Manchester City Council
Report for Information

Report to: Public Health Task and Finish Group – 26 June 2018

Subject: Public Health Annual Report (PHAR)

Report of: Director of Population Health & Wellbeing

Summary

The attached report provides the Task Group with an overview of the breadth of work undertaken by the Public Health Team that continues under the new Manchester Health and Care Commissioning (MHCC) arrangements (i.e. Population Health and Wellbeing Team).

The PHAR informed the development of the Manchester Population Health Plan which was presented to the Health Scrutiny Committee on 22 May 2018 (www.manchester.gov.uk/healthplan).

Also attached to this report is the 2017 Health Profile for Manchester published by Public Health England. The 2018 Health Profile is expected shortly.

Recommendations

The Task and Finish Group are invited to comment upon the report which will help to scope out the work programme of the group.

Wards Affected: All

Contact Officers:

Name: David Regan
Position: Director of Population Health and Wellbeing
Telephone: 0161 234 5595
Email: d.regan@manchester.gov.uk

Background documents (available for public inspection):

None

1. Introduction

1.1 The Director of Public Health (DPH) for any local authority area is required to produce an annual report on the health of the local population, under section 73 (B) (5) of the Health Service Act 2006.

1.2 The 2016-17 Manchester PHAR provides a summary of the work of the public health team across the life course and specialist areas (e.g. health protection) that the team is responsible for. The organisation of the team is entirely consistent with the Greater Manchester Population Health Plan Framework and the MHCC directorate structures. The team, however, has been renamed as the Population Health and Wellbeing Team.

1.3 The Manchester PHAR for 2018 will have a single issue focus on Air Quality and will be presented to the Health Scrutiny Committee when the work programme is agreed.

2. Health Profile and Joint Strategic Needs Assessment

2.1 Public Health England publishes an annual profile for each local authority area. The 2017 profile is attached and the 2018 profile will be published in the next few months. The profile gives a picture of people's health in Manchester. A separate profile is issued for the health of children and young people, however, a number of the key indicators for children and young people's health are included in the general profile.

2.2 As part of the Joint Strategic Needs Assessment (JSNA) local health statistics are updated regularly along with in depth reports on public health topic areas. This information can all be accessed via: www.manchester.gov.uk/jsna.

3. Priorities for 2018/19

3.1 The Population Health and Wellbeing Team will co-ordinate action against the five priorities contained within the Manchester Population Health Plan and continue to deliver statutory functions and mandated responsibilities on behalf of the City Council. The five priorities are:

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

MANCHESTER CITY COUNCIL

Public Health Annual Report

2016–2017

manchester.gov.uk

Contents

Foreword 4
Introduction 5
Chapter 1: Strategic context and population health 6
Chapter 2: Wider determinants of health and wellbeing 10
Chapter 3: Starting well and developing well 13
Chapter 4: Living well and working well 18
Chapter 5: Ageing well 23
Chapter 6: Health protection and infection control 26
Chapter 7: Knowledge and intelligence 30
Chapter 8: Priorities for Manchester 33

Foreword

As Executive Member for Adults Health & Wellbeing, I welcome the publication of this Public Health Annual Report for Manchester. It describes some of the challenges we face as a city and reports on some of the excellent work that is making a positive difference to the health of our residents.

In January 2016, the Our Manchester Strategy was formally adopted by the Council. The strategy sets out our ambition for the city for the next ten years, and by 2025 we want to ensure that Manchester will be:

- Thriving through the creation of great jobs and healthy businesses
- Filled with talent – both home-grown and from around the world
- Fair – ensuring equal chances for all to unlock their potential
- A great place to live with lots of things to do
- Buzzing with connections, including world-class transport and broadband.

The strategy provides a framework to accelerate some of the improvements we have made in public health and take a different approach to the wider determinants of health that come under my portfolio. Therefore, I am particularly pleased to see the contributions the public health team have made in regard to addressing homelessness, the Age Friendly Manchester Programme's approach to reducing social isolation, and the collective action taken to improve mental health across the city (particularly around suicide prevention).

The next year will see the biggest set of changes to health and social care commissioning and provision in Manchester in a generation. The changes will only be deemed successful if health outcomes for our residents improve significantly. This is not just the responsibility of the Director of Public Health and the Public Health team based at the Council, but of all organisations in Manchester working in partnership with local communities to improve our collective health and wellbeing.

Councillor Paul Andrews
Executive Member for
Adults, Health & Wellbeing

Our Manchester

Introduction

As Director of Public Health in Manchester, I am required to produce an annual report on the health of the city's population.

This year's report is set against a backdrop of significant change for organisations that deliver health and care. The Greater Manchester Health and Social Care Partnership (GMHSCP) was established in April 2016 to oversee devolution and take charge of the region's £6billion health and social care budget. The GMHSCP, working with the ten local authorities, has also led the development of a Greater Manchester Population Health Plan (2017–2021), which was published in January 2017.

Manchester's locality plan – A Healthier Manchester – was published in April 2016 and details the local transformation that will take place across health and social care over the next five years.

Undertaking this transformation presents a significant challenge, particularly at a time when we need to deliver more for the health of the population with reduced resources. However, it is also a time of opportunity in public health, with a renewed focus and emphasis on population health and investment in services that actively promote health and wellbeing, prevent ill-health and deliver better health outcomes for the people of Manchester.

This year's report reviews the progress we have made in each of the life course areas the public health team is organised around – Starting and Developing Well, Living and Working Well, and Ageing Well. We also review the work we have done on health protection and community infection control, and demonstrate the importance of health knowledge and intelligence in informing the work we do. The report presents a series of case studies that demonstrate the breadth of work the public health team is involved in, and outlines our priority areas for 2017/18.

I hope you find the report useful.

David Regan
Director of Public Health
Manchester City Council

Chapter 1: Strategic context and population health

Strategic context

1.1 A Healthier Manchester details the strategic approach we are taking to improve health outcomes across the city. It is a commissioning plan for health and care integration that consists of three key strands:

- **A single commissioning system** (Manchester Health and Care Commissioning), which will ensure the efficient commissioning of health and care services on a citywide footprint
- **A Local Care Organisation** (LCO), which will deliver integrated, accessible out-of-hospital health and care services within Manchester's neighbourhoods
- **A single Manchester hospital service**, which will deliver cost efficiencies and strengthened clinical services.

1.2 The sustainable future of health and care services in Manchester depends on strong partnerships and effective collaboration. It depends on working closely with local communities and voluntary and community sector groups to make the best use of the existing skills, knowledge, support and resources that make such a valuable contribution to the overall health and wellbeing of our city.

1.3 This asset-based approach is the essence of what Our Manchester is all about, and working with residents and communities is an established way of working for the public health team. The Age-Friendly Manchester (AFM) programme has been an integral part of the Manchester public health system for over 12 years, supporting older people to play a full part in the community and to remain healthy and active for longer. We are well placed to take the learning from AFM and several other programmes and provide leadership across the local system as it looks to develop new ways of working.

1.4 Our approach to the planning and delivery of our services, and engagement with our communities, is built around the concept of person, partner and place. We will continue to focus on what matters to the person, ensure that residents and communities are active partners in their health and wellbeing, and use place-based assets and resources such as local groups, networks, community facilities, parks and libraries to work with Manchester people.

1.5 The Manchester Health and Wellbeing Board's vision is that 'By 2025 the people of Manchester will be living longer, healthier and more fulfilled lives, and that we will have moved our local population from some of the worst health outcomes in the country to some of the best, adding 'years to life and life to years'. We want to achieve a genuine shift in the focus of services towards preventative intervention rather than reactive care and establish a culture of proactively intervening early to prevent existing problems getting worse.'

1.6 To achieve this vision, we will make use of a number of different approaches to improve the public's health:

- **Using health intelligence and information** allows us to identify current and future health needs, trends and priorities within communities and across the whole population of Manchester
- **Reviewing evidence and examples of best practice** ensures that the specific healthcare services we commission or provide are designed and delivered based on interventions that have clearly demonstrated they improve health and wellbeing
- **Working with a range of different partner organisations** ensures we can both lead and support collaborative working to improve health outcomes at a strategic level
- **Working with communitie**s means we can develop, strengthen and mobilise community assets for health, as well as support community action and self-care initiatives that give residents more control over their health and wellbeing

– **Influencing and advocating for improved public policy** at local, regional and national levels provides us with a platform to help shape policies and strategies to give us the best possible chance of improving health and wellbeing in Manchester.

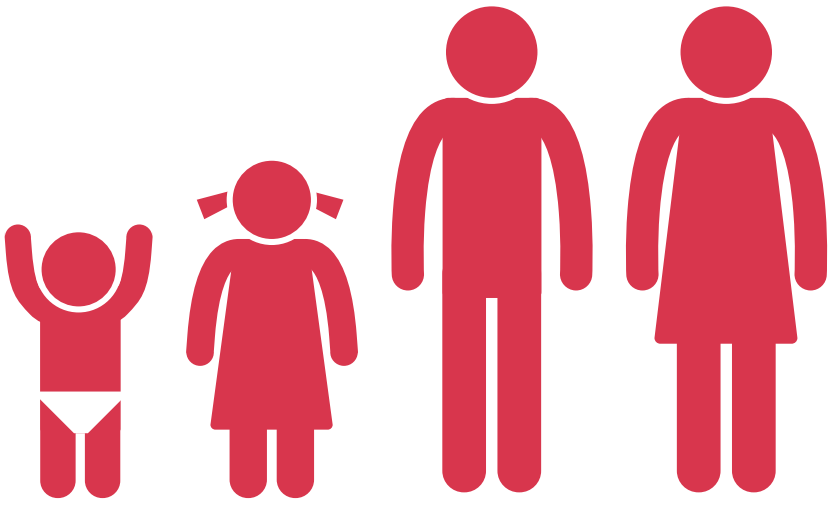
1.7 Examples of how we use these approaches are included throughout this report, along with further details about a broad range of services and interventions we fund and commission across Manchester. Readers who want to know more about a specific public health topic or programme of work can access the Joint Strategic Needs Assessment (JSNA) at **www.manchester.gov.uk/jsna**

Population health profile

1.8 Manchester has a resident population of 530,292 (mid-2015 population estimate), of which 20% are children aged 0–15; 70.6% are adults aged 16–64 and 9.4% are adults aged 65 and over. We have a lower proportion of older adults than England (18%) and a greater proportion of people from non-white ethnic groups (41% compared with 20% nationally). Manchester is one of the 20% most deprived districts/unitary authorities in England, and the health of people in Manchester is generally worse than the England average.

