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MANCHESTER CITY COUNCIL

Overview and Scrutiny Public Health Task and Finish Group

Date: Tuesday, 18 September 2018
Time: 2.00 pm
Venue: Council Chamber, Level 2, Town Hall Extension

Everyone is welcome to attend this committee meeting.

Access to the Council Chamber

Public access to the Council Chamber is on Level 2 of the Town Hall Extension, using the lift or stairs in the lobby of the Mount Street entrance to the Extension. That lobby can also be reached from the St. Peter's Square entrance and from Library Walk. **There is no public access from the Lloyd Street entrances of the Extension.**

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Membership

Councillors - J Wilson (Chair), Curley, Holt, S Lynch, Mary Monaghan, Riasat and C Wills

Agenda

Further Information

For help, advice and information about this meeting please contact the Committee Officer:

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This agenda was issued on **Thursday 13 September 2018** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 6, Town Hall Extension (Mount Street Elevation), Manchester M60 2LA

Health Scrutiny Committee – Public Health Task and Finish Group

Minutes of the meeting held on 26 June 2018

Present:
Councillor Wilson (In the Chair)
Councillors Curley, Holt, Mary Monaghan and Riasat

Councillor Craig, Executive Member for Adult Health and Wellbeing

Apologies: Councillors Lynch and Wills

HSC/PH/18/01 Public Health Annual Report

Members received the Public Health Annual Report (PHAR) that provided an overview of the breadth of work undertaken by the Public Health Team that continued under the new Manchester Health and Care Commissioning (MHCC) arrangements.

The Director of Population Health and Wellbeing introduced the report and said that the PHAR informed the development of the Manchester Population Health Plan for 2018-2022. Members of the Health Scrutiny Committee had received and considered that report at their meeting of 22 May 2018.

Members were also provided with the latest set of key statistics for Manchester which were published at the end of 2017 as part of the National Public Health Outcomes Framework (PHOF).

Some of the key points that arose from the Members' discussions were:-

- Welcoming the report and the inclusion of case studies was informative, especially when read in conjunction with the Manchester Population Health Plan;
- The importance of addressing the wider determinants of health such as housing and employment;
- Examples of good practice, including informal spaces should be evaluated and good practice implemented to improve public health;
- The premature mortality figures for Manchester were of concern and the issues of smoking; alcohol consumption and physical inactivity needed to be considered as part of the group's investigation;
- The need to target Public Health services and resources at the most deprived communities and to further 'zone in' on specific groups to influence behaviour change and improve health outcomes;
- Using the lessons learnt from the smoking cessation programmes to influence behaviour and cultural change; and
- The importance of screening to detect and treat cancer at an early stage.

The Director of Population Health and Wellbeing said that the new approach adopted to inform and produce the Joint Strategic Needs Assessment was evidence based and was informed by a range of evidence and data from a variety of sources, both nationally and internationally.

He said that staff training and development is important and involved a range of partners, including partners from the NHS. He said this was beneficial as this allowed for an increased awareness and understanding of the wider determinants of health to be understood amongst a range of health professionals.

In response to the comments made regarding smoking; alcohol consumption and physical inactivity he said that levels of smoking remained high in the most deprived communities in the city and accounted for 1 in 5 deaths in Manchester. He said a Greater Manchester response had been developed to deliver smoking cessation support services, implement smoke free zones and tackle the supply of illegal tobacco. He said the smoking cessation service in Manchester was being redesigned to deliver an improved service to residents and that the Local Care Organisation would be able to target these services at a neighbourhood level. He informed the group of a pilot scheme delivered at Wythenshawe Hospital, called the CURE Programme a ground-breaking, innovative and evidence based smoking cessation programme, intended to help the thousands of smokers who are admitted to Manchester hospitals each year. He said that initial analysis of this programme had been very positive and a business case was being developed to roll out this programme.

With regard to the issue of alcohol the Director of Population Health and Wellbeing said that the services provided in Manchester for people with acute conditions were very good, and patients requiring these services were seen very quickly following a referral. He further commented that the number of alcohol admissions to hospitals had reduced over recent years. In response to the discussion regarding high levels of alcohol consumption amongst the general population he said that this was a complex cultural issue and most people underestimated the amount of alcohol they consumed. He said people and health practitioners needed to have honest conversations regarding alcohol consumption and the associated health risks and more needed to be done to raise awareness of this issue, accompanied by campaigns, such as clearer labelling on bottles.

The Director of Population Health and Wellbeing said that the issue of physical inactivity represented a significant challenge and was a complex issue to address. He said it was important to improve levels of physical activity as this would reduce the levels of obesity and other health conditions, such as diabetes and heart disease across the general population, which in turn would reduce the pressures experienced in primary health care.

In response to the comments regarding screening the Director of Population Health and Wellbeing informed the group that NHS England retained responsibility for screening services and cancer screening was a nationally agreed programme. He said that north Manchester had successfully piloted Lung Health Checks as part of the Macmillan Cancer Improvement Partnership programme. The pilot had invited smokers and ex-smokers for a lung health check, coupled with a Computerised Tomography scan if above a risk threshold for lung cancer, and following evaluation it was envisaged that this would be rolled out across Greater Manchester.

The Executive Member for Adult Health and Wellbeing said that the Population Health Plan was a very important development for the city with the Public Health

ethos of prevention becoming embedded across all health practitioners. She said that she acknowledged the comments made regarding the importance of addressing the wider determinants of health and that consideration needed to be given to developing a Council wide approach to ensure this agenda was embedded into all activities. Members agreed that this approach was worthy of further investigation.

The Chair commented that the discussion on this item would inform the groups work programme and an additional meeting could be convened to look at the wider determinants of health if required.

Decision

The group notes the report.

HSC/PH/18/02 Terms of Reference and Work Programme

Following discussion of the previous agenda item the Members agreed to amend the Terms of Reference so the second objective included consideration to review good practice adopted nationally and internationally.

The Chair recommended that the Work Programme be amended so that meeting two focussed on the issues of alcohol; tobacco and healthy living and considered examples of good practice adopted nationally and internationally and in other Local Authorities across Greater Manchester to address these.

Meeting three would consider 'Public Health and Population Groups: Ageing Population' and this item would include information on screening services. Members agreed these recommendations.

The Chair said that he would canvass Members' availability with a view to arranging the next meeting of the Task and Finish Group for the week commencing 10 September 2018 and the third meeting arranged for the week commencing 1 October 2018. Times and dates would be confirmed and Members would be informed at the earliest opportunity.

Decision

To agree the terms of reference and work programme subject to the above amendments.

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Manchester City Council
Report for Information

Report to: Public Health Task and Finish Group – 18 September 2018

Subject: Tobacco, Alcohol and Healthy Living (Physical Activity)

Report of: Director of Population Health and Wellbeing

Summary

The attached reports provide the Task and Finish Group with an overview of the key strategies and plans that relate to work on tobacco, alcohol and healthy living (physical activity) in Manchester and Greater Manchester.

At the meeting of the Task and Finish Group, colleagues from the Greater Manchester Health and Social Care Partnership, Public Health England, Cancer Research UK and the University of Manchester will provide an objective assessment of what Manchester is currently doing and what we can learn from best practice elsewhere.

Recommendations

The Task and Finish Group are invited to comment on the current strategies and plans and based on the advice from experts in the field, consider the potential recommendations that will form part of the final report for the Health Scrutiny Committee.

Wards Affected: All

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Background documents (available for public inspection):

None

1. Introduction

1.1 The 2018 Health Profile for Manchester, published by Public Health England in July 2018, highlights the challenges facing the city. For the purposes of this report, the key indicators are:

- Estimated levels of adult smoking and smoking in routine and manual occupations are worse than the England average;
- The rate of alcohol related harm hospital stays is 741 per 100,000 population worse than the average for England. This is equivalent to 3,100 hospital stays per year; and
- Manchester has high levels of physical inactivity compared to England.

1.2 All of these factors contribute to poor health outcomes and increase the risk of developing the four long term conditions that are associated with the large majority of preventable deaths and health inequalities in Manchester. The conditions are cardiovascular disease (CVD), cancer, respiratory disease and diabetes.

2. Manchester Population Health Plan 2018-2027

2.1 This plan was endorsed by the Manchester Health and Wellbeing Board and presented to the Health Scrutiny Committee in May 2018.

2.2 The Population Health and Wellbeing Team will co-ordinate action against the five priorities contained within the Manchester Population Health Plan. These 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

2.3 Under priority 5 ("Taking action on preventable early deaths") the local programmes for tobacco control and physical activity will be implemented. The work on alcohol and drugs links to both priority 5 and priority 3 and is a shared priority programme with the Community Safety Partnership.

2.4 In the next section of this cover report, there is a brief summary of the current strategies and plans relating to tobacco control, alcohol and drugs and sport and physical activity. In addition, there is a commentary box with some of the initial views from partners who will attend the meeting. There will be further information provided by partners at the meeting in the form of a presentation relating to the three areas.

2.5 Finally, copies of the relevant plans and strategies are also attached so that the Task Group and invited partner agencies have all of the background information in advance of the meeting.

3. Tobacco

3.1 Introduction

3.1.1 There are estimated to be 92,700 smokers aged 18 and over in Manchester in 2017 and a current adult prevalence rate of around 22.0%. Manchester has the highest premature mortality rate in the country for heart disease and stroke and the second highest rate for lung cancer (the three major smoking related diseases).

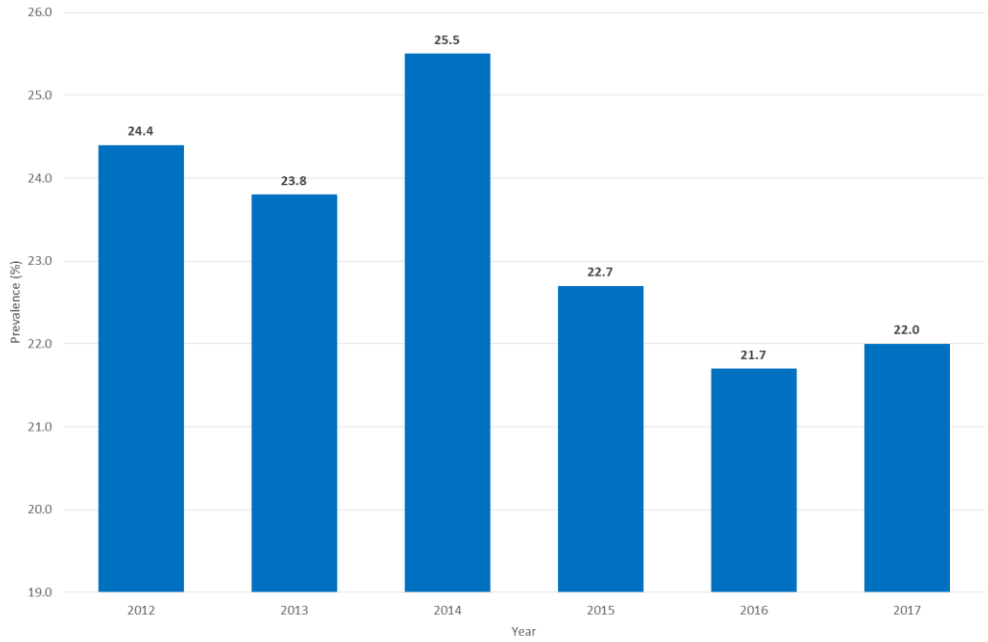
3.1.2 Manchester has a stretching target to reduce adult smoking prevalence from the current rate of 22.0% to 15% by 2021. To achieve this, a comprehensive, well defined and well led programme of activity is required. The Smoke Free Manchester Plan for Tobacco Control 2018-2021 aims to do this in line with Manchester Population Health Plan priority 'Taking Action on Early Preventable Deaths' and was approved by the Manchester Health and Wellbeing Board on 29 August 2018. The final version of the plan is attached (Appendix 1).

3.1.3 The Plan was produced with the Manchester Tobacco Alliance, a partnership of clinicians, cancer charities, voluntary and community sector (VCS) organisations and City Council and NHS teams committed to a collaborative approach to tobacco control. A brief overview of the plan is provided below.

3.2 Tobacco related harm in Manchester

3.2.1 The latest data from the ONS Annual Population Survey (APS) shows that in 2017, just over a fifth of all respondents (22.0%) reported that they currently smoke. This compares with an average prevalence of 14.0% across England as a whole. The chart below shows recent trends in the prevalence of current smoking in the city. It shows that the prevalence has fallen from a high of 25.5% in 2014 to 22.0% in 2017. However, the lack of progress in reducing smoking prevalence between 2016 and 2017 indicates that the achievement of the 15% target will be very challenging.

Figure 1: Smoking prevalence in adults (18+) in Manchester 2012-2017



3.2.2 This is only part of the picture as we know that in our most deprived communities, smoking rates are much higher than the average for the population as a whole. If we are to make the necessary progress towards our target for reduced smoking prevalence, we must focus efforts on involving specific groups and communities in line with the Our Manchester approach.

Smoking Related Conditions and Hospital Admissions

3.2.3 Smoking is the major preventable risk factor for Chronic Obstructive Pulmonary Disease (COPD), asthma and other respiratory illnesses. Nationally, around 17% of COPD patients are known to be smokers. However, data from GP practices summarised in the table below, shows that 49% of patients with COPD in Manchester are recorded as smokers. This is a significant variation.

Table One: GP data on respiratory conditions in Manchester

Respiratory Condition	Current Smokers (%)	Ex-Smokers (%)	Combination – Ever Smoked (%)
COPD	49%	33%	82%
Asthma	24%	14%	37%

3.2.4 Analysis of local data shows that the rate of non-elective hospital admissions for COPD and asthma is higher mong people recorded as being current smokers in primary care in Manchester compared with those recorded as being ex-smokers. The median cost of these admissions is also higher in current smokers compared with ex-smokers aged under 60. The higher costs of admissions in ex-smokers aged 60 and over reflects the residual effects of previous smoking history on the severity of the condition.

3.3 The Greater Manchester (GM) Programme

3.3.1 The Smoke Free Manchester Plan is aligned with the GM "Making Smoking History" programme. GMPOWER is an acronym for the approach that partners are taking across Greater Manchester and which we will adopt for the city of Manchester.

- Grow a social movement for a Tobacco Free Greater Manchester
- Monitor tobacco use and prevention policies
- Protect people from tobacco smoke
- Offer help to stop smoking
- Warn about the dangers of tobacco
- Enforce tobacco regulation
- Raise the real price of tobacco

The Plan attached provides further detail on the programme along with information on the GM Common Standards for Tobacco Control which we have also adopted.

3.4 Areas for development

3.4.1 It is acknowledged that there is more work to be done before we have a comprehensive whole system response to Tobacco Control in Manchester.

3.4.2 The Smoke Free Manchester Tobacco Control Plan will be officially launched as part of 'Stoptober', the annual national campaign to encourage people to quit smoking.

3.4.3 The implementation of the Tobacco Control Plan will be monitored by the Manchester Tobacco Alliance, chaired by the Director of Population Health and Wellbeing. The Executive Lead for Population Health at Manchester Local Care Organisation will ensure that there is a targeted neighbourhood focus for the delivery of the Plan.

3.4.4 The Director of Population Health and Wellbeing is also working closely with the Clinical Director at Manchester Health and Care Commissioning (MHCC) to look at a range of options to ensure Manchester has a robust specialist smoking cessation service. This will support these new programmes and also relate to the new Community Links for Health wellbeing service.

3.4.5 The implementation of the innovative CURE pilot at Wythenshawe Hospital (treating inpatient smoking addiction) and the roll out of the GM Baby Clear Programme (tackling smoking in pregnancy) will require additional capacity and resources in the community and primary care.

3.5 Commentary from external partners

Greater Manchester Health and Social Care Partnership

Making Smoking History and securing a tobacco free generation is a priority within the Population Health Plan. Following the July 2017 publication of the Making Smoking History Strategy, developed in collaboration with GM system partners, localities have been reviewing their local tobacco control strategies and plans and aligning them with collective and local ambitions to deliver 2021 goals. Localities contributions are key in continuing to deliver local tobacco control and local stop smoking support to drive down smoking prevalence; this is supported by a tobacco outcomes and common standards framework as part of the wider work on GM Population Health outcomes and assurance.

