strategic Commissioning Board, Clinical Cabinet and Professional Congress.

9.4 All relevant policies have and will be adhered to in this process e.g. decommissioning and engagement policies.

10 Timeline

10.1 The timeline is set out at Appendix A.

11 Actions Required

11.1 The Strategic Commissioning Board is asked to:

- Note this report;
- Support progression of the proposal to business case for future consideration by Strategic Commissioning Board.

Julie Gonda
Interim Executive Director of Communities and Wellbeing
October 2019

Bury Intermediate Care Review

Issues with current Intermediate Care provision	Service Review Aims	Methodology
Intermediate care in Bury requires clearer objectives and overall focus. A disproportionately high level of bed-based care that is financially unsustainable. Current intermediate care services are fragmented and provided inconsistently resulting in inefficiency. Some of our buildings are of lower quality. Some of our services are expensive when compared to others Services are not aligned to Best Practice. No Intermediate Care at Home Service. Rapid community response service is struggling to meet the level of demand and does not have the ability to manage complex health cases.	Building on the approved Intermediate Care Strategy further review the current commissioned service across health and social care to ensure that it meets the needs of service users in terms of capacity, performance and quality. Identify areas for development and improvements to benefit service users and enhance their experiences, and inform future commissioning Identify commissioning options to achieve a more sustainable Intermediate Care system. Develop plans for moving from 'as is' to 'new service model'	Refresh capacity and demand analysis Review finance contract and performance of existing services Process mapping the respite services pathways across health and social care. Stakeholder Analysis & Engagement Focus Group/Service User Engagement

DISCOVER

Milestone	Task	By whom	Date By
Project Governance	1.1 Define and agree project scope	JG/AC	Oct
	1.2 Establish Project Team	JG/AC	Oct
	1.3 Define and agree governance arrangements	JG/AC	Oct
	1.4 Develop and agree project architecture (inc risk register)	Project Team (PT)	Oct
	1.5 Decision to proceed from SCB	SCB	04-Nov
Intermediate Care provision	2.1. Identify how services are commissioned currently	PT	Oct/Nov
	2.2. Understand the current contractual process	PT	Oct/Nov
	2.3. Identify current value of commissioned activity/contracts. How is this managed?	PT	Oct/Nov
	2.4. Understand current assessment and acceptance criteria for IMC	PT	Oct/Nov
	2.5 Carry out estates review on existing provision	SEG	Oct/Nov
	2.6. Refresh capacity and demand analysis	PT	Oct/Nov
	2.7 Review finance contract and performance of existing services	PT	Oct/Nov
Respite provision	3.1. Identify how services are commissioned currently	PT	Oct/Nov
	3.2. Understand the current contractual process	PT	Oct/Nov
	3.3. Identify current value of commissioned activity/contracts. How is this managed	PT	Oct/Nov
	3.4. Understand current assessment and acceptance criteria for Respite	PT	Oct/Nov

		3.5 Carry out estates review on existing provision	**SEG**	**Oct/Nov**
		3.6. Refresh capacity and demand analysis	**PT**	**Oct/Nov**
		3.7 Review finance contract and performance of existing services	**PT**	**Oct/Nov**
	Integrated Discharge Service	4.1. Identify how services are commissioned currently	**PT**	**Oct/Nov**
		4.2. Understand the current contractual process	**PT**	**Oct/Nov**
		4.3. Identify current value of commissioned activity/contracts. How is this managed	**PT**	**Oct/Nov**
		4.4. Understand current assessment and acceptance criteria for IDS	**PT**	**Oct/Nov**
		4.5 Carry out estates review on existing provision	**SEG**	**Oct/Nov**
		4.6. Refresh capacity and demand analysis	**PT**	**Oct/Nov**
	Communication	5.1 Complete stakeholder analysis	**PT**	**Oct/Nov**
		5.2 Identify existing service user groups	**PT**	**Oct/Nov**
		5.3 Develop engagement plan	**PT**	**Oct/Nov**
DEFINE				
	Identify the Current Health Need of Service Users in Bury	6.1 Compare current commissioned service provision against statutory requirements and best practice and make recommendations on the findings.	**PT**	**Oct/Nov**
		6.2 Identify any gaps in service provision and make recommendations against these	**PT**	**Oct/Nov**
		6.3. Identify duplication across commissioned services and identify unmet need.	**PT**	**Oct/Nov**
	Work with the Local Authority and other partner organisations to scope future requirements	7.1. Identify redesign principles	**PT**	**Dec**
		7.2. Complete high-level model in line with redesign principles	**PT**	**Dec**
DECISION				
	Agreeing New Model	8.1 Share through governance arrangements and decision making, for new model services both within the Council and the CCG	**PT**	**Dec**
		8.2 Paper to SCB	**PT**	**Dec**
		8.3 Carry out public consultation	**OCO**	**Jan**
		8.4 Work with Providers to progress work	**PT**	**Jan/Feb**
MOBILISE				
	Develop an implementation plan	9.1 Commissioners to coproduce commissioning/decommissioning action plan as appropriate	**PT**	**Feb**
	Contract variation/New	10.1 Work with Providers to progress work	**PT**	**Feb/ Mar**