1.9 The largest contributors to the gap in life expectancy in Manchester are circulatory diseases, cancers and respiratory diseases. Recent data shows that we have made sustained progress in some areas, with notable reductions in teenage pregnancy rates, as well as reductions in premature mortality from cardiovascular diseases and suicide. However, there is still considerable work to be done to narrow the health gap between Manchester and the national average, as well as the need to reduce inequalities within different areas of the city. The latest data shows that life expectancy is 8.5 years lower for men and 7.1 years lower for women in the most deprived areas of Manchester compared to the least deprived areas.

1.10 The table below outlines the key health statistics for Manchester in 2016 and compares our health outcomes with the England average.



20%
of Manchester children are aged 0–15

70.6%
of Manchester adults are aged 16–64

Key health statistics for Manchester (2016)

Population		
Resident population estimates and 2011 Census	**Manchester**	**England**
Total population (mid-2015)	530,292	54,786,327
Children (0–15)	20%	19%
Working age (16–64)	70.6%	63.3%
Retirement age (65 and over)	9.4%	17.7%
Ethnic group: Non-White British (2011 Census)	40.7%	20.2%

Wider determinants of health		
	Manchester	**England**
Deprivation: Index of Multiple Deprivation (IMD) 2015 – % Lower Super Output Areas (LSOAs) in most deprived 10% nationally	40.8%	–
Child poverty – Children under 16 in low-income families (2014)	35.6%	20.1%
School-readiness (2015/16)	63.7%	69.3%
Educational attainment – 5+ GCSE A*–C English and Maths (2014/15)	46.9%	57.3%
16 to 18-year-olds not in education, employment or training (2015)	6%	4.2%
People aged 16-64 in employment	62.2%	72.9%
Jobseeker's Allowance (JSA) and Universal Credit (UC) claimants (December 2016)	2.6%	1.7%
Fuel poverty (2014)	14.5%	10.6%
Social isolation (2015/16)	44.2%	45.4%

Health improvement		
Births and conceptions	**Manchester**	**England**
General fertility rate (2015)	58.9	62.5
Low birth-weight births of term babies (2014)	3.7%	2.9%
Under-18 conception rate (2014)	32.3	22.8
Lifestyles	**Manchester**	**England**
Prevalence of obesity among reception-age children (2015/16)	11.4%	9.3%
Prevalence of obesity among children in Year 6 (2015/16)	25.1%	19.8%
Smoking prevalence – 18 years and over (2015)	22.7%	16.9%
Admission episodes alcohol-related conditions – Narrow (2014/15)	860	640
Reported prevalence of disease (QOF)	**Manchester**	**England**
Coronary Heart Disease (CHD) (2015/16)	2.5%	3.2%
Stroke or Transient Ischaemic Attacks (TIA) (2015/16)	1.3%	1.7%
Chronic Obstructive Pulmonary Disease (COPD) (2015/16)	1.9%	1.9%
Hypertension (2015/16)	10.3%	13.8%

Health protection		
Immunisation, vaccination and screening	**Manchester**	**England**
Childhood immunisation uptake (2014/15)	95.3%	95.7%
Influenza vaccination uptake 65+ years (2015/16)	70.1%	71%
Breast-screening coverage 53–70 years (2014/15)	61.6%	75.4%
Cervical-screening coverage 25–64 years (2015/16)	64.8%	72.7%

Healthcare and premature mortality		
Overarching indicators	**Manchester**	**England**
Life expectancy at birth (2013–15) – Males	75.6	79.5
Life expectancy at birth (2013–15) – Females	79.8	83.1
Infant mortality rate (2013–15)	5.1	3.9
5 year-old children free from dental decay (2014/15)	67.3%	75.2%
Injuries due to falls in people aged 65 and over (2014/15)	2,889.3	2,124.6
Premature mortality (directly standardised rates per 100,000)	**Manchester**	**England**
Mortality from causes considered preventable (2013-–15)	320.5	184.5
Cancers considered preventable: 0–74 years (2013–15)	129.3	81.1
Cardiovascular diseases considered preventable: 0–74 years (2013–15)	89.5	48.1
Respiratory diseases considered preventable: 0–74 years (2013–15)	45.9	18.1
Liver disease considered preventable: 0–74 years (2013–15)	29.4	15.9
Suicide and injury undetermined: 10+ years (2013–15)	10.5	10.2

For further information on any of the indicators used in this fact sheet, please contact:

Manchester Public Health Team
Town Hall Extension
Manchester, M60 2LA

Tel: (0161) 234 4089
Email: phm@manchester.gov.uk

Chapter 2: Wider determinants of health and wellbeing

2.1 Manchester's overall health status is significantly affected by the wider determinants of health and wellbeing – the conditions in which people are born, grow, live, work and age. The way in which the wider determinants are distributed across Manchester is strongly linked to health inequalities and the varying health status seen between different sections of the population.

2.2 Determinants such as lack of income, inappropriate housing, poor access to healthcare, poor air quality and exposure to violence are some of the factors that affect the health and wellbeing of Manchester residents. Similarly, determinants such as a good education, public planning that prioritises health, legislation that minimises exposure to harmful products and support for healthy living can all contribute to better life chances and improved health outcomes.

Key facts

2.3 We face many challenges related to the wider determinants of health and wellbeing. The most recent Indices of Deprivation (2015) rank Manchester as England's fifth most deprived local authority, and the second most deprived in terms of risk of premature death and the impairment of quality of life through poor physical or mental health. As of December 2016, 6% of the city's 16 to 18-year-olds are not in education, employment or training (NEET) compared to 4.2% nationally, and the proportion of adults aged 16 to 64 years claiming Jobseeker's Allowance and Universal Credit is higher than the national average (2.6% in Manchester compared to 1.7% in England). Only 62.2% of adults aged 16–64 in Manchester are in employment compared to 72.9% in England. 14.5% of households in Manchester experience fuel poverty compared to 10.6% of households nationally, and the percentage of adult social care users in Manchester who report having as much social contact as they would like is 44.2% compared to a 45.4 % average of service users in England.

62.2%

of Manchester adults aged 16–64 are in employment

Achievements in 2016

2.4 This year we have delivered a range of interventions and policy initiatives that directly address the wider determinants of health in a bid to improve the health status of those affected.

2.5 We have taken significant steps to address domestic violence and abuse in Manchester from a public health perspective, contributing to the development of a general practice-based training, support and referral programme known as IRIS (Identification and Referral to Improve Safety). The service, provided by Women's Aid, received 273 referrals for victims of domestic violence to access support in 2016. In conjunction with Manchester's Clinical Commissioning Groups (CCGs) and Women's Aid we have secured additional funding to ensure the project will cover all GP practices in Manchester over the next two years.

2.6 We used our new responsibilities in licensing to influence local action aimed at reducing the amount of alcohol-related harm in the city. We reviewed the Council's statement of licensing policy and demonstrated how legislation on the affordability and availability of alcohol affects use and misuse. We also led on a research project in the city centre identifying levels of illegal sales of alcohol to drunk individuals and its relationship with alcohol-related disorder and hospital admissions.

2.7 We have built on existing suicide prevention work in Manchester and developed a multi-agency suicide prevention action plan. As a group, we have mapped local assets, carried out a joint strategic needs assessment, strengthened local partnerships, aligned our approach with other local and national strategies, and gathered the views of a range of stakeholders, including people with lived experience. The plan outlines our commitment as a partnership to ensure local action is based on the best available evidence and data, and over the course of the next two years the partnership will be delivering a range of actions to raise awareness and reduce the stigma of suicide. This will include resilience workshops for the public, and suicide prevention awareness sessions for staff across Manchester.

2.8 This year we have maintained and promoted a food bank directory to support people using services to access emergency food provision and additional support. We have also worked with the Oral Health Improvement team to ensure that more families experiencing food poverty are able to access toothpastes and toothbrushes.

What's next in 2017?

2.9 This year we will continue to develop our work to introduce the domestic violence IRIS programme across all GP practices in Manchester. In addition to our input on alcohol licensing, we have established a new Manchester Tobacco Alliance, chaired by the Director of Public Health, which will include work with trading standards to tackle illicit tobacco products and investigate illegal sales of alcohol and tobacco to children under the age of 18 in the city.

2.10 We will lead partnership work to address the mental health and wellbeing needs of children and young people involved in, or at risk of being involved in serious crime.

We will lead the implementation of our suicide prevention action plan, including strengthening support for people at risk of suicide and those who have been bereaved.

2.11 There will be further work on food poverty and healthy eating this year, including an application to achieve accredited 'Sustainable Food Cities' status. Our work on sustainable food also complements our work on the climate change action plan, and we will be supporting our community food-growing projects to monitor their carbon savings through measuring crop yields.

2.12 Under the Neighbourhoods and Environment Scrutiny Committee a Task and Finish Group has been established to consider, among other things, the impact of poor air quality on health. The final report will be published in summer 2017 and the public health team, in partnership with Public Health England and other organisations, will develop a local action plan in response to the report's recommendations.

2.13 The case study below highlights one of the examples of work under this theme.

Case study: Growing Manchester

Target population group
All residents of Manchester

What the case study illustrates
- Working with partners
- Working with communities and asset-based approaches
- Enabling self-care

What the programme or commissioned service is aiming to do
Growing Manchester is a Food Futures programme to help support local community food-growing projects as part of our shared ambition to grow and live sustainably.

Originally established as a pilot programme in 2010 with ten projects, Growing Manchester has flourished and now supports over sixty-five Manchester-based community food projects to grow their own fresh, healthy and sustainable food.

Funded from the public health grant in Manchester, the aim of the programme is to ensure that local people and communities with the enthusiasm to grow food can access the support their project needs to succeed. We have commissioned a delivery partner called Sow the City, which provides hands-on expert horticultural support for our growing groups, helping them to become more self-sufficient and sustainable in the long term. Through this partnership, we also aim to use Growing Manchester as a platform to increase awareness of the effects of food production on climate change, and to improve the physical and mental wellbeing of not only those involved in our projects but the local and wider community as a whole.

