Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 29 October 2015

Subject: Reform of Public Health

Report of: Director of Public Health

Summary

This report provides and overview of the reform of public health in Manchester since the transfer of public health responsibilities to the City Council on 1 April 2013. The plans to redesign a wide range of public health services following the Council's budget options consultation process are described, along with the ongoing financial challenges relating to changes to the national public health grant.

Recommendations

The Committee is asked to:
i) Note the report
ii) Comment on the proposals to redesign public health services
iii) Comment on the proposed changes to the public health grant, including the in-year cut (section 3.2 and 3.3) and formula for distributing the grant (section 6.1)

Wards Affected: All

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Background documents (available for public inspection):

Public Health Transition – report to Manchester Health Scrutiny Committee, 9 January 2014
Children and Families Budget Options Consultation- reports to Manchester Health Scrutiny Committee, 12 February 2015
Public Health Staff Redesign-report to Manchester City Council Personnel Committee, 24 March 2015

1. Introduction

1.1 Following the transfer of public health responsibilities and resources from the Manchester Primary Care Trust to Manchester City Council (MCC) on 1 April 2013, the Director of Public Health has led a programme of reform that relates to two distinct phases:

Phase One Transfer of responsibilities and contract stabilisation (2013-14)
Phase Two Council Budget Options: Plans for savings and reinvestment (2014-16)
-Redesign of commissioned public health services
-Restructure of public health staff team at MCC

1.2 The Committee received an update on the successful transfer of responsibilities in January 2014 (phase one).

1.3 The savings and investment proposals for public health and proposals for service redesigns were presented to the Committee and Council Executive in February 2015 and agreed at Full Council on 6 March 2015. The restructure of the MCC public health staff team was agreed by the Council's Personnel Committee on 24 March 2015 (phase 2). This report will provide an update on the progress made in relation to the service redesigns and the priorities for the restructured public health team set out in the following sections:

2. Strategic Context

3. Budgetary Context (potential impact of the in year cut to the 2015/16 public health grant)

4. Redesign of Public Health Services
4.1 Health and Mental Wellbeing Services
4.1.1 The Wellbeing Service
4.1.2 Physical Activity Services
4.1.3 Community Falls Services
4.1.4 NHS Healthchecks
4.1.5 Community Weight Management Services
4.1.6 Oral Health Improvement Service
4.2 Drug and Alcohol Services
4.3 Sexual Health Services
4.4 Children's Public Health Services

5. Priorities for the Manchester Public Health Team
5.1 Introduction
5.2 Starting Well and Developing Well
5.3 Living Well and Working Well
5.4 Age Friendly Manchester
5.5 Health Protection
5.6 Knowledge and Intelligence Team

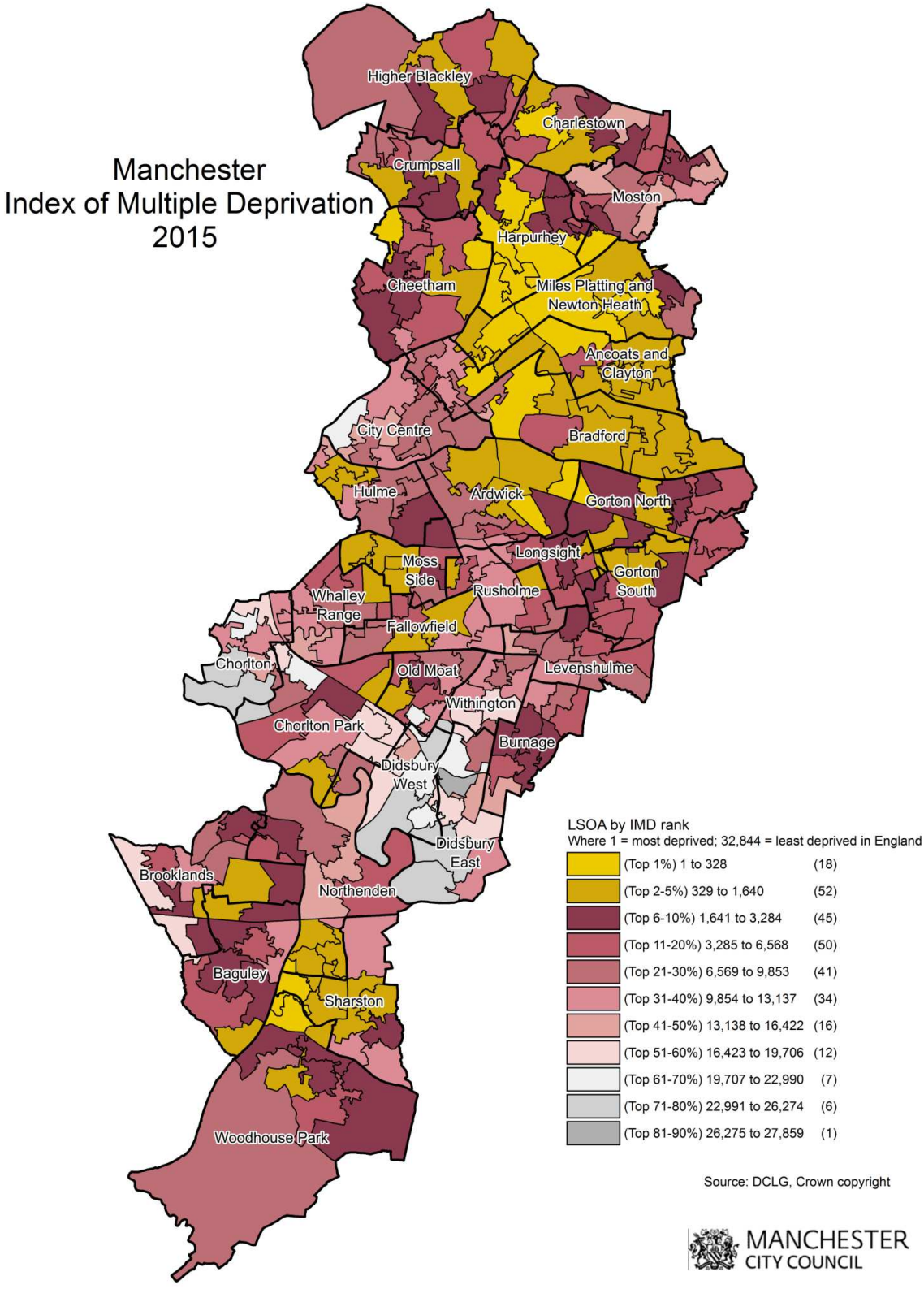
6. Finally section six looks ahead to Phase Three of the reform programme from 2016 onwards, taking account of the very challenging financial landscape.

This section provides a summary of the proposed changes to the formula for the public health grant, currently out for consultation. It also summarises the potential benefits of the Devolution Agreement and the plans to establish a more unified Greater Manchester public health system.

2. Strategic Context

2.1 Despite the economic and physical transformation of the city over the past 25 years and some tangible improvements in health outcomes, when it comes to the health inequalities Manchester still lags well behind the rest of the country.

2.2 The recent publication of the Index of Multiple Deprivation 2015 highlights the challenges faced by Manchester. The relative overall rank of the City on the Index improved slightly from 4th in 2010 to 5th in 2015. However, of the seven domains that make up the Index, it was the “Health and Disability“ domain that prevented Manchester from securing a lower ranking. There is a strong correlation between levels of deprivation and poor health outcomes (see Appendix 1: Key Health Statistics for Manchester) and on the map below it is very evident where local health inequalities persist.



2.3 The opportunity to do something about these stark health inequalities and take a different approach is at the heart of the reform programme, following the transfer of public health back to Local Government after a 40 year gap. The financial context will not make this task any easier. However, by having a greater focus on the wider determinants of health (i.e. education, jobs, housing and income) coupled with more cost effective public health services, the commitment to get the best possible health outcomes for the people of Manchester remains as strong as ever.

2.4 The vision set out in the Manchester Joint Health and Wellbeing Strategy provides the overarching framework for all public health activities in Manchester:

"Our vision is that in ten years the people of Manchester will be living longer, healthier and more fulfilled lives. We will have moved Manchester from some of the worst health outcomes in the country to some of the best, adding 'years to life and life to years'. And we will have achieved a genuine shift in the focus of services towards prevention of problems, intervening early to prevent existing problems getting worse – transforming the city's community based care system by integrating health and social care. "

2.5 This 10 year vision will be underpinned by the five year Manchester Locality Plan currently being developed and presented to the Committee on 2 October 2015. Public Health is one of the key transformation programmes and the final version of the plan in December will describe more fully the milestones, outcomes and positive impacts that the delivery of the plan will achieve by 2020.

3. Budgetary Context

3.1 Following an extensive public consultation, the proposals for savings and reinvestment of the public health grant were agreed by the Council Executive on 13 February 2013. The table below provides a summary of how the grant will be spent following the implementation of the savings programme.

Table 1: Breakdown of Public Health Grant

Public Health Grant 2015/16	£000
Health and Mental Wellbeing Services	4,682
Drugs and Alcohol Services	9,317
Sexual Health Services	7,621
Children's Public Health Services (*)	8,959
Early Years	2,671
Living Longer, Living Better	8,110
Complex Dependency	3,490
Other MCC prevention programmes	4,846
Workforce, infrastructure and overheads	3,228
Other public health Activity	820
TOTAL	53,744

(*)Includes £5.4 million 0-5s funding transferred on 1 October 2015.

3.2 In August 2015 the Department of Health (DH) consulted with local authorities on proposals to cut £200 million nationally from the public health grant in 2015-16. The DH preferred option of a blanket 6.2% reduction for each Local Authority (LA) would mean a cut of £3,332,000 for Manchester from the grant of £53.7 million. Manchester and Greater Manchester LAs submitted proposals for an alternative approach that would reduce the cut to £1.9 million for Manchester.

3.3 At the time of writing no decision has been made by DH, despite assurances that LAs would be informed by mid-October at the latest. The Director of Public Health was informed by DH on Tuesday 20 October that an announcement was expected "very shortly". It is therefore hoped that the Director will be able to give the Committee a verbal update at the meeting. The cut, whatever the final amount is, will be deducted from the January 2016 grant instalment from Public Health England to Manchester City Council. Furthermore as the indications have been that the cut could be recurrent, contingency plans have been developed which will impact on the service redesigns described below. As the cut will have to be "passed on" a number of service redesigns have been put on hold and others may have their funding envelope reduced significantly. There is still a requirement to balance the books despite the late notice of the grant withdrawal. The uncertainty this has created for providers is acknowledged, but there is little else that can be done until formal notice is received.

3.4 In the redesigns summarised below, the overview and background provides the public health context followed by the commissioning intentions and in some cases procurement process for each area.

4. Redesign of Public Health Services

4.1 Health and Mental Wellbeing Services

4.1.1 Wellbeing Service: Overview and background

1) The health of people in Manchester is generally worse than the England average at all stages of life and a key aim of Manchester's Locality Plan is to 'add years to life and life to years'. Life expectancy at birth for both men and women is currently among the worst in England. The latest figures show that Manchester has the second lowest (i.e. worst) life expectancy at birth for men and the lowest life expectancy at birth for women. There are also significant inequalities within the city such that life expectancy for men living in the most deprived areas of Manchester is 8.8 years lower than for men living in the least deprived areas. The equivalent inequalities gap for women is 7.4 years.

2) Healthy Life Expectancy (HLE) in Manchester is also significantly lower than the England average for both men and women. A boy born in Manchester can only expect to live 77% of his remaining years of life in good health compared with 87% of remaining years of life for a boy born in the healthiest part of England – a gap of 10 percentage points. Similarly, a girl born in Manchester can only expect to live 71% of her remaining years of life in good health

compared with 84% of remaining years of life for a girl born in the healthiest area of the country. Although men in Manchester live shorter lives on average than women, they spend a higher proportion of their lives in "Good" health.

