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MANCHESTER CITY COUNCIL

Health and Wellbeing Board

Date: Wednesday, 24 January 2024
Time: 10.00 am
Venue: Council Antechamber, Level 2, Town Hall Extension

Access to the Council Antechamber

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Membership of the Health and Wellbeing Board

Councillor Craig, Leader of the Council (MCC)
Councillor T Robinson, Executive Member for Member for Healthy Manchester and Adult Social Care (MCC) (Chair)
Councillor Bridges, Executive Member for Children and Schools Services (MCC)
Councillor Chambers Deputy Executive Member for Healthy Manchester and Adult Social Care (MCC)
Katy Calvin, Thomas - Manchester Local Care Organisation
Kathy Cowell, Chair, Manchester University NHS Foundation Trust
Bill McCarthy, Chair, Greater Manchester Mental Health NHS Foundation Trust
Mike Wild, Voluntary and Community Sector representative
Amanda Smith, Chair, Healthwatch
Paul Marshall, Strategic Director of Children's Services
David Regan, Director of Public Health
Bernadette Enright, Director of Adult Social Services
Tom Hinchliffe, Deputy Place Based Lead
Dr Murugesan Raja, Manchester GP Board
Dr Geeta Wadhwa, Manchester GP Board
Dr Doug Jeffrey, Manchester GP Board
Dr Shabbir Ahmad, Manchester GP Board (substitute member)
Dr Denis Colligan, Manchester GP Board (substitute member)

Agenda

1. Urgent Business
To consider any items which the Chair has agreed to have submitted as urgent.

2. Appeals
To consider any appeals from the public against refusal to allow inspection of background documents and/or the inclusion of items in the confidential part of the agenda.

3. Interests
To allow Members an opportunity to [a] declare any personal, prejudicial or disclosable pecuniary interests they might have in any items which appear on this agenda; and [b] record any items from which they are precluded from voting as a result of Council Tax/Council rent arrears; [c] the existence and nature of party whipping arrangements in respect of any item to be considered at this meeting. Members with a personal interest should declare that at the start of the item under consideration. If Members also have a prejudicial or disclosable pecuniary interest they must withdraw from the meeting during the consideration of the item.

4. Minutes 5 - 12
To approve as a correct record the minutes of the meeting held on 1 November 2023.

5. Manchester Partnership Board update
A verbal update will be given by the Deputy Place Based Lead from the meeting of the Manchester Partnership Board on 23 January 2024.

6. Update on Board Recommendations from 2023 13 - 30
The report of the Director of Public Health is enclosed.

7. Stopping the start: our new plan to create a smokefree generation 31 - 44
The report of the Director of Public Health is enclosed.

8. Manchester Child Death Overview Panel 2022-23 Annual Report 45 - 90
The report of the Director of Public Health is enclosed.

9. Joint Strategic Needs Assessments (JSNAs) - Health and Homelessness and Gypsy, Roma and Traveller Communities 91 - 238
The report of the Director of Public Health is enclosed.

10. Making Manchester Fairer: Tackling Health Inequalities in Manchester 2022-2027 239 - 250
The report of the Deputy Director of Public Health, Manchester

City Council is enclosed.

Information about the Board

The Health and Wellbeing Board brings together those who buy services across the NHS, public health, social care and children's services, elected representatives and representatives from HealthWatch to plan the health and social care services for Manchester. Its role includes:

- encouraging the organisations that arrange for the provision of any health or social care services in Manchester to work in an integrated manner;
- providing advice, assistance or other support in connection with the provision of health or social care services;
- encouraging organisations that arrange for the provision of any health related services to work closely with the Board; and
- encouraging those who arrange for the provision of any health or social care services or any health related services to work closely together.

The Board wants to consult people as fully as possible before making decisions that affect them. Members of the public do not have a right to speak at meetings but may do so if invited by the Chair. If you have a special interest in an item on the agenda and want to speak, tell the committee officer, who will pass on your request to the Chair. Groups of people will usually be asked to nominate a spokesperson. The Council wants its meetings to be as open as possible but occasionally there will be some confidential business. Brief reasons for confidentiality will be shown on the agenda.

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Smoking is not allowed in Council buildings.

Joanne Roney OBE
Chief Executive
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Manchester, M60 2LA

Further Information

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

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This agenda was issued on **Tuesday, 16 January 2024** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 2, Town Hall Extension (Library Walk Elevation), Manchester M60 2LA

Health and Wellbeing Board

Minutes of the meeting held on 1 November 2023

Present:

Councillor T Robinson, Executive Member for Member for Healthy Manchester and Adult Social Care (MCC) - In the Chair
Katy Calvin, Thomas - Manchester Local Care Organisation
Kathy Cowell, Chair, Manchester University NHS Foundation Trust
Paul Marshall, Strategic Director of Children's Services
David Regan, Director of Public Health
Bernadette Enright, Director of Adult Social Services
Tom Hinchliffe, Deputy Place Based Lead
Dr Murugesan Raja, Manchester GP Board

Apologies:
Councillor Craig, Leader of the Council
Councillor Bridges, Executive Member for Children and Schools Services
Councillor Chambers Deputy Executive Member for Healthy Manchester and Adult Social Care
Bill McCarthy, Chair, Greater Manchester Mental Health NHS Foundation Trust
Amanda Smith, Chair, Healthwatch

Also in attendance:
Jane Pilkington, Director of Population Health, NHS Greater Manchester
Dr Cordelle Ofori, Deputy Director of Public Health

HWB/23/20 Minutes

Decision

To approve the minutes of the meeting held on 20 September 2023 as a correct record.

HWB/23/21 Manchester Partnership Board Update

The Board considered the report of the Deputy Place Based Lead that provided an update on the topics discussed at the private meeting of the Manchester Partnership Board held 3 October 2023. Reference was made to ongoing work concerning:

- Commissioning work within Manchester and Greater Manchester, concerning the integrated commissioning function for health and social care with all partners.
- Winter planning relating to Urgent and Emergency Care Capacity Funding. It was reported that agreement had been reached on the most effective use for the limited level of funding available for the winter period. The funding will be used for additional capacity in primary care. It was acknowledged that work

with partners had enabled the funding available to be targeted in areas of need.

The Chair also reported that so far, no response had been received to the letter sent to the Secretary of State for Health, from him and Councillor Green (Chair of the Health Scrutiny Committee), concerning funding arrangements for the Integrated Care Board (ICB) for the 2023/24 winter period. Any response received would be circulated to members of the Board and the Health Scrutiny Committee. The Chair also reported that he will discuss the importance of using the Urgent and Emergency Care Capacity Funding effectively with the Deputy Chief Executive (Manchester Foundation Trust).

Decision

The Board noted the report.

HWB/23/22 Fairer Health for All

The Board considered the report of the Director of Population Health, NHS Greater Manchester Integrated Care and the Director of Public Health, Manchester City Council, that described the opportunities for the Manchester Locality, through the Health and Wellbeing Board, to input and shape priorities for co-ordinated action on health inequalities across Greater Manchester.

The report described that Fairer Health for All (FHFA) was a system-wide commitment and framework for reducing health inequality and tackling inequalities across the wider, social, and commercial determinants of health, leading to a greener, fairer, more prosperous city-region. In addition, it was noted that FHFA had been co-produced through extensive locality and community participation and engagement over the past fifteen months, which had taken place alongside the development of NHS Greater Manchester's Integrated Care Partnership strategy and the Five Year Joint Forward Plan.

Consideration would also be given to the proposed principles, targets and metrics in the Greater Manchester Fairer Health for All Framework. It was important to note that Manchester already had the well-developed Making Manchester Fairer Action Plan (2023-2027) and the Director of Public Health, Deputy Director of Public Health and the GM Director of Population Health would continue to work collaboratively to ensure plans were aligned and clear.

The Board was requested to review and comment on the Fairer Health for All Framework Engagement Draft and engagement questions outlined in section 2.2 of the report submitted.

The Director of Population Health provided an overview of the plan and outlined the ongoing work to align sectors in addressing health inequalities. The Board was informed that the document sets out a plan and provides practical tools and resources to help make Fairer Health for All a reality. This includes two central tools: a Fairer Health for All Academy to support learning and development and Health and

Care Intelligence Hub will foster shared learning and collaboration and collate vast and diverse intelligence, data and insights from across public and VCFSE partners.

Confirmation was given that the Fairer Health for All will be submitted to the Integrated Care Board and Integrated Care Partnership. Health Trusts will also receive the document for comment, via a task group appointed to provide the alignment to Manchester Foundation Trust. Discussions are currently ongoing to determine how the providers will be engaged.

The Chair welcomed and commented that the report is accessible to all audiences. In reference to the delivery work within localities it was requested that separate reference should be included in the final document to acknowledge this.

It was reported that the final report will include all linked plans as well as references to locality work.

The Chair invited questions and comments from the Board.

In response to the report the board made the following comments: -

In welcoming the report, the Chair of MFT highlighted the importance of using the document as a tool to help engage with and better inform local people and MFT members and use the input to complement the work of MFT Governors.

Reference was made to NHS community services/ Living Well at Home, and it was suggested that a more explicit reference on of role of community services within integrated urgent care should be included. Currently work across GM is working to standardise delivery of services and the inclusion of that work in the document would beneficial.

Reference was made to the importance of all partners working to the same plan and direction to ensure that the resources available to providers are used in the most efficient manner. The document contains information to help better support the dialogue for a joined-up and preventative care approach and inform financial planning to achieve it.

A comment was made that it is important that the inclusion of principles to provide a level of standards on what to expect at a local level within a neighbourhood setting is presented as an enabler rather than another strategy.

A comment was made that specific reference could be made to work on commissioning within the care market.

In response to the points and comments made, the Director of Population Health referred to discussions currently ongoing on contracting and commissioning arrangements to agree on a process to align social value on commissioning. With reference to principles, there are principles included within the document. The principles are being used in conjunction with GM system boards and other partners on the design of an assurance process/framework. The Fairer Health for All Academy website will be used to provide examples of the work and stories of

change. The comment made on alignment of partners feature strongly within work to build relationships and strengthen communication. Developing models of care also provide the opportunity to make financial savings. The Director also undertook to provide feedback on a social model for health and where possible to support arrangements for the work of MFT Governors.

The board was informed that the next steps of the process for the document would be presented to locality boards during November across Greater Manchester, with a final consideration by the ICB and ICP in January 2024.

Decision

The Board noted the report.

HWB/23/23 Making Manchester Fairer: Tackling Health Inequalities in Manchester 2022-2027

The Board considered the report of the Deputy Director of Public Health that described the key achievements of the Making Manchester Fairer programme in September as well as an update on the Communities and Power Theme and the Race & Health Education Programme.

The report and accompanying presentation described that a comprehensive and immersive education programme on Race and Health Equity had been developed and commissioned. The programme was launched on 18 September at the Manchester Art Museum with partners from across the council, health, and housing attending. 75 people had been invited as the first cohort which would enable our workforce to be better informed, equipped and confident to implement the right solutions that will improve outcomes for communities experiencing racial inequality and discrimination.

The report and accompanying presentation further described that a Communities and Power Steering Group, co-chaired by Manchester City Council's Deputy Leader Cllr Rahman, and Executive Member for Vibrant Neighbourhoods Cllr Igbon, had been established to drive forward the actions outlined within the two Manchester-specific themes of (i) Tackling systemic racism and discrimination, and (ii) Communities and power. The Communities and Power Steering Group work had developed several workstreams that would support the delivery of the aims and objectives of the MMF Action Plan.

The Chair invited questions from the Board.

A member asked if there is an opportunity for partners to join up existing workstreams relating to race and racism in the workplace to help amplify the approach across Manchester. With reference to neighbourhood working, and in particular community development work, the comment was made that it is important for community-based roles/skills to be co-ordinated to ensure that the same approach and methodology are used whenever the community is being engaged and amplify this across Manchester.

It was reported that the work to amplify workstreams is already taking place through the regular meetings with those linked to the various organisations involved. Highlighting the work would be discussed to decide how to best showcase what is happening and how specialist skills are used.

In response to a comment made on the importance of achieving the correct narrative for a holistic approach from organisations, the board was informed that partners involved in housing had set up a task group to work on all eight themes to engage with communities and reflect on the approach of the organisation. The task group has enabled specific matters to be addressed in a joined-up approach from the partner organisations.

A member referred to the Community Development Review and the importance of ensuring service users have a voice and that the voice is heard and asked how the services users will know they have been heard and how will that help to shape future actions.

It was reported that the maturity assessment quality standards will measure how the information received is used and will feed back to the participants on any action taken on issues raised. The Community and Residents Involvement Framework provides a description of the arrangements for engagement and accountability. A Making Manchester Fairer Community Forum will be established for residents with a lived experienced to help input on the best way to hold Making Manchester Fairer to account.

