AGENDA FOR

HEALTH AND WELLBEING BOARD

Contact: Kelly Barnett
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To: All Members of Health and Wellbeing Board

Voting Members : Councillor Dorothy Gunther, Councillor Tamoor Tariq, Supt Suzanne Downey, Val Hussain, Julie Gonda, Lesley Jones, Barbara Barlow, Steven Taylor, Councillor Andrea Simpson (Chair), Sajid Hashmi, Dr Jeffrey Schryer and Councillor Eamonn O'Brien

Non-Voting Members :

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, 14 April 2021
Place:	Virtual via Microsoft Teams
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 MINUTES OF PREVIOUS MEETING *(Pages 5 - 10)*

4 MATTERS ARISING *(Pages 11 - 16)*

For information only - The terms of reference for the Health and Wellbeing Board were approved at the Council meeting on 17th March 2021.

5 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.

6 CHAIRS REMARKS

Councillor Simpson, Cabinet Member for Health and Wellbeing to provide a verbal update.

7 REPORTS TO BE RECEIVED BY THE HEALTH AND WELLBEING BOARD

a BURY INTEGRATED SAFEGUARDING PARTNERSHIP - ADULT SAFEGUARDING ANNUAL REPORT 2019-2020 *(Pages 17 - 60)*

Kathy Batt, Independent Chair to provide an update. Report attached.

b CDOP ANNUAL REPORT *(Pages 61 - 170)*

Dr Rebecca Fletcher, Chair of Bury, Rochdale and Oldham Child Death Overview Panel to provide an update. Reports and presentation attached.

8 DEVELOPING THE POPULATION HEALTH SYSTEM FOR BURY

a RECAP ON OUTPUTS AND NEXT STEPS FROM THE HEALTH INEQUALITIES WORKSHOP

Lesley Jones, Director of Public Health to give a verbal update.

b OUTCOME AND PERFORMANCE - PROGRESS ON DEVELOPMENT OF THE FRAMEWORK AND MEASURING INEQUALITIES

Lesley Jones, Director of Public Health and Helen Smith, Performance and Intelligence Manager to provide a verbal update.

c QUADRANT UPDATE *(Pages 171 - 210)*

- Elective Care 'Building Back Better' – Presentation provided by Ian Mello, Director of Secondary Care Commissioning, Bury CCG and Penny Martin, Director of Operations Northern Care Alliance NHS Group. Presentation attached.

- Developing Neighbourhood Health Improvement Plans – Presentation provided by Jon Hobday, Consultant in Public Health and Lesley Jones, Director of Public Health. Presentation attached.

- Wider Determinants of Health: Work, Employment and Skills report provided by Tracey Flynn, Unit Manager - Economic Development. Report attached for information only.

- Social Prescribing Support for Health and Social Care – presentation provided by Sajid Hashmi, Acting Chief Officer Bury VCFA. Presentation attached.

9 COVID 19 UPDATE

Lesley Jones, Director of Public Health to give a verbal update.

10 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: 18 November 2020

Present: Councillor A Simpson (in the Chair)
Councillors D Gunther, T Tariq and E O'Brien.

Will Blandamer, Executive Director for Strategic Commissioning, Ruth Passman, Chair Bury Healthwatch, Sheila Durr, Director of Children's Services, Julie Gonda, Director of Community Commissioning across the Council and CCG and Director of Adult Social Services, Lesley Jones, Director of Public Health, Sharon McCambridge, Chief Executive of Sixtown Housing, Tyrone Roberts, Director of Nursing, Sajid Hashmi, Chair of Bury VCFA, Dr J Schryer, Chair of Bury CCG and Sue Downey, Police Superintendent Bury

Also in attendance: Bruce Holborn, Local Campaigns Manager
Alison Bunn, Greater Manchester & Lancashire Area Manager for the British Legion public Health Bury Council
Jon Hobday, Consultant in Public Health
Francesca Vale, Public Health Nutritionist.

Public Attendance: No members of the public were present at the meeting.

Apologies for Absence: None

HWB.322 APOLOGIES FOR ABSENCE

Apologies are noted above.

HWB.323 DECLARATIONS OF INTEREST

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

Councillor Tamoor Tariq declared that he is employed as the manager of Oldham Healthwatch.

HWB.324 MATTERS ARISING

It was agreed:

1. There were no matters arising.

HWB.325 MINUTES OF PREVIOUS MEETING

It was agreed:

That the minutes of the meeting held on the 30th September 2020 be approved as a correct record.

HWB.326 PUBLIC QUESTION TIME

There were no public questions.

HWB.327 LONELINESS AND SOCIAL ISOLATION IN THE ARMED FORCES COMMUNITY

Bruce Holborn, Local Campaigns Manager and Alison Bunn, Greater Manchester & Lancashire Area Manager for the British Legion attended to provide an update on loneliness and social isolation in the Armed Forces Community.

The Legion is calling on all local authorities in England to improve the measures they take to support members of the Armed Forces community who are feeling lonely or socially isolated. Specifically, by including loneliness and social isolation and its effects on the Armed Forces community in Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS).

Loneliness and social isolation are recognised as a national health priority, and Legion research has shown that the Armed Forces community can be more vulnerable to its effects.

The wider impact of Covid-19 and the lockdown specifically are still being analysed but early indications from the Mental Health Foundation indicate a significant increase in feelings of loneliness in the UK. In March 2020, 10% of UK adults said they felt lonely, increasing to 24% by the beginning of April 2020, and calls to the Legion's own Telephone Buddies service increased by 455% over this summer. It is therefore incredibly timely to consider additional measures to alleviate loneliness and social isolation and acknowledge it as a public health priority.

Referrals to the service are through self-referrals, however asking questions earlier on can support individuals to stop reaching a crisis point.

It was agreed:

1. Include loneliness and social isolation and its effects on the Armed Forces community in the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS).

2. Help members of the Armed Forces community find appropriate support when it is needed by ensure that all residents approaching health services are asked a question that will identify:

    - Former members of HM Armed Forces, Regular and Reserve
    - Spouse or Partner of serving or former members of HM Armed Forces
    - Widow(er)s of serving or former members of HM Armed Forces
    - Dependent children of serving or former members of HM Armed Forces
    - Recently divorced or separated spouses or partners of serving or former members of HM Armed Forces.

3. Councillor O'Brien to raise this and incorporate this into the Armed Forces Covenant which is being reviewed.

4. To note that free training can be provided to front line staff.

HWB.328 OUTCOME AND PERFORMANCE REPORT

Lesley Jones, Director of Public Health provided an update on the outcome and performance report.

Work is underway to develop a new outcome and performance framework for the Health and Wellbeing Board however there have been some capacity constraints due to Covid-19

Lesley discussed the submitted slides which provides an overview of some to the key indicators being considered. These indicators have informed the strategic priorities for population health previously agreed by the Health & well-being Board Strategic Commissioning Board

The overarching indicators and Life-course approach is used to monitor how the four 'King's Fund dimensions' of Population health come together to impact on health across our population. Discussions took place regarding the inequalities that have been heightened through the COVID-19 pandemic including access and utilisation of services.

Furthermore the board discussed how to engage with a community representative of the Bury Borough so that lived experience is more prominent in the discussions.

It was agreed:

1. To agree the approach going forward
2. To engage with people to attend the meeting to provide lived experiences at the Board.

HWB.329 COVID-19 UPDATE

Lesley Jones, Director of Public Health provided a verbal update on COVID-19.

Since the last board cases significantly increased to around 600 per 100 thousand and have since decreased to around 460 per 100 thousand which is important and the reductions are likely to be a result of the Tier 3 restrictions.

Seven local neighbourhood test centres are now open and lateral testing will shortly be made available. We are actively preparing for the COVID-19 vaccine once available.

It was agreed:

1. Lesley Jones, Tyrone Roberts, Will Blandamer and Dr Schryer be thanked for their updates.

HWB.330 HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

Will Blandamer, Executive Director for Strategic Commissioning provided a report on the draft Terms of Reference for the Health and Wellbeing Board. The aim is to widen the membership and focus the Board on the Population Health quadrant.

Discussions took place surrounding the current membership and it was agreed that more opportunities to co-opt and invite members to the board should be explored.

It was agreed:

1. To Refine and refresh board membership as required, in line with the Whole System Transformation agenda for Bury.
2. For full Council to approve the proposed Terms of Reference.

HWB.331 ANTI- POVERTY STRATEGY

Joh Hobday, Consultant in Public Health attended to provide a presentation and report on the Anti-Poverty Strategy.

Since March 2020 COVID has had a significant impact on local towns and communities within Bury. We have had increased numbers in Bury who have been furloughed and lost jobs, and as such have seen significant rises in the numbers of people trying to access support and benefits. Data from our recent local business surveys in October 2020 suggest that in Bury 70.5% of businesses had furloughed staff. Through our community groups we have also seen

- An increased number accessing food banks / food pantries and other support
- A new and different demographic of people requiring support i.e. the previously comfortable middle class who are suddenly out of work with mortgages and bills
- Increased debt and mental health related problems
- An increase in the numbers asking for help to understand and access what benefits they are entitled to

A range of support mechanisms have been set up or increased since March including:

- Increased welfare and hardship support made available
- Further investment to improve Citizen Advice offer
- Financial support to support food banks
- Development of the Bury Community Support network
- A Free school meal offer during school holidays
- A mechanism to effectively identify and distribute external funding and donation opportunities in a systematic way across the borough
- Increased partnership working between VCSE organisations and the community hubs to support those with financial difficulties

Next Steps

The plan going forward is to

- Work with the community to further develop the Bury Community Support Network (BCSN) to be an effective forum to drive anti-poverty related work
- In collaboration with BCSN refresh and update the existing anti-poverty strategy for Bury, which will have a robust action plan of delivery behind it
- Continue to use intelligence and feedback to shape delivered and commissioned services which impact the anti-poverty agenda e.g. support around revenues and benefits, employment, fuel poverty, housing and economic development and regeneration
- Firm up the longer term local delivery plan for supporting children with free school meals during school holidays – given central government's recent decision to fund free school meals during holidays

It was agreed:

1. To thank Jon Hobday for his update
2. To note the progress of the anti-poverty work
3. To endorse and support the ongoing work in this area
4. To support and endorse the next steps

HWB.332 FOOD & HEALTH STRATEGY

Francesca Vale, Community Nutritionist attended to make the Board aware of the creation of the Bury Food Strategy, and approve the adoption of the strategy for use in Bury.

The Bury Food Strategy aims to dovetail with the national and regional approaches to the food system and tailor these to suit our local population. Our local approach will focus on multi-agency collaborative working to improve our food environment.

A key output of the strategy will be to set up a Food Partnership in Bury, formed by a wide range of stakeholders to drive the food agenda forward and deliver on the Action Plan.

Adoption of this strategy will require collaboration both internally and externally, across a broad range of actions encompassing the whole food system in Bury. These are detailed in the strategy action plan, and will require time, capacity and resource to achieve.

This is a strategy for the next five years, and will evolve in response to the wider public health landscape over that time, in response to the work of all partners.

Councillor Morris and Councillor Gunther expressed an interest in providing a leadership role for the Strategy.

The Health and Wellbeing Board all agreed the Strategy is a great piece of work and wanted to support the strategy in their own work places.

It was agreed:

1. To thank Francesca for her update.
2. To note and comment on the Bury Food Strategy
3. To approve the adoption and implementation of the Bury Food Strategy
4. To support the strategy as outlined in recommendations for action
5. Councillor Morris and Councillor Gunther to be the Bury Food Strategy Lead's from the Health and Wellbeing Board

HWB.333 HEALTH CHECKS

Lesley Jones, Director of Public Health provided an update on health checks. Bury has achieved the highest proportion of eligible people in the country receiving their NHS health checks. This work helps to address inequalities in the short term.

The Board discussed the great work that has taken place and areas for future focus.

It was agreed:

1. To bring this back to a future meeting
2. To place on record a thanks to GP practices in Bury for the work along with the integrated team work

HWB.334 CARE HOME VISITS

A discussion took place regarding Bury's approach to Care Home visits arrangements.

It was agreed:

1. This can be picked up outside the meeting with Julie Gonda for further development when appropriate.

COUNCILLOR A SIMPSON
Chair

(Note: The meeting started at 6.00 pm and ended at 8.00 pm)

HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

1. VISION

The Health and Wellbeing Board will work with partners and communities and residents to galvanise all effort to improve health and wellbeing, and reduce health inequalities to ensure that all people have a good start and enjoy a healthy, safe and fulfilling life.

The Health and Well Being Board recognises the Bury 2030 ambition to significant reduce internal health inequality (measured by life expectancy and healthy life expectancy) in the borough, and between the borough and the England average, by 2026.

2. MEMBERSHIP

Membership of the Health and Wellbeing Board will be made up of leaders across the NHS, Social Care, Public Health, Wide Public Services and other services directly related to Bury operating as a Population Health System

Core voting members:

- Cabinet Member, Health and Wellbeing (Chair)
- A nominated representative from the voluntary sector
- Cabinet Member, Children and Young People
- Additional Labour Cabinet Member
- Deputy Cabinet Member, Health and Wellbeing and Public Health Lead
- Shadow Cabinet Member, Health and Wellbeing
- Executive Director of Children and Young People
- Executive Director for Strategic Commissioning
- Director of Community Commissioning across the Council and CCG and Director of Adult Social Services
- Director of Public Health
- Two nominated representatives from the Clinical Commissioning Group
- A nominated representative from Bury Health watch
- A nominated representative from Greater Manchester Police
- A nominated representative from Greater Manchester Fire and Rescue.
- A nominated representative from Northern Care Alliance

- A nominated representative from the Local Care Organisation
- A nominated representative from Pennine Care NHS Foundation Trust.
- A nominated representative from SixTown Housing

The Board may also decide to co-opt/invite by invitation additional members to advise in respect of particular issues. These may include representatives from:

- Lead Member for Public Health
- Six Town Housing
- NHS England;
- North West Ambulance Service;
- GM Police;
- Clinicians;
- Coroner;
- other provider organisations/government agency/representatives from the Charity sector.

The Health and Wellbeing Board can, once the board is established, in agreement with full Council, appoint additional members to the Health and Wellbeing Board (Section 194, Health and Social Care Act).

3. FUNCTION

The Health and Wellbeing Board will be a strategic forum to ensure a coordinated commissioning and delivery across the NHS, Social care, public health and other services, directly related to health and wellbeing.

The Health and Wellbeing Board will determine, shape and implement key priorities and integrated strategies to deliver improved health and wellbeing outcomes, for the whole of the population of Bury.

The Health and Well Being Board will undertake its ambition for population health improvement and a reduction in health inequalities, using the Population Health System Model for the Kings Fund (2018). In particular the agenda will reflect the 4 quadrants.

- Wider Determination of Population Health
- Behavioural and Lifestyle determinants of health
- The effect of place and community on health and well being
- the operation of the health and care system, and wider public service reform, in pursuit of population health gain

4. KEY RESPONSIBILITES OF THE BOARD

- To provide Strong Leadership and a governance structure for local planning and accountability of Population Health and Care related priorities and services.

- To assess and understand the needs and assets of the local population and lead the statutory integrated strategic needs assessment (JSNA).

- Agree annual strategic priority outcomes for JSNA needs assessments, ensure plans are in place and actions and recommendations are monitored and followed up.

- To promote integration and partnership working and build strong stakeholder relationships across areas through promoting joined up commissioning plans across the NHS, social care and public health.

- To develop a Joint Health and Wellbeing Strategy to provide the overarching framework for commissioning plans for the NHS, social care, public health and other services the Board agrees to consider.

- To review major service redesigns of health and wellbeing related services provided by the NHS and Local Government. Providing critical challenge and strategic steer

- Receive exception reports, manage risks and resolve issues from other strategic groups, challenge performance and provide strategic steer where relevant. To challenge and support joint commissioning and pooled budget arrangements, where all parties agree this makes sense.

- Oversee effective and appropriate community engagement, involvement and consultation with regards to health and wellbeing priorities, to ensure strategies and service redesign reflect the views of local people, users and stakeholders.

- Provide overarching communication for regional and national agendas, co-ordinate responses.

- Ensure overarching actions to reduce health and social inequalities.

- Any other function that may be delegated by the Council under Section 196 (2) of the Health and Social Care Act 2012.

5. MEETINGS

The Health and Wellbeing Board is a Committee of the Local Authority.

The Health and Wellbeing Board will meet every six weeks.

The **date and timings** of the meetings will be fixed in advance by the Council, as part of the agreed schedule of meetings.

Additional meetings may be convened at the request of the Chair, and with the agreement of the Council Leader.

The meeting will be Chaired by a Member of the Health and Wellbeing Board duly appointed by the Council. The Vice Chair will be the Deputy Cabinet Member, Health and Wellbeing and Public Health Lead. The Chair and Vice Chair would be appointed annually; the appointments would be ratified by Council. **In the absence of the Chair or Deputy Chair** - A replacement Chair will be elected for the duration of the meeting from the Core Membership. This will normally be the Lead Member for Public Health

A **quorum** of four will apply for meetings of the Health and Wellbeing Board including at least one elected member from the Council or one representative of the Clinical Commissioning Group or a nominated substitute.

Members will adhere to the agreed principles of the Council's Code of Conduct. It is expected that members of the Board will have delegated authority from their organisations to take decisions within their terms of reference.

Declarations of Interest – Any personal, prejudicial or pecuniary interests held by members should be declared in accordance with the Councils Code of Conduct on any item of business at a meeting, either before it is discussed or as soon as it becomes apparent. Interests which appear in the Council Register of Interests should still be declared at meetings, where appropriate.

Decisions are to be taken by **consensus**. Where it is not possible to reach consensus, a decision will be reached by a simple majority of those present at the meeting. Where there are equal votes the Chair of the meeting will have the casting vote, there will be no restriction on how the Chair chooses to exercise his/her casting vote.

The Executive Director of Strategic Commissioning, Communities and Wellbeing will act as the **lead officer**. Lead officer responsibilities will include ensuring that agendas are appropriate to the work programme of the Health and Wellbeing Board.

Workload – Work Programme to be determined annually by the Board. The Board must also have regard to any issue referred to it by the Health Scrutiny Committee, Council and its leadership, or the Executive Director of Strategic Commissioning.

The agenda and supporting **papers** shall be in a standard format and circulated at least five clear working days in advance of meetings. The minutes of decisions taken at the meeting will be kept and circulated to partner organisations as soon as possible. Minutes will be published on the Council web site.

Access to Information – It is important to ensure that all councillors are kept aware of the work of the Board and a copy of the minutes will be circulated to all Bury Councillors. The Board shall be regarded as a Council Committee for Access to Information Act purposes. Freedom of Information Act provisions shall apply to all business.

All meetings will be held in **public** with specific time allocated for public question time.

The Board will retain the ability to **exclude representatives** of the press and other members of the public from a defined section of the meeting having regard to the confidential nature of the business to be transacted, publically on which would be prejudicial to the public interest (Part 5A and Schedule 12A, Local Government Act, as amended).

Non members of the Health and Wellbeing Board may be co-opted onto the Board as a non voting member, with speaking rights, with the agreement of the Chair.

Meetings will be **clerked** by a representative of Democratic Services.

The Board will oversee and receive reports from a set of sub groups which will focus on the delivery of key targeted areas of work. The sub groups will report directly to the Health and Wellbeing Board. Provisions that apply to the HWB would also apply to any sub groups of the HWB.

The HWB must be mindful of their duties as prescribed in the Equality Act 2010 and the Data Protection Act 1998:
The Equality Act 2010, requires specified public bodies, when exercising functions to have due regard to eliminating conduct prohibited by the Act and advancing equality of opportunity.
The Data Protection Act 1998 makes provision for the regulation of the processing of information relating to individuals.

REPORTING STRUCTURES

The Health and Wellbeing Board has a direct reporting link to Council.

Although Health and Wellbeing Boards are not committees of a Council's Cabinet, the Council may choose to delegate additional functions to the Board. The Discharge of these functions would fall within the remit of scrutiny but the core functions are not subject to call-in as they are not Cabinet functions.

The Health and Wellbeing Board would consult and involve the Health Scrutiny Committee in the development of the JSNA and the Joint Health and Wellbeing Strategy. The Chair of the Health and Wellbeing Board will attend the Health Scrutiny Committee, as required.

The Health and Wellbeing Board will not exercise scrutiny duties around health and social care, this will remain the role of the Health Scrutiny Committee as defined in the Health and Social Care Act and related regulations.

Bury Integrated Safeguarding Partnership

Adult Annual Report 2019-2020

Contents

Foreword: Independent Chair

Welcome to the Annual report for the Adult Section of the Bury Integrated Safeguarding Partnership (BISP) The report covers the period from the 31st March 2019 through to the 1st April 2020. The report has been produced in the midst of the Covid-19 pandemic and as can be seen in the contributions from the various agencies, the extraordinary challenges that have arisen in the past few months have had an impact on the work of the BISP and will continue to do so for considerable time in the future.

Before anyone had heard of the Corona virus the agenda for the BISP was already crowded enough. The BISP came into being an amalgamation of the former Local Bury Safeguarding Children's Board and the Local Safeguarding Adult Board on the 29th September 2019. The first half of 2019 had been preoccupied with planning for the integration, establishing governance, structures and membership. This work continued into the autumn and it would be fair to say that some of the new sub groups struggled with their role and remit. Greater clarity was needed and two development sessions took place in December and January where the strategic objectives were set out which would form the basis of the business plans across the partnership. 2020 therefore began with a renewed sense of purpose and energy yet within weeks all the agencies were confronted with the challenges of lockdown. I would like to commend here the way that practitioners, managers and leaders in all the agencies moved swiftly and creatively to meet the needs of vulnerable adults in the community and in residential care despite the many difficulties they faced, all the while ensuring that the imperative of Safeguarding was not lost.

It is too early to say what the long term impact of the pandemic will be and greater detail will be available in the BISP report which is due in the autumn.

In this report you will find information about the effectiveness of all agencies in Bury who are involved in safeguarding adults at risk. In addition, in 2019 the SAB commissioned two Safeguarding Adult Reviews both of which were completed and reported after March 2020. Both of the reviews provided valuable learning which will now be incorporated into the multi-agency training programme .Some of the issues raised such as the fragmentation of mental health services and the tension around consent and the use of Section 42 enquires are not unique to Bury and in these as in so many other areas it is right to seek greater consistency across Greater Manchester.

This report provides information about some significant developments in safeguarding work such as the establishment of a jointly funded Social Work Advanced Practitioner post the aim of which is to improve services to those with complex needs, the establishment of Safeguarding Operations team in adult services and the adoption by Greater Manchester Police of Adult safeguarding policies and procedures.

It would be foolish to predict what the next year will bring in the way of challenges but the BISP will focus on planning ahead for the unexpected as well as the more routine. In the meanwhile I hope you find this report informative and that it does justice to the commitment and hard work of all the professionals involved in keeping adults at risk safe in Bury.

Kathy Batt – Bury Integrated Safeguarding Partnership Independent Chair

Introduction

The production of this report is one of the core statutory duties placed on the Bury Independent Safeguarding Partnership to detail what has been done during the last year to achieve its main objectives and strategic plan with reference to Adult Safeguarding. It also details what each member organisation has undertaken in order to implement the strategy, and details any findings of any Safeguarding Adults Reviews (SAR's), and their subsequent actions.

As per guidance laid out in the Care Act 2014, this report will be submitted to the three main partners:

The Local Authority including both the Chief Executive and the Leader of Bury Council

The Clinical Commissioning Group and the Chair of the Health and Well-Being Board

Greater Manchester Police via the Chief Superintendent for Bury Police Service

It will also be published for the public via the Bury Integrated Safeguarding Partnership's Website https://burysafeguardingpartnership.bury.gov.uk

Information regarding BISP, including this report, can be found on the Bury Directory website www.theburydirectory.co.uk

Information about the statutory role and function of safeguarding partnerships and safeguarding boards can be found using the following link: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

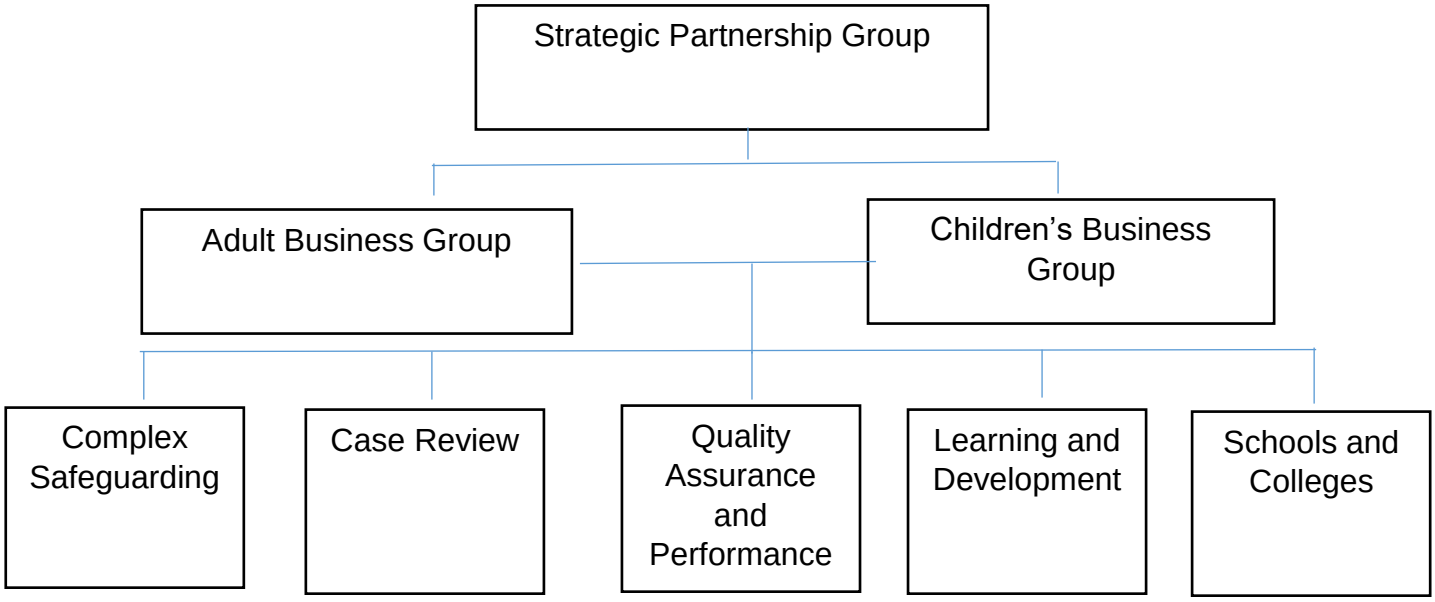
About Bury Integrated Safeguarding Partnership

Due to the changes in statutory obligations, learning from service /practice reviews and development sessions with both the BSAB and LSCB it was decided that Bury would move to having one integrated safeguarding board which will be known as the Bury Integrated Strategic Partnership (BISP)

The benefits of moving to this integrated model are seen as follows:

- Drive a more rounded approach to safeguarding i.e. via shared learning, joint workforce development, developing/improving joint practice, an all-aged shared focus and agenda.
- Avoid duplication both of officer time and resource investment
- Strengthen the links with and learn from local, regional and national partnerships.
- Ensure that Bury meets its obligations in relation to adult and child safeguarding statutory requirements and Greater Manchester Health and Social Care transformation plans.
- Ensuring that the customer/patient voice in entrenched in developing Bury's overall response to safeguarding

The new structure:
The new structure consists of Strategic Partnership Group, Business Groups for both Childrens and Adults, and five specialist sub groups.



This report is the first Annual Report to be published by the BISP, and focuses on the work undertaken by the Bury Safeguarding Adults Board, in the 2019-2020 reporting period.

As part of their statutory requirements defined in the Care Act (2014), the Adult Safeguarding Board is expected to produce a report at the end of each financial year on:

- What it has done during that year to achieve its objective

- What is has done during that year to implement its strategy
- What each member has done during that year to implement to implement the strategy
- The findings of the reviews arranged by it under Section 44 (Safeguarding Adults Reviews) which have concluded in that year (irrespective of whether they have started in that year or not)
- The reviews arranged by it under that section which are ongoing at the end of that year (whether or not they began that year)
- What it has done during that year to implement the findings of reviews arranged by it under that section, and where it decides during that year not to implement a finding of a review arranged by it under that section, the reason for that decision

The Bury Adult safeguarding Board's plans for 2019-2020 were based around transitioning into the new Bury Integrated Safeguarding Partnership and included as follows:

- Welcoming and inducting in the newly appointed Business Manager – Lauren Mitchell-Jones who was appointed in July 2019
- Finalising the terms of reference and membership for each meeting under the new integrated structure. – All subgroups and regular meetings have agreed terms of reference and representative members are allocated to relevant subgroups as agreed
- Agreeing and finalising all associated action plans including a performance management framework. – While there have been a number of action plans put in place, due to unexpected interruptions in the development of these plans and subsequent frameworks, some are still outstanding, especially as the Covid-19 pandemic resulted in the re-prioritising of workloads. At the end of the reporting year, Key Performance Indicators were still being agreed.
- Finalising independent scrutiny arrangements. – This piece of work is still ongoing and at this time is incomplete.
- Finalising and launching the new website. – The website has been updated to reflect the creation of the BISP and is continuing to be developed to include all its services.
- Evaluating and sense checking the new arrangements to ensure we are meeting our statutory duties and local priorities. – All new arrangements have been reviewed to ensure they meet statutory duties and policies.
- Establishing a robust multi-agency system to ensure that transitional safeguarding processes are in place to protect young vulnerable adults over the age of 18 years. – This piece of work is to link in to cross-Greater Manchester work and therefore further investigation into commissioning a seamless journey through services for young adults, particularly in reference to criminal exploitation

The plan for 2020-21 has included the following target areas focusing on scrutiny and challenging the system with specific focus on the areas below, including "Where will the assurance be sought from?"

1. 'To ensure interagency safeguarding practice is informed by the lived experience of children and at risk adults'
2. 'To establish effective sharing of information between all partner agencies working with children and at risk adults'
3. 'BISP should be confident that safeguarding services are accessible to every community and especially those who may be at risk'
4. 'To reduce the risk of harm and abuse through early intervention strategies and nurturing positive relationships'.
5. 'To ensure practitioners working with children and at risk adults are well trained, well informed and confident in fulfilling their roles and responsibilities'

6. To ensure that safeguarding remains effective during Covid and responds to local pressures

The BISP Adult Business Group is also supported by the Case Review Subgroup, which is responsible for:

- Disseminating learning from adults safeguarding cases.
- Scoping and commissioning Safeguarding Adult Reviews/learning reviews and monitoring the response to actions coming out of those reviews.

The work of the BISP is underpinned by six principles which have been taken from the Department of Health "Statement of Government Policy on Adult Safeguarding" 2011:

Key Principles	Description	What this means to people who live in Bury?
Empowerment	People are supported and encouraged to make their own decisions and informed consent.	*"I am asked what I want to happen and my views inform what happens"*
Prevention	It is better to take action before harm occurs.	*"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help"*
Proportionality	The least intrusive response appropriate to the risk presented.	*"I am sure people are working in my best interests, as I see them and will only get involved as much as needed"* *"I understand the role of everyone involved in my life"*
Protection	Support and representation for those in greatest need.	*"I get help and support to report abuse. I get help to take part in the safeguarding process to the extent that I want and to which I am able."*
Partnership	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.	*"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me."*
Accountability	Accountability and transparency in delivering Safeguarding.	*"I understand the role of everyone involved in my life"*

Annual Report 2019-2020

The next section of this report highlights the activities undertaken by the BISP and its partners during 2019-20 and its plans for 2020-2021.

Each Local Authority is responsible for collecting data relating to adult abuse in its area. This data collection process is called the “Safeguarding Adults Collection or “SAC”. Bury Council collect this data for all safeguarding cases within the Bury borough.
Bury Council also collects additional data around adult safeguarding enquires with regard to what people want to happen as a result of a safeguarding enquiry and how they feel after an enquiry has finished.
The information below lays out some of the key data collected and also the progress against the “Key Measures of Success” identified by the Adult Safeguarding Business Group.

Please note in order to produce this report in a timely manner, data for 2019-2020 has been provided via Bury Council internal data recording systems and not via NHS Digital who, are the national data controller. Therefore data contained in this section may differ slightly when compared with national reports.

	Data Definitions
Safeguarding Concern	A sign of suspected abuse or neglect that is reported to the council or identified by the council.
Safeguarding Enquiries	The action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult to a more formal multi-agency plan or course of action.
Section 42 Safeguarding Enquiries	The enquiries where an adult meets ALL of the Section 42 criteria. The criteria are: (a) The adult has needs for care AND support (whether or not the authority is meeting any of those needs) and; (b) The adult is experiencing, or is at risk of, abuse or neglect and; (c) As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The data below is taken from Bury Council’s adult social care customer database. Data shown below has been submitted as part of the statutory return to NHS Digital - the Safeguarding Adults Collection (SAC).

Key Board Measures

Two measures were chosen by the Safeguarding Adults Board in order to assess progress and development. These measures are as below:

1 The number of adults being abused is reducing

For this measure, data was recorded on whether there is evidence that a risk has been identified or "inconclusive" (meaning that no direct evidence has been found however there is uncertainty as to if a risk is present). A four year comparison can be seen in Table 1. It should be noted that while the number of enquiries in 2019/20 have increased, risks haven't seen the same growth.

Table 1 = Identified risk yearly comparison

Risk Identified	2016/17	2017/18	2018/19	2019/20
Yes	157	413	227	281
Inconclusive	64	101	45	63

2 The number of repeat incidents is reducing

Of the 519 adults that were supported via safeguarding enquiry in 2019/20, 80 also had enquiry within the previous 12 months prior. This is a reduction compared to 2018/19 when there were 107 enquiries.

Table 2= Repeat enquiries yearly comparison

Date period	Number of adults	Number of Enquiries		
		<3	3-4	5+
2016/17	37	32 (86%)	4 (11%)	1 (3%)
2017/18	116	83 (71%)	32 (28%)	1 (<1%)
2018/19	107	71 (66%)	31 (29%)	5 (5%)
2019/20	80	55 (69%)	24 (30%)	1 (1%)

In a further analysis of the case where 5+ enquires have been reported, it shows that 6 enquiries were reported for this individual service user and that all of the enquiries were with regard to concerns around their complex family dynamic. Protection plans and social work case management is in place to support this customer however as further issues arise these are rightly reported via the safeguarding route so that there can be investigation and protection, and support can be adjusted where needed.

One of the main reasons behind the improvements could be as a result of the introduction of the Safeguarding Team. They were established in April 2019 and have worked with referrers to educate into what constitutes an adult safeguarding referral and what does not.

The team have also acted as an "advisory" service for care providers and other organisations who have queries around safeguarding and have probably headed off inappropriate referrals in this way.

Making Safeguarding Personal (MSP)

Making Safeguarding Personal (MSP) is about having conversations with people with regard to how to respond in safeguarding situations in a way that enhances involvement, choice and control, as well as improving quality of life, wellbeing and safety. The Care Act and best practice advocates a person-centred rather than a process driven approach..

Table 3 (below) shows that the number of positive responses has seen a slight decrease this year; dropping from 49% to 37%.

Table 3 = Desired Outcome responses yearly comparison

Were they asked about their desired outcomes	16/17	17/18	18/19	19/20
Don't Know/Not Recorded	182 (49%)	129 (18%)	30 (6%)	52 (9%)
No, they weren't asked	113 (31%)	367 (51%)	200 (44%)	300 (54%)
Yes they were asked and no outcomes were expressed	15 (4%)	60 (8%)	60 (13%)	46 (8%)
Yes they were asked and outcomes were expressed	60 (16%)	166 (23%)	164 (36%)	160 (29%)
	370	722	454	558

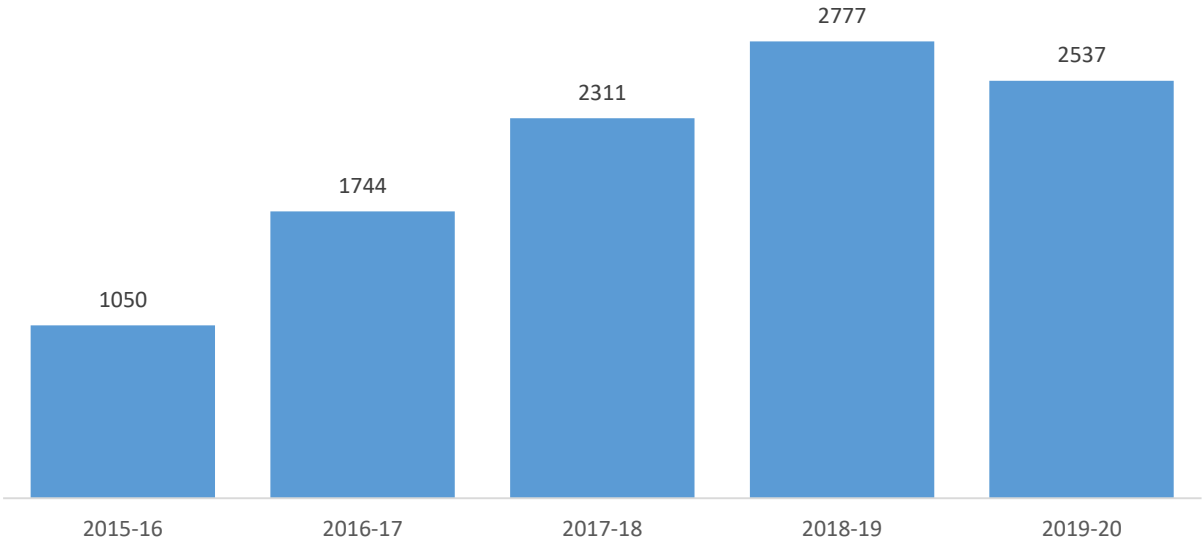
After scrutiny, the figures highlighted in the “Don’t Know/Not Recorded” and “No, they weren’t asked” categories can present as more negative than the actual picture, as these responses will show factors that may skew the data, for example where the customer:
Did not have the ability to make their views known (i.e. customers with expressive and receptive dysphasia /severe mental impairment etc.)
Following initial enquiries into the referral an alternative route to safeguarding was felt to be more appropriate and therefore views were not taken as the safeguarding enquiry did not continue.
The person died prior to their view being taken or did not consent to the enquiry progressing.
Work is ongoing to improve the customer journey and this includes improving the quality and the way in which Bury Council collects data pertaining to customer experience. It is therefore proposed that additional data will be introduced into next year’s report in order to give a more accurate picture around how we are meeting MSP principles.

Safeguarding Concerns and Enquires

There were **2,537** concerns raised regarding **1,791** individuals in 2019/20.

Safeguarding Concerns

Graph 1 – Number of concerns raised each financial year (i.e. 1st April to following 31st March)



The number of concerns raised in 2019-2020 has fallen slightly over since the previous year. This is thought to be due to two main factors:
Embedding of the Bury Council Safeguarding Operations Team who have started to work with colleagues from other agencies to reduce the number of inappropriate safeguarding referrals.
Towards the end of the financial year the number of referrals dropped as service /community priorities focussed on managing the Covid-19 pandemic – the drop in referrals at this point was also experienced at both regional and national levels.

Safeguarding Enquires

This following includes data on totals of section 42 enquiries and other safeguarding enquiries where a safeguarding concern that does not meet the Section 42 criteria is deemed appropriate.