Manchester continues to experience significant levels of tobacco-related harm and is a national outlier across the majority of measures contained within the PHE Local Tobacco Profiles. With over 90,000 of our 393,000 GM smoker population, Manchester's contribution to achieving our GM target of 13% GM prevalence cannot be underestimated. We are pleased to be working closely to ensure that we are able to geo-demographically segment and target smokers across Manchester and GM to motivate and empower them to quit. This includes work with LGBT smokers being delivered in partnership with the LGBT Foundation.

The GMHSC Partnership's focus is on implementing our GMPOWER model, with the right scale of investment in each component of work in combination with the right levels of cross-system engagement in the delivery of each component. Individual components will be most effective when they work together to produce the synergistic effects of a comprehensive GM-wide tobacco control programme delivered at scale.

Our priority programmes are:

- Empowering and motivating behaviour change at population level
- Delivering smokefree pregnancies and childhoods
- Curing tobacco addiction in our sickest smokers and delivering a Smokefree NHS
- Tackling illegal tobacco and strengthening tobacco regulation
- Building a social movement to Make Smoking History

There are opportunities to radically review the way we treat tobacco addiction and test and learn through the evaluation of our CURE programme.

Key to achieving our shared 2021 goals at both GM and Manchester and GM level will be sustained action at scale.

Public Health England

Prioritise those groups with the highest smoking rates
Reducing smoking is one of PHE's key priorities. Last year's tobacco control plan for England laid out the ambitions to achieve a smokefree nation. The actions set out in the Plan focus at the local level, and Local Government will need to prioritise people living in more deprived areas, manual workers, vulnerable and young pregnant women and people with a mental health problem to achieve the targets.

Work with the NHS
NHS settings provide a great opportunity to engage with many of these harder to reach smokers - 1 in 4 patients in acute hospital beds are smokers. If Local Government can support their NHS trusts to become smokefree encouraging and supporting anyone using, visiting and working in the NHS to quit smoking, the targets will be more attainable. Supporting and encouraging NHS trusts to make best use of The national Commissioning for Quality and Innovation (CQUIN) scheme No.9 ("Preventing Ill Health by Risky Behaviours") which identifies and supports inpatients who smoke, and embeds these interventions into routine care for patients will be beneficial. Implemented well, the CQUIN has the potential to reduce future hospital admissions and reduce the risk of a number of chronic conditions such as heart disease and, stroke and cancer. The Ottawa model has shown just how effective hospital-initiated smoking cessation advice can be when offered to every person admitted to hospital regardless of what they are in for.

Provide Stop Smoking Services and support those using e-cigarettes to quit
Most smokers want to stop but quitting is hard. Many people make several attempts before they succeed. To improve their chances of quitting, all smokers need a combination of effective services and therapies, supportive social networks and smokefree environments.

Local stop smoking services offer the best chance of success. They are up to 4 times more effective than no help or over the counter nicotine replacement therapy (NRT) and are usually commissioned by Local Government. Stop smoking services need good referral routes. Health professionals, such as GPs, midwives, pharmacists, dental teams and mental health staff are often well placed to refer smokers to these services. Services also need to be responsive to local needs and targeted to provide the right support to the people who need it most. For example, people with mental health problems may need higher doses of NRT and more intensive behavioural support than the general population.

Many people are choosing to use electronic cigarettes to help them quit smoking. Regular electronic cigarette use is confined almost entirely to smokers and ex-smokers. Electronic cigarettes are now the most popular quitting aid, according to a survey in the Smoking Toolkit Study, and emerging evidence indicates they can be effective for this purpose.

Smokers who want to use e-cigarettes to help them quit should be able to seek the expert support of their local stop smoking service. Stop smoking services should provide them with the support they need to stop successfully. PHE encourages all electronic cigarette users to quit tobacco use.

Public Health Campaigns
PHE delivers a number of national campaigns to encourage smokers to quit, including Stoptober, One You and the New Year campaign. Local authorities can link to these campaigns on their web sites, localise the messages and signpost people to their local stop smoking services during campaigns.

Monitor your progress
CLeaR is an evidence-based approach to tobacco control that every local authority and tobacco control alliance can use. By using the self-assessment framework, authorities can evaluate their work and prioritise future development to continue improving their services and strategic plans. We would recommend that the self-assessment process is refreshed periodically (at least every 2 years) to monitor any changes and reinvigorate local action.

Cancer Research UK

Smoking remains the biggest cause of preventable cancer and preventable death in the UK, which is why reducing smoking prevalence remains a key prevention priority for Cancer Research UK. Our ambition is to achieve a smokefree UK by 2035 - where less than 5% of adults smoke (across all socioeconomic groups). This will require concerted action from local authorities, the NHS and Government.

Cancer Research UK is pleased that reducing smoking prevalence is a target embedded in the GM Cancer Plan and Population Health Plan. It is our hope that this commitment is shared and acted upon at locality level.

Stopping smoking is the best thing an individual can do for their health, and comprehensive tobacco control is the best thing Local Government can do for public health. Local authorities should develop initiatives to reduce smoking rates locally, in collaboration with NHS and other partners. These initiatives should be part of a strategic approach to tobacco control:

CLeaR
CLeaR is an is an evidence-based improvement tool by PHE, designed to advise local authorities, tobacco alliances and Health and Wellbeing Boards on how they can assess, review and improve their tobacco control work. We encourage Manchester City Council to undertake CLeaR regularly to assess, review and improve tobacco control work.

Funding
Adequate resources should be made available to ensure evidence-based tobacco control services are commissioned to support smokers to quit and to support public-facing smoking cessation campaigns and measures to target illicit tobacco trade. We are concerned that Manchester City Council lacks sufficient funding to deliver the above, while recognising the impact of reductions to local authority and public health funding. We continue to call on Government for improved and sustainable public health funding.

Stop Smoking Services
There is strong evidence that Stop Smoking Services are the most effective (and cost-effective) way to support smokers to quit in the long term. Cancer Research UK would encourage Manchester City Council to commission a service in line with NICE NG92 guidelines - offering free one-to-one and group behavioural support, along with NRT and other stop smoking medication, provided by NCSCT trained professionals. We understand funding remains a barrier to commissioning.

Quit Campaigns
Mass media campaigns are highly impactful and cost-effective in encouraging smokers to quit and discouraging young people from taking up smoking. We recognise that Manchester City Council is working with the GM Health and Social Care Partnership on smoking cessation campaigns (e.g. Don't Be the One) and has also delivered a borough-specific campaign on Shisha. We would be keen for this to continue and would recommend additional activity to signpost smokers to local smoking cessation provision as it comes on-stream.

E-Cigarettes
Cancer Research UK support a balanced approach to e-cigarettes, which maximises their potential to help people quit smoking whilst minimising the risks of unintended consequences that could promote smoking. Given their increasing role in smoking cessation, local authorities and Stop Smoking Services should be supportive of e-cigarette use in order to maximise their reach and provide cessation support to as many smokers as possible. We recognise that there are likely to be differing views on e-cigarettes within Manchester City Council but would advocate for an evidence-based approach to policy-making.

Illicit Tobacco
Illicit tobacco products undermine the effect that price can have on reducing tobacco consumption, smoker initiation and cessation rates. Targeted regional activity can be effective in addressing illicit tobacco and we would therefore encourage Manchester City Council to continue its collaboration with other boroughs, through the GM Health and Social Care Partnership to take a joined-up approach.

Partnership-working
We are pleased that Manchester City Council has established a tobacco control alliance made up of a wide-range of partners, including Cancer Research UK. However, we would be keen to boost the effectiveness of the alliance by increasing the frequency of meetings, securing sponsorship and representation from an elected member and by clarifying the forward plan and areas of focus for the group.

NHS
Given the new pooled budget and integrated commissioning arrangements in place in Manchester, we would be keen to see a shared commitment to smoking cessation across Manchester Health and Care Commissioning (MHCC). One way to do this would be for MHCC to sign the NHS Smokefree Pledge. We applaud Manchester City Council for being an early adopter of the Local Government

Declaration on Tobacco Control, but it is important that it remains a 'live' commitment, with progress against the specific points monitored and acted-upon.

These new arrangements should make it far easier to increase the role of primary and secondary care in smoking cessation. Manchester is blazing a trail in rolling out the Ottawa model through the CURE programme - an approach we support. We hope to see all Manchester hospital sites will go smokefree in due course.

Cancer Research UK would also encourage the CCG to work with primary care providers to promote the value of Very Brief Advice for smoking patients, support the prescribing of NRT and pharmacotherapies and refer to Stop Smoking Services. While there is no service available borough-wide, we would encourage MHCC to provide further advice and support to primary care, to ensure smokers can receive support to quit in their community through the NHS.

Health Inequalities
Cancer Research UK believes that the implementation of a comprehensive local tobacco control plan must include a renewed focus on reducing the prevalence of smoking amongst those who are pregnant, living with mental health conditions and from low socioeconomic status (SES). Recent research by Cancer Research UK has shown that specialist Stop Smoking Services can be effective in reducing smoking related health inequalities, which may be another reason for Manchester City Council to explore the need for specialist Stop Smoking support that is increasingly targeted to the most deprived neighbourhoods/wards (informed by local data).

We acknowledge the positive work being done with GM partners to improve smoking in pregnancy.

WHO Framework Convention on Tobacco Control
The UK is one of the 180 parties to the World Health Organisation Framework Convention on Tobacco Control (WHO FCTC). The guidelines to Article 5.3 of the WHO FCTC recognise the "fundamental and irreconcilable conflict" which exists between the interests of the tobacco industry and the pursuit of public health improvement. Consistent with the guidelines, local authorities should reject partnerships and non-binding or non-enforceable agreements with the tobacco industry. We would seek assurances from Manchester City Council that it will abide by the convention and avoid engagement and agreements with the tobacco industry wherever possible.

Manchester Tobacco Control Plan
Cancer Research UK fed into the development of the plan, as an alliance member and is pleased to see that some of our feedback has been accommodated.

However, we feel there is scope to further develop and improve the plan by increasing the level of detail in respect of the activities to deliver the plan and by ensuring that all elements of the GMPOWER model are reflected in the plan. We further suggest that the detailed workstreams come back to the Tobacco Control Alliance for scrutiny and oversight.

Cancer Research UK also seeks clarity on the model of delivery for 'rebuilding smoking cessation services' and on whether the council will be adopting an evidence-based approach to e-cigarettes. It also seeks assurances that MHCC will support smoking cessation through primary care, including the prescribing of NRT and pharmacotherapies.

University of Manchester

People in Manchester smoke more than in other parts of England and smoking is the most common cause of being unwell and dying. The plan laid out above will be especially important where the problem is more concerning, such as pregnant women or young people, or where smoking is more common such as manual workers or people with lower incomes. Policies aimed at reducing smoking should be targeted at lower educated groups to reduce inequalities in smoking related diseases (Huisman M, Kunst AE, Mackenbach JP Educational inequalities in smoking among men and women aged 16 years and older in 11 European countries Tobacco Control 2005; 14:106-113).

The above will tackle some of those issues also with the huge opportunities from the devolved health and social care budget in Greater Manchester. It is envisaged that these interventions can be better tailored towards the needs of the residents of Manchester. We have lots of evidence and guidance, but there remains an implementation gap as well as little robust evaluation of services for cost and clinical benefit.

Also, where other parts of the country are seeing a drop in smoking rates, Manchester remains one of the highest. This is contributing to inequalities and the gap widening for many health outcomes.

We often observe highest smoking rates in those from the most deprived communities. This can then be seen as a reason to cut comprehensive services that reach out to and are best suited to these populations. We also know the rise in other tobacco products and e-cigarettes are a worrying trend. We do not actually know who our populations at risk are:

1. To prevent children and young people from starting to smoke, using tobacco products, e-cigarettes and other products
2. To help those people who smoke, use tobacco products or e-cigarettes quit

As well as the above, we would welcome discussion on:

1. Accurate measures of the population at risk. Without the epidemiology, it is difficult to target services. Commissioning local needs assessments at neighbourhood level will help with commissioning of safe, effective, evidence based services.
2. Banning advertising and regulate e-cigarettes/shisha etc.
3. Providing a holistic stop smoking service to include other tobacco products e.g. shisha and to withdraw from e-cigarettes
4. Evaluation of currently commissioned services and adding evaluative methods to any new commissioned services.

4. Alcohol

4.1 Introduction

4.1.1 Work has taken place over the last year to co-design a single Greater Manchester Drug and Alcohol Strategy with the widest possible range of partners, stakeholders, voluntary and community sector organisations and people with lived experience. Manchester has contributed significantly to the development of this strategy and the final version will be agreed by the Greater Manchester Health and Social Care Partnership Board in the autumn.

4.1.2 The draft strategy sets out Greater Manchester's collective ambition to significantly reduce the risk and harms caused by drugs and alcohol and help make it one of the best places in the world to grow up, get on and grow old. Manchester shares this ambition.

4.1.3 Drugs and alcohol are everybody's business. Drugs and alcohol impact on the health and wellbeing of our residents, the safety of our communities, and the vibrancy and economic future of our town centres and night time economies. It is everyone's responsibility to make sure we minimise the potential risks and harms they cause.

4.2 Alcohol related harm

4.2.1 Manchester has a strong history of addressing alcohol and drug related issues, but the nature and extent of the challenges that exist locally remain significant.

4.2.2 The key indicators:

- The most up-to-date estimates (from 20145/15) suggest that 2.4% of adults aged 16 and over living in Manchester are alcohol dependent. Based on the latest ONS population estimate, this is equivalent to around 10,230 adults in the city. It is further estimated that 28% of adults in Manchester are binge drinkers, compared to 17% nationally. 32% of adults in Manchester are estimated to drink over 14 units of alcohol per week (the recommended safe limit for alcohol with at least 2 alcohol free days), compared to 26% nationally.
- Mortality from alcohol-specific conditions is higher than the England average in Manchester and all GM local authority areas, and the same tends to be true for broader estimates of (the larger number of) alcohol-related deaths.
- The rate of hospital admission episodes due to alcohol-related conditions (741 per 100,000) is significantly higher in Manchester compared with the England average (636 per 100,000), although the rate has been falling (i.e. improving) in recent years.
- There are significantly larger numbers of Manchester residents claiming incapacity benefits where alcohol misuse is the main disabling condition.
- We also know that there has been a move away from drinking in a public setting to drinking at home, which has the potential to exacerbate existing challenges around hidden alcohol harm.

4.3 The Draft Greater Manchester Strategy (2018-2022)

4.3.1 The vision for the strategy is to make Greater Manchester a place where everyone can have the best start in life, live well and age well, safe from the harms caused by drugs and alcohol:

- A place where children, young people and families have the best start in life and future generations grow up protected from the impact of drug and alcohol misuse.
- A place where people who drink alcohol choose to do so responsibly and safely.
- A place where people are empowered to avoid using drugs and alcohol to cope with adversity and the stresses and strains of life.
- A place where our services and communities work together to build resilience and address the harms caused by drugs and alcohol.
- A place where individuals who develop drug and alcohol problems can recover and live fulfilling lives in strong resilient communities.

4.3.2 The strategy identifies 6 priority areas:

i) Prevention and early intervention
ii) Reducing drug and alcohol related harm
iii) Building recovery in communities
iv) Reducing drug and alcohol related crime and disorder
v) Managing availability and accessibility
vi) Establishing diverse, vibrant and safe night time economies

4.3.3 The draft implementation plan is currently high level and will be further developed as the work progresses. Manchester will develop a local plan in line with the strategy.

4.4 Areas for development

i) <u>Prevention and early intervention</u>

The Communities in Charge of Alcohol Project is now underway across Greater Manchester. The Manchester Project in Newton Heath and Miles Platting commenced in June 2018. Further details of this project are provided in Appendix 2, Section 1.

ii) <u>Reducing drug and alcohol related harm and building recovery in communities</u>

The Manchester Integrated Drug and Alcohol Service provided by Change, Grow, Live (CGL) has been operational since 1st April 2016. A summary of the service offer is provided in Appendix 2, Section 2.

iii) Reducing drug and alcohol related crime and disorder

The Manchester Community Safety Strategy 2018-2021 identifies "reducing the crime caused by alcohol and drugs" as one of its five priorities for the life time of the strategy. An example of a programme that is now underway is the Drinkaware Club Crew and more detail on this is provided in Appendix 2, Section 3.

iv) Managing availability and accessibility

Manchester will continue to work with GM partners on this priority area.

v) Establishing diverse, vibrant and safe night time economies

Manchester City Council established a member/officer night time economy group many years ago and this group continues to meet to address issues relating to the city's vibrant night life.

