Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 11 November 2015

Subject: Joint Strategic Needs Assessment for Children and Young people

Report of: Director of Children's Services
Director of Public Health

Summary

Overseeing the production of the JSNA is one of the statutory responsibilities of the Health and Wellbeing Board. The JSNA now being developed for Children and Young People, supports the delivery of the Joint Health and Wellbeing Strategy (JHWS) and aims to improve decision making in relation to programmes of work and service provision for children and young people in the city.

Recommendations

The Board is asked to:
i) Note the report
ii) Note the topics for inclusion in the JSNA Children and Young people as set out in section 3.5

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	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 lifelong effects on many aspects of health and wellbeing in adulthood from obesity, heart disease, mental health, educational achievement and economic status. The work described in this report contributes to improving the health and wellbeing of children and young people and getting them off to the best start.
Educating, informing and involving the community in improving their own health and wellbeing	Public health work with children and their families involves working with them to improve their knowledge and understanding of health issues and access interventions as early as possible when required.
Moving more health provision into	Many children's health services are community

the community	based. For example, School Health Services working in schools and health visiting services working in community clinics or with outreach workers in children's centres.
Providing the best treatment we can to people in the right place at the right time	Children's health services are well placed to identify need and offer Early Help and interventions to prevent problems from escalating.
Turning round the lives of troubled families	Children's health services contribute to work with troubled families, offering support and interventions for children and their families.
Improving people's mental health and wellbeing	Various services described in this report contribute to improving the emotional health and wellbeing of mothers,
Bringing people into employment and leading productive lives	As well as mainstream education provision for children and young people a number of services support work with mothers to look at their education and training and employment needs
Enabling older people to keep well and live independently in their community	

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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.

The current JSNA for Children and Young People 2014/15 can be downloaded from

the JSNA website at
http://www.manchester.gov.uk/downloads/download/6159/starting_well_and_developing_well_report_-_full_document.
The in-depth reports section of the website also contains more up-to-date and detailed topic information relevant to Children and Young People

1. Introduction

1.1 The September 2015 meeting of the Health and Wellbeing Board considered the draft refresh of Joint Health and Wellbeing Strategy (JHWS). The Strategy emphasises that 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 during 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.

1.2 The Strategy is underpinned by the Manchester Joint Strategic Needs Assessment (JSNA) which is also being refreshed. There is strong support for having a specific Joint Strategic Needs Assessment (JSNA) for Children and Young People in Manchester. This report provides the Board with an overview of the JSNA for Children and Young People that is now being progressed. The headlines from the summary health profile, drawn from the current JSNA , are presented below and highlight the challenges faced in Manchester. The report also includes an update on the current service responses to tackle these challenges, with a particular focus on the Early Years Offer.

2. The summary health profile of children and young people in Manchester

2.1 The health and wellbeing of children in Manchester is generally worse than the England average. 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.

2.2 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 the neonatal, post neonatal and infant mortality rates (deaths under 1 year) are not.

2.3 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.

2.4 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%).

2.5 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%.

2.6 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.

2.7 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. In Manchester 39% of five year olds have experienced tooth decay which is much higher than the national average.

2.8 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.

2.9 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 data for the number young people seeking treatment and support for alcohol or drug misuse shows that in 2013-14, 273 young received specialist treatment for substance misuse in Manchester.

2.10 Rates of common Sexually Transmitted Infections (STIs) including chlamydia are highest among residents aged 15-24. 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%).

3. Joint Strategic Needs Assessment (JSNA) for Children and Young people

3.1 Improving the health outcomes of children and young people in Manchester requires a multi-agency approach to the collation, analysis, presentation and publication of data, research and intelligence relating to the health and wellbeing of children, young people and families across the city. This requirement will be fulfilled by the Manchester JSNA for Children and Young People.

3.2 The JSNA for Children and Young People will ensure that local strategies for addressing poor health and care outcomes in Manchester are underpinned by

a strong evidence base in terms of the range and effectiveness of services to support children, young people and families. It will build on the existing JSNA which looks at the health needs of the population across the three 'life stages' of children and young people ('Starting Well and Developing Well'), adults ('Living Well and Working Well') and older people ('Ageing Well').

3.3 The JSNA will be the vehicle for developing insight from service users, removing barriers to delivery and reducing duplication across partners. It will be a 'living' resource that will be continually expanded and refreshed over time through consultation with key stakeholders and will incorporate the views of children and young people as standard good practice.

3.4 Having an effective JSNA for children and young people is also one of the key criteria used by OFSTED to judge the standard of local authority children's services and those service provided in partnership with others, such as the NHS and police. The City Council and partners must demonstrate that their decisions have been informed using detailed and relevant knowledge about local communities and specific groups, including looked after children and care leavers, contained in the JSNA. In addition the refreshed JSNA will also support the work of third sector organisations, for example, by informing funding applications to other bodies.

3.5 The structure and initial list of topics for inclusion in the JSNA for Children and Young People provided in the table below. These have been agreed in discussion with partners and the collation of material is being now being coordinated by the Manchester Public Health Team, drawing on the expertise of a wide range of individuals, agencies and groups in the city.

Table One: Structure and Topics for the JSNA for Children and Young People.

Setting the Scene – Local Context	Demographics - number of children in Manchester, ethnicity , why we need to focus on children and young people's health and wellbeing
Wider Determinants of Health	Child and Family Poverty, Education (including school readiness, attendance, attainment, children missing from education), Housing and homelessness, Deprivation
Pre-conception and Pregnancy	Smoking in pregnancy, Smoking at time of delivery, Antenatal care
Infancy and Early Years	Perinatal and infant mortality, Low birth weight, Breastfeeding, Communication – speech and language therapy
Childhood	Oral health – tooth decay, Childhood Obesity
Adolescence	Under 18 conceptions, Young people's sexual health (sexual transmitted infections, Chlamydia screening etc), Smoking, alcohol and drug use, 16-

	18 year olds not in education, employment or training (NEET), Physical activity and fitness, Healthy eating and weight (including positive self image), Safety - from sexual exploitation, domestic and interpersonal violence, accidents and psychological safety
Mental Health & Emotional Health and Wellbeing	Impact of parental mental ill health, Emotional resilience, Self harm and suicide,
Accidental injuries	Types of injuries, prevention of accidental injuries
Immunisation programmes	Childhood primary immunisation programmes, Rotavirus immunisation, Hepatitis B vaccination, Measles, mumps and rubella (MMR) vaccination, Vaccination against cervical cancer (HPV)
Safeguarding	Referrals to Children's Social Care, Assessments in Children's Social Care, Children in need, Child protection, Neglect, Child Sexual Exploitation, Emergency admissions to hospital, Deaths in childhood/vulnerable babies, Female Genital Mutilation, Domestic Abuse
Key Groups	Looked After Children and Young People, Care Leavers, Children with special educational needs and disabilities, Children with long term conditions (asthma, diabetes, epilepsy), Refugee and asylum seekers (including unaccompanied children), Children and young people experiencing domestic violence and abuse, Children of prisoners, Young LGBT people, Young Carers, Families at risk (Confident and Achieving Work), Teenage Parents, Young Offenders (including young people in custody)

