Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 22 May 2018

Subject: Manchester Population Health Plan

Report of: Director of Population Health and Wellbeing

Summary

The attached Plan was agreed by both the Manchester Health and Wellbeing Board and Manchester Health and Care Commissioning Board in March 2018.

The Plan identifies five priority areas for action and an engagement process is now underway with key strategic partnership groups and boards across the city to secure support for the delivery of the Plan.

Recommendations

The Committee are asked to:
i) Comment on the Plan; and
ii) Identify areas for further scrutiny as part of the annual work programme.

Wards Affected: All

Contact Officers:

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Background documents (available for public inspection):

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

None

Manchester Population Health Plan (2018-2027): Tackling health inequalities

Foreword

The Manchester Population Health Plan is the City's overarching plan for reducing health inequalities and improving health outcomes for our residents.

It reflects the ambition of the Our Manchester Strategy and aims to build on the successes and achievements of the past 20 years, whilst recognising that the population health challenges facing Manchester are considerable. However, the establishment of Manchester Health and Care Commissioning (MHCC), the Manchester Local Care Organisation (MLCO) and the Single Hospital Service (SHS) offer a real opportunity to break the cycle of health inequalities in Manchester and deliver prevention programmes at scale.

The Plan has been developed over the past six months in partnership with a wide range of stakeholders and is an integral component of the refreshed Locality Plan, "Our Healthier Manchester". The implementation of both plans will be monitored by the Manchester Health and Wellbeing Board.

It is also important to highlight that the Plan complements the following current Manchester and Greater Manchester strategies and documents. The successful delivery of these strategies will make a huge positive difference to health outcomes in Manchester, as many of them address the social determinants of health. We know that up to 80% of a population's health status is attributable to factors outside the health services:

- Our Manchester Strategy (2016-2025)
- Manchester Joint Health and Wellbeing Strategy (2016-2025)
- Manchester Locality Plan: Our Healthier Manchester (2016-2021 refresh underway)
- Manchester's Strategy for Enabling Self Care (2016-2020)
- Our Manchester, Our Children (2016-2020)
- Manchester Work and Skills Strategy (2016-2021)
- Manchester Community Safety Strategy (2018-2021, refresh underway)
- Manchester - A Housing Strategy (2016-2021)
- Manchester Homelessness Strategy (2018-2023, refresh underway)
- Manchester Early Help Strategy (2018-2021, refresh underway)
- Manchester Family Poverty Strategy (2017-2022)
- Greater Manchester Population Health Plan (2017-2021)
- Greater Manchester Strategy: Our People; Our Place (2017-2020)

Our vision is that by 2027 the people of Manchester will be living longer, healthier lives and we will have narrowed the health inequalities gap within Manchester and between Manchester, the national average and other comparable cities. We can only do this if we all come together to transform and integrate services and put people at the heart of what we do.

Sir Richard Leese
Chair of the Manchester Health and Wellbeing Board

Introduction

In recent years, Manchester has experienced significant population and economic growth and a vastly improved physical infrastructure. According to the Manchester City Council Forecasting Model (MCCFM), the population of the City has increased by nearly a third since 2001 and forecasts indicate that this growth is likely to continue in the future. The MCCFM suggests that, by 2027, there will be over 661,000 people living in the city, up from 503,000 at the time of the 2011 Census. There has also been a similar increase in the number of patients registered with GP practices in the City.

However, the benefits of this growth have not been felt equally by all sections of the population or areas of the city and economic improvements have not been matched by similar improvements in health outcomes or a narrowing of inequalities within Manchester. Statistics consistently show that residents of Manchester still have some of the worst health outcomes in England. People living in Manchester continue to experience higher levels of ill health and early death than other major cities and towns in England. Inequalities within the City also persist. Figures show that there are 3.5 times as many premature deaths (deaths under the age of 75) in the most deprived parts of Manchester (primarily in the north east of the city and in parts of Wythenshawe) compared with the least deprived parts. A summary of the key population health indicators for Manchester is provided in Appendix 1. A more comprehensive set of statistical information is available in the latest edition of the Manchester Compendium of Population Health Indicators (www.manchester.gov.uk/jsna).

Improving health outcomes across the whole of the population and reducing variations in health between different parts of Manchester will therefore be a key test of the success of the Population Health Plan and of the transformed health and care system as a whole.

This plan is being written at a time of great opportunity for the health and wellbeing of the people of Manchester. The Greater Manchester devolution deal has driven a major programme of change and reform, with increased local powers in areas such as transport, housing, planning and criminal justice. Significantly, devolution of the health and social care spending and decision making to Greater Manchester has facilitated a change to Manchester's organisational landscape.

We now have one strategic commissioning function - Manchester Health and Care Commissioning (MHCC), a partnership between Manchester City Council and NHS Manchester Clinical Commissioning Group. The organisations that provide community, health, social care, primary care and mental health services have started working in partnership to co-ordinate and join up out-of-hospital care as Manchester Local Care Organisation (MLCO). The MLCO will drive forward a place-based approach to service delivery in 12 neighbourhoods, allowing local people to play a greater role in the design, delivery and management of their health and care.

Furthermore, the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM) on 1 October 2017, to create Manchester University NHS Foundation Trust (MFT), is already demonstrating a number of significant benefits to patients and the public. The second stage of the Single Hospital Service (SHS) Project is now underway and this will see the transfer of North Manchester General Hospital, currently part of Pennine Acute Hospitals NHS Trust (PAT), into MFT.

During the engagement events to develop this plan, people spoke highly of Manchester's thriving Voluntary, Community and Social Enterprise Sector (VCSE). There were many examples of initiatives that have improved the wellbeing of local people, and a wealth of knowledge and insight about Manchester's communities. There are over 3,000 organisations delivering valuable services across the city, supported by over 100,000 volunteers. They will be key partners in the delivery of this plan.

This is also a time of great financial challenge across the public sector, with a knock-on effect on residents and communities, and rising demand for services provided by both statutory and non-statutory agencies. The organisations that commission and provide health and social care services are under increasing pressure and it has been estimated that without major transformation the health and care system will face a financial shortfall of £135 million by the end of 2020/21.

A major aspect of this transformation will be a much greater focus on self care and supporting people to take greater responsibility for their own health. This is a cross cutting theme for all of the priorities set out in the Plan and we will accelerate progress on the implementation of the Self Care Strategy agreed by the Manchester Health and Wellbeing Board in June 2016.

Finally in delivering this plan the greatest opportunity will come from applying the principles of Our Manchester and ensuring that all public services, the VCSE and other sectors come together in new ways to address the wider determinants of health. MHCC and the MLCO, supported by the City Council, will need to work with a much wider range of public and non-public sector organisations outside of the health and care system including: Greater Manchester Police (GMP), the Greater Manchester Fire and Rescue Service (GMFRS), schools and colleges, registered housing providers and private landlords, local developers and businesses. For example, MHCC and the MLCO have a key role in the emerging regeneration plans for the area towards the north of the city centre (the 'Northern Gateway') in order to assess the potential health impacts of the regeneration proposals and to understand and respond to the implications of population growth for service provision and integrated community care in that part of the city.

Where we need to focus our efforts

The Marmot Review into health inequalities in England outlined priority areas for action to narrow the gap between the healthiest and the least healthy. The report, 'Fair Society, Healthy Lives', asserted that we must address the conditions in which people are born, grow, live, work and age - the social determinants of health. This includes creating the conditions for people to take control of their lives, to have a voice and to have a greater sense of ownership and personal responsibility.

This aligns with the Our Manchester approach; focussing on what people say matters most to them, and building strong, connected, resilient communities. We need to foster strengths based, collaborative working that enables residents and communities to be active partners in their health and wellbeing. A strengths based approach is one that concentrates on the inherent strengths of individuals, families and communities. This is key to improving self care and greater responsibility for health and wellbeing, which in turn empowers residents, improves outcomes and reduces demand for services.

Improving health and wellbeing requires us to take action at every stage in a person's life, from before they are born until the end of their life. Narrowing the gap in health outcomes also requires more intense support and resources for the communities and parts of the City with the greatest needs. We know that people in more disadvantaged communities have worse health outcomes across all age groups. Moreover, some minority ethnic groups and people from lesbian, gay, bisexual and transgender (LGBT) communities can also experience worse health. Other groups, such as refugees and asylum seekers, disabled people, and people experiencing homelessness may also face barriers to accessing services and employment opportunities which can have an impact on their health and wellbeing.

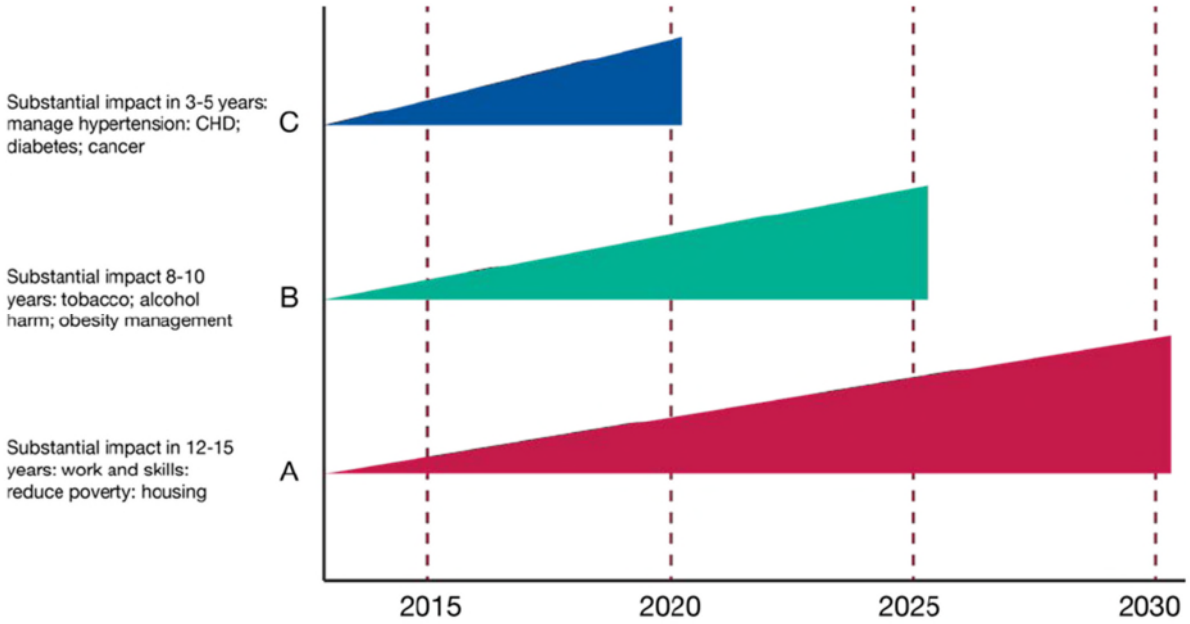
The Plan has been informed by the evidence from research, national and international best practice and local population insight. Manchester's local knowledge and intelligence includes both high quality evidence and quantitative data, and the information we gather from communities and people with lived experience. This approach is exemplified by the Manchester Joint Strategic Needs Assessment (JSNA) (www.manchester.gov.uk/jsna). The JSNA is co-produced with topic specialists and VCSE organisations and provides a continually updated body of intelligence and insight about the health needs of the City's population and the opportunities for addressing them.

Research has shown that prevention initiatives targeting social determinants of health, building resilience or promoting healthy behaviours can give a return on investment in both the short-term and the long-term, and that small investments can have large gains. Mental health promotion, promoting physical activity, housing insulation, healthy employment programmes and lifestyle diabetes prevention programmes are all examples of interventions that can show returns within one to two years. A focus on prevention and early help by all agencies will reduce future demands on more expensive public services.

Figure 1: Cost-Effective Public Health Interventions

Source: World Health Organisation (WHO). The case for investing in public health April 2013

Figure 2: Impact of population health interventions over time



Source: Public Health England (PHE). Reducing health inequalities: system, scale and sustainability. August 2017

Based on the above, we have identified five priority areas for action to be delivered over the lifetime of this plan. The priorities were refined following engagement with local stakeholders and build on existing exemplar programmes. A picture summary of feedback

from the engagement process is provided in Appendix 3 under the five priority headings.

The five priorities

1. Improving outcomes in the first 1,000 days of a child's life
2. Strengthening the positive impact of work on health
3. Supporting people, households, and communities to be socially connected and make changes that matter to them
4. Creating an age-friendly city that promotes good health and wellbeing for people in mid and later life
5. Taking action on preventable early deaths

The body of the plan will describe the following for each priority; why it is important with a summary of the rationale and evidence base; where we are now in Manchester; what we will do in the City under the governance of the Health and Wellbeing Board; and an example to illustrate our local approach.