4.5 Commentary from external partners

Greater Manchester Health and Social Care Partnership

Tackling the harms caused by Drugs and Alcohol remains a priority for the partnership and we are collaborating with colleagues from across the system to put in place comprehensive plans to tackle the issue.

The city-region, and particularly areas such as Manchester, continues to experience significant levels of alcohol-related harm and is a national outlier across the majority of measures contained within the PHE Local Alcohol Profiles.

Research undertaken by GMCA indicates that the annual cost of alcohol-related harm to GM is £1.3billion in terms of Police, Fire, Health, Social Care, unemployment and lost productivity.

To address this issue, 4 priority programmes of work are under development and will be in delivery over coming months:

a. The development and implementation of the first ever Greater Manchester Drug and Alcohol Strategy which is due for launch on 15/11/18.

b. The launch of a GM Big Alcohol Conversation on 15/11/18 to engage GM residents in a meaningful dialogue around the harms associated with alcohol in GM and the appetite for change, culminating in the development of a GM Ambition for Alcohol by 31/3/19.

c. The implementation of a programme to reduce Alcohol Exposed Pregnancies funded through GM transformation monies.

d. A full review of Drug and Alcohol commissioning across Greater Manchester to identify areas of strength, and opportunities for transformation and which is due for completion by 31/3/19.

Public Health England

Reducing alcohol consumption is a key priority for PHE. Key priorities at local level are:

- Alcohol as a part of Health and Wellbeing Boards' Joint Strategic Needs Assessment (JSNA) and that there are commissioned services to address the needs of the population
- Commissioned alcohol services adhere to clinical and public health standards (see NICE quality standards)
- Public health and other health concerns are represented in local alcohol licensing process and decisions
- Data is shared between health, social care and community safety organisations to target prevention activity and co-ordinate care
- Ensuring local Making Every Contact Count initiatives include alcohol screening and structured advice
- Ensure local health trainers screen for alcohol misuse and support peers to reduce drinking to lower-risk levels
- Commissioning community-based, alcohol outreach workers, to work with regular attendees and vulnerable groups such as street-drinkers
- Ensuring that alcohol screening and brief advice is delivered effectively in NHS health checks

Work with the NHS
Some people will benefit from a brief intervention consisting of a short alcohol health risk check in a range of health and social care settings. Brief advice helping the person to consider the reasons for change should be offered where relevant.

The national CQUIN scheme 2017 to 2019 No.9 ("Preventing Ill Health by Risky Behaviours") offers the chance to identify and support inpatients who are increasing or higher risk drinkers. It is intended to complement and reinforce existing activity to deliver interventions to those who use alcohol at higher risk levels and applies to community and mental health trusts and acute NHS Trusts. It covers adult inpatients only (patients aged 18 years and over who are admitted for at least one night) and excludes maternity admissions.

Public Health Campaigns
There are national campaigns to encourage people to drink less including Drink Free Days and Dry January. Local authorities can link to these campaigns on their web sites, localise the messages and signpost people to their local services.

Monitor your progress
PHE has produced an alcohol CLeaR self-assessment tool and supporting materials to support an evidence-based response to preventing and reducing alcohol related harm at local level. The materials build on experience from the

tobacco control CLeaR model. It provides assurance that resources are being invested in a range of services and interventions that meet local need and which, the evidence indicates, support the most positive outcomes

University of Manchester

Alcohol and harms from excessive alcohol consumption, demonstrate a similar picture to smoking. We have some of the highest rates of alcohol consumption, across all age groups, including the highest levels of binge drinking, and our research has added to the evidence base (see www.urhis.eu). The burden of the consequences of alcohol abuse extends across the health and social sector e.g. social harms from excessive alcohol abuse. PHE and NICE have issued guidance that are evidence based and we have a national strategy to reduce the harm. The above will tackle some of those issues also with the huge opportunities from the devolved health and social care budget in Greater Manchester. It is envisaged that these interventions can be better tailored towards the needs of the residents of Manchester.

We have lots of evidence and guidance but there remains an implementation gap as well as little robust evaluation of services for cost and clinical benefit. Bridging this implementation gap requires a multi-sectoral, multidisciplinary set of actions from health, social care, police and other statutory services. We also know that home drinking is becoming an increasing problem.

We have evidence that brief interventions are effective and would welcome discussion on:

1. Accurate measures of the population at risk. Without the epidemiology, it is difficult to target services. Commissioning local needs assessments at neighbourhood level will help with commissioning of safe, effective, evidence based services.
2. Local ban on advertising alcohol (especially around children so reduce advertising around schools and routes to schools) and plain packaging (similar to tobacco)
3. Change licensing to reduce outlets in and around places where children may be going to school or playing.
4. Provide a holistic brief interventions services in multiple settings
5. Evaluation of currently commissioned services and adding evaluative framework to newly commissioned services

5. Physical Activity

5.1 Introduction and Manchester context

5.1.1 Manchester Health and Care Commissioning (MHCC), Manchester City Council (Sport and Leisure) and Sport England are taking forward work to more closely align the physical activity and health agendas in the city. Underpinning this, is the ambition of achieving a greater degree of integration between health, population health and wellbeing and sport and leisure to

better address population health challenges and address inequalities with available resources and assets. This new approach will help to deliver increased physical activity and reduced physical inactivity levels in Manchester in line with GM Moving targets and PHE Chief Medical Officer (CMO) advice on activity levels across the lifecourse. A key part of this joint approach is reducing physical inactivity levels in the city, with a focus on people at risk of, or already suffering from, poor physical and mental health outcomes. An example of this is the Tackling Inactivity Initiative (funded by MCC and Sport England) to test new community-led approaches to tackling inactivity under the Winning Hearts and Minds programme (see Appendix 3).

5.1.2 To deliver the ambition a new single system for sport and physical activity in Manchester has been designed. This single system will ensure clarity of purpose for all involved, will simplify strategic and operational arrangements and will provide the golden thread between the strategic objectives and what residents experience in our neighbourhoods. Key components of the single system include 1) Strategy and Partnerships, 2) A streamlined role for Manchester City Council, 3) Creation of new governance arrangements - Manchester Active, 3) A new leisure facility operating contract (part of a provider network) 4) residents being engaged much more proactively than the current arrangements encourage.

- **Strategy & Partnerships** - A new strategy, overseen by new governance arrangements with new partnerships established between the traditional Sport and Physical Activity Partners, i.e. Sport England, National Governing Bodies of Sport, Clubs with non-Sport and Physical Activity organisations i.e. Housing, the wider Community Sector, Commercial Sector, Police, Fire and Rescue, Youth and Play Trust.

- **Manchester City Council** - The Council's role will be more streamlined and focused on getting the resources into the right organisations who can make the biggest impact in communities. This will result in all service delivery being contracted through service providers or commissioned through community organisations. The Council will seek to co-commission and co-design solutions with other public funding bodies, including Sport England and MHCC.

- **Manchester Active (MCRactive)** - A new not for profit organisation, owned by the Council, responsible for implementing the Sport and Physical Activity strategy on behalf of the Council. The role of MCRactive should not be a complex one - It is not a delivery organisation or simply a conduit to or for investment. MCRactive will seek to provide the leadership and a common narrative for sport and physical activity in Manchester. It will develop the plans which underpin the strategy and broker and facilitate relationships which will deliver it.

- **Leisure Operator** – The new single leisure operating arrangement will be established to share risk between the Council and the operator, whilst bringing to bear the expertise of a credible national operator who can drive the quality, efficiency and innovation which is required to deliver the

Strategy. The leisure operator's role will be more streamlined and focused on providing high quality facility management across 20 leisure facilities and underwriting financial and operating risk.

- **Residents -** Residents will be engaged much more proactively than the current arrangements encourage. This will be achieved by fully embracing the Our Manchester principles and approach. The role of the Council, MCRactive and the leisure operator will be designed to ensure that residents feel that there are extensive arrangements in place to ensure that they contribute to the strategy, are actively engaged, participate, spectate, officiate, volunteer and contribute constructively about what changes can be made to improve provision.

5.2 All ages approach

5.2.1 A number of other strategies and initiatives are contributing to addressing the challenges around physical activity across the lifecourse.

- Work in Early Years settings to increase physical activity and improve diet of children in early years and their families (e.g. City in the Community are working with Early Years settings to increase physical activity through the use of storytelling and fun activities
- Work by the School Health Service and the Healthy Schools Programme to increase physical activity and improve diet.
- Sport England has recently announced Greater Manchester will receive £1 million Active Ageing funding (2018 - 2020) of which Manchester will benefit from funding to test new approaches to engage inactive older people (55 years plus, achieving less than 30 minutes of moderate intensity physical activity per week). The Manchester project will focus on a place-based approach around Debdale in Gorton to create a physical activity offer co-designed by older people. In addition sustainable sessions will be created city-wide for groups by enabling peer-led functional physical activity classes.

5.3 Physical Activity Indicators

5.3.1 The key indicators are:

- Responses to the Active Life Survey for 2016/17 show that 24.9% of adults (aged 19+) in Manchester were physically inactive (i.e. they undertook less than 30 minutes of moderate intensity physical activity per week). This is significantly higher/worse than the England figure of 22.2%.
- Data from the What About YOUth (WAY) survey of 15 year old children in 2014/15 indicates that over 72% of children in Manchester were sedentary for more than 7 hours a day in an average week. This is slightly higher than the England figure of 70%.
- Manchester has the highest rates of premature mortality from heart disease and stroke in the country and physical activity is a contributory factor.

5.4 Greater Manchester Plan

5.4.1 Greater Manchester Moving: The Plan for Physical Activity and Sport 2017-21 is the comprehensive plan to reduce inactivity and increase engagement in physical activity and sport. It is aligned to the Greater Manchester Population Health Plan priority themes and the wider reform agenda.

5.4.2 Greater Manchester Moving 2017-21 has been developed following an extensive engagement process with cross sector partners across GM and in localities. Its development has been supported by the GM Moving Leadership group and other key system leaders.

5.4.3 GM Moving outlines a whole system approach to tackling inactivity and increasing active lives across the city-region. It presents an approach to transformational change, with GM people at the heart, led by insight, to support positive behaviour change. It starts by celebrating progress to date, whilst acknowledging the challenge that lies ahead.

5.4.4 The GM Moving Plan outlines twelve priority areas, with priority actions identified to begin this work, at scale and with pace. These are as follows:

<u>Leadership</u>

1. We will lead policy, legislation, and system change to support active lives, ensuring that physical activity becomes a central feature in policy and practice related to planning, transport, health and social care, economic development, education, and the environment.

2. We will provide strategic leadership to secure system change for physical activity and sport across the life course, with person centred, preventative approaches in an integrated system.

<u>Start Well</u>

3. We will ensure that young people aged 0-4 will have the best active start in life with physical literacy prioritised as a central feature of starting well.

<u>Develop Well</u>

4. Greater Manchester will be the best place in England for children, young people and young adults aged 5-25 to grow up, developing their life chances through a more active lifestyle, with a focus on reducing inequalities.

<u>Live Well</u>

5. Increased physical activity and sport across the adult population, reducing inequalities and contributing to health, wealth and wellbeing.

Age Well

6. Make Active Ageing a central pillar within the Greater Manchester Ageing Hub supporting the Greater Manchester ambition for an age friendly city-region, which will lead to better health, wellbeing and independence.

Place

7. We will develop more active and sustainable environments and communities.

8. We will maximise the contribution of the physical activity and sport sector to economic growth across Greater Manchester.

Workforce

9. Build the knowledge, skills and understanding of the workforce across GM to embed physical activity, make every contact count, and develop a diverse workforce fit to deliver the ambitions of this plan.

Evidence, Data and Insight

10. We will ensure that Evidence, Data and Insight inform the development of policy and practice to support active lives.

Evaluation

11. We will embed high quality evaluation into all GM Moving work, developing quality standards, helping to understand impact, learn and improve and support advocacy.

Marketing and Communications

12. High quality Marketing and Communications to support messaging and engagement of people from priority audiences in active lives.

5.5 Areas for development

5.5.1 As part of the Greater Manchester Plan and joint work between the Greater Manchester Health and Social Care Partnership and other partners, a Local Delivery Pilot (LDP) has been established and each local authority areas will receive an allocation of funding to work with target populations.

5.5.2 Manchester will shortly establish a Steering Group to progress the Local Delivery Plan arrangements.

5.6 Commentary from external partners

Public Health England

Increasing levels of physical activity is a key commitment for Public Health England.

PHE's national physical activity framework document Everybody active, every day, identifies areas for action, based on international evidence of what works.
Local authorities can encourage local leadership and action to increase physical activity and reduce inactivity through health and wellbeing boards, ensuring that physical activity is included in joint strategic needs assessments and joint health and wellbeing strategies. They should also weave their approach to physical activity across their relevant functions, including sport and leisure, planning, transport, social care and economic development.

Connections can be made to:

- Local spatial and neighbourhood plans
- Transport plans
- Community sports and physical activity plans
- Clinical Commissioning Group strategic plan
- economic regeneration plans

Local authorities should work with:

- Local Enterprise Partnerships to invest in cycling and walking infrastructure to support local businesses with active travel and retail
- leisure, fitness and sport providers to maximise the potential of local physical activity assets
- community groups to activate and maximise the potential of parks and green spaces

Local authorities can develop programmes of personalised travel plans. These aim to encourage people to change their travel habits by providing them with detailed information of possible alternatives. They involve identifying people who wish to make changes, providing them with information, and supporting them in making changes.

PHE has produced a briefing for local authorities on Working together to promote active travel. Other useful tools/ resources from PHE include:

- Physical Activity Clinical Champions programme - A free peer to peer programme for health care professionals to encourage physical activity conversations with patients
- National campaigns (Active 10, Change4life, 10 min shake ups, couch to 5k)
- Declaration of Healthy Weight Framework
- PHE Health in All Policies tool

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According to the World Health Organisation (WHO), insufficient physical activity is the fourth leading cause of non-communicable diseases, being responsible for 5.5% of all deaths. It is well established that regularly engaging in physical activity has physical health benefits such as improved cardiovascular and metabolic health, weight status, bone density and psychological wellbeing in adolescents. Physical activity also reduces fat mass and the risk of cardiovascular diseases in adulthood.

In addition, an association has been found between physical activity levels and quality of life and self-rated health status. A cross-sectional study of Australian adolescents aged 11–18 years found that as levels of physical activity increase there is a graded increase in health status. The correlation between physical activity and self-reported health status is significant even at low levels of physical activity, below current WHO recommended levels. It appears that the relationship between physical activity levels and health status is stronger in boys than in girls.

However, it is recognised that the relationship between physical activity levels and self-reported health status may vary between countries. Currently, the limited literature comparing findings between countries supports the theory of cross-national differences in the strength of the relationship, as engaging in physical activity may have a different meaning in different cultures.

The University is interested in discussing accurate epidemiology to assess need, including validated indicators to measure, and the robust evaluation of GM Moving for Manchester residents.

Greater Manchester Moving

Manchester partners are fully involved in the implementation of all aspects of GM Moving in the locality. Their work on ‘Winning Hearts and Minds’ is well aligned to the GM Moving approach, and the learning that emerges is something the whole of Greater Manchester will be able to benefit from.

Manchester partners are convened and working on the implementation plans for the Local Delivery Pilot, with Sport England and GM Moving team alongside. We are looking forward to testing novel approaches and making a difference to population health of the target audiences identified in the pilot. Through this work, physical activity will become fully embedded in social prescribing approaches locally and community assets will be strengthened.

Walking and cycling behaviour change will be achieved at neighbourhood level, through the Local Delivery Pilot and through the GM Walking City Region work, alongside their infrastructure plans.

In addition to these specific work areas, Manchester partners are engaged in all aspects of GM Moving: strategy and policy, people and plan, workforce transformation, and the ongoing development of insight, evidence and learning.