3) Around two-thirds of the life expectancy gap between Manchester and England as a whole is due to three broad causes of death: circulatory diseases, cancers and respiratory diseases. These, in turn, can be linked in part to poor lifestyle. Data from the latest Health Profile for Manchester shows that adults in the city have higher rates of obesity, alcohol misuse and smoking-related conditions. The rate of alcohol-specific hospital stays among adults is significantly worse than the average for England and estimated levels of adult smoking are also worse than the England average. There are around 750 smoking related deaths in Manchester per year.

4) Poor mental health and wellbeing has a significant impact on individuals, families and communities in the city. The North West Mental Wellbeing Survey for 2012/13 shows that low mental wellbeing among people living in Manchester is associated with employment status, poor general health and a higher prevalence of diagnosed medical conditions. Data from the latest national GP Survey shows that around 19% of patients in North Manchester, 15% in Central and 15% in South report moderate or extreme anxiety or depression compared to 12% nationally and it is estimated that between 1 in 8 and 1 in 10 Manchester adults are prescribed antidepressant medication. Although suicide rates in Manchester remain higher than the national average, the rate in both men and women has been steadily reducing over the last decade.

Commissioning of a Wellbeing Service

5) The former Public Health Development Service, provided by the Manchester Mental Health and Social Care Trust (MMHSCT), has considerable expertise in health improvement and prevention and is well placed to add value to health and wellbeing improvement in the city. Following the Council approved reductions in public health funding to wellbeing services it was agreed to work with MMHSCT to remodel a Wellbeing Service rather than going to procurement. Over the last six months the Trust has been working on transformational changes to the existing services.

6) The MCC Public Health team is working closely with colleagues from the Trust to agree the detailed service model, specification and outcomes to enable the new service to be in place by March 2016. Detailed design and specification work will take place between November 2015 and February 2016. The new model will align with the priorities of the Joint Health and Wellbeing Strategy and the Locality Plan. In particular there will be a stronger focus on neighbourhood working in line with the One Team approach set out in Living Longer, Living Better (LLLB). This relates to the 12 geographical areas for integrated working with frontline health and social care staff, based on practice populations of approx 50,000 people.

7) The new service will be based on a community asset building model and have three interlinked functions.

i) It will build capacity within communities via a network of neighbourhood health workers who will support the development of local capacity and infrastructure, linking with community groups. It will incorporate the best practice approaches from Age-Friendly Manchester, and will be a core component of the Social Movement work now underway. It will incorporate the current South Manchester Healthy Living Network. The MCC Zest Healthy Living Service which operates in North Manchester will align to the model to ensure equity of provision across the city and the current gap in provision in central Manchester will be addressed.

ii) There will be an element of one-to-one support for those who are unable to access community provision without additional support. This will comprise a holistic assessment of need, and support individuals to access services across all the domains of wellbeing: lifestyle, looking after yourself; managing symptoms; work, volunteering and other activities; money; where you live, family and friends; feeling positive. Detailed design is underway to determine how the one to one service will link to the LLLB One Team in the 12 neighbourhoods and the three Early Help Hubs launched in the last month. The hubs have a strong partnership model and bring other agencies such as the police, probation, schools and the voluntary sector as well as health and social care.

iii) The Wellbeing Service will retain a training and knowledge function to build capacity in the frontline workforce, offering training on key topic areas such as mental health, and self-care, and continuing delivery of emotional resilience courses for the public.

8) The following principles for the Wellbeing Service have been agreed:

- supports people of working age towards employment and addresses barriers to work; working jointly with other agencies who are also addressing this priority for the City
- is a core component of preventing mental ill health and promoting emotional resilience
- is an integral part of Living Longer Living Better (LLLB) and a core component of pathways for long term conditions, supporting prevention, rehabilitation/recovery and self care
- will promote independence and resilience at individual and community level
- takes a whole families approach working with individuals in the context of their wider circumstances
- improves access to other services that support health and wellbeing for more socially disadvantaged groups
- develops a workforce that can support behaviour change and enable people to self care and in doing so become more independent
- develops and supports community networks to build resilience and reduce isolation
- supports carers to improve their wellbeing
- provides prevention services as part of MCC's statutory obligation under the Care Act 2014

- the different elements of the Service (one to one support, training, partnership working and community asset building) work together to support outcomes for residents

9) The outcomes that the service will be expected to deliver include:
- Increase in social connection/reduction in isolation
- Improvement in other social determinants of health e.g. housing, debt, money.
- Improvements in activation and self-care: managing health condition/symptoms, lifestyle, mental wellbeing
- Engagement in learning, skills, volunteering or paid employment
- Increase in confidence levels in relation to obtaining employment
- Increase in employment levels

10) The work on redesign of this service will continue and negotiations with MMHSCT will commence when formal notice of the in year cut is received.

4.1.2 Physical Activity: Overview and background

1) It is estimated that over 40% of the adult population in Manchester is classed as physically inactive. Physical inactivity is becoming a public health problem comparable to smoking, responsible for 17% of premature deaths in the UK, 10.5% of heart disease cases, 13% of Type 2 diabetes cases and around 18% of cases of colon and breast cancer.

2) Enabling more people to be physically active throughout life is an area critical to delivering local wellbeing priorities including the reduction and management of long term health conditions. A strong focus on prevention, early intervention and behavioural change is necessary to stem the growing financial and societal costs associated with the increase in lifestyle-related chronic conditions. It is critical that we adopt a preventative strategy in order to ensure that the NHS remains free at the point of use for future generations.

3) The evidence for the effectiveness of physical activity in tackling some of the nation's most pressing health concerns is well established. Physical Activity can be instrumental in the prevention and management of a wide range of increasingly prevalent conditions including diabetes, cancer, coronary heart disease, obesity, stroke, musculoskeletal conditions and mental health.

4) The Chief Medical Officers (CMO) in all four home countries have made it clear that physical activity can reduce the prevalence of such conditions by up to 50%, yet we know that over two-thirds of the population are not currently meeting the recommended levels of physical activity. The Lancet refers to an “inactivity pandemic” with physical inactivity being the fourth leading cause of death worldwide. Evidence shows that the most significant health and clinical benefits are gained by an inactive person currently doing no physical activity starting to do even a little.

Commissioning of Physical Activity Services

5) The Public Health team currently commissions two key areas of bespoke Physical Activity (PA) provision – The Active Lifestyles Service (ALS) based within Manchester City Council (Growth and Neighbourhood)) and the Physical Activity on Referral Service (PARS), based within Manchester Mental Health and Social Care Trust (MMHSCT). ALS provides a population and preventative approach to tackle inactivity and PARS provides a chronic disease rehabilitation and management service.

6) The original intention was to redesign the service as a new single city wide community based service, in order to reduce duplication of both management and back office functions and front line service delivery. This was set out in the budget options paper with the agreed budget savings required The service would target the most inactive and the least active people in the city, especially those identified as the least likely to engage, most at risk of ill health owing to a sedentary lifestyle, and those experiencing chronic disease and ill health for whom physical activity is part of their clinical rehabilitation process.

7) Given the challenging and uncertain budget context, discussions are now taking place with both providers and the planned procurement process has been put on hold.

4.1.3 Community Falls Services: Overview and background

1) The World Health Organisation (WHO) states that approximately 28-35% of people 65 and over, fall each year. This figure increases to 32-42% for those aged over 70 years of age. Approximately 30-50% of people living in residential care fall each year and 40% of that group experience recurrent falls. Furthermore, the WHO states that more than 50% of injury related hospital admissions amongst people aged 65 and over are caused by falls. The major underlying causes for fall related hospital admissions are hip fracture, traumatic brain injuries and upper limb injuries.

2) The prevention of falls amongst our older population is a major issue for Manchester. The city compares poorly against national averages in terms of falls, injurious falls, mortality (deaths) related to falls, and subsequent costs to the Manchester health and social care economy.

3) In the three year period 2008-10, there were 192 deaths from unintentional (accidental) falls to Manchester residents – an age standardised rate 11.0 per 100,000 population. This compares with the England average of 3.8 per 100,000. Compared with England as a whole, Manchester has a significantly worse rate of hospital admissions (and emergency hospital admissions) due to an unintentional fall in older people aged 65 and over. In 2010/11, there were 2,313 hospital admissions resulting from an accidental fall among older people aged 65 and over in Manchester - a rate of 3,457 per 100,000 population compared with the England average of 2,475.

4) While there is very little routinely available data with respect to inequalities in falls related injuries and deaths within Manchester, it is very likely that the impact of falls is felt more by some groups of older people than others. There is some evidence that people in more deprived wards of the city are more affected by some of the factors that can contribute to falls, such as housing and its state of repair and other social and environmental issues.

Commissioning of Falls Services

5) In April 2013, Manchester City Council became the commissioner for Community Falls Prevention Services. These are as follows:

- Community Falls Service delivered in north Manchester, provided by Pennine Acute Trust (PAT). PAT was funded historically to provide services in north and south Manchester.
- Community Falls Service delivered in central Manchester, provided by Central Manchester University Hospitals Foundation Trust (CMFT).
- Get Active Through Exercise service provided by Manchester Mental Health and Social Care Trust.

6) The PAT and CMFT services are patient level services provided in the home to people who have already had a fall or who are at serious risk of a fall. Initial reviews showed that services were not provided equitably across the city and although the trusts above and University Hospitals South Manchester (UHSM) had highly specialised, multi-disciplinary teams of staff, their referral criteria and the framework within which they operated varied considerably. It is important to note that South Manchester CCG provide some funding for provision in this part of the City.

7) The Public Health team are now working on a collaborative commissioning approach with the Clinical Commissioning Groups under the One Team framework, given the strong patient and secondary prevention focus of the services. Agreement has been reached that a “city wide” falls service with equitable provision for all residents will be commissioned. The work to develop the specification continues, however, once again this will be affected by the scale of the potential in year public health grant cut.

8) The Public Health team will continue to focus on the primary prevention of falls, which includes evidence based physical activity and healthy ageing programmes.

4.1.4 NHS Health Checks: Overview and background

1) Cardiovascular disease (CVD) includes all the diseases of the heart and circulation namely coronary heart disease (angina and heart attack), heart failure, congenital heart disease and stroke. CVD shortens life expectancy and is the major cause of poor health and long term chronic conditions. The potential benefits of a preventative programme, offering clinical treatment, lifestyle advice and support are huge.

2) The NHS Health Checks programme is a systematic risk assessment and risk management programme for everyone between the ages of 40 and 74 who are eligible. It identifies an individual's level of risk of developing CVD and provides tailored advice on how that person can reduce that risk, through lifestyle changes and /or medication, and support them to achieve change. People are recalled for a NHS Health Check every five years so long as they remain eligible. Following the Health and Social Care Act and the disestablishment of the Primary Care Trusts, Local Authorities became responsible for the delivery of the NHS Health Check programme, one of six specific mandated responsibilities.

Commissioning NHS Healthchecks

3) The "Manchester Model" of delivery of the NHS Health Check has been recognised locally and nationally as innovative and is used as an exemplar for other areas. It is a mixed delivery model offered to Manchester residents through:

- GP practices via an enhanced service contract, to which approximately one third of Manchester practices are signed up.
- Community provision targeting communities where CVD outcomes are worst and GP coverage is poor.