The actions under "What we will do" have been presented within a specific priority for simplicity, but they are not meant to be mutually exclusive and will clearly contribute to other priorities. They include life course specific actions as well as actions that are important irrespective of a person's age or experience. Further information on where we are now and opportunities for action for specific issues can be found in the comprehensive JSNA and references for accessing important "facts and figures" have also been included in Appendix 3.

What we want to achieve

The Plan will be integral to the achievement of the five strategic aims of the refreshed Locality Plan, "Our Healthier Manchester" (see Figure 3) and will ensure that there is a sustained focus on reducing health inequalities between Manchester and the England average and between different areas within the City. The key measures of success for each priority area are presented in Table One below.

Figure 3 : Manchester Locality Plan

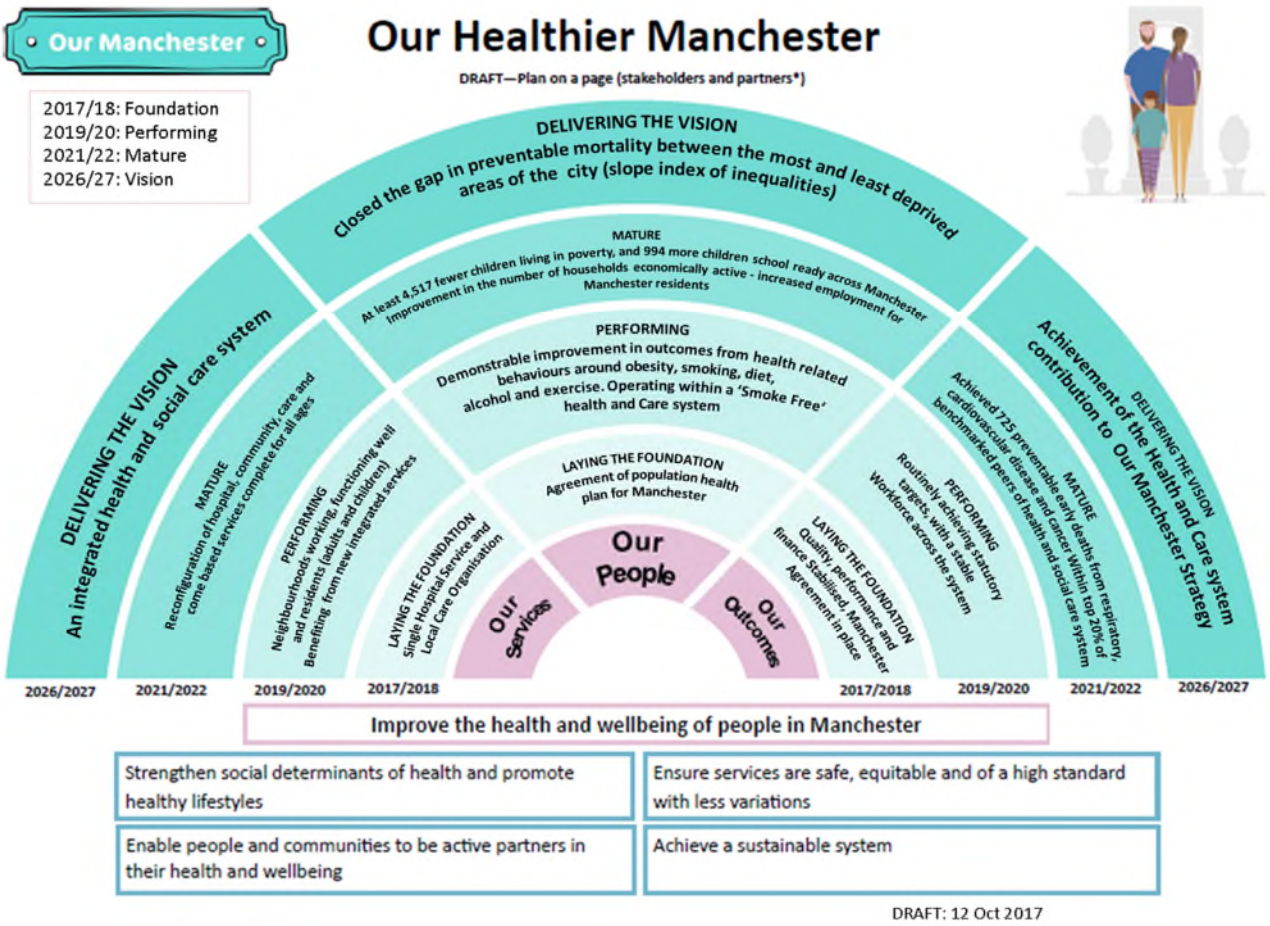


Table One - Measuring Success

The main overarching measure of success will be the extent to which we narrow the life expectancy gap between residents in different areas of the city and more broadly between Manchester residents and England as a whole.

Priority	Key measures of success
Improving outcomes in the first 1,000 days of a child's life	• Reducing the rate of infant deaths • Reducing the rate of mothers smoking in pregnancy • Reducing the proportion of low birth weight term babies • Increase rates of breastfeeding • Reducing the number of children (0-4) admitted to hospital with dental decay • Increasing the proportion of children who

	are ready for school
Strengthening the positive impact of work on health	● Reducing the rate of health related worklessness ● Improve the connections between out of work assets such as local work clubs ● Increasing the number of people with health problems helped back to work quickly ● Increasing recruitment of local people in health and care organisations
Supporting people, household, and communities to be socially connected and make changes that matter to them	● Reducing the rate of child poverty ● Reducing levels of fuel poverty ● Reducing the number of people experiencing homelessness and rough sleepers ● Increasing the proportion of people involved in decisions about their health and care ● Increasing the proportion of people confident in their ability to manage their own health
Creating an age-friendly city that promotes good health and wellbeing for people in mid and later life.	● Increasing the employment rate among the over 50s ● Increase in proportion of life years spent in good health (Healthy Life Expectancy) ● Reduction in rate of older people being admitted to hospital for falls related injuries
Taking action on preventable early deaths	● Increasing uptake of cancer screening and immunisation programmes ● Increase in the proportion of cancers diagnosed at an early stage ● Reduction in the proportion of adults who currently smoke ● Reduction in the proportion of adults who are physically inactive ● Reduction in proportion of adults reporting low levels of life satisfaction ● Reducing the rate of preventable premature deaths from CVD, cancer and respiratory diseases ● Reducing the rate of suicide ● Reducing the gap in preventable premature deaths between the most and least deprived areas of the city

For some of these success measures, we have agreed specific targets and improvement trajectories. These targets form part of our contribution to the aspirations set out in the Greater Manchester Population Health Plan and Manchester, along with the other nine

local authorities, has committed itself to improving local outcomes in line with these aspirations. Achieving Manchester's share of the Greater Manchester targets would mean that in five years time we would have:

- 916 more children starting school ready to learn, ultimately leading to better educational attainment
- 76 fewer very small babies (under 2,500g) being born
- 4,558 fewer children living in poverty
- 146 fewer children, aged between 0-4 years, being admitted to hospital with dental decay
- 383 fewer early deaths from Cancer considered preventable
- 174 fewer early deaths from Cardiovascular Disease (CVD) considered preventable
- 168 fewer early deaths from Respiratory Disease considered preventable
- 653 fewer people aged over 65 being admitted to hospital due to a serious fall
- smoking prevalence amongst adults down to at least 15%

The outcomes have also been included in the outcome frameworks that we have developed for the Locality Plan and the Manchester Local Care Organisation (MLCO). We will closely monitor and track those measures for which we have not set specific local targets, in order to make sure that we are making the necessary improvements over time and relative to other similar areas within England. This will involve collecting local data and intelligence in a timely fashion that allows us to respond earlier to problems as they arise (e.g. work on infant mortality).

Priority 1 - Improving outcomes in the first 1,000 days of a child's life

Why is this important?

Giving every child the best start in life was highlighted in the Marmot Review as being absolutely crucial if we are to improve health outcomes and reduce health inequalities in later life. The first 1,000 critical days, from pregnancy up to the age of two, is a peak period of growth for the brain to achieve its optimum development and nurturing. When a baby's development falls behind the norm during the first years of life, it is more likely to fall even further behind in subsequent years than to catch up with those who have had a better start.

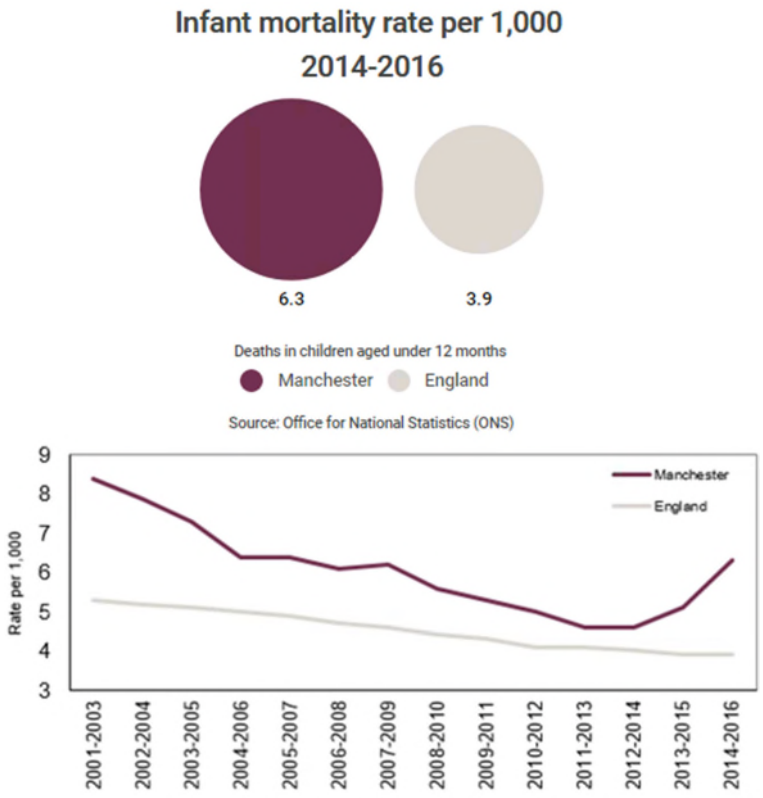
The foundations of physical, emotional, social and cognitive health and development are all set early - starting in the womb - and a poor start can have a lifelong negative impact on mental and physical health and brain development, including childhood obesity, educational attainment and future economic status. It is important to invest in early years education, have high quality maternity services and parenting support and build resilience and wellbeing in young children across the social gradient. There is evidence that interventions later in the life course are less effective when following a poor start in life.

Where are we now?

Infant Mortality

Infant mortality (deaths of children under 12 months) is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions.

Figure 4: Infant mortality



Prior to 2012/14, Manchester had seen a downward trend in infant mortality, at a greater rate than for the North West or England. In more recent years Manchester has seen increases in infant mortality, from a low rate of 4.6 deaths per 1,000 live births in 2012/14 to a rate of 6.3 in 2014/16. This is now significantly worse than the rate for the North West (4.5) and England (3.9).

Smoking in pregnancy

Smoking during pregnancy can cause serious health problems for the mother and baby, including complications during pregnancy and labour. Smoking during pregnancy carries an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy.

Figure 5: Smoking at time of delivery

Manchester has a higher percentage of mothers smoking during pregnancy than England. The percentage of mothers smoking has fallen between 2011/12 and 2016/17 and the percentage in Manchester has fallen at a greater rate than for England.

Low birth weight

Low birth weight increases the risk of childhood mortality and developmental problems for the child and is associated with poorer health in later life. Low birth weight (defined as weighing under 2,500g) at term can be caused by a number of factors including smoking, substance misuse and emotional and physical health problems. Babies born to women who smoke weigh, on average, 200g less than babies born to non-smokers.

Figure 6: Low birth weight of term babies

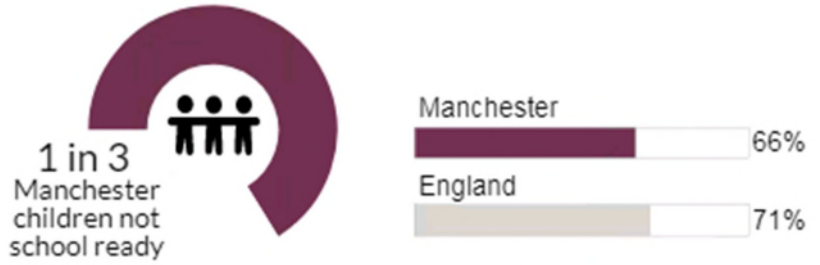
Source: Office for National Statistics (ONS)

Manchester still has a significantly higher percentage of low birth weight term babies than England despite improving at a faster rate than England between 2005 and 2015.