The Chair stated that it is important to reflect on what has taken place during the last twelve months on the work to develop Making Manchester Fairer and what has been achieved in that time. The initiative involves key stakeholders from across Manchester and it is important to maintain a spirit of versatility with integrity to ensure that tackling health inequality is the central focus while working towards Making Manchester Fairer a whole Council approach. Monitoring the delivery of the initiative will be the key to assure the residents of Manchester that the right approach has been taken.

Acknowledgement was given to the work undertaken by the lead officers involved in the two themes presented.

Decision

The Board noted the report.

HWB/23/24 Stopping the start: Our new plan to create a smokefree generation in Manchester

The Board considered the report of the Director of Public Health that provided an update to previous reports about the Tobacco Control and Vaping Programme and set out the response to the government's proposals.

Noting that on 4 October 2023, the Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care, wrote to Directors of Public Health to advise them of the government's future plans to control tobacco use and vaping. The letter was accompanied by the publication of a Command Paper titled, *"Stopping the start: our new plan to create a smokefree generation."* The Command Paper sets out the government's plan to prevent addiction to all forms of tobacco, to support current smokers to "quit" and to enhance the controls and legislation around electronic cigarettes, with the aim of curtailing the worrying phenomenon of youth vaping.

The proposals contained within the Command Paper are the subject of a major public and professional consultation which closes on the 6 December 2023.

The Department of Public Health at Manchester City Council welcomes the contents of the Command Paper because smoking remains the biggest cause of preventable death in Manchester. Government estimates suggest that there have been as many, if not more, deaths from smoking, as from COVID-19 in England since the start of the pandemic. In Manchester, although improvements have been made, smoking rates are still higher than national averages.

Vaping, when used appropriately, could be one of the treatment solutions available to support tobacco users to manage their addiction to Nicotine and ultimately to "quit" smoking. However, Manchester is experiencing some of the social problems associated with vaping, in terms of youth vaping and a significant counterfeit market.

Manchester City Council and partner organisations had taken a whole system approach to Tobacco Control for many years. The well-established partnership programme had been extended to incorporate the phenomenon of vaping and is well placed to implement all the government's recommendations and much of this work is already underway.

The report described that the Director of Public Health had worked with the Programme Lead for Tobacco Control to collate a Manchester response to the proposals contained within the Command Paper. These are set out in section 6.4 and the Health and Wellbeing Board are asked to comment on each of them. Pending any additions and changes suggested by the Board, the Chair, supported by the Director of Public Health, will submit the formal response to the consulation on behalf of the Board by 6 December 2023. The report presented the initial summary responses.

The Chair in acknowledging the importance of Tobacco Control and Vaping Programme, thanked officers for the work undertaken.

The Chair requested an update be submitted to the next meeting of the Board in January 2024, to set out what the intensions are for Manchester and the proposals to use the allocated funding from the Government.

The Board was advised that a bid will also be submitted for funding for the Swap to Stop Scheme. This will involve the creation of a focus scheme in Newton Heath and Miles Platting working with housing providers in those areas to identify and engage with smokers in those areas who are not known to the Stop Smoking service.

Members of the Board welcomed the report and acknowledged the challenge of changing the behaviour of smokers and communities.
The Chair referred to Section 4 of the report and asked if specific issues should be included in the Chair's response to the consultation.

The Board was informed that there are different reasons for vaping which include vaping to help stop smokers for health purposes and vaping that is not that is related to criminality. The use of vaping has grown massively across all sections of the city and Trading Standards officers have helped to uncover an illegal vaping market and have seized a high volume of vapes in the process which have been linked to organised crime groups.

A member of the Board asked if there are sufficient resources available to address the behavioural change needed to prevent the take up of vaping by young people.

It was reported that a training programme is being developed for professionals, parents and carers working with children to help address any confusion on the safety of vaping. A North West School Vaping Statement has been published and is being disseminated and will be circulated shortly. The increase in the use of vaping will need to be considered separately to tobacco control. The update report to be submitted in January 2024 will outline how funding received will be used on smoking cessation and will include a focus on the increase in vaping and youth vaping and how existing resources can be used and where additional capacity may be needed for local approaches.

The findings of the consultation and anticipated recommendations expected from the Government will help to start to address youth vaping through legislation on the marketing of products, similar to those used for tobacco products. This approach will be as important as the ongoing related health work.

Decisions

1. The Board noted the report and agreed that the Chair, supported by the Director of Public Health, responds formally to the consultation on behalf of the Manchester Health and Wellbeing Board as set out in section 6.4 of the report.

2. To circulate the Chairs consultation response to all Board members and the Member of Parliament for each of the Manchester constituencies (as set out in 1 above).

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Manchester City Council
Report for Information

Report to: Manchester Health and Wellbeing Board – 24 January 2024

Subject: Update on Board Recommendations from 2023

Report of: Director of Public Health

Summary

The Board met on four occasions in 2023 and the attached summary table (Appendix 1) provides the Board with an update on progress relating to reports and recommendations the Board agreed in the calendar year.

Recommendations

The Board is recommended to note the report.

Wards Affected: All

Environmental Impact Assessment -the impact of the issues addressed in this report on achieving the zero-carbon target for the city	The breadth of the work that the Board receives reports on includes several key programmes such as Making Manchester Fairer that have a strong focus on zero carbon.
Equality, Diversity and Inclusion (EDI) - the impact of the issues addressed in this report in meeting our Public Sector Equality Duty and broader equality commitments.	EDI is a fundamental component of the MMF programme, and other areas of work (e.g. Health protection, oral health) that the Board has received reports on in 2023

Manchester Strategy outcomes	**Summary of how this report aligns to the Our Manchester Strategy/Contribution to the Strategy**

A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	This important work of the Board contributes significantly to all of the Our Manchester strategy outcomes.
A highly skilled city: world class and home grown talent sustaining the city's economic success	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

Financial Consequences – Revenue
None.

Financial Consequences – Capital
None.

Contact Officers:

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Background documents (available for public inspection):

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

1.0 Introduction

1.1 The Health and Wellbeing Board (HWB) met on four occasions in 2023 and the attached summary table (see Appendix 1) provides the Board with an update on progress relating to reports and recommendations the Board agreed in the calendar year.

1.2 In 2024 the interface between the HWB, Manchester Partnership Board and GM Integrated Care System structures and arrangement will be further strengthened by the emerging strategies and plans for GM and the Manchester locality.

1.3 In focusing on Making Manchester Fairer, the social determinants of health and other public health issues in 2023 the HWB has ensured progress in these areas has been supported and not “stalled” because of organisational changes affecting the GM system.

1.4 The summary table and progress updates highlight that the Board has continued to play a vital role in Manchester and as a statutory committee of the Council it has a clear understanding of its roles and responsibilities.

2.0 Recommendation

2.1 The Board is recommended to note the report.

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Appendix 1 - Manchester Health and Wellbeing Board (HWB) – Recommendations made in 2023: Progress Update

Meeting: 25th January 2023

Report title	Presented by	Recommendations	Progress Update as at 1st January 2024
Further developments relating to the role of the Health and Wellbeing Board	Director of Public Health	1. To approve the further changes to the membership and chairing of the Board. 2. To note the inclusion of a regular report on the relationship to the Health and Wellbeing Board and the Manchester Partnership Board (MPB) for the remainder of the current year. 3. To agree for a letter of thanks be forwarded to Rupert Nichols in recognition of his involvement	1. Membership has remained stable in terms of roles; however, several people have moved on during the year (e.g. Chair of GMMH see below) 2. The Deputy Place Based Lead now provides regular reports to the HWB on the work of the MPB. 3. Completed
Making Manchester Fairer: Tackling Health Inequalities in Manchester 2022-2027	Deputy Director of Public Health	To note progress on the Making Manchester Fairer Action Plan and incorporation of the Anti-Poverty Strategy (APS)as a joint programme of work.	Focus of the report was MMF development and the integration and delivery of the APS. Progress Update: The Anti-Poverty Strategy (APS) was formally adopted at Council Executive in January 2023 and is the main route to delivering against the MMF theme of reducing poverty and debt. It sets out our vision that the whole of Manchester will work together to reduce poverty and lessen the impact of poverty on our residents. The Anti-Poverty Strategy was launched officially on the 27th of February and delivery and oversight has

			been integrated into the MMF, recognising that you can't tackle health inequalities without addressing the effects and causes of poverty. The APS actions prioritised for delivery in year 1 include: • We will review public sector organisations' approach to charges and debt recovery processes to make sure we are effectively supporting residents to access support and avoiding taking action that will make their situation worse. • Expanding access to advice in different settings, increasing access to debt advice, expanding access to in person advice, ensuring advice is available in accessible formats and languages. • We will set up and Anti-Poverty Insight Group • We will hold regular networking opportunities for people with lived and professional experience of poverty
Manchester Child Death Overview Panel (CDOP) 2021-22 Annual Report	Assistant Director of Public Health, Chair of the Manchester Child Death Overview Panel	1. The CDOP Manager will continue to work with Public Health colleagues in the development and delivery of the refreshed Reducing Infant Mortality Strategy. 2: Manchester CDOP continues to work with the other 3 GM CDOPs, GM Directors of Public Health, and the broader GM Integrated Care System (ICS) leadership to create a	1: This is ongoing whilst the refreshed strategy is completed in 2024. 2.This work has been made limited progress due to the ongoing establishment of the ICS. However, the new GM Population Health Committee (a subcommittee of the ICB) which will operate from February 2024, provides the opportunity to take this recommendation forward.

		sustainable and flexible GM workforce model.	
Manchester Pharmaceutical Needs Assessment (2023-2026) Final Draft	Director of Public Health	To approve the final report for publication	A Supplementary Statement update, detailing closures and changes to opening hours, was added in December 2023. There are no identified gaps in provision across the city.
Health Protection Board Update	Assistant Director of Public Health	To note the report	Focus of the report was an update on the responsibilities of the revised Health Protection Board and to highlight the issues raised at the December Health Protection Board 2022 meeting. The Health Protection Board continues to meet quarterly and the new arrangements to include agenda items covering health services emergency preparedness, resilience and response and Greater Manchester and Manchester City Council Resilience Forum feedback is working well. Action has been taken on the issues raised at the meeting, including the lack of funding and staff capacity for undertaking latent tuberculosis (TB) screening in asylum seeker hotels and the risks relating to this. The Director of Public Health is supporting the progression of this work with senior leads in NHS Greater Manchester Integrated Care

			through a newly established Greater Manchester Migrant Health Group. TB issues experienced in Manchester and in other areas have been raised at a national level by the Assistant Director of Public Health and Councillor Robinson at the national TB Conference in September 2024.

Meeting : 7th June 2023

The formal establishment of the Manchester Partnership Board	Deputy Place Based Lead Director of Public Health	The Board note the report.	MPB Updates are now a standing item on the HWB agenda.
Oral Health and Dentistry	Director of Public Health	1. Support the development of a Manchester specific action plan to address poor levels of oral health in the local population, drive improvements to NHS dental services and reduce inequalities for the Manchester population.	1. A Manchester Oral Health Improvement Conference took place on 18th October 2023, bringing together all local system partners to discuss what is required to deliver family-centred oral health improvement in Manchester. The actions and next steps agreed at the conference, alongside other priority work to address the needs of older people and inclusion health group form the basis of an action plan which will be developed further from January 2024.

		2. Support the development of GM strategy and action to address locality requirements around oral health promotion and improved access.	2. This work has made little progress due to the issues regarding GM ICS development, including financial challenges which are delaying implementation of previously agreed funding for oral health work.
		4. Request that the Director of Public Health, in consultation with Greater Manchester NHS and the Manchester Local Care Organisation reports back to the Board on progress and the priority actions agreed by the end of the year.	3. To be scheduled for the November 2024 HWB
		4. Recommend that the Head of Primary Care, NHS Greater Manchester provide a briefing note that describes the actions being taken to improve NHS dental access across the city that can be circulated to all members of the Council.	4. Completed.

Making Manchester Fairer: Tackling Health Inequalities in Manchester 2022-2027	Deputy Director of Public Health	1. The Board note progress made in implementing the Making Manchester Fairer Action Plan, the incorporation of the Anti-Poverty Strategy within the programme, and the work that is taking place across partner organisations to integrate the Making Manchester approach and principles system wide.	Focus of report was MMF Theme 4 - Prevention of ill health and preventable deaths: *Manchester NHS Foundation Trust (MFT) Health Inequalities (case study of work across partner organisations).* Progress Update: Following a Trust wide health inequalities away day in February 2023, MFT worked with partners to develop a plan of action to better define the Trust's role in tackling health inequalities. In June 2023, Jane Eddleston and other representatives from MFT presented an update on this plan to the Manchester HWB. Since then the HWB, the work has progressed in a number of key areas: Care Pathways: • Organisational wide work on health literacy and improving how we communicate • Better understanding our data and using it to drive change – making best use of MFT's Health Inequalities Dashboard • Health inequalities lead appointed for each hospital site and LCO to ensure site based leadership for this agenda • Understanding and reducing inequalities in specific pathways e.g.: Urgent Care Needs Assessment Bowel Cancer

		2. The Board recommend that a progress presentation be submitted for consideration in six months' time.	Social Determinants of Health: • Working with Citizens Advice. Two outreach workers have been appointed drawing on charitable funds to work at our Childrens and North sites from January providing financial advice to patients. Looking to expand to other sites. • Expanding on brief interventions and strengthening connections with other services that can support our patients e.g. housing. • Employment – recruitment events in community centres, targeting residents from our local areas. In November 2023 Bola Owolabi, the national NHS England Lead for Health Inequalities spent the day at MFT. She provided inspiration in leading a discussion with all senior teams from sites and spent time reviewing our work in detail thereafter. The feedback about the progress being made was very positive. MFT were recently awarded the HFMA tackling health inequalities award in recognition of this work. 2. MFT colleagues will be invited back in June 2024 to provide a progress update.