4) There are a number of challenges to the delivery of the local programme. In spite of a favourable contract value, the engagement of GP practices across Manchester is patchy. In addition, depending on the provider, the quality of individual NHS Health Checks is variable and requires close monitoring and quality assurance. Only about 40% of those invited for a NHS Health Check attend. The community-based approach is now successfully improving uptake in areas where health outcomes are poorest and the aim is to achieve an uptake rate of at least 66% through:

- Raising awareness in local communities
- Improving the quantity and consistency of NHS Health Checks provided in GP practices
- Maximising the potential to reach into communities with the greatest needs

5) The Manchester Public Health team is leading work on a consistent Greater Manchester approach to prevent some of the boundary and eligibility barriers that have impacted on the delivery of the scheme. The budget for this service has reduced significantly and as this is a mandated responsibility, opportunities for further savings are limited.

4.1.5 Community Weight Management Service: Overview and background

1) In Britain more adults are overweight than obese. Current figures show that 41 per cent of men and 33 per cent of women are overweight and around a quarter of adults are obese.

2) By this year (2015) reports estimate that obesity figures will rise to 36% of males and 28% of females; by 2025 it is estimated that these figures will rise to 47% of men and 36% of women and by 2050 60% men and 50% of women will be obese.

3) In Manchester it is estimated that 94,700 adults are now obese. The increase in the prevalence of adult obesity in Manchester by 2015 is lower than previously predicted (137,000). The predictions were modelled using the Health Survey for England data from 1994 to 2004. This suggests that adult obesity in Manchester has risen at a slower rate in the past 10 years.

4) In Manchester a further 164,000 adults are overweight, this is similar to the prevalence rate predicted (168,000) for 2015. This data suggests that a proportion of adults who were a healthy weight have become overweight in the past 10 years and a larger than expected amount of adults who were overweight have remained overweight.

Prevalence of obesity – children

5) The prevalence of obesity in children has increased since 1995, when 11% of boys and 12% of girls aged 2-15 were obese. The National Child Measurement Programme (NCMP) is one of the six mandated responsibilities and requires the weighing and measuring children at school in Reception Year and Year 6. The Public Health team currently have eight years of NCMP data. The year-on-year obesity levels in Manchester have varied but with the high levels of children measured the Team are confident that there is an accurate picture of obesity in primary school aged children.

6) In Manchester in 2013/14 the percentage of obese children in Reception (4-5 year olds) and Year 6 (10-11 year olds) was higher than the national average. In Reception 11.7% of children were classified as obese compared to 9.5% nationally, with levels more than doubling by year 6 to 25.0% in Manchester, compared to 19.1% nationally.

Commissioning of a Community Weight Management Service

7) The Public Health team is currently progressing with the tender for a provider to 'design and deliver a citywide, evidence based community weight management service in the community. The service will be targeted at children and young people between 2 and 18 years of age eligible for such a service in accordance with National Institute for Clinical and Health Excellence (NICE) guidelines

8) The community based lifestyle weight management programme will focus on the following:

- Diet and healthy eating habits
- Physical activity
- Reducing the amount of time spent being sedentary

- Strategies for changing the behaviour of the child or young person and all close family members

9) Group programmes will be provided for children and young people (2-18 years) and their families, with 1-1 programmes offered to individual families only where this better meets their needs (e.g. children with learning disabilities).

10) The provider will provide the NCMP feedback each year for Manchester, to parents/carers of children and young people in Reception and Year 6, who are overweight and obese. The provider will pro-actively follow up these parents/carers to engage the family into a supportive assessment and a weight management programme, provided by the service.

11) The programme will meet the needs of local children, and will be tailored to support the needs of children and young people that are of different ages, different stages of development and from different cultural backgrounds. The provider, on a case by case basis, will provide a service for overweight and obese children and young people with special needs and disabilities and will target its provision at population groups more at risk of being obese (e.g. some ethnic minority groups, wards and localities with higher levels of obesity).

12) In the light of the potential in year cut to the public health grant, the procurement process will be reviewed to ensure that the resources available can be modified via contract mechanisms depending on the scale of the reduction**.**

4.1.6 Oral health: Overview and background

1) Oral health is poor in the Manchester population and one of the main dental diseases, tooth decay continues to affect children and young people's lives, yet it is largely preventable. Inequalities in oral health do exist as children from more deprived communities have poorer oral health compared to those living in more affluent communities. For example, 21.2% of five year olds had tooth decay in south-east England compared to 34.8% in north-west England with even greater inequalities within local authorities, in Manchester 39% of five year olds have experienced tooth decay. On a positive note there have been some absolute improvements when looking at the last two national surveys. Manchester has moved from the bottom of the GM rankings up to the 7th ranked local authority between 2008 and 2012, in relation to tooth decay amongst 5 year olds.

2) Poor oral health can have an impact on general health as it can affect children's ability to eat, speak and socialise. Other impacts include pain, infections, poor diet and impaired nutrition and growth.

3) Untreated tooth decay can lead to young children needing dental treatment under general anaesthesia (GA), which presents a small but real risk of life threatening complications for children. The financial impact of dental disease

is also significant; tooth extractions under a GA are not only potentially avoidable but also costly. The cost of extracting multiple teeth in children in hospitals in England in 2011-12 was £673 per child- a total cost of nearly £23 million. In Manchester tooth extractions under a GA is still one of the major reasons why children are admitted to hospital.

Commissioning an Oral Health Improvement Service

4) The current service, provided by MMHSCT, has focussed on improving oral health in children aligned with childhood obesity work and the Health and Wellbeing Strategy's Priority 1, "Getting children off to the best start in life.

5) The Public Health team's commissioning intention is to align the commissioning of this service with other children's services, such as health visiting and school nursing, to ensure a better integrated provision of oral health improvement alongside other health promoting services targeted at children and their families. In addition there is an intention to expand the Dental Milk in Schools scheme, focussing on targeting schools in the most deprived areas and in areas where there is the poorest oral health.

6) The budget for this service has been significantly reduced although opportunities for further efficiencies will be explored in light of the potential in year grant cut

4.2 Drugs and Alcohol: Overview and background

4.2.1 Reducing alcohol and drug-related harm to individuals, families and communities is one of the public health priorities for Manchester.

4.2.2 There are an estimated 4,709 opiate (heroin) and/or crack cocaine users aged 15-64 in Manchester, a rate of 12.97 per 1,000 population (1.3%). This is higher than the estimated rate for England, which is 8.40 per 1,000 population.

4.2.3 Local prevalence estimates for other types of drug use are not available. According to national surveys, 4.7% of adults aged 16-59 reported using an illegal drug in the last month. Cannabis is the most commonly used drug among this group, followed by powder cocaine and ecstasy. 0.9% of adults aged 16-59 reported using a new psychoactive substance ('legal high') in the last year.

4.2.4 Local prevalence estimates for alcohol misuse are not available. According to national surveys, 22.5% of adults aged 16+ drink at increasing risk levels, and 8.8% drink at higher risk levels. It is estimated that 5.7% of adults are dependent on alcohol – this would equate to 22,670 adults in Manchester.

4.2.5 Due to historical imbalances in the funding and commissioning arrangements for alcohol and drug misuse treatment nationally and locally, there is currently more treatment available for drug dependence than alcohol dependence – over 50% of those dependent on opiate and/or crack cocaine are able to access treatment locally (n=2,712 in 2013/14), compared to approximately

10% of dependent drinkers (n=2,085 in 2013/14). The steps currently being taken to increase the availability of alcohol treatment locally are detailed later in this report.

4.2.6 Rates of alcohol and drug misuse among young people are falling nationally. In 2013, 6% of young people reported taking an illegal drug in the last month, with cannabis being the most commonly used drug. 9% reported drinking alcohol in the last week, compared to 25% in 2003. Local prevalence estimates for young people's alcohol and drug use are not available.

4.2.7 Local and national data indicates that despite overall reductions in the proportion of young people reporting drinking or taking drugs, the number seeking treatment and support for alcohol or drug misuse has not reduced. In 2013-14, 273 young received specialist treatment for substance misuse (alcohol and/or drugs) in Manchester.

4.2.8 Alcohol and drug misuse and dependence impact on the health and wellbeing of Manchester residents, families and communities in a range of ways, including:

- Crime, disorder and antisocial behaviour including acquisitive and violent crime
- Physical and mental ill-health resulting in increased illness and deaths and increased demand on services
- Harm to children as a result of parental alcohol and drug misuse, including safeguarding concerns and failure to thrive
- Unemployment, economic inactivity and long-term sickness-related benefit claims
- Homelessness and rough sleeping

Commissioning of Drug and Alcohol Services

4.2.9 The Manchester Alcohol Strategy (2012-2015) has an overarching aim of reducing alcohol-related harm to individuals, families and communities in the city, supported by partnership activity under five thematic outcome areas:

- Promoting and supporting change in attitudes and behaviours
- Ensuring alcohol is sold responsibly
- Improving access to effective early interventions and recovery-focused treatment and care
- Protecting children and families from alcohol-related harm
- Tackling alcohol-related crime, disorder and antisocial behaviour

4.2.10 Similarly, local approaches to addressing drug misuse mirror the key principles of the current national drug strategy:

- Reducing demand – by creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so, and making it easier for those that do to stop
- Restricting supply by tackling drug trafficking

- Building recovery in communities – by working with people who want to take the necessary steps to tackle their dependency on drugs and alcohol, and offering a route out of dependence by focussing on the goal of recovery and reintegration

4.2.11 Following a review and a public consultation in 2014, community-based alcohol and drug services for adults have been redesigned, and an open tender process is currently underway to identify a lead provider for a new integrated alcohol and drugs early intervention and treatment service for adults aged 18 and above. The service will include 4 components:

- Prevention and self care (including training on alcohol and drugs for other providers)
- Engagement and early intervention (including harm reduction)
- Structured treatment
- Recovery support

4.2.12 The service will be available city wide in a range of community-based settings, and will provide a single access, assessment, and care coordination process for all alcohol and drug misusers. The service will be accessible through a range of referral pathways, with particular focus on those individuals and groups who pose a high risk of harm to themselves and others, and the early help and 'complex dependency' cohorts in the city. The service will be expected to work with users/misusers of a range of substances - including alcohol, illegal drugs, new psychoactive substances, and misusers of prescription/over the counter medication – with a particular focus on increasing the availability of treatment for alcohol misuse. As well as providing clinical treatment for alcohol and drug dependency, the service will be expected to work in partnership with other services to support individuals to achieve a range of recovery goals and outcomes, including:

- enabling individuals to develop their potential and function productively
- improving health and wellbeing
- promoting freedom from dependence
- increasing individuals' resilience and personal capital
- strengthening families and social networks
- promoting citizenship and community integration

4.2.13 In addition to the integrated alcohol and drug early intervention and treatment service for adults, the following services will continue to be commissioned to support local alcohol and drug strategies:

- healthy schools service support for schools to develop and deliver effective alcohol and drug education
- a separate substance misuse (alcohol and drugs) early intervention and treatment service for young people aged up to 19, which includes a family service supporting the children of parents who are dependent on alcohol and/or drugs

- inpatient detoxification and residential rehabilitation in a range of out-of-area settings
- specialist social work and mental health support for alcohol and drug misusers
- support for drug users receiving treatment from GPs and pharmacies

4.2.14 It is important to note that this area of public health spend has already been reduced significantly although allowances have been made for the potential in-year cut to the public health grant as part of procurement and contracting process.

4.3 Sexual Health: Overview and background

4.3.1 Improving the sexual and reproductive health of the local population is one of the public health priorities for Manchester.