School Readiness

Some children from poorer backgrounds are much more at risk of poorer development and the evidence shows that differences by social background emerge early in life. A child's early experience is shaped by factors including their socioeconomic status, their experiences with their parents/carers and their experience in education. High-quality early education is crucial in countering the effects of socioeconomic disadvantage as is ensuring children are assessed and supported to reach their learning and developmental milestones from birth, such as communication and language skills, gross motor skills (e.g. rolling over), fine motor skills (e.g. picking up small objects), problem solving skills and personal social skills.

Figure 7: School readiness 2016/17



Source: Department for Education (DfE), Early Years Foundation Stage (EYFS) Profile

In 2016/17, 66.2% of children in Manchester achieved a good level of development at the end of Reception. Although levels of school readiness in Manchester remain lower than those across England as a whole, our local figures have been improving over the period since 2012/13, narrowing the gap between the Manchester and England averages.

What we will do

- Deliver a targeted programme that responds to local intelligence on infant deaths (infant mortality).
- Provide holistic support for maternal mental health, particularly during the perinatal period (immediately before and after birth)
- Adopt a 'think family' approach that recognises the broader social and family factors that impact on a child's health, such as housing, poverty and the impact of parental behaviour on children's health and wellbeing
- Work together to transform and commission children and young people's community health services more effectively
- Support pregnant women to give up smoking during pregnancy through implementing the Greater Manchester Baby Clear programme in maternity services
- Increase uptake of flu vaccination for pregnant women and uptake of immunisations and vaccinations for babies and children
- Work together to safeguard children and protect them from harm, including safer sleeping awareness and abusive head trauma prevention work
- Increase city wide breastfeeding initiation and continuation through various initiatives including the provision of an Integrated Infant Feeding Service in North Manchester and create a more welcoming environment for mothers breastfeeding in public
- Work with families to maintain healthy weight and prevent obesity and to improve dental health by identifying issues early and offering interventions, both during pregnancy and with babies and children. The focus on childhood obesity must be sustained beyond early years and a comprehensive programme for all school age children will be developed with the Manchester Local Care Organisation.

- Implement and evaluate the new Strengthened Health Visiting Model for families needing additional support, such as teenage parents and care leavers and ensure there is sufficient capacity to meet future population growth and complexity.

- Ensure that children are assessed and supported through interventions to reach their learning and developmental milestones from birth, through timely access to Healthy Child Programme (HCP) Checks and Early Help Assessments and interventions such as Speech and Language Therapy (SALT), mental health services and Early Help services.

Manchester's Health Visitors and Outreach Workers work together to give children the best start

The Early Years Delivery Model (EYDM) aims to increase the number of children who are ready to learn at two years old and ready for school at five years old. Teams of health visitors and outreach workers work together using an 8 stage assessment pathway at key stages in a child's life from pre-birth to 5 years of age. Evidence-based interventions, relating to parenting and child development, are applied for children and families identified as making less than expected progress in child development and parental attachment. Additional support is given to address barriers to achieving success, such as low skills or worklessness, engagement with health checks, take up of free childcare and early learning. The example below shows the impact that Manchester's Early Years Delivery Model can have with Health Visitors and Outreach Workers working together and offering support to families.

A family made up of Mum, Dad and an 11 month old child, came to Manchester from abroad. Mum was pregnant and had a traumatic, unplanned birth at home, assisted by Dad. An Outreach Worker from the local Sure Start Centre and a Midwife made a joint home visit and encouraged Mum to attend the Sure Start Centre for a baby play session and the healthy child drop-in clinic. The family were living in a small, dark and damp private rented flat. Dad was working very long hours, Mum had social anxiety and found it difficult to leave the house and the 11 month old baby had few toys, little space to play and was upset due to Mum's anxieties.

The Outreach Worker built up a good relationship with the family and worked with the Health Visitor and Midwife to complete an Early Help Assessment. Emotional, health, social and practical support for the family was organised including: access to local Children's Centre services; housing advice, hospital appointments; diagnosis and hospital treatment for Mum's postnatal depression and toys for the children.

The family now live in a more suitable house. Mum is happier and attends regular outpatient review appointments with a Psychologist. Mum feels empowered to do things under her own initiative and is able to contact her Outreach Worker if needed. Both children are now meeting their learning and developmental health milestones so they are on track to be ready to learn. Mum said: *"Thank you for being there for me and my children and being so supportive. So very thankful especially for you (Outreach Worker) and my Health Visitor".*

Priority 2 - Strengthening the positive impact of work on health

Why is this important?

The Marmot Review outlines the links between work, health, and health and social inequalities. Being in good employment can protect health and wellbeing, whilst unemployment can have short and long-term effects on health and is linked to increased rates of long-term conditions, mental illness, and unhealthy lifestyle behaviours. Access to good quality work (i.e. sustainable, offering a living wage, with opportunities for development and flexibility to balance work and family commitments, with protection against adverse working conditions) is central to reducing health inequalities and improving health and wellbeing.

The positive impact of employment, and the negative impact of unemployment, affect the whole population across the lifecourse, influencing the lives of children, adults and older people living in the city. Work can have a major positive impact on health and wellbeing through both economic reward and participation in society. For young people a bad early experience in the job market can have a lasting effect for many years. Increasing the skills of, and employment opportunities for families will contribute to improving education and training outcomes for them and their children and so will contribute to the wider ambition to reduce their social exclusion, health inequalities and family and child poverty. For adults and older adults, intermittent and unstable employment results in reduced self esteem and confidence and poorer mental and physical health.

Where are we now?

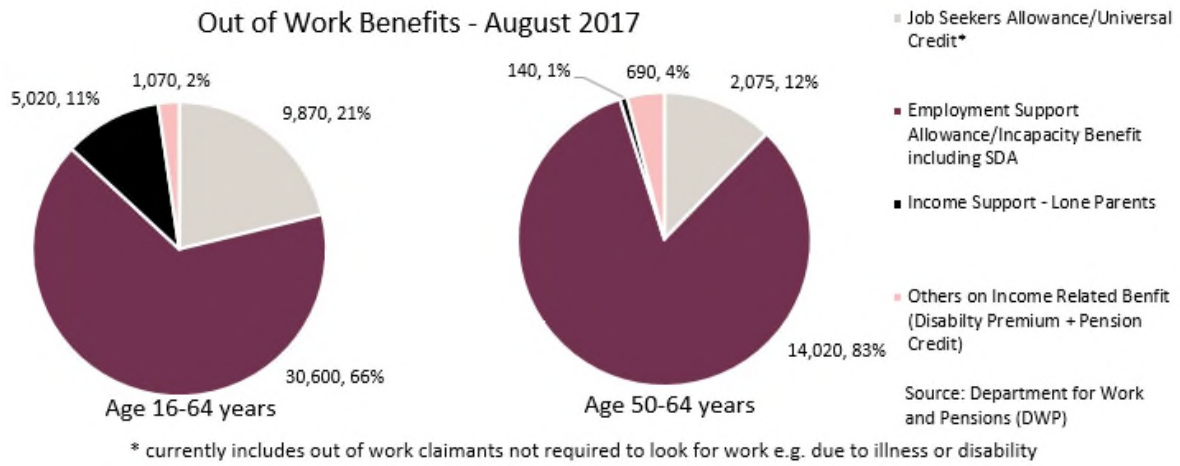
We have a well established Work and Health Programme in Manchester endorsed by the Health and Wellbeing Board and the Work and Skills Board. The primary care led Healthy Manchester (people out of work with a health condition) and Fit for Work (people in work but off sick) services have informed the development of the Greater Manchester Working Well/Early Help Programme.

Out of work benefits

High rates of health-related worklessness have persisted in the city during times of economic growth as well as during the economic downturn. Getting back into employment increases the likelihood of reporting good health and boosts quality of life.

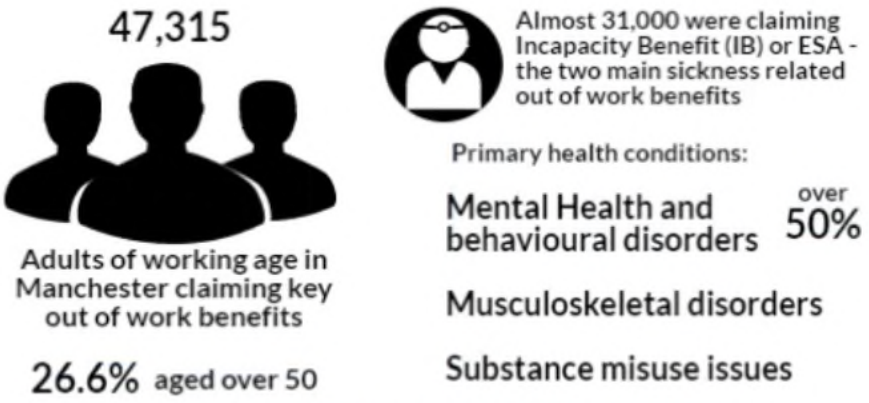
Almost 31,000 people are claiming sickness related out of work benefits, with mental health and behavioural disorders, musculoskeletal disorders and substance misuse issues being the top three most prevalent causes of sickness absence.

Figure 8: Breakdown of types of benefits claimed



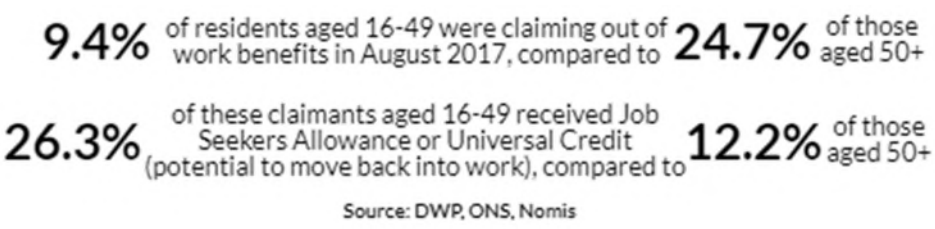
* currently includes out of work claimants not required to look for work e.g. due to illness or disability

Figure 9: Sickness related benefits



In the 50-64 age group 24.7% residents are claiming out of work benefits (9.4% in the under 50s) whilst only 12.2% of the 50-64 age group are claiming benefits with the potential to move back into work (26.3% in the under 50s).

Figure 10: Age profile of benefit claimants (August 2017)



These levels of benefit claimants both reflect and reinforce the health and social inequalities and comparatively poorer health of the 50-64 age group.

Getting back to work

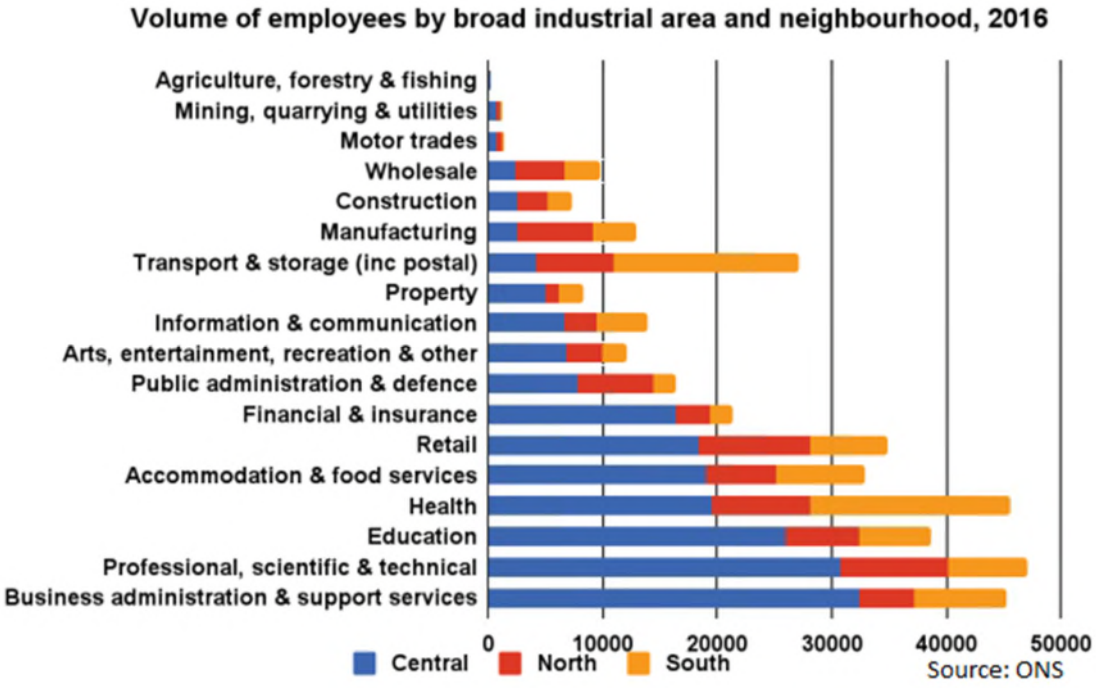
A key part of a more proactive approach is maximising opportunities to refer residents to health and employment services and to connect residents to community assets such as community work clubs.