3.6 The information on each topic area will be based on a standard template (see Appendix 1).

3.7 The refreshed version of the JSNA can be accessed through the Manchester City Council website at www.manchester.gov.uk/jsna. Each section and topic area will be quality assured by a small team reporting to the Director of Children's Services and Director of Public Health, before being uploaded onto the website. A number of examples of the work completed to date are provided in Appendix 2. The multi-agency approach adopted in the JSNA will mean that each topic will vary in terms of its content and methodological approach. This is reflected in the examples provided. It is envisaged that the first cut of all of the sections and topic areas listed in the table will be completed by 30 November 2015. These will provide the basis for engaging with key stakeholders over the coming months. It is evident that some of the

topic areas will be able to include the views of children and young people and their families through the good user involvement mechanisms that already exist. However, it is acknowledged that for other areas more time will be required to ensure appropriate involvement.

3.8 The Children's Board will oversee the development of the JSNA for Children and Young People and there is a real opportunity to use the approach as a template for work to refresh other parts of the JSNA covering adults and older people.

3.9 Finally the development of a refreshed JSNA for children and young people provides an opportunity to strengthen communication and engagement surrounding the JSNA. This will ensure that commissioners are not only more aware of the JSNA but also better able to use it. Training and other support materials for commissioners and for use by the wider user community will be developed in order to increase people's understanding and encourage the better use of information in the JSNA.

4. Commissioning children's health services

4.1 Work is now underway to strengthen the commissioning of child health services as part of the One Team approach and Locality Plan developments. This work will also reflect the additional commissioning responsibilities of the City Council in relation to children's public health services. These are summarised below and more detail is provided in Appendix 3.

- Health Visiting Service (from 1 October 2015)
- Family Nurse Partnership (from 1 October 2015)
- Homeless Families Health Visiting Service
- School Health Service (including School Nursing and Healthy Schools)
- National Child Measurement Programme
- Child Accident Prevention
- Oral Health Improvement Service
- Young People's Sexual Health Services
- National Chlamydia Screening Programme
- Young People's Substance Misuse Service (Alcohol and Drugs)

A more integrated and less fragmented commissioning approach will also ensure that the JSNA becomes the key document and tool used for decision making as it will be owned by all partners.

4.2 CMFT as the provider of the Health Visiting Service and other children's health services has been a strong and visible lead partner working, with the city Council and others on the Early Years Offer and Early Years Delivery Model in Manchester. The Board has received regular updates on this important area of work and a further progress report is provided below.

5. The Early Years Offer – an update of work undertaken since April 2015

5.1 Manchester's strategic vision for Early Years and the transformation of Early

Years Services in the city brings together key elements of reform at a locality level to provide a universal and targeted offer for children 0-5 and their families. In this context a three part Early Years Offer for the city has been developed:

(i) the Early Years Delivery Model based on integrated working with health partners;
(ii) ensuring families are connected to an integrated and targeted family offer delivered by Sure Start Children's Centres through the revised Sure Start Core purpose and
(iii) access to good quality, accessible and affordable childcare and early learning places across the city.

A summary of the three elements is provided below with the detail on service specific updates in Appendix 4.

Element 1 - The Early Years Delivery Model

5.2 The Early Years Delivery Model is designed to provide an integrated pathway for all children from pre-birth to 5 years of age supported by healthcare and early years professionals. The key components of the model include an 8 stage assessment based on use of the best available tool (the Ages and Stages questionnaire -ASQ3). This leads to better targeted assertive outreach to children and families, identified through the assessments as requiring intervention to achieve age- appropriate child development and school readiness. It also supports a secure pathway into work for the parents and carers to reduce long term dependency. The phased roll out of the model began in April 2015. This included full implementation of the assessment stages and the commissioned evidence based interventions at scale for all babies born after 1st April 2015.

5.3 There are 156 health visitors now in post in Manchester. This has enabled full roll out of the model across the city for all babies born between April 1st 2015 and March 31st 2016. Integrated teams of health visitors and Early Years outreach workers are in place in each Sure Start group. A stock take of working arrangements has also been completed to identify areas of good practice to be shared and to identify any barriers to integration. The key principles established during the early implementation of the model governing the working of the integrated teams, have been re-emphasized by team leaders.

5.4 NHS England expects performance against all 5 of the Healthy Child Programme assessments, when fully rolled out, to be at 95% nationally. Current data indicates that for Quarter One (April –June 2015) performance for the new birth visit is at 93% in line with current recruitment expectations. Data sharing processes to enable monitoring and reporting of impact have been developed and the first impact report and dashboard will be available by the end of November 2015.

Element 2 - Sure Start Children's Centres

5.5 From April 2015 Sure Start Children's Centres (SSCC) began to operate in 14 place based groups. The operation and management of 6 of these groups was commissioned out to not for profit providers and 8 groups are managed by MCC. The Sure Start Children's Centre Governance Group has formed and met and is responsible for securing improvement across Sure Start provision. The governance group meets 6 times per year, reporting to the Manchester Children's Board.

5.6 External Quality Assurance (QA) has been commissioned to mirror the successful process used by the LA in schools. Between April and September 2015, 38 separate QA reports have been produced, one for each Sure Start Children's Centre. In addition bespoke guidance has been provided to support the production of accurate self evaluation against the current Ofsted framework. All SSCC have plans to put agreed actions into place. From November 2015 the QA reports will take the form of one report for each group of SSCC to focus on the impact of the work across the locality whilst still identifying the performance of individual centres.

Element 3 - Good quality, accessible and affordable childcare

5.7 Work continues to improve the quality of provision offered by providers in the private, voluntary and independent sector (PVI). Providers, supported by the Early Years QA team are succeeding in improving outcomes as judged by Ofsted. Out of the 149 providers that have been inspected 81% are currently judged Good or better.

5.8 The picture for childminders also continues to improve. There are 434 registered childminders in Manchester. Of the 270 childminders who have been inspected, 77% have been judged Good or better. A particularly positive feature is that more newly registered childminders are achieving Good at their first inspection.

5.9 In addition to improving the quality of provision a key element of the Early Years offer is access to sufficient ,affordable early education and childcare. The implementation of the Free Early Education Entitlement (FEEE) of a 15 hour funded place for targeted two year olds and the universal 15 hours entitlement for all three and four year olds is central to the offer.

5.10 The city is performing positively when compared with the national average. Currently the Local Authority has placed 2943 eligible two year olds against a Department for Education (DfE) target of 4471 two year olds (65.8%). The city is above the national average take up of 63% but below the average for the North West region. The average take up recorded by statistical neighbours is 60%.