4.3.2 Manchester has the highest prevalence of HIV outside of London and the South East (5.76 per 1,000 people aged 15-59). 2,102 residents aged 15-59 received treatment and care for HIV in 2013, up from 1,983 in 2012. 103 residents entered HIV treatment services in 2013.

4.3.3 There is an upward trend in the number of new cases of selected sexually transmitted infections including gonorrhoea and infectious syphilis among residents of Manchester. Manchester residents accounted for 3,257 cases of chlamydia, 1,087 cases of genital warts, 714 cases of gonorrhoea, 448 cases of genital herpes and 90 cases of infectious syphilis diagnosed at Genito-Urinary Medicine(GUM) clinics and other settings offering screening in 2014.

4.3.4 Rates of common Sexually Transmitted Infections (STIs) including chlamydia are highest among residents aged 15-24. Rates of several infections including HIV are high among men who have sex with men (MSM) as well as women and men from black African and black Caribbean communities living in Manchester.

4.3.5 The uptake of contraception among residents of Manchester is good and there has been a welcome increase in the proportion of women opting for a long-acting, reliable method of contraception such as the implant. However, despite a decline in the number of abortions provided for our residents, the rate of abortions for Manchester (21 per 1,000 women aged 15-44) is higher than the rate for England (17.5 per 1,000). 2,895 abortion procedures were performed for women living in Manchester in 2014, down from 2,878 (-0.5%) in 2013.

4.3.6 Good progress has been made to reduce the number of under-18 conceptions. The rate for Manchester peaked at 71.9 per 1,000 women aged 15-17 in 2005 and stood at 36.5 per 1,000 in 2013. There were 286 under-18 conceptions in 2013 compared to 591 in 2005 (-52%). However, the under-18 conception rates of 36.5 per 1000 is still considerably higher than the national rate of 24.3.

Commissioning of Sexual and Reproductive Health Services

4.3.7 The Public Health team is acting to improve the sexual health of the resident population. The team are working to ensure that sexual and reproductive health services provided within Manchester are affordable, organised to meet the needs of residents, and continue to be safe and effective.

4.3.8 The Team have responded to the outcome of the public consultation that was held in December 2014 on the options for public health services, including sexual and reproductive health services.

4.3.9 Most of the respondents to the public consultation agreed with the option to establish an integrated sexual and reproductive health service and the process of procuring an integrated service for people of all ages is now underway. It is anticipated that the new service will be operational in the summer of 2016. It will offer HIV testing, STI testing and treatment, and contraception on a hub and spoke basis. The integrated service will replace the current arrangement, that is, the provision of three GUM clinics and a separate contraception service delivered from six locations.

4.3.10 Most respondents agreed with the option to maintain a dedicated contraception service for young people. Therefore, the Team is also procuring a dedicated clinic for young people, and this service will also commence next summer.

4.3.11 Commissioners within the Public Health team have worked with colleagues in the public health teams in the other local authorities to plan and coordinate the procurement of sexual and reproductive health provision across Greater Manchester. Commissioners have developed and agreed a standard service specification and have benchmarked and costed provision. The aim is to ensure that clinics across Greater Manchester offer the same range of routine and intermediate provision and that specialist provision will be rationalised.

4.3.12 It is important to note that local authorities are mandated to commission and fund open-access and comprehensive sexual and reproductive health services for all persons present in their area regardless of residence. This requirement is at odds with the terms of the Public Health Grant that restricts local authorities to funding provision for their residents only. Commissioners from each of the local authorities in Greater Manchester have been working over the last six months to agree cross-charging arrangements for the region, to ensure that residents can continue to attend the service of their choice, whilst ensuring that each local authority can recompense providers for services offered to their residents.

4.3.13 The Public Health team has also reviewed the provision of HIV/STI prevention and support services and the provision of additional sexual and reproductive health provision offered within general practice and pharmacies. The intention is that, in conjunction with our colleagues in the other local authorities, a similar process will commence to re-model and if required to re-procure provision during 2016.

4.3.14 There remains a strong commitment to continue with the GM collaborative approach for commissioning third sector organisations who contribute significantly to the delivery of HIV prevention and sexual health services. The current arrangements will remain in place for 2015/16.

4.3.15 The commissioning arrangements in relation to HIV treatment, which currently sit with NHS England will hopefully become less fragmented through the Devolution Agreement. NHS England have signed up to the Memorandum of Understanding in relation to public health (see section 6.2) and they currently commission HIV treatment services delivered by hospitals in Greater Manchester. This includes GUM departments and the Regional Infectious Diseases Unit based at North Manchester General Hospital.

4.3.16 It is important to note that this area of public health spend has reduced significantly and the GM approach will ensure Manchester as an "importer" of non-Manchester residents who use local services is compensated appropriately. This will mitigate against the potential in year cut although some savings will still need to be made.

4.4 Children's Public Health Services: Overview and background

4.4.1 The health and wellbeing of children in Manchester is generally worse than the England average. 25.4% of the population of Manchester is under the age of twenty and 55.4% of school children are from a black or minority ethnic group. There were 1,375 children in care at 31 March 2014 which gives a higher rate when compared to the England average.

4.4.2 The level of child poverty in Manchester is significantly worse than the England average with 33.9% of children aged under 16 years living in poverty compared with the England average of 19.2%. Health and life expectancy are linked to social circumstances and child poverty. Poverty is associated with a higher risk of illness and premature death and has significant consequences for pre-school children in terms of their physical health and their wider functioning, for example, language development.

4.4.3 Over the last decade, the number of infant deaths in Manchester has fallen by 22% and the infant mortality (death) rate has fallen by 45% (2001-03 to 2011-13). In Manchester, the perinatal mortality rate (still births and deaths of infants under 7 days old) is significantly higher than England but our neonatal, post neonatal and infant mortality rates (deaths under 1 year) are not.

4.4.4 About 75% of lifetime mental health disorders have their onset before 18 years of age, with the peak onset of most conditions being from 8 to 15 years. The rate of young people aged 10 to 24 years in Manchester who are admitted to hospital as a result of self-harm is lower in the last three year reporting period (2011-2014) compared with the 2008-2011 period and is slightly lower than the England average.

4.4.5 Breastfeeding improves quality of life for women and children through reducing acute and chronic diseases. Prevalence of breastfeeding at 6-8

weeks is a key indicator of child health and wellbeing. Local data from the health visiting team shows that breastfeeding initiation is at 65.1% but there is a significant drop off with 40% fewer women breastfeeding at 6-8 weeks (only 25.2%).

4.4.6 Immunisation is one of the most effective public health interventions. 91.8% of children in care are up-to-date with their immunisations compared to an England average 87.1%. For the general child population we achieved 92.9% for Measles/Mumps/Rubella (MMR) at 2 years of age compared to an England average of 92.7%.

4.4.7 As highlighted in section 4.1.5, children in Manchester have worse than national average levels of obesity and this will have a significant impact on health outcomes in later life (e.g. type 2 diabetes) unless more children in Manchester achieve a healthy weight.

4.4.8 Similarly as stated in section 4.1.6, in relation to dental health the percentage of 5 year olds with one or more decayed, missing or filled teeth is significantly worse than the national average. This issue has clear links to obesity, in terms of food and drink consumption, and to dental self care in the community.

4.4.9 The rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years per 10,000 resident population is 181.6 (2013/14 data), significantly higher than the England rate of 112.2. It is important to note injuries in children will be much higher than this as there will be many that do not result in a hospital admission.

4.4.10 The national figures for young people who report drinking alcohol in the last week, or taking drugs in the last month, are summarised in section 4.2.6. However rates of alcohol and drug use are higher among vulnerable young people, including young people excluded from school, young offenders and children in the social care system. It is also worrying that 65% of adult smokers in England report that they started smoking before they were 18 years old.

4.4.11 As stated previously is section 4.3.6 , the under 18 conception rate has continued to fall in Manchester with a 40% reduction since 1998. However, ward level data shows wide variation across the city with a range from 10.7 per 1000 young women to 85.7. The lowest rates are in West Didsbury, Chorlton and Rusholme wards and the highest rates in Harpurhey and Miles Platting/Newton Heath wards.

Commissioning of Children's Public Health Services

4.4.12 The public health team at Manchester City Council is responsible for commissioning the following children's public health services from CMFT:

- Health Visiting Service (from October 2015)
- Family Nurse Partnership (from October 2015)
- Homeless Families Health Visiting Service

- Provision of Vitamin D to pregnant mothers as part of Healthy Start
- School Health Service (including School Nursing and Healthy Schools)
- National Child Measurement Programme
- Child Accident Prevention

And the following services from other providers:

- Oral Health Improvement Service
- Young People's Sexual Health Services
- National Chlamydia Screening Programme
- Young People's Substance Misuse Service (Alcohol and Drugs)

4.4.13 The responsibility for commissioning the 0-5s public health services (Health Visiting Service and Family Nurse Partnership) transferred from NHS England to Manchester City Council on 1st October 2015. The Strategic Lead for Children and Young People's Public Health worked closely with the NHS England Lead Commissioner and the provider of these services (CMFT) to ensure that a smooth commissioning transfer took place. The Public Health team also negotiated with CMFT and reached agreement on the new service model for the School Health Service within a reduced funding envelope and have progressed with discussions on other services provided by the Trust.

4.4.14 Nationally, the current commissioning landscape of children's health services is fragmented and is split between LA Public Health teams, Clinical Commissioning Groups (CCGs) and NHS England. These arrangements are now under review with the agreed aim to commission for outcomes and secure value for money. In Manchester, the commissioners from all three commissioning organisations are working closely together and the opportunities for a collaborative Greater Manchester approach are also being explored.

4.4.15 In relation to the potential impact of the in-year cut, the Public Health team will continue to work with the main provider of children's public health services, CMFT, and other providers to agree any service changes and funding reductions.

5. Priorities for the Manchester Public Health Team

5.1 Introduction

The following sections cover the work programme areas of the public health staff team based at Manchester City Council, following the restructure of the team which commenced in April 2015. The restructure is now complete and will deliver recurrent savings of £500,000 in line with the MCC budget options proposals. The team is organised around the Life Course themes and Health Protection (a mandated responsibility) and will be supported by the Public Health Knowledge and Intelligence team. The commissioning and contract functions have been integrated under the Strategic Head of Commissioning at MCC. Finally there is a designated lead assigned to each CCG, to ensure that

the mandated responsibility of providing public health advice to CCGs is fulfilled.

5.2 Starting Well and Developing Well

5.2.1 Giving every child the best start is crucial to reducing health inequalities across the life course. What happens before and during pregnancy, in the early years and childhood has life long effects on many aspects of health and wellbeing in adulthood from obesity, heart disease, mental health, educational achievement and economic status.

5.2.2 Children's public health work is delivered as part of the starting well and developing well life course, whist recognising that some areas, such as safeguarding, emotional health and wellbeing and domestic violence and abuse run across all life course areas.

5.2.3 The Strategic Lead for Children and Young People's Public Health sits on the Children's Board, the Early Years Delivery Model Steering Group, Manchester Safeguarding Children's Board and Early Help Operational Board and has attended the OFSTED Improvement Executive and Board. This facilitates good communication and working relationships between public health and other teams within the council as well as with partner organisations.

5.2.4 Starting Well is one of the major transformation programmes in the Greater Manchester Public Health Memorandum of Understanding (see 6.2.3) and this is consistent with the emerging Locality Plan and refreshed Joint Health and Wellbeing Strategy.