Meeting : 20th September 2023

Report title	Presented by	Recommendation	Progress as at 1st January 2024
Urgent Business - Manchester Partnership Business	Deputy Place Based Lead	To note the update.	Standing item
Health Protection - Operational Local Health Economy Outbreak Plan Manchester and Update on Tuberculosis	Director of Public Health	1. Approve the Operational Local Health Economy Outbreak Management Plan for Manchester, as detailed in appendix 1, of the report submitted. 2. Are informed of the current issues around TB and recommend that the Director of Public Health a) escalates migrant health related issues to the newly established NHS GM Migrant Health Group; b) advocates through professional networks for more latent TB testing to be available for all residents with higher risk of TB,	The Operational Local Health Economy Outbreak Management Plan that was signed off at the Health and Wellbeing Board meeting has been used to support the management of recent outbreaks in local settings, including Covid-19, flu, chickenpox, scabies, scarlet fever and diarrhoea and vomiting outbreaks. The plan has been tested using measles outbreak scenario exercises led and co-ordinated by the Department of Public Health. The scenarios included outbreak of measles in an early years setting and in a university setting. 2.Work continues to progress on TB with the Greater Manchester Migrant Health Group overseeing progress. Sector led improvement workshops have been coordinated across Greater Manchester with support from the Local Government Association. A Greater Manchester TB business case is being worked up in partnership with the GM Trust Provider Collaborative.

		not just new entrants and not just adults	
Joint Local Health and Wellbeing Strategies (JLHWS)	Director of Public Health	1. Note the report and its statutory duties and powers in relation to the Joint Local Health and Wellbeing Strategy. 2. Agree to delegate the co-ordination of the approach to comply the statutory duty to the Director of Public Health and the Deputy Place Based Lead.	This work is being progressed through the Strategic Planning group, one of the enabling groups under the MPB.
Armed Forces Community JSNA	Strategic Director of Children and Education Services	1. Note the content of the Joint Strategic Needs Assessment. 2. Support the opportunities for further action described in the JSNA. 3. To endorse the inclusion within the JSNA of GP surgery liaison and consultation to raise awareness of the OP Courage and Transition intervention and liaison service.	Manchester City Council and the Primary Care Commissioning (Manchester) Team of NHS Greater Manchester Integrated Care have developed a joint communications plan to increase awareness of the of services available to support armed forces veterans. The Regional RCGP Veteran Friendly Accreditation Lead has been engaged and has agreed to support this work. Members of the City-wide GP practices meeting will receive a presentation and offer of support in February 2024. Following this, all GP practices will receive communications messages through a number of channels to further encourage and support practices seeking the RCGP accreditation.
Making Manchester Fairer: Tackling Health Inequalities in	Deputy Director of Public Health	The Health and Wellbeing Board note progress made in implementing the Making	The focus of this report was MMF Theme 5 - Homes and Housing - *Manchester Housing Provider Partnership (MHPP) Strategy Away Day Case Study*

Manchester 2022-2027		Manchester Fairer Action Plan. As well as noting the work that is taking place across partner organisations to integrate the Making Manchester approach and principles system wide.	*focused on how housing partners can collaborate towards tackling health inequalities and the delivery of MMF* *Progress Update:* Making Manchester Fairer is now a standard agenda item at each quarterly MHHP meeting. In December Martin Oldfield, Head of Housing Strategy at MCC provided an update on the workplan, and highlighted the impact of health inequalities on life expectancy across different neighbourhoods in Manchester. There was also a discussion on the impact that housing providers can make to reducing inequalities through building more affordable and more adapted homes - in particular larger family housing – and through undertaking adaptations. It was highlighted that MHPP has a representative on the Manchester Disabled Peoples Board, and that the MHPP Growth & Affordable Homes group would review the provision of larger and adapted housing. Shefali Kapoor, MMF lead for the communities and strength theme, also presented to MHPP. She highlighted the importance to wellbeing of being listened to and heard, and updated on the Community Engagement Maturity Assessment that MCC is undertaking with a review of quality standards. She also delivered a comprehensive presentation on the 2021 census findings which was interesting, timely and relevant given the work being undertaken across the housing sector on diversity

			and using household insight to shape services. It was agreed that a focus group would be set up to contribute to the work on engagement standards. A number of senior officers and managers from across housing providers working in Manchester are participating in the Race and Health Equity Education programme.
Children and Young People's Health Summit	Deputy Director of Public Health	The Health and Wellbeing Board note the key outputs from the event and proposed next steps.	The agreed actions from the Summit are all being taken forward and good progress is being made on the MMF Kickstarter projects. In addition, the work on UNICEF Child Friendly City status and the priority being given to Children and Young People's Health by the Provider Collaborative Board and Joint Commissioning Board under the MPB will accelerate progress in 2024.

Meeting : 1st November 2023

Report title	Presented by	Recommendations	Progress as at 1st January 2024
Manchester Partnership Board Update	Deputy Place Based Lead	Note the discussions at the Manchester Partnership Board meeting held 3rd October 2023. The Board noted the report.	Standing item
Fairer Health for All	Director of Population Health, NHS Greater Manchester Integrated Care	Review and comment on the Fairer Health for All Framework Engagement Draft and engagement questions outlined in section 2.2 of the report	The NHS GM ICB Director of Population Health welcomed the opportunity to receive direct feedback from Board members and Manchester was the second locality to be visited. Visits to the other eight localities are now underway.

	Director of Public Health, Manchester City Council		Through the DPH the Manchester Locality is well connected to the Fairer Health for All Framework. Furthermore, the Chair of the HWB and Chair of MFT are both on the GM Integrated Care Partnership (ICP) where the final version will be signed off
Making Manchester Fairer: Tackling Health Inequalities in Manchester 2022-2027	Deputy Director of Public Health	The Board is asked to note progress made on implementing the Making Manchester Fairer Action Plan, and work that is taking place in the Communities and Power, and Tackling Discrimination and Racism Themes.	The focus of this report was MMF Theme 7 & 8 - Communities & Power (Theme 7) Progress Update: The Commissioned provider TPX Impact continued to progress the Community Engagement Maturity Assessment; a review of MCC policies and strategies has been completed, a workshop has taken place to agree Quality Standards for the project, and observations and focus groups continue to take place Systemic and structural racism and discrimination (Theme 8) Progress Update: The first masterclass of Phase 2 of the Race & Health Equity Education programme was held, with two further classes confirmed for January and March 24 Two of the three training cohorts for of the Race & Health Equity Education programme have completed Module A of the programme

			A commissioned provider has been identified to deliver the Women of Colour Leadership Programme.
Stopping the start: Our new plan to create a smokefree generation in Manchester	Director of Public Health	1. The Board noted the report and agreed that the Chair, supported by the Director of Public Health, responds formally to the consultation on behalf of the Manchester Health and Wellbeing Board as set out in section 6.4 of the report.	Consultation responses from partners also submitted with follow up paper to be presented at HWB on 24.1.24.

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Manchester Health and Wellbeing Board
Report for Information

Report to:	Manchester Health and Wellbeing Board – 24 January 2024
Subject:	Stopping the start: our new plan to create a smokefree generation
Report of:	Director of Public Health

Summary

This report is a follow up to an initial report called, *"Stopping the start: Our new plan to create a smokefree generation in Manchester*" which was presented to the Health and Wellbeing Board on the 1 November 2023.

On 4 October 2023, the Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care, wrote to Directors of Public Health to advise them of the government's future plans to control tobacco use and vaping. This letter was accompanied by the publication of a Command Paper titled, "Stopping the start: our new plan to create a smokefree generation (2)." The Command Paper set out the government's plan to prevent addiction to all forms of tobacco, to support current smokers to "quit" and to enhance the controls and legislation around electronic cigarettes, with the aim of curtailing the worrying phenomenon of youth vaping.

Since then, a major public and professional consultation has taken place. The consultation closed on the 6 December 2023 and Manchester partners on the Health and Wellbeing Board responded to it.

In November 2023, the Manchester Health and Wellbeing Board welcomed the contents of the Command Paper, and in particular, a commitment from the government to double investment in smoking cessation treatment in England. The board requested a further update paper for January 2024, which would specifically focus on this increased investment and how we planned to use this in Manchester.

Recommendations

The Board is asked to:

i) Note the report
ii) Support the proposed investment plan and Swap to Stop scheme.

Our Manchester Outcomes Framework

Manchester Strategy outcomes	Summary of how this report aligns to the OMS/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	A thriving and sustainable city economy relies upon its residents being healthy and economically active. Smoking is the biggest cause of preventable disease and premature mortality and places a heavy economic burden on the city. By ending tobacco addiction residents will also have more money available to them for other uses
A highly skilled city: world class and home grown talent sustaining the city's economic success	A thriving and sustainable city economy relies upon its residents being healthy and economically active. Smoking is the biggest cause of preventable disease and premature mortality and places a heavy economic burden on the city. By ending tobacco addiction residents will also have more money available to them for other uses
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	The proposals contained within this report are progressive and in line with international good practice. They would bring forward new legislation and protections to reduce health inequalities and supporting work towards Manchester being a Child Friendly City
A liveable and low carbon city: a destination of choice to live, visit, work	Cigarettes are the biggest source of microplastic pollution globally. Disposable electronic cigarettes are made from single use plastic, lithium and from production, transportation, use and then disposal, place a significant carbon burden on countries of production and Manchester
A connected city: world class infrastructure and connectivity to drive growth	This work reduces health inequalities, which is vital to help residents achieve their full potential. The tobacco and vaping control programmes are also part of a national and international system of Public Health through the WHO Framework Convention on Tobacco Control, which we have adopted

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Background documents (available for public inspection):

1) Report to the Health and Wellbeing Board, Stopping the start:our plan to create a smokefree generation, 1st November 2023.
2) https://www.gov.uk/government/publications/stopping-the-start-our-new-plan-to-create-a-smokefree-generation/stopping-the-start-our-new-plan-to-create-a-smokefree-generation
3) https://www.gov.uk/government/publications/local-stop-smoking-services-and-support-additional-funding
4) (https://makesmokinghistory.co.uk/partner-resources/the-cure-project/

1. Introduction

1.1 In the governments Command Paper, “Stopping the start: our new plan to create a smokefree generation” *the* Chief Medical Officer, Professor Sir Chris Whitty, outlined the ongoing devastating Public Health crisis and health inequalities which are caused by tobacco use in the UK. The paper goes on to present a detailed analysis of Public Health problems relating to tobacco use and the more recent phenomenon of youth vaping in the UK. The Command Paper proposes measures to address these Public Health problems, which can be summarised as follows:

i) To bring forward legislation that will ensure that children turning the age of fourteen, or younger, will never legally be sold tobacco.
ii) To increase investment in stop smoking services.
iii) To support the use of vaping devices for existing tobacco smokers who wish to stop. The “Swap to Stop” scheme will provide up to one million free vapes in England (in conjunction with local services).
iv) A suite of measures to protect and discourage children from vaping.

NB. The tobacco products included in new legislation include cigarettes, cigarette papers, hand rolled tobacco, cigars, cigarillos, pipe tobacco, waterpipe tobacco products (for example shisha), chewing tobacco, heated tobacco, nasal tobacco (snuff), herbal smoking products.

1.2 Final decisions, following the public consultation about legislative changes in relation to the age of sale of tobacco and the marketing of vaping, have not been reached by government. However, the Department of Health and Social Care *have* pressed ahead with announcements on new investment in smoking cessation services and the “Swap to Stop” Scheme. Manchester City Council will benefit from both.

1.3 This report provides an update on measures (ii) and (iii) above.

2. Background

2.1 Smoking tobacco is the main cause of preventable morbidity and premature death in the UK. This is also the case in Manchester. Two thirds of smokers become addicted to the Nicotine contained in tobacco before the age of 18 and are almost always destined to a lifetime of compromised health as a result. One in two long term smokers will die from smoking related disease and tobacco use causes approximately 8 million deaths globally every year. As well as the personal and family tragedy of all the above, smoking related ill health drives thousands of hospital admissions in Manchester every year. It places a huge financial burden on the NHS, Social Care, employers and the wider economy. Smoking is also a significant driver of stillbirth and infant mortality.