5.11 Work continues to seek to increase the take up of the FEEE places for two year olds including a refresh of communications; outreach worker support to identify eligible families; strengthening relationships between SSCC and private childcare providers and childminders and the successful roll out of the

on-line eligibility checker which has enabled more parents to check their eligibility for the entitlement.

5.12 The autumn headcount will be available in November 2015.

Appendix 1 : JSNA Template

MANCHESTER JOINT STRATEGIC NEEDS ASSESSMENT 2015/16

CHILDREN AND YOUNG PEOPLE
(STARTING WELL AND DEVELOPING WELL)

HEADING: ……..

THEME: ……

Why is this important?

The Manchester Picture

What would we like to achieve?

What do we need to do to achieve this?

What are we currently doing?

Community and Stakeholder Views

References and Links

Other JSNA Topics that this links to

Date first version completed:
Date of latest revision:

Appendix 2 : JSNA Sample Sections and Topic Areas

MANCHESTER JOINT STRATEGIC NEEDS ASSESSMENT 2015/16

CHILDREN AND YOUNG PEOPLE
(STARTING WELL AND DEVELOPING WELL)

HEADING: Smoking, alcohol and drug use among young people

THEME: Adolescence

Why is this important?

This topic focuses on smoking and substance misuse among young people (aged 18 or under). Substance misuse is defined as intoxication, regular excessive consumption, or dependence leading to social, psychological, physical or legal problems. The term covers a range of substances including volatile substances, new psychoactive substances ('legal highs'), alcohol, and illegal drugs.

Rates of smoking, drinking and drug use among young people have declined in recent years.[1] According to national survey data for 2013:

- 22% of pupils said that they had smoked at least once (the lowest level recorded since the survey began in 1982) compared to 42% of pupils in 2003.
- 16% of pupils had ever taken drugs, 11% had taken them in the last year and 6% in the last month. This is similar to 2011 and 2012 levels but lower than 2001 levels
- 39% of pupils had drunk alcohol at least once, and 9% had drunk in the last week. In 2003, 25% of pupils surveyed had drunk alcohol in the last week

The prevalence of smoking, drinking and drug use increases noticeably with age. In 2013:

- less than 0.5% of 11 and 12 year olds said that they smoked at least one cigarette a week, compared with 4% of 14 year olds and 8% of 15 year olds
- 5% of 11 year olds reported ever having taken drugs, increasing to 30% of 15 year olds. There were similar patterns for drug use in the last year (from 3% to 24%) and in the last month (from 1% to 14%)
- Older pupils were more likely to have drunk alcohol in the last week: the proportion increased from 1% of 11 year olds to 22% of 15 year olds

Reductions in the overall prevalence of substance misuse use among young people are encouraging. However it remains a concern due to the detrimental effect it can have on physical, mental and sexual health, educational attainment and employment opportunities, safety, and general wellbeing for those young people who do smoke, drink or use drugs.

Of particular and continuing concern is the link between substance misuse and other vulnerabilities. Evidence suggests that a number of risk factors (or vulnerabilities)

increase the likelihood of young people using drugs, alcohol or tobacco. The more risk factors young people have, the more likely they are to misuse substances. Risk factors include experiencing abuse and neglect, truanting from school, offending, early sexual activity, antisocial behaviour and being exposed to parental substance misuse.[2] There are also links between substance misuse and young people's mental health or behavioural problems, homelessness, and sexual exploitation.

Smoking is the primary cause of preventable morbidity and premature death in England, and alcohol misuse is the third-greatest overall contributor to ill health, after smoking and raised blood pressure. These compound existing health inequalities in the city, and particularly impact on more deprived areas. Effective responses to young people's smoking and substance misuse are key strands of public health and citywide strategies to reduce health inequalities, improve health and wellbeing, and prevent the development of complex needs.

The Manchester Picture

Local authority-level data on young people's smoking, drinking and drug use is now being collected through the What About YOUth (WAY) study, which is funded by the Department of Health.[3]

Smoking prevalence data from the WAY study was published in August 2015. Data for 2014/15 shows that 8.9% of 15 year olds in Manchester are current smokers, compared to 8.2% in England and 8.0% in the North West. Of these, 5.6% of 15 year olds are regular smokers, compared to 5.5% in England and the North West, and 3.2% are occasional smokers, compared to 2.7% in England and 2.5% in the North West. Similar local prevalence data on alcohol and drug use is due to be published later in the year.

Data on hospital admissions for alcohol and substance misuse is also included in the Child Health Profiles issued by Public Health England. This shows that in Manchester:

- Between 2011/12 and 2013/14, the rate of hospital admissions due to alcohol specific conditions for under 18s was 55.4 per 100,000 population, compared to 40.1 per 100,000 for England and 60.4 per 100,000 for the North West
- For the same period, the rate of hospital admissions due to substance misuse for under 18s was 73.7 per 100,000 population, compared to 81.3 per 100,000 for England and 116.5 per 100,000 for the North West

Data on outcomes for children looked after continuously by local authorities for at least 12 months show that 8.5% of looked after children in Manchester are identified as having a substance misuse problem, compared to 3.4% in the North West and 3.5% in England.[4] This may represent either higher levels of substance misuse or more robust approaches to screening and early identification in this group of young people.

Young people's substance misuse treatment

Data from Public Health England shows that 273 young people accessed specialist substance misuse services in the community in 2013/14, compared to 277 young people in the previous year. 87% of young people cited cannabis as a problem substance (compared to 84% nationally) and 59% cited alcohol (compared to 56% nationally). [5]

Many young people receiving specialist interventions for substance misuse have a range of vulnerabilities. They are more likely (compared to the general population of young people) to be not in education, employment or training (NEET), have contracted a sexually transmitted infection (STI), experiencing domestic violence, experiencing sexual exploitation, be in contact with the youth justice system, be receiving benefits by the time they are 18 and are half as likely to be in full-time employment.

In Manchester, young people accessing substance misuse services are more likely to be a looked after child (21%, compared to 10% nationally), to be involved in offending (34%, compared to 24% nationally), and to be affected by others' substance misuse (22%, compared to 16% nationally).

What would we like to achieve?

Local authorities became responsible for public health in April 2013. This included taking on responsibility for commissioning smoking, alcohol and drug services for adults and young people.

As noted earlier, evidence suggests that a number of risk factors (or vulnerabilities) increase the likelihood of young people using drugs, alcohol or tobacco. Therefore, building resilience and reducing risk factors are central to approaches to preventing and responding to young people's smoking, drinking and drug use. It is vital that all services work together to strengthen factors that promote resilience, such as educational achievement, training and employment, good health, positive relationships and meaningful activities. Evidence shows that physical and mental wellbeing, and good social relationships and support are all protective factors.[6] Important predictors of wellbeing are positive family relationships, and a sense of belonging at school and in local communities.