Impact
The Growing Manchester programme was formally evaluated by The University of Manchester in 2013, and it was found to contribute towards an increase in food-growing skills, a wider consumption of fruit and vegetables, and increased physical activity. There was also clear evidence of the therapeutic benefits derived from the project's gardening activities, including improving and calming mood, and the increased confidence developed through a sense of achievement. In 2015, over 650 people engaged in one of the bespoke training sessions or workshops provided as part of the package of support we commission for groups. The programme has been successful in connecting different communities and, as the programme grows, we hope to better demonstrate the full range of positive impacts that Growing Manchester has on the health and wellbeing of our communities. The programme will continue to support groups to become more self-sufficient and sustainable in the long term, with dependency on Growing Manchester lessening as groups feel more confident in successfully running their own growing initiatives.

over 65

Manchester-based community food projects are supported by Growing Manchester

Chapter 3: Starting well and developing well

3.1 There is a substantive body of evidence that a child's life chances are most heavily predicated on their development in the first five years of life. Family background, parental education, good parenting and the opportunities for learning and development in these crucial years all play a significant role in helping to determine whether a child's potential is realised in adult life.

3.2 Investing in children's public health is potentially the most important – and most effective – commitment any society can make to its future. What happens before and during pregnancy, in the early years and during childhood has lifelong effects on many aspects of health and wellbeing in adulthood, such as obesity, heart disease, mental health, educational achievement and economic status. To make a meaningful difference and reduce avoidable inequalities in health, we need to tackle not just the health problems but the determinants of those problems (the 'causes of the causes').

3.3 We commission a number of public health services for babies, children and young people. We have responsibility for the citywide health-visiting service for 0 to 5-year-olds, and our School Health Service delivers the Healthy Child Programme, screening services (vision, hearing and looked after children reviews), school-age immunisations, and the National Child Measurement Programme (NCMP). The NCMP is one of the Council's mandated public health responsibilities, requiring the measuring and weighing of children at school in their reception year and year 6. We also commission a community weight-management service, which assists obese and overweight children between the age of 2 and 18 years to reach and maintain a healthier weight.

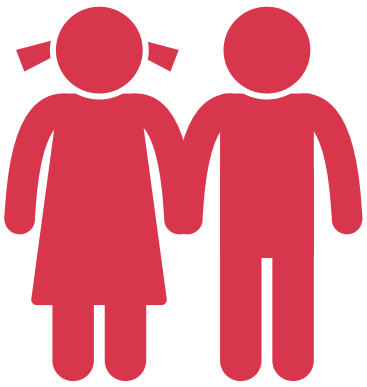
3.4 To reduce avoidable accidents or harm to young children we commission two child-accident prevention programmes: the Early Learning for Safety programme, and the Injury Minimisation Programme for Schools. We also have an Oral Health Improvement Team, which focuses on improving oral health in babies and children, and runs the dental-milk-in-schools scheme. We have input into other services commissioned by colleagues within the public health team, and children and young people are catered for in our sexual health, substance misuse and domestic violence strategies and services.

Key facts

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

3.6 The level of child poverty in Manchester is significantly worse than the England average, with the latest data showing that 35.6% of children aged under 16 years live in poverty, compared with the England average of 20.1%. Poverty has significant consequences for preschool children in terms of their physical health and wider functioning, such as reading ability and speech and language development. In 2015/16, only 63.7% of children in Manchester achieved a good level of development based on factors such as communication and literacy skills prior to entry to formal education. This is lower than the England average (69.3%).

3.7 25.1% of children in year 6 are classified as obese. Levels of teenage pregnancy, GCSE attainment, breastfeeding initiation, and smoking at time of delivery are also worse than the England average. In March 2015, 1,235 children were in the local care system.



63.7%
of Manchester children achieved a good level of development prior to formal education

Achievements in 2016

3.8 We have focused on redesigning and commissioning new services to make them more sustainable and help us meet the needs of children in Manchester. Responsibility for commissioning children's public health services was fully transferred to the Council this year, and we produced a comprehensive JSNA for children and young people.

3.9 We introduced a new model for school nursing and strengthened our relationships with other departments within the Council, providing leadership at both the Children's Board and Safeguarding Children's Board. We have implemented more than seventy Change 4 Life clubs in primary schools to increase the physical activity of children.

3.10 We have commissioned a new sexual and reproductive health service for young people. As well as the clinical aspect this service provides a strong educational element. A team of sexual health education outreach workers are available to deliver workshops, group work and one-to-one sessions directly to young people across a wide range of settings.

Working with colleagues across Greater Manchester we have also commissioned a new opportunistic chlamydia screening programme for 16–24 year olds.

3.11 Every mainstream school in Manchester now has a named school nurse, and in 2016 the school nursing service delivered health-promotion activities and sessions to almost 15,000 children, 850 staff and over 200 parents. We have also seen a reduction in the number of obese reception-age children, resulting in the lowest prevalence of obesity recorded in Manchester since the introduction of the NCMP in 2006. However, it is acknowledged that the figures for year 6 children remain a serious cause for concern that require our ongoing attention.

What's next in 2017?

3.12 This coming year we will be focused on delivering the Greater Manchester Population Health Plan, which aims to deliver the greatest improvement in health and wellbeing by raising population health outcomes in Greater Manchester compared to those projected for England over the next five years. The programme will aim to improve a wide range of outcomes for children in Manchester, including a reduction in the number of low birth weight babies and the number of children living in poverty, by raising the number of parents in good work.

3.13 We will continue our work to improve childhood immunisation uptake coverage, as well as focus on the reduction of tooth decay and risky alcohol and drug misuse in young people across the city. Our safeguarding agenda will include further work on tackling child sexual exploitation and female genital mutilation, as well as a formal review of Manchester's substance-misuse strategy for young people to ensure that our services are able to meet the evolving needs of the local population. Finally, we will strengthen our input to the Reducing Childhood Obesity in Manchester (RCOM) programme to ensure that there is a co-ordinated approach across all partner agencies and clear milestones for improvement over the medium to long term.

3.14 The two case studies below provide further information on work under this theme.

Case study: Integrated Children's Public Health Service (Manchester City Council and Clinical Commissioning Groups)

Target population group

The Integrated Children's Public Health Service is a universal service for school-aged children and young people.

What the case study illustrates

- Working with partners
- Influencing and advocacy at local, Greater Manchester and national levels
- Commissioning.

What the programme or commissioned service is aiming to do

The Integrated School Health Service comprises the School Nursing Service and Healthy Schools Team. The service is commissioned by Manchester City Council and provided by the Central Manchester Foundation Trust (CMFT). Following consultation and reconfiguration of services, the service was launched in November 2016 with the aim of providing a universal, integrated offer for school-aged children and young people in Manchester to improve their health and wellbeing. The service provides resources, training and delivery for staff and pupils on topics such as healthy eating, emotional health, sex and relationships, drugs and alcohol, and accident prevention.

Impact

- Every primary school in Manchester has an offer of three hours' service each week from their named school nurse, and every secondary school has an offer of six hours' service from their named school nurse.
- 87% of schools are engaged with the Healthy Schools Programme.
- The launch of the new model has increased school-nurse capacity to deliver health-promotion activities and continue their safeguarding role.
- Healthy Schools practitioners have delivered training sessions to 840 school staff and 26 bespoke in-school training sessions to meet the identified needs of individual schools. There have been 179 visits to schools to engage them in the Healthy Schools Programme, resulting in a higher-than-expected number of schools signing up to the new delivery model.
- Trained school staff in appropriate responses to emergencies (including first aid).

87%
of Manchester schools are engaged with the Healthy Schools Programme

Case study: Teenage pregnancy prevention and sexual health education outreach

Target population group

Young people aged 19 and under (24 and under for young people with special educational needs).

What the case study illustrates

- Using health intelligence and evidence
- Working with partners
- Working with communities and asset-based approaches
- Enabling self-care
- Influencing and advocacy
- Commissioning

What the programme or commissioned service is aiming to do

Sexual ill health is a particular issue for young people in Manchester. Young women and men account for over half of all diagnoses of genital warts and genital herpes and over four-fifths of all diagnoses of chlamydia. The under-18 conception rate for Manchester, though falling, is higher than rates across Greater Manchester and England.

We are keen to improve the sexual and reproductive health of young people. We want to ensure that young people have the knowledge and understanding, skills and confidence to negotiate and practise safe and consensual sex, and to develop and form healthy, positive relationships. This is based on a rights-respecting model.

We continue to address teenage-pregnancy prevention and support, not least because we understand that outcomes for teenage parents can be poorer than for older parents. This is also the case for their children.

We commission and fund dedicated sexual health services for young people. Brook and Fresh (part of the Northern Sexual and Reproductive Health Service) deliver centre-based and outreach services. Young people are able to obtain the full range of sexual and reproductive health provision from these services.

We also support work to improve the provision of Sex and Relationships Education (SRE) in schools and other settings. SRE is a strong, protective factor for young people, and addressing issues such as consent has the potential to contribute to other agendas around safeguarding and child sexual exploitation (CSE) through enabling young people to recognise, navigate and avoid potentially abusive or exploitative relationships. The Brook and Fresh outreach teams work with the SRE lead in the Healthy Schools Team, who has led the development of the 'I Matter' safeguarding curriculum for key stages 3 and 4 (high schools and academies).

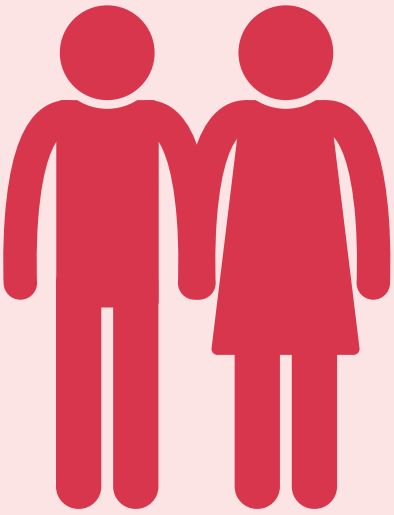
The sexual health education outreach workers deliver group work, informal education sessions and workshops, which encourage and empower young people to take ownership of their sexual and reproductive health needs. The sessions are adapted to meet the needs of the specific group of young people and all echo the content of the 'I Matter' safeguarding curriculum. The educational outreach workers also offer one-to-one sessions with individual young people who are identified as being particularly vulnerable. Young people may also be referred to the clinical outreach team, a Fresh clinic or to the Brook clinic.

Our partnership approach aims to ensure that the offer is available across a wide range of settings, including schools and colleges, pupil referral units (PRUs), residential care homes and supported housing provision. It is important that the reach is extensive, as some of the young people who might be most at risk of early parenthood and/or poor sexual health might also have had poor school attendance and have missed relevant lessons.