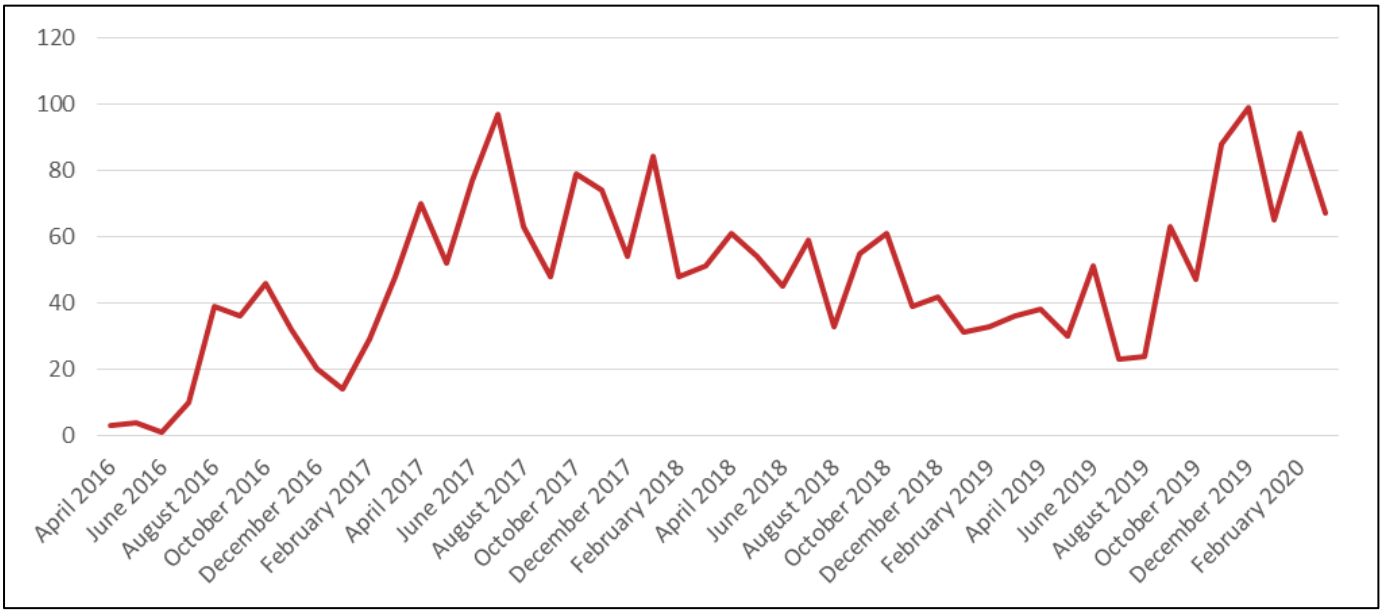
677 of the 2,537 concerns raised during 2019/20 proceeded to either a Section 42 safeguarding enquiry or an “Other Safeguarding Enquiry”. This equates to 27% of all concerns proceeding through to enquiry. The conversion rate over the years has fluctuated considerably, with 2018/19 showing the lowest rate.

Year	Concerns	Enquiries	Conversion Rate
2015-16	1050	422	41%
2016-17	1744	460	26%
2017-18	2311	869	38%
2018-19	2777	519	19%
2019-20	2537	677	27%

As advised previously, the Bury Council Safeguarding Operations Team are now in place and are looking to drive down the number of inappropriate referrals received which in turn will increase the conversion to enquiry rate – we can see evidence of this upturn above.

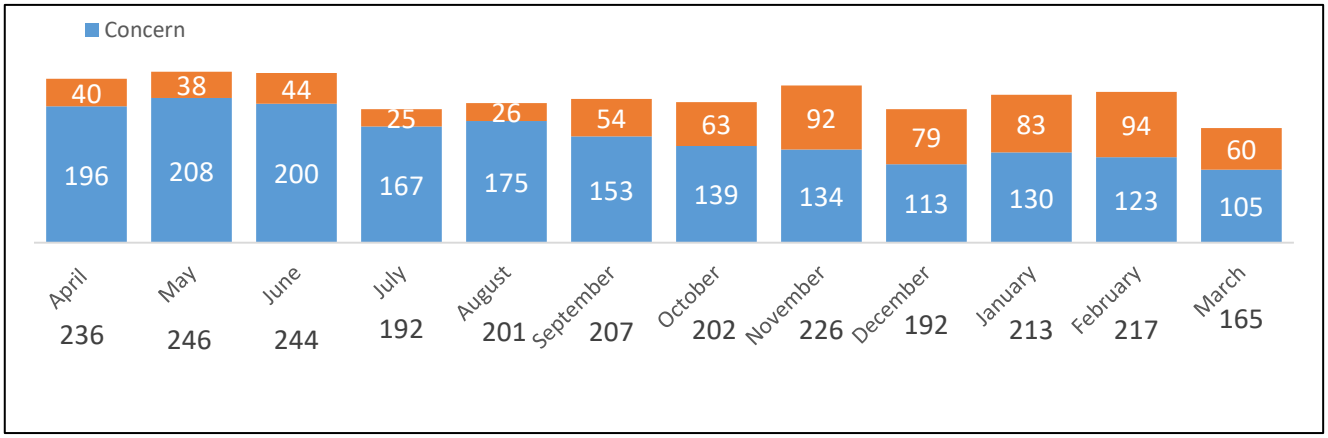
Graph 2 shows an upward trajectory in enquiries over the last 4 years, with significant increase in the last financial year.

Graph 2 - Enquiries between 2016/17 and 2019/20



Source of Referral

A piece of analysis was requested and conducted a number of times throughout 2017/18 in order to ascertain:
Where the majority of concerns were coming from i.e. the source of referral
What the conversion rate to enquiry was for the source of referral categories.
The analysis has been carried out each year with a comparison to previous years where possible.
This analysis looks at the 2541 records recorded on Protocol. Further safeguarding concerns are raised and recorded directly within the Community Mental Health Teams. This information is included in the statutory return, but is not able to be analysed yet within this section.



There was an average of 212 safeguarding referrals each month (a reduction on last year's average of 230). However, in contrast to last year, 72% remained at concern stage, compared to 80% last year.

Graph 4 = Safeguarding Referrals each month

There were 35 different sources of referral recorded this year, with 'Other', 'Ambulance' & 'Hospital in borough' being the biggest referrers (459 [18%], 406 [16%], and 360 [14%] referrals respectively).

Analysis has been carried out to try and establish what was being recorded under "Other". Whilst more detail is recorded for some these, over three quarters have no further information. Where there is detail, the Fire Service, Care Quality Commission (CQC), Care providers and the community are all prominent referrers.

Table 4 4: The conversion rate of the top three referrers

Source	Total Referrals	% of all referrals	Concerns	Enquiries
Other	429	18%	68%	32%
NWAS	406	16%	84%	16%
Hospital In borough	360	14%	80%	20%

As the conversion rates from concern to enquiry are very low for the above main referrers, the data behind this will continue to be analysed and advice given to those organisations who are submitting inappropriate referrals.

Demographics

This demographic data below shows the number of concerns raised by **individual** follows a similar pro rata break down in 19/20 to previous years.

	19/20	18/19	17/18	16/17
Gender				
Male	950	1005	1260	683
Female	1402	1389	1090	1041
Age				
18-64	1113	1121	998	654
65-74	251	304	271	196
75-84	476	451	512	403
85-94	416	446	470	381
95+	96	71	95	87
Unknown	0	1	4	3
Ethnicity				
White	1872	1979	2041	1523
Mixed / Multiple	14	13	16	5
Asian / Asian British	16	94	91	48
Black / African / Caribbean / Black British	21	18	18	9
Other Ethnic Group	18	27	22	15
Refused	0	0	0	0
Undeclared/ Not Known	411	263	162	124
Total Individuals in year	**2352**	**2394**	**2350**	**1724**
Total Concerns in year	2537	2777	2311	1744

Deprivation of Liberty Safeguards Data 2019-2020

Deprivation of Liberty Safeguards (DoLS) are put in place to ensure that people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Applications for DoLS must be made to the Local Authority, and can only be used if it is in a person's best interest.

Please note that this information is taken from local data sources, and figures could differ slightly from the ratified statutory data return.

Number of applications per year:

	Number
2014-2015	224
2015-2016	835
2016-2017	1102
2017-2018	1421
2018-2019	1695
2019-2020	1777

Applications by Disability:

	No Disability	Hearing Impairment	Visual Impairment	Dual Sensory	Physical Other	Dementia	Other Mental Health	Learning Disability	Other
2014-2015	0	0	0	0	21	132	30	35	6
2015-2016	13	7	13	1	22	648	46	62	23
2016-2017	10	3	16	4	36	883	50	81	19
2017-2018	3	2	1	3	39	1132	62	168	11
2018-2019	4	0	0	1	34	1306	56	219	75
2019-2020	1	0	0	0	27	944	483	283	39

Applications by Age:

	18-64	65-74	75-84	85-94	95+
2014-2015	66	30	55	67	6
2015-2016	124	121	247	285	58
2016-2017	157	132	371	374	68
2017-2018	277	187	448	428	81
2018-2019	349	194	515	539	98
2019-2020	441	205	519	533	79

Applications by Gender:

	Male	Female
2014-2015	102	122
2015-2016	297	538
2016-2017	372	730
2017-2018	544	877
2018-2019	629	1066
2019-2020	636	1141

Number of Applications Granted/Not Granted at time of reporting:

2014-2015		
Granted		200
Not Granted		5
Withdrawn		11
Not signed off		8
		224
2015-2016		
Granted		739
Not Granted		38
Withdrawn		55
Not signed off		3
		835
2016-2017		
Granted		893
Not Granted		32
Withdrawn		111
Not signed off		66
		1102
2017-2018		
Granted		858
Not Granted		33
Withdrawn		435
Not signed off		95
		1421
2018-2019		
Granted		828
Not Granted		738
Withdrawn		
Not signed off		127
		1695
2019-2020		
Applications Granted		833
Not Granted		794
Not Signed off		150
		1777

Analysis of applications granted/not granted

N.B: Please note, the "withdrawn" category was removed for 2019-2020 under guidance from NHS digital.

The "not signed off" applications denotes those applications at point of March 31st which have not gone through the full assessment and sign off process, the outcomes of which will feature in the 2020-2021 return.

833 applications were granted in 2019-2020 which is a slightly lower overall percentage when compared with previous years, the removal of the "withdrawn" category accounts for this change in picture. Where applications which were previously classed as "withdrawn" these now feature in the "not granted category".

The majority of applications classed as "not granted" originate from hospital settings where patients are often admitted for a very short period of time and assessments cannot be arranged prior to their discharge. This is a common occurrence nationally and Bury is not an outlier in this area.

Partner Contributions 2019-2020

Bury Council

Board Member:

- Julie Gonda – Director of Community Commissioning

Our Achievements

As highlighted in last year's report we have focused on a number of work areas this year:

1) Embedding of the Safeguarding Operations Team.
2) Development of the internal and partnership response to PREVENT and Channel.
3) Preparing for the introduction of the new Liberty Protection Safeguards.
4) Supporting the Transition over to the Bury Integrated Safeguarding Partnership.

Embedding of the Safeguarding Operations Team and Development of the Safeguarding Offer

One of the main areas of work for Adult Social Care this year has been the development of the Safeguarding Operations Team who are responsible for managing the majority of safeguarding cases coming into the Local Authority.

On average the Team dealt with approximately 20 safeguarding referrals per day.

The team's establishment consists of:

1 x Operations Manager

1 x part time Safeguarding Chair

6 x Social Workers (including 1 Advanced Practitioner)

2 x Social Care Officers

2 x Administrators

The Team have also supported a number of student social workers with their work based placements. Following qualification, one of these students has now been recruited into a substantive post.

Having a specific Safeguarding Operations Team has increased our ability and capacity to support colleagues from other organisations around submission of appropriate referrals, offering advice and guidance where alternative support is more fitting. In time this should help the understanding of what constitutes an adult safeguarding referral reducing the number of inappropriate referrals received, and in turn, minimising the time it takes for vulnerable adults to receive the correct care and support.

Since the introduction of the new team we feel that continuity of customer journey has also improved. Previously a customer, depending on their needs, could potentially find

themselves being supported by more than one service which in some instances lead to delays in provision of support and service navigation difficulties for the customer. The Safeguarding Operations Team oversee any required liaison with internal and external departments and where possible ensure that the customer has a single dedicated officer throughout their journey. In 2020-2021 we will be doing more work to understand exactly how the journey is for our customers and what we can do to improve

A number of our partner colleagues have dedicated safeguarding teams. Establishing the new team has enabled us to build more robust and supportive relationships throughout Bury and with health and social care providers across the Greater Manchester region.

As reported last year in partnership with our Clinical Commissioning Group colleagues we recruited a Social Work Advanced Practitioner (complex needs) who acts in a consultancy capacity to support other professionals as well as managing cases relating to people who have extremely complex needs. This officer started in post in August 2019 and is based with our police colleagues at Bury police station. Her role is primarily to support people who suffer with mental health needs but do not meet the criteria for community mental health services, people with complex Autism, Acquired Brain Injury and other customers with complex needs. The role also includes delivering training, Chairing Multi-Disciplinary professional risk meetings, supporting the MAPPA (Multi Agency Public Protection Arrangements) and working closely with local safeguarding practitioners.

Following are 2 case studies which illustrate the types of cases supported by the Advance Practitioner:

Customer 1:

Adult male who was discharged from prison with care and support needs, high risk, MAPPA 3 and is on the public protection register. Following accommodation at a long stay hospital he was found a property after his release from prison.

In order for successful resettlement into general society it was essential that he was found the appropriate support services, however this proved difficult due to him spending a number of years outside of mainstream services and within secure facilities.

The Advanced Practitioner worked with Customer 1 to secure a supported accommodation placement which has afforded him the care he needs to remain safe.

***Outcome** - Although this gentleman still presents with challenging behaviours he has not re-offended.*

Customer 2:

Adult male with brain injury.

This customer suffered numerous evictions from placements due to his very challenging behavioural difficulties. This not only caused distress and disruption to the gentleman himself but also consumed a great deal of social work time. The Advanced Practitioner supported this gentleman to find accommodation in a specialist Neuropsychiatric placement and managed his court of protection case.

***Outcome** - Doing well and settled in this placement.*

Customer 3:

Adult female with diagnosis of complex autism, agoraphobia and other complex needs.

This customer was unfortunately present at the Manchester Arena attack in 2017 which unfortunately exacerbated her difficulties. Due to her complex presentation she did not fit naturally into any of the specialist social work services.

***Outcome** – The Advanced Practitioner will continue to work with this customer in order to move towards giving her the confidence to leave her home and hence bring some normality back to her life.*

Additionally, in September 2019 the Safeguarding Strategic Manager's role was extended to include (as well as other duties) the management oversight of this team and was retitled as "Head of Adult Safeguarding". This extended role is a key link role between the Team and the wider partnership, including the Bury Integrated Safeguarding Partnership (BISP).

Development of the internal and partnership response to PREVENT and Channel

The Head of Safeguarding has for the past year actively supported this agenda stepping in as Chair for the multi-agency Channel Panel and the Prevent Steering Group.

Main areas of work this year have been:

- Supporting numerous vulnerable adults and children away from extremist beliefs and activity.
- Embedding new ways of working, with the Local Authority now taking overall lead responsibility for this agenda.
- Benchmarking how as a Borough we are meeting best practice standards in preparation for peer review.
- Developing a multi-agency training package and cohort of professionals to deliver this training.

Preparedness for the introduction of the new Liberty Protection Safeguards

Bury Council currently holds the responsibility for the management and administration of the Deprivation of Liberty Safeguards. These are safeguards put in place (following independent assessment) to support people who lack the capacity to agree to their own care and treatment.

In 2018 following a review of the Mental Capacity Act, of which these Safeguards sit under, it was mandated that new legislation in the form of the Liberty Protection Safeguards (LPS) was required. This change in legislation brings about a sharing of management responsibility which, once introduced, will fall not just to the Local Authority but also to the Acute Trusts (i.e. hospitals) and the Clinical Commissioning Group.

In order to prepare for this change Bury Council have undertaken a scoping review to understand the impact of the new legislation so that we can re-model our services to meet this new way of working. We have also attended various legal training sessions and from

there have delivered a number of face-to-face sessions and briefing notes in order to support our care providers to also understand the impact of the changes on them.

Additionally, in order to underpin best practice, our Safeguarding Strategic Team and other named social work practitioners continue to deliver Mental Capacity Act training, lead the North West Deprivation of Liberty Safeguards Practitioner Group and the local Best Interest Assessor Forum. The Head of Safeguarding is also now member of the Greater Manchester LPS Group and national Mental Capacity Act Forum.

Supporting the Transition over to the Bury Integrated Safeguarding Partnership

As you will see within the Annual Report this year, 2019-2020 has been a year for change as we embed the new safeguarding structure within Bury - the Bury Integrated Safeguarding Partnership (BISP).

This year we have been heavily involved in supporting the transition over to the new ways of working from helping design the new structure to developing various multi-agency protocols and procedures.

Officers from Adult Social Care now support each layer of the structure with our Interim Director having a lead role within the Strategic Partnership Group.

Our Plans for 2020-2021

Business Continuity and Recovery

As with our other partners the Covid-19 pandemic has had a significant impact on Adult Care Services and the way in which services are delivered as well has having life-changing consequences for many of our vulnerable customers and their carers.

Although some practical aspects of investigating safeguarding enquiries and managing Deprivation of Liberty assessments will need to change in response to the pandemic isolation measures, our responsibility around protecting and supporting vulnerable adults will not alter. Therefore a key priority this year will be adapting services to ensure business continuity and, planning how we can support customers and our care providers as we move into the “recovery phase” of the pandemic.

Learning and Development

In previous years Bury has had very few Safeguarding Adult Reviews (SARs). Due to the development of a dedicated backroom office team who support the BISP the opportunity to more readily recognise and facilitate SAR enquiries has emerged. This year two significant Reviews have been commissioned and will be completed in the forthcoming year. One of our main priorities therefore for next year will be to ensure we align any required developments in practice/protocols with the Review findings.

Customer Journey

"Making Safeguarding Personal" is a set of principles which moves professionals away from process driven approaches towards a truly collaborative customer focused approach to safeguarding. We have worked hard in Bury to ensure customers and their representatives have a lead role in any enquiries relating to them. With the establishment of the Operations Team we now have the opportunity to further build on these principles and develop a richer picture of what works well and what needs improvement from a customer perspective. Next year we will aim to start a system review of the "safeguarding customer journey" with a view to further improving our support and response.

Liberty Protection Safeguards (LPS) Preparation for Implementation

As mentioned above the Liberty Protection Safeguards are a significant change for both Local Authorities and our colleagues within some Health organisations.

The implementation phase of LPS was scheduled to start in October 2020 but due to the need to support Brexit legislation change, Central Government have put this phase temporarily on hold. We are currently waiting on a revised timetable which will likely be announced in late 2020 and will then work towards preparing for implementation and delivery.

NHS Bury Clinical Commissioning Group

Board Member:
Cathy Fines – Executive Lead for Safeguarding, Clinical Director NHS Bury CCG
Clare Holder – Designated Nurse Adult Safeguarding NHS Bury CCG

Our Achievements

During the last year, we have successfully built on the work of previous years. We continue to assure the providers who we commission to ensure that they provide good quality, safe services for the residents of Bury. This work includes working with large providers, such as Pennine Care Foundation Trust and Pennine Acute Trust, but, we also work with nursing and residential homes where Bury residents live. Additionally, we undertake an assurance process with some of the large private providers, such as Cygnet and Priory as they are located within Bury.

All contracts with providers include a set of Greater Manchester (GM) safeguarding standards and the CCG via an assurance process works with a range of providers to establish the level of adherence to them. NHS Bury CCG is the lead commissioner for Pennine Acute Trust.

The Safeguarding and Quality Forum for Nursing Homes continues to meet every 2 months and promotes the sharing of ideas, good practice and to review safeguarding experiences. During 2019/20 The Specialist Nurse for Adult Safeguarding and Quality completed a safeguarding audit of 9 nursing homes across Bury which has highlighted an improved compliance to GM Safeguarding Standards with all but one home achieving overall RAG rating of green. The one home which required improvement readily engaged through continued support from CCG and Local Authority.

The CCG safeguarding team provide clinical supervision and safeguarding supervision to a number of local providers who deliver care to vulnerable patients; this includes to Registered Nurses from our Nursing Home Providers and the Virgin Healthcare Sexual Health Services, Cygnet Hospital, Greater Manchester Mental Health Trust (Prestwich Hospital Site) and the Priory. We also provide one to one clinical supervision to senior staff working at Bury Hospice and Designated Colleagues across GM.

The Designated Nurse for Adult Safeguarding is a member of the Adult Business *G*roup and Case Review Group. Head of Safeguarding is the chair of the Case Review Group and all subgroups have representation from other members of the CCG Safeguarding Team. Both Head of Safeguarding and Designated Nurse for Adult Safeguarding are members of a number of NHS England regional forums and Greater Manchester Health and Social Care Partnership groups and forums; which influence and challenge the work streams within NHS England Safeguarding.

The Executive Lead for Safeguarding is a member of the Strategic Board.

The Safeguarding Team continue to deliver a calendar of training to Primary Care in Bury, and on behalf of Health Education England to GP trainees across the North East Sector. In addition to recognition and response to adult abuse training, we have delivered a range of training on a variety of topics, such as, MCA (Mental Capacity Act) Prevent (preventing radicalisation of vulnerable people), the impact in adulthood of ACES (Adverse Childhood Experiences), Domestic Violence and the emerging concerns around complex safeguarding. The Designated Nurse for Adult Safeguarding is a member of the Domestic Violence Steering Group in Bury.

NHS Bury safeguarding team continue to deliver Prevent training as part of the programme offered to GP's and CCG staff. The Designated Nurse for Adult Safeguarding has also delivered Prevent training in Cygnet Mental Health Hospital, Bury Hospice and at The Quality and Safeguarding Nursing Home Forum. Bury CCG Prevent Lead is a member of the Prevent Multi Agency Steering Group in Bury and is a member of the multi-agency Hate Crime Forum.

React to Red, a national initiative aimed at residential care homes and domiciliary care providers to ensure they have good awareness and knowledge regarding pressure relief and prevention of pressure ulcers, is now embedded in practice with Bury residential and domiciliary care providers. An annual training session continues to be facilitated by the team in response to demand, to capture new providers and staff, to cascade new information and good practice, and to offer ongoing support.

2019/20 built on the previous year's work which introduced the Red Bag Scheme. The Red Bag Scheme is designed to support care homes, ambulance services and the local hospital in improving the transition between inpatient hospital setting and community or care homes. Priory Bury have joined the scheme this year and Bury CCG continue to support colleagues from other areas across GM as they implement the scheme.

The CCG safeguarding team have visited all GP practices as part of a bi-annual assurance process. The practices complete a self-assessment using a modified Greater Manchester tool. A practice visit is then completed to discuss the assessment and agree any actions required. The visits are supportive and the assessment and any plans remain the ownership of the Practices.
The visits were an opportunity for the safeguarding team to update practices on changes to the multi-agency safeguarding arrangements, introduce new team members, and discuss emerging areas of complex safeguarding and to expand the knowledge of the practice staff.

The findings from this series of visits show improvement from the visits in 2017. The 2019/2020 assurance visits to all the practices in Bury provides, along with the CQC ratings, a continued high level of assurance of engagement with the safeguarding agenda for both adults and children. This in addition to the improvement noted or continued achievement within many of the standards, demonstrates that this good practice is well-embedded across the borough. All the practices welcomed the visits and took the opportunity to explore wider issues than the tool. Occasionally, there were case discussions.

Unfortunately the end of the annual report year saw Coronavirus present services with extraordinary challenges and the importance and effectiveness of multi-agency working through the local safeguarding partnerships has been clearly demonstrated. Safeguarding remains a priority service although as a team we have supported many other work streams within the CCG and LA.

Our Plans for 2020/21

The CCG will continue to work with statutory and other wider agencies in Bury to reduce the risk of abuse to vulnerable adults. We will achieve this by undertaking assurance visits to a wide range of health providers, delivering training on existing and newly emerging safeguarding topics and bringing new learning and understanding into Bury from our work across Greater Manchester, and, from the north region.

The CCG team have been actively involved with the integration agenda and are supporting the establishing of arrangements for the governance of safeguarding within the new emerging One Commissioning Organisation

Liberty Protection Safeguards system under the Mental Capacity (Amendment) Act 2019 is intended to come into force on 1 October 2020. The CCG will become a responsible body under the Mental Capacity Amendment Act (2019). The CCG as a responsible body will identify, assess and authorise a deprivation of liberty under the LPS. CCG Safeguarding Team will be working with Bury Local Authority DoLs team and Head of Adult Safeguarding to ensure that the CCG are meeting their statutory responsibilities.

As lockdown restrictions are eased and we become aware of emerging hidden harms, many due to the stresses placed on families as a result of the pandemic; we will strive to ensure that families get access to information, advice and support that they need.
We will support the BISP by considering the nature and level of harm experienced by residents of Bury and respond to any trends emerging from these incidents in a timely way

Pennine Care NHS Foundation Trust 2019/20

Board Member: -

- Dan Lythgoe, Managing Director
- Sarah Davidson, Head of Safeguarding

Our Achievements:

During 2019/20 the Pennine Care NHS Foundation Trust continues to be committed to ensuring the principles and duties of safeguarding adults at risk are holistically, consistently and conscientiously applied at the centre of what we do. The transfer of Community Services from the Trust in July 2019 had an immediate impact on the safeguarding resource and workload which required the development of a revised safeguarding model. The smaller safeguarding team based in Bury transferred with community services therefore from July 2019 advice support and guidance for Bury frontline practitioners was provided as part of the revised model by Trust Central Safeguarding Team.

Despite the changes within the Trust it has been committed to supporting the development of the Bury Integrated Safeguarding Partnership. There has been consistent Trust representation at the Adult Business Group and relevant Sub Groups.

Prior and post the transfer of community services the Trust safeguarding team continued to provide expert advice, support, supervision and specialist training to support all Trust staff to fulfil their safeguarding responsibilities and duties. The Trust strive to ensure all safeguarding processes are robust and effective, that we are responsive to emerging local and national needs, that we achieve full compliance against all our contractual safeguarding standards, and that the adult at risk of experiencing neglect, harm or abuse always remains in our 'line of sight', their voice is always heard, lived experienced is considered and they remain at the centre of all assessments, decisions, actions and future planning.

The Trust Safeguarding Strategy recognises a 'Think Family' approach as children, adults and their families and carers do not exist or operate in isolation

The Specialist Safeguarding Families Practitioners continue to review every Trust safeguarding adult incident, providing specialist support and advice and signposting as necessary to the Local Authority.

The Trust Safeguarding Training Strategy has been reviewed and updated to reflect intercollegiate framework, Adult Safeguarding: Roles and Competencies for Health Care Staff (2018). All Trust staff has access to mandatory safeguarding adults training, including Mental Capacity Act and Deprivation of Liberty Safeguards either via e-learning or face to face depending on the level of training their role requires.
Prior to the transfer of community services a series of monthly 'lunch and learn' workshops were facilitated where learning is shared from local safeguarding reviews. There was also an established model of group safeguarding supervision for specific services, identified by level of need and complexity of caseloads, an example being the highly specialised podiatry team.

The Safeguarding Team has continued to work with existing forums within the Trust to include safeguarding as a standing agenda item such as the Acute Care Forum and have attend larger meetings such as the Trust Nurses Forum to increase visibility and promote the work of the team and the Board.

Plans for 2020-21:

- To continue support Bury Integrated Safeguarding Partnership including representation at all relevant forums to reduce the risk of harm and ill treatment of adults at risk and continue to promote the safeguarding adult agenda across the workforce.
- Develop a skilled and knowledgeable workforce that is able to competently and confidently undertake Section 42 [The Care Act, 2014] adult safeguarding enquiries.
- To develop the offer of safeguarding supervision within adult mental health and learning disabilities services and embed a culture of reflection and learning in relation to safeguarding work.
- To continue the provision of safeguarding advice, support and guidance and oversight of adult safeguarding incidents within the Trust.
- Establish mechanisms within the Trust to ensure lessons learnt from reviews can be shared with frontline practitioners.
- To continue to work with safeguarding adult partnerships to identify themes and improve outcomes for adults at risk using our services

Six Town Housing

Board Member:

Sharon McCambridge – Chief Executive Six Town Housing.

Our Achievements

Our locality model means that our staff are based within the community and have a better relationship with our customers. This allows early detection and intervention, particularly in cases of neglect. Working at the Radcliffe and Bury East Neighbourhood HUBS has encouraged a more joined up approach to complex cases with a better understanding of partners' roles and responsibilities and a sharing of expertise and information.

We have mobilised our workforce to meet the needs of our customers during the pandemic, making 1272 calls to over 70's and/or those with underlying health issues and referring those with food or medical needs to the Community Hubs. Our drivers were on hand to assist with deliveries when required. We have used our social media outlets such as Facebook and Twitter to keep our tenants up to date with the latest information and offered support and encouragement through initiatives such as our digital photography and gardening competitions.

We continue to have a strong presence in MARAC meetings discussing 229 cases this year, a rise of 42% on last year, to support the most vulnerable people in the community. We installed 55 home security measures for survivors of domestic abuse through our sanctuary scheme.

The engagement in adult safeguarding by all our housing staff is pivotal to the requirements of the safeguarding statutory guidance of the Care Act 2014. Our Safeguarding procedures are constantly reviewed and updated to meet new legislation and to ensure recording and monitoring is robust and reported through the performance framework.

A mandatory e-learning package has been delivered to all existing staff incorporating all adult safeguarding elements for employees, complemented by regular briefings and awareness raising sessions, ensuring safeguarding remains high on everyone's agenda. This package also forms part of the induction programme for all new members of staff

As our staff are based predominately within our communities they are best placed to be vigilant, recognise the symptoms of abuse and be able to respond to adult safeguarding concerns. This year has seen an increase in self-neglect and hoarding and we have submitted 128 safeguarding referrals to Adult Social Care as well as liaising with other public and third sector agencies on complex cases.

Our Designated Safeguarding Officer is a senior manager taking a lead role in organisational and inter-agency safeguarding arrangements including BISP Adult Business Group; Learning & Development Group; Case Review Group and Q&A group.

Our local knowledge has provided valuable information to improve the quality of Serious Case Reviews and Safeguarding Adults Reviews

We have contributed to wider agendas including prevention, awareness raising and training thereby reaching into local communities on issues such as safeguarding, domestic abuse, hate crime, self-neglect, hoarding, anti-social behaviour, poverty and dementia and have reinforced the message through our social media outlets that safeguarding is everyone's business.

Once again we have invested in and improved our focus on the empowerment and prevention by enhancing the work of our Tenancy Sustainment Team and their links to the neighbourhood based staff and the multi-agency hubs. The team case manage and support our most vulnerable and complex customers to establish their level of need and support to enable them to live independently; stabilise their lifestyle and ensure they have the correct support in place to sustain their tenancy. This year we have focused on supporting care leavers through their transition to independent living by seconding a member of the Tenancy Sustainment Team to Bury Councils Young People and Culture Department offering housing advice and training to those on their journey to independent adulthood.

Our 'Eyes Wide Open' initiative makes it easy for all our employees, including our repair operatives, to report concerns for safety and wellbeing of tenants. These concerns are passed to our Dedicated Safeguarding Officer and Neighbourhood Teams to follow up, we investigated 46 reports last year. We also led 2 locality based multi-agency 'Eyes Wide Open' sessions for Radcliffe and Prestwich front line staff to raise awareness of issues when entering clients' homes; share knowledge, experience and best practice and to offer outlets for disseminating information. Further sessions across the other townships in the Borough will be offered later in the year.

Our Plans for 2020/2021

We will continue to lead the way with raising awareness of Eyes Wide Open with staff; tenants and partners and aim to further develop monitoring arrangements for safeguarding actions and participate in multi-agency work to ensure the best outcome for our customers.

We want to ensure that partnership working remains key and plan to:

- Lead the way in raising awareness of Adult Safeguarding issues through new groups established as part of BISP
- Further develop links for appropriate support services for those who have been effected by COVID-19, particularly those with disabilities and/or mental health issues;
- Move to place based working to further develop data sharing protocols and joint initiatives with partners for the benefit of customers;
- Ensure resources continue to be available to attend relevant panels and case
- reviews; and
- Develop staff awareness of the supporting roles of other agencies and how to access them.

Greater Manchester Police (GMP)

Board Members:

- Detective Superintendent Stephen Keeley

Our Achievements 2019-20

During 2019-20 Bury Police have continued to place safeguarding and vulnerability at the heart of all investigations.

Greater Manchester Police revised and launched the Adults at Risk Policy and Procedure; this document and accompanying toolkit, will enable GMP officers and staff to provide a standardized and coherent response to all safeguarding concerns and allegations of abuse, to ensure that the best possible protection is afforded to victims and witnesses.

A new Case Management Team started work at Bury in April 2019 resulting in a dedicated resources committed to delivering case conference, strategy meetings and Multi Agency Risk Assessment Conference (relates to high-risk domestic violence and abuse cases), thus further developing and supporting good relationships with partner agencies and delivering an improved service to some of the most vulnerable sections of the community.

An Investigation and Safeguarding Review is ongoing, looking at the effectiveness of the Case Management Team and the police triage, safeguarding and investigation units with a view to ensuring continuous improvement in safeguarding practices.

The district has further embedded placed based working to ensure vulnerable community members receive the appropriate help they need from the right source either from the police, partner agencies or a combination of both. Three dedicated neighbourhood inspectors continue to embed and develop neighbourhood policing these being Inspector Rob Findlow, Inspector Scott Brady and Inspector Gareth Edwards. This approach has delivered demonstrable results for victims who have had had their needs met and a reduction in demand and repeat calls not only for police but partner agencies. Cases continue to be reviewed for learning on a regular basis as this new way of working is embedded. This approach ensures that we continue to work towards the Target Operating Model for Greater Manchester.

Another exciting piece of work that is ongoing at Bury is the design of the Public Sector Reform (PSR) Hub, the ‘Engine Room’. This aims to have clearer demand streams coming into the hub and a multi-agency, co-located problem solving approach towards cases based on individual needs as well as developing placed based services. The Engine Room has developed and is now conducting daily multi agency risk planning meetings to discuss high risk domestic abuse cases and safety plan in relation to these cases, which underpins and supports the Multi Agency Risk Assessment Conference (MARAC) process.

The district continues to develop its response to complex safeguarding, in particular the multi-agency response to Criminal Exploitation and the complex safeguarding sub group. A small unit of dedicated officers have been identified to develop the tactical response to complex safeguarding. Detective Inspector Ian Partington oversees the complex

safeguarding unit that consists of Child Sexual Exploitation (CSE), Child Criminal Exploitation (CCE) and Organised Crime Groups.

There is continued engagement with Prevent (This is support for those at risk of radicalisation) with dedicated District prevent officers.

Our Plans for 2020-21

- Further Development of PSR Hub which will aim to encompass appropriate partner agencies including adult services
- Development of place based working will continue to develop via the PSR and support the five Community HUBS across Bury.
- We will continue to raise the profile of adult safeguarding within GMP and within the community to ensure we are better able to tackle those at risk of crime through vulnerability
- Development of complex safeguarding in particular response to criminal exploitation

We will continue to work with partners on the most complex cases.

Greater Manchester Fire Service

Board Member:

- Wendy Hall, Community Safety Manager, Designated Safeguarding Officer covering Bury, Oldham and Rochdale.

Programme for Change

Following the close of consultation on the Outline Business Case proposals for the GMFRS programme for Change, the Greater Manchester Mayor, Andy Burnham, signed off the approved changes in November 2019, which will see a new vision and purpose for GMFRS, re-focusing on a “frontline first” approach.

An extensive re-model will see a reduction in fire stations, fire engines and firefighter posts. The role of the firefighter will include a redesigned “Safe and Well” process to ensure a clear focus on fire prevention, with the support of our Community Safety Teams.

In line with the newly approved structure, there will be a reduction in prevention post and as we move towards a new delivery model, there will be a change from the universal Safe and Well offer to a more targeted person centred fire risk assessment. Our remaining specialist staff will support the most complex cases and address safeguarding concerns.

Our Achievements 2019-2020

Closer working with partners across Bury to ensure awareness of reducing fire risk to the most vulnerable in our communities and to embed the referral process for people at increased risk of fire

Partners trained in Fire Risk indicators for Vulnerable People and referral pathway include:

Bury One Recovery, Older People’s Staying Well team, Placed based hubs, and Pennine Care Mental Health, Bury Six Town Housing, Bury Shared Lives and Bury Society for the Blind.

Annual statistics for Bury…

- Our Free Community Safety promotional vehicles were utilised 29 times to deliver a wide range of activities for the residents of Bury, with partners from the falls team, mental health, probation and stop smoking services.

- The Prevention Team delivered 2 Safe4Campaigns to Secondary Schools to increase awareness of water safety, hoax calls and fire safety.

- Our Crews delivered 4 Safe4Campaigns to Primary school children, getting ready for the summer holidays

Our 12 week Prince Trust Programme continues to run 3 times per year, with a successful presentation evening attended by dignitaries from a range of service at the end of each cohort.

Our Fire Parade Pump, firefighters, volunteers and young people took part in Bury Pride again as part of our inclusivity agenda, #proud to be visible, across our LGBT Communities.

2019-2020 in Bury….

- 121 Priority Safe and Well Visits - Reducing arson threat to life
- 338 Vulnerable People at increased risk of fire received a home visit to help reduce fire risk, improving health and wellbeing.
- 638 Safe and Well Visits for families and individuals: Helping to keep communities Safe & Strong.
- 421 Defective alarms replaced helping to keep families safe.
- 16 Fire smart interventions with young fire setters: Equipping them with skills for life.
- 2929 Targeted letters posted promoting Safe and Well visits in areas affected by fire, or harder to reach communities.

GMFRS Bury Safeguarding Referrals for April 2019 / March 2020

Bury	Adults	Children
Quarter 1	9	3
Quarter 2	11	1
Quarter 3	9	2
Quarter 4	2*	0
Total	31	6

**Due to Covid-19 Lockdown commencing during March 2020 GMFRS withdrew face to face Safe and Well visits. All Safe and Well referrals were triaged over the phone and where risk reduction equipment was identified as being required operational crews undertook deliveries. Lack of initial face to face visits may have seen a temporary reduction in Safeguarding Referrals.*

Completed training for GMFRS Prevention Teams include:

- Internal Adult & Children e-learning Safeguarding module.
- External - Self- Neglect & Hoarding
- Internal - Dealing with Conflict in the Workplace
- Internal - Act Awareness / Prevent
- External - Challenger
- Internal – Inclusivity Training
- Internal – Information Governance Training

Our Plans for 2020-2021

Our Priorities aligned to Greater Manchester Strategy. “Our People, Our Place”. With a focus on Public Sector Reform and Place Based Working.

Programme for change will bring a new prevention model from September 2020. We will keep partners updated on the redesign of our service.

Diversity and Inclusivity; Implementing our 2019-20 D&I strategy across the organisation. The aim of which is to develop a diverse workforce and inclusive culture, enabling us to better support our staff and stakeholders, to ensure we represent the communities we serve.

Continue to support the work of the Bury Integrated Safeguarding Board, through GMFRS representation. Ensure Safeguarding legislation and training, is current and cascaded across GMFRS employees.

The participation in key events and campaigns throughout the year to support the priority agenda within the Local Authority, GMP, Health Services, Housing and other key services across Bury to reduce the risk of fire across Bury communities. E.g. Collabor8 & Bury Pride

Closer working with Drug & Alcohol Services, Mental Health services inclusive of Suicide Prevention, and support the Homelessness agenda across Bury.

Our planned work for 2020/2021 has been impacted by Covid19. We are currently looking at what our recovery looks like. It is clear that elements of our Prevention Work will be re-designed in order to focus on highest risks within our community.