The strongest single predictor of the severity of young people's substance misuse problems is the age at which they start using substances.[7] Therefore it is important that all professionals and services that come into contact with young people and families (particularly those working with groups of young people who are at increased risk of smoking, drinking or drug use) understand the indicators and impact of young people's smoking and substance misuse, and are able to identify young people at risk and provide appropriate early interventions or support engagement with specialist services.

Young people's smoking, drinking and drug use is also influenced by the adults around them (parents, carers, siblings) and their wider environment. Smoking and

substance misuse prevention are not achieved by youth-targeted interventions alone and early interventions and treatment to address adults' smoking, alcohol and drug use will also benefit children and young people. Similarly, there is evidence that interventions that address availability, affordability and advertising of alcohol and tobacco will impact on the likelihood of young people smoking or drinking.

These approaches should result in the following outcomes:

- Resilient young people who make healthier life-choices and develop skills to make informed decisions
- Services that help prevent escalating harm and that provide evidence-based interventions to young people who are at risk of developing substance misuse problems
- Reductions in smoking, drinking and drug use, related offending, drug or alcohol-related deaths and hospital admissions and risk-taking behaviours more widely.
- Young people with improved confidence, self-esteem, school attendance and involvement in positive activities, and longer-term improvements in education and employment outcomes, wellbeing, mental health and family relationships
- Commissioners and services working together to develop and support a workforce that is competent to work with young people and their families, improving outcomes for them

What do we need to do to achieve this?

Public Health England identifies four key principles for preventing drug, alcohol and tobacco use in young people and responding to those already experiencing harm.[8]

- Commission effective, evidence-based, universal and targeted interventions to prevent young people's use of drugs, alcohol and tobacco
- Provide a full range of alcohol, drug and tobacco interventions for young people in need
- Integrate commissioning across prevention and specialist interventions and the wider children's agenda
- Have a skilled workforce in place to provide effective interventions at all levels

Improving outcomes for children and young people and reducing smoking and substance misuse prevalence and harm requires action at a number of levels, supported by robust and effective partnership working. This is reflected in current national smoking and substance misuse strategies, including *Healthy Lives, Healthy People: a tobacco control plan for England,* the current national drug and alcohol strategies *Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life* and *The Government's Alcohol Strategy;* and also the *Greater Manchester Alcohol Strategy* and *Manchester Alcohol Strategy.*

Public Health England advise that comprehensive interventions for young people's tobacco, alcohol and drug misuse should be delivered at the following levels:

Universal prevention

- accurate and relevant information about risks and harms from alcohol, drugs and tobacco, delivered through 'whole school' approaches
- evidence-based education and information (in line with NICE and other relevant guidance)
- effective tobacco, alcohol and drug policies in schools
- national resources that provide information and build resilience used to support local delivery
- intelligence and enforcement activity to tackle illegal supply of tobacco / alcohol / new psychoactive substances (e.g. underage sales and proxy purchasing)

Targeted prevention

- vulnerable young people and those at increased risk should receive targeted smoking/substance misuse interventions, aligned with other interventions to reduce risk and build resilience
- multi-component programmes that address young people's issues alongside wider family interventions (including parenting support) should be considered
- integrated commissioning arrangements should be developed to support targeted work with vulnerable groups (e.g. developing links with children's commissioning, offender health and criminal justice commissioning)
- awareness of and responses to substance misuse needs should be embedded within other vulnerable young people's services e.g. young people affected by domestic abuse, involved in sexual exploitation, involved in youth offending services, early help services

Specialist early intervention and treatment

- A range of high-quality, evidence based interventions that are appropriate to the age and development of young people, and that can respond to young people's changing needs and the needs of particular groups
- Higher levels of support including multi-agency care packages should be available for young people with multiple vulnerabilities/complex needs, supported by joint working protocols
- Brief interventions for young people who smoke should be delivered by a range of frontline workers (e.g. school and youth settings) and evidence-based stop smoking interventions should be available for young people
- A range of specialist substance misuse interventions should be in place – including harm reduction, psychosocial and pharmacological interventions
- Arrangements should be in place to ensure continuity of care for young people leaving the secure estate and needing ongoing substance misuse treatment in the community

Workforce skill and capacity building

- Workers in children and families services should be trained to discuss alcohol, drugs and smoking with young people, including screening to identify young

people at risk
- Workers in substance misuse settings should be competent to identify and respond to young people's wider health and social care needs, supported by joint working protocols with a range of agencies

What are we currently doing?

Universal prevention

The Manchester Health Improvement Service for Children and Young People works citywide to support schools to adopt a whole school approach to improving the health and wellbeing of children and young people, by encouraging and supporting schools to contribute to key public health priorities for the city. Within this, the Manchester Healthy Schools Programme supports schools to develop and deliver evidence-based 'whole school' smoking, alcohol and drug education and information for young people, and to develop effective tobacco, alcohol and drug policies in schools. This includes use of national resources to support local delivery as appropriate.

Manchester City Council carries out test purchasing in partnership with Greater Manchester Police, to identify premises in the city that are selling tobacco, alcohol or 'legal highs' illegally to young people (e.g. through underage sales or selling to adults who are buying on behalf of young people), outcomes of this then inform partnership enforcement activity with retailers to reduce the availability of these products to young people.

Targeted prevention

Manchester's young people's substance misuse service, Eclypse, provides training and support to practitioners in services that work with vulnerable young people, to develop skills and capacity in early identification of young people's substance misuse; this includes working with services for looked after children, pupils excluded from schools, youth offending services, early help, youth services, and further and higher education settings. Eclypse also deliver early interventions in these settings for young people at risk of developing substance misuse problems, including group work delivered in partnership with service staff, and work with services to develop robust pathways into specialist substance misuse services for those young people who need additional support.

Specialist early intervention and treatment

Eclypse, the young people's substance misuse service, provides a range of early intervention and treatment services for young people; this includes a full range of harm reduction and psychosocial interventions to treat young people with substance misuse problems, and access to pharmacological treatment interventions if required.

Treatment interventions are delivered within a context of a holistic understanding of young people's other needs and vulnerabilities, supported by multi-agency care packages to ensure that young people's wider needs are met (e.g. homelessness,

mental health, and sexual health). 89% of young people in Manchester successfully complete their substance misuse treatment, compared to 79% nationally.

Robust referral pathways are in place with a range of agencies, to ensure that vulnerable young people are able to access services quickly. These include accident and emergency departments, youth offending services, mental health services, and education and children and families services.

Eclypse also provide a family service to support young people affected by parental substance misuse and develop their resilience to reduce the risk of inter-generational transmission of substance misuse within families. The family service works in close partnership with the adult treatment services that work with the parent(s).