Our work is informed by a range of data and intelligence sources, including guidance and research specifically about teenage pregnancy prevention published during the course of the national Teenage Pregnancy Strategy (1999–2010), data from the Office for National Statistics (ONS), local intelligence and expertise within Greater Manchester, and national networks.

Impact

- The clinical and education outreach teams have contributed significantly to improving the knowledge and understanding of the risks associated with unprotected sex. They have raised awareness of the importance of using condoms and reliable methods of contraception, as well as sexually transmitted infections and regular screening.
- This is contributing to a reduction in the number of under-18 conceptions, unintended conceptions, and controlling the transmission of sexually transmitted infections.
- Investing in sexual health services has delivered cost savings for local authorities and the NHS, including the costs of treating infections and providing abortion services.



reduction

in the number of under-18 conceptions, unintended conceptions and sexually transmitted diseases

"Interactive sessions encourage and empower young people to take ownership of their sexual and reproductive health"

Chapter 4: Living well and working well

4.1 There is a clear relationship between being in meaningful work and improved health and wellbeing. Employment and socioeconomic status are the main drivers behind improved physical and mental health; conversely, unemployment often results in poorer general health, an increased likelihood of longstanding illness, poorer mental health and a higher number of medical consultations and hospital admission rates.

4.2 Poor skill levels and worklessness still characterise many of the city's communities. Progression into more and better-paid work for our local population is a priority, and this needs to be supported through increased skill levels to enable more of our residents to benefit from job growth within Manchester. In recent years, the public health team and our healthcare partners have focused on the integration of health, work and skills provision to help get more people in Manchester back into employment.

4.3 Our living and working well approach also focuses on a range of wider determinants of health, such as good-quality housing, community connections and being employed in meaningful work. We also commission specific services that address lifestyle factors detrimental to health, such as tobacco use, poor diet, substance misuse and physical inactivity.

4.4 We commission a range of services to support our living well and working well goals for Manchester. The HEALTHY Manchester service, jointly commissioned by the Council and the Manchester CCGs, works with patients who are experiencing difficulty managing their health conditions and so find it difficult to find or remain in work. Delivered via a number of GP practices across the city, the programme helps patients receive appropriate support and management for conditions or concerns that are holding them back from gainful employment, and helps prepare them to return to work.

4.5 The public health team has helped develop the strategic response to the growing problem of rough sleeping and homelessness in the city, and we have been heavily involved in the development of the Manchester Homelessness Charter. The charter identifies priority areas for homeless people, such as improving mental health provision, increasing emergency accommodation for rough sleepers, creating an indoor evening provision for rough sleepers, increasing employment opportunities, and improving substandard temporary accommodation.

4.6 We have a citywide community nutrition support service that identifies people who are malnourished or at risk of malnourishment, and a community lifestyle weight-management service for overweight adults and children that provides advice on diet and healthy eating habits, physical activity, reducing the amount of time spent being sedentary, and strategies for changing behaviour. We also have a specialist weight management service that provides targeted interventions to specifically address maternal and adult obesity.

4.7 Our drug and alcohol services provide a comprehensive range of services for adults across the city. Our integrated sexual and reproductive health service also offers routine, intermediate and specialist sexual and reproductive health services in clinics and via outreach services. Our HIV/STI prevention services work with most at-risk populations to promote safer sex and to support efforts to control and prevent the transmission of infections. Our HIV support services work to improve outcomes for children, young people and adults living with HIV.

4.8 We also commission Primary Care to deliver services. Community pharmacy provide clean needles to individuals and dispose of used needles. They also provide supervised consumption of methadone for individuals receiving treatment for their opiate use. They also provide free emergency hormonal contraception, and are able to provide testing and treatment for chlamydia and gonorrhoea. General Practice provides long acting reversible contraception to women, alongside testing and treatment for sexually transmitted infections. The NHS Health Checks programme is

delivered by General Practice. The practice invites patients who meet the criteria to have a health check. The health check can identify people who have an increased risk of cardiovascular disease (CVD) and provide the necessary advice to help reduce an individual's CVD risk.

4.9 Our 'buzz' wellbeing service delivers health promotion services, such as stop smoking support, advice on reducing alcohol consumption, improving nutrition, and increasing levels of physical activity. The service also delivers training and produces a range of information resources to support collaborative working between a range of health and social care partners.

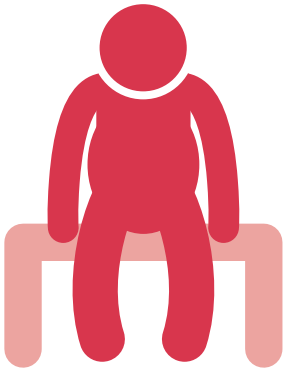
Key facts

4.10 The health and wellbeing of adults in Manchester is generally worse than the England average.

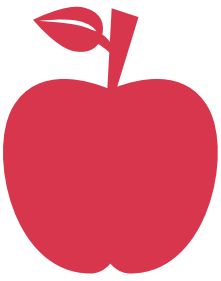
4.11 In Manchester, high rates of health-related worklessness have persisted throughout periods of both economic growth and economic downturn. As of 2016, 44,340 Manchester residents claim out-of-work benefit, with 31,270 of this number claiming Incapacity Benefit (IB) or Employment Support Allowance (ESA). Over 50% of those claiming sickness-related benefits have mental and behavioural disorders as the primary health condition and/or substance-misuse issues (it is common for claimants to have multiple conditions, but the Department for Work and Pensions only reports the primary condition for data purposes).

4.12 22.7% of adults in Manchester smoke compared to the national average of 16.9%, with smoking resulting in 734 deaths per year in Manchester. Around 61.5% of adults in Manchester are classified as being overweight or obese, and 33.9% are physically inactive. Less than half of adults (41.4%) meet the recommended guidance to eat five portions of fruit and vegetables on a usual day.

4.13 The number of admissions to hospital for alcohol-related conditions in Manchester is 860.8 per 100,000 population, compared to 640.8 per 100,000 nationally. The number of emergency admissions to hospital for self-harm is 225 per 100,000 population, with 1,263 self-harm related stays in hospital per year.



33.9%
of Manchester adults
are physically inactive



41.4%
of Manchester adults
meet the five-a-day guidance

Achievements in 2016

4.14 During a year of organisational change we reshaped our services to better meet the needs of our local population. We delivered a new community-based model for our NHS Health Checks programme, with pop-up clinics now available in libraries and numerous other community settings making access to services easier and more equitable for local residents.

4.15 We have played an increasingly active role within wider partnerships in the city. The Director of Public Health (DPH) is the lead for reducing alcohol and drug-related crime for the Community Safety Partnership (CSP) and we have also led CSP-funded projects on new psychoactive substance use.

4.16 The HEALTHY Manchester service has been a considerable success and received positive feedback from patients who have used the service: over 75% of patients recorded an improvement in their mental health and 90% reported positive adjustments in their attitude towards health, lifestyle and confidence in managing their own wellbeing. More than a quarter of service users made fewer appointments with their GP and over a third were in employment at the point of discharge (more details on the HEALTHY Manchester service and our wider health and work programme can be found in the 2016 State of the City Report).

What's next in 2017?

4.17 Work and health is a key priority in the Greater Manchester Population Health Plan and this will support a number of strategic developments planned for the year ahead. The HEALTHY Manchester service will be delivered in more GP practices in the city, and possibly in other boroughs in Greater Manchester. With the Department for Work and Pensions we will also be looking at further opportunities for innovation and investment to reduce the number of people out of work in Manchester; this will include the development of an early intervention model for Universal Credit claimants to improve health and work outcomes. As advocates for appropriately paid work as a means to improve health and wellbeing, we will also continue to support the implementation of the local living wage policy.

4.18 We will be reviewing and updating our JSNA in relation to living well and working well, and we also have responsibility for overseeing the production of Manchester's Pharmaceutical Needs Assessment (PNA). We will also be reconvening a professional advisory group for alcohol and drugs, and evaluating the impact our redesigned substance-misuse services have on patient outcomes. Moreover, we will be reviewing our investment in primary care sexual and reproductive health provision.

4.19 The two case studies below provide further information on work under this theme.

75%
of patients recorded an improvement in their mental health

Case study: Commissioning an integrated alcohol and drug early intervention and treatment service for adults

Target population group

Adults aged 18 and above who are dependent on alcohol and/or drugs, or who are at risk of becoming dependent.

What the case study illustrates

- Using health intelligence and evidence
- Working with partners
- Working with communities and asset-based approaches
- Enabling self-care
- Commissioning.

What the programme or commissioned service is aiming to do

We have been working with partners to review and redesign alcohol and drug early intervention and treatment services for adults in Manchester. The previous treatment system for adults is comprised of three drug treatment services, two alcohol services, and additional services for harm reduction (needle exchange) and prevention.

Using health intelligence data to understand current alcohol and drug-related needs and service capacity in the city, we identified a need to rebalance our services to increase the availability of alcohol treatment due to changing patterns of use. A new integrated service was designed, based on the best available evidence from Public Health England and the National Institute for Health and Care Excellence (NICE). This was put out to consultation with service users, health and social care services, the voluntary and community sector, and members of the general public. Following the consultation and a competitive tender process, the new integrated alcohol and drug service for adults became operational in April 2016.

The service works towards a number of outcomes aimed at reducing alcohol and drug-related harm to individuals, families and communities in the city.

The wider determinants of health that impact on the health and wellbeing of service users, their families and the wider community are addressed by:

- Recovery from alcohol and drug dependence
- Improving physical and mental health and wellbeing
- Reducing alcohol and drug-related crime
- Access to accommodation, education and employment
- Strengthening families and other relationships.

Our priorities for the first year of delivery are to increase access for people with alcohol misuse issues and reduce waiting times for access to treatment (for all substances). To support increased accessibility and availability of alcohol and drug early interventions and treatment, the service is working from a number of community venues. The service uses strength-based approaches to assessment and care planning, and offers a range of harm reduction, brief interventions and treatment. These include needle and syringe exchange, alcohol treatment for different treatment goals (such as reduced/controlled drinking or abstinence), recovery-focused psychosocial interventions for users of a range of substances (including new psychoactive substances), substitute prescribing for heroin users, peer mentoring, and mutual aid support both during and after treatment.