Safe4Summer & Safe4Autumn Campaigns in Schools & Safe Drive initiatives will be linked to the National Fire Chief's Council's Stay Wise programme, which is a curriculum based approach. Delivery of our key messages will be supported by our Firefighters and Bury Safety Centre staff.

We will continue to offer Safe & Well Home Visits to increase safety awareness and reduce fire risk across Bury, which will be targeted at those at increased risk of fire.

National Probation Service

Board Member:

Joanne Hickey – Assistant Chief Officer NW NPS – Bury Rochdale Oldham

Our Achievements

As part of the NPS North West Business plan 2019/20, a key objective linked to safeguarding was the reduction in the number of short custodial sentences. Wider focus was also on BAME and women service users too. Other priorities were linked to the ongoing probation reform programme and ensuring that staff receive greater professional support/improving professionalism and getting the change right.

Additional actions were set to have a greater understanding of our violent offender cohort in order to develop our approaches to improve outcomes for this group.

We continued to build upon localised links to improve service user stability upon release from custody with sustained focus on partnership working to address the needs for homeless individuals, addressing complex dependences.

All staff have completed mandatory e-learning on Safeguarding Adults, Safeguarding Children and Domestic Abuse. Continuous Professional Development days in Bury, which are mandated for all practice staff, have continued and adult safeguarding sessions this year have focused on Care Leavers; findings from local and national Domestic Homicide Reviews and Safeguarding Adult Reviews, including themes pertaining to neglect and exploitation; information pertaining to the assessment of capacity and interventions for men who commit sexual offences were also covered. A CPD session was run looking at subjectivity in recall decision making, a pilot commencing late in the year pertaining to effective licence management, as per work that commenced the previous year.

Attendance is monitored and to date we have over 97% attendance monthly; 100% of practice staff across the Bury, Rochdale and Oldham cluster have completed Safeguarding Adults e-learning. We have engaged in briefing staff in respect of professional curiosity, working with difficult to engage individuals, serious violent and knife crime. Practice staff have also completed training in conscious/unconscious bias, this will be mandated for all by the end of 2020. Additional professional development sessions have focused on Transactional Analysis; hopelessness in clients and in you; learning from lived experience - *Service User Network presentation; c*ommunity based psychological interventions for Personality Disorder; Substance misuse – Chemsex then alcohol and offending have also taken place.

Criminal exploitation has been a significant theme of localised learning, the NPS working with other agencies to safeguard vulnerable adults at risk of exploitation, and over the next 12 months want to look at how we are able to effect a strengthened to our engagement with partners on this. We also remain active within Channel and work with Probation Counter Terrorism Unit colleagues with regard to Pathfinder cases held locally and daily high risk review meetings alongside MARAC.

A professional development session was held, with additional e-learning, in respect of suicide prevention and we continue to review all deaths under supervision, sharing learning as required with all practitioners. This consolidates work commenced in previous years.

The NPS contributes to the early identification of care and support needs for service users in the community. In addition new material was added to interventions for working with young adults in transition and those aged under 25. This remains a mandated package of work which can be tailored to meet individual need and risk and quality assurance reviews into this work shows high levels of service user engagement. We currently second one part-time Probation Officer into Bury Youth Justice Service to work with all transition cases.

Reflective supervision has been a focus this year with the introduction of SEEDS as a means of engaging staff, with line managers undertaking practice observations, as well as there being management oversight of all MAPPA service users. Reflective case management is enhanced via input of the Insight Personality Disorder team and the psychotherapist who leads on professional development groups monthly too.

The NPS maintain local co-ordination and responsible authority chairing of Multi Agency Public Protection Arrangements. Training is undertaken annually for Duty to Co-operate agencies and MAPPA Chair Training for GMP colleagues who are a Responsible Authority, has also been refreshed during the year.

Our plans for 2020/21

The end of 2019/20 saw a change to management via an Exceptional Delivery Model in light of COVID19. This resulted in the identification of priority groups which not only included those posing a high/very high risk of serious harm, but other cohorts where there were identified vulnerabilities linked either to the service user or others they were resident with. The recovery planning phase will be a significant focus of the next year.

The Probation Reform programme with the unification of the CRC and the NPS will be a substantive focus of the next 12 months. Collaboration with partners within Greater Manchester should be enhanced by the closer alignment of the newly formed NPS which will see a separation of GM offices from the North West.

Training in the next year will focus on Honour Based Abuse with further input on capacity in respect of adult safeguarding. A greater level of engagement with the Engine Room is also hoped to facilitate strengthened collaborative approaches to safeguarding.

Northern Care Alliance (NCA)

Board Member:

Gail Winder ADNS - Adult Safeguarding NCA Group,

Linda Collins-Izquierdo - Associate Director of Nursing Governance & Corporate Nursing NCA Group

Background: The Care Act (2014) provides statutory legislation for adults at risk, it is expected that health will co-operate with multi-agency partners to safeguard adults. As a health provider, Fairfield General Hospital and Community Services is affiliated under the wider remit of the Northern Care Alliance (NCA).

NCA and its care Organisations have responsibilities to provide safe, high quality care and support. The wider safeguarding context continues to change in response to the findings of large scale enquiries, such as Francis (2013) and Lampard (2015) and legislation such as the Care Act (2014). Contextual safeguarding issues present all agencies with new challenges in recognising and responding to cross generational, cross border risks affecting all aspects of the societies in which we all live.

Our Achievements:

To address the Bury Adult Safeguarding Agenda, responsibility and accountability is embodied at board level and is encompassed within the Group Chief Nurse role and responsibilities. The operational and strategic delivery of the Bury Safeguarding Adult programme is led by the Assistant Director of Nursing for Safeguarding Adults for the Northern Care Alliance under the Leadership of the NCA Group Associate Director of Nursing for Governance & Corporate Nursing and the Director of Nursing for NCA.

Recruitment has taken place to key safeguarding posts in 2019/2020, the Adult Safeguarding Team currently have a full establishment of staff members to meet the health needs of the service within the borough of Bury.

During the period 2019/20 the Adult Safeguarding team has continued to strengthen the existing embedded Adults Safeguarding practices across the organisation. The demands on the service remain multifaceted, complex and challenging, however the Adult Safeguarding Team continue to work together with Children's Safeguarding Agenda and multi-agency partners supporting a "Think Family" approach. The detail of work undertaken for the period of 2019/20 is as follows:-

- A great deal of work has been undertaken to ensure that the Greater Manchester Contractual Standards for Safeguarding Children, Young People and Adults at Risk are achieved and compliance is maintained for the period 2019/20. The team meet regularly with Bury CCG to offer assurance with regards to compliance thresholds.
- The service continues to review each Adult Safeguarding notification submitted by the Trust offering support to all wards and departments across the acute and community setting, Monday to Friday 9am – 5 pm. The Adult Safeguarding team offer multi agency partner engagement/information gathering with section 42 enquiries in

accordance with the Care Act 2014 where applicable and support with investigations accordingly.

- As part of the Community Safety Partnership the Adult Safeguarding Team are engaged with lessons learnt from serious incidents, Safeguarding Adults Reviews (SAR), Domestic Homicide Reviews (DHR)'s.
- The Adult Safeguarding Team continues with the provision of organisational support with "Managing allegations of abuse against staff" across the Trust and community setting.
- Work has been undertaken to strengthen and improve organisational links with governance teams across the Trusts to ensure safeguarding is considered within the NHS Patient Safety strategy for serious incidents. This is achieved by the implementation of alert DATIX/Safeguarding notification pathways and the attendance by the Adult Safeguarding Team members at relevant SI meetings within each organisation.

- The Adult Safeguarding team have strengthened working practices with the Nursing Assessment Accreditation System (NAAS) nursing team. Key Lines of Enquiry (KLOEs) relating to the Adult Safeguarding Agenda/MCA/DOL's have become embedded within the self-assessment audit programme across the organisation.

- As part of the Adult Safeguarding Training Strategy the Adult Safeguarding Team have review and updated Adult Safeguarding/MCA training packages that align with the Intercollegiate document (2018) and developed a programmed of delivery for 2020/21.

- The Adult Safeguarding Team fulfils the Trust's statutory duty in attendance at Safeguarding Adult Board Sub groups from the board.

In relation to the COVID – 19 unprecedented period, despite the relaxation of some elements of the Care Act 2014, the Adult Safeguarding Team continued to operate a "business as usual" service provision, albeit a slight amendment to the usual operational practices to encompass social distancing measures and visibility across the Organisation.

From the onset of the COVID – 19 pandemic the Adult Safeguarding Team were mindful that there were no governmental announcements declaring relaxation of the Mental Capacity Act 2005, therefore there were no changes to the application of the MCA legislation. All MCA/Best interest decisions must be lawful, failure to comply with legislation would run the organisational risk of a human rights beach and an indefensible liability claim for "blanket approach" to DNAR/CPR, this accompanied with the concern that the redeployed staff may not be well accustomed to the application of MCA/DOL's within their line of work highlighted a risk to the organisation relating to the legitimacy of the application of DNAR/CPR for patients experiencing cognitive impairment due to dementia and learning disabilities/autism.

In order to mitigate against this risk the Adult Safeguarding/LD/Cognitive Team operated collaboratively with the "end of life team" and contacted wards and departments, on a daily basis, across the trust to offer advice and support which included staff members who do not routinely work on the wards/departments but have been placed as part of redeployment. The team provided assistance with the completion of Safeguarding Notifications/MCA/DOL's applications which included DNAR/CPR and DASH risk assessments where appropriate.

Key Safeguarding priorities 2020/21

- The team will continue to build on and strengthen achievements set out from the previous period of 2019/20.
- There are changes to the CCG monitoring arrangements of the Greater Manchester Contractual Standards for Safeguarding Children, Young People and Adults at Risk. Historically, the monitoring of the contractual standards across the PAHT site has been monitored by Bury CCG on behalf of the North East Sector (excluding Salford). Future arrangements for 2020/21 are to be implemented that each organisation will be monitored by their assigned CCG, creating greater organisational insight into the associated Safeguarding/MCA risks and the monitoring of measures that have been implemented to mitigate against the identified risks.
- To continue to work towards complete compliance of the Greater Manchester Contractual Standards for Safeguarding Children, Young People and Adults at Risk are achieved and compliance is maintained for the period 2019/20.
- A key priority is the undertaking of a quality assurance of the mental capacity assessments within the organisation via random dip sampling of the MCA assessments, complimented by the implementation of an MCA Audit programme. A quality review of the random sampling and audit analysis will inform the MCA Training and target areas for improvement.
- As per, the Adult Safeguarding/Learning Disability/Autism, Dementia and Falls Service interlink of working arrangements the LD/Autism and Dementia Service are to include the MCA element to their training strategy. This is already a key feature in the falls training strategy across the NCA.
- The Adult Safeguarding/MCA training strategy has been designed to meet the needs of the NCA requirements, the team are currently in the process of adapting the existing training programmes to accommodate the new social distancing programmes during the recovery phase of the COVID – 19 measures. The team are currently in the process of working with Learning and Development Service and IMT to develop an IT platform which will meet the requirements for training programme delivery across all sites.
- The Self Neglect/Non concordance element of Adult Safeguarding thematic review is a key feature identified within the majority of NCA commissioned Safeguarding Adult Reviews and is a key priority for the Adult Safeguarding Boards. To address this issue, considerable effort has been undertaken with the development of an NCA non concordance pathway. The challenge and priority for 20/21 is to embed non-concordance pathway in everyday practices across the NCA foot print for both the acute and community settings.
- The DHSC announced the intention to replace the Deprivation of Liberty Safeguards (DOL's) with a new initiative Liberty Protection Safeguards (LPS) due to the COVID – 19 outbreak the implementation of the LPS programme has paused, however the government are considering the announcement of a new timetable for implementation. Once this has been announced the implementation strategy for LPS will form the priorities for 2020/21.

North West Ambulance Service

The North West Ambulance Service submits a report relating to its activities across the North West, encompassing Cumbria & Lancashire, Greater Manchester and Cheshire & Mersey. The following summarises activities across all three areas and therefore is not specific to Bury.

Below are the key achievements and ambitions undertaken in the last year by NWAS:

Achievements 2019-2020

- 2 new Safeguarding Practitioners have been recruited to cover the Cumbria and Lancashire and the Greater Manchester areas. The practitioners are a welcome addition to the team which had been experiencing significant pressure due to staffing vacancies.

- The Safeguarding Team continue to work with the 111 service to ensure high levels of safeguarding assurance can be given to the senior leadership team.

- The Trust were partially inspected by the CQC, and the safeguarding leads were interviewed by a CQC Inspector, in addition to providing evidence. The Trust are awaiting the report from the inspection.

- Project Emerald has been designed and tested, and the safeguarding concern sheet has been streamlined. There has been a working group in place for the latter half of the year, and a testing timetable has been agreed. Following a rigorous testing process project emerald will be rolled out across the Trust.

- Numerous level 3 safeguarding face to face courses have been delivered by the safeguarding team to assure high levels of escalation processes are available.

- The Trust is committed to the safeguarding of adults with learning disabilities and are engaged with the LeDeR programme which makes all deaths involving adults with learning disabilities notifiable. The learning disabilities mortality review aims to make improvements to the lives of people with learning disabilities. The LeDeR programme was set up following a recommendation from the CIPOLD, funded by the Department of Health, to investigate the premature deaths of people with learning disabilities.

Ambitions 2020-2021:

- Management and leadership of the safeguarding activity within the 111 service to come under the corporate safeguarding team remit.

- Increase the size of the safeguarding team to include an additional Practitioner to oversee the safeguarding activity within the Clinical Hub and the 111 service

- Move to a fully electronic safeguarding concern raising system. Project Emerald will continue and allow for this ambition to be achieved.

- Establish Safeguarding Champions Network across the Trust to provide support to all staff including PES, PTS, 111 and EOC staff.

- Develop a system for sharing information with schools for children who are identified as suffering from an adverse childhood experience. This work is underway and has been presented to the Digital Design Forum. The Safeguarding Manager is working with the IT team to continue to develop this.

- To monitor repeat adult concerns and engage with Adult Social Care agencies to offer a holistic, multi-agency approach.

- Continued engagement in the Serious Case Review process and the development of level 3 training modules using lessons learned from the reviews. When a child or adult review is completed a report is produced by the commissioning Safeguarding Board, included in the report is any learning that has been identified. The Safeguarding Manager will ensure that this learning is applied to the Trust's safeguarding processes where relevant.

- The Safeguarding Manager and the Chief Nurse will engage with all of the regional safeguarding systems lead groups. These groups have been setup to have input from all aspects of health to ensure safe consistent safeguarding approaches are taking place across large geographical areas.

- To develop early help safeguarding contacts with multi-agency partners to allow safeguarding concerns to reach the appropriate Social Care Teams.

Further Safeguarding Processes

In addition to the partner contributions, the BISP have engaged or supported in a range of processes and arrangements with these partners, which are detailed below.

The Engine Room

The purpose of the Public Service Reform Hub, known locally as the Bury Engine Room, is to co-locate and integrate public services, systems and processes to ensure co-ordinated identification, assessment, planning and intervention at locality level and support local neighbourhood partnership work. Intelligence will sit in one place - the Engine Room and so, ensuring a holistic view of demand and response to drive further commissioning and reform of services. The outcomes achieved by this will be to strengthen communities and improve outcomes for people in Bury. Specifically aimed at those who are defined as High Risk, Vulnerable and or Complex cases

It will serve all age groups within Bury, bringing together a range of services, organisations and initiatives to realise a preventative, early and crisis response through co-located and integrated working.

The focus of the Engine Room is based on the need to improve outcomes that will be supported by the integration of intelligence, data and analysis and timely communication between the Police, Local Authority and Health services and other key stakeholders.

Safeguarding Adult Reviews 2019-2020

A Safeguarding Adult Review (SAR) is a multi-agency review process which seeks to determine what agencies and individuals involved with an adult could have done differently that could have prevented death or significant harm from taking place.

There were 3 Safeguarding Adult Reviews during the 2019-20 reporting year, all of which were ongoing at the end of the period. This is a significant rise for Bury, and includes a nationally rare case of a SAR being undertaken on an adult who is still alive.

All recently published Safeguarding Adult Reviews can be found on the BISP website.

Multi Agency Training

It is part of the BISP's role to provide Multi-Agency Safeguarding training, on a variety of subjects to enhance is the development of its partner agencies. The following courses are currently available:

- Mental capacity Act Awareness
- Advanced Mental Capacity Act for SW's
- Safeguarding Vulnerable Adults Awareness
- Safeguarding Training for Social Workers
- Self-Neglect and Hoarding
- Raise Awareness of Domestic Violence
- Prevent
- Human Rights Awareness

Due to the change in the structure and provision of these services, there currently is no data available to analyse the effectiveness and impact of this training on the safeguarding practices in Bury, however it is intended to be included in the future reports to both the strategic partners and the relevant sub-groups.

Considerations for the 2020-2021 Report

As the transition into the BISP is completed, there are some areas that have been identified during the process of producing this report that should be considered for the next reporting period.

First of all, there is an inconsistency in the information provided by our partners, mainly due to the varying breadth and volume in which they operate. It is therefore advised that all services are asked for the same base of information and this is competed in identical formats to ensure a standardised and succinct response.

Secondly, as our responsibilities change, we will be expected to report on the process of Managing Allegations against a Person in a Position of Trust, in a similar vein to how referrals and outcomes are recorded and reported by the Local Authority Designated Officer (LADO) in relation to safeguarding children.

Acknowledgements and Closing Remarks

As the new Bury Integrated Safeguarding Partnership develops, there will no doubt be further challenges to overcome. At the time of writing this report, the country is still combating a global pandemic, which has led to the widespread changes in working and provision of services. The impact it has had will be felt for years, and will fundamentally change how we work moving forwards. This being said, it is vital to recognise the hard work and dedication of those staff who are making great sacrifices and taking substantial risks in ensuring that the most vulnerable citizens of Bury are supported and cared for in these challenging times.

Thanks also to all the services who contributed to the writing of this report, and to the partner agencies for providing their support and expertise in its development.

Agenda Item 7b

Classification Open / Closed	Item No.

Meeting:	Bury Health and Wellbeing Board
Meeting date:	14 April 2021
Title of report:	Child Death Overview Panel (CDOP) 2019/2020 Annual Reports for:- Bury, Rochdale and Oldham, Greater Manchester National Child Mortality Database.
Report by:	Insert Cabinet Members name and portfolio area Dr Rebecca Fletcher, Consultant in Public Health, Oldham Council, Chair of Bury, Rochdale and Oldham Child Death Overview Panel
Decision Type:	**Information/ Discussion or Decision *(delete as appropriate)*** Information
Ward(s) to which report relates	**Borough Wide**

Executive Summary:

The Bury, Rochdale and Oldham Child Death Overview Panel was established by Child Death Review Partners, Bury, Oldham and Heywood, Middleton and Rochdale Clinical Commissioning Groups and Bury, Oldham and Rochdale Councils to review the deaths of children under the requirements of the Children Act 2004 and working Together to Safeguard Children 2018.

Bury, Rochdale and Oldham 2019/2020 Child Death Overview Panel (CDOP) Annual Report has been written in line with the Child Death Review: Statutory and Operational Guidance (England). https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

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

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

This report reviews the deaths of children normally resident in the areas of Bury, Rochdale and Oldham, aged 0-17 years of age (excluding stillbirths and legal terminations of pregnancy) and focuses on the analysis of the number of cases closed in the year 1 April 2019 to 31 March 2020. The richness of the data and information collated assists in the identification of factors antenatally, postnatally and throughout the child's life. This report aims to highlight relevant factors and modifiable factors that are likely to contribute to Bury, Rochdale and Oldham child mortality rate.

Bury, Rochdale and Oldham CDOP is one of four CDOP's that operate within the Greater Manchester Network. This framework allows for the development of agreed standards and processes across Greater Manchester which includes the production of a Greater Manchester CDOP Annual Report the 2019/2020 Annual Report is included for your information.

2019 saw the introduction of a National Child Mortality Database (NCMD) which is an NHS funded programme, delivered by the University of Bristol. All CDOPs in England provide data to NCMD. The national data collection and analysis system is the first of its kind anywhere in the world to record comprehensive data, standardised across a whole country, on the circumstances of children's deaths. A copy of the NCMD 2019/2020 Annual Report is provided for your information.

The aim of CDOP and the NCMD is to drive improvements in the quality of health and social care for children in England and to help to reduce child mortality.

Recommendations

That Boards Members:

- Consider the recommendations in the presentation
- That the Board seek assurance that plans are in place to address potential modifiable factors identified in these reports.
- Disseminate these reports to the relevant departments within the health and wellbeing partnership to ensure shared learning
- That the Board note that arrangements are in place to discharge their statutory responsibilities in relation to Child Death Reviews.

Key considerations:

Introduction/ Background:

In 2019/2020 there were 79 cases notified to Oldham Bury and Rochdale CDOP and 29 cases were closed as their review process was completed. It is pertinent to note

that this report looks in detail at the 29 closed cases, however these deaths did not necessarily occur in the last 12 months. The duration of the review process can vary meaning that not all cases are closed in the same year that they are notified. This year closed cases numbers have been low across GM, and nationally, due to the introduction of new guidance and the additional workload associated with this change in practise.

The local and regional report consider the key characteristics of the child deaths that were reviewed by CDOPs in the past year. In addition, they draw out themes from the potentially modifiable factors in order to inform local work to reduce the risk of child deaths.

Key Issues for the Board to consider:

Modifiable risk factors are areas which may contribute to an increased risk of child death, and if addressed at a population level can reduce the risk of future child deaths. Modifiable factors recognised by Greater Manchester, that were identified in our local cases included: Maternal obesity, maternal smoking in pregnancy, parental smoking and unsafe sleeping. Other factors identified included drug and alcohol use, hospital and clinical factors and housing issues. Maternal obesity was the most common risk factor identified followed by maternal smoking in pregnancy. In 59% of the child deaths occurring in children under the age of 1, the mother was classified as obese or overweight. Until recent years this factor was not documented by the CDOP. This data highlights the risks associated with maternal obesity, and that this modifiable factor is becoming increasingly common. This is also reflected in the GM data.

Community impact/links with Community Strategy

Equality Impact and considerations:

Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to -

(a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*

(b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*

(c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Equality Analysis	*Please provide a written explanation of the outcome(s) of either conducting an initial or full EA.*
None	

**Please note: Approval of a cabinet report is paused when the 'Equality/Diversity implications' section is left blank and approval will only be considered when this section is completed.*

Legal Implications:

To be completed by the Council's Monitoring Officer

Financial Implications:

To be completed by the Council's Section 151 Officer

Report Author and Contact Details:

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Background papers:

- Oldham, Rochdale and Bury CDOP Annual Report
- GM CDOP Annual Report
- NCMD Annual Report

Please include a glossary of terms, abbreviations and acronyms used in this report.

Term	Meaning
CDR	Child Death Review
CDOP	Child Death Review Panel
GM	Greater Manchester
NCMD	National Child Mortality Database
NHS	Nation Health Service

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BURY, ROCHDALE & OLDHAM

Child Death Overview Panel

Annual Report

April 2019 – March 2020

Data Analysis & Author: Dr Annie Lowe,
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Support: Dr Rebecca Fletcher, PhD,
Consultant in Public Health
Bury, Rochdale and Oldham CDOP Chair

Publication: January 2021

Contents

Executive Summary:

This is an annual review of the Child Death Overview Panel (CDOP) data for Oldham, Rochdale and Bury (ORB), which combine to make one of the four CDOPs in Greater Manchester (GM). The CDOP reviews all child deaths under 18 years, but not including still births, late foetal loss or termination of pregnancy. The panel do not determine the cause of death but instead explores all the factors surrounding the death of the child. This learning enables required actions to be taken to protect the welfare of children and prevent future deaths.

Every year, each CDOP collates information on the cases that have been closed in the last 12 months in order to review for themes. This enables each area to identify any lessons learnt and recognise where population level interventions are required to reduce future child deaths. The report is supported by a GM report which gives an overview of patterns across all four CDOPS. In view of the relatively small numbers, and consequent difficulties with data analysis, this can be helpful when analysing for themes.

Key Findings in Oldham, Bury and Rochdale (ORB)

In 2019/2020 there were 79 notified cases and 29 closed cases. It is pertinent to note that this report looks in detail at the 29 closed cases, however these deaths did not necessarily occur in the last 12 months. Only once a case is closed is there the level of detail required to develop a narrative surrounding the death and therefore draw out themes. The duration of the review process can vary meaning that not all cases are closed in the same year that they are notified. The 79 notified cases in 2019/2020 are children that have died in the last 12 months, however at the time of writing this report these cases have not yet been reviewed. It is important to hold this in mind when interpreting the results of this report. This year closed cases numbers have been low across GM, and nationally, due to the introduction of new guidance and the additional workload associated with this change in practise. In addition, local factors such as a period of vacancy in the CDOP officer role and an organisational restructure of the local acute care provider, have created a backlog of cases which the team are currently working through.

The closed cases for the ORB CDOP equate to 33% of the total closed cases across GM, and ORB has a higher rate of notified cases, 5.09 per 10,000 compared to GM at 3.74 per 10,000. This is a consequence of the high rates of notified cases in Oldham, 7.22 per 10,000. The duration of review of cases was on average 579 days across ORB, this is longer than the average duration across GM which is 391 days. This is due the review duration in Oldham (633 days) and Rochdale (618 days), the highest in Greater Manchester. Many factors can affect the duration of the review process for example if a case requires a serious case review or Coroner's Inquest, the case will be delayed.

66% of the closed cases across ORB were expected deaths and 69% occurred within a hospital setting, with home setting being the second most common location. Males were overrepresented in closed cases at 62%, this is consistent with GM and national findings year on year, the reason for this is unclear.

Children are at the highest risk of death in the first year of life, and this is identified within the ORB data, 34% of cases were in the neonatal period and 58% in the first year of life. In relation to this, perinatal and neonatal events continue to be the most common cause of death, this is consistent with GM and national findings. Across ORB 35% deaths were caused by a perinatal/neonatal event, the leading cause of child death locally and nationally. The second most common cause of death was chromosomal/genetic/congenital abnormalities equating to 18% of the closed cases.

It is important to note that all the closed cases related to chromosomal, genetic and congenital abnormalities were children of BME ethnicity, and overall, there were higher rates of child deaths in BME groups across Bury and Oldham, but not Rochdale. This was consistent across GM and it is important that this inequality is addressed. Consanguinity is a known risk factor for congenital abnormalities and therefore an important risk factor when addressing child deaths. However, in the closed cases in this report where chromosomal, genetic and congenital causes were identified as the cause of death, consanguinity was not found to be a factor associated with the deaths.

Oldham and Rochdale also have higher rates of deprivation when compared to the North West and nationally. In relation to child deaths, there is a clear trend that as levels of deprivation increase, so do the number of child deaths. In ORB 31% of cases were in the most deprived decile and 79% were in the 5 lowest deciles, where decile 1 equate to the 10% most deprived of the population.

Modifiable risk factors are areas which may contribute to an increased risk of child death, and if addressed at a population level can reduce the risk of future child deaths. 31% of closed cases had modifiable risk factors identified. Modifiable factors recognised by GM that were identified in ORB cases included: Maternal obesity, maternal smoking in pregnancy, parental smoking and unsafe sleeping. Other factors identified included drug and alcohol use, hospital and clinical factors and housing issues. Maternal obesity was the most common risk factor identified followed by maternal smoking in pregnancy. In 59% of the child deaths occurring in children under the age of 1, the mother was classified as obese or overweight. Until recent years this factor was not documented by the CDOP. This data highlights the risks associated with maternal obesity, and that this modifiable factor is becoming increasingly common. This is also reflected in the GM data.

Introduction

The aim of this report is to analyse the child deaths within Oldham, Bury and Rochdale (ORB), to make observations on the causes and modifiable factors, in order to identify recurring themes. This helps guide population level interventions to reduce childhood mortality within the area. This annual report is presented to the Health and Wellbeing board to inform on the findings, the current interventions in place and future recommendations.

When a child dies a review process occurs to enable learning and to identify where changes could be made to prevent similar child deaths in the future. The Child Death Overview Panel (CDOP) will review the child deaths of all children under 18-years, but not including still births, late foetal loss or termination of pregnancy. Oldham, Bury and Rochdale combine to make one of the four CDOPS in GM.

The four CDOPs in Greater Manchester are split as follows:

- Manchester North – Oldham, Bury, Rochdale, CDOP
- Manchester South -Tameside, Trafford, Stockport CDOP
- Manchester West -Bolton, Salford, Wigan CDOP
- Manchester City -Manchester CDOP

Every year, each CDOP collates information on the child death in the last 12 months to enable thematic learning to guide decision making on population level interventions. The report is supported by a GM report which gives an overview of patterns across all four CDOPS. In view of the relatively small numbers, and subsequent difficulties with data analysis, this can be helpful when analysing themes.

This report includes information for cases closed between 1st April 2019 and 31st March 2020. During this time there were 129 closed cases and 241 notified cases of child death across GM. Within the ORB CDOP there were 29 closed cases and 79 notified cases. A case is defined as closed at the end of the CDOP review process.

Infant Mortality in the UK and comparisons with ORB

Over recent decades the UKs infant mortality rates has fallen, however the rate of improvement has slowed when compared to other European countries. After three years of slight increases in infant mortality between 2014 and 2017, a small decrease was noted in national data in 2018[1].

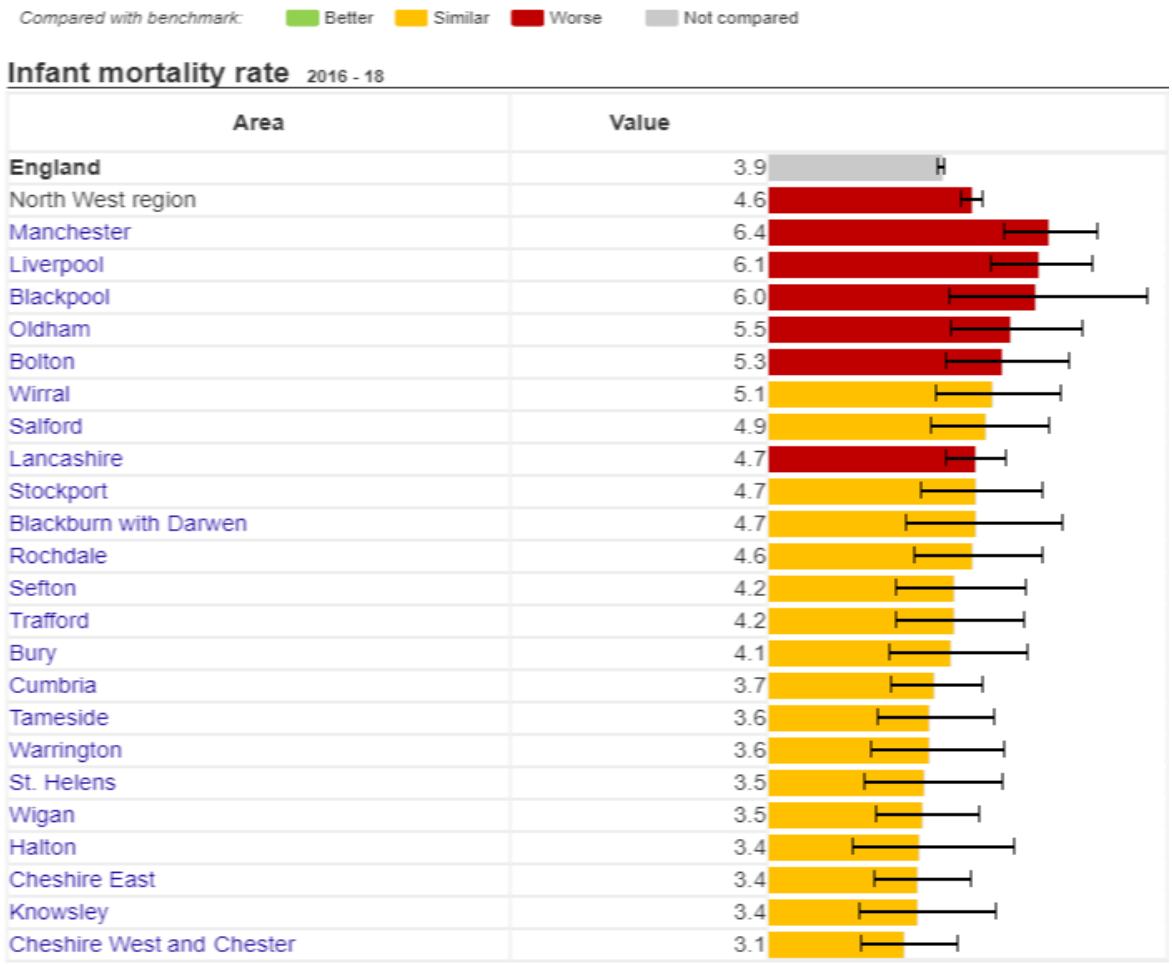
Across the UK, there are inequalities in child deaths and factors such as geography, deprivation and ethnicity affect rates of childhood mortality. For example, infant mortality rates are significantly higher in the 10% most deprived areas compared with the 10% least deprived areas in England. In

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/childhealth/articles/ukdropsineuropeanchildmortalityrankings/2017-10-13

addition, infant mortality rates are highest among babies of Pakistani ethnicity and lowest in babies of white ethnicity[2]. These themes are reflected within this report.

The crude rate Infant mortality (2016-2018) across England is 3.9 per 1000 births, across the North West it is higher than nationally at 4.6 per 1000 births. Whilst Bury and Rochdale have a similar infant mortality rate to the rest of England, Oldham performs worse at 5.5 per 1000, this is demonstrated in figure 1.

Figure 1: Infant Mortality Rate, per 1000 births, by local authority, 2016-2018



Source: Office for National Statistics (ONS).
https://fingertips.phe.org.uk/search/Infant%20mortality#page/3/gid/1/pat/6/par/E12000002/ati/202/are/E08000002/iid/92196/age/2/sex/4/cid/4/tbm/1/page-options/ovw-do-0_cin-ci-4_car-do-1

[2] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018#:~:text=1.-,Main%20points,of%203.6%20recorded%20in%202014

Overview of Oldham, Bury and Rochdale Population aged under 18yrs

Across ORB there are approximately 153,288 children under the age of 18, equating to 24% of the total population of the area. There is minimal difference and when comparing the percentage of the population under 18 years of each local authority to GM and national population data. One thing to note is that Oldham has a slightly higher percentage of under 18 years within its population at 25%, as seen in Table 1.

Table 1: Number of children aged under 18 in Oldham, Bury and Rochdale

Area	Under-18 Population size	Total Population	% population under -18
Bury	43,289	190,990	23%
Oldham	59,592	237,110	25%
Rochdale	50,407	222,412	23%
Bury, Oldham, Rochdale (ORB)	153,288	650,512	24%
Greater Manchester (GM)	644,540	2,835,686	23%
England	12,642,441	56,286,961	22%

Source: Mid-2019: April 2020 local authority district codes version of this dataset[*https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland*]

Reviews of child death cases 2019/2020

Closed Cases 2019/2020

In 2019/2020 there were 29 closed cases across the ORB CDOP. As seen in table 2, the closed cases in ORB account for 23% of GM closed cases. Oldham has the highest rate of closed cases, 2.35 per 10,000 of the population.

Table 2: Number and percentage of deaths (cases closed) across ORB 2019/20			
Area	**Total Deaths (Closed Cases)**	**Percentage of overall GM deaths (Closed cases)**	**Rate of Closed cases per 10,000 population**
Bury	7	5%	1.62
Oldham	14	11%	2.35
Rochdale	8	6%	1.59
ORB	29	23%	1.89
GM	129	100%	2.00

Source: GM CDOP Data 2019/2020

It is important to note that whilst these cases were closed during this time, the deaths did not necessarily occur in the same 12-month time frame, due to the variable duration for a case to be closed. Seven of the closed cases were deaths that were notified in the 2019/2020 time period, equating to 24% of the closed cases reviewed in this paper, this compares to 15% average across GM, see table 3. For the purpose of the CDOP annual report, the closed cases are discussed, as these offer the level of detail required to identify themes. It is important that this is kept in mind when interpreting the findings of this report.

Table 3: Notified cases closed in the same year (2019/20)				
Area	**Total Number Notified Cases 2019/20**	**Total Number of Closed Cases 2019/20**	**Number of cases notified and closed in 2019/20**	**% Cases notified and closed in 2019/20**
ORB	79	29	7	24%
GM	255	129	38	15%

Source: GM CDOP Data 2019/2020

This year the number of closed cases has fallen across both ORB and GM, table 4 demonstrates these trends. This is the lowest number of closed cases seen for the last 8 years. This issue has been seen nationally, due to the introduction of new guidance and the increase in workload that this has created. In addition, locally the CDOP Officer role has been vacant, and the local acute care provider has been going through a major organisational restructure. As part of this restructure a new IT data collection system has been introduced, this means that data has been archived which has slowed down the recovery of information requested by CDOP. Previous drops in ORB closed cases in 2013/14 and 2016/17 are also due to the CDOP officer role not being covered.

Table 4: Number of Closed Cases compared by year across each area								
Area	**Number of Closed Cases per year**							
	2012/13	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Bury	20	13	17	17	11	14	12	7
Oldham	27	24	36	29	25	31	14	14
Rochdale	25	20	28	28	15	26	27	8

ORB	72	57	81	74	51	71	53	29
GM	267	216	262	236	231	274	204	129

Source: ORB CDOP report 2017/2018 & GM CDOP data analysis 2019/2020

Notified cases 2019/2020

Between 1st April 2019 and 31st March 2020 there were 79 notified child deaths across ORB, this equates to 33%, an over representation of the child deaths in GM, this is consistent with previous years. Whilst Bury and Rochdale have a similar rate of notified cases compared to GM, Oldham has a higher rate at 7.22 per 10,000 of the population and equates to approximately half of the child deaths in the ORB CDOP, see table 5.

Table 5: Number, percentage and rate per 10,000 of notified deaths across ORB, 2019/20

Area	Number of Notified Deaths	Percentage of overall GM deaths	Population 0-17 yrs	Rate of Notified cases per 10,000 population
Bury	16	7%	43289	3.7
Oldham	43	18%	59592	7.22
Rochdale	20	8%	50,407	3.37
ORB	79	33%	153288	5.15
GM	241	100%	644540	3.74

Source: GM CDOP Data 2019/2020

Duration of Reviews

The duration of review can be described as the number of days from the notification of death to closing the case following the CDOP review. In 2019/20 the range for duration of review of ORB closed cases was 1855 days. The average duration of review across ORB was 597 days, higher than the GM average at 391 days. Oldham and Rochdale had the longest average duration of review compared to all other local authorities across GM at 633 days and 618 days respectively, see table 6. There may be a number of explanations for this range, for example factors such as the cause of death or when additional investigations such as coroner's inquest or serious incident investigations are required, which can delay a case from reaching CDOP. The factors discussed as reasons for a reduction in the number of closed cases, are also likely to have contributed to delays in the review process.