Community and Stakeholder Views

The Eclypse service is delivered by Lifeline, a voluntary and community sector service, who work in close partnership with other VCS services working with young people in the city. Engagement of children, young people and families is a key element of the work delivered by Eclypse. In addition to treatment services, a range of engagement activities are delivered, including targeted activities with groups that have historically engaged less well with services, for example, a Girls' Group has recently been established to address the barriers to young women accessing substance misuse early interventions and treatment services.

Young people's substance misuse services were included in the recent Manchester City Council 2015/7 budget proposals consultation. A range of consultation events were held, including a number of events specifically for young people, whose views about young people's substance misuse services have been fed back to commissioners and will inform future commissioning options for young people's health and wellbeing services.

References and Links

1. Smoking, drinking and drug use among young people in England in 2013, HSCIC
2. Young people's drug, alcohol and tobacco use: joint strategic needs assessment (JSNA) support pack - Good practice prompts for planning comprehensive interventions in 2016-17
3. PHE Children and Young People's Benchmarking Tool - http://fingertips.phe.org.uk/profile/cyphof
4. https://www.gov.uk/government/statistics/outcomes-for-children-looked-after-by-local-authorities
5. Young people's substance misuse data: JSNA support pack, PHE, 2015
6. Young people's drug, alcohol and tobacco use: joint strategic needs assessment (JSNA) support pack - Good practice prompts for planning comprehensive interventions in 2016-17

7. Ibid
8. Ibid

Other JSNA Topics that this links to

- Wider determinants of health
- Mental health and emotional health and wellbeing
- Safeguarding
- Key groups (children and young people)
- Alcohol misuse

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MANCHESTER JOINT STRATEGIC NEEDS ASSESSMENT 2015/16

CHILDREN AND YOUNG PEOPLE
(STARTING WELL AND DEVELOPING WELL)

CHAPTER: Safeguarding (across Starting Well and Developing Well)

THEME: Deaths in Childhood

Why is this important?

Child deaths include all babies and children up to the age of 18 years. Manchester experiences approximately 60 child deaths every year with around two thirds of these child deaths occurring in babies under the age of 1 year old. This reflects the national pattern for deaths under 1 year.

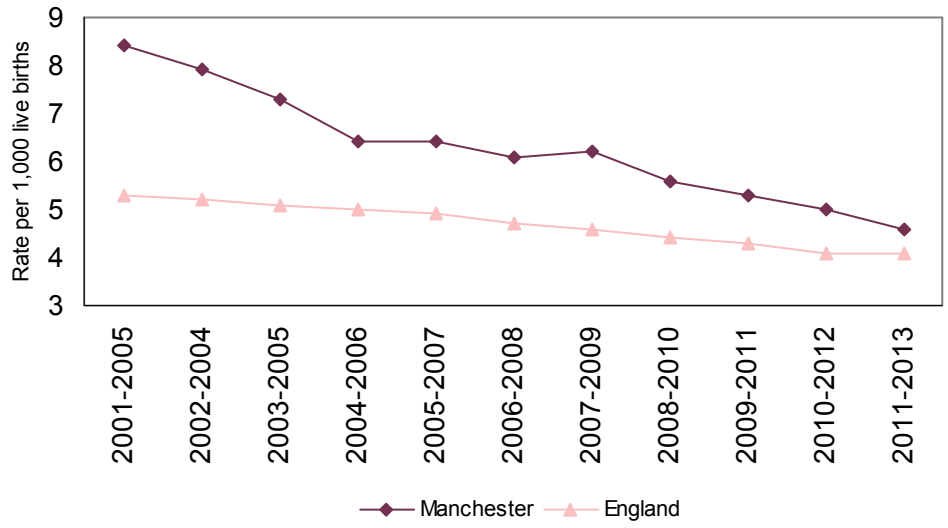
We know that poverty influences the health of mothers and their babies. Mothers living in poverty are more likely to have poor physical and mental health themselves and tend to smoke more. Babies born into less affluent families are more likely to be born prematurely, have a low birth rate and are twice as likely to die as babies born into affluent families. Teenage mothers have higher risks of infant mortality, low birth weight babies, are 6 times more likely to smoke and have one third lower breast feeding initiation.

Other key factors influencing the well being of babies and children are access to maternal healthcare, maternal and infant nutrition and vaccinations.

The Manchester Picture

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.

Infant Mortality Rate

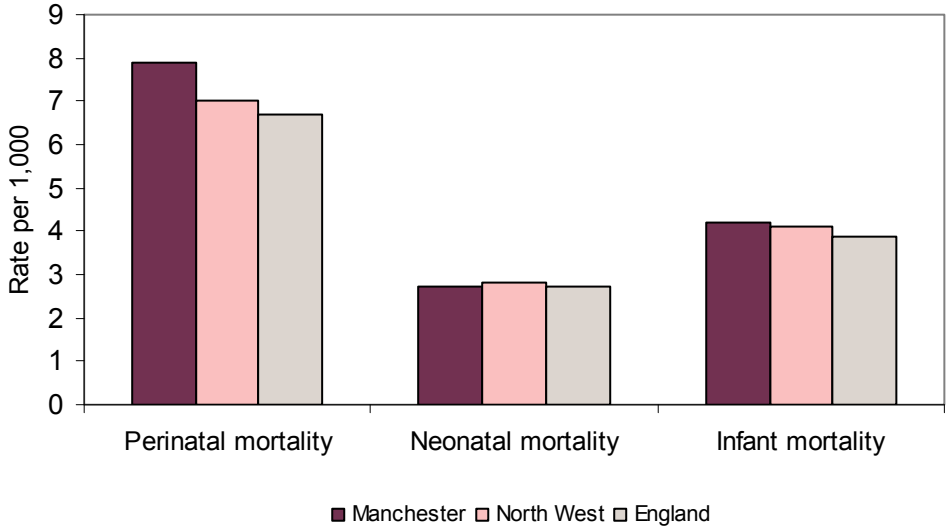


Source: Office for National Statistics © Crown Copyright 2015

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 (per 1,000 live births and still births) is significantly higher than England but our neonatal, post neonatal and infant mortality (deaths under 1 year) rates per 1,000 live births are not significantly higher.

Infant Mortality Rate - 2013 data



Source: Office for National Statistics © Crown Copyright 2015

In 2014-15, 72% of child deaths occurred to children living in the 20% most deprived communities. In addition, children from ethnic minority populations have a higher rate of child deaths. Asian/Asian British children account for 26% of all deaths and

Black/Black British account for 18%, whilst only making up 14% and 5% of Manchester's population respectively.

What would we like to achieve?

- Better communication between agencies/professionals
- Improve maternal health to reduce the numbers of premature babies born
- Increase public awareness of specific subjects e.g. safe sleeping, using social marketing/ events/education

What do we need to do to achieve this?