Impact

The redesign of services in Manchester ensures that we are better able to meet the changing patterns of substance misuse in the city. Our investment addresses the increasing number of people who require access to alcohol misuse interventions, representing better value for money and the most appropriate use of limited resources. The redesign was also an excellent opportunity to strengthen links with other agencies to provide targeted support for specific groups, such as older people with alcohol and prescription drug misuse, and homeless people specifically identified as at risk of heroin overdose. As the longer-term impact of the redesign becomes clear, we expect to see improvements in successful treatment completion, and reduced alcohol-related hospital admissions.

Case Study: Homelessness

Target population group
People who are homeless

What the case study illustrates
- Working with partners
- Working with communities and asset-based approaches
- Influencing and advocacy

What the programme or commissioned service is aiming to do
The public health team has helped develop the strategic response to the growing problem of rough sleeping and homelessness in the city. One of the key components has been to drive the process of developing the Manchester Homelessness Charter.

The city has come together to develop a Charter to co-ordinate the response to homelessness across all sectors, including members of the public, the business community, voluntary groups, the faith sector, health and social care services, and homeless people themselves. Working alongside Mustard Tree – a Manchester-based homelessness charity – a pledge framework and action groups have been developed to co-ordinate a response to the issues that homeless people themselves have identified as the most important. Central to this is the belief that solutions are developed in partnership with people who have experienced homelessness and that they must play a central role in each action group.

Impact
The city is working in a more co-ordinated way than before to tackle the challenge of homelessness. People with experience of homelessness are actively involved in the design of new approaches, and co-producing solutions in the following areas they identified as the most important:

- Finding employment for people who have been homeless
- Redesigning the women's direct-access hostel
- Improving the experience of presenting as homeless at the Council
- Improving substandard temporary accommodation
- Improving access to appropriate substance-misuse services
- Ensuring that there are alternative ways for the public to give money and reduce begging
- Addressing mental health issues in homeless people
- Increasing the supply of emergency accommodation
- Developing evening services for homeless people
- Increasing opportunities for homeless people to engage in the arts through the city's cultural institutions and industries.

Manchester's Clinical Commissioning Groups and Central Manchester Foundation Trust have signed up to the Charter and are supporting the work to improve inclusion for homeless people. This is done by pledging to ensure that homeless people get equal and fair access to NHS services and that they are regularly represented in our patient advisory groups. Manchester's health and care organisations have also committed to connecting to the commissioning of health and social care services with housing, employment and education colleagues.

Chapter 5: Ageing well

5.1 Older people in Manchester deserve every opportunity to age well in communities that value their experience. As people grow older they generally tend to spend more time in their own neighbourhoods and communities, and increasingly use local services and amenities. In Manchester, we want to ensure that every community is 'age-friendly' and that it provides older people with what they need to live a happy, healthy life.

5.2 Building an age-friendly community requires an integrated approach to thinking about the places people live and how best to promote older people's wellbeing and engagement with their physical and social environments. This may include considering the quality of the built environment, housing with extra care options, good transport, accessible healthcare, and the availability of events, networks and social groups that reduce the likelihood of older people experiencing social isolation and loneliness.

5.3 Making our city a better place to grow older and in turn improving the lives of older people have been at the heart of public health work in Manchester for over 12 years. Our Age-friendly Manchester team, working in partnership with older people and a range of public, private, voluntary, community and social enterprise sectors, is recognised regionally, nationally and internationally for its work. It has played an influential role in Manchester becoming the first UK city to join the World Health Organization's Global Network for Age-friendly Cities and Communities.

5.4 We commission the buzz Health and Wellbeing Service to deliver age-friendly networks across the city, and we have a falls prevention service that has 12 classes citywide designed for older people who have been identified as at risk of falling. We have a community falls prevention service made up of a multidisciplinary team that includes physiotherapists, occupational therapists, nurses, and falls rehabilitation practitioners. In addition, we fund and help facilitate a range of social and activity groups, such as community-led crafts, exercise and IT classes, swimming sessions, and dementia-friendly cafés, to support people to stay active, maintain community links and reduce the likelihood of loneliness and social isolation.

Key facts

5.5 Manchester has a smaller-than-average older population (9.4% of residents aged over 65 compared to a national average of 17.7%). The shifting demographic and significant growth in the number of younger people in Manchester mean many older residents live in areas that are changing and developing to meet the needs of a younger population. This can place older residents in Manchester at risk of social isolation and loneliness, both factors increasing the likelihood of poorer health and wellbeing, and subsequently placing higher demands on health, social care and housing services across the city.

5.6 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 and life expectancy at age 65 is poorer in Manchester than most parts of the country. Our hospital length of stay and total bed days for those aged over 65 are all significantly higher than the national average.

5.7 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, and according to recent estimates 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.

36.6%

of older people living in Manchester are classed as living in income deprivation

Achievements in 2016

5.8 We have contributed to the launch of the Greater Manchester Ageing Hub, which brings together planning, health and social care, culture, local authorities, the academic, voluntary and community sectors and economic partners to develop an ageing strategy for the Greater Manchester region. Greater Manchester also has a partnership with the Centre for Ageing Better, which has Big Lottery funding to invest in projects for a better later life, linked directly to the wider determinants of the economy, employment, planning, transport and housing.

5.9 Our Age-Friendly Manchester team launched the Older People's Charter to promote ageing well by reinforcing the rights of all older people in Manchester to live in an age-friendly city. Organisations across the city have made pledges towards the Charter, giving commitment to make real changes that improve life for older people.

5.10 Members of our Older People's Forum have contributed to Greater Manchester's Transport 2040 vision consultation, and we have seen a significant increase in older people accessing the arts and cultural activities.

5.11 We have been actively involved in a review of the Later Life Mental Health Services programme and dementia services in Manchester. This has seen the reinstatement of dementia adviser posts and there is ongoing work on improving diagnosis rates for dementia to ensure patients and carers can access support and advice at an earlier stage.

"We have seen a significant increase in older people accessing the arts and cultural events"

What's next in 2017?

5.12 We will continue to support the development of the Greater Manchester Ageing Hub and the Ageing Well theme of the Greater Manchester Population Health Plan.

5.13 We will focus on actions to improve the wider determinants of health for older people across the city. We have set a target of achieving 50 pledges from organisations to implement the Older People's Charter in the delivery of their services and will be supporting a range of initiatives to improve housing, reduce fuel poverty and address growing levels of social isolation. Working with our academic partners, we will continue to ensure that Manchester remains respected regionally, nationally and internationally as a centre of excellence for evidence-based, age-friendly initiatives.

5.14 We will continue to work in partnership with other Council colleagues and health and social care organisations to improve dementia awareness through our Dementia Friends programme. Our input into the local housing strategy will include incorporating dementia-friendly design in all new housing developments for older people, and we will explore opportunities to use assistive technology and telehealth to provide support for patients with dementia and their carers across the city.

5.15 There is more work to do to ensure that our falls prevention service has equitable coverage across Manchester. We will embed falls prevention classes at new community locations, and improve the monitoring and evaluation of the programme citywide with the introduction of a new outcomes framework. We will also look at developing our links with Manchester Leisure and the Greater Manchester Fire & Rescue Service to help identify older people at risk of falls in their own home who would benefit from a referral into our falls prevention services.

5.16 The case study below provides further information on work under this theme.

Case study: North City Nomads

Target population group

Older people living in or using services in north Manchester.

What the case study illustrates

- Working with partners
- Working with communities and asset-based approaches
- Reducing loneliness and social isolation
- Promotion of self-care.

What the programme or commissioned service is aiming to do

North City Nomads is a community membership group for people living, working or attending social groups in north Manchester. The group organises low-cost, accessible one-day trips out of the city to destinations such as Southport, Chester, Llandudno, Windermere and Blackpool.

North City Nomads grew out of the Age-Friendly Manchester locality networks and a desire to do something practical to help reduce social isolation and loneliness among older residents in north Manchester. Many older residents living in north Manchester experience multiple difficulties that contribute to limited social interaction, including lack of confidence, mobility and affordability issues, as well as difficulty accessing information.

The group offers members the option of purchasing low-cost tickets (usually around £10) for at least four seasonal outings every year. A group of volunteers manage the trips, which have a series of pick-up points. The trips are used as an opportunity to promote and raise awareness about a range of public health issues and priorities. For example recent trips have been used to promote campaigns for the flu jab and bowel cancer screening, resulting in over 150 completed screening questionnaires. Nomad's activities are also an opportunity for health partners to carry out focused engagement with older residents.

Impact

Demand for the service has been exceptionally high, and over the first 18 months there were almost 600 membership registrations from older people living in north Manchester, virtually all by word of mouth.

Feedback from members has been overwhelmingly positive. A lady aged 71 who lives alone on the tenth floor of an apartment block fed back that "just knowing that there are planned trips for the future is a comforting thought".

The group has evolved and now has a volunteer management committee, which is leading the development of the project and encouraging the community to take control of the group itself where possible. In the longer term the level of support provided by the Age-Friendly Manchester team can reduce once the group becomes more self-sufficient.

almost 600

membership registrations in the first 18 months

Chapter 6: Health protection and infection control

6.1 Protecting the health of the population is a key part of our work in public health. Our health protection team help to keep the people of Manchester safe from disease through the promotion of preventative measures (such as vaccination and good hygiene) and proactively managing outbreaks in conjunction with a number of health and care partners. Our Community Infection Control Team (CICT) provide advice, training and education around infection prevention and control. Through the proactive prevention and control of disease, they have a significant role to play in helping reduce levels of attendance at accident and emergency departments, as well as reducing ill health and length of illnesses that can impact on day-to-day life at school, work, home or when in care.

6.2 The health protection team also advise organisations responsible for delivering vaccination and screening programmes on how to improve their uptake, and act to ensure that all residents in Manchester have timely, equitable access to services.

Achievements in 2016

6.3 This year, we have focused a significant amount of effort on care homes in Manchester, helping to raise standards of cleanliness through a comprehensive audit programme. We introduced an infection control champions programme and launched revised documentation around outbreak control and cleaning to improve practice in care homes.

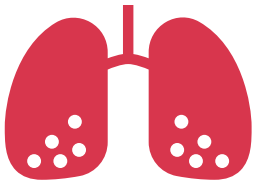
6.4 Our planned and reactive auditing of care and nursing home infection control procedures has led to significant improvements in standards, reducing risk to vulnerable adults receiving care.

We have worked with partner organisations to improve:

- compliance with local prescribing guidance,
- catheter care
- safe discharge planning
- quality record-keeping.

6.5 In conjunction with partners we have helped develop a toolkit for community providers to help health and care organisations prevent or reduce the spread of Carbapenamase Producing Enterobacteriaceae (CPE). We developed and provided 'Bug Busting' wellbeing information and training advice for all council staff to reduce avoidable infections in the workplace, and led investigations into MRSA (Methicillin-Resistant Staphylococcus Aureus) bloodstream infections.