Table 6: Average Duration of Review by Area	
Area	**Duration of Review (Days)**
Bury	425
Oldham	633
Rochdale	618
ORB	579
GM	391

Source: GM CDOP Data 2019/2020

Expected/ unexpected deaths

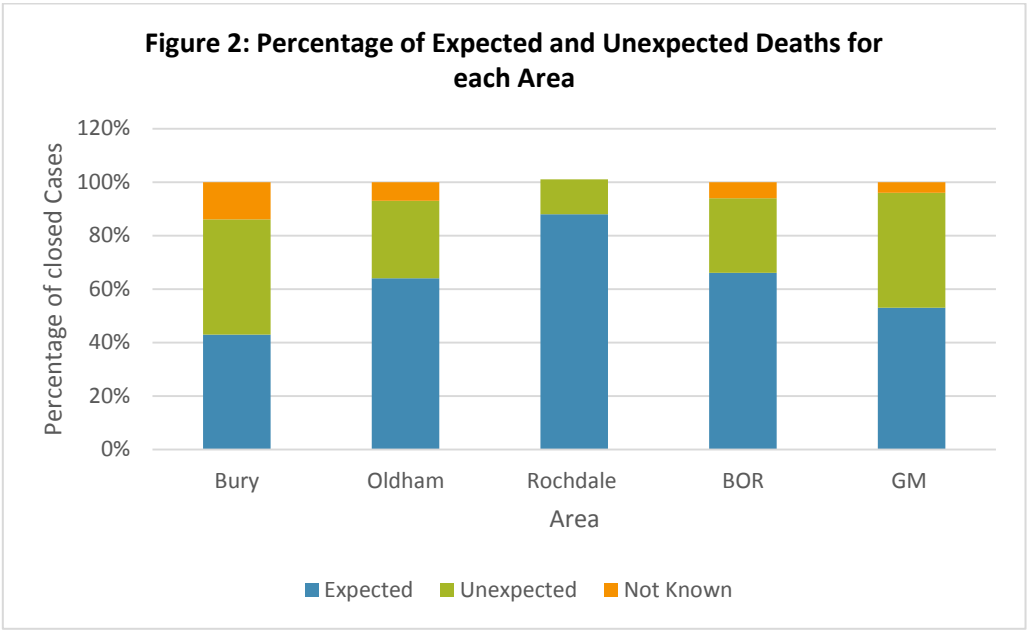
Table 7 shows that 66% of ORB deaths were expected and only 28% were unexpected. This is less unexpected deaths when compared to GM. This may represent a greater burden of childhood chronic disease.

Table 7: Comparing Expected and Unexpected Deaths by Area (2019/2020)							
Area	**Expected**		**Unexpected**		**Not Known**		**Total**
	No	**%**	**No**	**%**	**No**	**%**	**No**
ORB	19	66%	8	28%	<5		29
GM	69	53%	55	43%	5	4%	129

Source: GM CDOP Data 2019/2020

Figure 2 shows the proportion of expected deaths compared to unexpected deaths for each local authority area. Of the three local authorities Bury appears to have the highest percentage of unexpected deaths, however this more likely to be due to the small number of deaths, rather than a significant finding.

Figure 2: Percentage of Expected and Unexpected Deaths for each Area



Source: GM CDOP Data 2019/2020

Location of Death

The majority of deaths occurred in a hospital setting across all three localities. Table 8 shows that ORB had a higher percentage of deaths in hospitals when compared to GM. This year GM had a higher percentage of deaths in other locations compared to previous years, this is not reflected in the ORB data. Deaths in hospital are more likely to do due to a perinatal or medical cause, rather than sudden unexpected death which would be more likely to occur in the home environment.

Table 8: Comparison of Location of Death 2019/2020

Area	Hospital		Home		Other	
	No	%	No	%	No	%
ORB	20	69%	7	24%	<5	
GM	60	47%	34	26%	35	27%

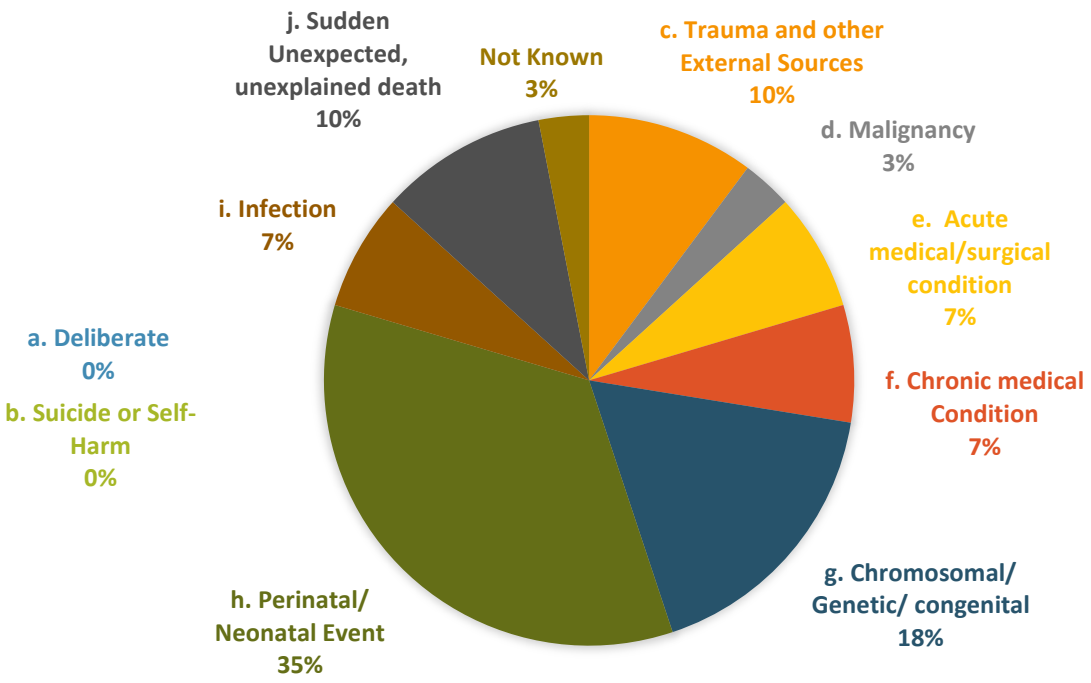
Source: GM CDOP Data 2019/2020

Causes/Category of Death

As part of the CDOP process each case is assigned a category of death from 10 defined options. The classification system is hierarchical therefore the category of death with the most relevance will be recorded as the primary category and cause of death, and others as secondary categories. The nationally defined categories of death as follows:

a. Deliberate inflicted injury, abuse or neglect
b. Suicide or deliberate self-harm
c. Trauma and other external factors
d. Malignancy
e. Acute medical or surgical condition
f. Chronic medical condition
g. Chromosomal genetic and congenital anomalies
h. Perinatal/neonatal event
i. Infection
j. Sudden unexpected, unexplained death

FIGURE 3: PIE CHART TO SHOW CAUSES OF DEATHS ACROSS ORB AS PERCENTAGE OF ALL CLOSED CASES



Source: GM CDOP DATA 2019/2020

Figure 3 clearly demonstrates that perinatal and neonatal events were the most common cause of death, followed by chromosomal, genetic and congenital abnormalities. When combined, these two categories equate to half of the child deaths in ORB. This is consistent across GM, in line with national trends and the same as previous years. There were no deaths classified as deliberate or suicide and self-harm. All other categories equate to a small number of deaths.

Due to the small number of cases it is difficult to compare causes of deaths by local authority. However, perinatal/neonatal events and chromosomal/genetic/congenital causes are the leading category of death across all three local authorities.

Socio-demographics of cases closed in 2019/2020

Gender

When comparing deaths across the local authorities by gender, males appear to be over-represented at 62% when compared to females 38%, as seen in table 9. This is consistent with GM findings and national trends. The reason for this discrepancy is unclear.

Table 9: Number of cases closed by Gender in ORB and GM				
Area	Female		Male	
	No	%	No	%
ORB	11	38%	18	62%
Greater Manchester	61	47%	68	53%

*Source: GM CDOP DATA 2019/2020 *Note that 1 closed case in GM where Gender was not determined*

Ethnicity

In all three areas, White British is the predominant ethnicity, with 68% of the child population across ORB classified as white and 32% as BME. This is similar to the variance in ethnicity across GM. Of note, Oldham BME child population is 40% compared to 28% GM, see table 2. Both are substantially higher than the UK national figures, which according to 2011 census data, 13% of the UKs population belong to BME groups[3], see table 10.

Table 10: Child Population Ethnicity across Oldham, Bury and Rochdale, using mid 2019 population estimates.					
Area	Total under 18 population	White		BME	
		No	%	No	%
Bury	43289	34631	80%	8658	20%
Oldham	59592	35755	60%	23837	40%
Rochdale	53299	36243	68%	17056	32%
ORB	156180	106629	68%	49551	32%
GM	629278	451275	72%	178003	28%

Source: GM CDOP Data analysis 2019/2020. Based on mid-2019 population estimates

Table 11 shows that ORB and GM figures are similar when comparing child deaths by ethnicity. Both show a higher percentage of child deaths in the white population which is to be expected in view of higher proportion of the population of this ethnicity. However, both have a higher rate of closed cases in the BME population, suggesting that although numbers are small that BME child deaths are over-represented. This is most striking in Oldham where the rate of child deaths is 3.36 per 10,000 in BME children compared to 1.68 per 10,000 in white children, exactly double. Clearly there is a health inequality associated with ethnicity. Rochdale does not show this trend, however this may be due to the small number of total cases.

[3] https://www.ethnicity-facts-figures.service.gov.uk/

Table 11: Cases Closed by Ethnicity for Each Area						
Area	White			BME		
	No	%	Rate/10,000	No	%	Rate/10,000
Bury	<10		1.44	<5		2.31
Oldham	6	43%	1.68	8	57%	3.36
Rochdale	<10		1.93	<5		0.59
ORB	18	62%	1.69	11	38%	2.22
GM	79	61%	1.75	50	39%	2.81

Source: GM CDOP data analysis 2019/2020

When comparing the cause of death and ethnicity, difficulty arises due to the small number of cases. The one clear finding is that all the closed cases with chromosomal, genetic and congenital causes were in children of BME ethnicity. This corresponds with national data that identified that whilst prematurity related conditions were the main cause of infant mortality overall, in Pakistani and Bangladeshi ethnic groups more infant deaths were caused by congenital anomalies[4]. Having consanguineous parents is a known risk factor for congenital abnormalities, and potential explanation for this variation nationally. However, the closed cases in this report where the category of death was chromosomal, genetic and congenital causes were not found to be related to consanguinity.

Inequalities & Index of Multiple Deprivation (IMD)

Deprivation is known to be a contributing factor to many of the risk factors associated with child deaths. The index of multiple deprivation 2019 (IMD) is an overall measure of deprivation taking into account not only income deprivation, but also key resources needed for an individual to meet their basic needs, such as education, employment, health and disability, housing and living environment.

All three local authorities have higher rates of deprivation when compared to both GM and nationally. Oldham and Rochdale in particular, are categorised as being in the 'most deprived' quintile, as demonstrated in table 12. Both have a higher percentage of people living in the 20% most deprived areas in England, when compared to Bury, GM and nationally.

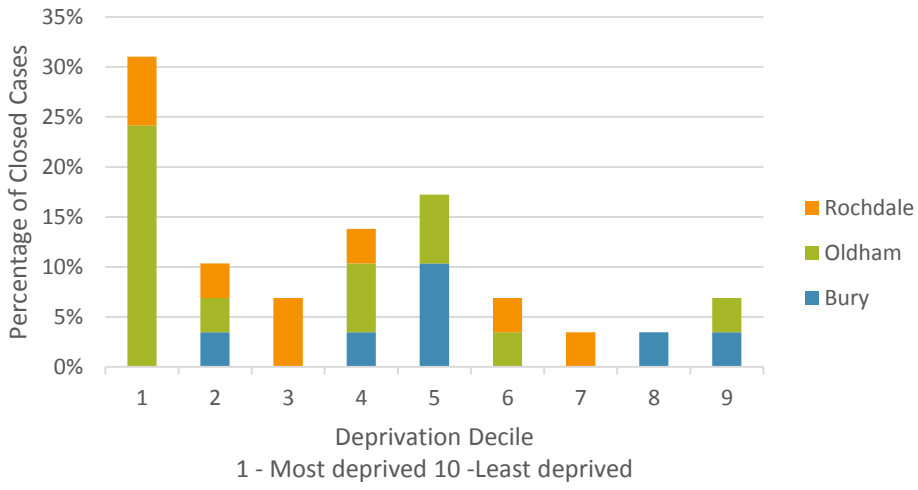
[4] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018#:~:text=1.-,Main%20points,of%203.6%20recorded%20in%202014

Table 12: Comparison of Deprivation, by IMD 2019 and percentage of people living in the 20% most deprived areas in England, for Oldham, Bury and Rochdale.		
Area	**IMD 2019**	**Percentage of people living in the 20% most deprived areas in England**
Bury	23.7	20.5%
Oldham	33.2	43.6%
Rochdale	34.4	44.5%
North West	28.1	31.9%
England	21.7	20.2%

Source:https://fingertips.phe.org.uk/search/deprivation#page/3/gid/1/pat/6/par/E12000002/ati/102/are/E06000008/iid/93553/age/1/sex/4/cid/4/page-options/ovw-do-0_car-do-0

IMD scores can be split into deciles to enable comparisons to be made, where decile 1 equates to the most deprived 10% of the population and decile 10 is the least deprived 10%. Figure 4 shows a clear trend between deprivation and the risk of child deaths, with 31% of closed cases in ORB being in the most deprived decile, and 79% of cases in the lowest 5 deciles. As deprivation falls so does the number of child deaths, this is in keeping with national trends. Oldham appears to have the highest numbers of death in the most deprived decile, despite similar deprivation levels to Rochdale. This may be due to the higher number of closed cases within Oldham.

Figure 4: Percentage of Closed Cases in each Decile of Deprivation split by Area

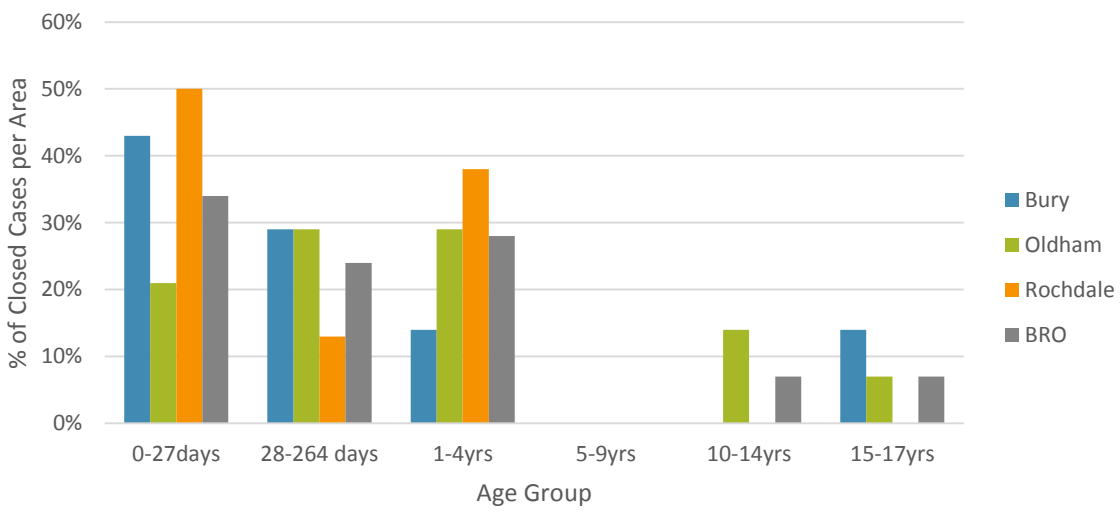


Source: GM CDOP Data 2019/2020

Age at death

Younger children have the highest risk of childhood mortality, and the highest risk of death is during the neonatal period[5]. Figure 5 demonstrates that as age increases the number of deaths falls. In ORB 34% of closed cases were in the neonatal period and 58% within the first year of life. This is consistent with GM and national trends. The percentage of closed cases in the neonatal period is less than previous years, for example in 2016/2017 neonatal deaths accounted for 59% of the deaths. Across all three local authorities most closed cases are before the age of 5 years.

Figure 5: Proportion of Closed Cases by Age Band for each Area



Source: GM CDOP Data 2019/2020

Figure 5 shows that whilst Bury follows the expected trend, both Oldham and Rochdale have a higher proportion of closed cases in the 1-4 years category than previous years. It is important to note that numbers are small, with a total of 8 closed cases in this category, therefore it is difficult to identify a reason for this and may be due to chance. Deaths in this age group appear to fall into three main categories:

- A health condition that subsequently led to the death
- Trauma and external factors
- Sudden unexpected unexplained death

Interestingly, 50% of these cases had modifiable risk factors, higher than average across the CDOP area. Table 13 summaries the number of child deaths and percentages for ORB and GM. Due to the small number of cases, individual areas are not included in this table.

[5] https://www.who.int/maternal_child_adolescent/documents/levels_trends_child_mortality_2019/en/

Table 13: Closed Cases by Age Band for Bury, Oldham, Rochdale and Greater Manchester												
Area	Age Category											
	0-27days		28-264 days		1-4yrs		5-9yrs		10-14yrs		15-17yrs	
	No	%	No	%	No	%	No	%	No	%	No	%
ORB	10	34%	7	24%	8	28%	0	0%	<5		<5	
Greater Manchester	47	36%	36	28%	19	15%	9	7%	13	10%	5	4%

Source: GM CDOP Data 2019/2020

Low birth weight and Prematurity

Preterm delivery is defined as any birth before 37 weeks of pregnancy and can be subdivided depending upon gestational age[6]:

- Extremely preterm -less than 28 weeks
- Very preterm -28-32 weeks
- Moderate to late preterm -32-37 weeks.

Preterm delivery and the associated complications are the leading cause of infant mortality[5]. The earlier the gestation at which a baby is born, the higher the risk of infant death[7]. Preterm delivery is associated with risk factors such as poverty and maternal smoking[8]. 76% of all deaths in children under 1 year were born prematurely across ORB. This was consistent across all three localities ranging from 71% -80%.

Low birth weight, defined as under 2500 grams, is often caused by a premature birth, and whilst some risk factors are unavoidable others include maternal smoking, drug and alcohol use, poor pregnancy health and nutrition, pregnancy related complications and mothers young age[9]. Birth weight for closed cases under the age of 1 have been compared across the localities in table 14. Across ORB 59% of closed cases under 1 year were associated with a low birth weight.

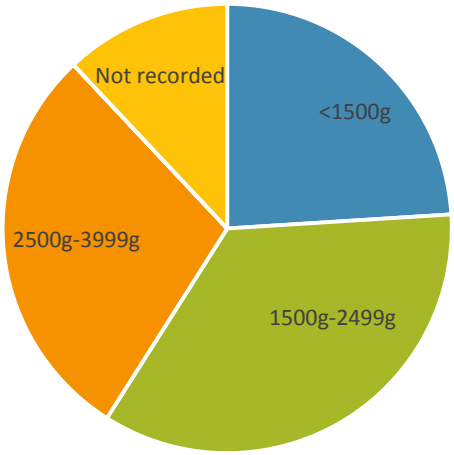
Table 14: Birth weight of closed cases for babies under 1 year only							
Area	<2500g Low Birth Weight		>2500g Healthy Birth weight		Not recorded		Total
ORB	10	59%	<10		<5		17
GM	46	56%	28	34%	8	10%	82

Source: GM CDOP Data 2019/2020

[6] https://www.who.int/news-room/fact-sheets/detail/preterm-birth
[7] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018#:~:text=1.-,Main%20points,of%203.6%20recorded%20in%202014
[8] https://www.rcpch.ac.uk/sites/default/files/2018-10/child_health_in_2030_in_england_-report_2018-10.pdf
[9] https://www.nuffieldtrust.org.uk/resource/low-birth-weight

Figure 6 demonstrates the further breakdown of birth weights in closed cases under 1 years. 1500g-2499g was the most common weight category, but 24% were less than 1500g, known as 'very low birth weight'. A low birth weight, particularly below 1500g is associated with higher mortality rates[10]. All three localities had closed cases where birth weight was less than 1500g.

Figure 6:Birth Weight for Closed Cases under 1 years across ORB



[10] https://www.who.int/bulletin/volumes/95/8/16-180273/en/#:~:text=Compared%20with%20other%20infants%2C%20low,to%20the%20nearest%20health%20facility.

Modifiable and other risk factors

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

Form C, the child death review analysis form, is used by CDOP. All available information, gathered from different agencies, is reviewed in order to develop an understanding of the circumstances of the child's death and whether there were any associated modifiable factors. Through this process lessons can be learnt and shared, and local level action can be taken in order to reduce the risk of child death.

As part of the review, any factors that may have contributed to the child's death are identified.

These are split into four domains:

- Domain A: Factors Intrinsic to the Child
- Domain B: Factors in Social Environment including Family and Parenting Capacity
- Domain C: Factors in the Physical Environment
- Domain D: Factors in Service Provision

The level of influence is then determined, given one of the following:

- 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

Factors identified in closed cases in ORB that may have contributed to vulnerability, ill health or death

Domain A: Factors Intrinsic to the Child
• Acute Sudden onset illness • Other Chronic long- term illness (excluding Asthma, epilepsy and diabetes) • Learning disability • Motor Impairment • Sensory Impairment • Other disability or impairment
Domain B: Factors in Social Environment including family and parenting Capacity
• Emotional/behavioural/mental/physical health condition in a parent or carer
Domain D: Factors in Service Provision
• Prior medical Intervention

89% of the factors identified were in domain A, factors intrinsic to the child, which are unavoidable. The most common was acute sudden onset of illness identified in 23 cases, 79%.

Modifiable Factors

Some factors associated with a child's death are modifiable, these are important as targeted interventions can be used to reduce risk where factors reoccur. A set standard of modifiable factors has been agreed by the GM CDOP Network to ensure consistency when categorising the preventability of child deaths. This is to reduce the subjectivity surrounding these matters.

The agreed definition of Modifiable Factors Identified is:

'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'

The Modifiable Factors are categorised and defined as:

Modifiable Factors in Perinatal / Neonatal Deaths
• Maternal smoking in pregnancy • Maternal Obesity (BMI 30 +) • Mothers who are Underweight (BMI < 18.5) • Unbooked pregnancies • Concealed pregnancies • Necrotizing Enterocolitis (NEC) where the baby was not fed expressed breast milk
Modifiable Factors in Sudden Unexpected, Unexplained Deaths
• Unsafe sleeping arrangements (co-sleeping bed/sofa) • Parental smoking
Modifiable Factors in Consanguineous Related Deaths
• Where there has been an older sibling who has died or is affected by the same genetic autosomal recessive disorder

Across ORB 31% of cases had modifiable factors identified, ORB had a lower proportion of cases with modifiable factors when compared to GM demonstrated in table 15. All cases across ORB had sufficient information to identify modifiable factors.

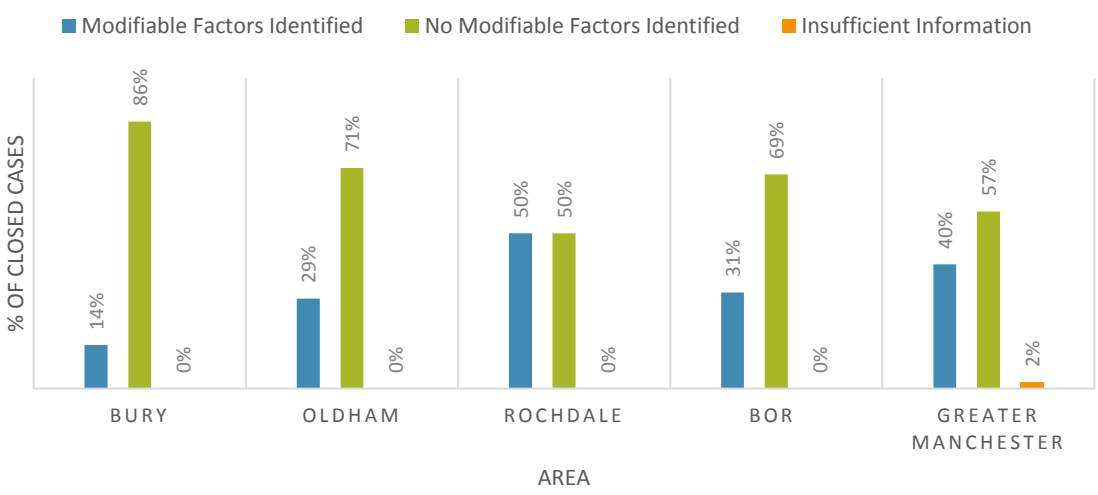
Table 15: Modifiable and Non-Modifiable Factors Contributing Towards Child Deaths in Oldham, Bury and Rochdale

Area	Modifiable Factors Identified		No Modifiable Factors Identified		Insufficient Information		Total
	No	%	No	%	No	%	No
ORB	9	31%	20	69%	0	0%	29
GM	52	40%	74	57%	3	2%	129

Source: GM CDOP Data 2019/2020.

When comparing the three localities, using Figure 7, Rochdale appears to have the highest proportion of modifiable factors, however, the actual number of cases with modifiable factors is equivalent to Oldham. Of the cases where modifiable risk factors were identified 78% had more than one factor, suggesting that modifiable factors are less likely to be found in isolation and in fact multiple factors combined are more likely to put a child's life a risk.

FIGURE 7: PERCENTAGE OF CLOSED CASES WITH MODIFIABLE FACTORS IDENTIFIED



Source: GM CDOP 2019/2020

Modifiable Risk Factors identified by the ORB CDOP in the closed cases of 2019/20 included:

- Maternal Obesity
- Maternal Smoking in Pregnancy
- Parental Smoking
- Unsafe Sleeping arrangements

It is important to note that whilst these factors were identified as modifiable factors, they were not felt to be factors that may have contributed to vulnerability, ill health or death of the child, and therefore not allocated a 2 when scored. Across GM maternal obesity has been recorded for the last three years, however, is not yet assessed to see whether this contributed to the child's death. Data was not recorded for un-booked pregnancy or concealed pregnancy, two of the modifiable risk factors defined by GM.

Other Identified Risk Factors

Other issues raised within the closed cases across ORB that are not defined within the GM CDOP Network:

- Modifiable factors in sudden, unexpected, unexplained deaths such as drug and alcohol use and housing

- Factors in service provision
- Consanguinity
- Window Blind Cord Injury

Understanding Modifiable Risk Factors and Local Initiatives

The following section will explore the modifiable risk factors that have been raised in further detail, and provide examples of what is being done to reduce the risk of child deaths through targeted interventions across the three localities.

Maternal Raised BMI

Preventing perinatal child deaths begins with a healthy pregnancy. Maternal obesity is a risk factor associated with many complications around birth and increased morbidity and mortality for baby. It is also known that social deprivation is associated with maternal obesity[11].

24% of closed cases in children under the age of 1 had maternal obesity identified. In 18% of closed cases in children under the age of 1, maternal obesity was felt to be a modifiable factor. Also, in this group 59% of mothers were overweight or obese, consistent with GM findings. Across GM obesity has overtaken smoking as the largest modifiable risk factor in child deaths, although numbers are small it would appear that a similar trend is emerging across ORB. In 29% of the child deaths under the age of 1, maternal BMI was not recorded. In view of the increasing concerns surrounding this issue, it is important that going forward this is recorded to enable review and understanding of the scale of the issue.

Health visitors across the three boroughs promote healthy eating particularly at times where infant feeding, weaning and child health promotion is carried out.

Oldham

A new Health Improvement and Weight Management service brings two previously separate services together to deliver a jointly commissioned, integrated service to Oldham. The new service will go-live on 1st January 2021.This new model of delivery will be family-centred and aligns with the wider work being undertaken within the Oldham's CCG's long-term conditions portfolio. The objectives for the new service model will contribute to:

- Reducing the proportion of adults who smoke
- Reducing the proportion of adults and children who are overweight or obese
- Reducing the proportion of adults who are physically inactive
- Provide advice regarding drinking alcohol within safe limits
- Reducing the proportion of adults that have a high vascular risk score through post NHS Health Check support
- Reduce the level of health inequalities.

[11] https://www.publichealth.hscni.net/sites/default/files/Maternal%20Obesity%20in%20the%20UK.pdf

Maternal Smoking in Pregnancy

Maternal smoking in pregnancy is known to double the risk of preterm delivery[12]. In 2018/19, nationally 10.6% of mothers were known to smoke at the time of delivery, this was higher in Oldham (13.6%) and Rochdale (16.1%)[13]. In this report maternal smoking during pregnancy was identified in 10% of cases, however maternal smoking was felt to be a modifiable risk factor and related to a perinatal/neonatal event in 3% of cases. In 13% of cases maternal smoking was not documented.

Health visitors make smoking enquiries at the first contact with the family and brief interventions are carried out using health promotion/motivational interviewing techniques. Smoking risks are discussed in relation to pregnancy at antenatal contacts and in relation to safe sleep/ongoing health of children. A smoke free home is promoted to support reduction of risks for pregnant women and/or other children from passive smoking. They also signpost to smoking cessation services, such as Lifestyle Service, and GP services.

Oldham and Rochdale

Since 2018 as part of the Saving Babies Lives requirements, Royal Oldham Hospital has used Babyclear, the GM smoke free pregnancy programme. This is funded up until March 2021. It is a midwifery led model, providing mothers with behavioural support, nicotine replacement therapy (NRT) and risk perception interviews with women who do not engage with services. Mothers from Rochdale will usually access Oldham or North Manchester for delivery, as there is no delivery unit in Rochdale, so would access the services provided within Northern Care Alliance.

Oldham have recently appointed a new midwife who, alongside maternity support workers, will delivery of this service. In order to reduce barriers to accessing NRT, the maternity unit are also piloting a service where NRT can be supplied directly to mums from the hospital. With recent COVID restrictions the team have not been able to use carbon monoxide monitoring, an important part of their service, however it is hoped that it will be reintroduced in the coming months. The team collect and review monthly data to look at trends, they have noted that across both Oldham and Rochdale the number of women smoking at the time of delivery is starting to decline. It is hoped that the recent changes will help to further this decline. The other elements of Saving Babies Lives are explored further in a later section of this report.

Risk factors associated with Sudden, Unexpected, Unexplained Deaths: Parental Smoking & Unsafe Sleeping

Whilst the exact cause for a sudden and unexpected child death is not known, a number of risk factors are likely to contribute, making a child more vulnerable to death. 300 infants die suddenly and unexpectedly in England and Wales each year, these deaths often occur in families where

[12] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

[13]https://fingertips.phe.org.uk/search/smoking#page/3/gid/1/pat/6/par/E12000002/ati/102/are/E08000004/iid/93085/age/1/sex/2/cid/4/page-options/ovw-do-0_car-do-0

circumstances put the child at an increased risk[14]. Safe sleeping advice is known to significantly reduce the risk of child death, and around 60% of sudden infant deaths could be avoided if no baby was exposed to smoke[15].

10% of closed cases were identified as sudden, unexpected and unexplained deaths in ORB. Two thirds of these were felt to have modifiable factors including smoking, safe sleeping, housing, drugs and alcohol. Information regarding prone sleeping, co-sleeping and overheating was not routinely collected, and only mentioned when identified as a modifiable risk factors or issue.

Across ORB safe sleeping guidance is discussed by health visitors at contacts from the antenatal period through the first year of life. Guidance from the Lullaby Trust and Basis is promoted. Risk assessments based on a family's individual circumstances are made where the checklist in a childs Red Book (PCHR) is checked, this has usually been completed by the midwife. Conversations are tailored to the individual family using motivational interviewing techniques, for example if risk factors are present these are discussed to support parental decision making. The health visiting teams receive regular updates from Lullaby Trust and utilise their parent information resources to provide information.

Rochdale

Rochdale Local Safeguarding Partnership have developed an initiative 'Keep Baby Safe', their current focus in on safe sleeping and coping with crying/abusive head trauma. These areas have been informed by local safeguarding reviews. They have developed multiagency sleep guidance and risk assessments which will be launched at a sleep training event in October 2020. These are underpinned by the findings of the national safeguarding panel review of Sudden Unexpected Death in Infancy. The Lullaby trust campaign materials are used during the antenatal and postnatal journey in order to raise awareness with parents, this includes events, information in antenatal packs, discussion with families and briefing professionals across multiple agencies to give the same clear message. The team have Public Health for one year to provide room thermometers which contain the key sleep safe messages.

Parental Alcohol/Substance Misuse

Parental drug and/or alcohol misuse was identified as an issue in 7% of closed cases. Across GM 8% of cases were identified as having drugs and alcohol as a factor which may have contributed to the childs death.

Routine enquiry is made at first contacts with the health visiting service and ongoing support is provided if this becomes or is an ongoing need for the family. Brief interventions are provided in terms of risks and dangers of drug/alcohol misuse around children. A referral to other services is made when a risk of potential significant harm is identified.

[14] https://www.gov.uk/government/publications/safeguarding-children-at-risk-from-sudden-unexpected-infant-death
[15] https://www.lullabytrust.org.uk/safer-sleep-advice/what-is-sids/

Consanguinity

Under the GM definitions of modifiable risk factors consanguinity is only recognised as a modifiable risk factor if the parents have had a previous child who has died from, or is affected by a genetic abnormality. Although consanguinity came up as an issue, no cases had a previous death related to the genetic abnormality and therefore was not formally identified as a modifiable risk factor. However, consanguinity remains a concern in view of the fact that child deaths are overrepresented in ethnic minority groups, particularly in Oldham, and the higher representation of deaths related to chromosomal and genetic disorders.

Health visitors provide supportive discussion around this and signpost families to the appropriate services such as genetics, this referral would likely be done by the GP. Health visitors would promote the importance of accessing national screening programmes to support the family in future pregnancies.

Oldham

In 2016 a Genetic outreach service in Oldham was established. The service works with local communities on genetic literacy and improving access to services. Aims of the service include reducing the prevalence of genetic disorders in the borough, empowering affected families in their decision making and providing support to affected families.

Access to Appropriate Health/Social Care

There were clinical concerns raised in 10% of cases with regards to hospital systems and the approach to care. Themes such as lack of early recognition of warning signs and appropriate escalation, poor record keeping, and the following of procedures were seen in the cases. However, each case occurred in a different departments and teams. When problems with the delivery of healthcare are identified these are managed before the CDOP review. They are discussed during the child death review meeting where professionals who have been directly involved in the child's care meet to discuss how things can be improved. Where patient safety is felt to have been compromised an NHS serious incident investigation will also be carried out. CDOP therefore acts as safety net, or a fresh pair of eyes, at the end of the process to ensure that nothing has been missed. In these cases, the panel sought assurance that the action plans initiated following on from Serious Incidents had been implemented.

Saving Babies Lives

Saving Babies Lives is a national evidence-based care bundle that aims to reduce perinatal mortality. The care bundle has recently been updated to version two and brings together five elements including: reducing smoking in pregnancy, improved detection and management of babies who are

small for gestational age, raising awareness of reduced fetal movements, effective fetal monitoring during labour and reducing preterm births.[16]

At Royal Oldham Hospital the maternity service is fully compliant across all areas apart from fetal monitoring, where a few minor amendments are being made, and preventing premature births, once a premature clinic is set up in November, all requirements will be met. Recent changes have been made to ensure compliance with version 2 of saving babies lives, and to improve the service offered. This has involved many areas of work including improved training packages for midwives, sonographers and clinicians, developing a competency tool around fetal growth, regular auditing of notes, computerised CTGs for reduced fetal movements (particularly for small babies and other at risk pregnancies), and a new prematurity clinic to start in November. Changes to the smoking service are discussed earlier in this report.

Emotional/behavioural/mental/physical health condition in a parent or carer

The emotional, behavioural, mental or physical health condition of a parent or carer may have an effect upon the health of a child and the care they receive. In 10% of cases a parent or carers health was felt to have contributed to vulnerability, ill health or the death of the child, however in two thirds of these cases no modifiable factors were identified. It is important that in situations where parents have their own health difficulties appropriate support is available to ensure that the health and welfare of the child is not compromised.

Accidents and Trauma

Trauma and other external sources accounted for 10% of closed cases, these included accidents such as blind cord injury and road traffic collision. The Royal Society for the Prevention of Accidents works across the UK to help prevent accidents occurring in view of their devastating consequences. As part of this work they have a specific campaign for blind cord injuries. They report that at least 33 young children across the UK have died due to blind cords since 2001. Their work includes working with manufacturers to make products safer and also providing education and campaign materials.

Health visitors across ORB address the accidents and trauma reports from the local A&E and Children's hospital departments via the 'Duty' process. A&E/Hospital admissions are reviewed on receipt via the service and documented on the chronology for the child. The review is provided in the context of the child's records and the risk factors present are considered. If the child has a named health visitor they will be informed and appropriate follow up provided. If the child is 'universal' and attends A&E, the incident is reviewed and follow up provided if needed. If the child attends for 3 or more incidents within one year this will also be reviewed and follow up provided. A&E and hospital attendance information will be shared with the Multi-agency Safeguarding Hub

[16] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

(MASH) and safeguarding/child protection multi-agency if required. Health visitors may challenge cases and escalate to the Safeguarding Team if the acute settings have not followed procedures for potential non-accidental injuries in children. Support is also provided for parents in regards to 'coping with crying'. Health visitors can signpost to relevant resources such as the Institute of Health Visiting (iHV) Parent Tips 'Coping with a Crying Baby During the Covid-19 Pandemic[17]'and ICON[18].

Other Risk Factors:

Other Risk factors that can be associated with child deaths, but not identified in the cases discussed in this report:

- Domestic Violence
- Statutory Intervention
- Suicide or self-harm
- Late Booking or concealed pregnancies.

These risk factors were not identified in the closed cases discussed in this report.

[17] https://ihv.org.uk/wp-content/uploads/2020/04/PT-Coping-with-a-crying-baby-during-COVID19-FINAL-VERSION-14.4.20.pdf
[18] https://iconcope.org/parentsadvice/

Recommendations and Actions

The following recommendations and actions are based upon the findings of this report.

Actions

- This year a reduction in closed cases has been seen across GM. ORB CDOP have reflected on potential reasons for this and the reasons for the increase in the length of the review process. The team are working hard to access the information required to work through the backlog of cases.

Recommendations

- Whilst the CDOP process is extremely thorough in its review of potential modifiable risk factors, there are several additional factors that could be considered. CDOPs could consider looking at factors such as a maternal age, as a risk factors, and breastfeeding as protective.[19] These may help to identify other areas where intervention may be required such as young mothers services, or breast feeding education and services.

- Data for unbooked pregnancy and concealed pregnancy was not recorded in the ORB data set, these are modifiable risk factors recognised by GM and therefore there may be benefit from reviewing these. Note that these may not have been included because these factors did not arise in the cases this year.

- Be aware that maternal obesity is of growing concern as a risk factor for neonatal death. It is becoming increasingly common across Greater Manchester, and the ORB CDOP. It is important to record maternal obesity in child deaths under the age of one, where it may be relevant, in order to observe for trends in the data. GM could consider inclusion of obesity as a risk factor to review whether it contributed to the child death using the standardised review system.

- Children living in deprived neighbourhoods or who are BME ethnicity continue to be over-represented in the child deaths, this needs continued acknowledgement and address. This knowledge should be embedded within services, and teams educated, in order to raise awareness for these discrepancies and to ensure that work is done wherever possible to reduce child deaths.

- It is advised that this report is disseminated to the relevant departments, within the health and wellbeing partnership organisations, in order to share learning.

[19] https://www.rcpch.ac.uk/sites/default/files/2018-10/child_health_in_2030_in_england_-report_2018-10.pdf

Greater Manchester Child Death Overview Panels (CDOP)

2019/2020 Annual Report

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Publication: 15 December 2020

CONTENTS

1. EXECUTIVE SUMMARY

1.1 Introduction

This is the 8th annual report reviewing all infant and child deaths reported to the four Greater Manchester (GM) Child Death Overview Panels (CDOP). This report includes data from cases closed between 1st April 2019 and 31st March 2020 (2019/20).

All deaths of children between 0-17 years of age are reported to a CDOP. The CDOP analyses the social and medical circumstances surrounding these deaths, including risk factors which could potentially be avoided to prevent future child deaths. The aim of this report is to inform and guide local organisations on preventing further child deaths.