Co-ordination and leadership Strong local leadership is vital for an effective inter-agency approach to improving maternity and early years services and reducing infant mortality and to ensure that governance arrangements are in place so that local areas can work together to deliver reductions in infant mortality.

Commissioning Integrated commissioning will ensure a whole systems approach to tackling infant mortality and improving infant and maternal health. We must work closely with colleagues in Clinical Commissioning Groups (CCGs), Public Health England (PHE) and NHS England to ensure a seamless care pathway for families between services.

Communication Community engagement and understanding the preferences and needs of the local population is essential in developing flexible, responsive, acceptable services for the use of those who need them.

Care pathways The development of clear care pathways is vital to support sustained improvements in service delivery and quality.

What are we currently doing?

There are a wide range of factors and service developments that are aimed at protecting and improving the health of our child population. These include:

- Ensuring that children's public health services support the Early Help agenda
- Ensuring that the Health Visiting Service works in partnership to deliver the Early Years Delivery Model in Manchester
- Improving the safeguarding system to protect children
- Preventing sudden unexpected infant deaths
- Increasing childhood immunisations
- Reducing accidents in children and young people
- Reducing teenage pregnancy and improving young people's sexual health
- Supporting teenage parents

As the percentage of deaths in children under 1 year old remains high - locally and nationally - and that these deaths have common features around low birth weight, prematurity and maternal smoking, associated issues of hypertension, diabetes and obesity, and links to poverty and infant nutrition, the Public Health Team is planning to review current work and devise an action plan to address the areas identified.

Community and Stakeholder Views

Engagement work with key stakeholders and community groups will follow over the coming months.

References and Links

1. Manchester Child Death Overview Panel reports (Manchester Safeguarding Children Board, 2006/7- 2014/15)
2. Statistical Release – annual child deaths (Department for Education)
3. Reducing infant mortality in London: An evidence-based resource (Public Health England, 2015)
4. Unexplained Deaths in Infancy: England and Wales, 2013 (Office for National Statistics, 2015)
5. Child death reviews: improving the use of evidence: Research Report (Department for Education, 2013)

Other JSNA Topics that this links to

- Safeguarding
- Pre-conception and Pregnancy
- Infancy and Early Years
- Accidental Injuries

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MANCHESTER JOINT STRATEGIC NEEDS ASSESSMENT 2015/16

CHILDREN AND YOUNG PEOPLE

HEADING: Safeguarding (Starting and Developing Well)

THEME: Domestic Violence and Abuse

Why is this important?

Anyone can experience domestic violence and abuse. The UK Home Office definition of domestic of domestic violence as 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- Psychological
- Physical
- Sexual
- Financial

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assaults, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

This definition also includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage.

Nationally each year 100,000 people in the UK are at imminent risk of being murdered or seriously injured as a result of domestic abuse.

Who is most at risk?

- Gender: Women are much more likely than men to be the victims of high risk or severe abuse - 95% of those going through Multi-Agency Risk Assessment Conferences (MARAC) or accessing the Identification and Referral to Improve Safety (IRIS) Project Services are women
- Income: Women in households with an income of less than £10,000 were 3.5 times more at risk than those in households with an income of over £20,000 (1)
- Age: Younger people are more likely to be subject to interpersonal violence – the majority of high risk victims are in their 20s and 30s (2)
- Pregnancy: 30% of domestic abuse starts in pregnancy and it escalates in situations where abuse already exists (3)
- Drug and alcohol abuse: Victims of abuse have a higher rate of drug and / or

alcohol misuse (whether it starts before or after the abuse). At least 20% of high-risk victims of abuse report using drugs and / or alcohol (4)
- Mental Health: 40% of high-risk victims of abuse report mental health difficulties (4)

Children and domestic abuse

- Nationally, 140,000 children live in households where there is high-risk domestic abuse (4)
- 64% of high and medium risk victims have children (on average 2 each)
- A quarter of children in high risk households are under 3 years old. On average high risk abuse has been going on for 2.6 years which means these children are living with abuse for most of their life (4)
- 62% of children living in domestic abuse households are directly harmed by the perpetrator – in addition to the harm caused by witnessing the abuse of others (5)

Physical and mental health impacts of domestic abuse on victims

1 in 5 high-risk victims attended A&E as a result of their injuries in the year before getting help. (4) As well as short term injuries there can be long-term physical health consequences. The following health conditions are associated with abuse:

- Asthma
- bladder and kidney infections
- cardio-vascular disease
- fibromyalgia
- chronic pain syndrome
- central nervous system disorders
- gastrointestinal disorders
- migraines and headaches (6,7,8)

Domestic abuse often has reproductive consequences too including gynaecological disorders, sexually transmitted infections (STIs) and pregnancy difficulties (9)

In terms of mental health, 40% of high-risk victims report having mental health issues, 16% report that they have considered or attempted suicide and 13% report self-harming as a result of abuse. (2,4) Other psychological consequences for victims include anxiety, depression, low self-esteem, inability to trust others, flashbacks, sleep disturbances and emotional detachment. (9)

The impact of domestic abuse on the victim and on children - even once safety has been achieved - is severe and long lasting. Children are suffering multiple physical and mental health consequences as a result of exposure such as behavioural problems, sleeping difficulties, problems with social development and relationships, risky behaviour, worry, anger and sadness. On top of being directly harmed the impact of poor parental mental health cannot be underestimated - poor parental mental health and wellbeing can have a significant impact on young people getting the best start in life. It can affect children's school readiness, physical and emotional

health and wellbeing, ability to develop healthy social relationships and their own mental health as they grow up. Poor mental health in parents is a risk factor for poor mental health in children and unlike with physical health problems, it is common for mental health problems to start in earlier age.

The Manchester Picture

Manchester has higher rates of domestic violence and abuse compared to the national average. Between April 2013 and March 2014 the number of domestic abuse crimes reported (based on GMP data) was 2830 - an increase of 7% on the previous year. Of these, 76.4% were linked to violent crime. Domestic abuse is unequally distributed across the city.

Within the city, domestic abuse is a significant factor in homelessness presentations - 28% homelessness applications were due to 'a violent breakdown of relationship involving partner'.

At the end of March 2013 56% of Child in Need cases were recorded as being due to domestic abuse compared to an England average of 47%. , For Child Protection Plans 56% recorded domestic abuse and for Looked After Children 50% (compared to England averages of 41% and 56% respectively).

Domestic abuse also features in 83% of existing identified troubled families.

What would we like to achieve?