6.6 Our ongoing work around TB prevention through the introduction of a Latent TB screening programme has contributed to a significant drop in the number of active cases recorded in Manchester, with a 25% reduction in cases of TB recorded since the programme began in 2014.



25% reduction

in the number of TB cases recorded since 2014

What's next in 2017?

6.7 We will continue to deliver a range of educational events across the health and social care sector, as well as develop our infection control champions network. This will include sessions on oral health and dehydration in the elderly, and cover information and advice around legionella.

6.8 Local health and social care system redesign will see an increase in the amount of care that is delivered to patients in their own home, and infection prevention and control in a home setting is an issue of significant importance. Consequently, we will be placing a greater focus on homecare and infection control this year, developing appropriate guidance and training for community health professionals and carers. We will also contribute to the issue of antimicrobial resistance, working locally with Public Health England, NHS England and medicine management teams to develop approaches to reducing the unnecessary prescribing or misuse of antibiotics.

6.9 This year will see the Latent TB screening service move out of secondary care and into GP practices across Manchester, and we will continue to support the Clinical Commissioning Groups that are responsible for delivering this service to ensure it remains equitable and accessible to all eligible patients. Having reached an all-time high in 2014/15 following our commissioning of a specific immunisation promotion project, immunisation coverage rates for children in Manchester have dropped over the course of the past year. We know that data quality and population transiency contribute significantly to lower coverage rates, and we will be using our expertise in this area to provide operational advice and support for GP practices and the child health information service, to ensure coverage improves to meet World Health Organization targets.

6.10 The two case studies below provide further information on work under this theme.

"We will continue to deliver a range of educational events across the health and social care sector"

We will support GP practices and the child health information service, to ensure immunisation coverage improves.

Case study: Screening for Latent Tuberculosis (TB) in new entrants

Target population group
All residents of Manchester

What the case study illustrates
- Using health intelligence and evidence
- Working with partners
- Influencing and advocacy.

What the programme or commissioned service is aiming to do
The majority of TB cases in England are the result of 'reactivation' of Latent TB Infection (LTBI), an asymptomatic phase of TB, which can last for years. LTBI can be diagnosed by a single blood test and treated with antibiotics, preventing active TB disease from developing. The purpose of the Latent TB screening programme in Manchester is to decrease and eliminate TB cases that result from the reactivation of Latent TB in new arrivals. Late diagnosis of TB is associated with worse outcomes for the individual, and in the case of pulmonary TB is a transmission risk to the public. LTBI screening is an important intervention for reducing avoidable harm, and it has also been shown to be an effective and cost-effective strategy to reduce the active TB burden across Manchester.

The location of our LTBI screening services has been determined by health intelligence data, including National Insurance number registrations, the distribution of active TB in Manchester, and access to healthcare services that are able to provide the service. We know that patients being able to book their own appointment time, or combining the LTBI screening service with a new patient health check, improves uptake and results in more patients attending and being screened. We also know that there is confusion among eligible patients around the different tests for Latent and Active TB, and this has informed the training we deliver to practice staff to ensure patients understand the difference – and importance – of attending for screening. We also know that some migrants may have more complex needs than the UK-born population, and that there is a strong stigma attached to TB in many BME groups that can potentially lead to both late diagnosis and a failure to undertake the full course of treatment.

Delivering a Latent TB screening service requires a number of different partner agencies to make it work effectively. We work very closely with our CCG commissioning colleagues across Manchester to plan the services we require, and work closely with primary and secondary care colleagues who deliver the screening service. We also work closely with Public Health England (which has national oversight of the programme), NHS England (which provides funding for the national programme), the North West Commissioning Support Unit (which supports us with the collection of all TB-related data), and a number of other voluntary sector organisations, such as The Black Health Agency and TB Alert. We are also part of a Greater Manchester TB Collaborative, which includes Bolton and Oldham CCGs – this will include an additional seven CCGs in 2017/18 that will deliver targeted LTBI screening for their local populations.

We provide much of the local and Greater Manchester leadership around LTBI screening because we have been running an LTBI screening service in Manchester since 2014. We are well placed to help other CCGs looking at commissioning and delivering their services for the first time. We have input at a national level as representatives on the LTBI delivery board, and have advised a number of CCGs around the country that are looking at developing their own screening programmes.

Case study: Managing outbreaks of communicable disease in a nursery or school setting

Target population group
All residents of Manchester

What the case study illustrates
- Using health intelligence and evidence
- Working with partners
- Enabling self-care.

What the programme or commissioned service is aiming to do
Reducing the risk of transmission of infection in the community is the main aim of the infection control team. Outbreaks of common childhood communicable diseases, such as gastroenteritis infection, norovirus, rotavirus and scarlet fever, are managed by the team. In the event of an outbreak situation, we work in conjunction with the Council's education services, health and safety team, environmental health, Public Health England (PHE), clinical services provided by NHS Trusts, and all staff who work in the nursery or school where the outbreak has occurred.

We are notified of outbreaks from a range of sources and it is our responsibility to obtain key information regarding the outbreak timeline, symptoms, numbers affected, ages and any contacts. Information regarding contacts is particularly important, as it may indicate a risk to vulnerable staff, for example those who are pregnant, or babies and young children who may not have been vaccinated against a particular infection.

During outbreaks we remain in daily contact with the school or nursery and provide advice on preventing the spread of infection, which can include information on school attendance, specific cleaning regimes, products for the environment, and care of toys. Advice on hand hygiene practices, laundering of items, baby changing/potty hygiene and toilet areas can be key to preventing the outbreak continuing.

Once the outbreak is over, we visit the site to undertake a post-outbreak review and an infection-control audit. We also use this opportunity to educate staff, pupils and parents, helping them to understand what has happened and how they can help reduce their risk, including information on self-care, immunisations, hand hygiene and general good-hygiene advice for keeping healthy at home.

Public health intelligence from a range of sources can help to inform or highlight where particular health-protection concerns may be in Manchester. For example, health intelligence on measles, mumps and rubella (MMR) vaccination may highlight particular areas in the city where coverage is lower than expected and allow us to consider our response to this from an outbreak management perspective. Similar health intelligence could be used for other communicable diseases, such as TB and seasonal flu.

Impact
Infection-control advice and support protects individuals in Manchester from unnecessary exposure to communicable infections and helps reduce the risk of transmission within the local population. Our collection and sharing of information on known outbreaks of infections with key partners and stakeholders in a daily report aids the surveillance of infection by Public Health England and contributes to national statistics on infections. We also help to ensure that ambulance services, hospital trusts or care providers put systems in place to prevent the spread of infection during transportation or on arrival at their destination care facility.

Chapter 7: Knowledge and intelligence

7.1 Knowledge and intelligence is one of the key functions of the public health team. Good-quality health intelligence supports health and social care organisations in Manchester to work together, and enables professionals to gain the knowledge, skills and tools they need to inform good-quality decision-making.

7.2 We have expertise in sourcing, analysing and synthesising the data, information and evidence required to understand the needs of the population, and we redesign, monitor and evaluate locally commissioned services. We also support teams and organisations to access and contribute to the local and national evidence base and help to translate this knowledge into actions that will improve the health and wellbeing of Manchester residents.

7.3 The impact of our work is seen in the way the planning, commissioning and delivery of services by the wider public health team and its partners is based on the best possible information, intelligence and insight into the health and care needs of the local population.

Key achievements in 2016

7.4 The use of health intelligence underpins all the work undertaken in public health. This year we produced the Children and Young People's Joint Strategic Needs Assessment (JSNA) and played a key role in the work to refresh the Health and Wellbeing Strategy for Manchester. We modelled the anticipated benefits of Manchester's new prevention programme to show the intended outcomes and benefits for Manchester residents and updated the Compendia of Population Health Statistics for Manchester.

7.5 On a day-to-day basis, we provided advice and support for a wide range of individuals, teams and organisations across both the statutory and voluntary and community sectors within Manchester and beyond. More widely, we contributed to the development of outcome measures as part of the Greater Manchester Population Health Plan and worked to inform and influence national policy through our involvement with the Health Statistics User Group for the UK.

7.6 We have provided training in order to help people access and make sense of published data and intelligence relating to the health needs of the population of Manchester. As part of a new postgraduate course developed by the University of Bolton and Central Manchester Foundation Trust, we delivered seminars for nurse practitioners to show them how being able to interpret and understand health data was crucial to the planning and delivery of services that better meet the health needs of local communities. We also co-ordinated Manchester's input to its work as part of the UK Healthy Cities Network and collected performance data for a range of our commissioned services.

7.7 We led the public health input into Manchester's 'Green and Blue' infrastructure strategy, providing advice and guidance on how improving the quality and accessibility of this would increase utilisation of active pursuits such as walking, cycling, jogging and sports to improve the health of residents and the city's large working population.

The use of health intelligence underpins all the work undertaken in public health

What's next in 2017?

7.8 We will be leading on the production and dissemination of the Adults and Older People's JSNA as well as the continuing development and update of the Children and Young People's JSNA.

7.9 We will be working with Manchester Health and Care Commissioning (MHCC) colleagues to develop a more joined-up business planning and intelligence system. This will underpin the strategy and business planning of the new single commissioning function that we will have in Manchester.

7.10 We will also support the new Local Care Organisation (LCO) by producing neighbourhood profiles for each of the 12 localities across Manchester in order to inform the development of local delivery plans for community services as part of the 'One Team' model of health and social care. In addition, we will support the development of new models of care for key groups of people through the production of profiles for specific population cohorts.

7.11 We will be leading on the evaluation and monitoring of the new citywide prevention programme as part of the work to understand the impact of different elements of Manchester's locality plan.

7.12 We will work with the Centre for Health Services Research and Primary Care at The University of Manchester and other local partners as part of a Medical Research Council (MRC)-funded study. This will investigate the potential for using a patient-based outcome measure for Chronic Obstructive Pulmonary Disease (COPD), the Living with COPD Questionnaire, at a local community level to capture the overall everyday impact of living with a long-term condition from the patient's perspective.

7.13 We will continue to provide day-to-day advice and guidance to help people and organisations access and make sense of data and intelligence relating to current and future demand for services. We will continue to encourage and support them to make the best use of the available evidence to inform the planning and commissioning of more integrated, cost-effective services locally.