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Manchester Health & Care Commissioning
A partnership between Manchester City Council and NHS Manchester CCG

MANCHESTER CITY COUNCIL

NHS Manchester Clinical Commissioning Group

SMOKE FREE MANCHESTER: OUR PLAN FOR TOBACCO CONTROL 2018-2021

DAVID REGAN, DIRECTOR OF POPULATION HEALTH & WELLBEING, CHAIR OF THE MANCHESTER TOBACCO ALLIANCE

Authors: Julie Jerram and Neil Bendel with contributions from partners of the Manchester Tobacco Alliance

Contents

1. Introduction

1.1 Manchester has above average rates of smoking in all age groups and the highest premature mortality rate in the country for the three major smoking related conditions; lung cancer, heart disease and stroke. Smoking is the single largest cause of health inequalities in Manchester. The human cost of these challenging statistics is why this tobacco control plan is so important for the City.

1.2 Adult smoking rates have reduced in recent years nationally and in Manchester (see section 2). Major cultural change was achieved when smoke free legislation was introduced in England in 2007. However, whilst we still have such stark smoking related health inequalities, tobacco control remains a high priority as described in the Manchester Population Health Plan.

1.3 We must continue to help Manchester people who smoke to stop and work towards having a city where children and young people do not start smoking and everyone is protected from tobacco related harm.

1.4 In 2017 the Tobacco Control Plan for England, "Towards a Smoke free Generation" (1) and the first ever Tobacco Control Plan for Greater Manchester, " Making Smoking History, A Tobacco Free Greater Manchester" (2) were launched. In both Plans, ambitious goals were set out for the further reduction in smoking rates and tobacco use, with interim targets set for 2021/22. The Government's vision is to achieve a smoke free generation, with an adult national smoking prevalence rate at 5% or below by 2030.

1.5 The Smoke Free Manchester Plan is consistent with both the national and Greater Manchester (GM) Tobacco plans and we will continue to work closely with Public Health England and the Greater Manchester Tobacco Programme teams.

1.6 It is acknowledged that Manchester will benefit from investments in the Greater Manchester "Making Smoking History" Programme. For example, the development of the CURE Programme (3) at Wythenshawe Hospital (see section5) which if successful will be rolled out across Greater Manchester.

1.7 Manchester City Council and Manchester Health and Care Commissioning teams have led work on enforcement programmes, such as tackling Shisha smoking, illicit tobacco supplies and cigarette littering. We have a strong platform to build on, but there is much more to be done over the coming years.

1.8 In December 2016 the Director of Population Health and Wellbeing established the Manchester Tobacco Alliance, a multi-agency partnership. The Alliance has co-produced this plan and will continue to oversee the implementation of the various programmes over the next three years.

1.8 The targets that have been agreed with partners are:

- **By 2021/22 we will aim to reduce adult smoking prevalence from 21.7% to 15% or less in Manchester**
- **By 2021/22 we will aim to reduce Smoking in Pregnancy from 11.6 % to 6%**

1.9 To achieve these targets the Plan will:

- Adopt an evidence based approach reviewing new emerging evidence (e.g. e-cigarettes) as it becomes available
- Align with and support the Greater Manchester Tobacco Programme, " Making Smoking History"
- Be based on "whole system" partnership working, Tobacco Control cannot be achieved by one agency alone
- Prioritise work with local communities through the Our Manchester approach

1.10 The production of the Smoke Free Manchester Tobacco Control Plan has been co-ordinated by the Tobacco Control and Health Intelligence leads of the Population Health and Wellbeing Team in partnership with the Manchester Tobacco Alliance. The Plan should be read alongside the Joint Strategic Needs Assessment for Tobacco Control (www.manchester.gov.uk/jsna).

1.11 The Delivery Plan is provided in section 4 and further information can be obtained from Julie Jerram, Manchester Population Health and Wellbeing Team, j.jerram@manchester.gov.uk. The Delivery Plan will be reviewed and refreshed each year.

2. Tobacco Related Harm in Manchester

Table 1 : Smoking in Manchester

HEADLINES : SMOKING IN MANCHESTER
There are estimated to be just under 91,500 smokers aged 18 and over in Manchester. This is equivalent to 21.7% of the population compared with the England average of 15.5%.
Smoking prevalence in Manchester has been falling for a number of years but the rate of reduction is much slower than in other parts of the country
There are around 5,999 smoking related hospital admissions per year costing approximately £5.4 million per year to the NHS in Manchester
Manchester has the highest rates of smoking attributable deaths in England
222,288 GP consultations, 43,227 practice nurse consultations, 117,109 GP prescriptions and 27,868 outpatient visits are estimated to be related to smoking, costing approximately £13.5 million per year to the NHS in Manchester
Lost productivity caused by smoking related illness, disability or death is estimated to cost the city approximately £106.2 million per year
The additional smoking related social care costs of current or former smokers are estimated to be approximately £11.6 million per year
Greater Manchester Fire and Rescue Service attend approximately 2 smoking related house fires per week (an average of 7 a month) in Greater Manchester and smoking related fires are still the biggest cause of fire related death in Greater Manchester.
Approximately 977,000 cigarettes are smoked in Manchester every day resulting in 145kg of waste daily. Much of this is dropped as litter which must be collected and which causes environmental damage associated with plastics
Although cigarettes bought through legal channels raise money for the exchequer, the costs attributed to tobacco are one and a half times as much as the duty raised, resulting in a net cost to Manchester of about £47.6 per year
It is estimated that the average smoker in Manchester will spend £2,050 per year on cigarettes

Sources: Action on Smoking and Health (ASH): Local Costs of Tobacco 2018 and Public Health England Local Tobacco Control Profiles

2.1. Smoking prevalence in Manchester and the wider context

2.1.1 The latest data from the ONS Annual Population Survey (APS), based on sample of 1,331 adults aged 18 and over in Manchester, shows that in 2016, just over a fifth of all respondents (21.7%) reported that they currently smoke. This compares with an average prevalence of 15.5% across England as a whole. The graph below shows that prevalence has fallen from a high of 25.5% in 2014 to 21.7% in 2016. However, early indications are that rates will remain the same in 2017. The graph showing Greater Manchester data is also provided (Figure 2).

Figure 1 : Smoking prevalence in Manchester

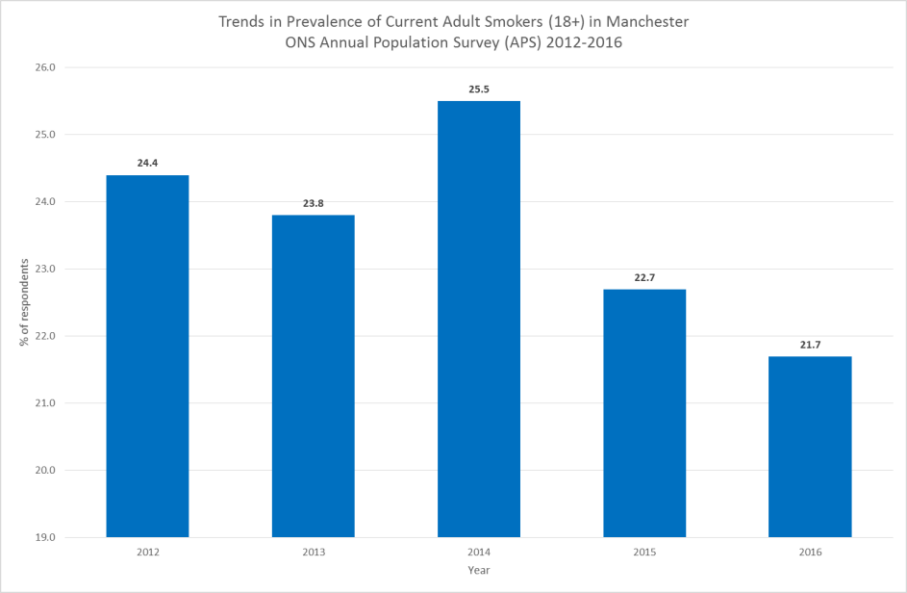
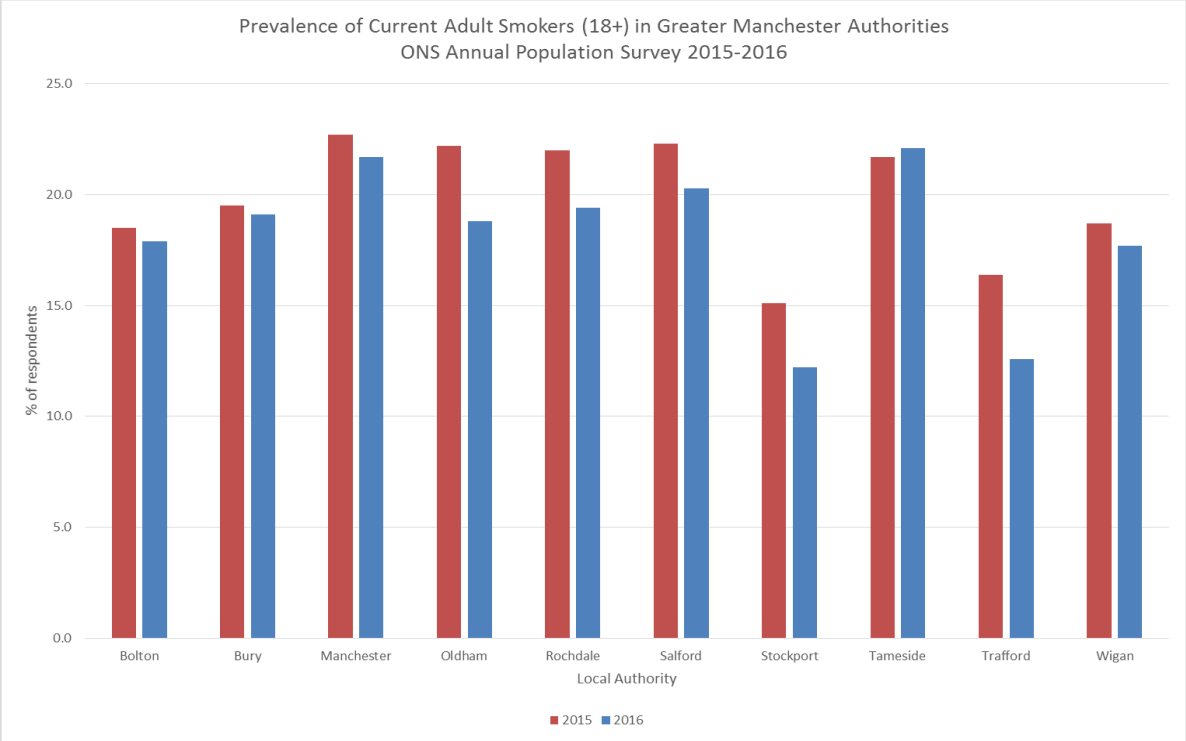
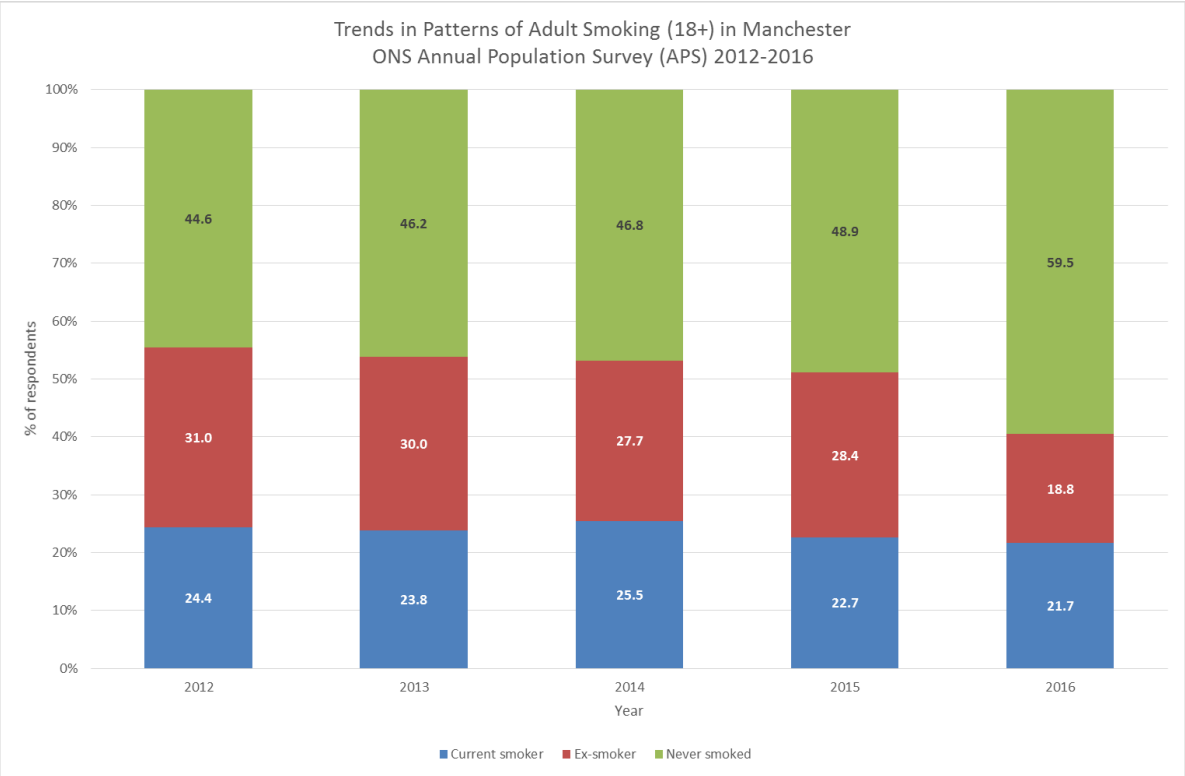


Figure 2 : Smoking prevalence in Greater Manchester



2.1.2 It is also helpful to look at the proportion of adults in Manchester who currently smoke, those that have smoked in the past and those that have never smoked (see Figure 3).

Figure 3 : Trends in patterns of adults smoking in Manchester



The latest figures for 2016 show that, compared with 2015, the proportion of people who currently smoke has fallen very slightly. In contrast, the proportion of adults who reported that they have smoked ('ex smokers') has fallen sharply from 28.4% to 18.8%. At the same time, the proportion of adults who reported that they have never smoked has increased from 48.9% to 59.5%. However, it should be noted that in 2016 there was a change in the questions in the APS, which has had an impact on the calculation of ex-smokers. Furthermore indicators based on self-reported behaviours are likely to underestimate the true level of cigarette consumption and to a lesser extent cigarette smoking prevalence. Evidence suggests that when respondents are asked how many cigarettes they smoke per day, there is a tendency for respondents across all age groups to round the figure down to the nearest multiple of 10.

2.1.3 Data extracted from primary care systems indicates that just under 119,000 patients registered at GP practices in Manchester were recorded as smokers. This is equivalent to 22.7% of the GP registered population and is similar to the national estimate of smoking prevalence generated from the APS (21.7%). The same analysis shows that 17.6% of the GP registered population were recorded as ex-smokers and 74.4% were recorded as being non-smokers.

2.1.4 We know that in some population groups and areas of deprivation, smoking rates are much higher than the average for the population as a whole. For example, workers in routine and manual occupations are twice as likely to smoke as those in professional or managerial roles. Unemployed people are also twice as likely to smoke as those in employment (4). Smoking is twice as common among people with mental health disorders and it is estimated that 37-56% of people with severe mental illness smoke. People from the lesbian, gay and bisexual

communities are also more likely to smoke (5) and prevalence may also vary between minority ethnic groups (6).

2.1.5 Most current adult smokers started smoking before the age of 18 and a key component of this tobacco control plan is to stop people from starting to smoke. Plain packaging legislation introduced in England in May 2017 aims to stop tobacco companies marketing cigarettes in a way that makes them attractive to young people.

2.1.6 People in poorer communities face many other physical and mental health inequalities and smoking serves to make those inequalities even worse by causing serious damage to their health over time. People are more likely to start smoking if they grow up or live in certain areas and may find it harder to give up than people who live in settings where fewer people smoke, or if their circumstances are materially easier (7), (8). We also know that some groups will be more exposed to illegal tobacco sales or the sale of cheaper, unregulated, illicit tobacco.