Figure 11: Out of work assets

Employment sectors

Training and support is required to improve access to jobs in the major employment sectors and health and care is by far one of the largest employers in the city.

Figure 12: Manchester residents' employment by industry



What we will do

- Integrate the evidence based programmes that support residents to stay in, and get back into work as part of the wider wellbeing service offer to residents
- Pilot a joint initiative with Job Centre Plus, for people newly unemployed with a

health condition, under the Greater Manchester Working Well/Early Help Programme

- Increase employment rates for the over 50s by developing "Age Friendly" approaches within the existing employment support system and strengthen links between over 50s seeking work and the sectors where there are large numbers of vacancies and skills shortages e.g. the health and social care system

- Encourage all Manchester health and care organisations to recruit more local people with targeted support for disabled people, those people in mid life with long-term health conditions, other under-represented groups and through the Apprenticeship Levy.

- Continue to target support programmes for households with children to reduce the cycle of unemployment across generations

- Encourage a positive attitude to work and career aspirations for young people through good work experience and meaningful job opportunities

- Support more people who become disabled or acquire a health condition to start or stay in work through good employment practice such as flexible recruitment and in work support.

- Promote good employment conditions across all employers, with Manchester public sector organisations acting as exemplars by implementing the recommendations of the 2017 Workplace Health Baseline Assessment (Health and Wellbeing Board) and prioritising social value through procurement and other processes.

- Develop more opportunities for volunteering and training to improve self esteem and social connectedness with specific target groups (e.g people with substance misuse problems)

- Improve health and work outcomes through in-house policies and service commissioning e.g. host young disabled people to gain work experience and a job through supported internships

The journey back to work

Manchester has a citywide GP referral service, working with people who are finding it difficult to find work because of ill health and related problems. Those referred must be of working age (16-64 years), not in work and experiencing wider issues impacting on their health that medical treatment alone cannot address.

Following assessment by a case manager, an intervention programme is designed to meet the individual's needs in relation to their current circumstances, health and wellbeing and condition management, all of which can affect their employment potential. For those people who have a desire to find employment, specialists will support them to find work that would suit their health condition, vocational aspirations, skills and qualifications. People will also receive guidance and advice on employment skills and

how to have effective conversations with potential employers and agree the optimum level of role/responsibility to maintain healthy mental wellbeing.

An example of how the service works can be demonstrated by a positive outcome for an out-of-work woman in her mid-30s suffering with long term depression. In the past, her low mood and frustrations had led to self-harm and attempted suicide.

Following a referral from her GP she was provided with a range of support including motivational interviewing to incorporate changes to routines, counselling to enable her to understand her depression and anger and confidence-building to apply for jobs and attend interviews. The programme also provided wellbeing advice, addressing her increased alcohol intake related to boredom/lack of routine and exploring alternative activities to relieve stress.

Her outcomes included a better understanding of how to manage situations more positively by thinking about them differently and gaining the confidence to enable her to successfully apply for a job and gain employment.

Priority 3 - Supporting people, households and communities to be socially connected and make changes that matter to them

Why is this important?

The conditions into which people are born, grow, live, work and age - the social determinants of health - are largely responsible for the gap in health outcomes between the healthiest and least healthy in society. These conditions such as good work, education, housing and social connections have a much larger influence on a population's health and wellbeing than healthcare services.

Fuel poverty is experienced by households which are unable to maintain an adequately heated home at prices they can afford. It can cause exacerbations of chronic conditions, with an increase in hospital admissions and deaths in the population during winter. It also has a negative impact on mental health.

The physical environment is also important for health. Accessible and pleasant surroundings can help people be more physically active, feel safe and secure and access the services they need. Poor air quality can worsen existing respiratory conditions such as asthma and Chronic Obstructive Pulmonary Disease (COPD) in the short term, and long-term exposure contributes to early death rates.

Social isolation is harmful to health and has been reported to be as damaging as smoking 15 cigarettes per day. Connected communities where people feel valued and involved in decisions that affect them, have a greater sense of control over their daily lives, and this can have a positive impact on their health and wellbeing. Communities may be groups of people living in the same place or people that share a common identity, experience or interest.

Where are we now?

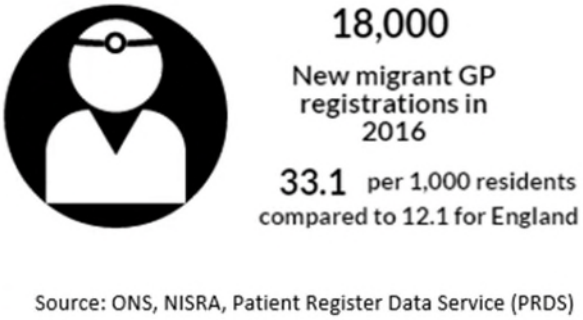
Health inequalities and Manchester's communities

In Manchester there are some big variations in health outcomes between different parts of the city and the communities living in it. For example, life expectancy is 8.1 years lower for men and 7.0 years lower for women in the most deprived areas of Manchester than in the least deprived areas.

Migrant communities

Manchester is also a very ethnically diverse city with a range of new migrant communities arriving in recent years. Each of these communities have particular health issues associated with their cultural background and experiences that need to be addressed in order to ensure that health inequalities within the city do not widen further.

Figure 13: New migrant GP registrations



Homelessness

Manchester also has a major challenge in dealing with the impact of homelessness on health, not just the rough sleeping population but also those living in Bed and Breakfast and hostel accommodation and those families registered as homeless.

Figure 14: Homelessness and rough sleepers

Carers

Manchester has a large community of carers, with approximately 15,000 people at the time of the last Census reporting that they provided some level of unpaid care. This figure is likely to have increased significantly over the past 7 years.

Figure 14: Residents providing care

Young People who have experienced care

Manchester has a high number of looked after children compared to the national average and the average for other core cities.

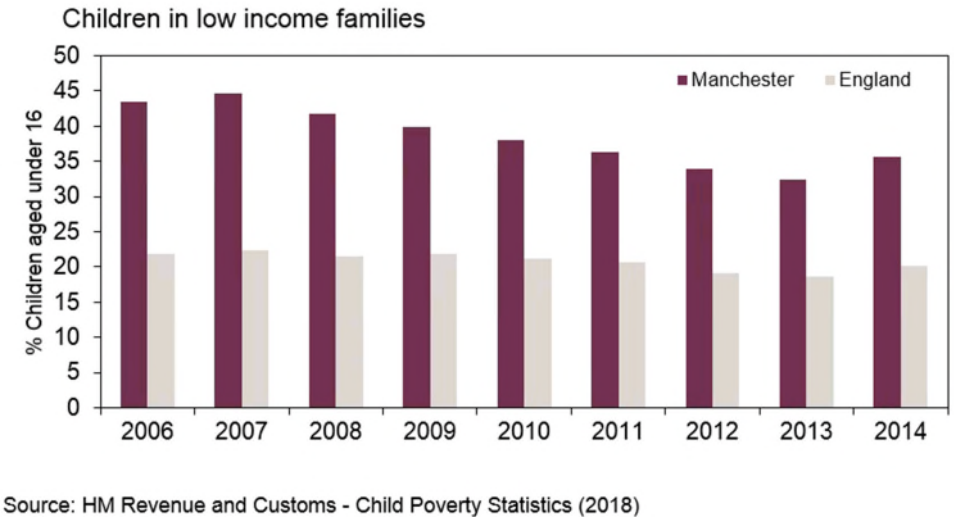
Figure 15: Manchester's care experienced young people

Research and inspection reports show that the quality of support for care leavers could be improved and that their journey through the first decade of adult life is often disrupted, unstable and troubled. They often struggle to cope and this can lead to social exclusion, long term unemployment or involvement in crime.

Child Poverty

Child poverty is defined as the proportion of children living in families in receipt of out of work benefits or tax credits, where their reported income is less than 60% of the median income. It is associated with a range of adverse health outcomes. Manchester has one of the highest rates of child poverty with 35.6% of children under 16 living in poverty; this equates to roughly 36,255 children. Of those living in poverty, the vast majority (70%) are living in out-of-work poverty and 14% are living in in-work poverty.

Figure 16: Child poverty



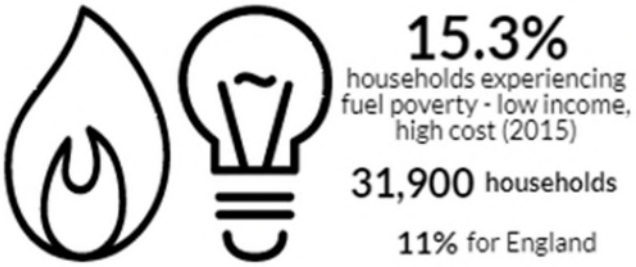
Source: HM Revenue and Customs - Child Poverty Statistics (2018)

Fuel Poverty

Fuel poverty is experienced by households which are unable to maintain an adequately heated home at prices that they can afford. The links between fuel poverty and poor health outcomes are well documented. Illnesses exacerbated by living in a cold home also put

additional pressures on health services. Levels of fuel poverty in Manchester are significantly higher than the England average.

Figure 17: Fuel poverty

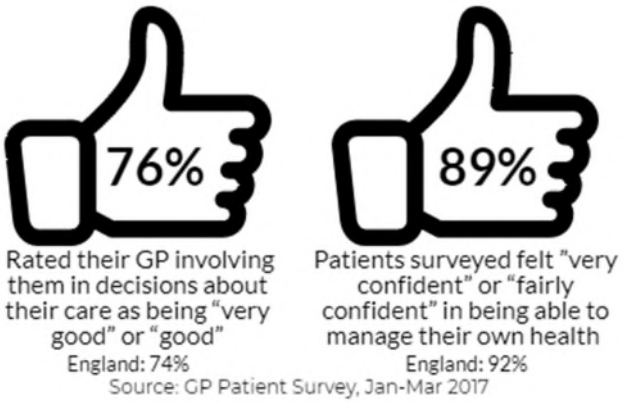


Source: Department for Energy and Climate Change

Support for self care

The national GP Patient Survey for the period January to March 2017 showed that a high proportion of those surveyed in Manchester rated their GP as “good” or “very good” for involving them in decision making, and the majority were confident in their ability to manage their own health.

Figure 18: GP Support for Self Care



Source: GP Patient Survey, Jan-Mar 2017

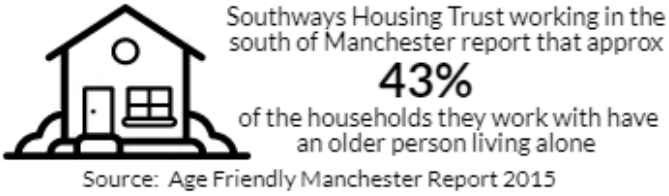
The Adult Social Care Survey (2016/17) indicated that residents of Manchester in receipt of services feel slightly less in control of their daily lives compared to England, but the majority (87.5%) feel the services they receive help them to have control.

Figure 19: Control of daily life - adult social care

Social isolation

Although Manchester has a smaller proportion of residents aged over 65 compared to England, there are parts of the City that have large numbers of older people living alone. Community groups tell us that social isolation is also an increasing problem among younger adults.

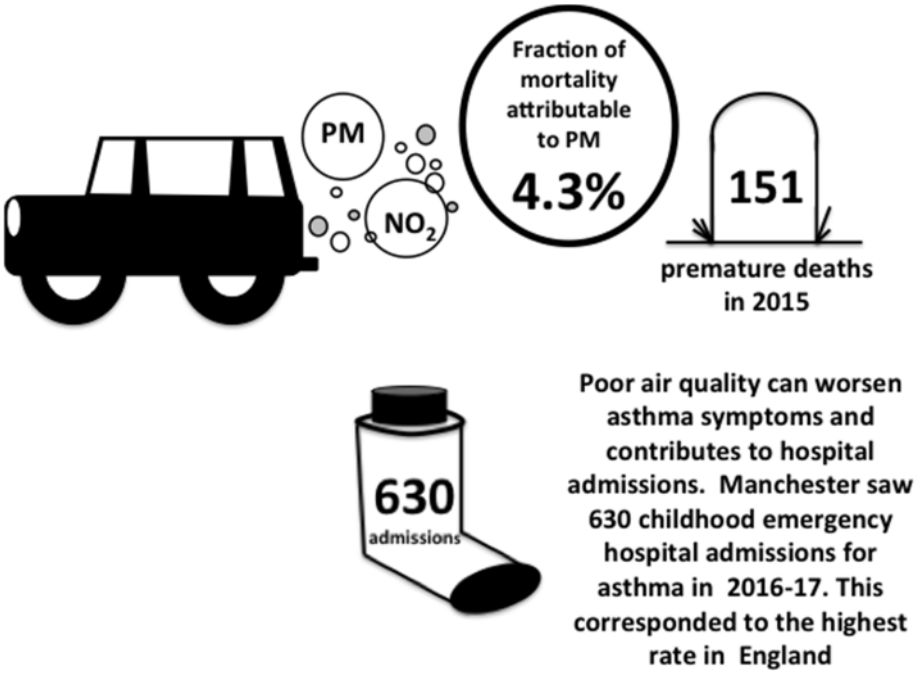
Figure 20: People living alone



Air Quality

As with other large urban centres with high levels of traffic, Manchester suffers from episodes of poor air quality, including high concentrations of particulate matter (PM) and Nitrogen dioxide (NO_2). Environmental Tobacco Smoke (ETS) is a major source of indoor air pollution.