7.14 The case study below provides further information on work under this theme.

"We will be leading on the evaluation and monitoring of the new citywide prevention programme"

Case study: Using data to understand neighbourhoods in Manchester

What the case study illustrates
Using health intelligence and evidence

Working with partners
- Influencing and advocacy at local and Greater Manchester levels
- Informing commissioning.

What the programme or commissioned service is aiming to do
In order to commission services effectively it is important to have a detailed understanding of our local population. One way of doing this is by using a population segmentation tool such as Mosaic. Mosaic can help us to understand the different types of households in the city, what they have in common, and how they are distributed, providing us with insight into how and why people make decisions about their health and care and how they are likely to respond to services. It allows us to tailor the services we commission so that they are in line with the needs and preferences of people living in different parts of the city.

Impact
Mosaic data has been used to gain a better understanding of the likely demand for health and social care services in Manchester by identifying the types of households more likely to require health and social care support based on factors such as average age, health behaviours and household income.

Mosaic data has also been used to support the development of our primary care-based prevention programme. We looked in detail at some of the health-related factors that might indicate the intensity of support different types of people will require in order to help them improve the way they look after their own health. This approach allows us to identify 'target' areas and population groups based on a combination of sociodemographic factors rather than using a conventional medical 'risk modelling' approach. This approach acknowledges the role that the wider determinants of health play in determining how our health and social care resources need to be distributed around the city, particularly when it comes to investing in services to reduce the number of individuals who become high users of healthcare services in the future.

Taking its lead from public health, Mosaic is also being used by other parts of the Council to improve the targeted delivery of neighbourhood services at local level and provide a more integrated response to key neighbourhood issues, such as crime and antisocial behaviour, fly-tipping, litter, graffiti, housing conditions and noise nuisance.

"Taking its lead from public health, Mosaic is also being used by other parts of the Council"

Chapter 8: Priorities for Manchester

8.1 Each of the preceding chapters provides a summary of what's next in 2017.

The overarching strategic priorities are:

- Manchester's contribution to the achievement of the objectives and outcomes contained in the Greater Manchester Population Health Plan
- Ensuring that Manchester Health & Care Commissioning (MHCC) has a strong focus on commissioning for population health and wellbeing (the public health team will be part of MHCC)
- Supporting the development and establishment of the Local Care Organisation with a focus on the One Team Prevention Programme starting in the north of the city. This programme will be an exemplar under Our Manchester.

8.2 In partnership with the CCGs and Greater Manchester colleagues, we will explore the opportunity for a number of population health campaigns in 2017/18:

- Smoke-Free City and reducing smoking in pregnancy
- Increasing the uptake of NHS Health Checks and other screening programmes
- Tackling childhood obesity
- Addressing poor air quality and promoting cycling and walking
- Healthy ageing (particularly social isolation).

8.3 Finally, in June 2017 a Population Health Plan for Manchester will be produced that brings together all the key actions identified in this report.

Public Health England

Protecting and improving the nation's health

Manchester

Unitary authority

This profile was published on 4th July 2017

Health Profile 2017

Health in summary
The health of people in Manchester is generally worse than the England average. Manchester is one of the 20% most deprived districts/unitary authorities in England and about 36% (36,300) of children live in low income families. Life expectancy for both men and women is lower than the England average.

Health inequalities
Life expectancy is 8.2 years lower for men and 6.4 years lower for women in the most deprived areas of Manchester than in the least deprived areas.

Child health
In Year 6, 25.1% (1,422) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 is 47*, worse than the average for England. This represents 54 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding initiation and smoking at time of delivery are worse than the England average.

Adult health
The rate of alcohol-related harm hospital stays is 764*, worse than the average for England. This represents 3,138 stays per year. The rate of self-harm hospital stays is 189*. This represents 1,057 stays per year. The rate of smoking related deaths is 509*, worse than the average for England. This represents 821 deaths per year. Estimated levels of adult smoking are worse than the England average. Estimated levels of adult excess weight are better than the England average. Rates of sexually transmitted infections and TB are worse than average. The rate of people killed and seriously injured on roads is better than average.

Local priorities
Priorities in Manchester include early years, strengthening the social determinants of health and promoting healthy lifestyles (including bringing people into employment), enabling people and communities to be active partners in their health and wellbeing and healthy ageing. For more information see www.manchesterpartnership.org.uk

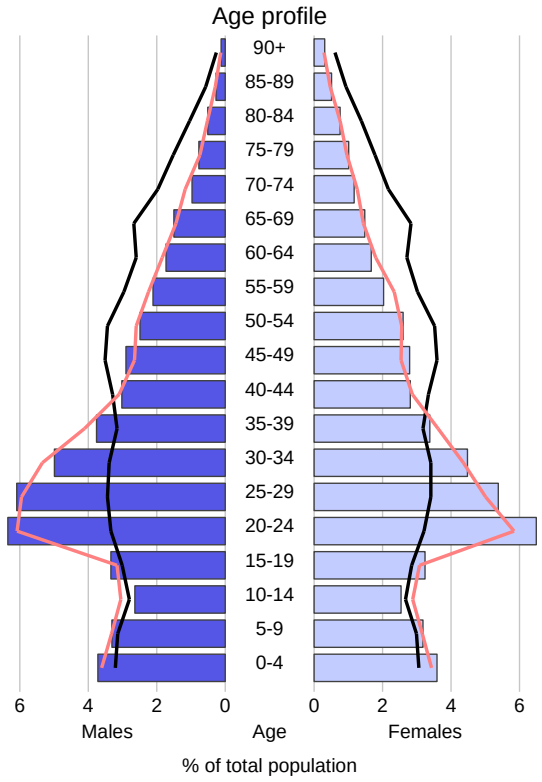
* rate per 100,000 population

This profile gives a picture of people's health in Manchester. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

Follow @PHE_uk on Twitter

Population: summary characteristics



	Males	Females	Persons
Manchester (population in thousands)			
Population (2015):	268	262	530
Projected population (2020):	285	270	555
% people from an ethnic minority group:	31.8%	31.3%	31.5%
Dependency ratio (dependants / working population) x 100			42.9%
England (population in thousands)			
Population (2015):	27,029	27,757	54,786
Projected population (2020):	28,157	28,706	56,862
% people from an ethnic minority group:	13.1%	13.4%	13.2%
Dependency ratio (dependants / working population) x 100			60.7%

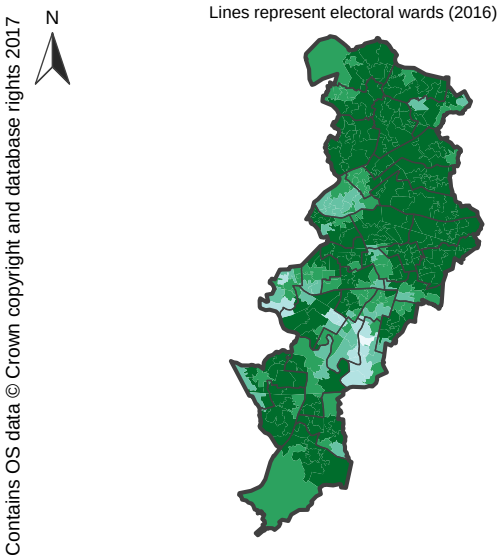
The age profile and table present demographic information for the residents of the area and England. They include a 2014-based population projection (to 2020), the percentage of people from an ethnic minority group (Annual Population Survey, October 2014 to September 2015) and the dependency ratio.

The dependency ratio estimates the number of dependants in an area by comparing the number of people considered less likely to be working (children aged under 16 and those of state pension age or above) with the working age population. A high ratio suggests the area might want to commission a greater level of services for older or younger people than those areas with a low ratio.

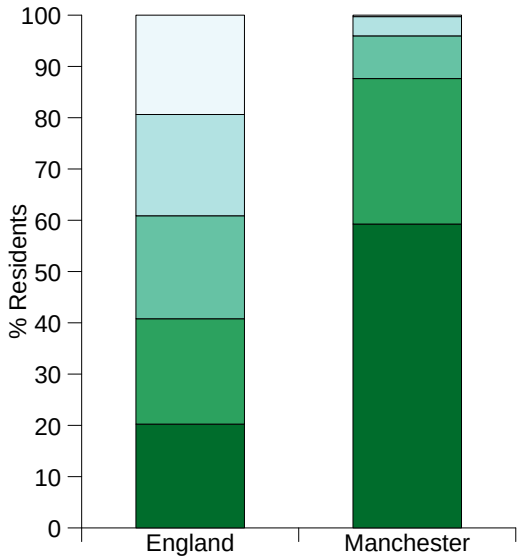
Manchester 2015 (Male)
Manchester 2015 (Female)
England 2015
Manchester 2020 estimate

Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD 2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.



This chart shows the percentage of the population who live in areas at each level of deprivation.

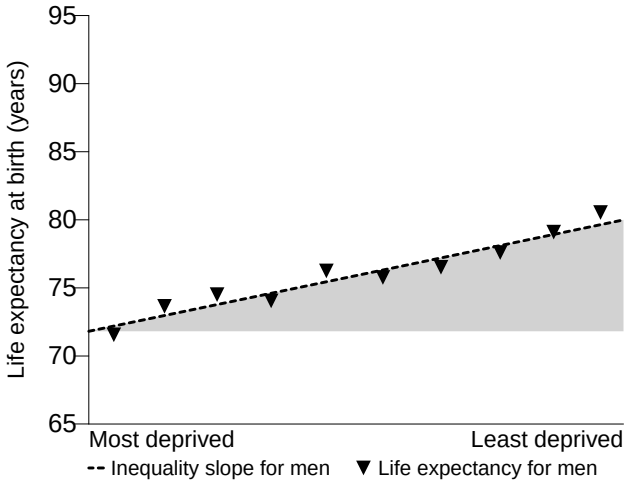


Most deprived quintile
Least deprived quintile

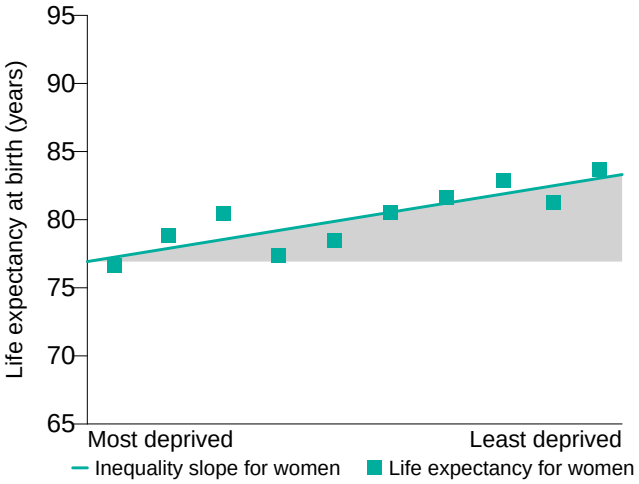
Life expectancy: inequalities in this local authority

The charts show life expectancy for men and women in this local authority for 2013-15. The local authority is divided into local deciles (tenths) by deprivation (IMD 2015), from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there was no inequality in life expectancy the line would be horizontal.