Contracts - OCO implications			
Mobilisation	11.1 Mobilise plan with timeline	**PT**	**Mar**
Go Live			**1.4.20**

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Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	04 November 2019	**Action**	Consider
Item No	9b	**Confidential / Freedom of Information Status**	No
Title	Commissioning Review - Learning Disabilities Respite		
Presented By	Julie Gonda, Interim Executive Director of Communities and Wellbeing		
Author	Kez Hayat, Programme Manager, Bury CCG Nasima Begum, Commissioning Manager, Bury CCG		
Clinical Lead	Dr Cathy Fines, Clinical Director		
Council Lead	Julie Gonda, Interim Executive Director of Community and Wellbeing		

Executive Summary

A savings proposal and financial update report was submitted to the CCG Governing Body meeting on the 28th August 2019.

The report proposed a number of schemes and service reviews for prioritisation and development in 2020-21 which was based on the work undertaken to date and discussions at the Clinical Cabinet and Professional Congress. It can be noted that savings targets have been attributed to these reviews in line with service redesign and delivery of value for money principles.

Attached is a copy of a scoping paper that has been developed in order to take forward the Bury Learning Disability Respite review.

The paper includes further details in relation to: -

- Review objectives
- Services in scope
- Proposed project teams
- Required outputs
- Governance
- Key Inter-relationships
- Risks
- Engagement
- Key Milestones & Timeline

Recommendations

It is recommended that the Strategic Commissioning Board:

- Note the content of this report and update provided;
- Support the next steps as outlined.

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations that will be affected been consulted?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☒	No	☐	N/A	☐
Are there any legal implications?	Yes	☒	No	☐	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☒	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐

Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☐
Additional details	The equality impact assessment will be developed as part of the project – this will be an iterative document					

Governance and Reporting		
Meeting	**Date**	**Outcome**

Review of LD Respite/Short Breaks

1. Introduction

1.1 The aim of this project is to undertake a review and redesign of respite services in Bury for people with a Learning Disability. This is with a view to commissioning an equitable and sustainable borough wide Learning Disability (LD) respite provision that meets the needs of service users. Current services give a lower quality experience in terms of meeting the needs of stakeholders as there is not a wide range of options for short breaks and respite. Issues include: lack of availability, consideration of value for money, limited choice and inconsistent allocation of nights available.

1.2 A savings proposal and financial update report was submitted to the CCG Governing Body meeting on the 28th August 2019. The savings target attributed to this work is £700,000.

1.3 This report provides the Strategic Commissioning Board with an update on progress against the Service Review of Learning Disability Respite/Short Breaks provisions commissioned by Bury Local Authority (LA) and the CCG.

1.4 This report highlights progress made to date against the action plan.

2. Background

2.1 Commissioning of LD respite/short breaks are undertaken separately by LA and CCG. As a result, there is a lack of shared detailed knowledge across the LA and CCG of the needs of the Learning Disability cohort. With the introduction of personalisation and personal budgets, people now have more choice and control over how they are supported to live their lives and be more independent.