Current Priorities

5.2.5 The children's public health team continues to lead and contribute to multi-agency work to improve health outcomes for children and young people by tackling health inequalities and having a prevention focus throughout all programmes of work. The approach is 'rights based', advocating for the protection of children's rights to have help and support to meet their basic needs and expand their opportunities to reach their full potential. The priority areas of work include:

- Ensuring that children's public health services support the Early Help agenda
- Ensuring that the Health Visiting Service work in partnership to deliver the Early Years Delivery Model in Manchester
- Improving emotional health and wellbeing of children and young people
- Preventing sudden unexpected infant deaths
- Increasing breastfeeding
- Increasing childhood immunisations
- Reducing childhood obesity (e.g. food policy and programmes)
- Reducing tooth decay in children
- Reducing accidents in children and young people

- Improving the health of adolescents
- Reducing teenage pregnancy and improving young people's sexual health
- Supporting teenage parents
- Contributing to Safeguarding children, including work on tackling Child Sexual Exploitation and Female Genital Mutilation; and domestic violence and abuse

5.2.6 Children's Joint Strategic Needs Assessment (JSNA)
The Children and Young People's JSNA is being updated to meet OFSTED requirements. One of the priorities is to ensure that people working within the city are aware of the updated JSNA and know how to use it to inform their work to improve the health and wellbeing of children and young people. There will be a mix of approaches to this, including knowledge and intelligence, sharing through workshops, as well as written communication with partners.

5.2.7 Participate in a North West Review on reducing infant mortality
Over the last decade, the number of infant deaths in Manchester has fallen by 22% and the infant mortality rate has fallen by 45% (2001-03 to 2011-13). The Manchester rate is lower than both Birmingham and Nottingham but higher than Newcastle and Bristol. There are different stages of infant mortality, namely deaths in the perinatal (stillbirths and deaths under 7 days), neonatal (deaths under 28 days) and post neonatal periods (deaths 28 days to 1 year). The contributing factors underneath each stage can be different. In Manchester, the perinatal mortality rate is significantly higher than England but our neonatal, post neonatal and infant mortality rates (deaths under 1 year) are not.

The review work will include a self-assessment to identify activity in place to reduce child deaths for children under 1 year old, identifying key themes and recommendations at a LA level, GM level, North West level and sharing good practice and innovation to improve outcomes.

5.2.8 Strengthen commissioning of child health services, to ensure the effective transformation of services
There are already good working relationships between the commissioners of child health services (CCGs, NHS England and Manchester City Council Public Health). It has been suggested that a formal Board should be established to oversee the transformation of children's services in Manchester, with all commissioners on this. The Board could potentially look at options to commission an integrated children's public health service, including school health services and health visiting along with other services. There are a variety of models being used across Greater Manchester that will be reviewed, to see which model shows the best evidence of effectiveness as well as best value for money. This review will inform the approach in Manchester.

5.2.9 Ensuring that key performance indicators on children's public health are included within the Early Help work and the work of Children's Centres
The team has been working with leads from Early Help and the Strategic Lead for Early Years to ensure that others contribute to key performance indicators

for public health. This includes working with children and families to increase the number of children who are a healthy weight and who have good oral health. Developing emotional resilience will underpin all work with children and young people.

5.3 Living Well and Working Well

5.3.1 The conditions into which people are born, grow, live and work and age are fundamental to the health of the population. The social and economic circumstances of Manchester people largely determine their health outcomes and underpin the health inequalities within our city and in England as a whole. The approach to Adults Public Health in the city, under the new team, is to focus on the 'wider determinants' of health – employment, housing, community connection, skills and learning, income, and environment. The lifestyle factors which cause disease such as smoking, obesity, substance misuse and physical activity, will also be addressed by the Adults Public Health team.

5.3.2 The Living Well components of the current public health programme focus on the redesign of Health and Mental Wellbeing Services (see 4.1.). The Working Well components focus on work as a health outcome as employment is a key determinant of health. This is now a major priority for the team and the detail of the work now underway is provided in section 5.3.10 and appendix 2.

5.3.3 The Strategic Lead for Adults Public Health sits on the Work and Skills Board, the Confident and Achieving Manchester Board, Manchester Investment Board, Welfare Reform Board, Manchester Adult Safeguarding Board. This facilitates good communication and working relationships between public health and other teams within the council as well as with partner organisations.

Current Priorities

5.3.4 The adults public health team works in partnership with a range of agencies to drive health improvement and address health inequalities. The main priorities for the team are:

- Redesign of Health and Mental Wellbeing Services (see 4.1).
- Delivery of strategic Work and Health programme (see below)
- Integration of public health services within Early Help Hubs and Confident and Achieving Manchester programmes
- Supporting the delivery of the Manchester Community Safety Strategy (e.g. tackling alcohol and drug related crime)
- Co-ordination of response to Rough Sleeping in the City
- Lead work on Cancer (Locality Plan priority), Cardio Vascular Disease (CVD) and diabetes prevention programmes in partnership with the CCGs

Other areas off work include:

5.3.5 <u>Strengthening the public health input to Adult Safeguarding</u>

Following the peer review of adult social care it had been agreed to revamp the Manchester Adults Safeguarding Board and the public health team will be members of both the Board and Executive Group.

5.3.6 Working with teams in Growth and Neighbourhoods, Transport and Environmental Strategy to support public health activities
As part of the refocus on the wider determinants of health, the relationships that already exist with various teams within MCC will be formalised to develop joint work programmes. This will help to create the conditions to make healthier choices easier, for example, walking and cycling as part of improvements to the public realm.

5.3.7 Leading work on Self-Care
As part of LLLB, a group has been established under the leadership of public health to develop a consistent whole system approach to self care across Manchester. This includes workforce development with frontline staff, to support behaviour change and self management and public education and community asset building (see 4.1.1.)

5.3.8 Refreshing the Manchester Tobacco Control Strategy
It is acknowledged that a new partnership approach is required in Manchester for the delivery of Stop Smoking services. This will take account of recent legislative changes, the emerging evidence base in relation to e-cigarettes , the enhanced role of primary care providers such as GPs and pharmacists and national campaigns (e.g. Stoptober). The refreshed strategy will be launched in May 2016.

5.3.9 Formalising partnerships with national organisations and charities
Over the past month discussions, led by the Director of Public Health, have taken place with Macmillan and Diabetes UK to look at the opportunities for further joint work and potential investments in Manchester. Future partnership models will also build on existing relationships with the British Heart Foundation and other charities, who are keen to support public health work in the City.

5.3.10 Work and Health: Overview

1) People who are in work live longer, healthier lives. However the following statistics for people of working age who are out of work show:
- 20% higher rate of preventable deaths and 1.5 - 2.5 times higher risk of fatal or non-fatal cardiovascular disease and events
- 1 in 7 men is diagnosed with clinical depression within six months of losing their job and unemployed young men are 25 times more likely to attempt suicide than employed young men
- 16 to 34 % increased incidence of psychological problems for those who experience prolonged unemployment
- Prevalence of psychiatric disorders in children aged 5-15 in families with parents who have never worked is double that of children with parents in

low skilled jobs, and 5 times higher than those with parents in professional occupations
- Higher rates of alcohol and tobacco consumption among those out of work
- Lower rates of physical activity among those out of work

2) Very high rates of health-related worklessness have persisted in Manchester regardless of the economic climate, and the number of health-related benefit claimants has remained high even during times of economic growth. In many cases, there will be multiple health conditions accompanied by a range of complex social circumstances for example low skills, family and relationship issues, social isolation, debt and housing problems.

3) Good work ensures that the health benefits of employment are realised and sustained. A healthy workplace is characterised by a safe and healthy working environment, clarity of expectation on staff, feedback on performance, and employees having some control and influence over their work. The business case for promoting and supporting employee health and well-being has been well documented. Employers can gain clear benefits in reducing employee turnover and increasing the productivity and engagement of employees.

4) The latest Department of Work and Pensions (DWP) information on out of work benefit claimants in the city indicates that whilst the total number of claimants has continued to drop, with 5,100 fewer claimants between November 2013 and November 2014 (which does however not include Universal Credit claimant figures). Employment Support Allowance (ESA) claims have steadily risen and the proportion of people claiming an out of work benefit because of a health condition has therefore increased.

5) In November 2014 over 33,000 Manchester residents were claiming Employment Support Allowance and other sickness related out of work benefits. Half of those are claiming primarily because of a mental health condition. There is also a flow of new claims for Employment Support Allowance from residents who have fallen out of work due to a mental health condition that it is critical to stop. There is strong evidence that once out of work, an individual's health is more likely to deteriorate and they risk falling into poverty, impacting on their family. 80% of people off sick for more than six months or longer will still be off work five years later.

6) Supporting individuals back into work and assisting them to sustain work where they have long term health issues, not only boosts the local economy but improves the life chances and health outcomes for individuals and their families

Commissioning and Delivery of the Manchester Work and Health Programme

7) Strategic Priority 7 of the Joint Health and Wellbeing Strategy, 'Bringing people into full employment and leading productive lives' is a shared responsibility between the Work and Skills Board and the Manchester Health

and Wellbeing Board and is driven by public health. A joint work programme has been agreed, more detail of this is provided in Appendix 2. Wok and Health is a core element within the Manchester Locality Plan and GM Public Health Memorandum of Understanding (see section 6.2).

8) The work programme is overseen by the Work and Health Driver Group chaired by Dr Mike Eeckelaers, Central Clinical Commissioning Group (CCG) and a member of both Boards. The Group meets regularly to take forward the delivery plan, which focuses upon improving employment outcomes for people with health conditions based on three workstreams listed below (see detail in appendix 2).

- Health and Work Programmes
- Primary Care & Commissioning
- Organisational Leadership for Healthy Work

5.4 Ageing Well/ Age Friendly Manchester

5.4.1 Although the population of Manchester contains a smaller proportion of older people than other parts of the country, the older people that do live in the city tend have poorer health (and experience this poorer health earlier in their lives) and hence place greater demands on health and social care services. Life expectancy at age 65 for men in Manchester is the lowest in England and Wales for men and the third lowest for women. Frailty is a significant factor underlying the poor physical and mental health of older people in Manchester. The rate of emergency hospital admissions for injuries due to falls in people aged 65 and over in Manchester remains significantly higher than the average for England National research suggests that inequalities in levels of frailty are widening and that levels of frailty are increasing over time for the poorest in our population.

5.4.2 The Age Friendly Manchester (AFM) programme aims to create a city that, as the World Health Organisation states, “encourages active ageing by optimising opportunities for health, participation and security in order to enhance quality of life as people age.” AFM is a key component of the public health lifecourse approach with the aim of enabling people to keep well and live independently as they grow older in order to improving healthy life expectancy and reducing demand on public services.

5.4.3 Governance of the programme is provided by a Senior Strategy group, chaired by the Councillor Sue Murphy, and by the AFM Older People’s Board, which consists of a dozen older people, drawn from a wide range of communities and organisations. The Strategic Lead for AFM drives the work of the Senior Strategy Group and is also the public health lead on the Transforming Adult Social Care (TASC) Board , LLLB Citywide Leadership Group and other key partnership Boards dealing with older people’s pubic health issues. This facilitates good communication and working relationships between public health and other teams within the council as well as with partner organisations.