Figure 21: Impact of Air Quality (indoor and outdoor)



What we will do

- Take forward the work of the Health and Homelessness Task Group, to better integrate primary care, mental health and substance misuse services that will improve outcomes for the homeless population in Manchester.

- Ensure that there are effective arrangements in place to support care leavers with their health, housing, education and employment needs when they leave care.

- Develop and deliver an inclusion health strategy to address the needs of other vulnerable or marginalised communities including new migrants and asylum seekers.

- Listen and respond to what local communities say about how to improve their surroundings in a way that supports good health; invest in community capacity building; and facilitate more opportunities for people to connect, collaborate and find local solutions for better health and wellbeing.

- Develop and deliver an infrastructure for person and community centred approaches to health and care services, through the Prevention Programme. The programme encompasses a number of initiatives including Be Well - the citywide social prescribing model or “one stop shop”, connecting people to sources of support for health and wellbeing within their communities.

- Support Manchester Local Care Organisation’s neighbourhood teams to develop and deliver action plans for population health and wellbeing collaboratively with neighbourhood partners, using the Health Development Coordinator role. Neighbourhood partners include local employers, housing providers and schools, as well as community groups and residents.

- Provide accessible information on community resources for practitioners and professionals to support self care.

- Extend the development and delivery of the workforce development programme for enabling strengths based conversations and person centred care (Person, Partner, Place) and embed approaches to reinforce workforce behaviour changes that enable self care.

- Develop and improve access to technologies that give people greater control over their health and wellbeing.

- Reduce the harm caused to individuals and communities by problematic substance misuse and strengthen partnership work to reduce the crime impacts caused by alcohol and drugs particularly in relation to the Evening and Night Time Economy (ENTE).

- Develop and deliver a coherent programme to support children; people with long-term conditions; and vulnerable adults to have a healthy, warm and safe home environment, including improving access to available funding.

- Expand the Early Help work with children, families and adolescents to include single adults. Early Help works with people to identify and put into place information, advice, and support to reduce the need for social care services.

- Support the local implementation of the Greater Manchester Air Quality Action Plan (AQAP), including strategies to reduce emissions; increasing travel by sustainable means; and promoting the use of green spaces. The 2018 Public Health Annual Report will have a single issue focus on Air Quality.

Urban Village Medical Practice - The road to home and health

Urban Village Medical Practice is a GP practice based on the outskirts of the city centre. The practice specialises in providing healthcare and support for homeless people. The Practice works closely other agencies to coordinate care and facilitate social support

A 28 year old man was sleeping rough, injecting drugs and funding his drug use by begging at a nearby train station. He had attended A&E 24 times in the previous 12 months and had been admitted six times – due to complications of injecting drugs but also for warmth and shelter overnight. He tended to discharge himself, before successful treatment of his physical health and so kept returning. At this point he had no GP, was not engaged with drug services, had no benefits in place and no plan for accommodation.

Over a period of a couple of months, a case manager from Urban Village Medical Practice traced him in the community and made repeated attempts to engage him without success. However, when he was admitted to hospital again, the case manager and the GP were able to establish a rapport with him and negotiate with him to remain in hospital to complete his treatment. They established treatment for his drug problem whilst he was there, explained the consequences of not completing the treatment for his physical health issues during his current stay and liaised closely with the ward staff

during the whole of his stay.

During this time, the case manager worked with him to prepare for an effective and safe discharge. This included registering with Urban Village, supporting him to attend the drop in sessions, and setting up the continuation of drug treatment at the practice. The manager also as facilitated a benefit claim and a homelessness assessment which resulted in temporary accommodation.

He remained engaged with treatment and support from the service following discharge and has not returned to the hospital since. Twelve weeks following discharge he felt in a position to make contact with his family again and made the decision to live with them. The practice facilitated the transfer of his treatment and identified a local GP practice.

This is a great example of services working together to support someone to make important changes to improve their health and wellbeing and reconnect with their family.

Priority 4 - Creating an age-friendly city that promotes good health and wellbeing for people in mid and later life

Why is this important?

Older people can face a number of challenges around social inclusion as they move into later life including poor or inadequate housing, declining economic activity, deteriorating health and risks of social isolation and loneliness. The suitability and age-friendliness of neighbourhoods is a key factor in determining outcomes for older people, both in terms of their lived experience and their health and wellbeing. These are all factors in the level of demand placed upon health, social care and housing services.

Shifting demographics and significant growth in the number of younger people living in cities means many older residents live in areas which are changing and developing to meet the needs of a younger population. Consequently many older people feel left behind, becoming more isolated and living in communities which do not meet their needs.

Older people experience high levels of economic disadvantage. Being in good employment beyond the age of 50 not only supports financial resilience but also promotes positive emotional wellbeing and opportunities to remain socially connected. Employment in people over 50 further functions as a key asset that is strongly predictive of improved health expectancy.

Older people often experience inequalities as a result of ageism and the negative images used to represent them across a range of media. This can result in older people experiencing poor self image and negative emotional wellbeing.

Where are we now?

Manchester has a smaller than average older population, compared to other Greater Manchester boroughs and England as a whole. 22% of Manchester's population is over 50 compared to 36% of the population of England as a whole, while 9.4% of residents are aged over 65 compared to a national average of 17.7% of the population of England as a whole.

Local forecasts suggest that, over the next 10 years, the number of people aged 50-64 living in the city is likely to increase by 35%, whilst the numbers aged 65 and over are likely to grow at a much lower rate. Older people in Manchester are more likely to live alone.

Findings from the English Longitudinal Study of Ageing suggest that health inequalities between the poorest over-50s and the rest of the older population is growing and that younger (middle-aged) cohorts in the poorest quintile have higher levels of ill-health than older cohorts at the same age.

Worklessness and Income Deprivation

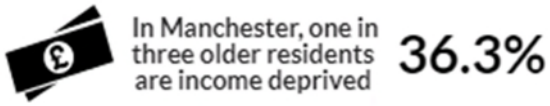
In Manchester 26.6% of out-of-work benefit claimants are over the age of 50 and a third of 50-64 year olds have no formal qualifications. Approximately 6% of the total workforce aged 50-64 has not worked for 20 years, which suggests that some have not worked from midlife onwards.

Figure 22: Out of work benefit claimants

Source: Department of Work and Pensions 2017

There are high levels of disadvantage and ill health among older residents. 36.3% of older people living in Manchester are classed as living in income deprivation.

Figure 23: Income deprivation of older residents

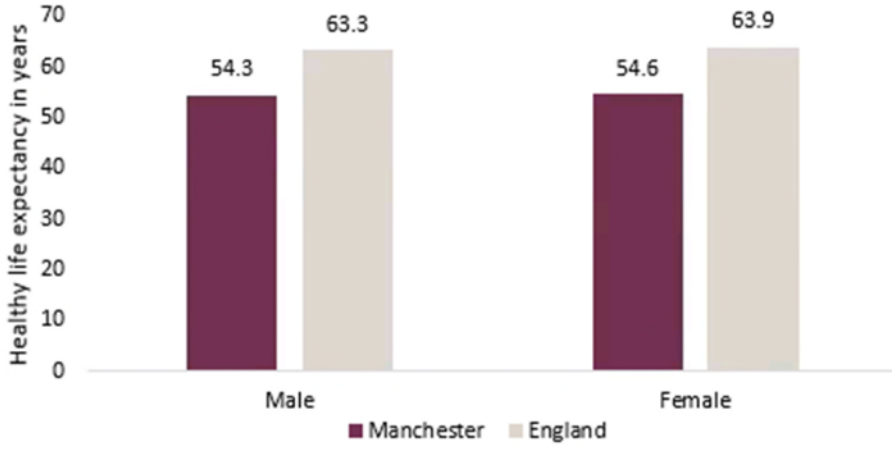


Source: Income Deprivation Affecting Older People Index, 2015

Healthy Life Expectancy

Older people in Manchester spend a smaller proportion of their remaining years of life living in a state of good health (healthy life expectancy) than their peers living in other parts of the country. The hospital length of stay and total bed days in those aged over 65 are all significantly higher than the national average.

Figure 24: Healthy life expectancy 2014-2016



Source: Office for National Statistics (ONS)

Falls

Older people are particularly vulnerable to injuries from accidental falls. Manchester has a higher rate of hospital admissions (and emergency hospital admissions) due to an unintentional fall in people aged 65 and over than the England average. In 2016/17, 1,260 older people aged 65 and over in Manchester were admitted to hospital for a falls-related injury - a rate of 2,540 per 100,000 population. This is significantly higher than the rate for England as whole (2,134 per 100,000 population)

Figure 25

Dementia

Recent figures suggest that less than two thirds (62%) of the estimated 3,650 people with dementia in Manchester had received a diagnosis of the condition from their GP.

What we will do

The Age-Friendly Manchester partnership has updated the City's Ageing Strategy, *Manchester: A Great Place to Grow Older 2017-2021.* It was launched in October 2017.

The strategy has three key priorities:

1. Develop age-friendly neighbourhoods
2. Develop age-friendly services
3. Promote age equality

With these in mind we will:

- Create an age friendly neighbourhood working model that incorporates different services and organisations' ways of working in neighbourhoods. Making sure that these are better connected to each other and to older people. In doing so this will influence the development of the LCO's locality model and ways of working in a way that supports age-friendly neighbourhoods and services

- Promote and increase awareness of the range of services and activities delivered at a neighbourhood level for older people

- Target approaches that reach and engage those most marginalised older people - both in terms of informing and raising awareness of what is on offer but also as a way of understanding different needs of these groups

- Build on local programmes that aim to improve employment rates for the over 50s and increase significantly the number of age-friendly employers

- Ensure there is an age-friendly dimension to all-age commissioned services, when these are recommissioned

- Improve access to population health services by older people, in particular, NHS Health Checks and Lung Checks, alcohol and substance misuse services and sexual health services

- Ensure there is a much greater emphasis on earlier falls prevention that supports the transformation of the existing falls services in Manchester

- Strengthen the link between the dementia and age-friendly activities and networks at a neighbourhood level

- Facilitate more intergenerational opportunities and support the positive role older people can play within families in delivering key population health messages

- Promote age equality: tackle and eliminate the use of age-discriminatory language in communications and how services are offered

North City Nomads

North City Nomads has had long-term support from Age-Friendly Manchester. The project is run by volunteers for people aged over 50 living in North Manchester which offers fun, affordable and accompanied days out for people who might experience difficulties taking a day trip.

The idea for the project was developed by the North Manchester Age-Friendly Networks following a discussion about reducing isolation and loneliness. Consultation with local older people revealed that significant numbers missed out on the opportunity of having a fun day out and many could only reminisce about taking holidays abroad.

Reasons given for not having days out were very similar: not knowing anyone to go with, no longer having the confidence to book day trips and privately run coach trips being too expensive. Those who had previously participated in day trips organised by local church groups or their sheltered scheme warden recalled fun days at the seaside, the camaraderie experienced on the coach and happiness felt anticipating the day itself.

In the summer of 2015 North City Nomads set off on their first trip to Southport. Over 250 local people took part, boarding a convoy of five coaches (including a specially adapted vehicle which allowed residents of a local Nursing Home to attend).

Since that first highly successful trip the group has grown to over 800 members. Volunteers have gone on to organise eleven different trips, including York, Leeds and the Christmas Markets at Chester. Trips to the coast are popular in summer and places of cultural interest such as the museums and galleries of Liverpool provide entertainment when the weather might not be guaranteed.

In addition to fulfilling its original aims the group has created opportunities for older people to exchange information about, and engage in, other local events and activities. It has also provided a platform for services to promote public health messages and canvass the views of older people, e.g. flu vaccinations and bowel cancer. Finally the Nomads have facilitated opportunities for volunteering and recently volunteers established a formal charity with elected committee members. This will give the group a stable basis for raising funds and sustaining its activities into the future.

Priority 5 - Taking action on preventable early deaths

Why is this important?

It has been reported that just three lifestyle behaviours - tobacco use, unhealthy diet and a sedentary lifestyle - increase the risk of developing the four long-term conditions that are associated with the large majority of preventable deaths and health inequalities; cardiovascular disease (CVD), cancer, respiratory disease and diabetes. Creating the conditions and providing the support for people to stop smoking, eat healthy food and become more physically active will have a big impact on population health. Detecting illnesses early with the right treatment and support can also halt the progression of disease or minimise the impact of ill-health on a person's quality of life.