Life expectancy gap for men: 8.2 years



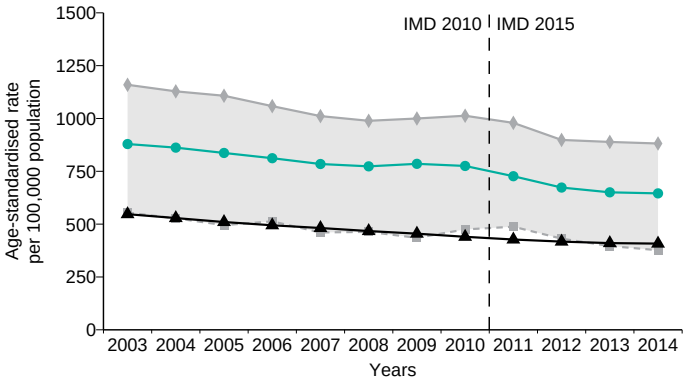
Life expectancy gap for women: 6.4 years



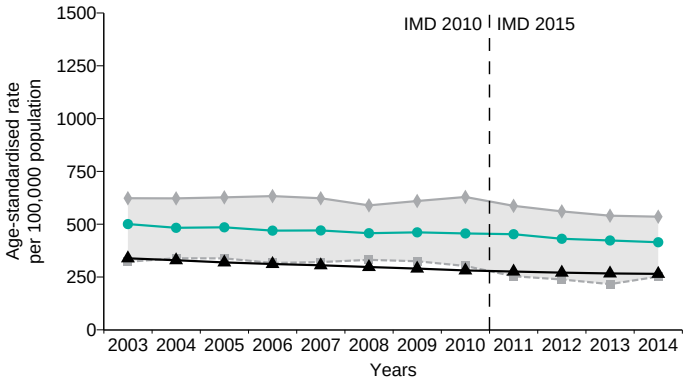
Health inequalities: changes over time

These charts provide a comparison of the changes in death rates in people under 75 (early deaths) between this area and England. Early deaths from all causes also show the differences between the most and least deprived local quintile in this area. Data from 2010-12 onwards have been revised to use IMD 2015 to define local deprivation quintiles (fifths), all prior time points use IMD 2010. In doing this, areas are grouped into deprivation quintiles using the Index of Multiple Deprivation which most closely aligns with time period of the data. This provides a more accurate way of discriminating changes between similarly deprived areas over time.

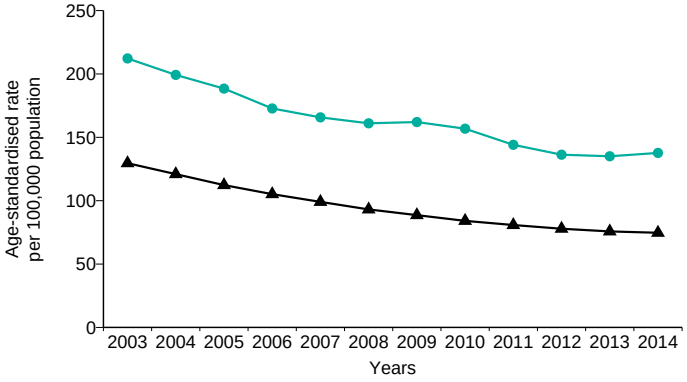
Early deaths from all causes: men



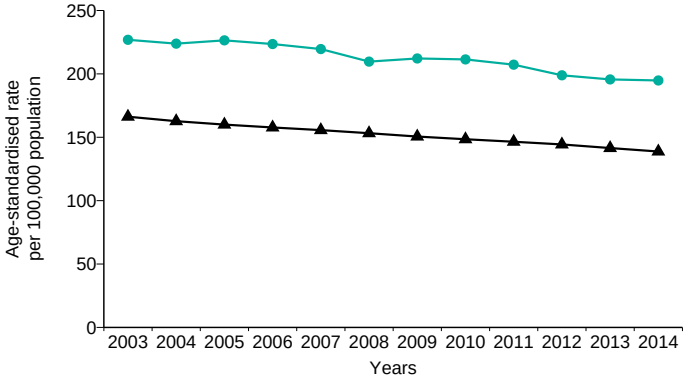
Early deaths from all causes: women



Early deaths from heart disease and stroke



Early deaths from cancer



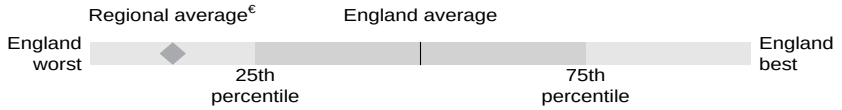
Data points are the midpoints of three year averages of annual rates, for example 2005 represents the period 2004 to 2006. Where data are missing for local least or most deprived, the value could not be calculated as the number of cases is too small.

England average | Local average | Local least deprived | Local most deprived | Local inequality

Health summary for Manchester

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



Domain		Indicator	Period	Local count	Local value	Eng value	Eng worst	England range	Eng best
Our communities	1	Deprivation score (IMD 2015)	2015	n/a	40.5	21.8	42.0		5.0
	2	Children in low income families (under 16s)	2014	36,255	35.6	20.1	39.2		6.6
	3	Statutory homelessness	2015/16	548	2.6	0.9			
	4	GCSEs achieved	2015/16	2,481	49.8	57.8	44.8		78.7
	5	Violent crime (violence offences)	2015/16	13,335	25.6	17.2	36.7		4.5
	6	Long term unemployment	2016	1,668	4.5 ^20	3.7 ^20	13.8		0.4
Children's and young people's health	7	Smoking status at time of delivery	2015/16	957	11.6	10.6 $1	26.0		1.8
	8	Breastfeeding initiation	2014/15	5,609	67.6	74.3	47.2		92.9
	9	Obese children (Year 6)	2015/16	1,422	25.1	19.8	28.5		9.4
	10	Admission episodes for alcohol-specific conditions (under 18s)†	2013/14 - 15/16	162	47.0	37.4	121.3		10.5
	11	Under 18 conceptions	2015	229	28.8	20.8	43.8		5.4
Adults' health and lifestyle	12	Smoking prevalence in adults	2016	n/a	21.7	15.5	25.7		4.9
	13	Percentage of physically active adults	2015	n/a	55.3	57.0	44.8		69.8
	14	Excess weight in adults	2013 - 15	n/a	61.5	64.8	76.2		46.5
Disease and poor health	15	Cancer diagnosed at early stage	2015	731	50.7	52.4	39.0		63.1
	16	Hospital stays for self-harm†	2015/16	1,057	189.0	196.5	635.3		55.7
	17	Hospital stays for alcohol-related harm†	2015/16	3,138	763.5	647	1,163		374
	18	Recorded diabetes	2014/15	28,655	6.2	6.4	9.2		3.3
	19	Incidence of TB	2013 - 15	423	27.0	12.0	85.6		0.0
	20	New sexually transmitted infections (STI)	2016	5,283	1390.7	795	3,288		223
	21	Hip fractures in people aged 65 and over†	2015/16	310	627.2	589	820		312
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2013 - 15	n/a	75.6	79.5	74.3		83.4
	23	Life expectancy at birth (Female)	2013 - 15	n/a	79.8	83.1	79.4		86.7
	24	Infant mortality	2013 - 15	123	5.1	3.9	8.2		0.8
	25	Killed and seriously injured on roads	2013 - 15	461	29.5	38.5	103.7		10.4
	26	Suicide rate	2013 - 15	130	10.5	10.1	17.4		5.6
	27	Smoking related deaths	2013 - 15	2,462	509.0	283.5			
	28	Under 75 mortality rate: cardiovascular	2013 - 15	1,092	137.6	74.6	137.6		43.1
	29	Under 75 mortality rate: cancer	2013 - 15	1,539	194.8	138.8	194.8		98.6
	30	Excess winter deaths	Aug 2012 - Jul 2015	678	20.6	19.6	36.0		6.9

Indicator notes

1 Index of Multiple Deprivation (IMD) 2015 2 % children (under 16) in low income families 3 Eligible homeless people not in priority need, crude rate per 1,000 households 4 5 A*-C including English & Maths, % pupils at end of key stage 4 resident in local authority 5 Recorded violence against the person crimes, crude rate per 1,000 population 6 Crude rate per 1,000 population aged 16-64 7 % of women who smoke at time of delivery 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery 9 % school children in Year 6 (age 10-11) 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population 11 Under-18 conception rate per 1,000 females aged 15 to 17 (crude rate) 12 Current smokers (aged 18 and over), Annual Population Survey 13 % adults (aged 16 and over) achieving at least 150 mins physical activity per week, Active People Survey 14 % adults (aged 16 and over) classified as overweight or obese, Active People Survey 15 Experimental statistics - % of cancers diagnosed at stage 1 or 2 16 Directly age sex standardised rate per 100,000 population 17 Admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population 18 % people (aged 17 and over) on GP registers with a recorded diagnosis of diabetes 19 Crude rate per 100,000 population 20 All new diagnoses (excluding chlamydia under age 25), crude rate per 100,000 population aged 15 to 64 21 Directly age-sex standardised rate of emergency admissions, per 100,000 population aged 65 and over 22, 23 The average number of years a person would expect to live based on contemporary mortality rates 24 Rate of deaths in infants aged under 1 year per 1,000 live births 25 Rate per 100,000 population 26 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 10 and over) 27 Directly age standardised rate per 100,000 population aged 35 and over 28 Directly age standardised rate per 100,000 population aged under 75 29 Directly age standardised rate per 100,000 population aged under 75 30 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths (three years)

† Indicator has had methodological changes so is not directly comparable with previously released values. € "Regional" refers to the former government regions.
^20 Value based on an average of monthly counts $1 There is a data quality issue with this value

If 25% or more of areas have no data then the England range is not displayed.

Please send any enquiries to healthprofiles@phe.gov.uk