The Manchester Multi Agency Domestic Abuse Strategy (2010-2014) highlights the overarching aims for addressing domestic violence and abuse in the city:

- To ensure domestic abuse is a strategic priority for all
- To improve early identification and prevention of domestic abuse
- To reduce the prevalence of domestic abuse
- To ensure that victims of domestic abuse *and their children* are adequately protected and supported
- To hold perpetrators to account through effective and early interventions

Key objectives of the strategy are:

1. Communication - specifically the key message that domestic abuse will not be tolerated
2. Prevention - working with partner agencies to change attitudes, provide early intervention and prevent abuse
3. Provision - working collectively with other agencies to support those affected by domestic abuse
4. Protection - Supporting the criminal justice system to provide an effective response to domestic abuse.

Through the Delivering Differently Programme, the following outcomes have been identified:

- Improved life outcomes and independence for victims / survivors
- More defined interventions for particular cohorts
- Earlier intervention
- Reduction in the number of people who are repeated victims
- Reduction in the number of people who are perpetrators
- Reduction in the number of young people with a Child Protection plan related to domestic abuse
- Improved links to early years support
- A more streamlined route into and within support
- Reduction in system costs

What do we need to do to achieve this?

In March 2014 Manchester was selected as one of 10 local authorities to be part of the 'Delivering Differently' Programme - a joint initiative between the Cabinet office, the Department for Communities and Local Government (DCLG), the Local Government Association (LGA) and the Society of Local Authority Chief Executives (SOLACE). The programme was designed to support councils to identify and implement new models of delivery for their public services through the provision of specialist consultancy support. Consultants worked closely with Manchester City Council (MCC) until November 2014 and identified key drivers for change and recommendations.

Domestic abuse is costly, both to victims and their children and to the public purse. Manchester City Council spends approximately £1.3 million on direct services for those affected and it is estimated that the total wider cost to MCC is £24.5million. Of this total spend, only just over 5% is spent on prevention, early intervention and recovery interventions.

The new delivery model is currently being developed – the principles of which are:

- A more proactive response – tackling the root causes of DV&A
- Less complex than the current model
- Supports and empowers victims
- Manages perpetrators
- Reduces costs to the whole system
- Recognises the need for preventative work with younger people

Specifically, the new model will have clear referral pathways to ensure a consistent approach to risk assessment and intervention. There are new pathways for children including for children and young people showing violent behaviours. There will also be an updated self-help offer including universal support from 'Help and Support Manchester', the End The Fear website, and a universal campaign will be run based

on the following typologies:

- Parents with children living at home
- Children and young people
- LGBT communities
- Older people
- BME (including so called honour based violence, FGM and forced marriage)
- Perpetrators
- Intergenerational DV&A

For medium risk victims and perpetrators, help will be located within the Early Help Hubs and includes time limited Early Help DV&A coach posts to build capacity within the hubs and within schools. They will also liaise with specialist midwifery IDVAs and IRIS cases.

High risk cases will be supported by a new Multi-Agency Risk Assessment Safeguarding Hub (MARASH) function located within Multi Agency Safeguarding Hub. This will include a new family assessment tool for DV&A, access to homelessness to DV&A cases and specialist refuge provision and a better response to the most life-threatening and complex DV&A cases. This will be supported by an enhanced training offer for lead professionals and key workers. There will also be a new social work assessment tool.

The new delivery model is being further refined with partners and is proposed to go live in April 2016.

What are we currently doing?

Many of the current commissioned and provided services focus on supporting victims at crisis point. Current key services include:

- Refuges – currently delivered by three providers – MCC, Manchester Women's Aid and Saheli. All services have been operating to capacity since 2010/11 and provide housing and extra support services such as support and safety plans, help with drug or alcohol issues, job, education and training support and help to find permanent accommodation.
- Independent Domestic Violence Advisors (IDVAs) – help to keep victims and their children safe from harm from violent partners or family. IDVAs normally work with clients from the point of crisis. They discuss the range of suitable options, develop plans for immediate and long term safety, represent clients at the MARAC and help with legal and housing options. A specialist IDVA is based at St Mary's Hospital working with women attending maternity services. This recognises the additional risk to women during pregnancy.
- Sanctuary Scheme – administered by the IDVA Service, this scheme helps victims to remain in their own home through providing enhanced security measures to their property.
- MARAC – Multi-Agency Risk Assessment Conferences meet every four weeks to discuss the highest risk domestic abuse cases. MARAC coordinators and

administrators work with partner agencies to enable them to be part of MARAC and works with the Chair to identify gaps. There are three MARACs (North Manchester, South Manchester and Wythenshawe) and the system is oversubscribed. Manchester's IDVA system is currently underfunded based on the number of MARAC cases in the system – significantly higher that other parts of greater Manchester.

- IRIS – The Identification and Referral to Improve Safety (IRIS) Project is commissioned by the Manchester CCGs and the MCC Public Health Team and delivered by Manchester Women's Aid. It provides training, support and an enhanced referral pathway for GP practices to make enquiries when domestic abuse is suspected in order to refer the patient on to appropriate services. IRIS is a national, evidence-based programme administered locally by appropriate third sector providers.
- Victim Support Worker – MCC funds one specialist Victim Support Worker to work with victims of domestic abuse – primarily to provide help regarding the criminal justice system but also to provide other types of support.
- Children's worker – MCC funds a specialist domestic abuse worker for children and young people who have been adversely affected by domestic or sexual abuse. The project is provided by Resolve – part of The Children's Society. The service provides practical support for children and their families as well as counselling and intensive case work for children.
- End The Fear – endthefear.co.uk website and helpline offers generic support and advice and is funded by 9 out of 10 of the Greater Manchester Authorities (with Manchester being the primary funder). It offers generic support and advice to women, men and children affected by domestic violence and signposts to other services.

In addition to these specialist services a number of other services provide support on domestic abuse such as homelessness and housing-related support services, Troubled Families, Social Work teams and the Contact Centre.

Community and Stakeholder Views

Considerable consultation has taken place with victims, perpetrators and the VCS community as part of 'Delivering Differently' that highlighted priorities and gaps in the current system. (11)

Victims identified:

- Lack of housing to move onto from refuges
- A need for more specialist support to find a job
- Need for more support groups for Asian women

Perpetrators identified:

- More courses at better times for working life
- More help whilst in custody
- More help with alcohol

VCS providers identified:

- More programmes needed for young perpetrators
- More programmes needed for male victims
- A lack of services targeted at young women
- More education in schools on healthy relationships

Statutory providers identified the need for:

- The need for DV&A model to address more complex needs
- More work with perpetrators
- Strengthening the role of schools in prevention

References and Links

1. Walby, S. and Allen, J (2004), Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. London: Home Office
2. SafeLives (2015), Insights Idva National dataset 2013-14. Bristol: SafeLives
3. McWilliams,M. and McKiernan, J. (1993) Bringing out into the Open
4. SafeLives (2015), Getting it right first time: policy report. Bristol: SafeLives
5. In plain sight: Effective help for children exposed to domestic abuse CAADA's 2nd National Policy Report Feb 2014
6. Black, M.C et al (2011) The National intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary report. Atlanta GA
7. Crofford, L.J (2001), Violence, stress, and somatic syndromes in 'Trauma Violence Abuse' 8: 299-313
8. Leseman,J. and Drossman, D.A. (2007), Relationship of abuse history to functional gastrointestinal disorders and symptoms in 'Trauma Violence Abuse' 8: 331-343
9. CTC (2014), Website of the US Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention
10. Manchester Multi Agency Domestic Abuse Strategy 2010-2014
11. Delivering Differently MIB Options Appraisal September 2014

Other JSNA Topics that this links to

- Female Genital Mutilation
- Parental Mental Ill Health

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Appendix 3 : Public Health Services for Children and Young People

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

0-5s Public health services

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.