Recent research has highlighted the impact and relevance of Adverse Childhood Experiences (ACEs) for preventative strategies. ACEs are stressful events that occur in childhood such as abuse, neglect and living in a household with mental illness, domestic violence or substance misuse. Adults with four or more ACEs are more likely to have unhealthy lifestyles and suffer from mental and physical long-term conditions in adult life, leading to early death.

Population groups with shared experiences and additional health needs, such as those experiencing domestic violence, the homeless, refugees and asylum seekers and people with severe mental illness need targeted support to improve their prospects and quality of life, and reduce population-wide inequalities in health.

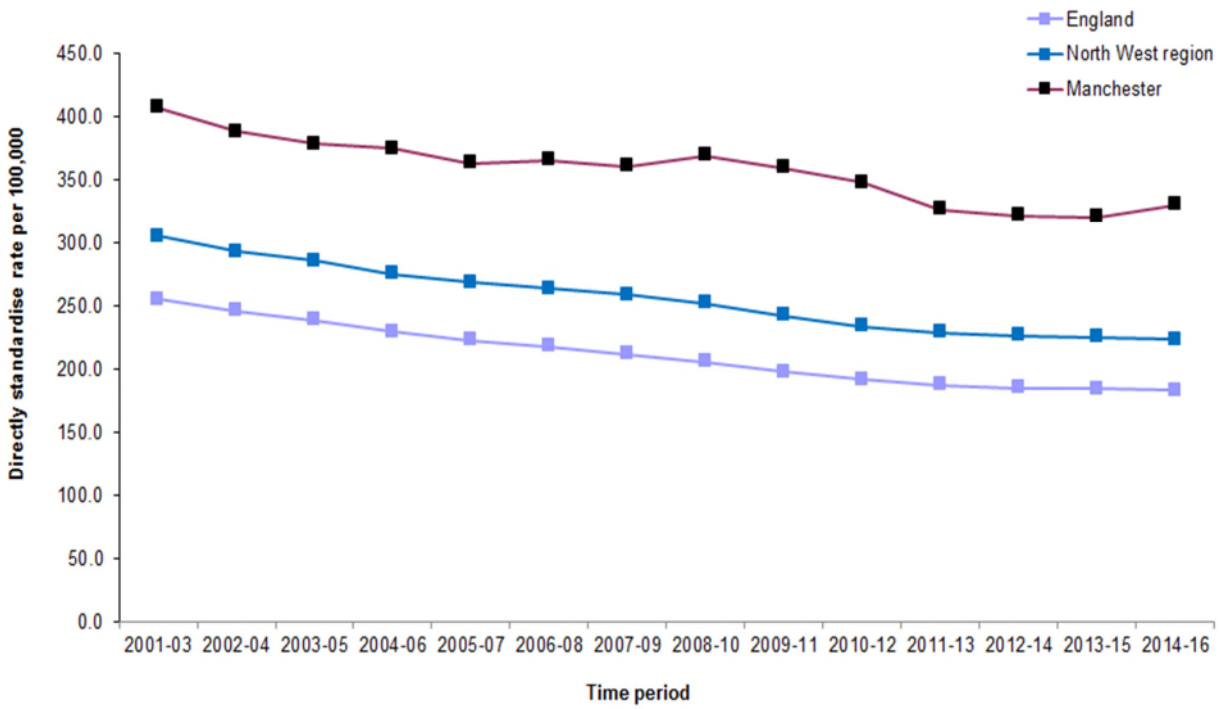
Population-wide interventions that enable healthy lifestyle choices are required alongside actions to protect the most vulnerable in society.

Where are we now?

Preventable deaths

Deaths from particular causes are defined as preventable when they could potentially be avoided through public health policy and interventions. There is a strong relationship with deprivation, with more deprived areas having higher preventable death rates.

Figure 26: Death rate from causes considered preventable

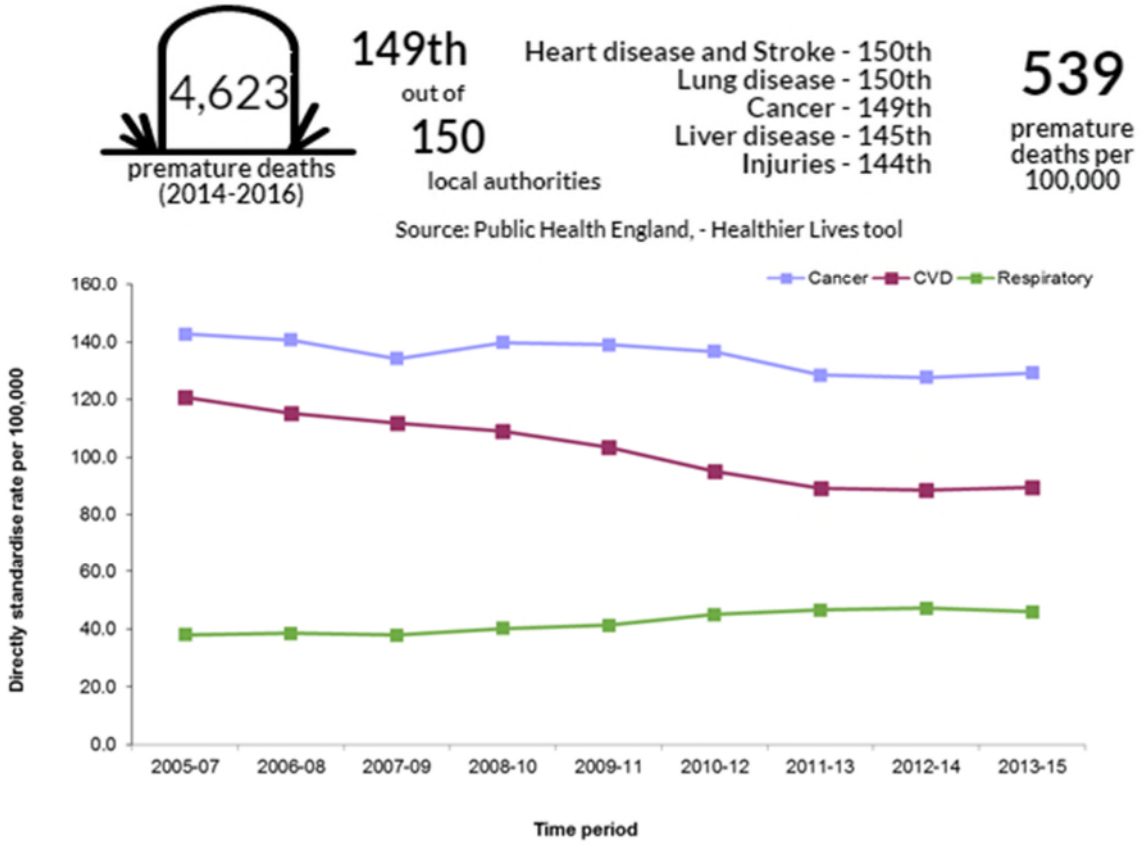


Source: Public Health England (based on ONS source data)

Premature deaths

Cardiovascular disease (CVD), cancer and respiratory diseases are the major causes of death in people aged under 75 in Manchester. There have been huge gains over the past decades in terms of better treatment and improvements in lifestyle. However, concerted action in terms of both prevention and treatment is needed to ensure that there continues to be a reduction in the rate of premature deaths from these diseases.

Figure 27: Premature Deaths- Manchester's Ranking and Rates

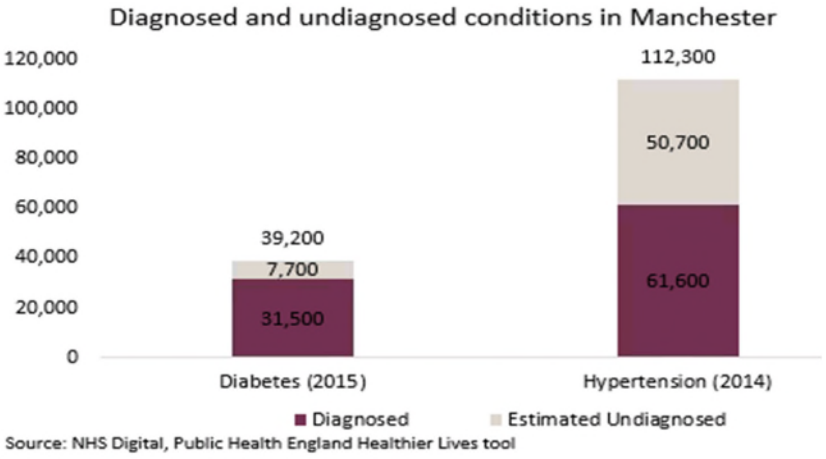


Compared with other local authorities, overall premature deaths (preventable and not-preventable) from cardiovascular disease, cancer and respiratory disease in Manchester are all the highest in England. Manchester is also the highest ranked local authority for overall premature deaths from these diseases when compared with other similarly deprived areas, suggesting that deprivation alone is not the key factor in the high rates of premature deaths in the city.

Long term conditions

Manchester experiences high levels of ill health and as a result has significantly lower healthy life expectancy than for England overall. Published data on long-term conditions diagnosed in GP practices derived from the Quality and Outcomes Framework (QOF) suggests that Manchester has lower levels of ill health. Although this is largely due to the fact that Manchester has a relatively young population structure compared to England, there is also evidence to suggest that some conditions are going undiagnosed, thus raising the risk of complications and greater use of emergency health services at a later stage.

Figure 28: Diagnosing conditions



Cancer Screening

Uptake of the national bowel, breast and cervical cancer screening programmes are lower than the national averages.

Figure 29: Screening uptake

Smoking

Manchester has higher levels of smoking prevalence than in England overall and, while some improvements have been seen, the gap has not been narrowed.

Figure 30: Smoking prevalence

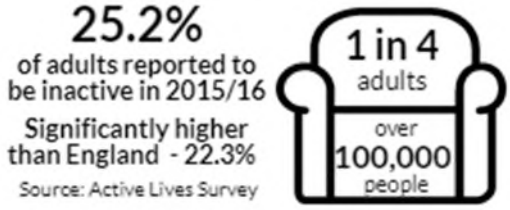
In total, 2,440 deaths in Manchester were attributed to smoking between 2014 and 2016 according to ONS. Manchester had a rate of 499.3 per 100,000 deaths attributable to smoking, which is the highest rate of all local authorities in England and significantly higher than the England rate of 272 per 100,000.

Physical activity

Manchester has high levels of physical inactivity compared to England. Physical inactivity contributes to poor health and wellbeing. In 2002 the World Health Organisation warned

that a sedentary lifestyle could be among the 10 leading causes of death and disability in the world.

Figure 31: Inactivity levels



Suicide

Suicide rates in the general population in Manchester have fallen between 1997 and 2015. The current rate (10.5 per 100,000 population) is still higher than the England average (10.1) but is now below the average for the North West (11.3). The proportion of people in contact with mental health services before suicide has varied over this time period, but the average proportion (26%) in contact is similar to national figures.

Figure 32: Suicide and mental health services

Source: Greater Manchester Suicide Audit 2015

<u>What we will do</u>

- Reduce early preventable deaths from heart disease by implementing the Winning Hearts and Minds Programme. This is a multi-agency approach developed in partnership with Manchester City Council Sport and Leisure Service and the emerging new strategic vehicle for sport and physical activity, Mcr Active that involves:

    - Investment in community led initiatives in the most challenging areas in the north of the City to help reduce health inequalities
    - Working with communities to identify new ways of encouraging physical activity through the Sports England funded Tackling Physical Inactivity Initiative
    - Delivery of community centred approaches to improving the detection of cardiovascular disease and its risk factors, optimising care, and reducing variation in care
    - Co-production of approaches to improving the physical health of people with severe mental illness

- Deliver community centred approaches to detecting conditions early by going

to places where people naturally and frequently congregate and working with people, groups and organisations that are trusted in communities. This includes targeted approaches for NHS Health Checks and the roll out of the Lung Health Check Programme as well as the promotion of cancer screening programmes (breast, bowel and cervical) for the groups of people who are most at risk.

- Improve outcomes and reduce unwarranted variation for people with respiratory illness through a system wide approach to change including; improving the timing and quality of diagnosis, better coordinated care and enabling self care.

- Support people to stop smoking through the implementation of "Smoke Free Manchester" driven by Manchester's Tobacco Alliance. This includes prevention from harm from environmental tobacco smoke, preventing young people taking up smoking, tackling the supply of illicit tobacco, smoke free spaces and access to stop smoking services. The CURE Programme (Curing tobacco addiction through more effective treatment in hospital settings) is likely to be piloted in Manchester.