2.1.8 In Manchester smoking prevalence differs from area to area and some groups are more vulnerable to smoking related harm than others. Parts of north and east Manchester for example, have much higher smoking prevalence rates and worse health outcomes. Therefore targeting help and support in these areas is a key element of work to reduce health inequalities in Manchester. Public Health England strongly advise such an approach in order to accelerate decline in smoking prevalence rates (1). This is consistent with our Population Health Plan.

2.2. The impact of smoking in Manchester

Smoking can have a significant impact on the prevalence of other long term conditions such as respiratory illness and also contributes to the higher rate of hospital admissions and early deaths in Manchester.

Long Term Conditions (LTCs)

2.2.1 Smoking is the major preventable risk factor for Chronic Obstructive Pulmonary Disease (COPD), asthma and other respiratory illnesses. Nationally, around 17% of COPD patients are known to be smokers. However, data from GP practices summarised in the table below, shows that 49% of patients with COPD in Manchester are recorded as smokers.

Table 2 : Smoking and LTCs in Manchester

Respiratory Condition	Current Smokers (%)	Ex-Smokers (%)	Combination – Ever Smoked (%)
COPD	49%	33%	82%
Asthma	24%	14%	37%

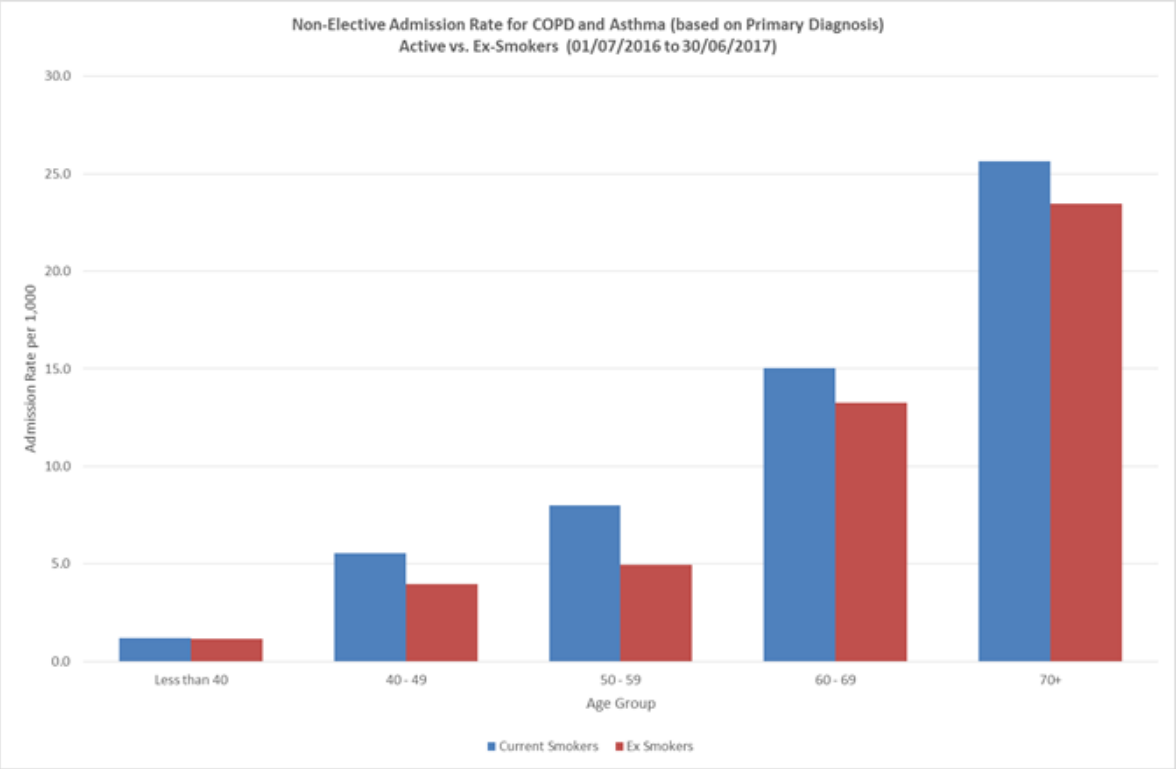
Smoking related hospital admissions

2.2.2 There are just under 6,000 smoking related hospital admissions per year costing approximately £5.4 million per year to the NHS in Manchester. High smoking attributable admission rates are indicative of both poor population health and high smoking prevalence.

2.2.3 The Manchester Health and Commissioning (MHCC) Data Warehouse allows us to look at differences in the care among current and ex-smokers as well as differences in the cost of this care. We can make potential savings from reducing the cost of care among current smokers

down to that of ex-smokers, through effective smoking cessation programmes. Analysis of data from June 2016 to July 2017 shows that the rate of non-elective (i.e. unplanned) hospital admissions for COPD and asthma was higher for current smokers compared with ex-smokers. This pattern persists across all age groups, although 'excess' was highest in patients aged 40-60 years.

Figure 4 : Non elective admission rates for COPD and Asthma



Smoking attributable mortality

2.2.4 Smoking remains the biggest single cause of preventable mortality in the world. It accounts for 1 in 6 of all deaths in England, killing around 79,000 people each year. Causes of death related to smoking include various cancers, cardiovascular and respiratory diseases and diseases of the digestive system. There are huge inequalities in smoking related deaths: areas with the highest death rates from smoking are about three times as high as areas with the lowest death rates attributable to smoking. (Source: Public Health England 2018). Cancer Research UK have provided an excellent summary on 'what influences the risk of cancer from smoking' and this is provided in Appendix 1.

2.2.5 In the three year period 2014 to 2016, there were a total of 2,440 deaths attributable to smoking among people living in Manchester. This is equivalent to around 813 deaths each year. Trends show that the rate of smoking attributable deaths in Manchester fell by just over 8% between 2008-10 and 2012-14, but more recent data suggests that the rate may now be on the increase. The current rate for the period 2014-16 (499.3 per 100,000) is around 9%, higher than that for the period 2012-14.

2.2.6 The rate of smoking attributable deaths in Manchester is the highest in England and is significantly higher than that of other similarly deprived local authorities, such as Hull, Blackpool, Liverpool and Middlesbrough (see Table 3 below). This suggests that deprivation

alone does not fully account for the extremely high level of smoking attributable deaths in Manchester.

Table 3 : Smoking attributable mortality

Smoking attributable mortality 2014 - 16 — Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	244,470	272.0	270.9	273.1
Most deprived decile (IMD2015)	–	24,151	382.2	377.3	387.0
Manchester	–	2,440	499.3	479.5	519.8
Kingston upon Hull	–	1,681	470.3	447.9	493.5
Knowsley	–	1,083	464.5	436.8	493.4
Blackpool	–	1,149	442.9	417.6	469.4
Liverpool	–	2,917	441.8	425.7	458.2
Middlesbrough	–	845	410.5	383.0	439.4
Rochdale	–	1,267	397.8	376.1	420.5
Nottingham	–	1,429	395.8	375.3	417.1
Stoke-on-Trent	–	1,505	393.0	373.2	413.5
Blackburn with Darwen	–	753	390.0	362.3	419.3
Barking and Dagenham	–	737	364.6	338.3	392.5
Tower Hamlets	–	617	340.3	313.1	369.1
Sandwell	–	1,533	333.6	317.0	350.7
Hackney	–	630	322.4	297.1	349.3
Birmingham	–	4,327	308.5	299.3	317.9
Wolverhampton	–	1,238	305.6	288.7	323.2

Source: ONS mortality file, ONS LSOA single year of age population estimates and smoking status from Integrated Household Survey/Annual Population Survey, relative risks from The Information Centre for Health and Social Care, Statistics on Smoking, England 2010.

2.3. Improving the use of health intelligence to support tobacco control

2.3.1 Public Health England provide robust data to local authorities to support their work. In Manchester the MHCC Data Warehouse, referred to in 2.2.3, allows data recorded in primary care to be stored in a central location. This can then be linked to other data sets (e.g. secondary care, community services, mental health and social care) via the NHS Number in an anonymised manner. Data recorded in primary care includes smoking status (current smoker, ex-smoker and never smoked) and smoking reviews, along with other demographic and diagnostic data at an individual patient level.

2.3.3 We can now conduct analysis of the current and historic levels of smoking among patients with a recorded long term condition in primary care, notably COPD and asthma patients who currently smoke or who have smoked in the past.

2.3.4 Another important source of intelligence vital for Tobacco Control, comes from our Council partners (Trading Standards, Environmental Health, Compliance) and Greater Manchester Police and Greater Manchester Fire and Rescue Service. This includes information about the supply and distribution of illicit tobacco, venues where the Health Act is breached (e.g. smoking is allowed indoors in some Shisha cafes) and areas where the sale of tobacco to children aged under 18 is common place. A good example of how intelligence for enforcement work is gathered is the bi-annual survey carried out by Trading Standards North West (TSNW) since 2005. Through schools in the region, young people are asked to complete confidential questionnaires about their tobacco and alcohol use and attitudes.

3. The Greater Manchester Programme

3.1 The Smoke Free Manchester Tobacco Control Plan is aligned with the GM "Making Smoking History" programme. GMPOWER is an acronym for the approach that partners are taking in Greater Manchester and which we have adopted for the city of Manchester.

- Grow a social movement for a Tobacco Free Greater Manchester
- Monitor tobacco use and prevention policies
- Protect people from tobacco smoke
- Offer help to quit
- Warn about the dangers of tobacco
- Enforce tobacco regulation
- Raise the real price of tobacco

> "The Tobacco Free Greater Manchester Strategy sets out a vision that is grounded in an innovative international evidence based framework, our GMPOWER model. This is based on the World Health Organisation (WHO) multi component GMPOWER model introduced globally in 2008, endorsed by the World Bank and UK Government15. This approach advocates a comprehensive, multi-component approach to tackling tobacco. Our Greater Manchester communities offer us a unique opportunity to add a seventh component to the original model to capitalise on coproduction and citizen engagement" Source: Making Smoking History (2).

3.2 In Manchester, helping smokers to stop smoking is only a part of what needs to be done. We also need to bring about a change in social norms across all communities. Social and cultural change was achieved relatively recently when smoke free legislation was introduced in 2007 in workplaces and enclosed public spaces. Compliance rates are now very high without the need for enforcement action in most cases.

3.3 The "de-normalisation" of smoking is crucial if we are to prevent generations of future smokers and also to protect people from the extremely harmful effects of secondary smoke, (also known as environmental tobacco smoke) from pre-birth onwards. National Institute for Health and Care Excellence (NICE) guidance for smoking prevention suggests that school based interventions, mass media interventions and enforcement to restrict illegal access to tobacco are effective in preventing young people starting smoking (4). Exposure to second hand smoke is hazardous to people at any age. Furthermore there is an increase in the risk of low birth weight babies and other harmful effects when women smoke during pregnancy. The Manchester Population Health Plan priority 'The first 1000 days of a child's life' will ensure that support for pregnant women in a range of settings is available.

3.4 We also need to reduce the demand for cigarettes and restrict and regulate their supply. The Council's Enforcement Teams (Trading Standards and the Licencing and Out of Hours Compliance Team) in Manchester work hard to ensure that all of the legislation, particularly around sales to people who are underage, is enforced.

3.5 Evidence shows that "raising tax" is a key tobacco control intervention which has been proven to have a greater effect on more disadvantaged smokers at a population level and so contribute to reducing health inequalities" (4). By making smoking cheaper, sales of illicit tobacco seriously undermine health measures intended to discourage smoking using regulatory and pricing regimes. Enforcement is therefore essential for good tobacco control.

The Manchester City Council teams and others excel in this area and they are valuable partners in the Manchester Tobacco Alliance.

3.6 The Manchester Tobacco Alliance is chaired by the Director of Population Health and Wellbeing and membership of the Alliance is broad in terms of agencies represented. It includes NHS and City Council commissioners, NHS providers, clinicians, GP/primary care representatives, Trading Standards, Environmental Protection, VCS organisations, charities such as Cancer Research UK and Macmillan, GM Fire and Rescue Service, Manchester Prison, Greater Manchester and Public Health England Tobacco Leads.

Greater Manchester Common Standards for Tobacco Control

3.7 The Greater Manchester (GM) Common Standards for Tobacco Control are set out under five overarching strategic outcomes and 'I' statements to show what the outcome will mean for GM residents:

- Improving the Health of the GM Population and Reducing Health Inequalities across GM (I will be increasingly unlikely to be affected by tobacco related health disease as a Greater Manchester resident)
- Start Well: Give every GM child the best start in life (I will ensure that babies, children and young people are protected from the harm caused by tobacco from conception through to adulthood)
- Live Well: Ensure every GM resident is enabled to fulfil their potential (All smokers in GM are given the help they need to quit)
- Age Well : Every adult will be enabled to remain at home, safe and independent for as long as possible (I will be supported to give up smoking to improve my quality of life and smoking related disease at any age)
- Enabling resilient and thriving communities and neighbourhoods (I will be protected from tobacco related crime, fire risk, litter and environmental smoke in my community and the places I visit)

Manchester will use this GM framework for our Tobacco Control Delivery Plan between 2018 and 2021 and this is set out in the next section.

4. The Delivery Plan

For each strategic outcome contained in the GM Plan, a set of common standards have been agreed by Greater Manchester with areas adding local standards if required. The tables below show what we are currently doing in Manchester to meet these standards and what else we need to do over the next three years.

4.1 GM Strategic Outcome 1: Improving the Health of the Population and Reducing Health Inequalities

4.1.1 It is recommended that each area within Greater Manchester will produce its own specific Tobacco Control Plan.

4.1.2 This Smoke Free Manchester Plan demonstrates the commitment of the members of the Manchester Tobacco Alliance, Manchester City Council, Manchester Health and Care Commissioning and Manchester Health and Wellbeing Board to adopt a whole system collaborative approach.

4.2 GM Strategic Outcome 2 : Start Well – Give every GM child the best start in life

4.2.1 Under this outcome we need to ensure that:

- Children are protected from tobacco related harm from conception onwards
- Children and young people will be protected from environmental tobacco smoke

4.2.2 Reducing smoking in pregnancy is the single most important factor in reducing infant mortality. Smoking during pregnancy can also cause serious health problems for the mother and baby, including complications during pregnancy and labour. Smoking during pregnancy carries an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy. The Manchester Population Health Plan priority 'The first 1000 days of a child's life' will focus on this area of work.

4.2.3 We also want to protect children from environmental tobacco smoke by initiating a major new work stream around "smoke free" homes. We will be supported by a leading academic from the University of Liverpool in this work and the Manchester Housing Provider Partnership will be a key partner in our Tobacco Control Programme.

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018-19	What we need to do by 2021 in order to meet this standard
All pregnant women will have a Carbon Monoxide (CO) breath test	The GM maternity services specification states that all women must have a CO test. However, at the present time not all women in Manchester are offered a CO breath test and this is an area identified for improvement for 2018-19. Manchester will benefit from GM funding to roll out the Baby Clear Programme, which will ask midwives and smoking cessation staff to give all women a CO breath test. Staff in the newly commissioned north Manchester Smoking Cessation service (part of Be Well) are expected to offer CO breath tests to all women who want one. Plans are now in place to share a midwifery post with Trafford to ensure Baby Clear can be rolled out in central and south Manchester.	All midwives must be trained, equipped and supported to carry out the CO breath test and provide brief advice about the result. We will rebuild our specialist smoking cessation services across all parts of the city and ensure that they work to NICE guidance, offering CO tests to all pregnant women who want one and who want to give up smoking.
All pregnant women who smoke are referred to services which can help them to stop smoking during their pregnancy	Manchester will benefit from GM funding to roll out the Baby Clear Programme which will ensure that all women can quickly access smoking cessation services if they need them. This standard will be met in 2018 in north Manchester for the first phase of Baby Clear. The Baby Clear Programme will then roll out in central and south Manchester in late 2018. As stated above additional midwifery capacity will be put in place later this year whilst plans for 2019-20 are developed.	Sustain the Baby Clear Programme

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018-19	What we need to do by 2021 in order to meet this standard
All families are supported to live in a smoke free home	This standard is met in part, however the number of children who live in a Smoke Free Home in Manchester is not quantified. Working towards this standard is a high priority in terms of protecting the health of babies' and children, but also in terms of changing norms to prevent teenagers starting to smoke and becoming addicted at a young age. We have initiated a Smoke Free Homes work stream. This is a long term piece of work supported by the research findings of a leading academic at the University of Liverpool. Positive early discussions have started with the Manchester Housing Provider Partnership. The Smoke Free Homes work stream will work across all tenures and types of housing. GM Fire and Rescue Service will also be a key partner.	Trying to ensure that Manchester homes, irrespective of tenure are Smoke Free, especially where children live, will be a priority for 2019-20. We will focus on voluntary measures 'working with' rather than 'doing to' households and communities. Partnership working will be essential, including children's health professionals, frontline council staff, Greater Manchester Fire and Rescue Service and landlords and homeowners across all tenures. Good community engagement will be essential. The Manchester Local Care Organisation will be the key delivery vehicle for this standard in future years.
Strengthen efforts to prevent young people starting smoking (Manchester Standard)	The Council's Trading Standards team will continue with existing measures to prevent underage sales of tobacco and reducing the supply of illicit tobacco.	We will work with GM colleagues who are looking at the opportunities afforded by devolution and a GM tobacco licensing scheme. It is possible that Manchester could take a lead role for this area of work on behalf of all 10 local authorities pending further discussions.
Strengthen efforts to prevent young people starting smoking (Manchester Standard)	At the present time, School Nurses provide support for young people who smoke and the Population Health and Wellbeing Team commissioned specialist smoking cessation training for working with children and young people who smoke.	We will involve young people in the development of other interventions and evaluate change in behaviours and attitudes. This will be done with the Healthy Schools Team.