1.2 Key Findings

During 2019/20, there were 129 child death cases closed and 240 child death notifications. This is a significant reduction in the number of cases closed (204 in 2018/19), mainly a consequence of the significant changes to the child death review process. This reduction in closed cases means it is difficult to draw statistically significant conclusions in comparison to year's previous data. The number of child death notifications during 2019/20 (240) is similar to previous years.

The majority of child deaths occurred within the first year of life (n=83; 64%), with a large proportion occurring in the first month (47; 36%). This is similar to previous report findings. The older age groups: 1-4, 5-9, 10-14 and 15-17, accounted for 15%, 7%, 10% and 4% respectively.

Of all closed cases in 2019/20, 94 cases (72%) were due to medical causes. 'Medical causes' encompasses multiple official categories of causes of death including acute medical or surgical, chronic medical, chromosomal, perinatal/neonatal event, malignancy and infection. Small numbers were attributable to non-medical causes including trauma, deliberate harm/abuse/neglect, suicide/self-harm and sudden unexpected/unexplained death (see Appendix 1).

Of the cases closed, 61 were female (46%) and 68 males (54%). This gender balance is in line with previous regional and national results. This difference is marked in age categories, reflecting that certain causes of death are gender and age specific. For example, trauma is more common in the older children/adolescents and males. However, owing to small numbers in these categories, it is difficult to draw significant conclusions.

GM has a significantly higher Black, Asian, and minority ethnic (BAME) child population (28%) than the UK average (15%). 63% of cases closed were children of White British ethnicity, whilst 37% were children from BAME groups. This clearly shows a higher proportion of child deaths within the BAME communities. These numbers represent 1.75 per 10,000 White British child deaths, compared to 2.81 per 10,000 BAME child deaths. This difference represents a significant health inequality.

Poverty and deprivation correlates closely with the patterns of child deaths in GM. 34% of children in GM fall within the fifth most deprived areas in England and Wales. Of the 129 cases closed, 55% of children lived in the most deprived quintile, compared to 62% in the previous year. A further 20% of deaths occurred in the second most deprived quintile meaning three quarters of all children who died resided in areas of deprivation.

A death is deemed to have potentially modifiable factors, where factors are identified as having contributed to the death of the child and which might, by means of locally or nationally achievable

intervention, be modified to reduce the risk of future child deaths. Specific examples of modifiable factors considered across GM can include unsafe sleeping arrangements where sudden unexpected/unexplained death occurs, maternal obesity in pregnancy in perinatal/neonatal deaths, and consanguinity in chromosomal, genetic and congenital anomaly related deaths. Modifiable factors were identified in 40% of all closed cases. Nationally, 27% of cases are identified to have associated modifiable factors meaning GM is above the national average.

Smoking was identified as a modifiable factor in 10% of all cases closed. Smoking was also identified as a risk factor (relevance score of 2, see Section 3: Modifiable Factors and Relevant Risk Factors) that may have contributed to vulnerability, ill health or death of the child.

Maternal obesity in pregnancy (Body Mass Index (BMI) 30+) was identified as a potentially modifiable factor in 9% of cases closed and considered a risk factor that may have contributed to vulnerability, ill health or death of the child in 11% of all cases. This is broadly in line with previous year's reports.

Though numbers are relatively small, this emphasises smoking and maternal obesity as key contributing factors and modifiable factors to child death. Despite ongoing efforts to reduce both, their influence in the death of children remains steady. The links between smoking and maternal obesity strongly correlate with deprivation, meaning highlighting a significant health inequality.

1.3 The Child Death Review Process

This is the 8th GM CDOPs Annual Report. In line with the publication of Working Together to Safeguard Children (2006), CDOPs became a statutory function from 1st April 2008. Local Safeguarding Children Boards (LSCBs) were tasked with establishing a multi-disciplinary CDOP Subgroup to conduct a review into the death of all children 0-17 years of age, normally resident in their geographical area. Following government recommendations that CDOPs cover a population of at least 500,000, four CDOPs were established across the GM footprint in conjunction with local coronial jurisdictions:

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

In October 2018, HM Government published the revised Child Death Review: Statutory and Operational Guidance (England) for Clinical Commissioning Groups (CCG) and Local Authorities as the Child Death Review Partners (CDR Partners)[1]. The guidance sets out the process that should be followed following the death of a child who is normally resident in England and adds detail to statutory requirements set out in Working Together to Safeguard Children (2018). The aim of the child death review process is to ensure that information is systematically captured for every death to enable learning and prevent future deaths.

2019/20 has been a period of change for CDOPs nationally following the publication of the revised guidance. The new arrangements build on the interface between the hospital/community led mortality reviews, also known as Child Death Review Meetings (CDRM), and the final CDOP review. It was anticipated that nationally CDOPs would see a decrease in the number of cases closed whilst new procedures were being imbedded.

[1] Child death review: statutory and operational guidance (England) https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

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

As of the 1st April 2019, it became a legal requirement that CDOPs across England submit data via the NCMD, from all completed Department of Health and Social Care (DHSC) CDOP templates, forms associated with the child death review process and the analysis of information about the deaths reviewed. This includes, but is not limited to, providing all data and information as collated using the national DHSC CDOP templates such as the Notification Form (Form A), the Reporting Form (Form B), additional Supplementary Reporting Forms and the Analysis Form (Form C). Local CDOP data submitted to the NCMD will support national learning and reviews.

Whilst the GM CDOPs welcomed the introduction of the NCMD, to support and identify local and national learning, this impacted heavily upon CDOP business functions and the time taken to manually input all of the requested NCMD data requirements for cases closed whilst maintaining NCMD live records for every child death notification therefore resulting in fewer cases closed across GM. Following changes to the national CDOP templates the current local GM CDOP Database is no longer fit for purpose and there are hopes to purchase and implement the eCDOP system.

Each of the four GM CDOPs s meet regularly to discuss child deaths for their areas. This process can only occur once coronial investigations have concluded and the final cause of death has been ascertained. Likewise, any death associated with criminal activity can only be discussed once court proceedings or child safeguarding practice reviews and internal agency reviews have concluded.

The review process is based on information gathered about the child, their family environment, their home environment and their access to services. This allows the CDOP to reflect on the presence of risk factors and their contribution to the death of the child. GM CDOPs draw conclusions on what may be influencing child deaths and make recommendations to appropriate authorities and agencies to prevent further deaths. This data is submitted to the Department of Health and Social Care (DHSC) via the NCMD.

1.4 Child Health Profile

Infant, child and adolescent death rates have been decreasing steadily since the 1980s in England and Wales. The lowest ever recorded rate was in 2014 with 3.6 deaths per 1000 live births, rising to 3.9 in 2018. The most recent data from 2019 demonstrates a modest decrease to 3.8. These figures demonstrate that the steady decrease in child deaths has plateaued[2].

Though England often performs more poorly than other comparable European nations on child death statistics, the causes for this are complex[3]. Consequently, the solutions to this appear equally difficult. There are marked social inequalities in child death rates in multiple domains including poverty levels and ethnicity. The majority of deaths occur in the first year of life. After this, death by trauma, injury and suicide/self-harm remain key causes of death in childhood.

[2] PHE Fingertips Tool – Child and maternal health profiles, 2019.

[3] 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.

2. GREATER MANCHESTER CHILD DEATH OVERVIEW PANELS CHILD DEATHS 2019/20

2.1 Child Death Notifications & Cases Closed

Between 1st April 2019 and 31st March 2020 (2019/20) there were 240 child death notifications and 129 cases closed. 30% of the deaths notified during 2019/20 were also closed in the same period. Cases notified data does not provide a full dataset but supports real time information about the frequency of child deaths and their area of residence.

Figure 1.1: Percentage of child death notifications by local authority

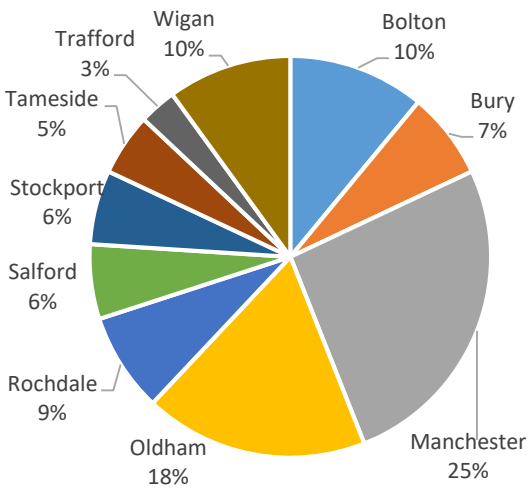
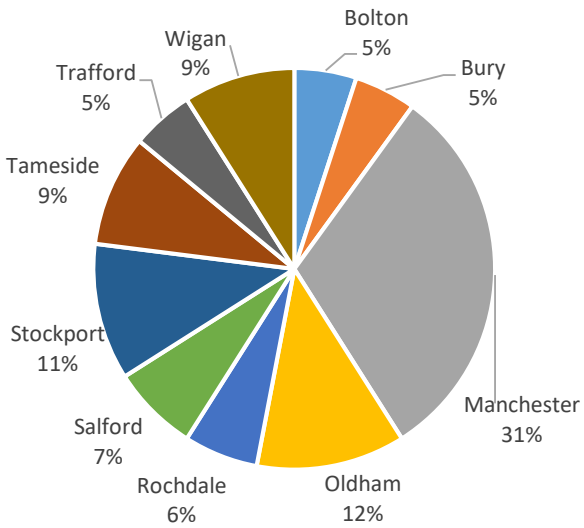
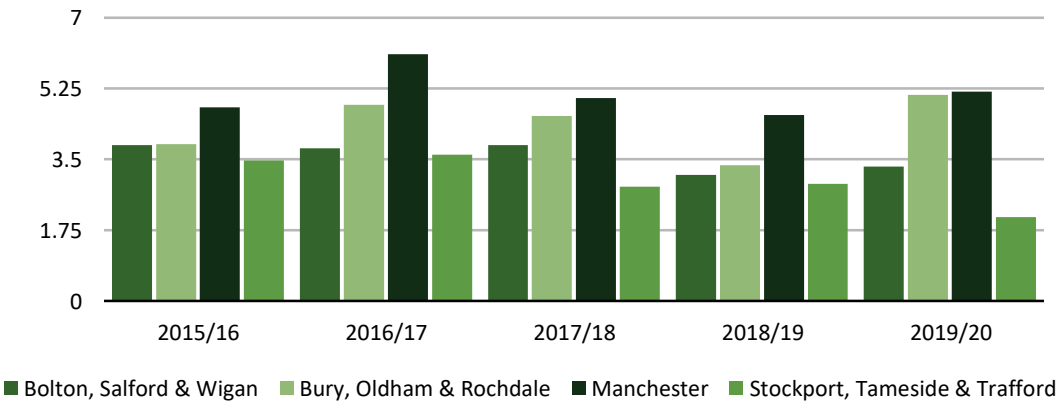


Figure 1.2: Percentage of cases closed by local authority



Owing to changes to the child death review process, there has been a decrease in the number of cases closed compared with previous years. The number of 2019/20 child death notifications has remained stable. Since records on child deaths began in the 1980s, there has been a steady reduction in the rate of child death. This reduction stalled in the last few years, leading to a 'levelling out' of the death rates, with some areas appearing to show a slight increase in the rates of death. The chart below uses rates of notified deaths per 10,000, rather than closed cases, as this provides a more accurate and contemporaneous overview of child death patterns across the four CDOP areas.

Figure 2: Rate of child death notifications per 10,000 by CDOP area 2015/20

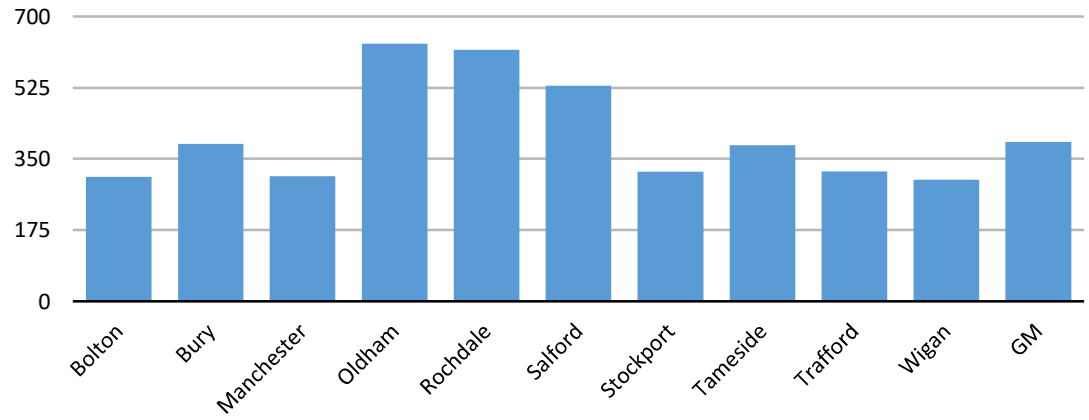


As demonstrated, all areas but Stockport, Tameside, Trafford demonstrated an increase in rate of child death notification compared to the previous year (see Appendix 2).

2.2 Duration of Reviews

The duration of a review refers to the time taken from notification of the death to closing the case at the CDOP. Certain categories of deaths can take longer to close, for example, if a post mortem examination is required or the death is subject to pending investigations. The average time taken to close a case was 391 days. 30% of the 2019/20 child death notifications were closed in the same period so there is limited real time data in the CDOP analysis. Conclusions are drawn over a number of years rather than a single report.

Figure 3: Average duration of reviews (from date of notification to date closed) by local authority



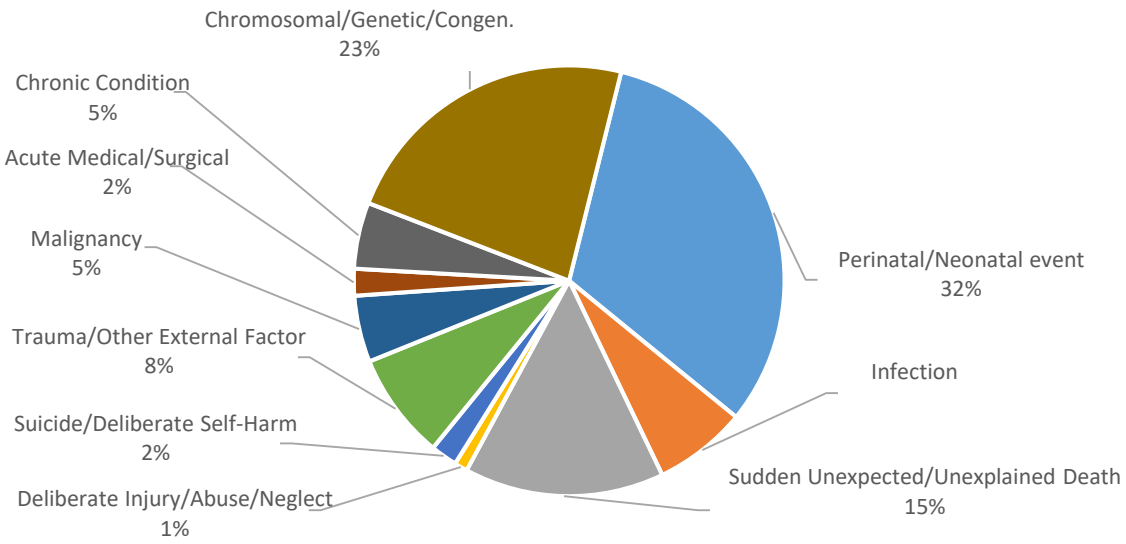
2.3 Categorisation of Death

There are 10 defined categories to which all deaths can be ascribed. It is hierarchical, so should a death fall into more than one category the cause highest on the list is chosen. These nationally defined categorises allow standardisation across the country. These categories are:

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 condition
6. Chronic medical condition
7. Chromosomal, genetic and congenital abnormalities
8. Perinatal/neonatal event
9. Infection
10. Sudden unexpected, unexplained death

There has been a consistent pattern in the categories of death over a number of years. Perinatal/neonatal events remain the single largest category of death, with chromosomal, genetic and congenital causes second. These 2 categories account for over half of all closed cases.

Figure 4: Percentage of cases closed by category of death 2019/20

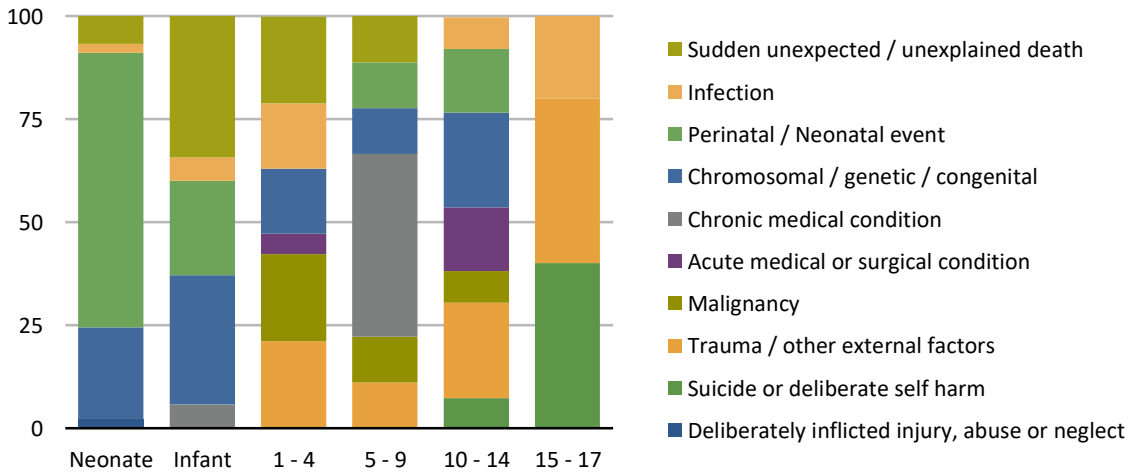


2.4 Age

The correlation between age and death is well established, with the first 28 days of life (neonate) being the most vulnerable period, accounting for 36% of the cases closed. The majority of these deaths were catergorised as a perinatal/neonatal events i.e. problems in the antenatal period, during labour, birth and the first 28 days of life. 64% of all deaths occurred in the first year of life[4].

For 2019/20, there is generally an inverse relationship between increasing age and proportion of deaths. This is different to previous years in which the 15-17 age group showed a spike in deaths due to risk taking behaviour including death by suicide. The numbers for these older groups are small and require caution in their interpretation.

Figure 5: Percentage of cases closed by category for each age group



[4] Zhao, D. et al, 2016, Gender Differences in Infant Mortality and Neonatal Morbidity in Mixed-Gender Twins. Scientific Reports, 7, 8736: 1-6: http://www.nature.com/articles/s41598-017-08951-6

2.5 Sex

Of the 129 closed cases, 68 were males (60%) and 61 females (40%) which is broadly in line with previous GM results. For example, the split in 2017/18 was 58 to 42, and in 2018/19 60 to 40 in males and females respectively. This is also in keeping with national data. Why this should be the case is not well understood[5]. Though there are 1053 males born to every 1000 females in the UK, this discrepancy does not account for differences seen in death rates.

2.6 Location at Time of Death

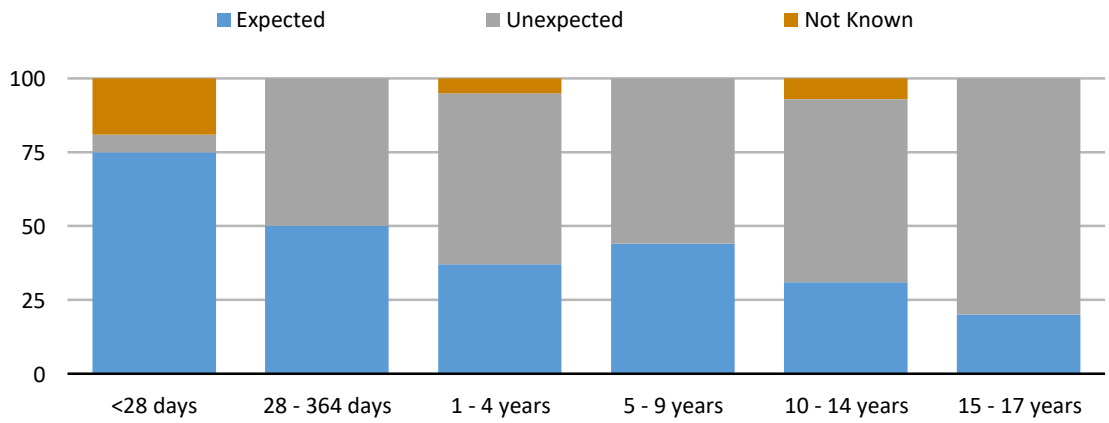
47% of cases closed were children that died in hospital (although the preceding event itself may have occurred in the community), 26% at home and 27% in 'other' settings. This represents a significant decrease in the number of deaths in an acute hospital setting from 2018/19 (71%) and an increase in the percentage of deaths occurring at home (20%). The deaths out of hospital/out of home represent a range of locations from abroad (multiple countries), public spaces, highways and some in a hospice setting.

2.7 Expected & Unexpected Deaths

A unexpected death is defined as 'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death'[6].

Where recorded, 56% of deaths were deemed expected. This is broadly in line with the previous 5 years of annual reports, all of which were between 60-69%. Proportions of expected deaths per age category gives similar results year on year. Broadly, most neonatal/infant deaths are expected, with a large proportion of these associated with prematurity. In line with previous results, there is an increase in the proportion of expected deaths in the age group 5-9 years, relative to other age groups. Deaths in the eldest age category are mainly unexpected with causes of death including suicide and trauma related events accounting for the most.

Figure 6: Percentage of cases closed, expected deaths per age group



[5] Drevenstedt, G., et al., 2008, The rise and fall of excess male infant mortality, Proceedings of the National Academy of Sciences of the United States of America, 105 (13), 5016-5021.
[6] Working Together to Safeguard Children 2015

2.8 Neonatal & Infant Deaths (0-365 Days of Life)

Neonates are defined as babies under 28 days of life and infants as those aged between 28 days and 365 days of life. This group has represented the lion's share of child deaths throughout the history of CDOP reporting. For example, in 2018/19, 42% of all GM deaths occurred in the neonatal period and 61% in the first year of life. Results from 2019/20 demonstrate a similar pattern with 36% of cases closed occurring in the neonatal period and 64% in the first year.

The most common causes of death for this age category are perinatal/neonatal events, followed by chromosomal, genetic and congenital anomalies, and sudden unexpected/unexplained death, making up 32, 15 and 13 cases respectively. The numbers for the other causes of death in this age category are too small to draw any meaningful conclusions.

Chromosomal, genetic and congenital anomalies related deaths account for the second largest share of neonatal and infant deaths both regionally and nationally[7]. Where recorded, 63% of those children catergorised as having chromosomal, genetic and congenital anomalies, resided in the most deprived quintile.

2.9 Gestational Age

Prematurity is categorised as:

- Extreme prematurity (<26 weeks)
- Premature (26 to <37 weeks)
- Term (37+ weeks)

In 2019/20, 49% of all neonatal cases closed were infants born extremely premature and a further 23% premature. This is in line with the results of previous reports with 59% extremely premature and 21% premature in 2018/19.

2.10 Birth Weight

Low birth weight (LBW) is associated with an increased risk of infant and child mortality. It is associated with multiple factors including maternal smoking, maternal age/weight and multiple births. Whilst birth weight correlates with gestational age, babies born on the lowest centiles for their gestational age have the poorest prognosis. Low birth weight is also linked to maternal health which strongly correlates with deprivation and socioeconomic status. Low birth weight is categorised as:

- Low Birth Weight (LBW) <2500g
- Very Low Birth Weight (VLBW) <1500g
- Extremely Low Birth Weight (ELBW) <1000g

Owing to small numbers ELBW and VLBW have been grouped together in this report. Where recorded, 23% were deemed LBW and 33% VLBW. This is an improvement on 2018/19 where these values were 19% and 50% respectively.

2.11 Ethnicity

Ethnicity was recorded in all closed cases in 2019/20. As per the 2011 census data, 14.6% of the UK population is classified as belonging to BAME ethnic groups[8]. Since 2017, subcategories of BAME

[7] National Perinatal Epidemiology Unit. The contribution of congenital anomalies to infant mortality. Oxford: University of Oxford, 2010. Inequalities in Infant Mortality Project Briefing Paper 4.
[8] Source: ONS Census data, 2011 applied to 2019 mid-year population estimates

groups have been established. GM has a significant ethnically diverse population in comparison to the national average, with 28% classified as BAME. Indeed, this is the case for all local authorities aside from Wigan which is lower than the national average (see Appendix 3). 63% of the cases closed were children of White British ethnicity and 37% from BAME groups. This is in line with national data. Closed cases demonstrate 1.75 per 10,000 White British child deaths, compared to 2.81 per 10,000 BAME child deaths in GM.

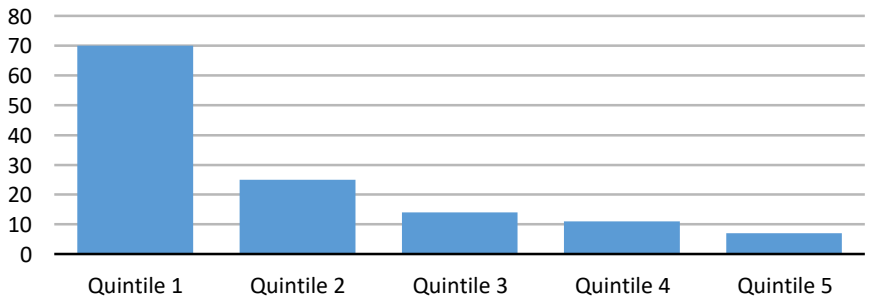
Significant differences exist in rates of death between White and ethnic minority groups across GM. This is especially marked in certain local authorities with Manchester and Oldham being the most prominent. Across GM, this represents a 61% increased risk of death in BAME children compared to children who are White British.

National research has identified certain ethnic groups at an increased risk of death by specific causes, notably in the first year of life. Pakistani children run the highest risk of death by chromosomal, genetic, congenital causes. Black children run the highest risk of death by sudden unexplained/unexpected death. The reasons behind this are complex and thought to represent a combination of deprivation, behavioural and cultural factors[9] [10]. It has been suggested that pregnant women from BAME groups may face barriers in accessing appropriate healthcare, representing another potential health inequality[11].

2.12 Deprivation

Factors for many causes of child death correlate with deprivation or socioeconomic inequality[12]. The Index of Multiple Deprivation is a composite score based on multiple factors including income, employment, education, health, and quality of home and community[13]. These scores allow populations to be categorised into quintiles with a score of 1 representing the most deprived and 5 the least deprived quintile. In GM, 6 out of 10 local authorities have higher scores than the North West average and all but Trafford perform worse than the UK average. By this measure, Manchester is the most deprived area in GM with 41% of its population living in the most deprived quintile. Trafford is the least deprived with 3% living in the most deprived group.

Figure 7: Number of cases closed by deprivation quintile



[9] ONS, Pregnancy and ethnic factors influencing births and infant mortality: 2013. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/pregnancyandethnicfactorsinfluencingbirthsandinfantmortality/2015-10-14#ethnicity

[10] DfE, Ethnicity, deprivation and educational achievement at age 16 in England: trends over time. June 2015.

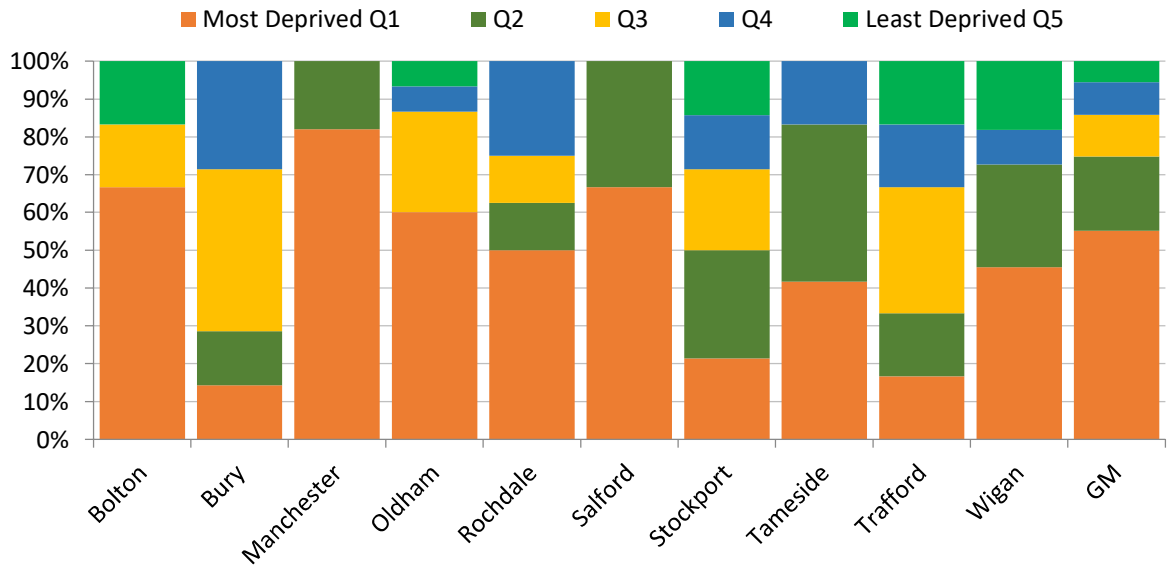
[11] Hollowell. J, Oakley. L, Vigurs. C, Barnett-Page. E, Kavanagh. J & Oliver S. (2012) Increasing the early initiation of antenatal care by Black and Minority Ethnic women in the UK. Oxford: *National Perinatal Epidemiology Unit.*

[12] 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. Marmot, M, Goldblatt, P., Allen, J., 2010, Fair Society Healthy Lives. See: http://www.instituteofhealthequity.org/

[13] CDOPs calculate an IMD score of a child's lower-super-output-area using the national postcode lookup tool (http://imd-by-postcode.opendatacommunities.org/).

Figure 7 demonstrates the link between deprivation and risk of child death, with the risk steadily decreasing as deprivation decreases. Over half of all cases closed in 2019/20 were in the most deprived quintile, and a further 20% in the second most deprived; these two quintiles accounting for three quarters of all deaths. There is significant correlation between local authority levels of deprivation and child deaths.

Figure 8: Percentage of cases closed by deprivation quintile per local authority



3. MODIFIABLE FACTORS & RELEVANT RISK FACTORS

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

> Modifiable factors identified: The panel has identified one or more factors across any domain which may have contributed to the death of a child and which might, by means of locally or nationally achievable intervention, be modified to reduce the risk of future child deaths.
>
> No modifiable factors identified: The panel have not identified any potentially modifiable factors in relation to the death.
>
> Inadequate information upon which to make a judgement: the panel was not provided with sufficient information.

The identification of modifiable factors depends heavily upon the circumstances leading to death and the cause of death ascertained. Modifiable factors may include substance/alcohol misuse by the parent/carer, child abuse/neglect, consanguineous relationships and difficulties with access/uptake of healthcare services.

The CDOP is responsible for analysing information to determine relevant risk factors that may have contributed to vulnerability, ill health or death of the child. These factors fall into four domains:

- Factors intrinsic to the child
- Factors in social environment including family and parenting capacity
- Factors in the physical environment
- Factors in service provision

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

0 - No information available
1 - No factors identified, or factors were identified but are unlikely to have contributed to the death
2 - Factors identified that may have contributed to vulnerability, ill health or death

(There was previously a category 3 in which 'factors identified provided a complete and sufficient explanation of death', though this has been removed by the DHSC)

Modifiable factors were identified in 40% of 2019/20 cases closed, 58% with no modifiable factors and 2% having insufficient information to make a judgment. The most recent national data from 2017 demonstrates modifiable factors were present in 27% of cases, indicating a significantly higher proportion of local cases where modifiable factors may have contributed to the death of the child. Across GM factors such as smoking, maternal substance use and unsafe sleeping arrangements are all identified as modifiable factors, although this is not the case across the whole of England.

The GM CDOPs continue to conduct reviews in line with the agreed GM set standard of modifiable factors, as developed by the GM CDOP Network. The standard ensures consistency across the four GM CDOPs when undertaking review and identifying modifiable factors.

A greater proportion of the 2019/20 cases closed were either neonatal deaths where maternal factors in pregnancy are identified, or sudden unexpected deaths, where risk factors in the sleeping environments are identified. Fewer hospital deaths were closed during 2019/2020, and these cases often have fewer modifiable factors identified.

Figure 9: Number and percentage of cases closed with modifiable factors by CDOP area (2012/20)

CDOP Area	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bolton, Salford & Wigan	39% (34)	28% (13)	26% (17)	38% (21)	34% (23)	35% (29)	44% (28)	26% (7)
Bury, Oldham & Rochdale	21% (15)	30% (17)	25% (20)	22% (16)	41% (21)	46% (33)	40% (21)	31% (9)
Manchester	29% (16)	20% (10)	18% (15)	29% (16)	27% (17)	34% (21)	32% (15)	38% (16)
Stockport, Tameside & Trafford	18% (10)	27% (17)	31% (25)	42% (21)	29% (14)	47% (27)	38% (15)	65% (20)

3.1 Smoking

Smoking in pregnancy is associated with multiple poor health outcomes[14]. These include reduced fetal growth, higher risk of miscarriage and still birth, low birth weight and increased risk of sudden unexpected death in infancy. It is estimated that maternal smoking can increase the risk of child mortality by 40%, as well as increasing risk of disease in later life[15].

Public Health England (PHE) uses smoking at time of delivery (SATOD) to measure how many women continue to smoke during pregnancy. The most recent figures show this to be 10.8% nationally and 12.6% in GM[16]. Of the 10 GM local authorities, 7 were deemed to have SATOD rates above the national average, all of which scored above average in the Index of Multiple Deprivation rankings. Indeed, over half of the cases in 2019/20 where smoking was deemed likely to have contributed to the death of a child were in families in the lowest deprivation quintile. For 2019/20, 15% of deaths involved maternal smoking which was considered a modifiable factor. This is an increase from the 11% of cases in which smoking was a modifiable factor in 2018/19.

3.2 Maternal Obesity in Pregnancy

As with smoking, maternal raised body mass index (BMI) scores are associated with worse outcomes for infants including miscarriage and still birth as well as complications with delivery[17] [18]. As a consequence, across GM, a maternal BMI of 30 and over or a BMI less than 18.5 has been considered a potentially modifiable factor in perinatal/neonatal deaths due factors including prematurity delivery and difficulties in labour. The link between obesity and deprivation is well established. BMI can be stratified as follows:

- <18.5: Underweight
- 18.5-24.9: Healthy
- 25-29.9: Overweight
- 30-39.9: Obese
- >40: Morbidly Obese

Maternal obesity was recorded as a modifiable factor in 11% (14) of cases closed. This is an increase from the 8% of cases closed in 2018/19, though broadly in line with the national trend which demonstrates a steady year-on-year increase in levels of maternal obesity as a modifiable factor.

3.3 Genetic Disorders & Consanguinity

Consanguinity is defined as a relationship between two people who share an ancestor, or share blood. There is an increased risk of congenital birth defects and genetic conditions in consanguineous relationships. Unrelated parents have a 2% risk of having a child with a severe abnormality, whilst parents who are first cousins have a 5% risk and second cousins have a 3% risk. However, couples that are more closely related, such as a family with a history of cousin marriages going back generations, will have a higher risk of having a child with autosomal recessive disorders.

As a couple may not be aware that they carry a gene anomaly in their first pregnancy, this is not recorded as a modifiable factor by GM CDOPs. However, if a condition is recognised in a first

[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] Parliamentary Office of Science and Technology, 2016, Infant Mortality and Stillbirth in the UK. Available at: http://researchbriefings.files.parliament.uk/documents/POST-PN-0527/POST-PN-0527.pdf
[18] Maternal obesity in the UK: findings from a national project (2010) UK. Centre for Maternal and Child Enquiries

pregnancy/child and then a second child is born with the same condition, this is deemed potentially modifiable.

Over the past several CDOP reports, the numbers of deaths in which consanguinity was deemed a risk factor has decreased, falling to fewer than 3% of cases (<5 cases in total in 2018/19). For 2019/20 cases closed, there were 11 deaths where consanguinity was considered a contributing factor to a death of the child which represents 9% of all child deaths. Despite this, it was considered a modifiable factor in only 3 cases, owing to the above definition that it is only considered modifiable in the event of a second affected pregnancy/child.

All 11 cases where consanguinity was identified as a factor were children from Asian/Asian British communities, 9 children being of Pakistani heritage. 1.1 per 10,000 BAME children in GM will die of a congenital problem, compared to 0.15 per 10,000 White British children, representing a near 7 fold increased risk in BAME groups[19] [20]. This emphasises that education of congenital disorders will require complex and sensitive societal interventions. The Manchester Foundation Trust Genetics Service is developing strategies to support both practitioners and families to raise awareness of genetic disorders and the support available.

3.4 Alcohol & Substance Use

In 2019/20, 8% of cases closed were identified as having substance or alcohol use as a factor which may have contributed to the death of the child. Over the past 2 reports, this number has been 5%. Though numbers are small, substance and alcohol is recognised in cases categorised as a perinatal/neonatal event or sudden and unexpected death in infancy.

3.5 Unsafe Sleeping Arrangements

Whilst unsafe sleeping practices may not be proven causal in sudden and unexpected deaths of infants, it's recognised as a strong correlation between unsafe sleeping and child deaths. Across GM, when one risk factor is present such as maternal smoking it is usually associated with other risk factors. Educational campaigns to raise awareness of safer sleeping arrangements have shown to be effective and have reduced the number of deaths due to sudden infant death syndrome (SIDS). 5% of the 2019/20 cases closed, compared to the 4% in the previous two GM CDOPs reports, identified co-sleeping as a potentially modifiable factor. Maternal smoking in pregnancy and household smoking is recorded as a contributing factor but these factors overlap significantly.

3.6 Domestic Abuse & Violence

There were 9 cases closed where domestic abuse/violence was present and thought to be a relevant contributing factor which represents 7% of all cases closed. It must be emphasised that these numbers are small and may not represent a statistically significant change.

[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. Inequalities in Infant Mortality Project Briefing Paper 4.

3.7 Access & Uptake of Healthcare Services

Accessing and uptake of appropriate healthcare was noted as a modifiable factor in 7 cases, the majority of which were categorised as a perinatal/neonatal event. There appears to be a link between accessing and uptake of healthcare services in areas of deprivation, with all cases in the two most deprived quintiles. It is also possible that there is a discrepancy in access to health care between ethnicities, though numbers are insufficiently large in this report to draw a meaningful conclusion[21]. Homelessness was referenced in several of these cases. This may draw attention to a possible lack of support and service uptake for mothers and families with no fixed abode.

3.8 Social Environment, Family & Parenting Capacity

Poor parenting was identified as a risk factor in 15 deaths, whilst child abuse/neglect was identified as a risk factor in 10 deaths. There is considerable overlap between these two categories. The factors stated above give an indication of the increased need for multi-agency support for the family.

4. CONCLUSION

Though there has been a reduction in the number of closed cases for the period 2019/20 (129), the number of child death notifications remains steady (240). This means that rates of child death in the GM population have not decreased in the last year. The number of closed cases, is significantly fewer this year than in previous years. This reflects national changes in the operational aspects of the child death review process. Unfortunately, this makes statistical analysis difficult owing to the very small numbers of children in certain categories, and the skew towards the relative increase in the proportion of other categorises.

The majority of deaths continue to occur in the first year of life, with the first 28 days being the most vulnerable. The figures for these age groups remain roughly the same as in previous years. Perinatal/neonatal events account for the majority of these deaths, closely followed by chromosomal, genetic and congenital anomalies. These proportions are in line with previous reports and also correlate with factors such as deprivation levels, consanguinity and maternal health. Improvements to neonatal care have contributed to preventing and in some cases delaying death, especially in the premature infants. certain Modifiable factors such as maternal smoking and maternal obesity in pregnancy continue to be key factors in deaths categorised as a perinatal/neonatal event. Further efforts to reduce the impact of these factors should be a public health priority for all agencies.