5.4.4 The AFM 2015/6 programme action plan is organised around five themes. The summaries relating to the first three themes are provided below, with further detail on themes 4 and 5 and other AFM initiatives provided in Appendix 3:

1. age-friendly neighbourhoods;
2. age-friendly services;
3. influence;
4. communication and involvement;
5. knowledge and innovation

Current priorities

5.4.5 Age-friendly neighbourhoods

Working at a neighbourhood level has been central to the AFM approach – bringing community groups together with local services to plan and work towards creating places that are great to grow old in. During 2015, the programme has made progress in the following areas:

i) Ambition for Ageing
Three new age-friendly neighbourhood projects will be launched in November 2015 as part of the Big Lottery-funded, GM Ambition for Ageing project. These projects – based on a similar model to the age-friendly Old Moat project - will run for five years, with the opportunity for additional initiatives being funded after two years.

ii) AFM Locality working
The first outings for the North City Nomads supported 240 residents, including the residents of a residential home, from North Manchester to take part in trips to Southport and Llandudno, which has created a blueprint for similar initiatives in other parts of the city. A number of AFM Networks are continuing to organise work at a local level, for example, East Manchester networks organised a Spring into Summer Festival which brought together a programme of 30 community events. A new winter warmth campaign is being launched to bring together organisations that work with vulnerable older people to promote services and opportunities during the winter months.

5.4.6 Age-friendly services

i) AFM Housing
The Housing for an Age-friendly Manchester strategy is led by a multi-agency group, chaired by the Director of Housing. This wide-ranging approach has supported some important initiatives including the development of 'HOOP' a project led by Northwards Housing with North CCG, in north Manchester that advises older people on current and future housing options. In south Manchester a NORC (Naturally Occurring Retirement Community) project, led by Southway Housing, is working to bring together services where there is a high-concentration of people aged over 65. The AFM Design Group is providing support to this work.

ii) Manchester Older People's Charter

The Charter was launched on 1st October 2105 – International Older People's Day – at an AFM Forum meeting addressed by Sir Richard Leese and representatives of the Manchester CCGs, the University of Manchester, and the AFM Board. The Charter has been written by the AFM Older People's Board over the last nine months, and is the result of a consultation process that received over 100 responses. A plan for city organisations to adopt the charter is underway.

iii) AFM Culture Programme
The AFM Culture programme brings together over 20 arts organisation to improve the wellbeing of older people through the arts. Projects include those aimed at people with dementia and people living in care settings to older people creating art in later life. Manchester leading role in this field has been further highlighted by a new Whitworth Gallery publication and event aimed at involving older men, especially those most excluded, from participating in arts activities. An important strategic development has been the Commissioning Learning Programme project which is exploring ways in which the city could build on the Age-friendly Culture Programme by building on and extending the links between the city's culture and health sectors. Alongside the appointment of a new AFM Culture Coordinator based at the Whitworth Gallery, the Vintage FM project, funded by the Baring Foundation, will use radio broadcasting as a way to tackle loneliness.

iv) Living Longer, Living Better
The AFM team is working with LLLB project group, Manchester Carers' Forum, and NHS colleagues to design a wellbeing model for older people who are well. This project is aiming to maintain healthy and active lifestyles and reduce the need for health and care services.

5.4.7 Influence

i) Greater Manchester Work
Good progress has been made on the Greater Manchester Ageing Hub. Initial scoping work has been undertaken and the proposal has been approved by the Greater Manchester Combined Authority (GMCA). A small working group involving the AFM team are developing workstreams and costing proposals. A Greater Manchester response to the Centre for Ageing Better (CfAB) consultation was submitted, and a visit by the Chair and interim Chief Executive of CfAB took place May.

ii) International
Manchester hosted the Eurocities Urban Ageing working group in September, where areas for collaboration and joint future projects were discussed. In December Manchester will sign a new EU Covenant on age-friendly cities and environments and the AFM team has been asked by the World Health Organisation to give expert advice on its forthcoming Global Healthy Ageing Strategy.

5.5 Health Protection: Protecting the public's health against old, new and more common infectious disease threats

5.5.1 Health protection is one of three core domains of public health practice. It is a relatively specialist area concerned primarily with infections and infectious diseases. Health protection is a key element of the public health functions of local government, and is a mandated duty of local authorities. In particular, there is a duty to ensure there are plans in place to protect the health of the population.

5.5.2 A specialist in health protection, the Consultant in Public Health Medicine, supports the Director of Public Health in his lead health protection role. The Community Infection Control Team – who transferred to Manchester CC from the Primary Care Trust in 2013 – also support the health protection work of the Public Health Department, and, in particular, provide a community infection control service.

5.5.3 A Health Protection Expert Advisory Group, which reports to the Health and Wellbeing Board, is now well established. The primary roles of the Health Protection Expert Advisory Group are to enhance partnership working, and to assist the Director of Public Health in ensuring oversight, particularly in providing a strategic challenge to health protection plans/arrangements of partner organisations. The agenda includes, in particular, discussion of recent outbreaks and serious incidents, the levels of healthcare acquired infections in Manchester, vaccination coverage locally, Tuberculosis trends, and plans in the event of a major outbreak.

Potential new infectious disease threats: Ebola and MERS

5.5.4 The outbreak of Ebola Virus Disease (EVD) in West Africa has reduced dramatically in recent months, although cases are still occurring. At the time of writing, Liberia has not had any EVD cases at all for nearly three months, but both Guinea and Sierra Leone have had cases recently.

5.5.5 Although the number of EVD cases is now only a handful, or less, each week, the overall burden of disease over the year-long EVD outbreak has been unprecedented, over 28,000 cases and more than 11,000 deaths. In addition, late complications of the disease – although not posing a particular outbreak threat - are proving more common that expected. The recent readmission to hospital of a volunteer Scottish nurse who contracted EVD in West Africa is an illustration of this problem.

5.5.6 It is not clear when the outbreak will be finally over, and, until then, heightened vigilance against EVD remains. Whilst the threat of EVD is now diminishing, a new threat has emerged, Middle-East Respiratory Syndrome (MERS). This has been reported in several countries in the Middle East, being thought to be acquired from contact with young camels. However, it can also be transmitted person-to-person on occasion, including to healthcare workers. The early symptoms are of a 'flu-like' illness, but it can cause severe lung infections and is associated with a high mortality (death rate), possibly as high as 30%.

5.5.7 Although the risk of an *actual* MERS case being imported in to the UK is low, possible ‘false alarm’ cases are not uncommon. This is because the clinical

picture of MERS is similar to flu or a severe chest infection. Therefore, travellers returning from a number of countries in the Middle East - including Saudi Arabia, where the Hajj was recently held - who develop a fever/chest infection need, as a precaution, to be tested for MERS. This has happened on a number of occasions in Manchester, the tests always proving negative. The problem of possible cases has increased recently, as some pilgrims returning from the Hajj have had Flu A.

5.5.8 Continued vigilance will be necessary, and the specialist Infectious Diseases Unit at North Manchester General Hospital is an excellent source of advice about any patient who may have EVD or MERS.

Renewing the fight against an old infection threat: Tuberculosis

5.5.9 The incidence of TB has fallen significantly in Manchester in recent years. In 2011, the rate of new cases of TB was 43.9 per 100,000 population, above the 40/100,000 threshold used by the World Health Organisation to define an area of high TB incidence. In 2013, the rate dropped to 32.3 cases per 100,000 population, a fall of more than a quarter. However, Manchester still has one of the highest rates of TB in the country.

5.5.10 This fall is very welcome, and the local TB services work hard to prevent TB cases. There is, however, no room for complacency, and probably the main cause of the fall is a change in the demographic make-up of new entrants to Manchester. It is important that we improve our efforts to prevent TB. Most of those who develop TB disease were infected as children, and have had latent ('hidden') TB for many years. Using a blood test, we can now screen for latent TB in high-risk groups and offer effective treatment.

5.5.11 Manchester is establishing a new entrant screening programme for Latent TB infection, starting on a small scale, this year. This blood test screening will be undertaken in general practice and anyone proving positive referred to a TB specialist clinic. It is hoped to attract national funding to roll-out this programme – which is being developed collaboratively with Greater Manchester partners – more widely in 2016/17.

Tackling a common 'everyday' infectious disease threat: Norovirus

5.5.12 A common, 'everyday' bug is Norovirus, sometimes called 'winter vomiting virus'. This is the commonest cause of the diarrhoea and vomiting episodes that so many of us, and our families, experience most winters. Although not a particularly serious infection in the healthy, norovirus is highly infectious and can be more serious in a situation such as a care home, when the bug can spread quickly, and become more of a problem in a large group of elderly, vulnerable residents causing dehydration, and in some cases admission to hospital.

5.5.13 Manchester City Council's Community Infection Control Team (CICT) work closely with care and nursing homes to help improve their infection prevention and control practices. This includes; providing advice, support and training, undertaking audits of the environment and encouraging compliance with the

Care Quality Commission's standards (derived from the Health and Social Care Act 2008: Code Of Practice on the Prevention and Control of Infections). The CICT have also developed a training programme with the aim of having an infection control 'champion' in each care home.

5.5.14 Although this work is aimed at a wide variety of infections, the improvement of practice is particularly useful when a potentially fast-spreading outbreak of norovirus occurs. The training provided by the CICT ensures that staff know to quickly manage the outbreak by isolating patients with symptoms, that they undertake the correct procedures to protect other vulnerable residents, and reduce the likelihood of admission to hospital. This is vital to reduce the spread of norovirus, reducing disruption and further ill health in the busy winter period.

Summary and Next Steps

5.5.15 The new, old and 'everyday' challenges described above will be the focus of the health protection work of the Public Health team in the coming months. Other key priorities will be, working with NHS partners to maintain low levels of healthcare associated infections in Manchester, both in hospitals and in the community, renewing efforts to improve vaccination coverage in Manchester, particularly in younger children, and, working across Greater Manchester, starting to screen for TB in those in particular risk groups.

5.5.16 Organisationally, within the context of Devolution in Greater Manchester, and the creation of a Unified Public Health Leadership System (see section 6.2), the team will be working with Public Health England and other partners to strengthen health protection functions on a GM footprint.

5.6 Public Health Knowledge and Intelligence Team

5.6.1 The public health restructure has provided an opportunity to ensure that the work of the Public Health Knowledge and Intelligence Team (KIT) has a greater focus on evidence and knowledge management. In particular there will be more support for health and social care commissioners to make better use of existing evidence and intelligence in order to improve the quality and robustness of decision making.

5.6.2 Taking its lead from the Public Health England (PHE) Knowledge strategy, the Knowledge and Intelligence Team will seek to:

- Furnish health and social care professionals across the system with the knowledge, skills and tools to make the right decision at the right time based on the best available evidence;
- Generate, source and process high-quality data, adding to the evidence base and continuously working to translate this knowledge into actions which measurably protect and improve the health and wellbeing of Manchester residents and reduce inequalities;

- Foster a culture, which seeks to encourage new ideas and innovation while supporting staff with a framework of standards to ensure consistency and efficiency;
- Work closely with external partners in both the academic and commercial sectors to conduct relevant research and share knowledge in order to ensure a speedier transition of innovation into practice.

5.6.3 The Knowledge Management Strategy for the public health team is in development. The following key principles will underpin this strategy:

- Health and social care professionals should be spending less time finding the public health information and knowledge they need and more time using it;
- The right knowledge should be available to the right people at the right time in a form that they are likely to use it;
- The Public Health team itself should be information-led and the experiences of frontline health and social care workers in Manchester will contribute to the knowledge base.

5.6.4 At the heart of the strategy will be a refreshed Joint Strategic Needs Assessment (JSNA) that connects commissioners and other users to the latest data, best practice guidance and research evidence relating to key population groups and health issues in Manchester. A series of user briefings will be developed, along with other engagement activities to raise the profile of the JSNA. This will ensure a more proactive approach in sharing the information collated and making sure that the information is better utilised.

5.6.5. Finally, the Knowledge and Intelligence Team will lead the implementation of the Public Health Information Governance Improvement Plan in order to ensure that the internal processes adopted by the Public Health team are in line with corporate standards, statutory requirements and best practice.