4.3 GM Strategic Outcome 3 : Live Well – Ensure every GM resident is enabled to fulfil their potential

4.3.1 Under this outcome we need to ensure that:

- All smokers in Manchester understand the risks of smoking and tobacco related harm
- Manchester smokers are able to access all available frontline pharmacotherapies and combination Nicotine Replacement Therapies (NRT) should always be an option. Any pharmacotherapy supplied should be alongside motivational support
- Tobacco Control measures, including smoking cessation support, focus on groups who have higher smoking prevalence rates in order to further reduce smoking related health inequalities
- All smokers admitted to hospital are assessed and treated for nicotine addiction irrespective of the cause of admission. Working towards zero tolerance to smoking for staff, patients and visitors on all hospital and health service sites.

4.3.2 Statistically the most effective way to give up smoking is using a dual approach of appropriate pharmacotherapy and psychological / motivational support. Manchester Health and Care Commissioning are committed to rebuilding community based smoking cessations services based on the latest evidence and NICE guidance. These community based services will support the pathways of new programmes such as Baby Clear and CURE. Specialist Smoking Cessation services will be commissioned to reach into those communities where smoking prevalence is highest and target population groups, including people in routine and manual occupations, people with mental health problems, the LGBT community, homeless people and offenders.

4.3.3 In Manchester, we have senior clinicians in our acute hospital trusts who are committed to making sure that their hospitals fulfil NICE guidance PH48 (9) and that all patients are offered a high quality smoking cessation service. The CURE programme, led by Dr Matthew Evison is a pioneering example of this (see section 5). Manchester hospitals will benefit from funding made available from the GM Health and Social Care Partnership to develop and implement CURE.

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018	What we need to do by 2021 in order to meet this standard
Each area in GM will adopt a Making Every Contact Counts approach: all front line staff are able to talk about the risks associated with smoking.	In 2018 we will partially meet this standard. We successfully piloted training for school nurses and staff working with families with complex needs in 2017. This will be repeated.	We will identify all front line staff who need to be trained to talk to people about smoking and to deliver brief interventions. We will work in a creative way with staff and their respective organisations to ensure that appropriate training is provided. This work will also be crucial if we are to increase the number of smoke free homes in Manchester.

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018	What we need to do by 2021 in order to meet this standard
	Staff working for our integrated health and wellbeing service, buzz, offer support and advice to people who would like to stop smoking. The staff working for Be Well, our new social prescribing service, will also offer support and advice.	
Publicised arrangements are in place for smokers to access pharmacotherapy and motivational support in all areas (including advice about Nicotine Inhaling Products i.e. e-cigarettes).	Publicised arrangements are in place for services in Manchester. Information has been made available to all GP practices about the Be Well service and buzz, who can offer support for smokers. Information is available on the Health and Wellbeing pages of the Manchester City Council (MCC) website. Manchester benefits from information hosted on the GM Making Smoking History platform and can access a telephone based smoking cessation service. This number is listed on the MCC website too. We are aware that there is controversy around the use of Nicotine Inhaling Products (e-cigarettes), Manchester supports the approach of Public Health England and GM in supporting the use of these products as a "harm reducing" aid to giving up smoking completely. E-cigarettes are thought to be 95% safer than smoking normal cigarettes because they do not contain tobacco (Source: PHE/CRUK). However, there still appears to be widespread confusion about how safe e - cigarettes are relative to normal cigarettes and we will make sure that accurate information is available to smoking cessation	In line with PHE advice we will continue to develop local policies around the use of nicotine inhaling products for our smoking cessation services. As smoking cessation services develop and change across Manchester, we will ensure that all websites and other communications are up to date and widely available to professionals and residents. Consider the recent findings of the Parliamentary Science and Technical Committee in relation to e-cigarettes and vaping.

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018	What we need to do by 2021 in order to meet this standard
	practitioners, health care professionals and smokers themselves.	
All areas will have plans to focus resource on the areas and groups with the highest prevalence of smoking (e.g. people in routine and manual occupations, LGBT people, people with mental health issues, people with complex long term conditions and offenders)	In conjunction with our partners, Manchester has made a good start in respect of this standard. The first of our new stop smoking services was launched in north Manchester in 2018. North Manchester has high numbers of smokers from all of the vulnerable and at risk groups mentioned and high deprivation. The LGBT Cancer Support Alliance has a strategy called Proud2Bsmokefree which is supported by the Manchester Tobacco Alliance. In 2017 Manchester Prison became Smoke Free.	The NHS target for Mental Health Trusts to be Smoke Free remains a challenge across the country. We will work with Greater Manchester Mental Health Trust to progress work in local settings. We need to ensure that targeted stop smoking services for key vulnerable groups are available across the city by 2020. Further work needs to be carried out to address high levels of smoking and subsequent health inequality in our LGBT community. This will include work initiated in 2018 to make PRIDE smoke free in years to come. The highly successful Lung Health Check Service, which was piloted by the Macmillan Cancer Improvement Programme (MCIP) in north Manchester will be rolled out across Manchester and GM. This programme targets smokers in deprived communities many of whom may be in routine and manual work or un employed.
All smokers admitted to hospital will receive appropriate pharmacotherapy and motivational support as inpatients and on-going support on discharge. The "CURE" programme is the model for actioning this in GM.	This standard describes what is actually recommended in full by NICE guidance PH48 (9) for people in secondary care, mental health patients and pregnant women. Acute trusts in Manchester (and beyond) have not met the recommendations of PH48 and this standard is not met currently. However, the CURE programme (8),	Phase 1 of CURE will launch in Wythenshawe hospital in 2018. Phase 1 will test proof of concept and "iron out" operational issues. This programme is ambitious and innovative and we anticipate will deliver not only improved health outcomes for patients, but also reduce hospital admissions. If successful, CURE will be rolled out across all GM and Manchester sites

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018	What we need to do by 2021 in order to meet this standard
	launched at Wythenshawe hospital in September 2018 will fulfil and exceed this guidance if fully implemented.	We acknowledge that CURE is dependent upon the provision of specialist community stop smoking services which all patients will be able to access on discharge from hospital. It is therefore a priority for MHCC to commission city wide stop smoking services which will deliver our intended outcomes and support the CURE pathway. Proposals will be developed in 2018-19 for implementation in 2019-20.

4.4 GM Strategic Outcome 4 : Age Well – Every adult will be enabled to remain at home, safe and independent for as long as possible

4.4.1 Under this outcome we need to ensure that:

- People who have conditions caused by, or exacerbated by smoking will be supported to stop smoking
- All smokers aged 50 and over admitted to hospital will be assessed and treated for nicotine addiction, irrespective of the cause of admission. Working towards zero tolerance to smoking for staff, patients and visitors at all hospital sites and health service settings.

4.4.2 The important principle underlying our commitment to this particular standard is that we believe that it is never too late to stop smoking. No matter how long an individual has smoked health outcomes can be improved significantly in the short and long term if smoking is ceased. Stopping smoking will not only impact on life expectancy but also "healthy life expectancy". We recognise that some older people might have smoked for many years and giving up might be really difficult. However, we will make sure that older people receive the help they need to stop smoking, which will include a pharmacotherapy offer and working with the Age Friendly Manchester Team will inform our approach. The CURE programme will also be an important intervention for this age group.

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018	What we need to do by 2021 in order to meet this standard
All people aged 50 and over who have a smoking related or smoking exacerbated chronic	We will promote this standard by making the 2018 Festival of Ageing a voluntary "Smoke Free" event with the support of the GM Making Smoking History team.	The first "Smoke Free" Festival of Ageing events will demonstrate the commitment to becoming Smoke Free at

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018	What we need to do by 2021 in order to meet this standard
condition will be offered evidence based support to stop smoking	Whilst many Smoke Free events will be aimed at children and families, it is important to value the health of older people and to address health inequalities in this group.	any age. We also acknowledge the important intergenerational influence that this age group can have. We acknowledge that there are gaps in our smoking cessation service provision citywide and we will address these as described earlier. Over 50s must be offered services based on need and older smokers must also be supported to stop at any age.
All smokers, irrespective of age, who are admitted to hospital will receive appropriate pharmacotherapy and motivational support as inpatients and on-going support on discharge. The CURE programme (8) is the appropriate model for accessing this in GM.	Please see information in relation to the CURE programme (see section 5) which will offer support to smokers irrespective of age.	Please see information in relation to plans for the implementation of the CURE programme.

4.5 GM Strategic Outcome 5: Enabling resilient and thriving communities and neighbourhoods

4.5.1 Under this outcome we need to ensure that:

- Tobacco legislation is enforced and the supply of illicit tobacco is tackled
- There are fewer smoking related accidental dwelling fires so homes and residents are safer
- Smoke free hospitals - working towards zero tolerance to smoking for staff, patients and visitors at all hospital sites and health service settings
- There will be more smoke free public spaces in Manchester
- We have a smoke free public sector

4.5.2 This set of standards relate to the wider determinants of smoking and will be challenging to achieve. For example, whilst there is general acceptance that people should be supported by health services to stop smoking and that children should be protected, there may be resistance to further changes. However, if residents of the city are involved in shaping programmes so much more can be achieved.

4.5.3 We can build on the excellent work of the Council's Enforcement Teams (Trading Standards and the Licensing Out of Hours Compliance Team). The Teams enforce all tobacco related legislation across the city. For example, the partnership work to combat the health harm caused by widespread smoking of Shisha in some parts of the city. Work is planned and carried out in conjunction with other agencies such as Greater Manchester Police, HM Revenue and Customs, Greater Manchester Fire and Rescue Service, the Population Health and Wellbeing Team, Border Force and the Prevent Team as part of wider measures to ensure all legislation to keep people and premises safe is monitored.

4.5.4 Manchester has also added "tobacco related littering" as a local standard to support the Council's Waste, Recycling and Street Cleansing team. We aim to reduce cigarette littering and associated plastic pollution as part of a wider campaign launched this year with Keep Britain Tidy.

4.5.5 Greater Manchester Fire Service are a critical partner in terms of making communities safer by preventing fires and also important work they do in carrying out domestic "Safe and Well" checks. At the present time, smoking remains the top cause of fire ***deaths*** in Greater Manchester, despite the huge improvements in fire prevention and associated reduction in domestic fires generally.

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018	What we need to do by 2021 in order to meet this standard
Publicised arrangements are in place for members of the public to report concerns about illicit tobacco and breaches of legislation, e.g. underage sales.	We believe that this standard is met in 2018 and that by running a communications campaign annually, we will improve publicised arrangements. Most reports received by Trading Standards come through the National Trading Standard's Helpline which is hosted by Citizens Advice. Reports are also received via a website called keep-it-out.co.uk. The Council and partners advertise these places and numbers.	The objectives of enforcement teams are clear and set out in legislation. Our aim for 2018-2021 would be to ensure that these operations can continue.

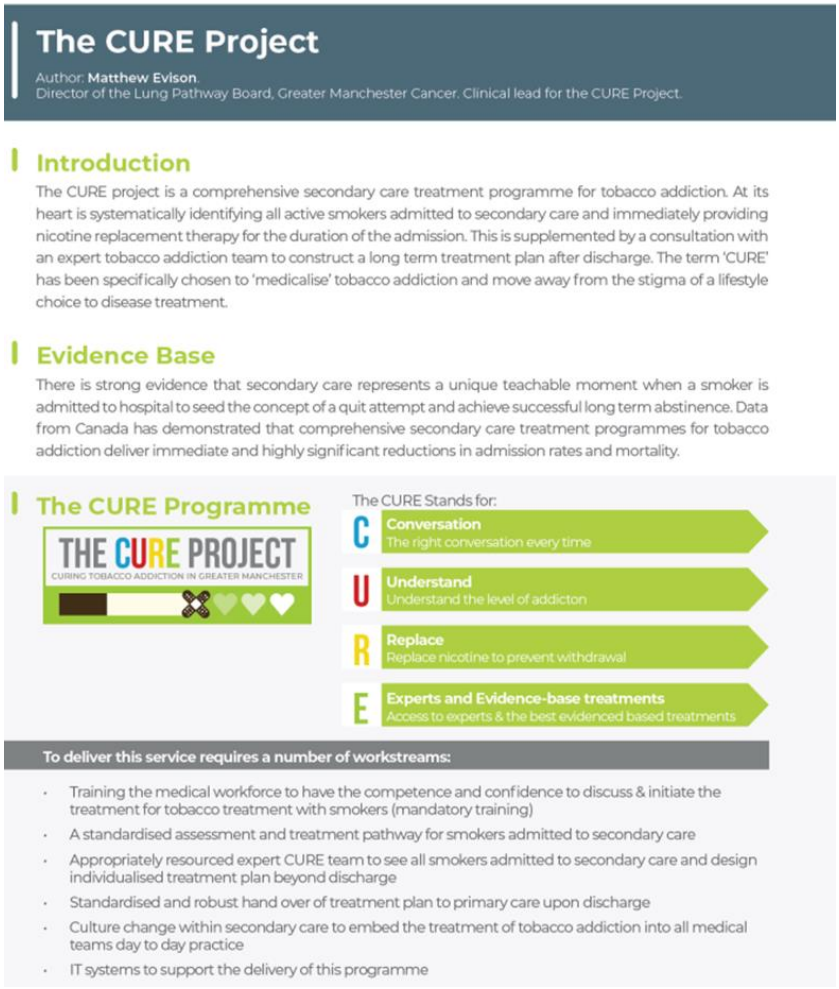
Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018	What we need to do by 2021 in order to meet this standard
	We want to do more to improve intelligence reporting and subsequently intelligence led operations. We have initiated work with the MCC Communications Team to run a campaign in 2018 which will aim to increase the number of reports received and to explain to the public why tackling these issues is important for them and their communities. The Shisha work which has run throughout 2018 will continue. An ongoing programme of operations is carried out by the Council's Trading Standard team to prevent sales of tobacco and related products to people aged under 18. This includes the action against supply of illicit tobacco and ensuring legislation around tobacco advertising and plain packaging is complied with.	
Manchester will work towards making all homes Smoke Free	Elements of this standard relate to accidental dwelling fires. The Greater Manchester Fire and Rescue service Safe and Well check programme has been strengthened in recent years.	We will progress our partnership work on Smoke Free Homes as set out in section 4.2.
All acute and mental health trusts to develop and implement a Smoke Free policy	Whilst the hospital and mental health trusts in Manchester do have Smoke Free policies, full implementation remains challenging. This situation is not unique to Manchester and Public Health England and the GM teams will provide	CURE, if fully implemented, will provide an excellent catalyst for Smoke Free hospital sites. Further work will be undertaken with the Greater Manchester Mental Health Trust (GMMHT) as described earlier.