2.2 The Manchester Tobacco Control Plan is based on an established World Health Organisation Tobacco Control Framework which involves measures to prevent all smoking and tobacco use, protection from “environmental tobacco

smoke", enforcement of tobacco related legislation and, crucially, treatment services for anyone who smokes, or uses other forms of tobacco (including children). Public Health and partners nationally and locally are very clear that only concerted, long term, whole system, partnership working will drive down the use of tobacco, but this work requires significant resource.

2.3 Reducing smoking and tobacco use is a major Public Health commitment for the government's levelling up agenda. The government are aiming for all parts of England to reduce adult smoking rates to less than 5% by 2030.

2.4 The latest published data covers the calendar year 2022 and suggests that 17.3% of adults aged 18 and over in Manchester currently smoke cigarettes. Therefore, Manchester is currently *not* on track to reduce smoking rates to under 5% by 2030.

2.5 The government's proposed investment in smoking cessation services in Manchester could help us to scale up our existing community treatment services and to treat more smokers. N.B. It is beyond the scope of this paper, but city council Trading Standards teams will also receive further funding to carry out their essential enforcement of tobacco related legislation and combatting illicit tobacco.

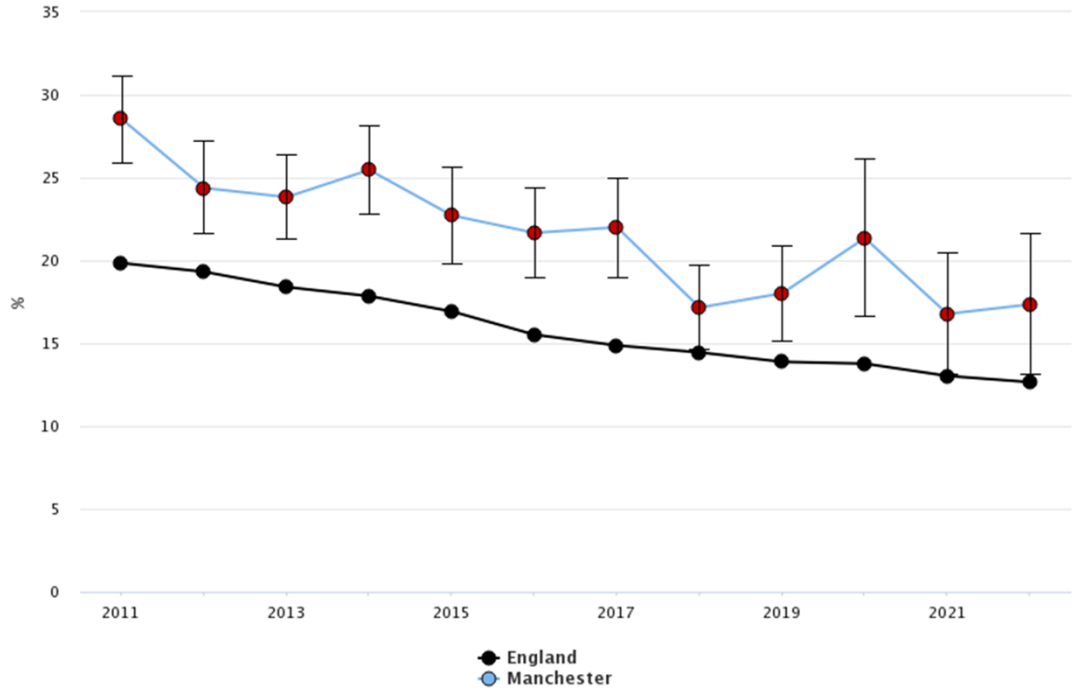
2.6 In addition to increasing investment in smoking cessation services, the government have introduced an innovative project called "Swap to Stop". This programme aims to boost smoking cessation work at a grass roots level by providing up to one million vapes and starter kits for Public Health teams and partners in England, to enable them to support even more smokers to make a "quit" attempt. Although we are very aware of the negative impacts of vaping in some age groups and contexts, we do know that vaping can help some adult smokers to "quit" and vaping is significantly less harmful than smoking tobacco. Therefore, the Department of Public Health in Manchester *did* make a bid to the first "pathfinder wave" of Swap to Stop, which was successful. This is outlined in more detail below.

3. Epidemiology Summary

3.1 Information on the prevalence of cigarette smoking in Manchester is based on data collected as part of the Annual Population Survey (APS), a continuous household survey, carried out by the Office of National Statistics (ONS). Survey respondents are asked whether they have ever smoked cigarettes regularly and, if so, whether they smoke cigarettes at all nowadays. Based on this, respondents are classified as a "current smoker", "ex-smoker" or "non-smoker". The APS focuses on cigarette smoking and does not cover other modes of tobacco consumption, such as shisha or chewing tobacco unfortunately.

3.2 The latest published data covers the calendar year 2022 and suggests that 17.3% of adults aged 18 and over in Manchester currently smoke cigarettes. This compares with a figure of 12.7% in England as a whole. The current figure is a small but not statistically significant increase on the figure for 2021

(16.8%). Looking back further, the prevalence of cigarette smoking among adults in Manchester has fallen since 2011, when the prevalence rate was estimated to be 29.5% (see chart below).



3.3 Although we have made progress in reducing smoking prevalence, based on the current trajectory, Manchester would not be on track to meet the current government target of less than 5% smoking prevalence rate by 2030.

3.4 The prevalence of smoking is not consistent across the whole of the adult population in the city; there are differences between men and women and between people from different occupational groups and housing tenures. For example, in 2022, 20.5% of adult men in Manchester were estimated to smoke, compared with 13.9% of adult women. This pattern is broadly consistent over time. Smoking prevalence is also higher in people renting from a local authority or housing association (34.7%) compared with those who own their house outright (10.9%) or with a mortgage (10.5%).

3.5 Smoking prevalence among in adults (aged 18-64 years) working in routine and manual occupations remains much higher than that for the general population. In 2022, smoking prevalence among in adults in routine and manual occupations (27.2%) was nearly 10 percentage points higher than that for the general adult population (17.3%). Adults working in a routine or manual occupation in Manchester were just over twice as likely to smoke compared with those working in another occupation.

3.6 The impact of persistently high rates of smoking among adults in Manchester can be seen in the rate of hospital admissions and deaths attributable to smoking. In 2019/20, there were 4,393 hospital admissions attributable to

smoking in Manchester - a rate of 2,422 admissions per 100,000 population compared with the England average rate of 1,398 admissions per 100,000.

3.7 The most recent set of data (for the three-year period 2017-2019) shows that around 637 deaths each year can be attributed to smoking. This is equivalent to a rate of 389 deaths attributable to smoking per 100,000 population. This compares with a rate of 202 deaths attributable to smoking per 100,000 population across England as a whole. The rate of smoking attributable mortality in Manchester is the highest of any local authority in the Northwest region and the second highest in England (behind Kingston upon Hull).

3.8 Smoking costs the NHS and social care sector millions of pounds each year in direct costs. It also places a burden on the economy in various ways, for example, in lost earnings, unemployment caused by ill health and premature death. Action on Smoking in Health (ASH) research suggests that being a smoker is associated with a 7.5% lower probability of being employed and about £1,424 lower earnings a year. Government estimates suggest that each lung cancer case costs society £360,000 from lost productivity, morbidity and mortality. This impact is amplified in Manchester because a greater percentage of our adults smoke compared to many more affluent areas. Although we do not have Manchester specific data for this report, ASH estimates that smoking causes a £897 million productivity loss in Greater Manchester, compared to a £191 million in Cambridge and Peterborough.

3.9 The long history of tobacco use in cities like Manchester is beyond the scope of this paper, but its use correlates highly with deprivation. Tobacco is usually burned and used in the form of cigarettes, hand rolled tobacco, cigars, cigarillos, pipe tobacco, waterpipe tobacco products (for example shisha). Less commonly tobacco can be chewed, heated, or used as nasal tobacco (snuff). All types of tobacco are highly carcinogenic, toxic and addictive. However, we know that by far the most popular way for tobacco is used in Manchester is smoking cigarettes, which is why the government (and this report) will use the terms “smoking cessation” and “stop smoking services” very often. It is important to stress that the Manchester Tobacco Control Programme and treatment services do address and treat all forms of tobacco use.

4. Current Community Smoking Cessation Services in Manchester

4.1 The community Smoking Cessation (Tobacco Addiction) Service in our city is commissioned by the Department of Public Health, Manchester City Council.

4.2 The community service is separate from local NHS Tobacco Treatment programmes, such as the CURE (4) and the Smoking in Pregnancy Services, but the pathways do link and there is cross referral. We believe that secondary care, maternity based *and* community-based services are essential, however the Public Health commissioned community based service does have the unique opportunity to offer primary prevention to smokers who have not yet suffered any smoking related ill health, as well as those who

have smoking related health conditions. The reach and benefits of upstream prevention are crucial to achieving 5% adult smoking prevalence by 2030.

4.3 Tobacco contains the highly addictive chemical, Nicotine. Nicotine in the short term, helps people to relax, to concentrate and is extremely addictive. Tobacco is highly carcinogenic and contains many other toxic chemicals which cause harm to humans. The additive agent, Nicotine, consumed in an isolated form, without tobacco, is much less harmful. Evidence shows that successfully giving up smoking involves managing Nicotine withdrawal and behavioural triggers.

4.4 Although, some people still believe that smoking is a lifestyle choice and that stopping is a matter of “willpower” alone, most clinicians, Public Health and addiction professionals know that this is *not* the case. The majority of smokers become addicted under the age of twenty and many of those will face many years trying to “quit”. It is understood that the addictive nature of Nicotine affects human physiology and in short, produces very unpleasant physical and psychological symptoms when the smoker or tobacco user tries to stop using tobacco. In many cases, it is the symptoms and cravings caused by Nicotine withdrawal that cause a person’s “quit” attempt to fail.

4.5 Latest NICE guidance NG209 (November 2021) states that the most effective way to treat smokers and tobacco users, is to provide pharmacotherapy and behavioural support in parallel. Managing Nicotine withdrawal often involves isolating Nicotine from tobacco and providing it in the form of “Nicotine Replacement Therapy (NRT)”. In recent years electronic cigarettes, also known as vapes, have also provided a form of Nicotine Replacement Therapy. NRT can be offered alongside other medication, such as Buproprion or Varenicline, although there have been supply issues with some of these medications in recent years.

4.6 In April 2020, the Department of Public Health launched a new, city-wide smoking cessation/Tobacco Addiction Treatment Service. The service is called Be Smoke Free and is provided by Change Grow Live (CGL). Most clients of the service are cigarette smokers, but the service does treat all forms of tobacco use.

4.7 Our service was designed by the Department of Public Health and the model was an innovative one for a community service. This is because the service is nurse led and we offer all available “stop smoking” medications free and direct to the client, alongside one-to-one support. The rationale for the nurse led service was that the team could be highly mobile if needed and led by Nurse Prescribers, could give clients their medications directly. This contrasts with many community services who have voucher schemes, for example. We wanted to remove barriers for smokers and to make starting a “quit” attempt as simple as possible.

4.8 Our service launched just after the first lockdown of the Covid-19 pandemic. At this time, smoking cessation services were stopped from seeing patients face to face. We worked closely with our provider, CGL, to quickly adapt the

treatment model. We immediately saw the benefit of the nurse led model, as nurses were able provide telephone and virtual assessments and one to one support but were also able to deliver and provide medications to clients' homes. Since then, our service has continued to develop in a responsive and dynamic manner.

4.9 Commissioners, partners and the Manchester Health and Wellbeing Board have been satisfied with the ongoing excellent performance of Be Smoke Free. The provider, Change, Grow, Live (CGL) have done everything they could to respond to the ever-changing landscape around Tobacco Control and were leaders in the field when they became Care Quality Commission registered. The service has consistently exceeded minimum Key Performance Indicators stipulated by NICE guidance and the commissioner.

4.10 The Commissioner at the Department of Public Health and CGL continue to work in a highly collaborative way and have tried to support NHS secondary care programmes, primary care and communities in which smoking, or tobacco use, is very high. However, the service is commissioned and funded to see a specific number of clients each year and the service have been exceeding this figure for some time. Without additional funding for staff, medication, and treatment space, we have not been able to scale up this service, or the number of clients seen any further.

5. Details of New Government Investment for Smoking Cessation Treatment in Manchester.

5.1 On the 8th November 2023, Departments of Public Health in England were advised of their increased allocations (3).

5.2 Allocations have been calculated using local smoking prevalence data. As such, the fact that Manchester has high rates of adult smoking prevalence relative to other parts of England, means that our city has received one of the highest allocations.

5.3 The allocation will be delivered subject to a new Section 31 grant. If grant conditions are met, Manchester will receive £929,359 in 2024/25. Subject to conditions and further adjustments, the city can reasonably expect a similar allocation in 2025/26, 2026/27, 2027/28 and 2028/29.