2.2 There has been some good progress in Bury and people with a Learning Disability have started to have greater choice and control by having their own tenancies, gaining employment and being part of their wider community. However, we are aware there is more to do.

2.3 This review however, focusses on respite services across health and social care for both children and adults with learning disabilities. The review aims to:

- To ensure that it meets the needs of service users in terms of capacity, performance and quality.
- Identify areas for development and improvements to benefit service users and enhance their experiences and inform future commissioning.
- To commission an equitable and sustainable service.
- Improve outcomes for Service Users and their family where possible
- Achieve financial savings.

3. A Service Review LD Respite/Short Breaks

3.1 Working in partnership, the CCG and LA we will be reviewing LD Respite/Short Break

provision. The following methodology will be used:

- Analysis of activity, finance, contract and performance;
- Process mapping the respite services pathways across health and social care;
- Clinical Service/Quality Review;
- Carryout Quality Impact and Equality Impact Assessment

3.2 A Task & Finish Group has been established to undertake this work. The Group meet fortnightly and have the following in place:

- **Terms of Reference**
  - Governance - The Task and Finish group will report to the Joint Clinical Cabinet and Professional Congress.

  - Oversee review of current services and processes in partnership with the Local Authority and by engaging with providers and service users and their Carers/families.

  - Develop options for commissioning intentions for 2020/21 and possible options of pooled budgets.

- **Project Team**
  - Kez Hayat - Commissioning Programme Manager, Bury CCG
  - Cathy Fines – Clinical Lead (Children), Bury CCG
  - Nigget Saleem – Clinical Lead (Learning Disability), Bury CCG
  - Nasima Begum - Commissioning Manger, Bury CCG
  - Ruth Wheatley – Strategic Lead (Strategy and Commissioning), Bury Council.
  - Nicola Lee – Strategic Planning & Development Lead, Bury Council.
  - Deb Yates - Provider Relationship Manager, Bury Council.

3.3 Project lead will be Kez Hayat (CCG) and Julie Gonda (Bury Council) as the Senior Responsible Owner. In addition, the Group will co-opt members with specific knowledge when reviewing evidence submitted such as:

- Finance
- BI / analytics
- Workforce
- Estates

4 Associated Risks

4.1 Consideration of risks will be managed through a risk log, maintained by the project group. Key risks identified to date include:

- It is likely that any changes in service provision will impact on LA provided services (and vice versa) and therefore a full understanding of all services and their inter-dependencies is recommended before significant changes are implemented;
- In addition, any savings to be realized through de-commissioning of services

may be delayed due to the notice period within the current contract arrangements.

5 Engagement

5.1 A detailed engagement plan is currently being developed in respect of customers and other key stakeholders.

5.2 It is critical that we work effectively with all stakeholders to ensure that service developments and changes are delivered safely, 'right first time' and at pace.

5.3 An agile approach to delivering change will be adopted with clear gateways where:

- Progress can be assessed;
- Decisions to continue can be made;
- Necessary changes to the approach can be made;
- Communication about progress can be shared with stakeholders;
- Impact assessments can be revisited as required.

5.4 A process will be agreed, and the progress will be monitored through the Health and Care Recovery Board (which reports to the Joint Executive Team) with regular updates to Strategic Commissioning Board, Clinical Cabinet and Professional Congress.

5.5 All relevant policies have and will be adhered to in this process.

6 Key Milestones and Timeline

6.1 Key milestones are identified in the table set out at Appendix 1.

7 Decisions Required

7.1 The Strategic Commissioning Board is asked to:

- Note that the review of LD respite/short breaks provision is underway;
- Support the next steps to work in partnership with key providers to develop the provision of more equitable and flexible provision; and
- To note that any de-commissioning of services will have to be implemented in line with contractual arrangements which may delay the realisation of savings in full.