Health Visiting Service

Health visitors play a vital role in supporting parents through public health interventions carried out in the family home or in community settings. The goal is for every child to be 'school ready'. Bespoke packages of care are designed following clinical assessment of health and well-being at key Healthy Child Programme milestones or where other indicators of additional health and developmental need are identified.

Health visitors lead delivery of the full Healthy Child Programme and they are commissioned to deliver the National Service Specification with some additional Greater Manchester items in line with the Early Years New Delivery Model. The current Service Specification ensures full delivery of the 0-5 Healthy Child Programme and articulates the health visitor's role in meeting key outcomes for babies and children.
Some elements of the Healthy Child Programme are mandated and local authorities should provide universal health review to:

- a woman who is more than 28 weeks pregnant (Antenatal Contact)
- a child who is aged between one day and two weeks (New Birth Visit)
- a child who is aged between six and eight weeks (6-8/52 Review);
- a child who is aged between nine and 15 months (9/12 Review);
- a child who is aged between 24 months (two years) and 30 months (two years and six months) (2yr Review).

Health visiting is a major contributor to the Early Help Strategy, developing health pathways to identify needs within families and offer support with the aim of reducing demands on services at a higher level of social need.

Family Nurse Partnership

The Family Nurse Partnership (FNP) programme is a targeted offer within the 0-5 healthy child pathway, focusing on vulnerable young mothers (under the age of 20 at conception) in their first pregnancy. This evidence based, licensed programme is highly structured and supports families from early pregnancy until the child is 2 years old. Early parenthood is strongly associated with the most deprived and socially excluded young people and the programmes aim to improve outcomes for these mothers in pregnancy alongside improving child health and development and improve parental self-efficiency.

Homeless Families Health Visiting Service
The Public Health team fund the Health Visitor Homeless Families Service, which provides a citywide service for homeless families that include a child who is under 4.5 years or a pregnant woman. The service delivers the Healthy Child Programme to homeless families and addresses issues such as breastfeeding, postnatal depression and obesity, uptake of immunisations, dental health, smoking cessation, support on child accident prevention, and appropriate use of hospital and primary care services.

School Health Service (including School Nursing and Healthy Schools)
The responsibility for the commissioning of the School Health Service transferred to MCC when Public Health transferred from the NHS in April 2013. However, MCC are not exclusive commissioners of the School Health Service, as NHS England commission immunisation and vaccination programmes from the School Nursing Service and the Manchester CCGs commission the School Nursing Service input into Special Schools.

As part of the Child and Adolescent Mental Health Services review, MCC and the CCGs have integrated the school health service and emotional health in schools service. All services are working to key principles to improve children and young people's emotional health and wellbeing.

National Child Measurement Programme and Community Weight Management Service
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.

A tender process is underway for a provider to design and deliver a citywide, evidence based accessible multi component lifestyle children and family weight management service in the community.

The community based lifestyle weight management programme will be multi-component and 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

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. The provider will provide the National Child Measurement Programme (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 multi-disciplinary assessment and a weight management programme, provided by the service.

Child Accident Prevention

The public health team commission two child accident prevention programmes. ELFS (Early Learning for Safety) & I.M.P.S. (Injury Minimization Programme for Schools) have been adapted to focus on the priority areas for action for:

- 1-4 year olds (scalds from hot drinks & other liquids, burns from hot appliances, falls downstairs & from high beds and accidental poisoning from medicines, tablets and household chemicals);
- 5-9 year olds (falls from playground equipment, pedestrian and cycling injuries); &
- 10-14 year olds (falls from/out of/through buildings or structures & playground equipment, pedestrian and cycling injuries).

Oral Health Improvement Service

The oral health improvement service is provided by Manchester Mental Health and Social Care Trust and focuses on improving oral health in babies and children. The service works with Early Years providers, health visiting and schools and runs 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.

Young People's Sexual Health Services

Improving the sexual and reproductive health of the local population is one of the public health priorities for Manchester and is included in the Public Health Outcomes Framework. The Public Health Team commissions dedicated contraception services for young people, Sexual Health Education Outreach Services and a Chlamydia Screening Programme for young people up to the age of 25.

Young People's Substance Misuse Service (Alcohol and Drugs)

Public health commissions healthy schools service support for schools to develop and deliver effective alcohol and drug education and a substance misuse 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/drugs.

Appendix 4 : Early Years
Service specific updates

Children and Parent Service (CAPS)
Initial impact evaluation of the Children and Parenting interventions indicate that more children under two are now being seen since April 2015. A primary aim of the New Delivery Model (NDM) is to move more of the current CAPS provision to under two year olds, increasing the number of families identified with high, complex needs and risk factors, earlier to make cost savings later. Delivery of Baby Incredible Years (Baby IY) parent courses has begun, with a projected increase by the end of 2016, once new staff are appointed and trained.

Successful co-delivery of Baby IY with health visitors has proved effective at engaging vulnerable families and improving child development. Seven health visitors have been released and trained to date and have reported greater understanding of attachment; child development and parental engagement. CAPS has trained 12 outreach workers in Preschool Incredible Years (Preschool IY), with a further 18 outreach workers to be trained in November 2015.

CAPs is also reporting improved parental confidence significantly, moving parents from clinical to non-clinical ranges on the Karitane Parenting Confidence Scale, a standardised, valid measure used in child research.

Speech and Language Intervention
Following an emphasis on workforce development and working alongside childcare providers, children at risk of language delay can now be identified through the ASQ assessment. Attendance at Universal provision that gives rise to concern by either Early Year's practitioners or parents and children through their Early Years Foundation Stage observations as showing possible language delay can be dealt with appropriately.

Childcare Sufficiency Assessment
The Childcare Sufficiency Assessment Report has now been completed and presents the outcomes of an assessment of local childcare demand and supply within Manchester. The assessment report is a working document to provide up to date information about the supply and demand for childcare to enable the Council to plan to secure sufficient childcare for local families.

The assessment contributes to an understanding of supply and demand by Sure Start Children's Centre group; enables identification of gaps in childcare provision and will be used to inform a strategy for childcare that will, over the next 3 years, seek to address gaps in childcare provision identified by the assessment.