The older age groups, 1-4, 5-9, 10-14 and 15-17 years of age, account for 15%, 7%, 10% and 4% of deaths respectively. Though they largely follow the trend from previous years the absolute numbers in the eldest groups are very small, meaning that it is difficult to draw meaningful conclusions in isolation and must be viewed as a trend over several years. The vast majority (72%) of these deaths are due to medical causes (perinatal/neonatal, acute medical, chromosomal, chronic medical, malignancy, infection). This demonstrates that good antenatal, postnatal and ongoing medical care remain integral to reducing both infant and child mortality.

The two eldest age groups (10-14 and 15-17 years of age) remain particularly vulnerable to the non-medical causes of death, including suicide and trauma related death. This is in line with national results and statistics from previous reports, though, it is not possible to state their statistical significance as they represent only a handful of cases closed rather than real-time notification data. Anecdotally, there continues to be an increase in the apparent suicide of adolescents over the last few years. These cases are yet to be closed, and owing to their complexity may not be closed for some time. These

[21] 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.

delays may obscure trauma and apparent suicide related deaths as an ongoing or growing problem. This may be further exacerbated in the coming year(s) due to the effect of the COVID-19 pandemic on social and medical services. Indeed, there are indications that the 'lockdown' period has seen a further increase in apparent suicides. As one child suicide is one too many, this report emphasises the need for GM to continue in its suicide prevention strategy and streamline its reporting process.

There continues to be a link between the rate of child deaths and deprivation, with the majority of closed cases involving children, and their family, residing in the most deprived quintile. Whilst tackling deprivation lies outside the scope of this report, it stands to show that the underlying causes of infant and child mortality rates are complex and long term solutions are required such as tackling the access and uptake of healthcare services in areas of deprivation and BAME communities.

Modifiable factors were present in 40% of cases closed. Much like deprivation, and often inextricably linked, factors such as smoking, substance use and maternal obesity in pregnancy may be deemed contributing factors to death. With regards to the latter, the growing problem of obesity represents a real future challenge for local authorities. Smoking rates remains higher in areas of deprivation than the national and regional rates. Consanguinity associated with congenital abnormalities remains a significant contributing factor in deaths across GM. This report has identified Manchester's Pakistani population at particularly high risk for congenital abnormalities, strongly correlating with consanguineous relationships. As with many cultural/social practices, this is a complex issue requiring sensitive and community inclusive solutions.

5. RECOMMENDATIONS

The following should be considered by the 10 GM Local Safeguarding Partnerships and Health and Wellbeing Boards including distribution to relevant agencies:

1. Health inequalities lie at the heart of child deaths across GM. BAME communities are disproportionately represented with in child deaths, with a strong link to deprivation. This report must be used, in conjunction with other relevant data, to show how reducing inequalities will improve the life chances for children with particular attention and support provided for BAME communities.

2. Smoking remains a key modifiable factor contributing to child deaths. GM has made progress in reducing smoking with mothers who smoke during pregnancy being identified as a priority group. This work must continue to drive down smoking rates in the GM population.

3. Obesity is also a major public health issue and maternal obesity in pregnancy remains a key modifiable factor. GM local authorities need to reduce levels of obesity throughout the population with a focus on maternal obesity to improve the health and wellbeing of the mother and the unborn child, in order to contribute to the reduction in childhood mortality.

4. In light of the small numbers of cases closed in each report, it is often difficult to detect significant patterns in annual trends. By pooling the data gathered over a longer period of time, it may be possible to draw reliable statistical conclusions. The GM CDOPs are to explore any potential capacity and resources available to carry out an additional review such as a 5 year snapshot of cases closed.

5. Though based on anecdotal evidence from child death notifications reported to the GM CDOPs, there appears to have been an increase in the rate of apparent suicide in adolescents. Naturally, these cases will require lengthy reviews due to pending investigations. Owing to the urgency of these deaths and the potential to identify real time emerging themes, this report recommends a streamlining of reporting to CDOPs where suicide is deemed likely cause of death, to provide live data to support appropriate suicide prevention agencies. An appropriate electronic system will need to be implemented to support such requests for live data to highlight real time trends.

6. Following the introduction of the NCMD (1st April 2019), CDOPs have a statutory requirement to submit data relating to all child deaths in England. The CDOP data is used to support the NCMD influence national strategy and improve the child death review process. The NCMD programme team requests real time data to support changes to NHS systems and promote public health messages. Due to the level of data collated and national demand for information, 52 of the 54 CDOPs (outside of GM) have purchased the eCDOP system which automatically populations the NCMD and supports local CDOPs identity live emerging trends. The GM CDOPs have been in discussions with QES, as the eCDOP provider, regarding the functionality of the system and how this will support clinicians, multi-agency representatives, local CDOPs and fulfil national statutory requirements. GM CDOP Chairs are to liaise with local authority budget holders in their area(s) to request and agree funding arrangements to purchase and implement eCDOP.

6. APPENDICES

Appendix 1: Number of 2019/20 GM CDOPs cases closed, duration of reviews (average, minimum and maximum days) by category of death

Category	No. Cases Closed	Average	Min Days	Max Days
1. Deliberately inflicted injury, abuse or neglect	*	963	963	963
2. Suicide or deliberate self-harm	*	406	331	500
3. Trauma and other external factors	10	439	101	1072
4. Malignancy	6	465	171	801
5. Acute medical or surgical condition	*	601	339	1079
6. Chronic medical condition	6	396	104	786
7. Chromosomal, genetic and congenital abnormalities	29	239	100	641
8. Perinatal/ neonatal event	41	392	91	1918
9. Infection	9	400	93	1596
10. Sudden unexpected, unexplained death	20	445	211	1079

Appendix 2: Number of 2019/20 GM CDOPs child death notifications and cases closed by rate per 10,000 population

Local Authority	No. Deaths Notification	Rate of deaths notifications (per 10,000 population)	No. Cases Closed	Rate of Cases closed (per 10,000 population)
Bolton	25	3.69	8	1.02
Bury	16	3.7	7	1.62
Manchester	61	5	41	3.25
Oldham	43	7.23	14	2.52
Rochdale	22	4.18	8	1.5
Salford	15	2.65	9	1.57
Stockport	15	2.37	14	2.2
Tameside	12	2.39	11	2.37
Trafford	8	1.42	6	1.06
Wigan	23	3.36	11	1.6
Greater Manchester CDOPs	240	3.77	129	2
Bolton, Salford & Wigan	63	3.32	28	1.4
Bury, Oldham & Rochdale	81	5.09	29	1.93
Manchester	61	5.17	41	3.28
Stockport, Tameside & Trafford	35	2.07	31	1.89

Appendix 3: Number and percentage of 2019/20 GM CDOPs cases closed by ethnicity per local authority

Local Authority	White		BAME	
	Number	%	Number	%
Bolton	46,502	68	21,883	32
Bury	34,631	80	8,658	20
Manchester	55,311	45	67,603	55
Oldham	35,755	60	23,837	40
Rochdale	36,243	68	17,056	32
Salford	43,664	76	13,788	24
Stockport	52,720	83	10,798	17
Tameside	41,544	82	9,120	18
Trafford	40,123	71	16,388	29
Wigan	64,781	94	4,135	6
Greater Manchester	451,275	72	178,003	28

Appendix 4: Number and percentage of 2012/20 GM CDOPs cases closed by category of death

Category of death	2012/13		2013/14		2014/15		2015/16		2016/17		2017/18		2018/19		2019/20	
Deliberately inflicted injury, abuse of neglect	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Suicide or deliberate self-harm	11	4%	*	*	*	*	7	3%	6	3%	*	*	*	*	3	2%
Trauma and other external factors	*	*	10	5%	14	5%	15	6%	8	7%	15	5%	13	6%	10	8%
Malignancy	12	4%	20	9%	18	7%	15	6%	18	6%	20	7%	16	8%	6	5%
Acute medical or surgical condition	16	6%	20	9%	*	*	12	5%	11	5%	11	4%	14	67%	3	2%
Chronic medical condition	11	4%	12	6%	10	4%	11	5%	7	5%	16	6%	8	4%	6	5%
Chromosomal, genetic and congenital abnormalities	70	26%	50	235	68	26%	56	24%	60	24%	67	24%	41	20%	29	23%
Perinatal or neonatal event	97	37%	81	38%	97	37%	78	33%	93	33%	102	37%	66	32%	41	32%
Infection	18	7%	*	*	12	5%	18	8%	7	8%	12	4%	17	8%	9	8%
Sudden unexpected or unexplained death	20	7%	10	5%	19	7%	24	10%	16	10%	19	7%	20	9%	20	16%

NCMD
National Child Mortality Database
Knowledge, understanding and learning to improve young lives

Child Death Review Data: Year ending 31 March 2020

November 2020

HQIP
Healthcare Quality Improvement Partnership

Contact us

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Acknowledgements

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Table of contents

1. Introduction

Child death review (CDR) processes are mandatory for Child Death Review Partners (CDR Partners) in England. The CDR process has been in place in England since 1 April 2008 and was previously the responsibility of Local Safeguarding Children Boards (LSCBs). CDR Partners are responsible for reviewing the deaths of all children up to the age of 18. This function is carried out through local Child Death Overview Panels (CDOPs). The overall purpose is to understand why children die and to put in place interventions to protect other children and reduce the risk of future deaths.

In 2018, the Department of Health and Social Care (DHSC) published new and revised statutory and operational guidance related to CDR. The new guidance requires all CDR partners to gather information from every agency that has had contact with the child, during their life and after their death, including health and social care services, law enforcement, and education services. This is done using a set of statutory CDR forms.

The National Child Mortality Database (NCMD) launched on 1 April 2019 and collates data collected by CDOPs in England from reviews of all children, who die at any time after birth before their 18th birthday. There is a statutory requirement for CDOPs to collect this data and to provide it to the NCMD.

The data in this report covers the number of reviews of children whose death was reviewed by a CDOP between 1 April 2019 and 31 March 2020. It should be read in conjunction with the following two data tables:

- Reference Tables – “Child Death Reviews Data (year ending 31 March 2020)”
- Table 1 CSV data

These data have been published for a number of years and are used by CDOPs to inform the production of their local annual reports. Data for 2018/19 and 2017/18 was published by NHS Digital and prior to that it was published by Department for Education. The format has been kept consistent with previous publications, however due to a change in data collection processes there are a few changes which are listed in Section 6. Additionally, it reports the number of notifications of children that died between 1 April 2019 and 31 March 2020.

The second NCMD annual report will follow this publication in Spring 2021 to include detailed analysis along with key messages and recommendations informed by the data and in consultation with the NCMD stakeholder professional and public representation groups.

2. Deaths occurring between 1 April 2019 and 31 March 2020

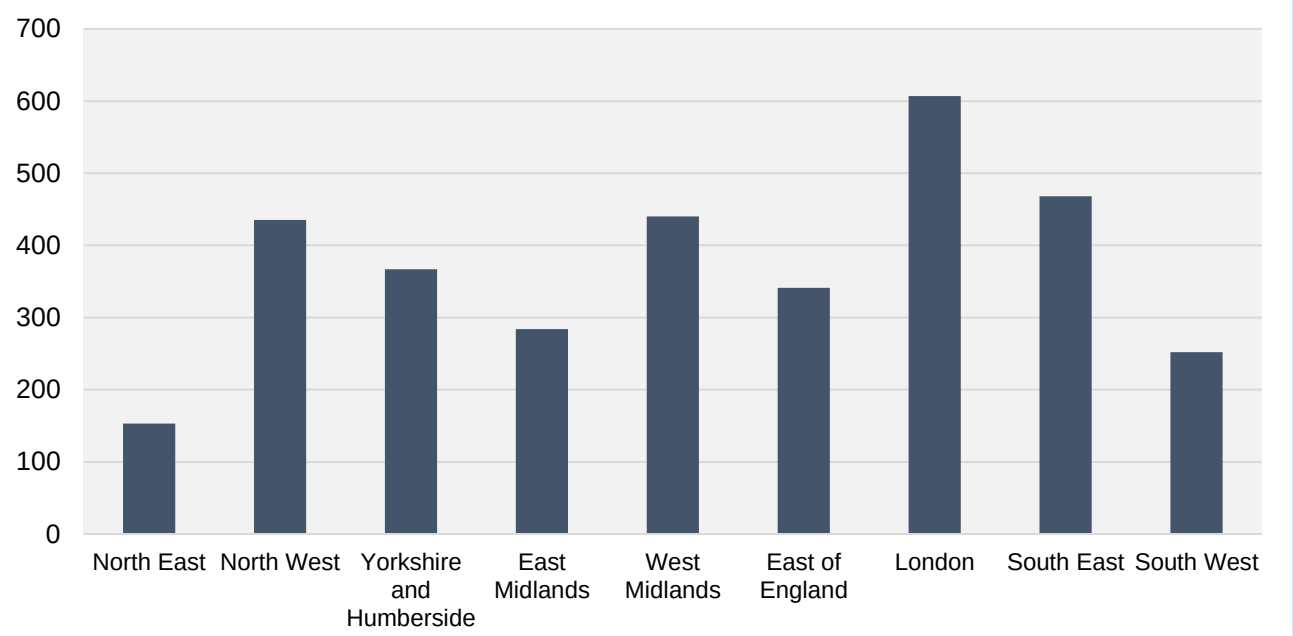
This section of the report focuses on the number of child death notifications received by NCMD where the child died between 1 April 2019 and 31 March 2020.

The number of child death notifications (Reference Table 1)

The NCMD received **3,347** child death notifications from CDOPs in England where the child died between 1 April 2019 and 31 March 2020. CDOPs in the London region submitted the most child death notifications to NCMD (607), where the North East region submitted the least number of notifications (153).

A more detailed breakdown of notification data will be available within the second NCMD Annual Report.

Figure 1: The number of child death notifications received by Child Death Overview Panels by region, Year ending 31 March 2020



3. Deaths reviewed between 1 April 2019 and 31 March 2020

This section of the report presents the number of child death reviews completed by CDOPs between 1 April 2019 and 31 March 2020. It is important to note that the CDOP review of the child death may not be completed in the same year as when the death occurred. Therefore, the population of children reported in Section 2 partially overlap but is distinct from the population of children described in this section of the report.

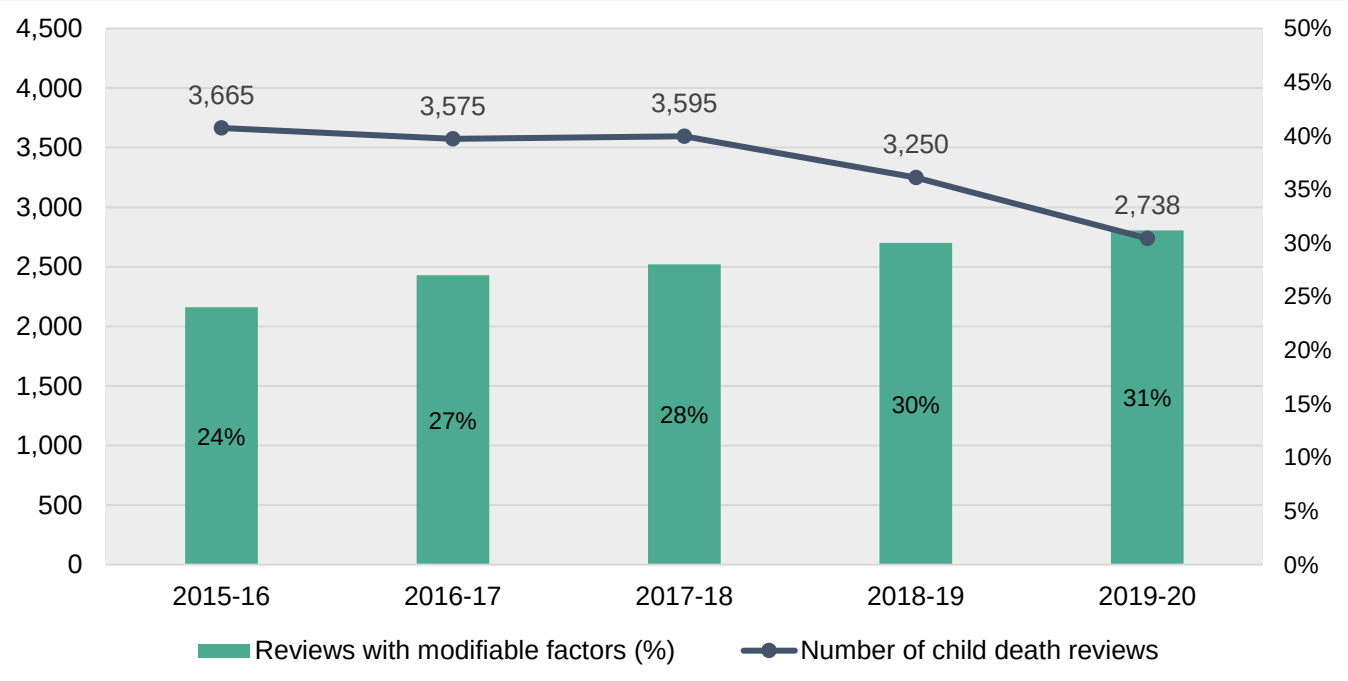
During the child death review the CDOP is responsible for identifying any modifiable factors in relation to the child's death. A modifiable factor is defined as any factor which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

The number of child death reviews (Reference Table 1)

2,738 child deaths were reviewed in England between 1 April 2019 and 31 March 2020, which is a decrease of 512 (16%) in comparison to the previous reporting year. The decrease in the number of reviews for 2019-20 is likely because fewer CDOP meetings took place whilst they were working under transitional arrangements. In addition, many CDOP meetings were cancelled in March 2020 due to the response to the COVID-19 pandemic.

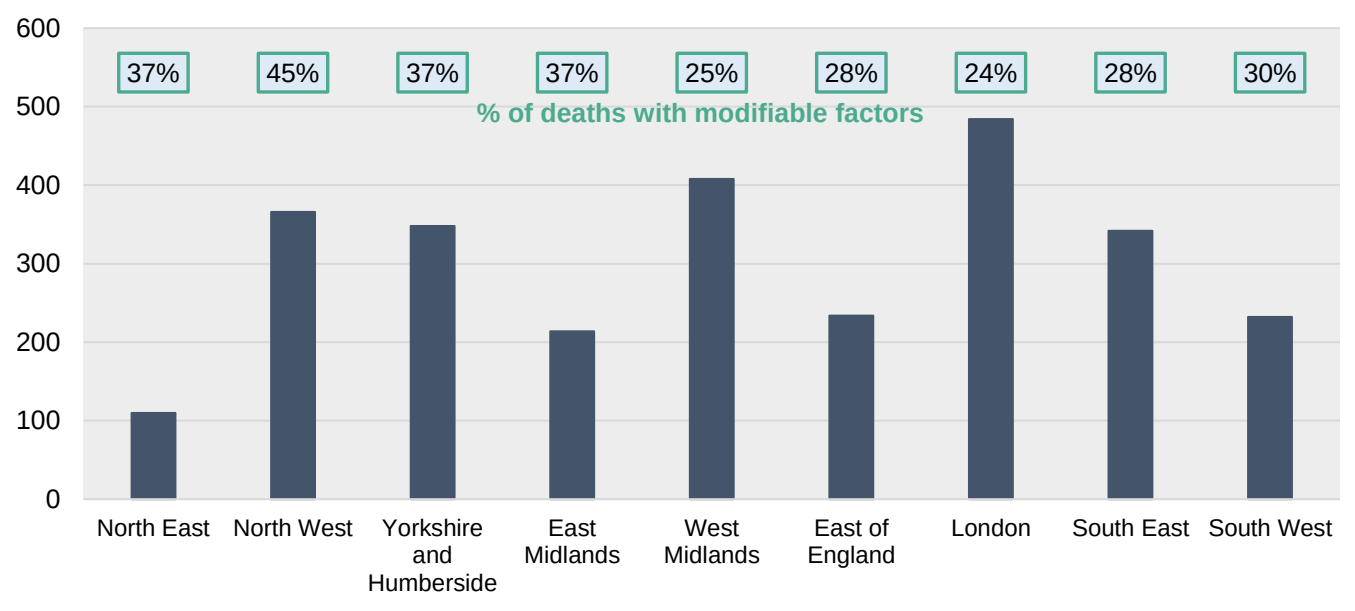
862 (31%) of these reviews identified one or more modifiable factors. This percentage is comparable to the figure reported in 2018-19, but the proportion of cases identified with modifiable factors has increased by 7% since 2015-16.

Figure 2: The number of child death reviews completed by Child Death Overview Panels in England, Year ending 31 March 2020



CDOPs in London reviewed the most child deaths (484), where the North East reviewed the least (110) which is consistent with the number of notifications submitted to NCMD. CDOPs in the North West identified the highest proportion (45%) of modifiable factors in the child death reviews they completed, where London reported the lowest proportion of cases with modifiable factors (24%).

Figure 3: The number of child death reviews completed by Child Death Overview Panels and the proportion of cases with modifiable factors identified by Region, Year ending 31 March 2020



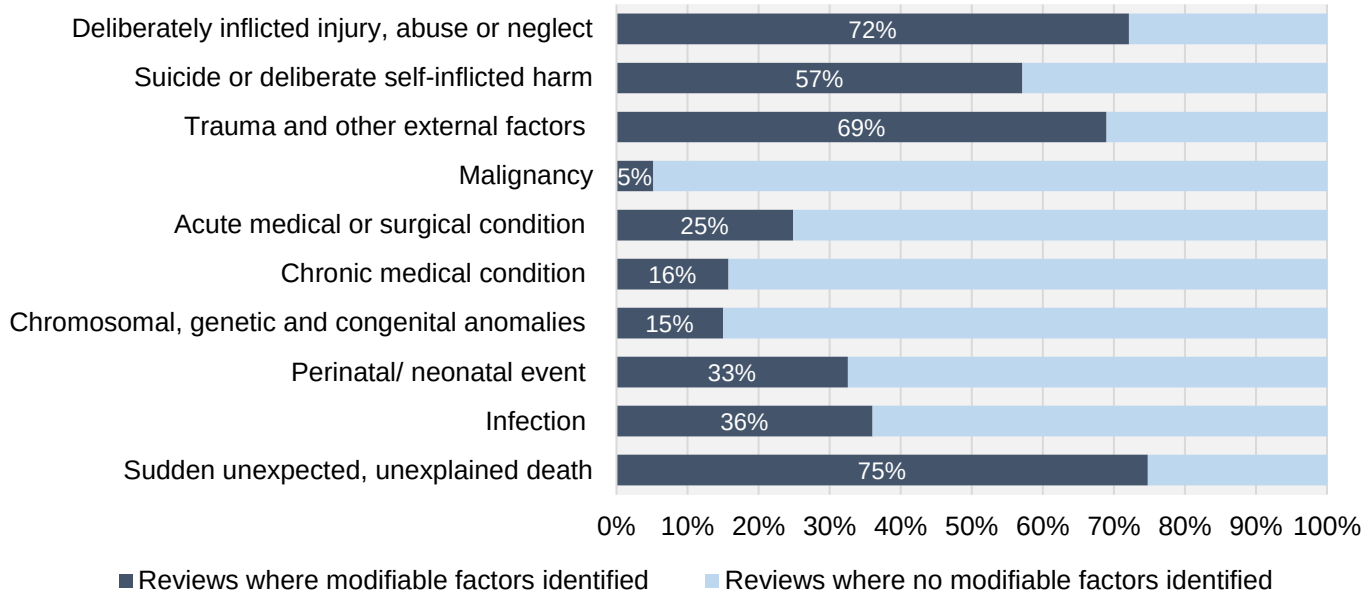
Category of death (Reference Table 4)

CDOPs are required to assign a category of death to each death reviewed within the Analysis Form, the final output of the child death review process. The classification of categories is hierarchical where the uppermost selected category is recorded as the primary category should more than one category be selected.

851 reviews (31%) recorded a primary category of “Perinatal/neonatal event”, and a further 674 reviews (25%) recorded a primary category of “Chromosomal, genetic and congenital anomalies”. These two categories combined represent over half (56%) of reviews completed.

Deaths with a primary category of “Sudden unexpected and unexplained” had the highest proportion (75%) of deaths identified as having modifiable factors, closely followed by deaths with a primary category of “Deliberately inflicted injury, abuse or neglect” (72%). Deaths with a primary category of “Malignancy” had the lowest proportion (5%) of deaths identified as having modifiable factors. This is consistent with previous years’ data.

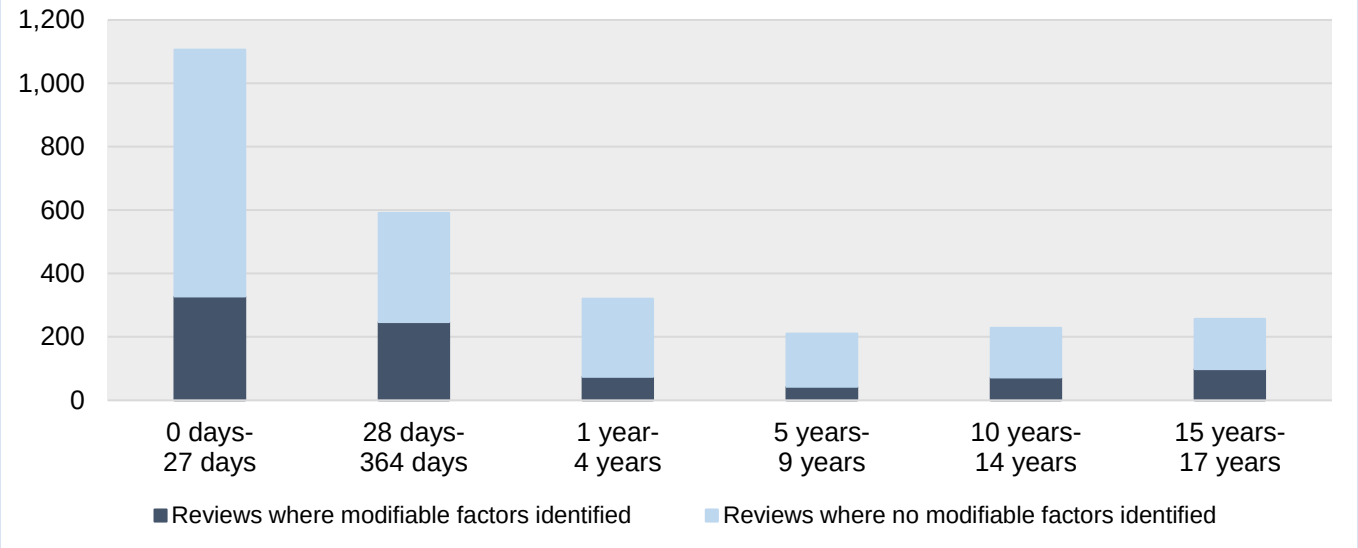
Figure 4: The proportion of child death reviews completed by Child Death Overview Panels with modifiable factors identified by primary category of death, Year ending 31 March 2020



Demographics (Reference Table 9)

Deaths occurring in the neonatal period (0–27 days) represented the largest proportion of deaths reviewed (n=1106, 41%) and a further 591 (22%) deaths were within the 28-364 days age group. Together, deaths where the child was aged under 1 represented 63% of child deaths reviewed during 2019-20. The largest proportion of cases with modifiable factors identified was the 28-364 days age group (42%), where the lowest proportion was in the 5-9 years age group (20%).

Figure 5: The number of child death reviews completed by Child Death Overview Panels by age group, Year ending 31 March 2020



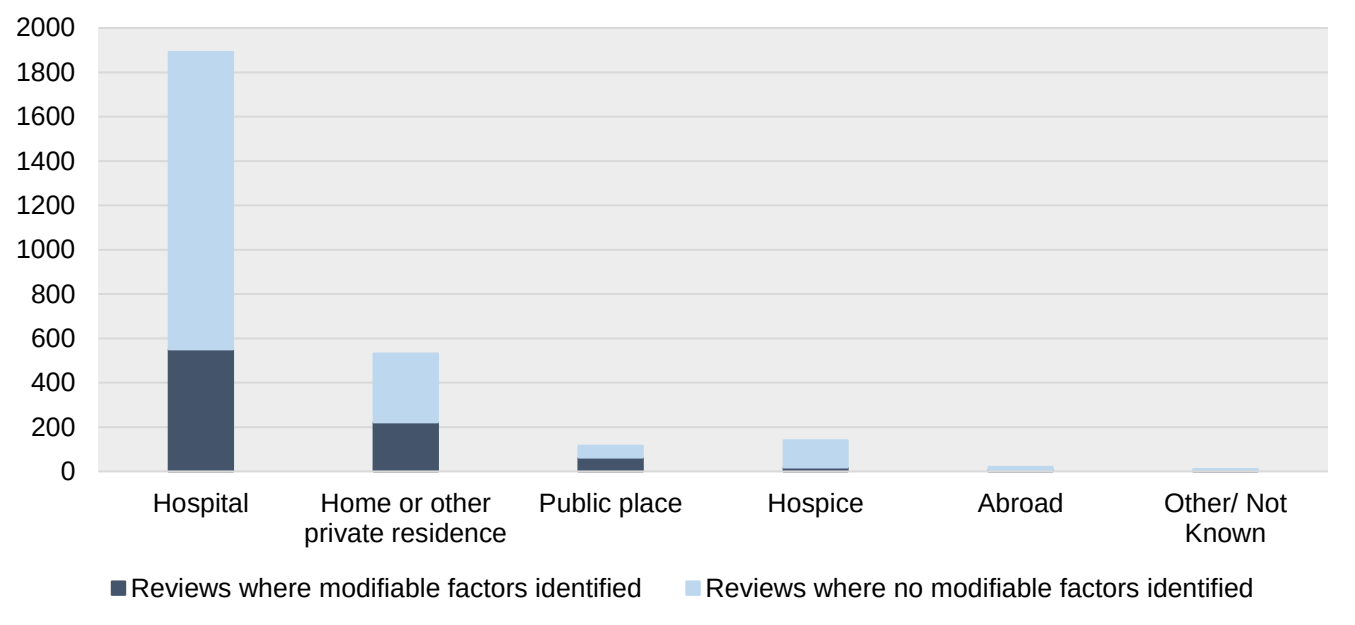
Males represented just over half of child death reviews (56%) and had the same proportion of deaths identified as having modifiable factors to females (32%).

1,570 reviews were completed of deaths of children from a White background, accounting for 65% of reviews completed where the child's ethnicity was recorded. By contrast, 760 (31%) of the deaths reviewed were for children from a Black, Mixed or Asian ethnic background.

Location (Reference Table 6)

1,892 (70%) of the deaths reviewed occurred in a Hospital Trust and 532 (20%) of deaths reviewed had occurred at Home or another private residence. The highest proportion of deaths with modifiable factors could be seen in deaths that occurred in a public place (54%). The lowest proportion of deaths with modifiable factors was seen in deaths that occurred in a Hospice (13%).

Figure 6: The number of child death reviews completed by Child Death Overview Panels by location at the time of event or illness, Year ending 31 March 2020



School not presented in the figure due to low numbers

Child Safeguarding Practice Review (Reference Table 7)

A Child Safeguarding Practice Review (previously Serious Case Review) is conducted when a child is seriously harmed, or dies, as a result of abuse or neglect. The review identifies how local professionals and organisations can improve the way they work together. Out of the number of child death reviews completed throughout the year, the NCMD received information that a Child Safeguarding Practice Review was carried out for at least 48 child deaths. Of these, 79% identified modifiable factors in the review.

Social care (Reference Table 8)

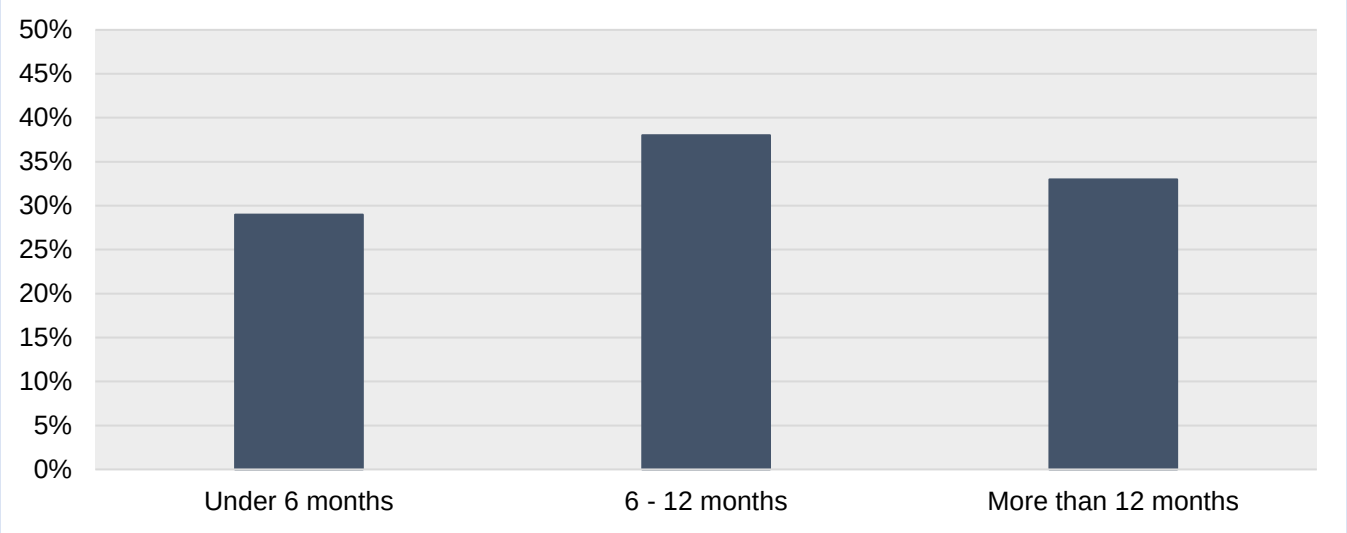
The NCMD received information on 253 children whose death was reviewed during the year were known to social care at the time of their death. Of these, 41% had modifiable factors identified in the review. See Table 8 for a detailed breakdown of how these children were known to social care.

Duration of reviews (Reference Table 2 & Reference Table 3)

740 (27%) reviews completed by CDOPs were of children who died between 1 April 2019 and 31 March 2020, while 1,998 (73%) reviews were of children who died during previous years.

776 (29%) reviews were finalised within 6 months of the child's death, while 1,806 (67%) of the reviews were finalised within 12 months of the child's death. The 909 (33%) reviews that took over 12 months to complete presented the highest proportion of reviews where modifiable factors were identified (44%), compared to 17% for reviews taking under 6 months. There are a number of factors that may contribute to a longer length of time between the death of a child and CDOP review, for example; the return of reporting forms, the receipt of the final post mortem report, undertaking of a criminal investigation or a Child Safeguarding Practice Review, and receipt of the final report from the local child death review meeting. In addition, on occasion when the outcome of a Coroner's inquest is awaited, there may be a longer delay before a case can be reviewed by the CDOP.

Figure 7: The percentage of reviews completed by Child Death Overview Panels by the number of months between the date of death and the date of the Child Death Overview Panel meeting, Year ending 31 March 2020



4. List of Reference Tables

Table 1	Number of child death reviews completed by Child Death Overview Panels by region
Table 2	Number of child death reviews completed by Child Death Overview Panels by the year in which the child death occurred
Table 3	Time between the death of a child and the completion of the CDOP review
Table 4	Number of reviews completed by Child Death Overview Panels by category of death
Table 5	Number of reviews completed by Child Death Overview Panels by event which caused the child's death
Table 6	Number of reviews completed by Child Death Overview Panels by location at time of the event or illness which led to the death
Table 7	Number of reviews completed by Child Death Overview Panels by Child Safeguarding Practice Review (previously Serious Case Review) status
Table 8	Number of reviews completed by Child Death Overview Panels by Social Care status
Table 9	Number of reviews completed by Child Death Overview Panels by age of the child at the time of death, gender and ethnicity
LAA to region mapping	Mapping of local authority areas to regions
Disclosure and methodology	Description of the methodology used in the CSV and Data tables
Data descriptions	Contains information and field definitions about the accompanying CSV file

All Reference Tables can be found here.

5. Further information

Child death reviews: Year ending 31 March	Previous versions of this publication can be found at the following websites: 2018 and 2019: https://digital.nhs.uk/data-and-information/publications/statistical/child-death-reviews/2019 2017 and earlier: https://www.gov.uk/government/collections/statistics-child-death-reviews
Child death review forms	The data collection forms used to gather information on child deaths can be found here: https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths
Child death review statutory and operational guidance	The child death review statutory and operational guidance can be found here: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england
Child death review process	For information on the child death review processes, see Chapter 5 of the 'Working Together to Safeguard Children' document which can be found here: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

6. Technical information

Data in this report represents data that was submitted to the NCMD. As a newly established continuing data collection and with some transitional arrangements still ongoing, more data may be submitted retrospectively, and the figures represented here may change.

All data was checked by the NCMD team prior to data analysis. This includes exclusion of cases that did not meet the criteria for CDOP review and removal of any duplicates.

From May - July 2020 the NCMD team contacted CDOPs to confirm that the data held was correct:

- 52 CDOPs confirmed that the data held was correct
- 3 CDOPs were unable to submit so partial data (i.e. only data which they had submitted) were included for analysis
- For a further 3 CDOPs, the NCMD team was unable to confirm whether the data submitted was correct. These data have been included but are unconfirmed.

Data was downloaded on 30 September 2020.

In a small number of cases (23 reviews in the year ending 31 March 2020), panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. These cases have been included in the number of reviews completed in Tables 1 and 2 but excluded from Tables 3 to 9. This methodology was kept consistent with previous years' publications.

Changes to previous publications

Data on children subject to a statutory order has been withdrawn from the data collection process, and therefore this table is no longer published.

The number of times which CDOPs met and the number of child deaths where the child was not normally resident within the Local Safeguarding Children Board area and are not reported within this publication.

Table 1 now presents data on notifications submitted to the NCMD, rather than death registration data from ONS.

Table 3 has been grouped into smaller timeframes to improve presentation of this data.

Table 5 and 6 now present slightly different categories to represent changes in data collection.

Table 8 has been changed due to a change in the structure of how this question is now asked within the data collection forms.

Table 9 was previously presented as Table 10 in previous publications.

For further information on NCMD data processing please see our Privacy Notice.

NCMD
National Child Mortality Database
Knowledge, understanding and learning to improve young lives

National Child Mortality Database (NCMD)
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Child Death Reviews Data: year ending 31 March 2020

(previously LSCB1 data collection)

Published: 12th November 2020

Introduction

This analysis focuses on the number of child death reviews completed and the decisions made by Child Death Overview Panels (CDOPs) on behalf of their CDR Partners in England. The tables included show child death reviews completed within the year, including modifiable factors, child characteristics and circumstances of the death. These tables should be read in conjunction with the descriptive report titled "Child Death Reviews Data (year ending 31 March 2020)" which has been published simultaneously on the NCMD website.

Note: Figures prior to year ending March 2018 were published by Department for Education and figures in year ending March 2018 and 2019 were published by NHS Digital.