Nasima Begum
Commissioning Manager
Nasimabegum@nhs.net
October 2019

Appendix 1 : Learning Disability - Respite/short Break

Director: Julie Gonda
Programme Lead: Kez Hayat
Clinical Lead: Cathy Fines/Nigget saleem
Project Lead: Nasima Begum

Priorities, Scheme and Key Milestones	Lead	Supported By	Completion Date	Milestone Checkpoints (x)														
				Sep-19	Sep-19	Oct-19	Oct-19	Oct-19	Nov-19	Nov-19	Dec-19	Jan-20	Jan-20	Feb-20	Feb-20	Mar-20	Mar-20	Mar-20
1. Review Respite provision																		
Identify how services are commissioned currently - block contract or Spot purchasing	Kez Hayat	Nasima Begum	**Sep-19**		x													
Send Service Review Template to CCG commissioned Service Lead/Manager	Kez Hayat	Nasima Begum	**Nov-19**		x													
Understand the current contractual process - speak to CCG Finance	Kez Hayat	Nasima Begum	**Oct-19**		x													
Identify current value of commissioned activity/contracts. How is this managed	Kez Hayat	Nasima Begum	**Oct-19**		x													
Scope the LD respite services commissioned by the Council for both children and adults	Kez Hayat	Marie Thomson / Matt Logan	**Oct-19**		x	x												
Review current clients with CCP and Local Authority from both a clinical and social work	Kez Hayat	Nasima Begum	**Oct-19**				x	x										
Review Care Pathway	Kez Hayat	Nasima Begum	**Oct-19**			x												
Understand current assessment and acceptance criteria	Kez Hayat	Nasima Begum	**Oct-19**			x												
Develop detailed engagement plan	Kez Hayat	Nasima Begum	**Oct-19**				x											
Consider options available for those clients assessed as not meeting the criteria and whose budgetary arrangements would cover the use of alternative respite facilities	Kez Hayat	Nasima Begum	**Oct-19**							x								
Review packages to see if alternative respite arrangements suitable i.e. home from home, personal budget	Kez Hayat	Nasima Begum	**Nov-19**							x								
Clinical reassessment and social care review	Kez Hayat	Nasima Begum	**Nov-19**						x									
Explore arrangements where existing personal assistant and agency staff can support the CYP in a short stay placement.	Kez Hayat	Nasima Begum	**Nov-19**						x									
Review risks	Kez Hayat	Nasima Begum							x									
Set up risk register and mitigation plan	Kez Hayat	Nasima Begum						x	x									
Present service review finding to Task and Finish Group for comments and finalise report	Kez Hayat	Nasima Begum	**Nov-19**							x								
Produce a service Review Report for Clinical Cabinet, JET to consider options	Kez Hayat	Nasima Begum	**Nov/Dec**							x								
2. Plan integrated future service delivery / alternative service delivery models																		
Understand each organisation statutory responsibilities	Kez Hayat	**TBC**								x	x							
Understand what is delivered by commissioned services whilst not documented in service specifications.	Kez Hayat	**TBC**								x	x							
Understand what is commissioned (or otherwise made available) by other partners), including Voluntary and Community Sector	Kez Hayat	**TBC**								x	x							
Identify any gaps in service provision and make recommendations against these										x	x							
Identify duplication across commissioned services and identify unmet need.										x	x							
Identify opportunities for alignment/ streamlining across contracts for efficiency savings										x	x							
Identify any opportunities for virtual pooling of budgets										x	x							
Understand the Personal Health Budget and its impact on the current cohort										x	x							
Coproduce a model of care that is suitable for LD Service Users in Bury												x						
Service Specification developed												x						
Workshop for feedback												x						
co-produce service specification												x						
Put through governance arrangements and decision making, for new model services both within the Council and the CCG												x						
Carry out soft Market testing												x						

Meaningful engagement and Consultation with Service Users for developing and implementing new Model																		
Identify patient groups and invite to project group/engagement events												x						
Carryout engagement event with children and young people and their families												x						
Engagement with staff around new pathways												x						
Develop an implementation plan																		
Commissioners and Stakeholders to coproduce commissioning/decommissioning action plan as appropriate													x					
Consider requirements for Communication, Stakeholder involvement, projects steering Groups, Referral processes, reporting mechanisms													x					
Implementation risksreviewed													x					
Contract variation/New Contracts - LCO & OCO																		
Consider option for CV or going out to Tender														x				
Communication plan all stakeholders re decision														x				
Go live plan finalised														x				
Mobilisation																		
Implement Go live plan															x	x		