- Prevent attempted suicides and deaths through delivery of our local Suicide Prevention Plan including: awareness raising and training; anti-stigma campaigns; and work with the rail network and highways to limit access to high risk locations.

- Implement and evaluate place based, routine enquiry training on Adverse Childhood Experiences (ACEs) and offer interventions to ensure that people with ACEs are supported to overcome issues and take control over their lives.

- Lead the delivery of the Greater Manchester "Ending all new cases of HIV in a Generation" programme in partnership with key VCSE organisations.

Suicide Prevention is everyone's responsibility

Manchester's local suicide prevention plan was launched in 2017. The plan was developed through a collaborative approach that recognised the role that everyone can play in suicide prevention, and in particular acknowledged the crucial role played by communities working alongside statutory services.

To support suicide prevention efforts in Manchester half day suicide awareness training has been provided to a broad range of people from statutory and voluntary services. Staff from different organisations who are part of the Manchester Suicide Prevention Partnership have worked together to co-deliver training either within their own organisation or as part of a multi agency training pool within existing resources. The training explores facts, figures and myths about suicide, identifies risk factors and warning signs, provides insight into suicidal feelings, identifies factors that make people feel uncomfortable about starting a conversation about distress and suicide and gives people the opportunity to develop skills to talk with someone who may have suicidal thoughts or plans. The training also provides information about what help is available in Manchester for people needing more support.

There has been very positive feedback about the training programme and demand is high. To meet demand and reach a greater number of people there is need to increase the suicide awareness offer through existing workforce training programmes and community- based training.

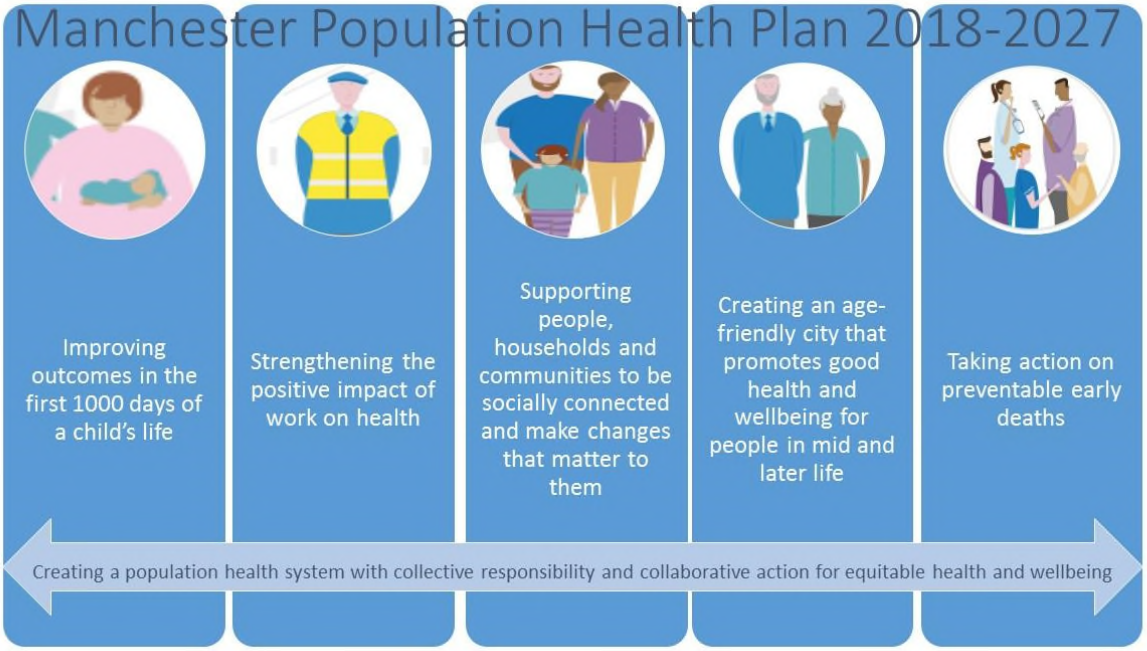
One of the participants said: '*The training has been informative and has made me feel at ease approaching someone who is suicidal and knowing what support is on offer.*'

This is a good example of how raising awareness across workforces and communities can help to make it much more likely that people in emotional distress or who are considering suicide are able to speak about their feelings and receive support at the earliest stage.

Delivering the Plan in 2018-19

We encourage all partners and agencies across Manchester to use this plan and work with us to improve health and wellbeing and reduce health inequalities in Manchester. The actions identified under each priority are interdependent and they will all need to be delivered for the measures of success for each priority to be achieved.

Figure 33 – Population Health Plan Summary



The Population Health and Wellbeing Directorate at MHCC will coordinate and drive the delivery of the Plan and detailed actions and milestones for year one are set out in the MHCC Operational Plan for 2018/19, under the tackling health inequalities transformation priority. All of the other six MHCC Operational Plan priorities will be crucial to the achievement of population health improvement in Manchester and these are summarised in Appendix 4.

The existing wide range of population health commissioned services and mandated public health responsibilities (see appendix 5) provide a strong platform for effective action. The investments recently agreed by MHCC for the Citywide Prevention Programme, Winning Hearts and Minds, Health and Homelessness and Infant Feeding Programme will all make a significant impact on reducing health inequalities.

Manchester will also contribute to the implementation of the 20 programmes contained in the Greater Manchester Population Health Plan and will provide visible leadership for a number of these (e.g HIV and Sexual Health. Work and Health, Tobacco Control through the CURE Programme and Lung Health Checks).

However, one of the best opportunities to achieve the "radical upgrade in population health" referred to in the GM Plan, will be through the Manchester Local Care Organisation and the development of their Population Health Strategy in 2018/19. The neighbourhood plans to be developed by the MLCO will address specific challenges in localities. We will also strengthen and support the significant role the Single Hospital Service and VCSE

sector can play in addressing the wider determinants of health (e.g. social value and recruitment of local people).

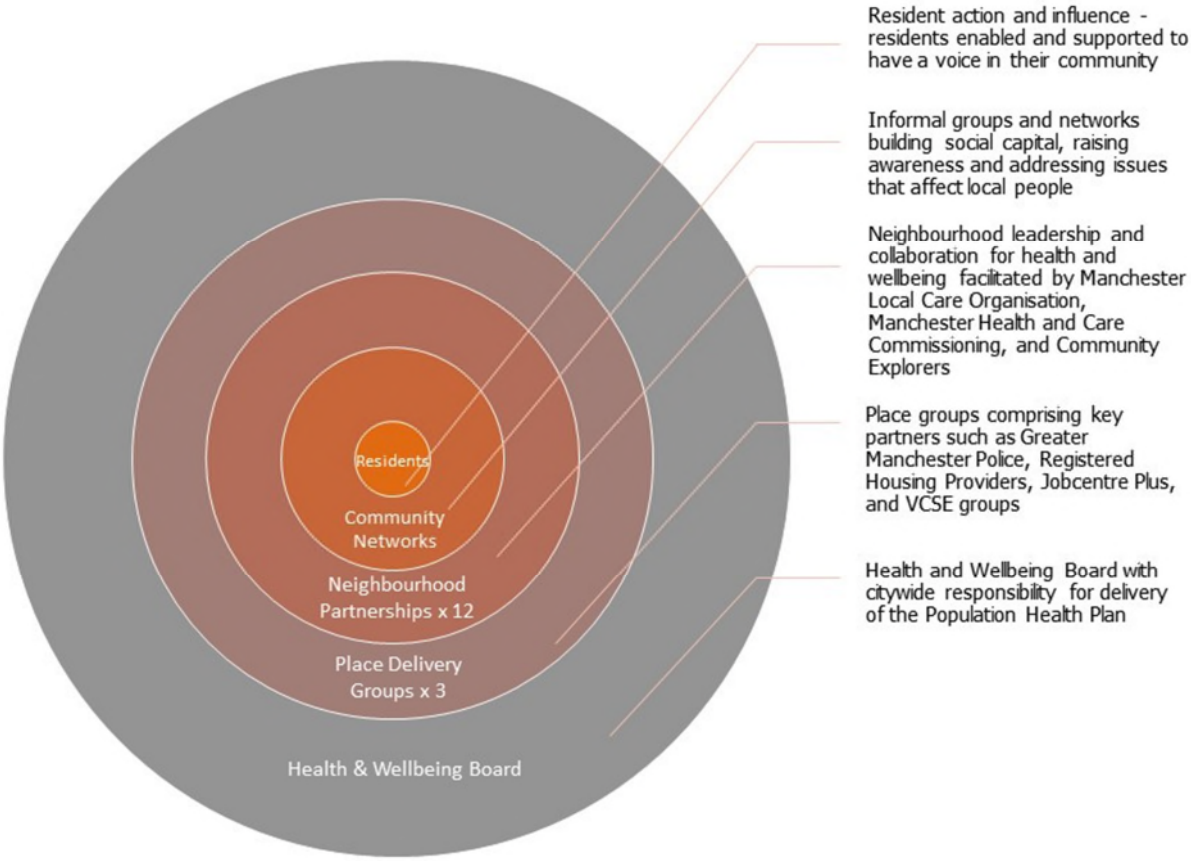
Laying the foundations - creating a population health system for Manchester

A population health system can be described as all of the organisations in the City, both statutory and non-statutory, that have an influence on population health working together in a coordinated way to improve outcomes. It is a response to the recognition that health and care services alone have a limited impact on population health. Despite the best efforts of the NHS in Manchester over many years, health outcomes have not improved and lag behind the improvements we have seen in other areas such as education.

A population health system will therefore be created (see figures 32 and 33) through integration of health and care services with the other sectors that influence the broader determinants of health. The Our Manchester principles are fundamental to this; recognising and building on the strengths of communities, working collaboratively with communities to develop solutions, and enabling people build better lives. Community driven approaches will be facilitated and encouraged to (i) develop and deliver solutions to some of the complex barriers to health in the city; and (ii) make the most of the wealth of community resources and activities that support health and wellbeing.

Figure 34: Population Health System-principles based on the Our Manchester Approach

Figure 35: Population Health System - facilitating collaboration in Manchester



Conclusion

Manchester has always been a pioneer in developing new approaches to tackle entrenched public health problems. Edwin Chadwick, born in Longsight, led the sanitary reforms that reduced deaths and communicable diseases in Manchester in the 1830's, by ensuring pure water was piped into the city and sewage piped out. Furthermore, in the 1950's Manchester Corporation (i.e. the City Council) led the way in ensuring the Clean Air Act was introduced.

The City has also demonstrated its incredible resilience in recent years. We know that by working together with our local communities, we can pioneer work on population health that will narrow the unacceptable health gap that we have lived with for too long.

Appendices

Appendix 1 - Key Population Health Indicators for Manchester

POPULATION		
Resident population estimates and 2011 Census	**Manchester**	**England**
Total population (Mid-2016)	541,263	55,268,067
Children (0-15)	20.1%	19.0%
Working age (16-64)	70.7%	63.1%
Retirement age (65 and over)	9.3%	17.9%
Estimated Non-UK Born Population (2016)	26.4%	15.4%
WIDER DETERMINANTS OF HEALTH		
	Manchester	**England**
Deprivation: % Lower Super Output Areas (LSOAs) in most deprived 10% in England (Index of Multiple Deprivation (IMD) 2015)	40.8%	-
Child poverty: Children under 16 in low income families (2014)	35.6%	20.1%
School readiness (2016/17)	66.2%	70.7%
GCSEs at Grades A*-C in both English & Maths (2015/16)	55.3%	59.3%
16-17 year olds not in education, employment or training (2016)	9.4%	6.0%
People aged 16-64 in employment (2016/17)	63.0%	74.4%
Job Seekers Allowance (JSA) and Universal Credit (UC) Claimants (Dec 2017)	2.4%	1.9%
Statutory homelessness - households in temporary accommodation (2016/17)	5.2	3.3
Fuel Poverty (2015)	15.3%	11.0%

Social isolation (2016/17)	41.6%	45.4%
HEALTH IMPROVEMENT		
Births and conceptions	**Manchester**	**England**
General Fertility rate (2016)	57.1	62.3
Low birth weight births of term babies (2016)	3.3%	2.8%
Under 18 conception rate (2015)	28.8	20.8
Lifestyles	**Manchester**	**England**
Child excess weight in 10-11 year olds (2016/17)	40.3%	34.2%
Smoking prevalence - 18 years and over (2016)	21.7%	15.5%
Admission episodes alcohol-related conditions (2016/17)	741.2	636.4
Reported prevalence of disease (QOF)	**Manchester**	**England**
Coronary Heart Disease (2016/17)	2.4%	3.2%
Stroke or Transient Ischaemic Attacks (TIA) (2016/17)	1.3%	1.7%
Chronic Obstructive Pulmonary Disease (2016/17)	1.9%	1.9%
Hypertension (2016/17)	10.2%	13.8%
HEALTH PROTECTION		
Immunisation, vaccination and screening	**Manchester**	**England**
Childhood immunisation uptake (2016/17)	94.4%	95.1%
Influenza vaccination uptake 65+ years (2016/17)	63.8%	70.5%
Breast screening coverage 53-70 years (2017)	61.8%	75.4%