6. Phase Three of the Public Health Reform Programme

6.1 Responding to the consultation on proposed changes to the public health grant formula

6.1.1 The Advisory Committee on Resource Allocations (ACRA) advises the Department of Health (DH) on any proposed changes to formulae for the distribution of national resources. In the past this has covered resource allocations to Primary Care Trusts and more recently to CCGs.

6.1.2 ACRA were asked by DH to look at the formula for distributing the public health grant. DH are now consulting on the proposed changes to the formula that ACRA have come up with. It is important to note that this is a separate consultation exercise to the proposed 6.2% in year cut to the public health grant (see 3.2 and 3.3).

6.1.3 All Local Authorities have been invited to respond to the ACRA consultation by 5 November 2015 and the Director of Public Health is co-ordinating the

Manchester response. The consultation relates to the technical aspects of the formula that will be used in future to set the "target" allocation for each local authority area from 2016/17, in relation to the public health grant. It is difficult to estimate at this stage what the impacts of the formula changes will be in terms of the actual grant value that Manchester will receive each year from 2016/17 onwards.

6.1.4 However, it is clear from an initial assessment that whilst some aspects of the formula reflect Manchester's considerable public health needs and challenges (premature death rates in the under 75s), other aspects of the formula do not (substance misuse, sexual health and children's public health). This could potentially mean that Manchester will get a smaller slice of the national grant available in future, although the phasing or "pace of change" is not clearly set out in the consultation document. This point is particularly important, as losing >£5 million over a 10 year period for example requires a very different local response than if it was over 3 years.

6.1.6 It will be very important to develop a robust technical and evidence based response to the consultation questions, which are listed in Annex B of the full document (Web link provided below):

https://www.gov.uk/government/consultations/public-health-formula-for-local-authorities-from-april-2016

6.1.7 The response will be submitted by Manchester City Council and individual organisations represented on the Manchester Health and Wellbeing Board, will be requested to respond in support of the Council position. DH will report on the outcome of the consultation and any formula changes at the same time as LAs are informed of their 2016/17 allocations. This will be either December 2015 or January 2016.

6.2 Greater Manchester Devolution Agreement

6.2.1 Despite the successful transfer of key public health functions back to Local Government in April 2013, the public health system remains fragmented. The split of responsibilities across Public Health England (PHE), NHS England (NHSE) and Local Authorities (LAs) relating to health protection, health improvement and health intelligence has led to unnecessary duplication of effort in some areas and gaps in others.

6.2.2 As part of the Devolution Agreement, Greater Manchester now has the opportunity to develop a unified public health system, following the signing of the Memorandum of Understanding (MoU) on 10 July 2015.

6.2.3 In Manchester, the local reform of public health described in this report means that the City is well placed to support and benefit from the implementation of the MoU. The MoU priorities relate to the life course themes, strengthening health protection arrangements and a shared approach to public health knowledge and intelligence.

6.2.4 The recently established Greater Manchester Prevention and Early Intervention Board, chaired by the AGMA Lead Chief Executive, will be responsible for ensuring the MoU is implemented by bringing together resources from the 10 LAs, Public Health England (PHE) and NHS England. Other members of the Board include the Association of CCGs and the Greater Manchester Fire and Rescue Service (GMFRS). The Manchester Public Health team are working closely with the GMFRS on a number of initiatives and the potential for even greater collaboration will be progressed through the Board and reported back to the Health Scrutiny Committee at a later date.

6.2.5 A Greater Manchester Director of Population Health has now been appointed for a time limited period, to co-ordinate action on behalf of the Board and the key tasks over the next six months are to:

- develop a single GM Public Health Strategy, set of priorities and action plan that is consistent with Locality Plans and Health and Wellbeing Strategies;
- extend commissioning at GM level of activity (e.g. sexual health services) to improve health that achieves additional impact and is complementary to that at city/borough level;
- set out how health protection functions are to be commissioned and organised on a GM footprint with additional responsibilities aligned to wider GM resilience and civil contingency arrangements.

POPULATION		
Resident population estimates and 2011 Census	**Manchester**	**England**
Total population (Mid-2014)	514,417	53,865,817
Children (0-15)	19.9%	19.0%
Working age (16-64)	70.6%	63.5%
Retirement age (65 and over)	9.5%	17.5%
Ethnic group: Non-White British (2011 Census)	40.7%	20.2%
WIDER DETERMINANTS OF HEALTH		
	Manchester	**England**
Deprivation: IMD 2015 – % LSOAs in most deprived 10% nationally	40.8%	-
JSA Claimant Count (August 2015)	1.9%	1.9%
School readiness (2013/14)	52.8%	60.4%
Educational attainment - 5+ GCSE A*-C Eng & Maths (2014)	51.4%	53.4%
HEALTH IMPROVEMENT		
Births and conceptions	**Manchester**	**England**
General Fertility rate (2014)	59.4	62.1
Births <2500g (2013)	7.3%	7.4%
Under 18 conception rate (2013)	36.5	24.3
Lifestyles	**Manchester**	**England**
Prevalence of obesity among children in Year 6 (2013/14)	25.0%	19.1%
Smoking prevalence - 18 years and over (2013)	23.7%	18.4%
Admission episodes alcohol-related conditions (2013/14)	3,345.3	2,111.2
Reported prevalence of disease (QOF)	**Manchester**	**England**
Coronary Heart Disease – CHD (2013/14)	2.6%	3.3%
Stroke or Transient Ischaemic Attacks (TIA) (2013/14)	1.3%	1.7%
Chronic Obstructive Pulmonary Disease – COPD (2013/14)	1.9%	1.8%
Hypertension (2013/14)	10.4%	13.7%
Diabetes 17+ (2013/14)	5.9%	6.2%
HEALTH PROTECTION		
Immunisation, vaccination and screening	**Manchester**	**England**
Childhood immunisation uptake (2013/14)	96.2%	96.1%
Influenza vaccination uptake 65+ years (2013/14)	71.7%	73.2%
Breast screening coverage 53-70 years (2013/14)	60.3%	75.9%
Cervical screening coverage 25-64 years (2013/14)	66.7%	74.2%
HEALTHCARE AND PREMATURE MORTALITY		
Overarching indicators	**Manchester**	**England**
Life expectancy at birth (2011-13) – Males	75.5	79.4
Life expectancy at birth (2011-13) – Females	80.0	83.1
Infant mortality rate (2011-13)	4.6	4.1
Dental decay in 5 year old children (2011/12)	1.78	0.94
Premature mortality (directly standardised rates per 100,000)	**Manchester**	**England**
Mortality from causes considered preventable (2011-13)	319.7	183.9
All Cancers - 0-74 years (2011-13)	198.9	144.4
Cardiovascular Diseases - 0-74 years (2011-13)	137.0	78.2
Liver disease - 0-74 years (2011-13)	35.7	17.9

Suicide and injury undetermined (2011-13)	11.8	8.8

GLOSSARY	
Indicator	**Definition**
Admission episodes for alcohol-related conditions	Number of admissions to hospital among people usually resident in an area where the primary diagnosis or any of the secondary diagnoses are attributable to alcohol. Directly age standardised rate per 100,000 population European standard population.
Ethnic group	Ethnic group classifies people according to their own perceived ethnic group and cultural background, as recorded in the 2011 Census
Dental decay in 5 year old children	Mean severity of tooth decay in children aged 5 years based on the mean number of teeth per child sampled which were either actively decayed or had been filled/extracted
Directly standardised mortality rate (DSR)	Number of deaths to people usually resident in an area per 100,000 population, adjusted to take account of the age-structure of the population. Note: These have been updated to take account of ICD-10 coding changes and the introduction of the 2013 European Standard Population.
Educational attainment	Percentage of secondary school pupils achieving 5 or more GCSEs (or equivalent) including English and maths GCSEs at grades A*-C
General Fertility Rate	The number of live births per 1,000 women aged 15-44.
Childhood immunisation uptake rate	Number of children immunised against diphtheria, tetanus, polio, pertussis and Hib ('5 in 1 vaccine') by their 2nd birthday as a proportion of all children aged 2 living in an area (Target 95% of children immunised by age 2). Estimate based on former PCT areas.
Indices of Multiple Deprivation (IMD)	The Indices of Deprivation are the Government's official measure of deprivation. They bring together a range of indicators, covering different aspects or dimensions of deprivation, which are then weighted and combined to create the overall IMD Score.
Infant mortality rate	The number of deaths to infants aged less than 1 year resident in an area per 1,000 live births.
Influenza vaccination rate	The number of people aged 65 and over immunised against Influenza (seasonal flu) between 1st September and 31st January as a proportion of all people aged 65 and over living in the area.
Life expectancy at birth	The number of years a baby born in an area could expect to live if they experienced the age and sex specific mortality rates of that area for the whole of their life
Low birthweight	Percentage of all live and stillborn infants who are born with a stated birthweight weighing under 2,500 grams
Prevalence of obesity among	Percentage of school children in Year 6 who have had their weight measured and have been classed as being obese.

children in Year 6	
Reported prevalence of disease (QOF)	Percentage of a patients registered with a GP Practice who are on a disease register as reported through the Quality and Outcomes Framework (QOF)
Resident population estimates	Total number of people estimated to be usually living in an area, whatever their nationality.
School readiness	Percentage of eligible children achieving a good level of development at the end of reception year
Screening coverage rate	Number of eligible women who have been screened for breast and cervical cancer within the last 5 years as a proportion of all eligible women in an area.
Smoking prevalence	Percentage of respondents aged 18 and over who reported that they were a current smoker in the Integrated Household Survey (weighted to improve representativeness).
Under-18 conception rate	Number of births and conceptions to mothers aged under 18 per 1,000 females aged 15-17 years
Unemployment rate	Number of people claiming Jobseeker's Allowance (JSA) as a proportion of the resident working age population (aged 16 to 64)

Appendix 2: An in-depth overview of the Work and Health Programme

1. Introduction

1.1 The biggest local integrated health and work service development in recent years has been the development of the GM Working Well model which supports ESA claimants who have been through the Work Programme without moving into work. Prior to the design and development of Working Well which Manchester stakeholders were closely involved in, Manchester established two local programmes to test the integration of health and employment outcomes for a broader cohort of residents. 'Fit for Work' (out of work) was originally a pilot within North CCG to support patients with health conditions to move towards and into employment which has been rolled out to other areas of the city and is now known as 'Healthy Manchester'. Fit for Work (in work) is a city-wide service which supports patients who are in work but off sick and at risk of losing employment to return to work as quickly as possible.

1.2 A central outcome for both projects has been a step change in engagement by CCGs and GP practices in the employment agenda. The lack of integration between health and employment services has been a real barrier to the delivery of employment outcomes for people with health conditions previously. There is a need to build upon this to ensure that Manchester can proceed at pace with the GM Mental Health & Employment Pilot summarised in section 3.15 of the report and other devolution developments.

2. Health and Work Programmes

2.1 Fit for Work (North Manchester out of work pilot)

2.1.1 This pilot commenced delivery in the North Manchester CCG area in November 2013 prior to the commissioning of Working Well across GM, in recognition of the fact that unemployed Manchester residents with health conditions were not receiving the right support under mainstream employment support services, including the Work Programme. It was designed to test whether improved employment outcomes can be achieved through a health-focussed pathway. The service relies on GP engagement via referral of out of work patients of working age with health conditions to condition management and work progression services. Nine practices participated in the pilot which was delivered by Pathways CiC who also delivers the 'in-work' service. The service is telephone based and clients are offered access to support within three working days of referral and a bio-psychosocial assessment within ten working days. Importantly, GPs have not needed to establish eligibility for the service by benefit type or status which has been critical in terms of their willingness to participate in a simple referral process.