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018	What we need to do by 2021 in order to meet this standard
	additional support to progress local work in 2018-19.	
All areas will increase the number of voluntary schemes promoting Smoke Free family spaces	In 2018 Manchester does not have any voluntary smoke free family spaces. We will be making our Manchester Festival Of Ageing Smoke Free in summer 2018 and are exploring options to include other events.	The Population Health and Wellbeing Team will work with Manchester City Football Club and other partners to look at smoke free grounds and stadia policies, given the number of children and families who go to sporting events.
All public organisations' sites and grounds are supported to be smoke free	Achieving Smoke Free outdoor public spaces will be best achieved by working with partners across GM. Work has begun to make PRIDE 2019 partially Smoke Free. This is an important step in de-normalising smoking in the LGBT community where rates are much higher than the population average. The learning from this programme will be helpful in rolling out more smoke free spaces and events.	We will support the work of the GM Tobacco Regulatory Sub Group under the Combined Authority. This group is exploring options for tobacco licensing schemes and legislation to support Smoke Free outdoor spaces. Work on other smoke free spaces must involve the public of Greater Manchester and target population groups building on the survey results from Making Smoking History. For example, there was widespread support for Smoke Free Children's Playgrounds.
To reduce cigarette littering and plastic pollution caused by cigarettes (Manchester standard)	The Council's Waste, Recycling and Street Cleansing Team has launched a major new anti-littering campaign in conjunction with Keep Britain Tidy.	The wider impact of smoking on the environment and the involvement of communities will add momentum to this campaign in future years.

5. The CURE Programme

A number of standards refer to the CURE programme and this Plan would not be complete without crediting the Manchester team who have developed it. CURE is an approach to smoking cessation based on the Ottawa Smoking Cessation model (10). The approach involves a comprehensive treatment programme to people admitted to hospital both as in patients and on discharge. It treats smoking primarily as an addiction, necessitating pharmaceutical intervention in order to help smokers to quit.

CURE was a concept (see summary sheet) designed and developed by Consultant Dr Matthew Evison from Wythenshawe Hospital, now part of Manchester University Hospitals Foundation Trust. CURE, we hope will save many lives and reduce costs in relation to hospital admissions and morbidity in both the short and long term. The Manchester Health and Wellbeing Board endorsed the CURE Project and will support its development and delivery over the coming months and years. In June 2018, Greater Manchester Health and Social Care Partnership committed £2.5 million to support the roll out of CURE across Greater Manchester and phase 1 will be implemented at Wythenshawe Hospital in autumn 2018.



The CURE Project

Author: **Matthew Evison**.
Director of the Lung Pathway Board, Greater Manchester Cancer. Clinical lead for the CURE Project.

Introduction

The CURE project is a comprehensive secondary care treatment programme for tobacco addiction. At its heart is systematically identifying all active smokers admitted to secondary care and immediately providing nicotine replacement therapy for the duration of the admission. This is supplemented by a consultation with an expert tobacco addiction team to construct a long term treatment plan after discharge. The term 'CURE' has been specifically chosen to 'medicalise' tobacco addiction and move away from the stigma of a lifestyle choice to disease treatment.

Evidence Base

There is strong evidence that secondary care represents a unique teachable moment when a smoker is admitted to hospital to seed the concept of a quit attempt and achieve successful long term abstinence. Data from Canada has demonstrated that comprehensive secondary care treatment programmes for tobacco addiction deliver immediate and highly significant reductions in admission rates and mortality.

The CURE Programme

THE CURE PROJECT
CURING TOBACCO ADDICTION IN GREATER MANCHESTER

The CURE Stands for:

- **C** — **Conversation** — The right conversation every time
- **U** — **Understand** — Understand the level of addicton
- **R** — **Replace** — Replace nicotine to prevent withdrawal
- **E** — **Experts and Evidence-base treatments** — Access to experts & the best evidenced based treatments

To deliver this service requires a number of workstreams:

- Training the medical workforce to have the competence and confidence to discuss & initiate the treatment for tobacco treatment with smokers (mandatory training)
- A standardised assessment and treatment pathway for smokers admitted to secondary care
- Appropriately resourced expert CURE team to see all smokers admitted to secondary care and design individualised treatment plan beyond discharge
- Standardised and robust hand over of treatment plan to primary care upon discharge
- Culture change within secondary care to embed the treatment of tobacco addiction into all medical teams day to day practice
- IT systems to support the delivery of this programme

6. Summary

6.1 The delivery of the Smoke Free Manchester Tobacco Control Plan aims to reduce smoking prevalence in Manchester and to change norms to make smoking a thing of the past in our City. We will focus our efforts on parts of the City that have the highest smoking rates, in order to reduce health inequalities and prevent early deaths from the three major killers; cancers, cardiovascular disease and respiratory conditions.

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Gail Stott, Manchester Safeguarding Board

Louise Marshall, Population Health and Wellbeing Team, Manchester Health and Care Commissioning
Sarah Hardman, Greater Manchester Fire and Rescue Service
Clare Platt, Greater Manchester Fire and Rescue Service
Coral Higgins, Macmillan Cancer Commissioning Manager, NHS Manchester Clinical Commissioning Group
Stephanie Archer, Manchester Health and Care Commissioning

Appendix 1

Cancer Research UK
What influences the risk of cancer from smoking?

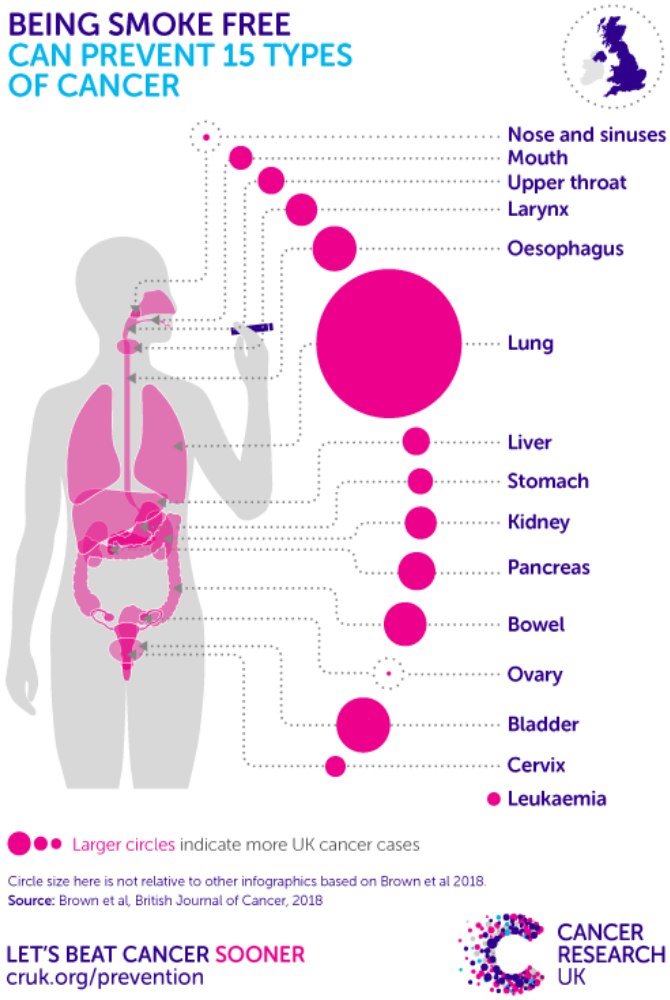
Smokers have a much higher risk of lung cancer than non-smokers, whatever type of cigarette they smoke. There's no such thing as a safe way to use tobacco. Cancer is perhaps the most widely known smoking related health risk, although as shown above, it is far from the only one. Many people are also not aware of how many cancers can be caused by smoking.

The type of cigarette an individual smokes has not been linked to a changed risk of developing a smoking related cancer. However, there is a positive relationship between the number of cigarettes smoked and the risk of developing cancer. Even "light" smoking can increase the risk of cancer.

Research has shown that the number of years spent smoking affects cancer risk even more strongly than the number of cigarettes smoked per day. For example, smoking one pack a day for 40 years is even more dangerous than smoking two packs a day for 20 years.

It usually takes many years, or decades, for the DNA damage from smoking to cause cancer. Our bodies are designed to deal with a limited damage but it's hard for the body to cope with the number of harmful chemicals in tobacco smoke. Each cigarette can damage DNA in many lung cells, but it is the build-up of damage in the same cell that can lead to cancer. Research has shown that for every 15 cigarettes smoked there is a DNA change which could cause a cell to become cancerous.

(Information provided by Cancer Research UK)



(Image courtesy of Cancer Research UK)

Appendix 2: Alcohol Services & Programmes

1. Community Alcohol Champions – Communities in Charge of Alcohol (CICA)

1.1 Background

A 'Communities in Charge of Alcohol' (CICA) project has been developed, which aims to develop a network of community alcohol champions across Greater Manchester (GM.) The project builds on the principle that local communities should be empowered to take charge of their own health and people in communities are best placed to influence their friends, families and colleagues.

The project is an innovative partnership between the 10 Greater Manchester Local Authorities, Public Health England (PHE), the Royal Society for Public Health (RSPH) and the University of Salford (who will be evaluating the work). The evaluation will look at whether the champions have an impact on alcohol related harm (including hospital admissions and alcohol related crime) and whether it is cost effective. If the answer is yes, there is a possibility of expanding the initiative at little cost.

CICA reflects the GM strategic commitment to develop innovative community and person centred approaches as part of the GM and Manchester Population Health Plans.

There is an ambition that the residents of GM will be active participants in achieving their own improved health outcomes, through their personal responsibilities and also through their advocacy in networks and social movements for change. Manchester already has a number of excellent examples of how this has been successful through innovation like the Age Friendly Programme and the hosting of the GM Recovery Walk in 2014.

1.2 Rationale

The social and health harms associated with alcohol hit Manchester and other areas in GM harder than in most areas of England as they do for the most of the North West. This is despite innovation and the provision of quality services in the community.

The 10 GM Local Authorities are identifying neighbourhoods of high alcohol related harm. The neighbourhoods are to consist of two LSOA (or lower super output areas) made up of approximately 3,000 residents.

Analysis has taken place of the following indicators across north Manchester:

- Perceptions of anti-social behaviour (drunk and rowdy behaviour) by Ward 2015-16
- Alcohol related incidents 2014-16
- Alcohol related crime locations 2014-16

- Alcohol related crime offender homes 2014-16
- Alcohol specific hospital admissions 2015-16
- Weekend evening A&E attendances 2015-16

High levels of alcohol related harm across all indicators are confirmed in a number of neighbourhoods in north Manchester including an area of Newton Health & Miles Platting. A survey of residents in 2015-16 shows that a higher proportion of residents in Newton Heath & Miles Platting (26.9 %) notice drunk and rowdy behaviour in their area more than residents across other areas in north Manchester. Community safety partnership data shows high levels of alcohol related crime call outs to the police also.

Consideration has been given to the location of two suitable LSOAs that are coherently located and represent a neighbourhood. It is proposed that a neighbourhood area in Newton Heath & Miles Platting (which includes Old Church Street and the adjacent end of Briscoe Lane would be suitable. This area contains a shopping district, residential areas, and a number of community services including library and health centre.)

1.3 Proposal

It is proposed that it would be beneficial to pilot the CICA project in this neighbourhood area. This is an opportunity to improve community health and wellbeing, and will involve identifying and training around 10 local residents or individuals who work in the area to become community alcohol champions. The Royal Society of Public Health (PSPH), local authority officers, and CGL will lead on the training. The aim is to provide community members with the knowledge, skills and key contacts to support them to:

- Have informal conversations about alcohol and health with family, friends and colleagues
- Support people to reduce drinking through brief advice or guiding them towards specialist services
- Attending local community events to speak to people about alcohol and health
- Provide support for communities to get involved with licensing decisions by helping them to raise issues with the local authority about venues selling alcohol

Through their conversations they will be able to influence a much large number of people who in turn will share their knowledge with others. Commissioned Public Health services will have a role in supporting the community alcohol champions.

The CICA project has been rolled out across Greater Manchester and the Manchester work started in Miles Platting and Newton Heath in June 2018. Other areas will follow over the next 9 months.

2. Manchester Integrated Drug & Alcohol Service provided by Change, Grow, Live (CGL)

2.1 The service is for adults (aged 18 +) and provides a number of key components summarised below:

i) Prevention and self-care, including training on alcohol for other providers. A comprehensive programme of alcohol and drug awareness and early intervention training, resulting in increased capacity for prevention of alcohol and drug-related harm.

ii) Engagement and early intervention, including harm reduction. A single referral, triage and assessment process for all alcohol and drug interventions delivered from a range of community-based settings including early help hubs and homeless/rough sleeper settings.

iii) Structured treatment. A comprehensive package of concurrent or sequential specialist drug and alcohol focused interventions that will address multiple/more severe needs.

iv) Recovery support. An increased focus on recovery from alcohol and drug dependence so that more individuals successfully complete their treatment and are able to access education, training and employment opportunities and reintegrate into the community.

2.2 The service is available city wide in a range of community-based settings in Manchester, and provides a single access, assessment, and care coordination process for all alcohol and drug misusers. The service is accessible through a range of referral pathways, with particular focus on those individuals and groups who pose a high risk of harm to themselves and others. The service works with users/misusers of a range of substances including alcohol, illegal drugs, new psychoactive substances (NPS) and misusers of prescription/over the counter medication. As well as providing clinical treatment for alcohol and drug dependency, the service works in partnership with other services to support individuals to achieve a range of recovery goals. These partnership arrangements are summarised below.

i) Acorn Housing Association Ltd who deliver structured group work programmes, including RAMP (Recovery and Motivation Programme) which aims to motivate people to consider and become abstinent from alcohol or drugs and DEAP (Dependency Emotional Attachment Programme) for people who have achieved abstinence and are motivated to achieve long term recovery.

ii) Emerging Futures who deliver asset based community development (ABCD) across the city, engaging with people in treatment for 2 years or more.

iii) LGBT Foundation who support people to access structured treatment, support people involved in chemsex and provide harm reduction advice to communities.

iv) The Work Company deliver the 'Building Employability and Self Confidence' programme, finding volunteering and employment opportunities and access to mentoring schemes.

3. Drinkaware Club Crew

3.1 Introduction

There is a memorandum of understanding between the Drinkaware Trust (Drinkaware), Greater Manchester Police (GMP), and Manchester City Council (MCC) to deliver the Drinkaware Crew. The programme aimed at reducing the harm caused by binge drinking and public drunkenness through consumer education and engagement in nightclubs in Manchester City Centre.

The Partnership will be implemented by activity commencing in Manchester City Centre starting in autumn 2018. GMP and MCC have agreed to fund a 3 month pilot of Drinkaware Crew in venues identified as meeting the criteria for needing additional alcohol and vulnerability support. This partnership will last until January 2019 but may be extended with all parties' agreement, and the individual premises are expected to continue employing Drinkaware Crew after the initial funded trial.

3.2 Overview of Drinkaware Crew

Drinkaware Crew are trained paid members of staff who work in venues at night with large numbers of 18 to 25-year-olds such as bars and nightclubs who are solely focussed on offering welfare support to those who are or are in danger of becoming vulnerable due to alcohol. They wear a clearly identifiable uniform and work in pairs during busy periods. They are trained to identify and deal with a variety vulnerabilities and sexual harassment.

Appendix 3: Physical Activity Programme

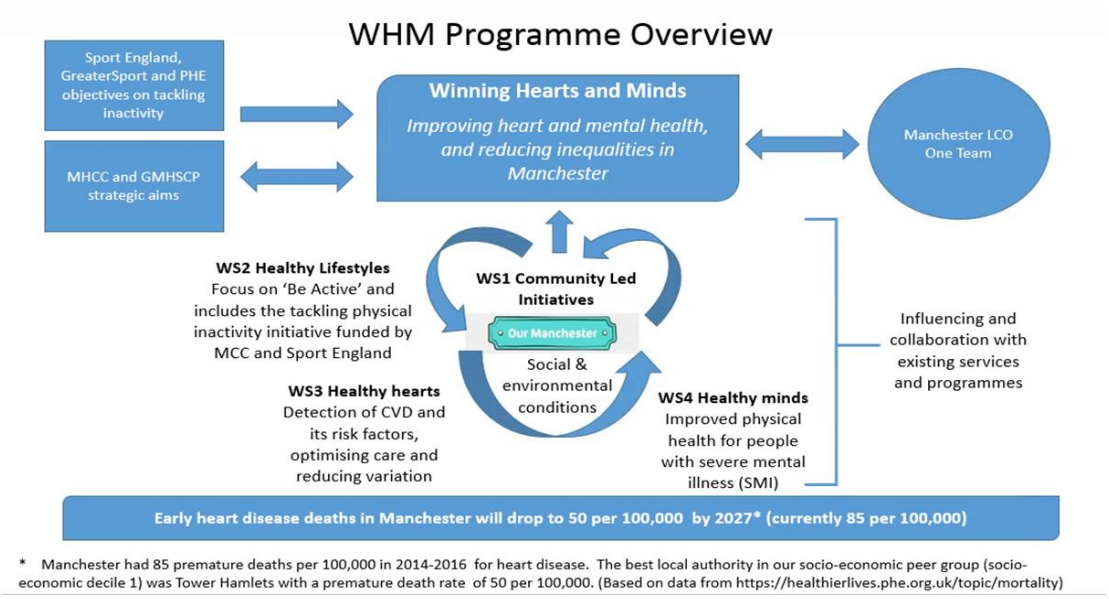
1 Winning Hearts and Minds

1.1 Introduction

Priority 5 of the Manchester Population Health Plan focuses on 'Taking Action on Preventable Early Deaths'.