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Period	Geog_Level	Geog_name	Review_total	Mod_total
2019-20	National	England	2738	862
2019-20	Region	North East	110	41
2019-20	Region	North West	366	164
2019-20	Region	Yorkshire and Humberside	348	128
2019-20	Region	East Midlands	214	79
2019-20	Region	West Midlands	408	102
2019-20	Region	East of England	234	66
2019-20	Region	London	484	116
2019-20	Region	South East	342	96
2019-20	Region	South West	232	70
2019-20	Local Authority Area	Barking and Dagenham	14	*
2019-20	Local Authority Area	Barnet	20	*
2019-20	Local Authority Area	Barnsley	17	7
2019-20	Local Authority Area	Bath and North East Somerset	*	*
2019-20	Local Authority Area	Bedford Borough	*	*
2019-20	Local Authority Area	Bexley	17	*
2019-20	Local Authority Area	Birmingham	176	24
2019-20	Local Authority Area	Blackburn with Darwen	*	*
2019-20	Local Authority Area	Blackpool	*	*
2019-20	Local Authority Area	Bolton	8	*
2019-20	Local Authority Area	Bournemouth, Christchurch and Poole	13	*
2019-20	Local Authority Area	Bracknell Forest	*	*
2019-20	Local Authority Area	Bradford	41	7
2019-20	Local Authority Area	Brent	19	5
2019-20	Local Authority Area	Brighton and Hove	7	*
2019-20	Local Authority Area	Bromley	17	10
2019-20	Local Authority Area	Buckinghamshire	25	6
2019-20	Local Authority Area	Bury	7	*
2019-20	Local Authority Area	Calderdale	8	*
2019-20	Local Authority Area	Cambridgeshire	24	5
2019-20	Local Authority Area	Camden	*	*
2019-20	Local Authority Area	Central Bedfordshire	*	*
2019-20	Local Authority Area	Cheshire East	16	7
2019-20	Local Authority Area	Chester and Cheshire West	12	*
2019-20	Local Authority Area	City of Bristol	19	5
2019-20	Local Authority Area	Cornwall	29	6
2019-20	Local Authority Area	Coventry	21	*
2019-20	Local Authority Area	Croydon	32	9
2019-20	Local Authority Area	Cumbria	21	5
2019-20	Local Authority Area	Darlington	*	*
2019-20	Local Authority Area	Derby	*	*
2019-20	Local Authority Area	Derbyshire	50	*
2019-20	Local Authority Area	Devon	31	6
2019-20	Local Authority Area	Doncaster	14	7
2019-20	Local Authority Area	Dorset	16	9
2019-20	Local Authority Area	Dudley	16	8
2019-20	Local Authority Area	Durham	17	*
2019-20	Local Authority Area	Ealing	9	5
2019-20	Local Authority Area	East Riding of Yorkshire	*	*

2019-20	Local Authority Area	East Sussex		12	*	
2019-20	Local Authority Area	Enfield		16	*	
2019-20	Local Authority Area	Essex		65		20
2019-20	Local Authority Area	Gateshead		5	*	
2019-20	Local Authority Area	Gloucestershire		23		7
2019-20	Local Authority Area	Greenwich		24		10
2019-20	Local Authority Area	Hackney and City		14	*	
2019-20	Local Authority Area	Halton	*		*	
2019-20	Local Authority Area	Hammersmith and Fulham		9	*	
2019-20	Local Authority Area	Hampshire		33		10
2019-20	Local Authority Area	Haringey		18		6
2019-20	Local Authority Area	Harrow		24	*	
2019-20	Local Authority Area	Hartlepool	*		*	
2019-20	Local Authority Area	Havering		8	*	
2019-20	Local Authority Area	Herefordshire		11	*	
2019-20	Local Authority Area	Hertfordshire		57		10
2019-20	Local Authority Area	Hillingdon		22		10
2019-20	Local Authority Area	Hounslow		25	*	
2019-20	Local Authority Area	Isle Of Man	*		*	
2019-20	Local Authority Area	Isle of Wight	*		*	
2019-20	Local Authority Area	Isles of Scilly	*		*	
2019-20	Local Authority Area	Islington	*		*	
2019-20	Local Authority Area	Kensington and Chelsea		10	*	
2019-20	Local Authority Area	Kent		74		19
2019-20	Local Authority Area	Kingston upon Hull		10		5
2019-20	Local Authority Area	Kingston upon Thames		7	*	
2019-20	Local Authority Area	Kirklees		34		21
2019-20	Local Authority Area	Knowsley		12		9
2019-20	Local Authority Area	Lambeth		10	*	
2019-20	Local Authority Area	Lancashire		86		38
2019-20	Local Authority Area	Leeds		75		24
2019-20	Local Authority Area	Leicester		17		11
2019-20	Local Authority Area	Leicestershire		14		8
2019-20	Local Authority Area	Lewisham		20		8
2019-20	Local Authority Area	Lincolnshire		29		13
2019-20	Local Authority Area	Liverpool		28		13
2019-20	Local Authority Area	Luton	*		*	
2019-20	Local Authority Area	Manchester		41		15
2019-20	Local Authority Area	Medway Towns		9	*	
2019-20	Local Authority Area	Merton	*		*	
2019-20	Local Authority Area	Middlesbrough		5	*	
2019-20	Local Authority Area	Milton Keynes		19	*	
2019-20	Local Authority Area	Newcastle upon Tyne		25		10
2019-20	Local Authority Area	Newham		31		13
2019-20	Local Authority Area	Norfolk		35		12
2019-20	Local Authority Area	North East Lincolnshire		7	*	
2019-20	Local Authority Area	North Lincolnshire		5	*	
2019-20	Local Authority Area	North Somerset		8	*	
2019-20	Local Authority Area	North Tyneside		11		6
2019-20	Local Authority Area	North Yorkshire		41		14

2019-20	Local Authority Area	Northamptonshire		20	*	
2019-20	Local Authority Area	Northumberland		9	*	
2019-20	Local Authority Area	Nottingham		28		15
2019-20	Local Authority Area	Nottinghamshire		56		26
2019-20	Local Authority Area	Oldham		16		9
2019-20	Local Authority Area	Oxfordshire		27		8
2019-20	Local Authority Area	Peterborough		7	*	
2019-20	Local Authority Area	Plymouth		18		5
2019-20	Local Authority Area	Portsmouth		10	*	
2019-20	Local Authority Area	Reading		5	*	
2019-20	Local Authority Area	Redbridge		22	*	
2019-20	Local Authority Area	Redcar and Cleveland	*		*	
2019-20	Local Authority Area	Richmond upon Thames		10	*	
2019-20	Local Authority Area	Rochdale		6		6
2019-20	Local Authority Area	Rotherham		35		15
2019-20	Local Authority Area	Rutland	*		*	
2019-20	Local Authority Area	Salford		9	*	
2019-20	Local Authority Area	Sandwell		28		6
2019-20	Local Authority Area	Sefton		9		6
2019-20	Local Authority Area	Sheffield		39		14
2019-20	Local Authority Area	Shropshire		12		8
2019-20	Local Authority Area	Slough		6	*	
2019-20	Local Authority Area	Solihull		8	*	
2019-20	Local Authority Area	Somerset		25		8
2019-20	Local Authority Area	South Gloucestershire		14	*	
2019-20	Local Authority Area	South Tyneside		9		5
2019-20	Local Authority Area	Southampton		12	*	
2019-20	Local Authority Area	Southend		7	*	
2019-20	Local Authority Area	Southwark		11	*	
2019-20	Local Authority Area	St Helens		9		6
2019-20	Local Authority Area	Staffordshire		24		8
2019-20	Local Authority Area	Stockport		16		9
2019-20	Local Authority Area	Stockton on Tees		9	*	
2019-20	Local Authority Area	Stoke on Trent		17	*	
2019-20	Local Authority Area	Suffolk		18		9
2019-20	Local Authority Area	Sunderland		11	*	
2019-20	Local Authority Area	Surrey		54		13
2019-20	Local Authority Area	Sutton		20	*	
2019-20	Local Authority Area	Swindon		10	*	
2019-20	Local Authority Area	Tameside		12		7
2019-20	Local Authority Area	Telford and Wrekin		7	*	
2019-20	Local Authority Area	Thurrock		16	*	
2019-20	Local Authority Area	Torbay		6	*	
2019-20	Local Authority Area	Tower Hamlets		9	*	
2019-20	Local Authority Area	Trafford		9		5
2019-20	Local Authority Area	Wakefield		14		7
2019-20	Local Authority Area	Walsall		30		9
2019-20	Local Authority Area	Waltham Forest		11		7
2019-20	Local Authority Area	Wandsworth		13	*	
2019-20	Local Authority Area	Warrington		13	*	

2019-20	Local Authority Area	Warwickshire		46		16
2019-20	Local Authority Area	West Berkshire	*		*	
2019-20	Local Authority Area	West Sussex		37		20
2019-20	Local Authority Area	Westminster		19	*	
2019-20	Local Authority Area	Wigan		11	*	
2019-20	Local Authority Area	Wiltshire		16		6
2019-20	Local Authority Area	Windsor and Maidenhead	*		*	
2019-20	Local Authority Area	Wirral		14		5
2019-20	Local Authority Area	Wokingham		5	*	
2019-20	Local Authority Area	Wolverhampton		10		5
2019-20	Local Authority Area	Worcestershire	*		*	
2019-20	Local Authority Area	York City	*		*	

NCMD

Child Death Reviews Data: year ending 31 March 2020

(previously LSCB1 data collection)

Published: 12th November 2020

Introduction

This analysis focuses on the number of child death reviews completed and the decisions made by Child Death Overview Panels (CDOPs) on behalf of their CDR Partners in England. The tables included show child death reviews completed within the year, including modifiable factors, child characteristics and circumstances of the death. These tables should be read in conjunction with the descriptive report titled "Child Death Reviews Data (year ending 31 March 2020)" which has been published simultaneously on the NCMD website.

Note: Figures prior to year ending March 2018 were published by Department for Education and figures in year ending March 2018 and 2019 were published by NHS Digital.

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Table 1: Number of child death[1] reviews completed by Child Death Overview Panels by region
Years ending 31 March 2016 to 2020
Coverage: England

	Number of child death reviews which were completed in the year ending 31 March[2,3]					Number of child death reviews completed which were assessed as having modifiable factors in the year ending 31 March[2,4]					Proportion of all completed child deaths reviewed which were assessed as having modifiable factors in the year ending 31 March[2,4]					Number of notifications received where the death occurred in the year ending 31 March
	2016	2017	2018	2019	2020	2016	2017	2018	2019	2020	2016	2017	2018	2019	2020	2020
England	3,665	3,575	3,595	3,250	2,738	863	974	1,015	965	862	24%	27%	28%	30%	31%	3,347
Region[5]																
North East	151	157	130	135	110	27	39	45	35	41	18%	25%	33%	25%	37%	153
North West	546	582	565	490	366	161	176	215	200	164	29%	30%	38%	41%	45%	435
Yorkshire and Humberside	407	414	380	315	348	115	126	130	100	128	28%	30%	34%	31%	37%	367
East Midlands	296	280	310	230	214	67	74	95	65	79	23%	26%	31%	27%	37%	284
West Midlands	489	444	595	485	408	96	125	150	140	102	20%	28%	25%	28%	25%	440
East of England	358	303	300	305	234	108	98	85	70	66	30%	32%	29%	22%	28%	341
London	555	600	605	600	484	108	125	125	170	116	19%	21%	21%	28%	24%	607
South East	545	500	455	465	342	91	130	110	115	96	17%	26%	25%	25%	28%	468
South West	318	295	255	225	232	90	81	60	80	70	28%	27%	24%	37%	30%	252

Source: LSCB1, NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. Figures prior to 2018 are shown to the nearest whole number. For 2018, all figures are rounded to nearest 5; therefore, subtotals may not add to totals due to rounding. Percentages are shown rounded to the nearest whole number and have been derived from unsuppressed figures.

3. Please note that not all child deaths which occur each year will have their child death review completed by 31 March. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.

4. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths. The denominator for the percentage is the number of all deaths reviewed. There were 23 deaths in 2020 where it was not known if there were modifiable factors. In 2019, there were 35 deaths (rounded), in 2018, there were 55 deaths (rounded), in 2017, there were 20 such deaths, in 2016, there were 39, and in 2015 there were 31.

5. Region definitions can be found on the tab: 'LAA to Region mapping'

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Table 2: Number of reviews completed by Child Death Overview Panels by the year in which the child death occurred
Years ending 31 March 2016 to 2020
Coverage: England

	Number[2] of child death reviews completed in the year ending 31 March[3]		
	Where the death occurred prior to the start of the year ending 31 March	**Where the death occurred during the year ending 31 March**	**All child death reviews completed in year ending 31 March**
2016	2,412	1,253	3,665
2017	2,280	1,295	3,575
2018	2,260	1,335	3,595
2019	2,080	1,170	3,250
2020	1,998	740	2,738
The number of which were assessed as having modifiable factors[4]:			
2016	663	200	863
2017	733	241	974
2018	690	320	1,015
2019	705	260	965
2020	707	155	862
Proportion of completed reviews which were assessed as having modifiable factors[2,4]:			
2016	27%	16%	24%
2017	32%	19%	27%
2018	31%	24%	28%
2019	34%	22%	30%
2020	35%	21%	31%

Source: LSCB1, NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.
2. Figures prior to 2018 are shown to the nearest whole numbers. From 2018, all figures are rounded to nearest 5; therefore, subtotals may not add to totals due to rounding. Percentages are shown rounded to the nearest whole numbers and have been derived from unsuppressed figures.
3. Please note that not all child deaths which occur each year will have their child death review completed by 31 March. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.
4. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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Table 3: Time between the death of a child and the completion of the CDOP review
Year ending 31 March 2020
Coverage: England

Length of time	All child death reviews completed in the year ending 31 March[2]			Percentage[2] of this length of time with:			Percentage of reviews in each year by duration
	Modifiable factors identified[3]	No modifiable factors identified[3]	Total	Modifiable factors identified[3]	No modifiable factors identified[3]	Total	
Under 6 months	130	646	776	17%	83%	100%	29%
6-12 months	335	695	1,030	33%	67%	100%	38%
More than 12 months	397	512	909	44%	56%	100%	33%
All	862	1,853	2,715	32%	68%	100%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.
2. Please note that not all child deaths which occur each year will have their child death review completed by 31 March. This is mainly because it may take a number of months to gather sufficient information to fully review a child's death.
3. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Table 4: Number of reviews completed by Child Death Overview Panels by category of death
Year ending 31 March 2020
Coverage: England

	Category of death[2]										
	Deliberately inflicted injury, abuse or neglect	Suicide or deliberate self-inflicted harm	Trauma and other external factors	Malignancy	Acute medical or surgical condition	Chronic medical condition	Chromosomal, genetic and congenital anomalies	Perinatal/ neonatal event	Infection	Sudden unexpected, unexplained death	All child death reviews completed in year ending 31 March 2020
All child death reviews completed in the year ending 31 March 2020[3]											
Number of which had:											
Modifiable factors identified[3]	43	60	80	11	43	21	101	277	62	164	862
No modifiable factors identified[3]	17	45	36	201	130	112	573	574	110	55	1,853
TOTAL	60	105	116	212	173	133	674	851	172	219	2,715
Percentage of this category of death which had:											
Modifiable factors identified[4]	72%	57%	69%	5%	25%	16%	15%	33%	36%	75%	32%
No modifiable factors identified[4]	28%	43%	31%	95%	75%	84%	85%	67%	64%	25%	68%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of each category of death under this assessment:											
Modifiable factors identified[4]	5%	7%	9%	1%	5%	2%	12%	32%	7%	19%	100%
No modifiable factors identified[4]	1%	2%	2%	11%	7%	6%	31%	31%	6%	3%	100%
Of all deaths	2%	4%	4%	8%	6%	5%	25%	31%	6%	8%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. Category of death and event are recorded at different times in the review process and there may be deaths where it was not possible to determine the intent and so classifications may differ. The number of deaths recorded as "suicide or deliberate self-inflicted harm" may be different to the number of deaths recorded as "apparent suicide" in Table 5. Similarly, the number of deaths recorded as "perinatal/neonatal event" may be different to the number recorded as "neonatal death" in Table 5.

3. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

4. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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Table 5: Number of reviews completed by Child Death Overview Panels by event which caused the child's death
Year ending 31 March 2020
Coverage: England

NCMD
National Child Mortality Database

	Event which caused the child's death[7]																		
	Neonatal death[8]	Known life limiting condition[6]	Sudden unexpected death in infancy	Vehicle collision	Drowning	Fire, burns or electrocution	Poisoning	Other non-intentional injury/ accident/ trauma	Apparent violent related death[2]	Apparent suicide[3] or self harm	Acute epilepsy	Acute asthma or anaphylaxis	Acute metabolic diabetic ketoacidosis	Cardiac congenital or acquired	Other chromosomal, genetic, or congenital anomaly	Infection	Oncology condition	Other	Unknown	All child death reviews completed in year ending 31 March 2020
All child death reviews completed in the year ending 31 March 2020[4]																			
Number of which had:																			
Modifiable factors identified[5]	290	18	151	35	7	6	*	21	42	61	5	11	*	33	90	54	11	10	11	862
No modifiable factors identified[5]	589	52	48	20	6	*	*	8	23	47	28	5	*	243	439	91	211	31	10	1,853
Total	879	70	199	55	13	6	*	29	65	108	33	16	5	276	529	145	222	41	21	2,715
Percentage of this event which had:																			
Modifiable factors identified[5]	33%	26%	76%	64%	54%	100%	100%	72%	65%	56%	15%	69%	60%	12%	17%	37%	5%	24%	52%	32%
No modifiable factors identified[5]	67%	74%	24%	36%	46%	0%	0%	28%	35%	44%	85%	31%	40%	88%	83%	63%	95%	76%	48%	68%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of each event under this assessment:																			
Modifiable factors identified[5]	34%	2%	18%	4%	1%	1%	*	2%	5%	7%	1%	1%	*	4%	10%	6%	1%	1%	1%	100%
No modifiable factors identified[5]	32%	3%	3%	1%	*	*	*	*	1%	3%	2%	*	*	13%	24%	5%	11%	2%	1%	100%
Of all deaths	32%	3%	7%	2%	*	*	*	1%	2%	4%	1%	1%	*	10%	19%	5%	8%	2%	1%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. A violent related death may be assessed as having no modifiable factors if the panel determines that the homicide was unforeseen, for example a random act where there were no previous concerns about the suspect.

3. Category of death and event are recorded at different times in the review process and there may be deaths where it was not possible to determine the intent and so classifications may differ. The number of deaths recorded as "apparent suicide" may be different to the number of deaths recorded as "suicide or deliberate self-inflicted harm" in Table 4. Similarly, the number of deaths recorded as "neonatal death" may be different to the number recorded as "perinatal/neonatal event" in Table 4.

4. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

5. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

6. Due to a change in data collection and more granular categories reported in the year ending 31 March 2020, Known life limiting condition presents less data than in previous years.

7. Due to a change in data collection, NCMD validated this data to improve data quality.

8. A neonatal death is related to neonatal or perinatal events.

Table 6: Number of reviews completed by Child Death Overview Panels by location at time of the event or illness which led to the death
Year ending 31 March 2020
Coverage: England

	Location at time of the event or illness							All child death reviews completed in year ending 31 March 2020
	Hospital	Home or other private residence	Public place	School	Hospice	Abroad	Other/ Not Known	
All child death reviews completed in the year ending 31 March 2020[2]								
Number of which had:								
Modifiable factors identified[3]	550	222	63	*	18	6	*	862
No modifiable factors identified[3]	1,342	310	53	*	123	14	9	1,853
Total	1,892	532	116	*	141	20	11	2,715
Percentage of deaths in this location which had:								
Modifiable factors identified[3]	29%	42%	54%	33%	13%	30%	18%	32%
No modifiable factors identified[3]	71%	58%	46%	67%	87%	70%	82%	68%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of each location under this assessment:								
Modifiable factors identified[3]	64%	26%	7%	*	2%	1%	*	100%
No modifiable factors identified[3]	72%	17%	3%	*	7%	1%	*	100%
Of all deaths	70%	20%	4%	*	5%	1%	*	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. In the year ending 31 March 2020, there were 23 deaths where panels has insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

3. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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Table 7: Number of reviews completed by Child Death Overview Panels by Child Safeguarding Practice Review (previously Serious Case Review) status[2,3,4]

Years ending 31 March 2016 to 2020

Coverage: England

Child Safeguarding Practice Review status		All child death reviews completed in the year ending 31 March			Percentage of this Child Safeguarding Practice Review status with:			*Percentage of reviews in each year by Serious Case Review status*
		Modifiable factors identified[5]	No modifiable factors identified[5]	Total	Modifiable factors identified[5]	No modifiable factors identified[6]	Total	
A Child Safeguarding Practice Review did not take place	2016	784	2,677	3,461	23%	77%	100%	95%
	2017	914	2,545	3,459	26%	74%	100%	97%
	2018	865	2,345	3,215	27%	73%	100%	91%
	2019	870	2,115	2,980	29%	71%	100%	93%
	2020	776	1,648	2,424	32%	68%	100%	89%
A Child Safeguarding Practice Review took place	2016	62	54	116	53%	47%	100%	3%
	2017	59	35	94	63%	37%	100%	3%
	2018	65	25	90	74%	26%	100%	3%
	2019	60	10	75	85%	15%	100%	2%
	2020	38	10	48	79%	21%	100%	2%
Unknown[6,7]	2016	17	32	49	35%	65%	100%	1%
	2017	1	1	2	50%	50%	100%	-
	2018	80	155	235	34%	66%	100%	7%
	2019	35	125	160	22%	78%	100%	5%
	2020	48	195	243	20%	80%	100%	9%
All	2016	863	2,763	3,626	24%	76%	100%	100%
	2017	974	2,581	3,555	27%	73%	100%	100%
	2018	1,015	2,525	3,540	29%	71%	100%	100%
	2019	965	2,250	3,215	30%	70%	100%	100%
	2020	862	1,853	2,715	32%	68%	100%	100%

Source: LSCB1, NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. Figures prior to 2018 are shown to the nearest whole numbers. For 2018, all figures are rounded to nearest 5; therefore, subtotals may not add to totals due to rounding. Percentages are shown rounded to the nearest whole numbers and have been derived from unsuppressed figures.

3. "-" represents percentages less than 0.5% but greater than 0%.

4. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. In 2019, there were 35 deaths (rounded); In 2018, there were 55 such deaths (rounded); In 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

5. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

6. It was unknown if the death resulted in serious case review. This may because this information is not collected by the panel or the information collected is not in the required format.

7. Due to submission issues in 2018 and 2019, there were more 'Unknowns' for SCR status

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Table 8: Number of reviews completed by Child Death Overview Panels by Social Care status[2,4]
Year ending 31 March 2020
Coverage: England

Known to Social Care		All child death reviews completed in the year ending 31 March			Percentage of this status with			*Percentage of reviews in each year by status*
		Modifiable factors identified[3]	No modifiable factors identified[3]	Total	Modifiable factors identified[3]	No modifiable factors identified[3]	Total	
Yes		**104**	**149**	**253**	**41%**	**59%**	**100%**	**9%**
	Child protection plan[5]	32	9	41	78%	22%	100%	-
	Looked after child[5]	12	13	25	48%	52%	100%	-
	Child in need[5]	31	74	105	30%	70%	100%	-
	Other[5]	47	70	117	40%	60%	100%	-
Previously, but not at time of death		**78**	**96**	**174**	**45%**	**55%**	**100%**	**6%**
Not at all		**407**	**1,022**	**1,429**	**28%**	**72%**	**100%**	**53%**
Unknown[6]		**273**	**586**	**859**	**32%**	**68%**	**100%**	**32%**
All		**862**	**1,853**	**2,715**	**32%**	**68%**	**100%**	**100%**

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.

2. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.

3. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

4. Due to a change in the way in which this question is answered following a change in CDR processes in the year ending 31 March 2020, it is not possible to compare this table to previous years. The deaths reviewed in the year ending 31 March 2020 will have used both the old and new data collection process, depending on when the child died. For children who died before 1 April 2019, CDOPs collected 'Was the child on a child protection plan?' with the following options: At the time of death; Previously, but not at time of death; Not at all; Unknown. From 1 April 2019, the question changed to 'Was the child known to children's social care prior to their death/the event leading to their death?' with the following options where more than one could be selected: Yes on a child protection plan; Yes, as a looked after child; Yes, as a child in need; Yes, as an asylum seeker; Yes, other; Previously known, but not an open case; No; Unknown

5. Each child death review included under 'Yes' can be known to social care in multiple ways and therefore these totals will not sum to the total of child death reviews reported under 'Yes'.

6. Due to a change in data collection and CDR processes in the year ending 31 March 2020, there were more 'Unknowns' for social care status.

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Table 9: Number of reviews completed by Child Death Overview Panels by age of the child at the time of death, gender and ethnicity
Year ending 31 March 2020
Coverage: England

	Age of the child at the time of death						Gender			Ethnicity						All child death reviews completed in year ending 31 March 2020
	0 days-27 days	28 days-364 days	1 year-4 years	5 years-9 years	10 years-14 years	15 years-17 years	Male	Female	Unknown/ Indeterminate	White	Mixed	Asian	Black	Other	Unknown/ not stated	
All child death reviews completed in the year ending 31 March 2020[2]																
Number of which had:																
Modifiable factors identified[3]	328	247	74	43	72	98	482	379	*	562	47	97	43	21	92	862
No modifiable factors identified[3]	778	344	247	168	157	159	1,039	797	17	1,008	89	336	148	66	206	1,853
Total	1,106	591	321	211	229	257	1,521	1,176	18	1,570	136	433	191	87	298	2,715
Percentage of this age group/gender/ethnicity which had:																
Modifiable factors identified[3]	30%	42%	23%	20%	31%	38%	32%	32%	6%	36%	35%	22%	23%	24%	31%	32%
No modifiable factors identified[3]	70%	58%	77%	80%	69%	62%	68%	68%	94%	64%	65%	78%	77%	76%	69%	68%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of each age group/gender/ethnicity under this assessment:																
Modifiable factors identified[3]	38%	29%	9%	5%	8%	11%	56%	44%	*	65%	5%	11%	5%	2%	11%	100%
No modifiable factors identified[3]	42%	19%	13%	9%	8%	9%	56%	43%	1%	54%	5%	18%	8%	4%	11%	100%
Of all deaths	41%	22%	12%	8%	8%	9%	56%	43%	1%	58%	5%	16%	7%	3%	11%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.
2. In the year ending 31 March 2020, there were 23 deaths where panels had insufficient information to determine if there were modifiable factors in the child's death. These deaths have been excluded from the table. In some cases this was because it was not possible to gather further information, for example if the coroner was unable to conclusively determine the cause of death and in other cases it was because of difficulties in obtaining accurate information, for example when a child died abroad and limited information was provided to the panel. In 2019, there were 35 deaths (rounded); in 2018, there were 55 such deaths (rounded); in 2017, there were 20, in 2016, there were 39 and in 2015 there were 31.
3. A death with modifiable factors is defined where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

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Local Authority Area to Region mapping

Region	Child Death Overview Panel	Local Authority Area
East Midlands	Derby and Derbyshire	Derby
		Derbyshire
	Leicester, Leicestershire and Rutland	Leicester
		Leicestershire
		Rutland
	Lincolnshire	Lincolnshire
	Northamptonshire	Northamptonshire
	Nottinghamshire and Nottingham City	Nottingham
		Nottinghamshire
East of England	Bedfordshire	Bedford Borough
		Central Bedfordshire
		Luton
	Cambridge and Peterborough	Cambridgeshire
		Peterborough
	Hertfordshire	Hertfordshire
	Norfolk	Norfolk
	Southend, Essex and Thurrock	Essex
		Southend
		Thurrock
	Suffolk	Suffolk
London	North Central London	Barnet
		Camden
		Enfield
		Haringey
		Islington
	North East London	Barking and Dagenham
		Havering
		Redbridge
	North East London (WELC)	Hackney and City
		Newham
		Tower Hamlets
		Waltham Forest
	North West London	Brent
		Ealing
		Hammersmith and Fulham
		Harrow

London	North West London	Hillingdon
		Hounslow
		Kensington and Chelsea
		Westminster
	South East London BGL	Bexley
		Greenwich
		Lewisham
	South East London	Bromley
		Lambeth
		Southwark
	South West London	Croydon
		Kingston upon Thames
		Merton
		Richmond upon Thames
		Sutton
		Wandsworth
North East	Durham and Darlington	Darlington
		Durham
	North and South of Tyne	Gateshead
		Newcastle upon Tyne
		North Tyneside
		Northumberland
		South Tyneside
		Sunderland
	Tees	Hartlepool
		Middlesbrough
		Redcar and Cleveland
		Stockton on Tees
North West	Blackpool, Blackburn and Lancashire	Blackburn with Darwen
		Blackpool
		Lancashire
	Bolton, Salford and Wigan	Bolton
		Salford
		Wigan
	Bury, Rochdale and Oldham	Bury
		Oldham
		Rochdale
	Cumbria	Cumbria
	Manchester	Manchester
	Merseyside	Knowsley
		Liverpool
		Sefton
		St Helens
		Wirral
		Isle Of Man
	Pan Cheshire	Cheshire East
		Chester and Cheshire West

	Pan Cheshire	Halton
		Warrington
	Stockport, Tameside and Trafford	Stockport
		Tameside
		Trafford
South East	Hampshire and Isle of Wight	Hampshire
		Isle of Wight
		Portsmouth
		Southampton
	Kent and Medway	Kent
		Medway Towns
	Milton Keynes	Milton Keynes
	Oxfordshire and Buckinghamshire	Buckinghamshire
		Oxfordshire
	Pan Berkshire	Bracknell Forest
		Reading
		Slough
		West Berkshire
		Windsor and Maidenhead
		Wokingham
	Pan Sussex	Brighton and Hove
		East Sussex
		West Sussex
	Surrey	Surrey
South West	Gloucestershire	Gloucestershire
	Pan Dorset and Somerset	Bournemouth, Christchurch and Poole
		Dorset
		Somerset
	South West Peninsula	Cornwall
		Devon
		Isles of Scilly
		Plymouth
		Torbay
	Swindon and Wiltshire	Swindon
		Wiltshire
	West of England	Bath and North East Somerset
		City of Bristol
		North Somerset
		South Gloucestershire
West Midlands	Birmingham	Birmingham
	Black Country	Dudley
		Sandwell
		Walsall
		Wolverhampton
	Coventry, Warwickshire and Solihull	Coventry
		Solihull
		Warwickshire

	Herefordshire and Worcestershire	Herefordshire
		Worcestershire
	Shropshire, Telford and Wrekin	Shropshire
		Telford and Wrekin
	Stoke on Trent and Staffordshire	Staffordshire
		Stoke on Trent
Yorkshire and Humberside	Barnsley	Barnsley
	Bradford	Bradford
	Doncaster	Doncaster
	East Riding of Yorkshire	East Riding of Yorkshire
	Kingston upon Hull	Kingston upon Hull
	Leeds	Leeds
	Northern Lincolnshire	North East Lincolnshire
		North Lincolnshire
	Rotherham	Rotherham
	Sheffield	Sheffield
	Wakefield, Calderdale and Kirklees	Calderdale
		Kirklees
		Wakefield
	York City and North Yorkshire	North Yorkshire
		York City

Disclosure control:

In order to minimise the disclosure risk associated with small numbers, we have applied the following controls to these tables:

- "*" denotes that a figure has been suppressed due to small numbers (less than 5, including zero)
- "-" denotes less than 0.5% but greater than 0%

Methodology

Data in this report represents data that was submitted to the NCMD. As a newly established continuing data collection and with some transitional arrangements still ongoing, more data may be submitted retrospectively and the figures represented here may change.

Figures reported are following data being checked by the NCMD team. This includes exclusion of cases that did not meet the criteria for CDOP review and removal of any duplicates.

From May - July 2020 the NCMD team contacted CDOPs to confirm that the data held was correct:
•52 CDOPs confirmed that the data held was correct
•3 CDOPs were unable to submit so partial data (i.e. only data which they had submitted) were included for analysis
•For a further 3 CDOPs, the NCMD team was unable to confirm whether the data submitted was correct. These data have been included but are unconfirmed.

Data was downloaded on 30th September 2020.

In a small number of cases (23 reviews in the year ending 31 March 2020), panels were unable to determine if there were modifiable factors in a child's death as there was insufficient information available. These cases have been included in the number of reviews completed in Tables 1 and 2 but excluded from Tables 3 to 9. This methodology was kept to be consistent with previous years publications.

Changes to previous publications

Data on children subject to a statutory order has been withdrawn from the data collection process, and therefore this table is no longer published.

The number of times which CDOPs met and the number of child deaths where the child was not normally resident within the Local Safeguarding Children Board area are not reported within this publication.

Table 1 now presents data on notifications submitted to the NCMD, rather than death registration data from ONS.
Table 3 has been grouped into smaller timeframes to improve presentation of this data.
Table 5 and 6 now present slightly different categories to represent changes in data collection.
Table 8 has been changed due to a change in the structure of how this question is now asked within the data collection forms.
Table 9 was previously presented as Table 10 in previous publications.

Data descriptions

The table below contains information and field definitions about the accompanying CSV file.

CSV data file column name	Description of field
Period	The reporting period
Geog_level	Geographical level breakdown (National, regional or local authority)
Geog_name	Geographical name breakdown
Review_total	Total number of child death reviews completed in the year ending 31 March 2020
Mod_total	Total number of child death reviews completed in the year ending 31 March 2020 where modifiable factors were identified in the review

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Annual Child Death Overview Report

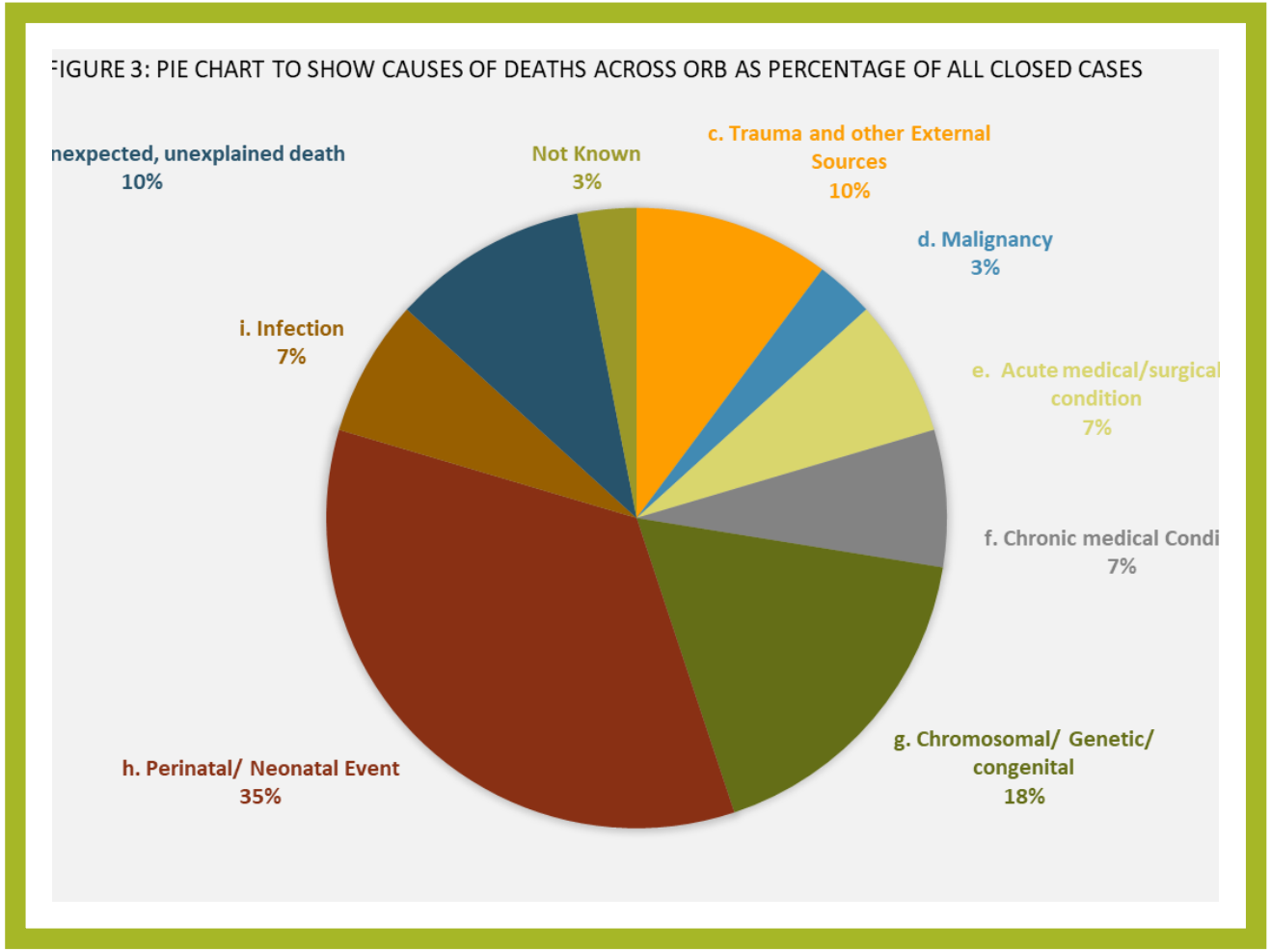
The Child Death Review Process

- All deaths of children and young people aged under 18 must be reviewed in a timely manner
  - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf
  - Initially Child Death Review Meetings must be held soon after death – usually led by the Acute Trust involving professionals
  - Following all other reviews and investigations, Child Death Overview Panels gather reports from services involved with the family to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified.