Cervical screening coverage 25-64 years (2017)	63.9%	72.0%

HEALTHCARE AND PREMATURE MORTALITY		
Overarching indicators	**Manchester**	**England**
Life expectancy at birth (2014-16) – Males	75.5	79.5
Life expectancy at birth (2014-16) – Females	79.4	83.1
Infant mortality rate (2014-16)	6.3	3.9
5 year old children free from dental decay (2014/15)	67.3%	75.2%
Cancer diagnosed at an early stage (2015)	50.7%	52.4%
Injuries due to falls in people aged 65 and over (2016/17)	2,540.4	2,113.8
Premature deaths (directly standardised rates per 100,000)	**Manchester**	**England**
Mortality from causes considered preventable (2014-16)	330.0	182.8
Cancers considered preventable - 0-74 years (2014-16)	128.6	79.4
Cardiovascular diseases considered preventable - 0-74 years (2014-16)	94.9	46.7
Respiratory diseases considered preventable - 0-74 years (2014-16)	46.7	18.6
Liver disease considered preventable - 0-74 years (2014-16)	28.5	16.1
Suicide and injury of undetermined intent (2014-16)	10.6	9.9

Appendix 2 - Where to find out more

More information about the topics covered in the JSNA can be found from the following sources:

Public Health England

Public Health England produces a number of profiling tools covering a wide range of public health areas and also provides access to data in respect of the indicators contained in the Public Health Outcomes Framework (see fingertips.phe.org.uk/)

An alphabetical listing of public health data and analysis tools published by Public Health England is also available at www.gov.uk/government/publications/phe-data-and-analysis-tools-a-to-z/phe-data-and-analysis-tools-a-to-z.

The Local Health tool (www.localhealth.org.uk/) provides access data for small geographical areas, such as electoral wards, and also contains the facility to generate bespoke neighbourhood profiles.

National Intelligence Networks

Public Health England has established five national health intelligence networks which are responsible for analysing information and data and turning it into meaningful and timely health intelligence to help commissioners, policy makers, clinicians and health professionals to improve services and outcomes. These networks are

- Cancer (www.ncin.org.uk/home)
- Cardiovascular Disease (www.ncvin.org.uk
- Child and Maternal Health (www.chimat.org.uk)
- Mental Health, Dementia and Neurology
- (fingertips.phe.org.uk/profile-group/mental-health)
- End of Life Care (www.endoflifecare-intelligence.org.uk)

Office for National Statistics

The Office for National Statistics (www.ons.gov.uk) is the main producer of official statistics and is the recognised national statistical institute of the UK. It is also responsible for the design, delivery and analysis of the Census for England and Wales. The Office for National Statistics are also responsible for Nomis – an service that provides free access to detailed and up-to-date UK labour market and Census statistics from official sources (see www.nomisweb.co.uk/).

NHS Digital

NHS Digital (previously known as the Health and Social Care Information Centre) is responsible for collecting and publishing information relating to health and care, including national indicators covering the quality of care, population health and the outcomes of treatments (see digital.nhs.uk/home).

Manchester City Council

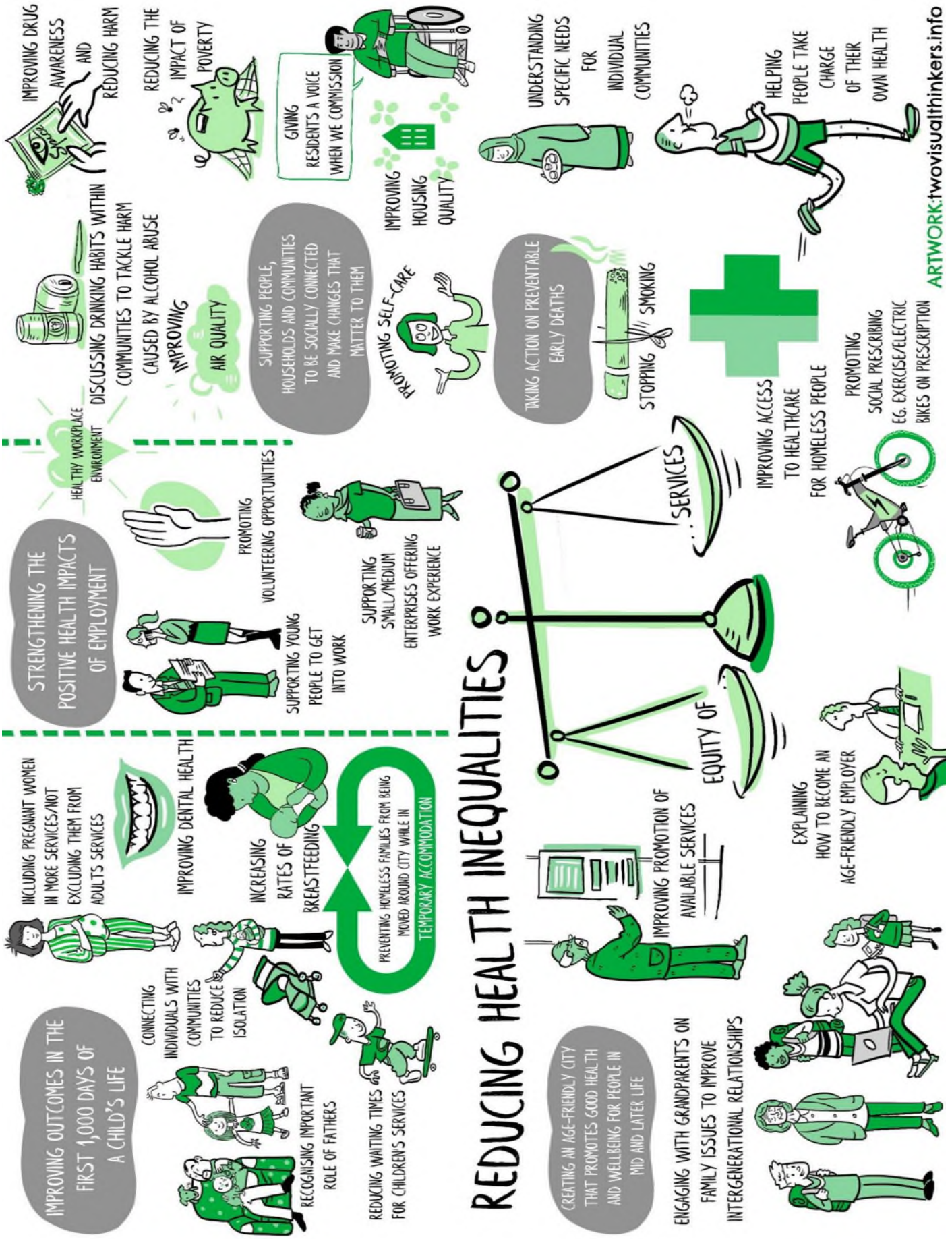
A range of local statistics and intelligence are available on the Manchester City Council website at www.manchester.gov.uk/info/200088/statistics_and_intelligence

The intelligence hub is an interactive tool which provides local information about Manchester across a range of themes including employment, education, crime and the

economy. The tool presents data in a variety of formats, such as maps and charts, and allows users to compare two datasets together and at different levels of geography (www.manchester.gov.uk/info/200088/statistics_and_intelligence/7611/intelligence_hub)

The Population Health Knowledge and Intelligence Team also produce a Compendium of Population Health Statistics for Manchester. (see www.manchester.gov.uk/downloads/download/5724/compendium_of_statistics-manchester.

Appendix 3 – Stakeholder engagement feedback



Appendix 4 – Manchester Health and Care Commissioning Operational Plan 2018/19 – 'Plan on a page'

Manchester Health & Care Commissioning

MANCHESTER CITY COUNCIL NHS

Our Strategic Aims:
1. Improve the health and wellbeing of people in Manchester
2. Strengthen social determinants of health and promote healthy lifestyles
3. Ensure services are safe, equitable and of a high standard with less variation
4. Enable people and communities to be active partners in their health and wellbeing
5. Achieve a Sustainable system

Delivery Priority 1: Deliver national and statutory requirements and drive the transformation of health and care in Manchester

Our Manchester	Safeguarding	Finance and Contracts	Performance & Quality Improvement	Business & Health Intelligence	Workforce & OD	Planning & Policy	Communications, Engagement & Governance	Information Technology	Estates	Nursing & Infection Control
Transformation Priority 2 Develop high quality, effective residential, nursing and home care		**Transformation Priority 3** Deliver effective out of hospital care		**Transformation Priority 4** Develop core primary care services		**Transformation Priority 5** Tackle health inequalities		**Transformation Priority 6** Deliver strategic programmes in line with Manchester's priorities		**Transformation Priority 7** Develop a transformed health and care system
Stabilise current provision of residential, nursing & home care		12 neighbourhood teams established and operating effectively		Develop primary care strategy and 3 year investment plan		Improve outcomes in the first 1,000 days of a child's life		Children's transformation plan		Deliver acute care reconfiguration to ensure clinical and financial sustainability of the sector ▪ MFT year 1 ▪ NMGH reconfiguration
		Implement new models of care: • High impact primary care • Extra care • Reablement bundle				Strengthen the positive impact of work on health		Mental health		
Develop and test new models of residential, nursing & home care (alternative to spot purchase)		• Frailty • Enhanced home from hospital • Crisis response • Assistive technology		Reduce unwarranted variation in activity in primary care through a neighbourhood based approach		Take action on preventable early deaths (including prevention care model)		Learning disability		Procure an effective LCO
		Deliver respiratory, cardiovascular and diabetes pathway redesign				Create an age-friendly city that promotes good health and wellbeing for people in mid and later life		Cancer		Deliver MHCC phase 2
Implement new primary care homes' service		Develop an integrated care pathway for people with dementia		Primary Care Medicines Optimisation		Supporting people, households and communities to be socially connected and make changes that matter to them		System resilience		
		Carers • Finalise carers' strategy & new care model				Inclusion health				

Appendix 5 - Commissioned services and mandated functions (population health and public health)

The Population Health and Wellbeing Directorate at MHCC commissions a wide range of services that will support actions across the five priorities in the Plan. The list below summarises the services the team is responsible for commissioning, delivered by public sector and VCSE organisations in Manchester.

Under the provisions of the Health and Social Care Act (2012) and associated public health regulations (2013), the Director of Population Health and Wellbeing will exercise their statutory Director of Public Health role to ensure the delivery of the six public health mandated functions for the City Council. These are highlighted in the list (*)

Children's Public Health

- Healthy Child Programme (*)
    - Health Visiting Service (including Infant Feeding Service)
    - School Health Service (School Nursing and Healthy Schools)
- Child Accident Prevention Service
- Oral Health Improvement Service
- National Child Measurement Programme (*)

Wellbeing Services

- Buzz Health and Wellbeing Service
- Be Well Social Prescribing Service (North Manchester with citywide roll out in 2018)
- Physical Activity on Referral Service and Active Lifestyles
- Community Falls Services
- NHS Health Checks (*)
- Community Weight Management Services (includes children's weight management)

Sexual Health Services (*)

- Northern Sexual Health, Contraception and HIV Service (universal provision for all ages)
- Brook (young people)
- Ruclear chlamydia screening programme (young people)
- Passionate about Sexual Health Programme (PaSH) - HIV/ Sexually Transmitted Infections (STI) prevention and support for residents from most at risk populations
- Primary care sexual and reproductive health services (GPs and pharmacy)

Alcohol and Drug Services

- Manchester Integrated Drug & Alcohol Service for Adults (aged 18+)
- Young Person's Substance Misuse Service (for young people aged under 19)
- In-patient Detoxification and Residential Rehabilitation service
- Primary care services for drug users (GP and pharmacy)
- Dual Diagnosis Liaison Service

Infection Control and Health Protection Function (*)

- Support the delivery of national targets for childhood and adult immunisation rates
- Assist care providers to deliver clean safe care
- Respond quickly and effectively to outbreaks of infection across the city
- Meet the national ambitions for the reduction of Healthcare Associated Infections (HCAIs)
- Respond to new and emerging issues such as the impact of New Psychoactive

Substances (NPS) on our most vulnerable communities and participate in one of the largest ever trials for the prevention of HIV transmission

Knowledge and Intelligence Function

- Development and maintenance of the statutory Joint Strategic Needs Assessment (JSNA) for Manchester on behalf of the Health and Wellbeing Board
- Knowledge transfer and evidence synthesis
- Population needs assessment and forecasting
- Advice and support to all commissioners of services (*)