'Winning Hearts and Minds' is a new and ambitious programme of work which seeks to take a whole system approach to improving heart and mental health outcomes and associated health inequalities in Manchester. It was established in 2017 to address the poor heart and mental health outcomes in Manchester. Early deaths from heart disease (deaths under the age of 75) in Manchester are currently 85 per 100,000. The footprint of the former North Manchester CCG has an early death rate from heart disease of 96.2 per 100,000. The headline target for the WHM programme is that **early deaths from heart disease in Manchester will drop to 50 per 100,000 by 2027**.

The WHM programme is being developed and delivered in partnership between Manchester Health and Care Commissioning, Manchester City Council's Sport and Leisure Team and Eastlands Trust, a provider of sport and physical activity opportunities in Council-owned facilities (MCC's sport and leisure team and Eastlands Trust will merge in mid-2018 to become MCRactive). The programme is being delivered through a multi-agency operational group and is governed by a multi-agency partnership board. The programme design places a strong emphasis on influencing and advocacy, working in close partnership across organisational boundaries and collaboration with existing services and programmes in order to achieve the ambitious programme target. Therefore, multi-agency working is key.



* Manchester had 85 premature deaths per 100,000 in 2014-2016 for heart disease. The best local authority in our socio-economic peer group (socio-economic decile 1) was Tower Hamlets with a premature death rate of 50 per 100,000. (Based on data from https://healthierlives.phe.org.uk/topic/mortality)

While some areas of the programme will be citywide, there will be an initial focus on North Manchester, where heart health outcomes are the worst in the city, with a view to testing new approaches and scaling up successful approaches city-wide. The programme design and delivery is aligned to the Our Manchester approach, with the 'Community-led Initiatives' workstream at its heart, informing the design and delivery of three further work streams that make up the full programme scope; Healthy Hearts, Healthy Minds and Healthy Lifestyles.

1.2 Community led Initiatives work stream

Enabling communities to take charge of their health - resident led partnership groups for neighbourhoods that are recognised by local people (e.g. populations of around 5000 people) will develop and deliver initiatives for Winning Hearts and Minds. In a similar way to the local Ambition for Ageing programme, relationships will be built with current groups and community development work where they already exist and new groups facilitated where there are gaps. People will be supported to develop activities addressing their own shared objectives. The evidence from HELP (Health Empowerment Leverage Projects) demonstrated that time-limited interventions of two years initiated sustained organisational and cultural change with measurable health benefits from year three (the projects were in disadvantaged neighbourhoods of approximately 5000 people).

Delivery of this workstream will be facilitated by Manchester's Prevention Programme and neighbourhood working within the Local Care Organisation, and make the most of other place-based approaches taking place in the city. This approach is being tested in Collyhurst and Cheetham initially with plans to roll out the approach across North Manchester and citywide. Over time, it is expected that the community led initiatives will inform activity that is commissioned and delivered by public services.

1.3 Healthy Lifestyles work stream

Work will initially focus on developing and delivering the Tackling Inactivity Initiative (TII), which will test new approaches to tackling physical inactivity; targeting adults aged 40-60 years old who are physically inactive (doing less than 30 minutes of physical activity per week) and at risk of developing cardiovascular disease or who already have poor mental health or a cardiovascular diagnosis. Currently under-represented groups in sport and physical activity (e.g. women, BAME and people with disabilities) will be targeted, where appropriate. Manchester Metropolitan University has recently been commissioned as the research and evaluation partner for this initiative to ensure a robust evidence base is developed and lessons learned are captured. Their role is to support the development of the TII and to work with a commissioned provider (not yet identified) to design and deliver interventions with the expectation that interventions are co-produced with target communities, for example, linking in with the resident-led partnership groups created or identified through the Community led Initiatives workstream.

This work will help to deliver Manchester's ambitions on tackling physical inactivity in line with Public Health England's national strategy (Everybody Active, Every Day) and to deliver against objectives and targets set out in the GM plan 'GM Moving' (2017-2021) and the MoU between Sport England, Greater Manchester Combined Authority and the NHS, as well as the new Manchester strategy on Sport and Physical Activity (2018-2022). Learning from this initiative will feed into the planning around the recently awarded Local Delivery Pilot for GM, funded by Sport England.

1.4 Healthy Minds work stream

This workstream is focussed on improving the physical health of people with severe and enduring mental illness (SMI). People living with SMI face one of the greatest health inequality gaps in England as this population group are at risk of dying on average up to two decades earlier than the general population. This disparity in health outcomes is partly due to physical health needs being overlooked, both in terms of identification and in receiving appropriate treatment. People are not being offered appropriate or timely screenings despite their higher risk of poor physical health. There is also a low uptake of information, tests and interventions relating to preventable health conditions such as physical inactivity, smoking, alcohol, obesity, diabetes, heart disease and cancer. Work is focusing initially on increasing the number of people with SMI receiving a full annual physical health assessment and appropriate follow up. This includes developing Manchester's NHS Health Check model so that people with SMI are targeted and supported appropriately. In addition a working group is being established to look at a community-driven approach for improving physical health of people with SMI, which will involve people with SMI.

1.5 Healthy Hearts

This workstream is being driven by a multi-agency CVD Steering Group and is focussed on improving the detection of cardiovascular disease and its risk factors, optimising care and reducing variation. The first phase will focus on targeted NHS Health Checks (cardiovascular/heart disease risk detection), atrial fibrillation (irregular heartbeat) and hypertension (high blood pressure). MHCC is working in partnership with Health Innovation Manchester (formerly GM Academic Health Science Network) and Right Care delivery partners to address variation, with learning from the Bradford Healthy Hearts Model (GM Healthy Hearts). Innovative approaches will be used to offer NHS Health Checks and find people who have hypertension or atrial fibrillation that has not yet been diagnosed, in non-health settings and using technology where appropriate. QRISK is a tool that GPs use to identify people who are at risk of developing cardiovascular disease over the next 10 years. People who have a 10 per cent or greater 10-year risk of developing cardiovascular disease can benefit from making lifestyle changes and taking a statin if their risk does not approve. The programme will work with local clinicians and their patients to ensure that people are getting the optimal care to lower their risk, and manage their conditions. This will include co-producing new approaches with people, as well as using the primary care standards (e.g. the Winning Hearts

and Minds standard) to incentivise quality care.

Through delivery of this workstream, we will prevent or delay the onset of cardiovascular disease by:

- Identifying people at high risk of cardiovascular disease with a focus on improving detection of hypertension among people in high risk groups, improving uptake of NHS health check among people in high risk groups and improving detection of atrial fibrillation

- Improving the management and support for people at high risk of cardiovascular disease by improving the management of poorly controlled hypertension and improving the support for and management of people with CVD risk of 20% and above

- Optimising the management and support for people with diagnosed conditions by supporting clinicians to focus on key clinical challenges to achieving blood pressure control, offering treatment to patients with an AF diagnosis that are not being treated and improving optimisation of patients on statins

2 New partnership approach to addressing physical activity challenges in Manchester

2.1 Introduction

MHCC, MCC (Sport and Leisure) and Sport England are taking forward work to more closely align the physical activity and health agendas in the city. Underpinning this, is the ambition of achieving a greater degree of integration between health, population health and wellbeing and sport and leisure to better address population health challenges and address inequalities with available resources and assets. This new approach will help to deliver increased physical activity and reduced physical inactivity levels in Manchester in line with GM Moving targets and PHE CMO advice on activity levels across the lifecourse. A key part of this joint approach is reducing physical inactivity levels in the city, with a focus on people at risk of, or already suffering from, poor physical and mental health outcomes. An example of this is the Tackling Inactivity Initiative (funded by MCC and Sport England) to test new community-led approaches to tackling inactivity under the Winning Hearts and Minds programme.

2.2 Strategic direction

To deliver the ambition a new single system for sport and physical activity in Manchester has been designed. This single system will ensure clarity of purpose for all involved, will simplify strategic and operational arrangements and will provide the golden thread between the strategic objectives and what residents experience in our neighbourhoods. Key components of the single system include 1) Strategy and Partnerships, 2) A streamlined role for Manchester City Council, 3) Creation of new governance arrangements -

Manchester Active, 3) A new leisure facility operating contract (part of a provider network) 4) residents being engaged much more proactively than the current arrangements encourage.

- **Strategy & Partnerships –** A new strategy, overseen by new governance arrangements with new partnerships established between the traditional Sport and Physical Activity Partners, i.e. Sport England, National Governing Bodies of Sport, Clubs with non-Sport and Physical Activity organisations i.e. Housing, the wider Community Sector, Commercial Sector, Police, Fire and Rescue, Youth and Play Trust.

- **Manchester City Council** - The Council's role will be more streamlined and focused on getting the resources into the right organisations who can make the biggest impact in communities. This will result in all service delivery being contracted through service providers or commissioned through community organisations. The Council will seek to co-commission and co-design solutions with other public funding bodies, including Sport England and the Manchester Health and social Care Partnership.

- **Manchester Active (MCRactive)** – A new not for profit organisation, owned by the Council, responsible for implementing the Sport and Physical Activity strategy on behalf of the Council. The role of MCRactive should not be a complex one - It is not a delivery organisation or simply a conduit to or for investment. MCRactive will seek to provide the leadership and a common narrative for sport and physical activity in Manchester. It will develop the plans which underpin the strategy and broker and facilitate relationships which will deliver it.

- **Leisure Operator** – The new single leisure operating arrangement will be established to share risk between the Council and the operator, whilst bringing to bear the expertise of a credible national operator who can drive the quality, efficiency and innovation which is required to deliver the Strategy. The leisure operator's role will be more streamlined and focused on providing high quality facility management across 20 leisure facilities and underwriting financial and operating risk.

- **Residents -** Residents will be engaged much more proactively than the current arrangements encourage. This will be achieved by fully embracing the Our Manchester principles and approach. The role of the Council, MCRactive and the leisure operator will be designed to ensure that residents feel that there are extensive arrangements in place to ensure that they contribute to the strategy, are actively engaged, participate, spectate, officiate, volunteer and contribute constructively about what changes can be made to improve provision.

2.3 All ages approach

A number of other strategies and initiatives are contributing to addressing the challenges around physical activity across the lifecourse.

- We are working with Early Years settings to increase physical activity and improve diet of children in early years and their families.
- City in the Community are working with Early Years settings to increase physical activity through the use of storytelling and fun activities
- We are continuing our school health, Healthy schools and community work to increase physical activity and improve diet.
- School age children - The Manchester Physical Education, School Sport and Physical Activity Strategy (2016-2021) is working towards the following priorities for school age children:

    1. Increasing physical activity and improved physical literacy for all children and young people.
    2. Increasing sporting pathways.
    3. High quality education and training to improve standards in the PESSPA workforce
    4. Gathering, analysing and sharing data to evidence the impact of opportunities.
    5. Strong communication and governance for PESSPA across the city
    6. Access to facilities and open places.

- Sport England has announced Greater Manchester will receive £1 million Active Ageing funding (2018 - 2020) of which Manchester will benefit from funding to test new approaches to engage inactive older people (55 years plus, achieving less than 30 minutes of moderate intensity physical activity per week). The Manchester project will focus on a place-based approach around Debdale in Gorton to create a physical activity offer co-designed by older people. In addition sustainable sessions will be created city-wide for groups by enabling peer-led functional physical activity classes.

Title	Public Health Task and Finish Group
Membership	Councillors Curley, Holt, Lynch, Mary Monaghan, Riasat, Wills and Wilson (Chair)
Executive Member	Councillor Craig, Executive Member for Adult Health and Wellbeing
Strategic Director	David Regan, Director of Population Health and Wellbeing
Lead Officers	
Contact Officer	Lee Walker, Scrutiny Support Unit
Objectives	The Task and Finish Group acknowledges the variation in health outcomes of Manchester residents. The group will seek to understand the range and impact of Public Health and Population Health initiatives on Manchester residents. 1. To review current Public Health and Population Health objectives, including self-care and health protection. 2. To review good practice adopted nationally and internationally and in other Local Authorities across Greater Manchester. 3. To review current academic research in the area of Public Health and Population Health. 4. To inform future discussions on Public Health and Population Health at the Health Scrutiny Committee.
Key Lines of Enquiry	Evidence is to be gathered from a range of stakeholders, including Public Health England; Manchester University Urban Collaboration on Health; Manchester Institute for Collaborative Research on Ageing (MICRA).
Operation	This Task and Finish Group will report its findings to the Health Scrutiny Committee by submitting minutes to the Committee. The Committee will be asked to endorse any recommendations from the Task and Finish Group. A final report will be submitted to the Committee presenting the findings and recommendations of the Task and Finish Group.
Access to Information	Meetings of this Task and Finish group will be open to members of the press and public except where information which is confidential or exempt from publication is being considered. Papers for the Task and Finish group will be made available to members of the press and public on the Council's website and the main entrance to the Town Hall except where information which is confidential or exempt from publication is being considered.
Schedule of Meetings	To be agreed.
Commissioned	September 2017

Health Scrutiny Committee
Public Health Task and Finish Group
Work Programme

Meeting 2: Tuesday 18 September 2018, 2pm in the Council Chamber. **Deadline for reports: Friday 7 September 2018**				
Item	Purpose	Lead Executive Member	Lead Officer	Comments
Examples of good practice adopted nationally and internationally and in other Local Authorities across Greater Manchester	To review Public Health good practice adopted nationally and internationally and in other Local Authorities across Greater Manchester to address the issues of alcohol; tobacco and healthy living.	Councillor Craig	David Regan Director of Population Health and Wellbeing	Invite to Professor Melanie Sirotkin, Public Health England and Professor Arpana Verma, University of Manchester
Terms of Reference and Work Programme	To review and agree the Subgroup's terms of reference and work programme, and consider any changes or additions that are necessary.		Lee Walker Scrutiny Support Officer	

Meeting 3 (Date and Venue to be confirmed) **Deadline for reports:**				
Item	Purpose	Lead Executive Member	Lead Officer	Comments
Public Health and Population Groups: Ageing Population	To consider the role and impact of Public Health and Population Health initiatives on the ageing population. The group will hear from Prof Chris Philipson Manchester Institute for Collaborative Research on Ageing An invitation will be sent to the Lead Member for Age Friendly Manchester. The group with also consider the issue of Health Protection and Infection Control and will hear from Public Health England clinicians. The group with also receive information on screening services.	Councillor Craig	David Regan Director of Population Health and Wellbeing Paul McGarry, Strategic Lead Age Friendly Manchester	Invitation to be sent to Prof Chris Philipson, Manchester Institute for Collaborative Research on Ageing & Dr Will Welfare, Public Health England
Feedback from Members on their findings	The purpose of this item is for members to feed back on the findings of this review and make recommendations that will inform the final report of the Task and Finish Group.		Lee Walker Scrutiny Support Officer	

Meeting 4 (Date and Venue to be confirmed)				
Item	Purpose	Lead Executive Member	Lead Officer	Comments
Final Report and recommendations	To agree the final report and recommendations of the Task and Finish Group. Following agreement by the Task and Finish Group, the final report will be submitted to the Health Scrutiny Committee.		Lee Walker Scrutiny Support Officer in consultation with the Chair	