5.4 The Section 31 grant conditions stipulate that this new funding must be invested in smoking cessation (tobacco addiction) work and that existing investment in such services must *not* be reduced. This must be evidenced via a specified reporting regime, which will include information about activity levels and "quit rates", the latter being a recognised Performance Indicator.

5.5 The council expects to receive confirmation of this grant in January 2024 and is expected to report on investment and activity from early in the financial year 2024/25.

6. Proposed Investment Approach

6.1 All options have been considered in terms of how to invest new smoking cessation funding. Section 31 grant conditions and the speed with which new investment must be mobilised, have led us to conclude that the quickest, but most importantly, the best way, to scale up our smoking cessation treatment programme, is to invest in and scale up our existing, expert community service, Be Smoke Free. This approach has been considered and supported by the City Treasurer and procurement leads at the Council.

6.2 For some time, both commissioners and the provider, CGL have understood the strengths and gaps in our current service provision. New investment will help us to address these issues.

6.3 How we propose to develop the Be Smoke Free Service using new government investment:

i) Be Smoke Free is a citywide service, but the main clinic base is currently in Ancoats. Some patients are seen virtually and some “face to face”. To make “face to face” access to NRT and other treatments easier for residents in North, East and South Manchester, where smoking prevalence is high, we propose to open a minimum of three additional clinic spaces, one in east Manchester, a second in Harpurhey and the third in Wythenshawe.

ii) Activity levels in terms of patients offered treatment could significantly increase with new grant funding. Currently, we specify that Be Smoke Free will offer treatment to 3650 clients per year (each of whom is then offered a 12-week course). This would increase to approximately 6000 a year with new funding. Increasing the number of available treatment courses per year will also mean that the service can take more referrals from NHS programmes, such as CURE and the Lung Health Check programme. We will continue to support General Practice to use the service too.

iii) To enhance our Community Engagement service - focussing on Health Equity and being linked to GPs and the NHS Manchester Local Care Organisation. This would include a range of social marketing, training opportunities and health promotion activity.

iv) To safely deliver these interventions, more staff will be recruited by CGL. They would recruit a Deputy Nurse Manager and recruit some non-clinical “Smoking Cessation Practitioners” too, who will work under the leadership of the Nurse Manager. Increased administration resource would be needed to manage referrals, patient journey tracking, contract monitoring, reporting to NHS digital, liaison with other services and medicines ordering and packaging.

6.4 These proposals have been discussed with CGL. Development at this scale, within tight timescales will be challenging, but also present great opportunity to reduce smoking and tobacco use rates.

7. Swap to Stop

7.1 Electronic cigarettes or vapes are substantially less harmful than smoking because they do not contain tobacco. They usually do contain Nicotine however. As stated above, Nicotine in isolated form is addictive, but not especially harmful when used in a managed way. This is why Nicotine Replacement Therapy (NRT), allows smokers to stop using cigarettes, or other tobacco products, by gradually reducing, their Nicotine dependency. Used properly, vapes can also be a type of Nicotine Replacement Therapy, because vaping liquids can contain measured concentrations of Nicotine which can be gradually titrated down until the user is no longer physiologically addicted to Nicotine.

7.2 Although vaping is often surrounded by controversy and misunderstanding, and there are significant issues around marketing, youth vaping, disposable vapes and counterfeit products, Public Health professionals *do* acknowledge that vapes can be a very effective tool in supporting smoking cessation. This is something we have been aware of in our stop smoking service, Be Smoke Free. Consequently, in 2022, Public Health commissioners and CGL made a decision to offer vapes to some clients, as part of full treatment course. Used alone or in combination with other pharmacotherapies, vapes have assisted some of our residents to stop smoking.

7.3 In April 2023, the government announced the first national “Swap to Stop” scheme, which would offer a million smokers across England a free vaping starter kit. Nationally, this scheme alone amounts to an investment of £45 million over two years.

7.4 In November 2023, the Director of Public Health approved a Manchester Expression Of Interest in the “pathfinder wave” for Swap to Stop. This application was successful, meaning that from early 2024, our provider, CGL can start to “draw down” a specified number of vapes from the Department of Health and Social Care portal. There is no financial charge to Manchester City Council or CGL.

7.5 The government have stipulated that vaping starter kits must only be given to smokers following an assessment by a Smoking Cessation Service and on condition that support to stop smoking is offered alongside provision of vaping kits. This approach is intended to ensure that vaping is offered as a way of stopping smoking and not something we recommend as a permanent switch. This aligns with the way Be Smoke Free have been providing vapes to clients since 2022 and is why we sought to bring this offer to Manchester.

7.6 It is important to note that any smoker or tobacco user coming to Be Smoke Free may be eligible and able to have a vape. However, we are using the Swap to Stop Scheme initially to provide three “mini pilots”.

7.7 These pilots trial some new approaches as follows:

i) We will pilot work with social housing providers and the Manchester Local Care Organisation and pending further discussions with ward councillors we have identified the wards of Miles Platting and Newton Health and Moston as a potential pilot area. We do not currently have specific pathways between “housing” and our Stop Smoking Service but there would be mutual benefits to establishing them. We have chosen this geographical area because Miles Platting, Newton Heath and Moston has very high rates of smoking attributable morbidity and mortality. This approach will provide more intensive support to residents and if successful, could be rolled out to similarly deprived parts of our city.

ii) We would also like to trial the provision of Vapes to people who are being treated at Manchester’s Substance Misuse Service. These clients often also smoke. Many are also rough sleepers. This cohort of our community have much lower life expectancy and smoking rates are a contributing factor. We trialled the use of vapes-cigarettes with this community during 2020 and the devices were extremely popular. Swap to Stop will enable us to try this again and reach out to a client group who have less stable lifestyles, less secure housing situations, but who still need help to stop smoking.

iii) Finally, we would like to offer the Swap to Stop Scheme to all Manchester City Council staff as part of our ongoing commitment to support staff health and wellbeing. In turn, this benefits the organisation. Staff can already access the services of Be Smoke Free.

7.8 This scheme in its current form lasts until March 2025. If successful, the Swap to Stop scheme allows us to apply for further vaping devices for our residents. Because a requirement of the scheme is that smokers must accept support from our community stop smoking service, the Department of Public Health acknowledges that the scheme makes demands on our Be Smoke Free provider, CGL, because of increased staff time in administration of the scheme, additional support and storage. The Section 31 grant funding will address this issue, if proposals to invest in our existing Be Smoke Free service are agreed.

8. Conclusion

8.1 The Department of Public Health remains very optimistic about the contents of the Command Paper described. In particular, we welcome new investment for smoking cessation and the Swap To Stop Scheme. We know that the programme and pace of work will be challenging but are optimistic about being able to help more Manchester residents to be free from tobacco addiction.

9. Recommendations

The Board is asked to:

i) Note the report.
ii) Support the proposed investment plan and Swap to Stop scheme.

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Manchester City Council
Report for Information

Report to: Manchester Health and Wellbeing Board – 24 January 2024

Subject: Manchester Child Death Overview Panel 2022-23 Annual Report

Report of: Assistant Director of Public Health

Summary

The Manchester Child Death Overview Panel (CDOP) reviews the deaths of children aged 0-17 years of age (excluding stillbirths and legal terminations of pregnancy), that are normally resident in the area of Manchester City. In line with the Child Death Review: Statutory and Operational Guidance (England) published October 2018, the CDOP has a statutory requirement to produce a local annual report which provides a summary of the key learning and emerging trends arising with the aim of preventing future child deaths. The Annual Report is attached as Appendix 1.

Recommendations

The Board is recommended to note the report and its recommendations.

Wards Affected: All

Environmental Impact Assessment -the impact of the issues addressed in this report on achieving the zero-carbon target for the city	No impact
Equality, Diversity and Inclusion - the impact of the issues addressed in this report in meeting our Public Sector Equality Duty and broader equality commitments	The inequalities issues associated with child deaths, both locally and nationally, relate to higher mortality rates in communities experiencing higher levels of health inequalities, and social and economic disadvantage. In addition, there have been higher rates of child deaths across non-white populations exacerbated, and added to, by social disadvantage. Given the levels of deprivation within Manchester and the ethnically diverse population the cumulative impacts of these factors contribute significantly to the child death rates in the city.

Manchester Strategy outcomes	Summary of how this report aligns to the Our Manchester Strategy/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	This important work contributes significantly to our efforts to be a more progressive and equitable city.
A highly skilled city: world class and home-grown talent sustaining the city's economic success	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

Full details are in the body of the report, along with any implications for:

- Equal Opportunities Policy
- Risk Management
- Legal Considerations

Financial Consequences – Revenue
None.

Financial Consequences – Capital
None.

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Background documents (available for public inspection):

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

- Manchester Reducing Infant Mortality Strategy (2019-24)
- Manchester CDOP Annual Reports 2011-22
- National Child Mortality Database (NCMD): Child Death Review Data
- National Child Mortality Database (NCMD): Child Suicide Rates during the COVID-19 Pandemic in England: Real-time Surveillance

Additional reports are available via the Manchester Safeguarding Partnership CDOP webpage:

https://www.manchestersafeguardingpartnership.co.uk/resource/cdop/

1.0 Introduction

1.1 The 2022-23 Manchester Child Death Overview Panel (CDOP) Annual Report (Appendix 1) provides a summary of the key factors and modifiable factors for cases closed between 1 April 2022 and 31 March 2023.

2.0 Background

2.1 Following the death of a child, the CDOP Coordinator liaises with a wide range of agencies to gather information regarding the circumstances of the death- these includes factors in the child, their social environment (including family and parenting capacity), the physical environment, and service provision. This information gathering is to ensure a full picture of relevant clinical and social issues are available for consideration at the CDOP.

2.2 The main CDOP and a Themed Panel (neonatal deaths less than 28 days) meetings are held on a quarterly basis to categorise the cause of death, highlight factors that may have contributed to vulnerability, ill health or death and identify modifiable factors which by means of a locally or nationally achievable intervention, could be modified to reduce the risk of future child deaths.

2.3 Manchester CDOP, similar to many CDOPs nationwide, has a backlog of cases due to a combination of factors including the implementation of the 2018 Statutory and Operational Guidance (see 6 below) and the pressures on public sector services resulting from the impact of the COVID-19 pandemic. In addition, the complexity of many of the cases in Manchester increase the timescales for closing cases resulting in lower numbers of cases closed in the last two years.

2.4 A key element of the child death review process is the response to sudden and unexpected deaths in infancy/childhood (SUDI/C) known as a Joint Agency Response (JAR). The Greater Manchester (GM) JAR Team conducts a rapid assessment of such deaths. A team of senior paediatricians provide 24/7 cover 365 days of the year, working in close collaboration with Greater Manchester Police, Children's Services, GM Coroner's Offices, and health services. Nationally this service provision is seen as the "gold standard".

2.5 The CDOPs national line of accountability transferred from the Department for Education (DfE) to the Department of Health and Social Care (DHSC). Published October 2018, the Child Death Review: Statutory and Operational Guidance (England) sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in Working Together to Safeguard Children and clarifies how individual professionals and organisations across all sectors involved in the child death review should contribute to reviews. The guidance sets out the process in order to:

- improve the experience of bereaved families, and professionals involved in caring for children.

- ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths.

2.6 The collation and sharing of the learning from reviews is managed by the National Child Mortality Database (NCMD) using standardised forms. Following the introduction of the NCMD there was an increase in data entry requirements, and a number of changes were made to the national templates used by CDOP to gather information following a child death. To ensure that the CDOP supplies the necessary information to the NCMD Manchester uses the eCDOP system which automatically populates the NCMD.

3.0 Main issues

3.1 The annual number of death notifications has fluctuated in the last 3 years, with a downturn in 2020/21 and a similar upturn in 2022/23, when compared to the 10-year average of 60 deaths per year. Whether or not this negative direction will be maintained will need to be monitored in future years, as will the impact on age-groups (65% of child deaths are aged under one), ethnic groups (higher rates in non-white Black and Asian groups), and families living in socially deprived conditions (over 80% of child deaths in Manchester are experienced by families living in the most deprived wards).

3.2 The number of cases being reviewed and closed by CDOP is increasing as the overall governance system for the review of child deaths develops and improves. Despite the variation in numbers of cases closed the two main causes of death, year on year, are chromosomal, genetic and congenital anomalies, and perinatal/neonatal events.

3.3 The CDOP seeks to identify the key modifiable factors in the population such as unsafe sleeping arrangements, housing conditions, reducing maternal smoking, and reducing maternal obesity, that can contribute to child deaths.

3.4 The work of Manchester CDOP is closely linked to the Manchester Reducing Infant Mortality Strategy (2019-2024)- with the information above informing the setting of priorities for the city- and the broader context of the Making Manchester Fairer Plan (2022-27).