Oldham, Rochdale and Bury (ORB)

Method

- Oldham, Rochdale and Bury have a shared Child Death Overview Panel
- A review of the 29 closed cases in Oldham, Rochdale and Bury
- Data collected between 1st April 2019 -31st March 2020
- Analysis of:
  - CDOP process
  - General Demographics of closed cases
  - Modifiable Risk Factors
- Interventions



Report Findings

66% of closed cases were expected deaths

69% of closed cases occurred in a hospital setting

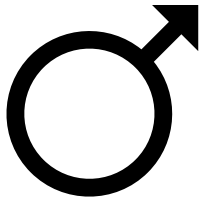
34% of closed cases occurred in the neonatal period

58% of closed cases occurred in the first year of life

Themes both Locally and Nationally

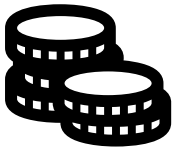
Prematurity

76% of child deaths under the age of 1 were born premature



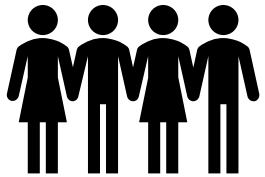
Gender

62% of closed cases were male



Deprivation

31% of closed cases were in the most deprived decile of the population



Ethnicity

Rochdale and Oldham have higher rates of closed cases in children of BAME ethnicity

Modifiable Risk Factors

Maternal Obesity

- Modifiable risk factor in 18% of closed cases under 1 year
- Intervention: Family centred health improvement and weight management service

Maternal Smoking

- Maternal smoking during pregnancy identified in 10% of cases
- Intervention: Baby clear, midwife led smoking cessation service

Risk Factors for Sudden, unexpected deaths in infants

- Risk factors include: Unsafe sleeping, parental smoking, drugs and alcohol
- Interventions: Safe sleeping advice, Risk Assessments, Lullaby Trust

Recommendations

- Consider other factors such as maternal age and breastfeeding
- Ensure data is recorded for unbooked pregnancy and concealed pregnancy
- Recognise the maternal obesity is a growing concern, and ensure that is recorded in child deaths under 1 year
- Acknowledge and address that children living in deprived neighbourhoods or of BME ethnicity are over-represented in child deaths
- Disseminate this report to the relevant departments within the health and wellbeing partnership to ensure shared learning

Greater Manchester CDOP Annual Report

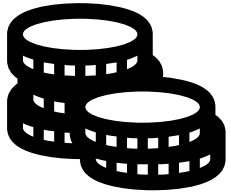
Greater Manchester CDOP Findings

- During 2019/20, there were 129 child death cases reviewed by GM CDOPs and 240 child death notifications
  - Bury, Rochdale & Oldham CDOP
  - Bolton, Salford & Wigan CDOP
  - Stockport, Trafford & Tameside CDOP
  - Manchester CDOP
- Reduction in number of cases reviewed across all CDOPs – mainly due to change in child death review process
- Potentially modifiable factors were identified in 40% of all closed cases

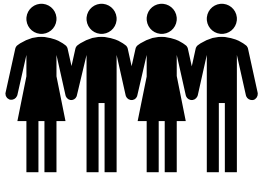
GM Findings - demographics

Age
64% of closed cases were in babies under the age of one

Cause
72% of closed cases were attributed to medical causes

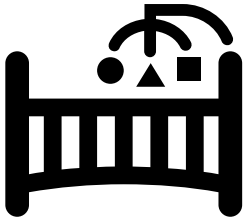


Deprivation
55% of the reviewed cases lived in the most deprived 20% of the population



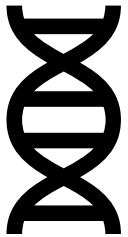
Ethnicity
There were higher rates of reviewed cases in children of BAME ethnicity

GM Findings – modifiable factors



Unsafe sleeping
in sudden and unexpected deaths in infants

Maternal obesity in pregnancy
in perinatal/ neonatal deaths



Consanguinity
In deaths related to chromosomal, genetic and congenital anomalies

Smoking
Smoking was identified as a modifiable factor in 10% of all cases closed

Recommendations

1. Local areas use the information on BAME communities being disproportionately represented, along with other local information, to inform work to address health inequalities
2. Continue to focus on smoking cessation in pregnant women
3. GM local authorities need to reduce levels of obesity throughout the population including women
4. GM CDOP Chairs to commission a 5 year GM CDOP analysis of cases
5. Local areas to consider real time data on suicides to inform more timely responses
6. Implement an electronic CDOP reporting system to improve the process

National Child Mortality Database Report (NCMD)

Key Findings

- The NCMD launched on 1 April 2019 and collates data collected by CDOPs in England. This is the first annual report.
- The NCMD received 3,347 child death notifications from CDOPs in England where the child died between 1 April 2019 and 31 March 2020.
- Decrease in the numbers of cases reviewed and closed nationally
- “Perinatal/neonatal event”, and “Chromosomal, genetic and congenital anomalies” combined represent over half (56%) of reviews completed. For 63% of deaths reviewed the child was aged under 1
- 31% of these reviews identified one or more modifiable factors
- Sudden, unexpected and unexplained deaths, deliberate injuries and trauma had the most modifiable factors identified

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Elective Care – 'Building Back Better'

Ian Mello
Director of Commissioning, NHS Bury CCG

Penny Martin
Director of Operations, Bury Care Organisation, Northern Care Alliance (NCA)

Introduction

- COVID 19 - significantly impacted upon the delivery of acute services across the NHS.
- Despite Bury having high quality health services across primary, community, secondary care and the third sector the scale and the depth of the impact of COVID means that the current models of care can't address the problem and support the recovery required.
- Exacerbation of pre-existing access and waiting time pressures - considerable increase in the time patients are waiting to receive non-urgent treatments.
- Burys response - NCA, Bury OCO and wider partners driving forward a joint programme of work to radically change our current ways of delivering acute care to patients and respond at pace.
- Key focus - addressing health inequalities and inclusion at a neighbourhood level.
- System's response to the pandemic - provided opportunities for rapid 'tests of change,' bringing partners together to successfully redesign pathways to ease pressures in the system e.g., Bury COVID Urgent Eye Service.
- Place based, Neighbourhood Focus - citizens and communities are at the core of coproduction.
- Lesson learnt and best practice will inform a blueprint for Burys work with other providers e.g., Manchester Foundation Trust (MFT) and the Independent Sector Providers (ISP).

Elective Care Performance – Summary

Since the global coronavirus pandemic began Bury has experienced significant decreases* in elective activity across acute providers.

Decreases in Elective activity

- 42% less elective admissions
- 22% less first attendances (*telephone consultations increased from 0.5% to 34%**)
- 9% less follow up attendances (*telephone consultations increased from 2% to 36%**)
- 24% less diagnostics

As of January 2021, Bury* had 18917 registered patients waiting for treatment compared to 15152 in January 2020 representing an overall increase of 25%

The latest waiting list data for the NCA indicates there are 15036 Bury registered patients waiting, an increase of 29% from January 2020.

- 43% of the patients on the waiting list are waiting 18+ weeks
- 10% of patients on the waiting list are waiting 52 weeks or longer.
- Initial analysis suggests age is a contributing factor for those on a waiting list

Neighbourhoods - East & Whitefield

East

- Significantly younger population with under 44 year olds being over the Bury average.
- Most deprived neighbourhood, having the LSOA with the most deprived IMD 2019 score in Bury.
- Life expectancy is significantly lower than other neighbourhoods.
- Higher BAME population when compared to Bury and national averages.

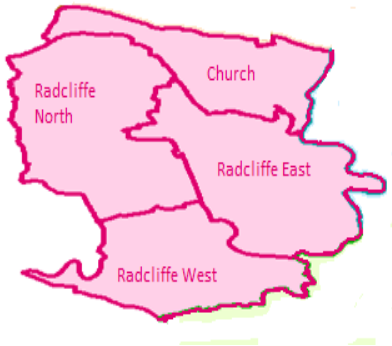
Whitefield

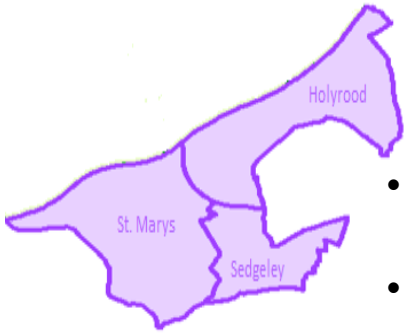
- Higher proportion of middle aged and older people (aged 45 plus) than the Bury average.
- Higher levels of Life Expectancy and Healthy Life Expectancy than the Bury average, especially for Males.
- Lower levels of household poverty than other neighbourhoods.

Neighbourhoods - West, Prestwich & North

West

- Lower levels of physical activity than other neighbourhoods and Bury average.
- Split population of over representation as 20-29 year olds and 50-59 year olds being significantly overrepresented.
- Nearly a third of Six Town housing is located in West, and there is much more social housing than any other neighbourhood in Bury.
- Median income for households is a lot lower than in other neighbourhoods.





Prestwich

- Younger population, but indicative of more families than other neighbourhoods with 0-14 year olds and 30-44 year olds being higher than the Bury average.
- Higher BAME population when compared to Bury and national averages.
- Higher levels of physical activity when compared to other neighbourhoods and the Bury average.

North

- Higher proportion of older people than the Bury average.
- Significantly lower BAME population than Bury and National averages.
- Least deprived Neighbourhood.

The Problem

- Patients are waiting longer for elective treatment than they ideally should. Waits will for routine urgency treatments continue increasing (waits were deteriorating nationally before this year, which is now exacerbated by COVID).

- Existing healthcare systems are not designed to support the closing of livelihood & wellbeing gaps across different socioeconomic groups, should they be present, which in turn affects health.

- Increased demands on primary care clinicians & secondary clinicians from maintaining safety (scanning) of patients held on waiting lists as a result of the backlogs.

- Longer patient waits worsen patient experience.

    - May include - increased anxiety (uncertainty) about receipt of treatment & treatment outcomes. In the meantime, patients will also be enduring physiological & psychological consequences of care that is delayed significantly beyond pre-COVID expectations, which is further exacerbated by high uncertainty about when COVID will ‘end’ & (the likely to remain) NHS constitutional standards framing patient expectations that are beyond the diminished process capability of the NHS.

Elective Care Programme - 'Building Back Better' Mission Statement

- To bring partners together to work as an **Integrated Care System** to actively pursue new innovative and collaborative solutions
- To achieve the **very best patient and population health outcomes**, through system collaboration and system leadership.
- This is a **collaborative partnership** between the Northern Care Alliance (NCA) and Clinical Commissioning Groups (CCGs) in the Salford and North East Sector localities.
- Phase 1 - working in collaboration with the NCA and Bury CCG, but with the aim of i**dentifying solutions that are scalable** across the system and therefore involving all Care Organisations and localities at key stages of the programme
- This will be achieved through a **change in culture within and between organisations** to support implementation of a shared vision and maximise the opportunity to collectively 'Build Back Better.'
- Partners will work as a single integrated system, **flexing organisational boundaries** through clear and agreed delegated authority.
- **Data and evidence will drive the questions and agreement as a system of one version of the truth** and help to frame the environment we want to create for the future, without jumping straight to solutions.
- Fundamental to this process will be exploring new approaches to redesigning **person-centred, neighbourhood based holistic models of care** across multiple agencies. The system will consider overarching socioeconomic approaches and drivers, rather than just statutory healthcare targets and measures, including **inequality and inclusion**.
- The programme will be **evaluated by outcomes** and will enable partners to have the required honest and open discussions to support a **better patient experience** and ultimately, deliver **improved patient outcome** for the people we serve.

Programme Key Principles

- To clearly articulate the problem and considerations to work as a single integrated system, flexing organisational boundaries through clear and agreed delegated authority.
- To achieve the very best patient and population outcomes through collaboration and system leadership.
- Be evaluated by outcomes, especially those which service users themselves identify and report.
- Drive forward a change in culture within organisations to support implementation of the shared vision and maximise the opportunity to collectively ‘Build Back Better.’
- To focus on approaches that deliver activity to both reduce demand through offering referral to diagnosis rather than just referral to treatment.
- To look at approaches to shape pathways to deliver better patient outcomes without necessarily resulting in an elective or planned procedure.
- Enable and not hinder the provision of integrated care and ensure that funding flows to where it is needed most to be utilised in the most effective way for the population.
- To redesign pathways in line with the existing initiatives that support innovation e.g., Community Diagnostic Hub strategy where appropriate.
- To consider the possibility of a holistic case management approach and develop a test of change.

Programme Key Principles

- To use data to drive the questions to interrogate the data further and to agree to one version of the truth.
- To use the data and evidence to keep a focus on the problem to produce a strategy and approach before moving to solutions.
- To roll this work out across the localities, as a system and to adopt a system wide approach to thinking and strategy, using the Bury locality as an initial test bed.
- To consider overarching socioeconomic approaches and drivers rather than just statutory healthcare targets and measures including inequality and inclusion.
- To widen the potential for lifestyle solutions, public health approaches and use of the local charity and voluntary sector where appropriate.
- To include the use of the Independent Sector resources and expertise in designing the solutions and actions.
- To have honest, open discussions, which are focused on the people we serve.
- To use single governance, joint reports and papers for all systems.

Tackling Inequalities Within Neighbourhoods

Plan, Do, Study, Act

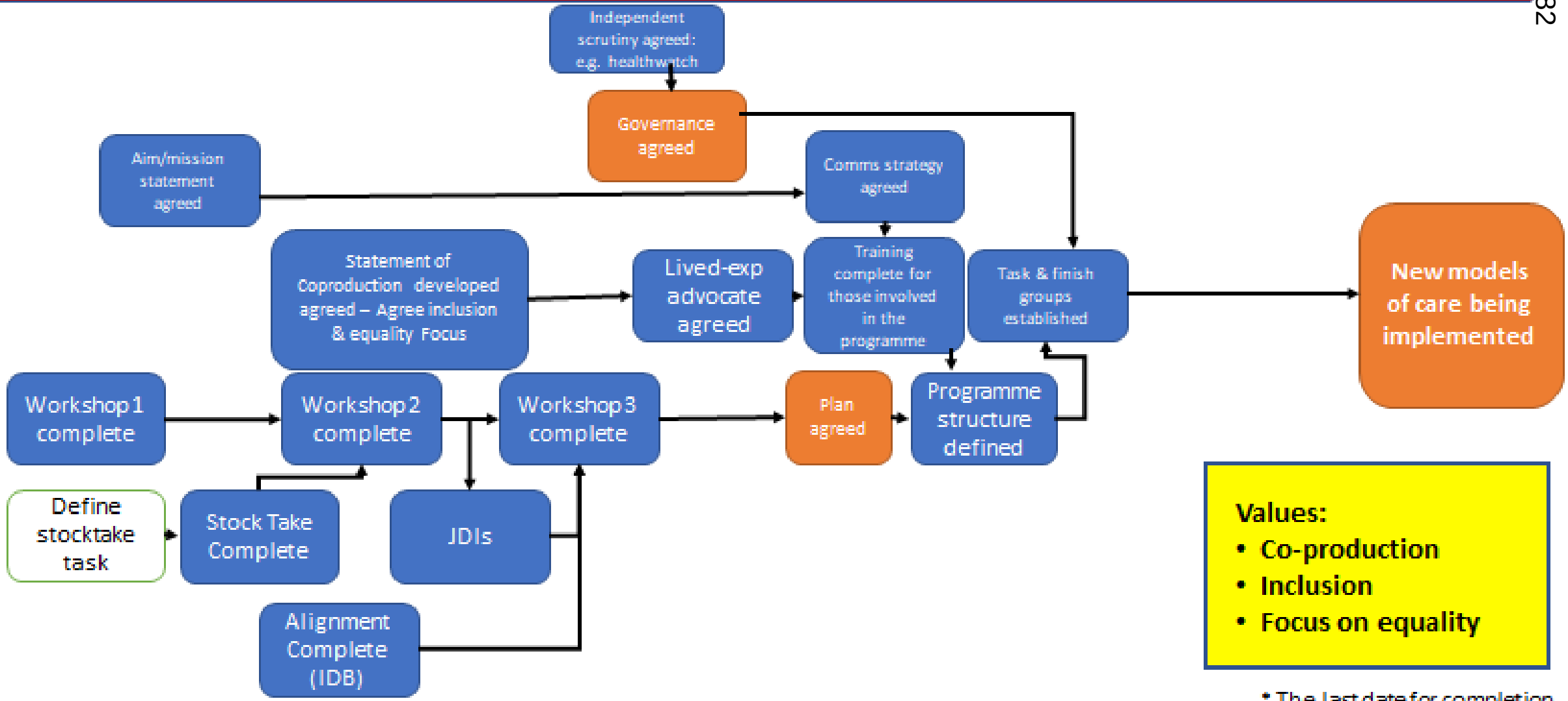
- Who are the total cohort that have the problem/ are of interest?
- Who within the cohort are aware of the problem? Who is not aware and why?
- Who in the cohort is eligible for Intervention? who is not and why?
- Who receives optimal Intervention? Who doesn’t and why?
- Who achieves full compliance with Plan? Who doesn’t and why?

Integrated System Working – Collaborating to 'Build Back Better'

- The Northern Care Alliance and Bury One Commissioning Organisation Joint Transformation Group is leading a series of meetings and clinically led system workshops, built on the values of co-production, inclusion and equality, to:
    - agree the approach and principles to 'build back' and recover from the changed environment.
    - identify the environment it will aspire to create for the future, rather than focussing on solutions.
    - enable partners to work together to describe the desired system and patient outcomes and results, before describing the solutions to get there.
    - ensure the use of neighbourhood assets and adoption of strength-based philosophies to mobilise resources and develop alternative and innovative models of care.
    - agree the 'blueprint' of where they want to be, and how as localities we will know when we are there through smaller 'tests of change' and via a methodology that is transferable across service reviews to aid transformation at large scale.
    - focus on the Bury locality as an initial test bed for change, before widening the scope of the work to other localities within the NCA footprint.
    - develop and deliver a Bury system Road Map for Recovery and Transformation.

Bury systemwide roadmap for recovery (critical path of outcomes*)

Mar 2021 | Apr | May | Jun | Jul | Aug | Sep



* The last date for completion

Developing Neighbourhood Health Improvement Plans

Healthier Bury

Lets Do it

Healthier Bury– Lets Do it
What is the data telling us ?

- Covid is having significant impacts on the lives of residents and the city region of Greater Manchester (GM) as a whole
- 1:4 GM residents have concerns about their children's mental health
- 1:4 GM Residents are sleeping less, doing less exercise and same proportion are drinking more alcohol
- In Bury - Around half of residents are extremely/very have been worried about coronavirus (47%)
- One in four Bury residents (26%) feel they need more support with their mental health
- In Bury around one in five need more support with staying active (19%) and eating healthily (20%)
- In Bury tackling the feeling of loneliness (20%) and caring for adult relatives (18%) or others in the community (18%) are concerns from Covid - which is in line with the GM average
- When asked whether they need more help, support or advice on a range of issues, one in four GM residents admit they need more help or support for their mental health, tackling the feeling of loneliness, staying active and eating healthily

Bury COUNCIL

Groups affected by the COVID-19

While it is clear from the findings outlined in this report that the concerns, anxieties and impacts of the pandemic have been felt throughout the GM population, certain groups appear to have been impacted more than others including :

- Young people, particularly those aged 16-24;
- Residents with young children, and particularly those aged 0-4yrs;
- BME residents overall, but Asian residents in particular;
- Muslim residents and those for whom English is not their first language;
- Carers, and residents where someone in their household has been told they are at high risk from COVID;
- Those with a disability;
- Residents that have served in the armed forces;
- Those living in the 'most deprived' communities of Greater Manchester, among others
- CEV / Shielded

Bury COUNCIL

COVID-19 and inactivity – Sport England (Oct 20)

- Nationally Active Lives Survey : During the mid-March to mid-May period, the number of active adults fell by 7.1%, or just over 3 million, whilst inactivity levels rose by 7.4% or 3.4 million adults.

- Bury Active Lives May 2019/20, has seen an increase (4.2%) in the inactive population in Bury in the last 12 months.

- Bury has seen the percentage of people active for at least 30 minutes a week, decrease by 3.1% since Active Lives began (November 2015/16) in comparison Greater Manchester as a whole has increased the moving population by 0.5% in the same time period

- Overall, the highest levels of inactivity are amongst the over 75's (47.8%), those from lower socio-economic groups, NS-SEC 6-8, (44.5%) and those with long term limiting disabilities (41.4%)

- The lowest levels of inactivity are amongst higher socio-economic groups, NS-SEC 1-2 (19.4%), those working full or part time (22.5%) and 16 to 34 year olds (26.8%).

- The proportion of children moving (achieving an average of at least 30 minutes of physical activity a day) in Bury has dropped significantly (-10.9%) since the Active Lives Children and Young People Survey launched in 2017/18.

Bury COUNCIL

Impacts

- COVID-19 is considered as the deconditioning pandemic
- The deteriorations in physical and mental health are profound
- The pandemic has increased inequalities

A structured systematic approach to support the health improvement of Bury residents is required.

Strategic Alignment

The neighbourhood improvement plans will closely align to the vision, aims and objectives of a number of existing key strategies including;-

- Bury 2030 Strategy
- Bury Corporate Plan
- Bury Moving Strategy
- Bury Food Strategy
- Bury Mental Health Strategy

Our Vision

Healthier Bury - Lets Do it

To ensure the people and communities of Bury are supported to recover both physically and mentally from living with Covid, individually and collectively.
This is to be achieved by creating conditions where the healthy choice is the easy choice.
We will also work to facilitate opportunities for individuals and communities to come together and thrive to lead happier healthier lives.

Bury COUNCIL

Our Approach

- Embed the programme into the new **Neighbourhood Model**
- **Place based approach**
- **Enable and empower the community** to lead and deliver interventions
- **Create an Enabling Role** to adopt a partnership approach
- Work alongside the health and care integrated teams
- Work alongside Children's and Adults early help
- A significant and **high-profile marcomms campaign** to highlight all the great outdoor and indoor facilities, activities and events available which can support positive health and wellbeing
- The programme will also adopt well-established **behaviour change** strategies to get people back moving, improve health and support the adoption of an active and healthy lifestyle as the norm.
- **Collaboration** at the heart of our programme
- **Consultation** to lead programme
- **Life course** approach
- **Targeted and tailored approaches** to ensure communities and groups who need more support are given it – to reduce inequalities

Bury COUNCIL

Marketing

- Robust marketing approach linked to the ‘Lets Do It’ strap line in the 2030 strategy
- Consistent branding of positive health related activities
- Creating something local, meaningful and relatable to Bury residents
- Tailored and targeted messages dependent on the group or locality

Bury COUNCIL

Key Programme Strands

- **Interventions to support positive behaviour change** including PA, diet, smoking, substance misuse, mental health and social isolation– Universal, Specialist and Targeted
- Marketing – ***Call to Action***
- Enabling / Empowerment – ***Working alongside the community***
- **Indoor** and **Outdoor** Activities
- Incentive/Rewards – ***Motivating behaviour change***
- Training and Upskilling – ***'Making Every Contact Count'***
- **Digital Offer** (Early Years)
- **Mental Health** (Connect 5)
- **Volunteering**
- **Engagement**

Bury COUNCIL

Delivery

- Designated overall Programme lead
- For each neighbourhood there will be a designated Public Health lead supported by a designated Live Well member of staff
- Localised budget for each neigbourhood
- Localised health improvement plan which compliment wider neighbourhood work that is currently happening
- Working collaboratively with the community and existing infrastructures

Bury COUNCIL

Classification Open / Closed	Item No.

Meeting:	Bury Health and Wellbeing Board
Meeting date:	14th April 2021
Title of report:	Wider Determinants of Health: Work, Employment and Skills
Report by:	Cllr. Andrea Simpson, Cabinet Member for Health and Wellbeing
Decision Type:	**For Information**
Ward(s) to which report relates	**All Wards**

1.0 Executive Summary:

1.1 A healthy population is one of any nation's greatest assets. A healthy population reduces the demand for costly interventions. These public interventions are wider than health related activity in a medical setting. An unhealthy population can be a drag on the economy with the associated costs of the benefits system, loss of productivity, and the impact on families and communities.

Health and Economic Development professionals recognise that there is a co-dependent relationship between health and work: good quality work is good for health, and economic growth relies on a healthy, productive workforce.

1.2 Residents with a long-term health condition are less likely to be employed in GM than elsewhere in the country. Therefore, the Greater Manchester Work and Skills Strategy identifies integration of health commissioning with work and skills support as an objective, and the GM Population Health Plan has made employment a key priority within the 'Living Well' theme.

1.3 The evidence base for work as a health outcome is very strong. There is clear evidence that unemployment is generally harmful to health, and leads to:

- Higher mortality;
- Poorer general health, long-standing illness, limiting longstanding illness;

- Poorer mental health, psychological distress, minor psychological/ psychiatric morbidity;
- Increased alcohol and tobacco consumption, decreased physical activity;
- Higher rates of medical consultation, medication consumption and hospital admission; and
- Increased risk of fatal or non-fatal cardiovascular disease and events, and all-cause mortality, by between 1.5 and 2.5 times.

2.0 Recommendation(s)

2.1 That the Bury Health and Wellbeing Board continue to support the integration of Health with regeneration, employment, work and skills activity.

3.0 Key considerations:

3.1 Introduction/ Background: Work and Skills – high level ambition

3.1.1 The GMCA, with the support of the 10 GM districts, continue to create an integrated employment and skills eco-system which has the individual and employer at its heart. This responds better to the needs of residents and businesses and contributes to the growth and productivity of the Greater Manchester economy.

The ambition is to realise a health, employment and skills system across GM where:

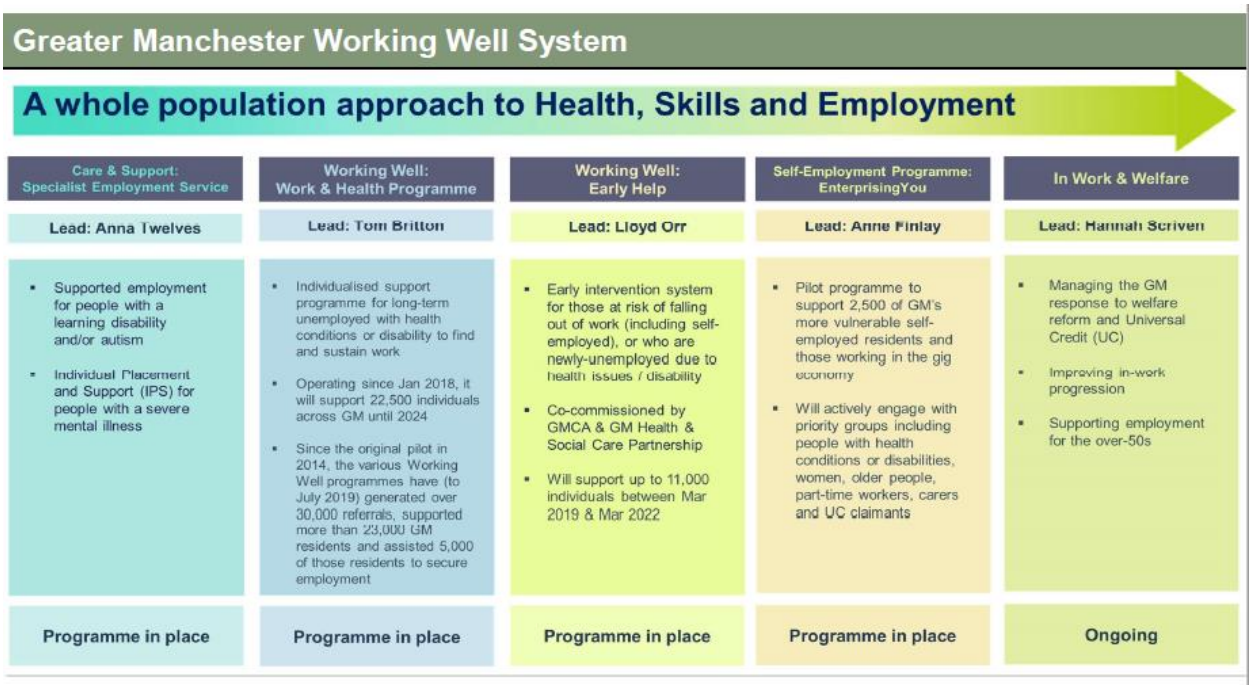
- Young people leave the education system with the knowledge, skills, and attributes they need to succeed;
- Working-age adults, who are out of work or who have low levels of skills, will have access to the support they need to enter and sustain employment; and
- All adults have the chance to up-skill and progress in their careers.

3.2 Established activity across GM

To support these priorities the following activity has been commissioned across the City region including Bury.

3.2.1 Working Well

Working Well is a family of services that embody Greater Manchester's devolved employment and health offer. They have been commissioned to support people experiencing or at risk of long-term unemployment.



3.2.2 Adult Education Budget (AEB)

The AEB was devolved to the Greater Manchester Combined Authority (GMCA) in August 2019. Devolved control over adult skills enables Greater Manchester to introduce new flexibilities to make it easier for people to access the skills training they need, including access to certain courses free of charge for adults earning less than the national living wage.

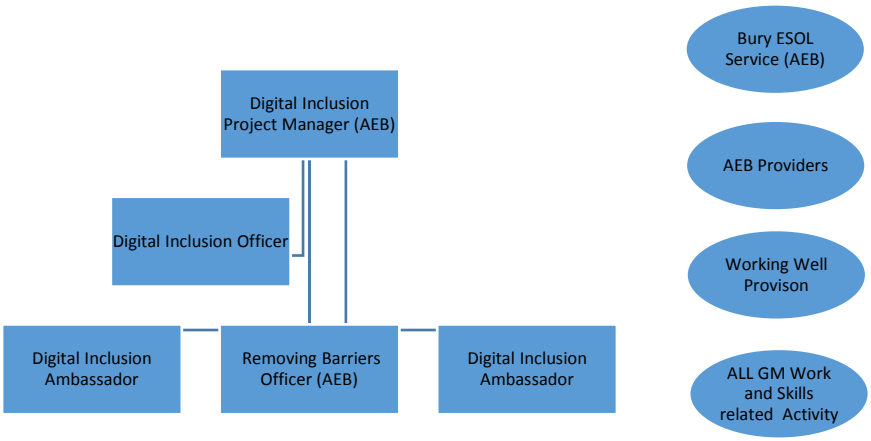
This enables all 10 districts to influence what skills are delivered, scrutinize outcomes and mold the provider market to deliver skills training that is relevant to employment and progression opportunities for residents.

AEB is worth approximately £92 million a year, so it is imperative that GM can demonstrate devolved budgets will work for the whole city regions.

Bury Council have received 250k to support the following:

- Reduce digital exclusion through bespoke projects;
- Purchase of kit to support communities and groups that do not have access to digital kit; and
- Provide integrated ESOL provision (English as a second language).

To do this an operational Digital Inclusion team will be established:



3.2.3 Apprenticeships

Greater Manchester Combined Authority's work to improve the quality and grow the number of apprenticeships focuses on these 7 key areas, including:

- **Removing Barriers** - Key to providing high-quality apprenticeship opportunities for all is to remove barriers to apprenticeships;
- **Supporting SMEs –** Established Greater Manchester small-to-medium enterprise apprenticeship package, which includes grants for non-levy paying employers, support with workforce planning and a levy matchmaking service;
- **Maximizing the levy impact** – Working with levy-paying employers to better support apprenticeship programmes, maximize levy investment back into businesses and the wider Greater Manchester community, and ensure there are opportunities to develop future talent;
- **Public sector apprenticeship approach –** Established Public Sector Working group with membership across local authorities, NHS, police, fire and transport services to ensure apprenticeships are at the heart of the public sector; and
- **Improving quality –** Providers and employers working together will create the highest quality apprenticeship programs tailored to directly meet business needs. Understanding labour market information and translating this into an apprenticeship context, brokering conversations between the two.

3.3 Bury Council

Bury Council contributes to all regional and national health, employment and skills activity. This is achieved through the Council's Economic Development Team who facilitate the Bury Health, Employment and Skills Task Group. The group comprises of multiple partners from within the Council and external to the Council. The group is chaired by Bury's Jobcentre Plus Partnership Manager.

The Economic Development Team are the Council's lead for:

- Integration of health as a key consideration in all workstreams
- Employment and Skills (ages 18+)
- Business Engagement
- Inward Investment
- Digital Inclusion
- Roll out of Digital Infrastructure
- Local Industrial Strategy/Economic Development Strategy

The team works across directorates supporting colleagues where there are complimentary cross cutting work streams, including:

- Healthy Workplaces (working with the Health and Wellbeing Team).
- Supporting the Council's Regulatory and Environmental Team (Trading Standards and Clean Air Team).
- Collaborating with several teams to maximise opportunities linked to the digital inclusion agenda and to promote best practice across Bury Council.
- Collaborative work with Bury Adult Education and other AEB providers.
- Collaborating with numerous departments, acting on their behalf in the dissemination of key information to and engagement with local businesses.

3.4 New Programmes and Activity supporting COVID Recovery

3.4.1 Skills and Employment Support:

- A new £2.9bn programme is being launched called 'Restart', supporting a million unemployed people over the next three years.
- £375m will be released from the National Skills Fund to support technical skills development and build on measures announced in the Plan for Jobs.
- Work and Health Programme - Job Entry: Targeted Support (JETS) has been designed to help people secure employment within six months. Participants will gain help with CV writing, interview skills and job searches.
- Young People and Labour Market Recovery work stream.

Bury Works – An online portal to support young people to navigate the regional a local employment and skills eco-system (ages 16 to 30). The Bury Works brand, which has been trademarked, is below:

4.0 Key Issues for the Board to consider:

4.1 The Economic Development Team have focused on delivering grants to Bury businesses impacted by Covid since the start of the pandemic. This is of key importance to stabilise the local economy, protect jobs and plan for recovery.

This has meant that a light touch approach to Health, Employment and Skills has been undertaken over the period. However, the Board will note that as recovery activity becomes crucial the team will return to their substantive workstreams to put health, employment and skills firmly back on the agenda.

4.2 The Board is asked to consider a strengthening of collaborative working, across directorates, across districts and government bodies to maximise capacity within the Council and deliver on our emerging Local Industrial Strategy, overarching Bury LETS Strategy 2030 and the Population Health Strategy.

4.3 The Board is asked to recognise and support the linkages between employment and skills with:

- Inward investment
- Business engagement
- Labour market intelligence
- Physical place regeneration

Community impact/links with Community Strategy

Fully links with Lets 2030

Equality Impact and considerations:

Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to -

(a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*

(b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*

(c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Equality Analysis	*Please provide a written explanation of the outcome(s) of either conducting an initial or full EA.*

**Please note: Approval of a cabinet report is paused when the 'Equality/Diversity implications' section is left blank and approval will only be considered when this section is completed.*

Legal Implications:

To be completed by the Council's Monitoring Officer

Financial Implications:

To be completed by the Council's Section 151 Officer

Report Author and Contact Details:

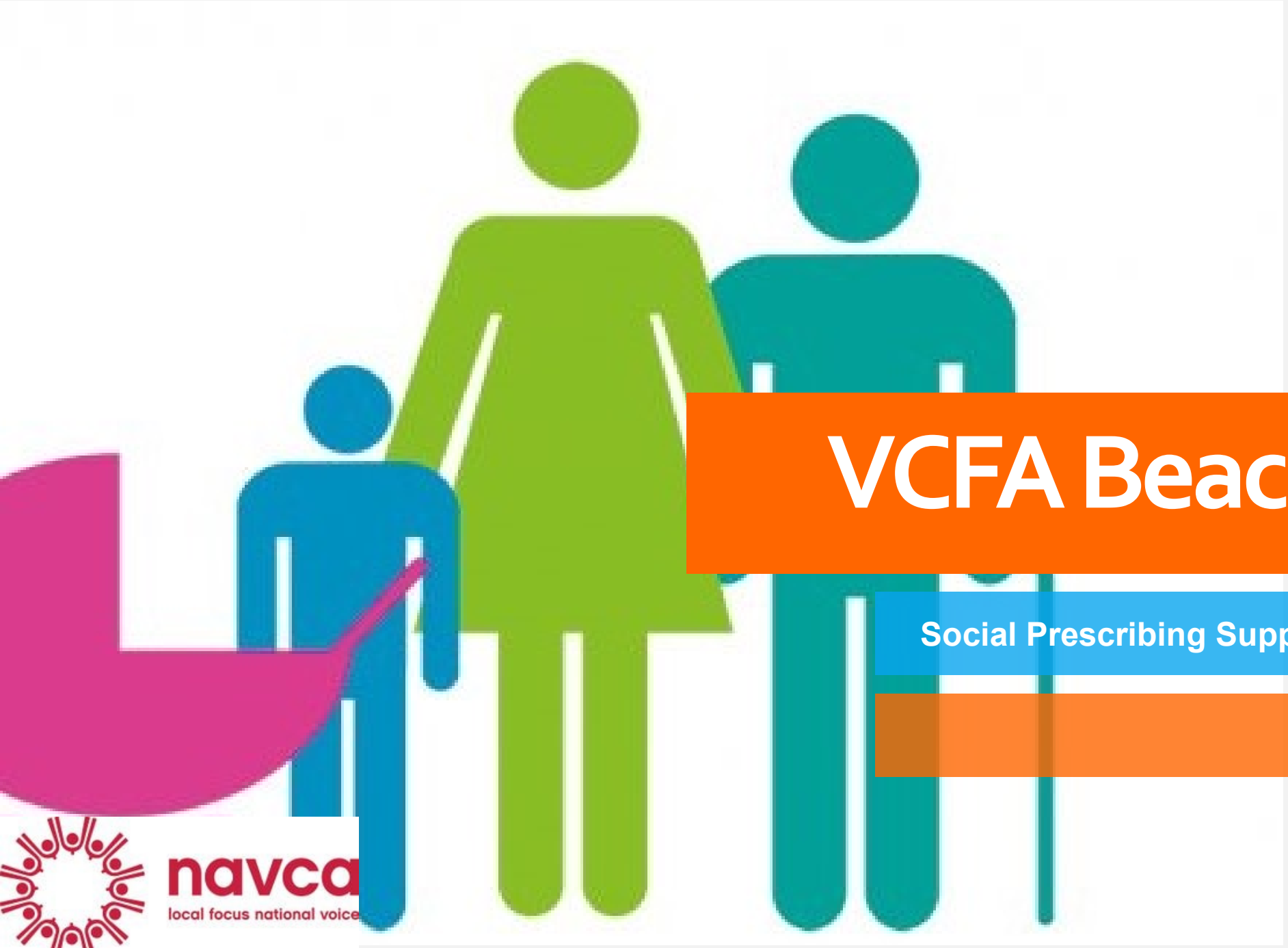
Tracey Flynn t.flynn@bury.gov.uk

Background papers:

Working Well Annual Report 2020

Please include a glossary of terms, abbreviations and acronyms used in this report.

Term	Meaning
AEB	Adult Education Budget
ESOL	English to Speakers of Other Languages
GM	Greater Manchester
GMCA	Greater Manchester Combined Authority
SME	Small and Medium Enterprises



VCFA Beacon Service

Social Prescribing Support for Health & Social Care

www.buryvcfa.org.uk

What is Social Prescribing

VCFA Beacon social prescribing service helps patients access support and help in the local Voluntary Community and Faith Sector (VCSE) that can help them improve their health and wellbeing. It is independent and not part of the NHS, however we work in partnership with our NHS especially the GP surgeries and Primary Care Networks.

The term 'social prescribing' is used to describe a service which supports people to access a range of non-medical services and activities in their local area.

Introduction

Beacon Service

Social Prescribing support for Health & Social Care

BEACON SERVICE

Social Prescribing in Bury

Offers patients something more than a medical intervention

Reduces pressure on stretched services – GP's and hospital services

Patients benefit from 'taking control' and finding ways to keep well

Lots of social activity and support in the community

Opportunity to improve health and wellbeing, reduce loneliness, chronic health conditions

BEACON SERVICE

Social Prescribing in Bury

Contractual requirement to help

- Low Self-esteem/Confidence
- Physical Inactivity
- Social isolation and loneliness
- Mental Health & Wellbeing
- Life events e.g. bereavement,
- Long term health conditions
- Anxiety due to issues such as housing Finance, work or relationships

Beacon does not provide any direct service we signpost to support via the VCSE sector

Eligibility

Beacon supports people who are:

- Aged 18+
- Registered with a Bury GP
- Is a Bury Resident
- Willing to engage with the programme and be supported

The service is voluntary and if a patient is not ready to be supported we may not be able to accept the referral

BEACON SERVICE

Beacon Service
How we help

Resources

- Over 500 VCSE groups on our database
- 100's of Volunteering Opportunities
- 1000's of community based activities
  - Social Clubs e.g. Lunch
  - Leisure activities – e.g. walking, gardening
  - Arts, culture and creative activities
  - Befriending and support groups.
  - Welfare benefits and financial support
  - Emotional wellbeing

Beacon does not provide any direct service we signpost to support via the VCSE sector

Our Service gives

- Clear navigation and simple access
- Wide range of support services in the VCSE.
- greater control of their own health
- Improve in mental health and wellbeing
- Involvement in the community
- Learn new skill or participate in a new activity
- Increase self- confidence and self esteem
- Better quality of life

BEACON SERVICE

Beacon Service Outcomes

Outcomes

- 877 patients supported in the last 12 months
- 66.7% of referrals are aged 45 and over
- 78% of referrals have accessed the service due to feeling socially isolated.
- 62% of referrals have accessed the service for mental support

Impact

- 60% referrals increased their satisfaction
- 40% increase in feeling worthwhile
- 80% increased happiness levels
- 80% decrease in anxiety levels

BEACON SERVICE

Beacon Service Outcomes

Outcomes

- 18 – 24 = 54
- 25 – 34 = 70
- 35 – 44 = 82
- 45 – 54 = 111
- 55 – 64 = 110
- 65 – 74 = 69
- 75 – 84 = 71
- Over 85 = 52
- Not Known - 258

Ethnicity

- Not currently recorded but this has now been amended and will collected from 1st April

Conditions

- These are captured in the individual patients notes. A summary will be provided in due course

BURY VOLUNTARY, COMMUNITY & FAITH ALLIANCE

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BEACON SERVICE