2.1.2 To date, the breakdown of benefit type of clients engaged has been; 53% ESA awaiting assessment, 17% JSA, 8% not claiming Out of Work benefits 8% ESA Work Related Activity Group (WRAG) and 8% ESA Support group.

2.1.3 An interim evaluation of the project was completed in September 2015. 64% of clients engaged up until March 2015 had mental health issues and 17% had

musculoskeletal problems as their primary condition. 56% were over 40 years of age, 47% had no qualifications, and 56% had been unemployed for over 2 years. The support delivered included motivational interviewing /behaviour change, health condition management and self-care, support to access mental heath services, work clubs and training courses. By March 2015, 28 patients had moved into employment, and others reported significant improvement in feeling positive about returning to work, anxiety/depression scores, pain/discomfort and self-care. Uptake of voluntary work and engagement in social groups also improved. Client consultations with GPs reduced by one third.

2.1.4 The Fit for Work (now 'Healthy Manchester) Out-of Work service has been commissioned as an expanded offer to cover selected practices within North, Central and South Manchester from April 2015. Eighteen GP practices have now signed Memoranda of Understanding to be pilot practices for the extended delivery.

2.1.5 In addition to GP surgeries, Healthy Manchester is now offering enhanced referral pathways to mental healthcare provision, including IAPT (Improving Access to Psychological Therapies) delivered with the Manchester Mental Health and Social Care Trust, IAPT delivered by Self Help Services, and EIP (Early Intervention into Psychosis). This is in line with the Greater Manchester Mental Health and Employment CQUIN described in section 4.2 of this report. We are monitoring the demand for Healthy Manchester services which arises from mental health providers. A piece of work is underway to develop clear pathways between healthcare providers and wider services e.g. Work Clubs, as Healthy Manchester is unlikely to have capacity to meet the referral demand.

2.1.6 The Fit for Work / Healthy Manchester service has been integrated with the Working Well programme, both through a sub-contracting arrangement between service delivery partners (Pathways and Big Life), and through the Manchester Working Well Integration Board, which now oversees both programmes. This will support learning between the two services and will build the evidence on what works for the up-scaling of Working Well. What has been evident from the pilot is that the role of the GP as an influencer on their patients can be extremely effective in encouraging people to engage with a health and employment service.

2.1.7 The expansion of the GM Working Well programme will afford us an opportunity to forward the Health and Work agenda in a number of ways, including the adoption of a 'key-worker' model for identified cohorts and a GP referral pathway. Work on this is ongoing and fits into the wider devolution agenda, however there are some challenges in the delivery of a model which replicates the universal referral route for workless patients, irrespective of benefit type.

2.2 Fit for Work (In work) service

2.2.1 This is a city wide service designed to take GP referrals of patients who are in work but off sick to prevent them from falling out of employment. Manchester City Council has funded this service from April 2013 following on from a GM pilot with a strong evidence base as an early intervention to prevent worklessness. The telephone based service provides condition management advice, access to Cognitive Behavioural Therapy (CBT) and physiotherapy, HR advice and negotiation of return to work plans between patients and employers. The three Clinical Commissioning Groups provided a contribution to funding the service in 2014/5.

2.1.2 ***Clients' views***
The integrated nature of the support that focuses holistically on the psychological and social determinants of health is recognised and valued by clients. Clients who responded to a Pathways survey noted:
"The Service helped me understand how making changes to my lifestyle, could help control my anxiety. I found the support incredibly helpful. "

Similarly,
"The Fit for Work service helped me to better understand my situation and assess my options. It helped me realise that the best decision was to change my choice of employment, taking up a new role and this has proven the right decision to date. The change of culture and environment, where I now feel appreciated and my skills and experience are better used, was a major step on my recovery from the stress-related depression I was suffering from. "

2.1.3 ***GP view***
"Fit for Work makes a big difference to my patients to enable them to have a holistic view of their problems and realistic and manageable goals back into work."

2.1.4 The service has delivered strong engagement from GP practices across the city – 77 practices referred in 594 patients between April 2013 and October 2014. 57% of the referrals were for patients who were off sick with a mental health condition. An interim evaluation of the service during that timeframe found that there were substantial improvements in health and wellbeing and ability of patients to self-manage conditions. Both patients and GPs believed that the service had enabled patients to return to work earlier and prevent the loss of jobs and that it enabled the wider determinants of health to be addressed. It is a relatively low cost intervention which falls well within the NICE cost effectiveness threshold. The programme is estimated to generate a total public value return of £5.74 for each £1 invested.

2.1.5 GPs have provided strong feedback that they find the fast assessment process and rapid access to CBT and physiotherapy highly valuable due to waiting times within existing services. This is reflected by the NHS Five Year Forward View published in November 2014, in which NHS Chief Executive Simon Stevens identified the need for the NHS to support people to move into and stay in employment.

3. Primary Care and Commissioning

3.1 Incentives to integrate work and health pathways

3.1.1 The lack of integration of health and employment services has been identified by the Health and Wellbeing and Work and Skills Boards, as well as practitioners across Greater Manchester as a key challenge within Public Service Reform.

3.1.2 A CQUIN (Commissioning for Quality and Innovation) has been developed for use by GM Mental Health commissioners in relation to mental health and employment. CQUINS are a payment framework which enable Clinical Commissioning Group (CCG) commissioners to reward excellence, by linking a proportion of the healthcare providers' income (up to 2.5%) to the achievement of local quality improvement goals. In Manchester, the Work and Health Delivery Group has led on the development of this CQUIN with the Manchester Mental Health and Social Care Trust.

3.1.3 In Manchester we have co-designed the CQUIN with the CCG City-wide commissioning team. We are also working with them to determine how the City Council and partners will work with the Trust to ensure that monitoring of employment status is effective, staff are trained on work as a health outcome and an integrated local employment offer is in place for the referral pathway. This has led to further discussions about the remodelling of psychological therapy services (IAPT) and how we can integrate a wider offer to improve work and health outcomes for people with mental health issues.

3.2 Routine monitoring of employment status in primary and secondary care

3.2.1 Both Boards have agreed a recommendation that the employment status of patients should be routinely monitored by all health care providers given the health risks associated with unemployment, and patients referred to the right support. This has proved complex to implement, however the following progress has been made.

- Employment outcomes have been included in the ‘One Team’ 2020 Commissioning Specification – the delivery vehicle for Living Longer, Living Better.
- All three CCG Executive Teams have endorsed the proposal to implement routine monitoring of employment status within healthcare provision. This is a requirement of all practices who have signed up to the Healthy Manchester service. Primary Care IT systems are currently being configured to make this a reality.
- Commissioners in South and North Clinical Commissioning Groups have made a request that we work within the redesign of their MSK (Musculoskeletal), pain and rheumatology services, to enable providers to focus on work as a health outcome and create appropriate referral pathways. This marks a significant step forward.

4 Organisational Leadership for Healthy Work

4.1 The significant efforts made at both Manchester and Greater Manchester level to move people back into employment will be limited if the workplace cannot support people with health conditions or contributes to poor health, particularly mental health.

4.2 The health of the workforce is central to the realisation of economic growth ambitions, particularly in the context of longer working lives. The opportunities and incentives that might be utilised through GM Devolution to support the interface between the Health & Care and Work and Skills elements are currently underdeveloped. The NHS Five Year Plan also identifies Workplace Health as a key area through which employers should be incentivised to support health improvement via implementation of recognised workplace health standards.

4.3 The focus should not only be on getting people into employment, but ensuring that those jobs support good health and enable career progression throughout the working life.

4.4 Sick people cost their employer £620,000 per year in businesses employing more than 500 people. Similarly, a DWP report (February 2014) stated that more than 130 million days (ONS) are still being lost to sickness absence every year in Great Britain and working-age ill health costs the national economy £100 billion a year. The report estimates that employers face a yearly bill of around £9 billion for sick pay and associated costs, with individuals missing out on £4 billion a year in lost earnings. Meanwhile, around 300,000 people a year fall out of work and into the welfare system because of health-related issues.

4.5 There is wide variance in practice across public sector partners in relation to local employment and social value. If those in the most disadvantaged neighbourhoods are not beneficiaries of local employment opportunities at scale, the impact of economic growth will not be realised in those neighbourhoods. Whilst there is some good practice in terms of local employment and apprenticeship schemes, the Social Value Act is an under-used mechanism for driving good practice.

4.6 Both the Health & Wellbeing Board and Work & Skills Board have agreed as a first principle that they should work towards being exemplar organisations in relation to workplace health and local economic benefit, and collaborate to set improvement goals and share good practice. The impact on public sector partners in terms of absenteeism and lost productivity is very significant, and current practice lags way behind leaders in the private sector. The first stage of this is a baseline audit across Board organisations. The work has been scoped by a senior management group from Central Manchester Foundation Trust, the three Clinical Commissioning Groups and Manchester City Council.

4.7 The potential reach of this work is to impact on the 40,000 people who are employed by Board organisations in the city, plus their supply chains and local people in the most disadvantaged neighbourhoods.

Appendix 3: Further information on Age Friendly Manchester (AFM) Priority Work Themes

Communication and Involvement

i) Working together
The AFM Communications Group brings together older people, communication experts and local partners give oversight to of all of the programme's communications and engagement activity. Good communication is recognised by the AFM Board and Core team as the cornerstone of effective working with older people, and this group, chaired by the Head of Corporate Services from the Manchester CCGs has an extensive plan to improve the AFM website, support the Manchester Older People's Charter, and promote best age-friendly, practice amongst city agencies.

ii) AFM Ambassador scheme
The AFM Ambassador scheme will have its first meeting in November 2015, bringing together opinion formers and leaders from the city's public and private sectors, in order the 'spread the age-friendly message'.

Knowledge and Innovation

i) Research into practice
The Manchester Ageing Study' led by the University of Manchester, released a short film, and handbook, at the end of June 2015. The full report is due in the autumn. The Life of the City project on the city centre as an age-friendly neighbourhood has completed its desk research and focus groups and an initial report is being considered by the project steering group.

ii) Economic opportunities of ageing
The Organisation of Economic Cooperation and Development launched its new report on urban ageing to a UK audience at the end of June in Manchester, attracting around 70 attendees. The report acknowledges Manchester as being a leading city on this agenda was featured in the Manchester Evening News. The AFM team has worked with New Economy to commission research into economic opportunities for Greater Manchester, which has been published with recommendations for the areas where Greater Manchester needs to focus its efforts.

Other Work areas

A number of topics are emerging as requiring reviews to improve effectiveness and value for money. These are:

i) AFM Locality programme
The AFM programme is currently working on a new approach to delivering its work a local level, including linking with the One Team structures to support older people at risk. The GM Ambition for Ageing programme represents a significant opportunity to develop a new phase of neighbourhood-scale working and learning.

ii) Age-friendly Greater Manchester
The Greater Manchester Ageing Hub working group is developing a programme that will bring together a number of new initiatives and partners, focusing on work in 'midlife', the economic opportunities of ageing populations, and building capacity across the city-region for demographic change.

iii) A review of governance arrangements promoting better involvement
The AFM Older People's Board and Forum and structures were last reviewed a number of years ago and it is timely to involve a wide range of older people and their organisations in a discussion about how they can be best represented in city life over the next five years.

iv) Healthy ageing and promoting physical activity.
AFM will be leading a new project around increasing the levels of physical activity amongst older people, especially in the poorest neighbourhoods. AFM are designing a place-based approach with experts from the local universities, and a national charity, to develop a new model of local delivery.