3.5 The CDOP Manager will continue to work with Public Health colleagues in the development and delivery of the refreshed Reducing Infant Mortality Strategy

3.6 Manchester CDOP will continue to work with the other 3 Greater Manchester (GM) CDOPs, GM Association of Directors of Public Health, and the broader integrated care system leadership to initiate a change programme to create a sustainable and flexible workforce model hosted by an appropriate organisation within GM.

4.0 Recommendations

4.1 The board is asked to note the report and its recommendations.

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MANCHESTER CHILD DEATH OVERVIEW PANEL (CDOP)

2022/2023 ANNUAL REPORT

1 April 2022 – 31 March 2023

BARRY GILLESPIE
Assistant Director of Public Health
Chair of the Manchester Child Death Overview Panel

MANCHESTER CITY COUNCIL

NHS Greater Manchester Integrated Care

PUBLISHED: JANUARY 2024

CONTENTS

1. WELCOME & INTRODUCTION

Welcome to the 2022/23 Manchester Child Death Overview Panel (CDOP) Annual Report which provides an overview of the deaths of children that are normally resident in Manchester City, aged 0 - 17 years of age (excluding stillbirth and legal terminations of pregnancy). The report focuses on the analysis of the number of cases closed between 1 April 2022 to 31 March 2023 (2022/23). Reporting on cases closed provides a full and complete data set, including the outcome of the final CDOP review.

During 2022/23 there were 73 child death notifications reported to the Manchester CDOP, which is the highest it has been since 2016/17. This has caused the 5-year average (2018/23) to rise to 61 notifications per year, compared to 59 (2017/22). The total cases reviewed increased to 35 in 2022/23 which is a significant increase compared to the two previous years- 27 (2021/22) and 29 (2020/21).

Following the publication of the HM Government Child Death Review: Statutory and Operational Guidance (England) in October 2018, changes were introduced to build on the interface between the hospital/community led mortality reviews (Child Death Review Meetings (CDRM) and the final CDOP review. The improvements to the revised child death review system have contributed to a reduction in the number of cases being reviewed, and closed, by Manchester CDOP.

The CDOP has a statutory requirement to prepare and publish a local report on:

a) what has been done as a result of the child death review arrangements; and
b) how effective the child death review arrangements are in practice.

The CDOP Annual Report is produced to advise Child Death Review (CDR) Partners on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process. The richness of the data and information collated assists in the identification of factors antenatally, postnatally and throughout the child's life. This report aims to highlight relevant factors and modifiable factors that are likely to contribute to Manchester's infant (under one year of age) and child (age 1-17 years) mortality rate.

I would like to thank those who have contributed to the child death review process including CDOP members, practitioners completing data returns and colleagues that have contributed to the content of this report.

Barry Gillespie
Assistant Director of Public Health
Manchester Child Death Overview Panel Chair

2. THE CHILD DEATH REVIEW PROCESS

In line with Working Together to Safeguard Children (2006)[1], the Child Death Overview Panel (CDOP) became a statutory function from 1 April 2008. Local Safeguarding Children Boards (LSCBs) were tasked with establishing a multi-disciplinary CDOP Subgroup to conduct a review into the death of all children 0-17 years of age, normally resident in their geographical area.

In October 2018, HM Government published the revised Child Death Review: Statutory and Operational Guidance (England)[2] for Clinical Commissioning Groups and Local Authorities as Child Death Review Partners (CDR Partners). CDR Partners are identified as Local Authorities and any Clinical Commissioning Groups for the local area as set out in the Children and Social Work Act 2017[3]. The guidance sets out the full process that follows the death of a child, who is normally resident in England and builds on the statutory requirements set out in Working Together to Safeguard Children (2018)[4]. The revised guidance clarifies how individual professionals and organisations across all sectors, involved in the child death review process, contribute to reviews to improve the experience of bereaved families and professionals involved in caring for children.

The publication of the revised guidance prompted significant changes to the way in which child deaths are reviewed. These changes include the expansion of the Department of Health and Social Care (DHSC) CDR dataset, the national templates used to collate information following a child death, the introduction of the Child Death Review Meeting (CDRM) and the implementation of local data management systems (eCDOP) to coincide with the National Child Mortality Database (NCMD).

2.1 DEPARTMENT OF HEALTH AND SOCIAL CARE (DHSC)

The DHSC have amended the data entry fields and national templates[5] used by CDOPs, to collate information following a child death. Year on year, the CDR dataset expands to collate multi-agency information to support CDOPs assess the causes of a child's death as part of the child death review process. Depending on the nature of the death, various templates are used to gather information regarding the circumstances leading to death, any underlying health conditions, the child's social and physical environment and details relating to service provision.

- A. Child death notification form
- B. Child death reporting form
- C. Child death analysis form

Supplementary Reporting Forms:

- Asthma and anaphylaxis
- Cardiac congenital or acquired
- Care pathway
- Chromosomal, genetic, or congenital anomaly excluding cardiac conditions

[1] https://webarchive.nationalarchives.gov.uk/20100408113130/http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00060/
[2] https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england
[3] https://www.legislation.gov.uk/ukpga/2017/16/part/1/chapter/2/crossheading/child-death-reviews/enacted
[4] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
[5] Child death reviews: forms for reporting child deaths - GOV.UK (www.gov.uk)

- Death as a result of fire, burns or electrocution
- Death of a child with an oncology condition
- Death as a result of injuries sustained from a falling object
- Death of a child with a life-limiting condition
- Deaths on a neonatal unit, delivery suite or labour ward
- Diabetic ketoacidosis
- Drowning
- Epilepsy
- Falls
- Infection
- Poisoning
- Sudden unexpected deaths
- Suicide or self-harm including alcohol or substance abuse
- Trauma or external factors
- Vehicle collisions
- Violent or maltreatment-related deaths

The completed forms help CDOPs collect information regarding child deaths in their area in a consistent way, assess the causes of child deaths to see if there are significant similarities between and recommend how to prevent similar deaths in future. CDOP areas were tasked with implementing arrangements to share the results of local CDRs with the NCMD, as a legal statutory requirement. Prior to the 1 April 2021, the DHSC templates were used by the Manchester CDOP to request child death information. As of the 1 April 2021, data is now captured electronically via the Greater Manchester eCDOP system which falls in line with the NCMD legal requirement, to submit CDR data at a national level.

2.2 CHILD DEATH REVIEW MEETING (CDRM)

The Child Death Review Meeting (CDRM) is a multi-professional meeting where all matters relating to an individual child death are discussed by the professionals directly involved in the care of the child during life and any investigation after death. The nature of the meeting varies according to the circumstances of the child's death and the practitioners involved. The CDRM can take place in the form of a final case discussion following a Joint Agency Response (JAR); a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit; a hospital-based mortality review meeting following the death of a child in a paediatric intensive care unit; or similar case discussion.

In all cases, the aims of the CDRM are:

- to review the background history, treatment, and outcomes of investigations, to determine, as far as is possible, the likely cause of death.
- to ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment, and service delivery.
- to describe any learning arising from the death and, where appropriate, to identify any actions that should be taken by any of the organisations involved to improve the safety or welfare of children or the child death review process.
- to review the support provided to the family and to ensure that the family are provided with:
    - the outcomes of any investigation into their child's death.

    - a plain English explanation of why their child died (accepting that sometimes this is not possible even after investigations have been undertaken) and any learning from the review meeting.
- to ensure that the CDOP and, where appropriate, the Coroner is informed of the outcomes of any investigation into the child's death; and
- to review the support provided to staff involved in the care of the child.

Information, reports, and notes of the CDRM are shared with the appropriate CDOP.

2.3 CHILD DEATH OVERVIEW PANEL (CDOP)

CDR Partners have a legal responsibility to ensure that the deaths of children normally resident in their area are reviewed. This function is carried out by the Child Death Overview Panel (CDOP) to ensure that a review is undertaken for all infant/child deaths age 0-17 years, excluding babies who are stillborn, late foetal loss and planned terminations of pregnancy carried out within the law.

In reviewing the death of each child, the CDOP considers relevant factor and modifiable factors in the family environment, parenting capacity and service provision. The CDOP identifies what action could be taken locally, regionally or at a national level with the aim of preventing child deaths and to improve the health and safety of children and young people.

The functions of the CDOP are:

- to collect and collate information about each child death, seeking relevant information from professionals.
- to analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths.
- to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety, and well-being of children.
- to notify the Child Safeguarding Practice Review Panel (CSPR) and Local Safeguarding Partnership (LSP) when it suspects that a child may have been abused or neglected.
- to notify the Medical Examiner and the Doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction.
- to provide specified data to the National Child Mortality Database (NCMD).
- to produce an annual report for child death review partners on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process.
- to contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

The Manchester CDOP membership is made up of senior multi-agency professionals who have knowledge and expertise in fields such as public health, children's social care, paediatrics, police, education etc. The panel consists of representation from a

range of organisations who can make a valuable contribution when undertaking a child death review. Each professional provides information and advice to enable a thorough review and analysis, with the aim of identifying relevant factors, modifiable factors, and emerging themes.

The purpose of a review and analysis is to identify any matters relating to the death(s), that are relevant to the welfare of children in the area or to public health and safety, to consider whether action should be taken. The aim of the child death review process is to ensure that information is systematically captured for every death to enable learning and prevent future deaths. The CDOP publishes an annual report which provides an overview of local patterns and trends.

2.4 MANCHESTER CDOP THEMED PANEL MEETINGS

Some child deaths are reviewed at a Themed Panel to discuss a particular cause or group of causes. The Manchester CDOP holds Themed Panel meetings to review perinatal/neonatal deaths (<28 days of life) and infant deaths (under 1 year of age), where the infant was never discharged from hospital. Such arrangements allow for the attendance of appropriate professional experts including the Manchester University NHS Foundation Trust Consultant Neonatologist and Designated Doctor for Child Death, to inform discussions and allow easier identification of themes. Deaths reviewed at the Themed Panel are pre-screened to highlight any relevant factors and/or modifiable factors during the antenatal/postnatal period, focusing on issues relating to service provision.

2.5 LEARNING DISABILITIES MORTALITY REVIEW (LeDeR) PROGRAMME

Once the Manchester CDOP is notified of the death of a child aged 4-17 years who has learning disabilities or is very likely to have learning disabilities but not yet had a formal assessment for this, information is shared, and the death is reported to the Learning Disabilities Mortality Review (LeDeR) Programme. The Manchester CDOP reports deaths to LeDeR via the online referral form and provides core information about the child which is submitted to the LeDeR Local Area Contact.

Once all investigations have concluded and sufficient information has been collated to ensure the CDOP can undertake a comprehensive review, the Manchester CDOP invites the LeDeR representative to attend the panel meeting at which the death is reviewed. During the CDOP meeting, the LeDeR Local Area Contact may offer advice and expertise about learning disabilities (if appropriate) and ensure that the CDOP provides sufficient core data to support the LeDeR Programme. Once the Manchester CDOP has conducted a review, documentation is submitted to the LeDeR Local Area Contact. This includes the final Analysis Form which highlights the:

- common contributory factors leading to deaths
- factors that may have contributed to the vulnerability, ill health, or death of the child
- modifiable factors that may reduce the risk of future child deaths
- learning points and issues identified in the review
- recommendations and actions that may inform and support local, regional, or national learning

2.6 GREATER MANCHESTER eCDOP

The eCDOP system operates in line with the statutory guidance to assist CDOPs and ensure compliance. The system is known for improving efficiencies throughout the multi-agency information gathering process. The eCDOP system automatically transfers multi-agency data at each relevant stage of the process into the NCMD therefore reducing the duplication of data entry. The information is then used to analyse data nationally to improve learning and implement strategic improvements in healthcare for children in England, with the overall goal to reduce infant/child mortality.

2.7 NATIONAL CHILD MORTALITY DATABASE

The National Child Mortality Database (NCMD) is a repository of data relating to all child deaths in England. The NCMD was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and is delivered by the University of Bristol, in collaboration with the University of Oxford, University College London (UCL) Partners and the software company QES. The NCMD enables more detailed analysis and interpretation of all data arising from the child death review process, to ensure that lessons are learned, that learning is widely shared and that actions are taken locally and nationally, to reduce child mortality. The introduction of the NCMD aims to learn lessons that could lead to changes to improve outcomes for children.

It is a statutory requirement that CDOPs across England submit data via the NCMD. For every child death, CDR Partners must ensure that:

1. A notification form is completed and sent to the CDOP secretariat or equivalent immediately after the death of a child
2. The details on the notification form are entered onto the NCMD within 24 hours of receipt of the form by the CDOP secretariat or equivalent
3. The CDOP gathers information from all agencies that were involved with the child during their life or after death through completion of a reporting form
4. The CDOP secretariat identifies the most appropriate agency to complete the relevant supplementary reporting forms, depending on the cause of death, and request for that agency to complete the relevant forms
5. When completed, reporting forms and supplementary reporting forms are returned to the CDOP secretariat or equivalent, and information is entered onto the NCMD
6. A local CDRM is convened, to include all professionals that were involved with the child during their life or after death
7. Anonymous versions of the completed CDOP templates (notification form, reporting form, supplementary reporting forms and draft analysis form) are presented to the CDOP, to conduct an independent review of the death
8. Following the CDOP review, the details are entered on the final analysis form and data is submitted to the NCMD.

3. MANCHESTER'S DEMOGRAPHICS

3.1 INDICES OF DEPRIVATION 2019

A key tool used in assessing deprivation is the Indices of Deprivation 2019 that combines data from across seven domains of deprivation to produce an overall relative measure of deprivation:

- Income: Measures the proportion of the population experiencing deprivation relating to low income
- Employment: Measures the proportion of the working age population in an area involuntarily excluded from the labour market
- Health Deprivation and Disability: Measures the risk of premature death and the impairment of quality of life through poor physical or mental health
- Education, Skills Training: Measures the lack of attainment and skills in the local population
- Crime: Measures the risk of personal and material victimisation at local level
- Barriers to Housing and Services: Measures the physical and financial accessibility of housing and local services
- Living Environment: Measures the quality of both the indoor and outdoor local environment

Each small area in England is ranked from 1 (most deprived) to 32,844 (least deprived)[6]. According to the 2019 Index of Multiple Deprivation (IMD), as an average score, Manchester ranks 6 out of 326 local authorities in England, 1 being the most deprived.

3.2 MANCHESTER'S CHILD HEALTH PROFILE 2023

The Manchester Child Health Profile 2023 provides a snapshot of child health across the city. Overall, comparing local indicators with England averages, the health and wellbeing of children in Manchester is worse than that of England. According to the ONS population estimate for mid-2021, children and young people aged 0-19 years account for 26.7% (140,047) of Manchester's total population. Children aged 0-4 years account for 6.2% (33,932) of the total population of the city. Manchester's infant mortality rate of 6.7 per 1,000 live births (2019-21), is worse than the England rate of 3.9, with an average of 47 infants dying before the age of one each year. This has increased from the previous years, where the rate was 6.1 and an average of 44 infant deaths per year (2018-20). Manchester's child mortality rate (2018-20) of 13.5 deaths per 100,000 children aged 1-17 years is worse than the England rate of 10.3, with an average of 15 child deaths each year. This is a decrease in comparison to previous years (2017-19) where the standardised rate of death was 16.2 per 100,000 children, with an average of 19 child deaths (aged 1-17 years) each year. 35.5% of Manchester children under 16 years of age are living in poverty in comparison to the England average of 27% (2020/21).

[6] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

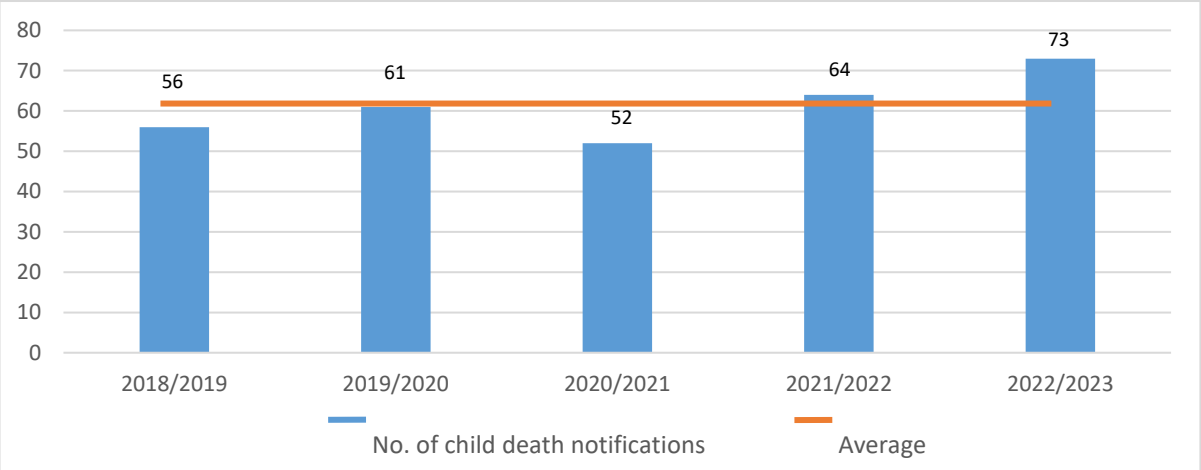
4. CHILD DEATH NOTIFICATIONS REPORTED TO THE CHILD DEATH OVERVIEW PANEL

There were 73 child death notifications reported to the Manchester CDOP from 1 April 2022 to 31 March 2023 (2022/23). At the end of the CDOP reporting year (31 March 2023) there was a total of 164 cases that remained open pending a CDOP review, 24 of which were historical child death notifications where the death occurred prior to 1 April 2021 and the remaining 140 where the death occurred during April 2021 – March 2022 period.

From 1 April 2018 to 31 March 2023 there were 306 child deaths reported to the Manchester CDOP. There has been a variation in the number of child deaths reported year on year, with an average of 61.2 notifications per year.

The latest Office of National Statistics (ONS) population estimate for mid-2021 suggests that there are 176,602 children aged 0-17 years living in Manchester. This is equivalent to 23.0% of the total resident population of the city (549,853). With a total of 73 child death notifications reported to the Manchester CDOP during the period 2022/23, this would indicate that Manchester's overall child death rate is 41.3 deaths per 100,000 children (aged 0-17 years), which is an increase in comparison to the previous year for 2021/22 of 36.2 child deaths per 100,000 population.

Diagram 1: Number of child deaths reported to the Manchester CDOP per CDOP year (2018/23)



Across the three-year period (2020/23), Manchester CDOP has received a total of 189 death notifications. In 2020/21, 52 notifications were received, and 35 (67%) were reviewed. In 2021/22, 64 notifications were received with all pending a review. In 2022/23, 73 notifications were received with all pending a review.

Diagram 2: Number of child deaths reviewed by year of death to the Manchester CDOP (2020/23)

Number of deaths notified by year of death				**Total**
Year	2020/21	2021/22	2022/23	
Deaths	52	64	73	**189**
% Reviewed	67%	0%	0%	**20%**

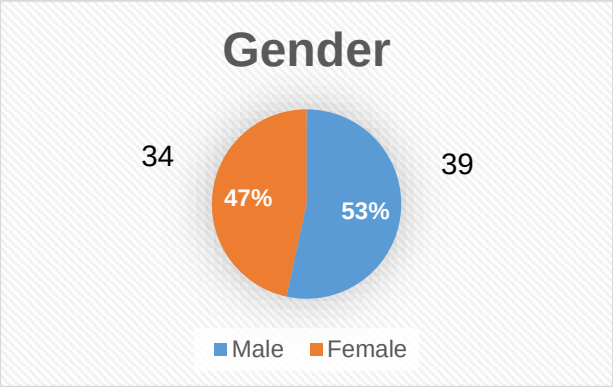
This is partly due to the publication of the revised guidance having a significant impact in terms of the operational aspects of the CDR process and the development of the new arrangements for CDOPs locally, which is far more complex in comparisons to previous requirements. This has resulted in an increase in case management functions, to ensure statutory requirements are adhered to.

There is a time lapse between a death being reported to the CDOP and the case being discussed and closed at panel. This depends heavily upon the circumstances leading to death, pending CDRMs and, for deaths subject to one or more forms of investigation, the CDOP must await the conclusion before conducting a review. Deaths subject to multiple investigations such as internal agency reviews, coronial investigations, criminal proceedings, and child safeguarding practice reviews, can take years before all have concluded and sufficient information is submitted to CDOP.

4.1 AGE, GENDER & ETHNICITY

Of the 73 cases notified, 34 (47%) children were female and 39 (53%) were male. 36 (49%) of the infants were neonatal deaths (<28 days). A further 18 (25%) deaths occurred before the first year of life (28-364 days), accounting for a total of 54 (74%) of cases closed.

Diagram 3: Cases notified to Manchester CDOP by gender and age at time of death (2022/23)



Age	Notified Cases[7]	
0-27 days	36	49%
28-354 days	18	25%
1-4 years	<5	0%
5-9 years	9	12%
10-14 years	5	7%
15-17 years	5	7%
Total	73	100%

Diagram 4: Cases notified to Manchester CDOP by ethnic grouping (2022/23)

Ethnicity	No. Cases Closed	
Asian or Asian British	24	33%
Black or Black British	16	22%
Mixed	<5	4%
Other ethnic group	<5	3%
White	25	34%
Not known or stated	<5	4%
Total	73	100%

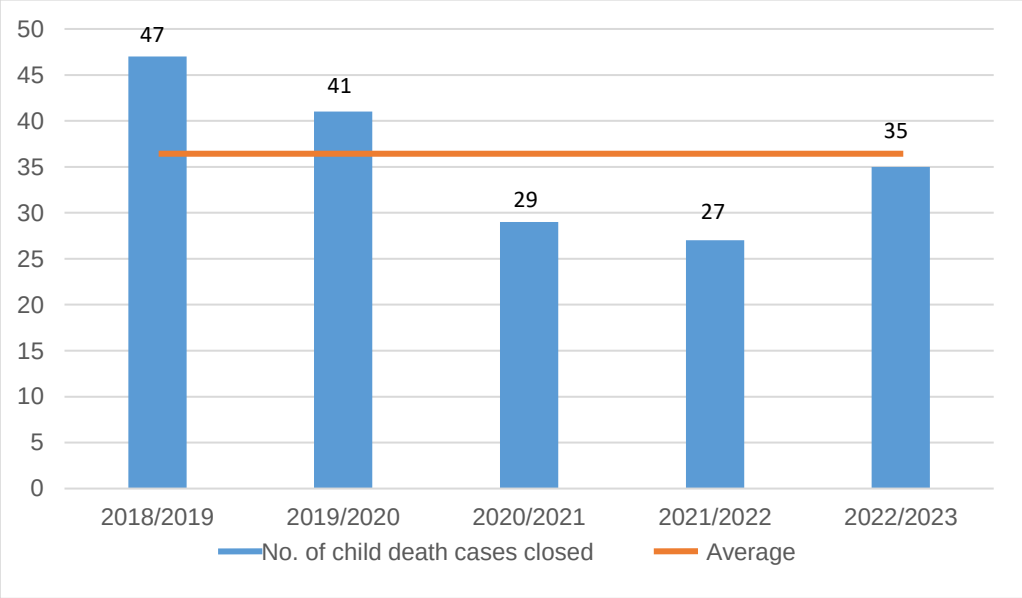
The ethnic breakdown of deaths follows the pattern of previous years with children who were Asian or Asian British (24, 33%) or White (25, 34%) being the groups experiencing the highest number of child deaths.

[7] Suppression of data to anonymise statistics: Personal data where the value is less than 5 has been removed (<5/1)

5. CASES CLOSED BY THE CHILD DEATH OVERVIEW PANEL (CDOP)

Once the CDRM has taken place, all investigations have concluded and sufficient information has been collated, the CDOP holds the final multi-disciplinary review. Examining deaths using the data of cases discussed and closed at panel, provides a full dataset to conduct analysis. This annual report focuses on data relating to the 35 cases discussed and closed by the CDOP from 1 April 2022 to 31 March 2023 (2022/23). Of the 35 cases closed during 2022/23, all were historical cases, where the death occurred prior to 1 April 2021.

Diagram 5: Number of cases closed by the Manchester CDOP per CDOP year (2018/23)



Following the publication of the revised Child Death Review: Statutory and Operational Guidance (England), it was anticipated that the CDOP would see a decrease in the number of closed cases per year due to additional national requirements. The national changes have drastically impacted upon the level of data as requested by the DHSC, the time taken to process case information and documentation during the CDOP review.

In previous years, the Manchester CDOP conducted timely reviews for expected child deaths, where the death was anticipated within 24 hours due to natural causes such as extreme prematurity and life limiting conditions. The Manchester CDOP operates in line with the current guidance, which stipulates that a CDOP review should not take place until the CDRM has concluded and information is shared for discussion at panel. Whilst the Manchester CDOP welcomes the new standardised approach to CDRMs, this impacts heavily on the timescale in which the panel undertakes a review, therefore resulting in fewer cases closed.

Information submitted following a CDRM is detailed and extremely useful in supporting the Manchester CDOP carry out a thorough review of the death. The CDOP utilises CDRM reports, assessing the care provided, to highlight any issues in relation to

service provision such as, the identification of illness, assessment, investigations, and diagnosis; treatment or healthcare management; communication or teamwork within or between agencies; and organisational or systemic issues. The Manchester CDOP identifies relevant factors including underlying staffing issues, equipment, work environment, education and training requirements and documents positive aspects of service delivery to record examples of excellent care.

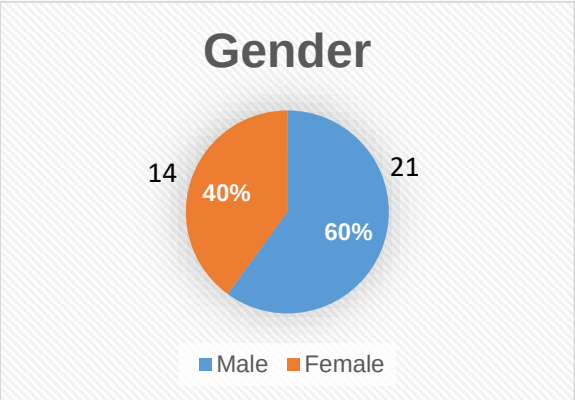
Whilst the number of child deaths reported to the Manchester CDOP varies year on year the average number has been around 60 deaths per year (2018/23 average is 61.2 notifications per year), it is anticipated that the panel will continue to see a lower number of cases closed over the coming years. It has been recognised by the NCMD programme team that the interface between the CDRM and CDOP process will impact the timescale of completed reviews due to operational aspects of the revised child death review process. The circumstances leading to death and the nature of the death also impact upon the number of cases closed by the CDOP. Deaths where the cause appears to be unnatural, sudden, and unexpected can be subject to multiple investigations that can remain ongoing for several years, which impacts on the timeliness of the CDOP review.

6. A SUMMARY OF 2022/23 CASES CLOSED

6.1 AGE, GENDER & ETHNICITY

Of the 35 cases closed, 14 (40%) children were female and 21 (60%) male. 17 (49%) of the infants were neonatal deaths (<28 days). A further 8 (23%) deaths occurred before the first year of life (28-364 days), accounting for a total of 25 (72%) cases closed. Of the 25 infant deaths (0-364 days), 13 (52%) had one or more modifiable factors identified in the review (see section 6.2).

Diagram 6: Manchester CDOP cases closed by gender and age at time of death (2022/23)



Age Group	No. Cases Closed[8]	
0-27 days	17	49%
28-364 days	8	23%
1-4 years	<5	3%
5-9 years	<5	0%
10-14 years	5	14%
15-17 years	<5	11%
Total	35	100%

Year on year, infants under the age of one account for the majority of cases with modifiable factors, with the most common factors occurring in the antenatal period such as maternal smoking in pregnancy.

Diagram 7: Manchester CDOP cases closed by ethnic grouping (2022/23)

Ethnicity	No. Cases Closed	
Asian or Asian British	11	31%
Black or Black British	10	29%
Mixed	<5	6%
Other ethnic group	<5	8%
White	9	26%
Total	35	100%

The largest number of cases closed were recorded in children who were Asian or Asian British (9, 31%) and Black or Black British (10, 29%). Breaking the data down further into specific ethnicities identifies the largest number of cases closed were children of Pakistani heritage (9, 25%) and children of African heritage (9, 26%). Comparing this data with 21/22, the largest number of deaths recorded was in children who were White (13, 45%) - children of English/Welsh/Scottish/Northern Irish/British heritage (10, 34%) and Asian or Asian British (9, 31%) - children from the Pakistani community (6, 21%).

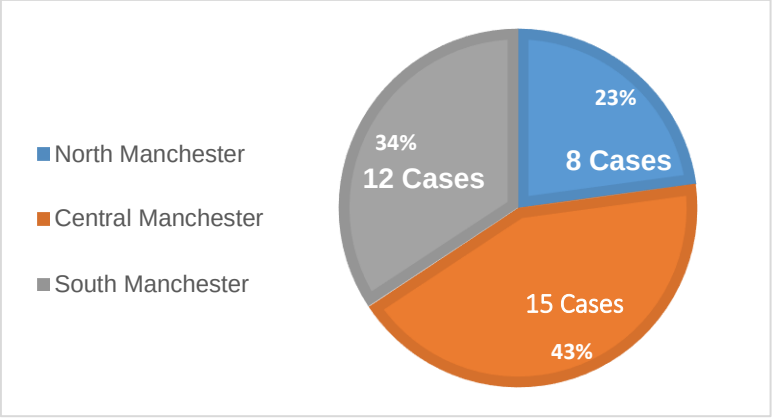
[8] Suppression of data to anonymise statistics: Personal data where the value is less than 5 has been removed (<5/1)

6.2 AREA OF RESIDENCE – DEPRIVATION AND POVERTY

The 2019 Index of Multiple Deprivation (IMD) ranked Manchester as 6 out of 326 local authorities in England (where 1 is the most deprived). 32.5 % of children (under 16 years of age) in Manchester are living in poverty (2020/21) which is higher than England (18.5%)[9]. The number of children (under 16 years of age) residing in relative low-income families have increased from 27.1%, 29,510 (2016) to 32.5%, 36,583 (2020/21). In 2021/22, the rate of households with dependent children owed a duty under the Homelessness Reduction Act in Manchester (34.7 per 1,000 households with at least one dependent child) is more than double the rate for England as a whole (14.4 per 1,000).

Within GM, Manchester has the highest proportion of residents (43%) residing in the most deprived 10% of neighbours in England[10]. Across GM, 6 of the 10 local authorities have a higher proportion of their population living in the most deprived areas of the country in comparison to the North-West average, with Manchester being the most deprived local authority. All GM local authorities but Trafford have deprivation scores above the national average. This emphasises that deprivation remains a significant public health concern and demonstrates a significant correlation between poverty and child death.

Diagram 8: Area of residence for closed cases by the Manchester CDOP (2022/23)



Of the 35 cases closed, the majority of children resided in areas of deprivation with 28 (80%) of families residing in quintile 1 (most deprived). A total of 15 (43%) of the children resided in Central Manchester[11]. Breaking the data down into neighbourhoods identifies Whalley Range having the largest number of deaths, accounting for 5 (14%) of the cases closed. Year on year, there continues to be a strong correlation with the higher rate of deaths in areas of deprivation where the Lower Layer Super Output Area (LSOA) are deemed most deprived.

A **position statement report** from the Royal College of Paediatrics and Child Health (*dated 21 Sep 2022*) focuses on poverty as a driver of health inequalities[12]. The report states:

The drivers of health inequalities are the social, economic, and environmental factors in which individuals live that have an impact on their health outcomes. This includes

[9] https://fingertips.phe.org.uk/profile/child-health-profiles
[10] https://secure.manchester.gov.uk/downloads/download/414/research_and_intelligence_population_publications_deprivation
[11] https://www.manchesterlco.org/howwework
[12] https://www.rcpch.ac.uk/sites/default/files/generated-pdf/document/Child-health-inequalities-driven-by-child-poverty-in-the-UK--position-statement.pdf

ethnicity, income, housing, climate change and being looked after by local authorities…. The influence of poverty on children's health and wellbeing is undeniable. Children living in poverty are more likely to have poorer health outcomes including low birth weight, poor physical health, and mental health problems. The health impacts of growing up in poverty are significant and follow children across their life. The current cost of living crisis will only exacerbate this by pushing more families into poverty. It is essential that health inequalities driven by poverty are addressed to improve child health outcomes, as well as reduce costs to the NHS in the long term.

Listed below are some of the findings from position statement:

Child poverty in the UK

- One in four (27%) children live in poverty in the UK, defined as living in a household with an income less than 60% of the median household income.
- The main drivers for child poverty are insufficient income and high living costs associated with raising children. However, employment does not necessarily provide a solution out of poverty; 75% of children in poverty have at least one parent working in at least one job.
- Children in specific family types are at higher risk of poverty. For example, lone parent families, the majority of which are headed by women, and having someone with long-term illness in the household increases the risk due to barriers to employment.
- There are stark ethnic differences in the rates of child poverty, and poverty is higher among certain ethnic minority groups. In England, 46% are living in poverty compared to 26% of children from white British families.
- *No recourse to public funds (NRPF) is a condition applied to those staying in the UK with any form of temporary immigration status. This prohibits migrant families from accessing most benefits, such as Universal Credit and free school meals, placing migrant children at increased risk of destitution.*

Evidence of how poverty drives health inequalities in the UK:

Mortality in childhood

- The UK has high rates of infant and child mortality when compared with other developed countries.
- The index of multiple deprivation (IMD) is an overall measure of deprivation based on factors such as income, employment, health, education, crime, the living environment and access to housing within an area. Infants in the 10% most deprived areas are twice as likely to die in infancy as those in the 10% least deprived. For each increase in decile of deprivation, the relative risk of mortality increases by 10%.
- There is a clear association between the risk of death and the level of deprivation for children who died in England between April 2019 and March 2020. Over a fifth of the 3,200 child deaths in the period examined might have been avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived.

Acute and long-term illness

- Children living in poverty are significantly more likely to suffer from acute and long-term illness. They are significantly more likely to require hospital admission and were 72% more likely than other children to be diagnosed with a long-term illness.

- Rates of obesity and severe obesity in children living in the most income deprived areas entering Reception and Year 6 are rising, while the rates are decreasing in the least income deprived areas in England.
- Children living in the poorest 20% of households in the UK are four times more likely to develop a mental disorder as those from the wealthiest 20%.

Indoor and outdoor air quality

- Air pollution exposure is highest in the most income deprived areas, and children are disproportionally exposed to the highest levels of pollution.
- Children in more income deprived families are three times more likely to be exposed to second-hand smoke.
- Children in income deprived areas are more likely to live in housing with poor ventilation and other features of substandard housing. Families in poverty may ventilate their house less because of problems such as fuel poverty.

How poverty affects child health outcomes

Paediatricians have told us how poverty has affected their patients, including the following:

- Parents in poverty are less able to afford healthy foods and offer their children a healthy lifestyle.
- Recent increases in household energy costs comes on top of food insecurity, which may mean families face a choice between paying energy bills and food. Living in a cold home has a negative impact on physical health by, for example, exacerbating respiratory illnesses.
- Low-income families may be unable to afford basic hygiene products due to financial constraints.
- Adverse childhood experiences, which are usually multiple, have a cumulative negative effect on physical and mental health in later life and are three times more common in the context of poverty than in affluence.
- Children in low-income families have less access to the medical care they need.
- Low-income families may also be experiencing digital exclusion, where households may not have a smartphone or internet access and are unable to benefit from digital health technologies as a result.

This position statement, alongside other articles such as ***What is the relationship between deprivation, modifiable factors and childhood deaths***[13] highlights that there is a clear gradient of increasing child mortality across England as measures of deprivation increase; with a striking finding that this varied little by area, age or another demographic factor. Over one-fifth of all child deaths may be avoided if the most deprived half of the population had the same mortality as the least deprived. Children dying in more deprived areas may have a greater proportion of avoidable deaths. Adult employment, and improvements to housing, may be the most efficient place to target resources to reduce these inequalities.

[13] What is the relationship between deprivation, modifiable factors and childhood deaths: a cohort study using the English National Child MortalityDatabase | BMJ Open

6.3 RELEVANT FACTORS & MODIFIABLE FACTORS

Information is collated using the Department of Health and Social Care (DHSC) national CDOP reporting forms[14]. Completed forms are presented during the CDOP meeting to assess the death. As part of the child death review process, the CDOP is responsible for analysing information to determine the categorisation of death (see appendix 2), relevant factors and modifiable factors.

Information is collated and categorised using the four domains:

Domain A: Factors intrinsic to the child:

Factors in the child (and in neonatal deaths, in the pregnancy) relating to the child's age, gender and ethnicity; any pre-existing medical conditions, developmental or behavioural issues or disability, and for neonatal deaths, the mother's health and wellbeing.

Domain B: Factors in social environment including family and parenting capacity:

Factors in family structure and functioning and any wider family health issues; provision of basic care (safety, emotional warmth; stimulation; guidance and boundaries; stability); engagement with health services (including antenatal care where relevant); employment and income; social integration and support; nursery/preschool or school environment.

Domain C: Factors in the physical environment:

Factors relating to the physical environment the child was in at the time of the event leading to death, and for neonatal deaths, the mother's environment during pregnancy including poor quality housing; overcrowding; environmental conditions; home or neighbourhood safety; as well as known hazards contributing to common childhood injuries (e.g. burns, falls, road traffic collisions)

Domain D: Factors in Service Provision:

Factors in relation to service provision or uptake including any issues relating to identification of illness, assessment, investigations and diagnosis; treatment or healthcare management; communication or teamwork within or between agencies; and organisational or systemic issues. Consider underlying staff factors, task factors, equipment, and work environment, education and training, and team factors.

For each of the four domains, the Manchester CDOP determines the level of relevance (0-2) for each factor, relating to the registered cause of death and to inform learning of lessons at a local, regional, and national level. The categories are:

0 Information not available

[14] https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths

1 No factors identified, or factors identified but are unlikely to have contributed to the death

2 Factors identified that may have contributed to vulnerability, ill health, or death

As part of the review, the CDOP is responsible for identifying modifiable factors, although categorising a death as having modifiable factors does not necessarily mean the CDOP regards the death in question as preventable, but that there may be emerging trends which could reduce the risk of future child deaths:

Modifiable factors identified: The review has identified one or more factors across any domain which may have contributed to the death of the child, and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths

No modifiable factors identified: The review did not identify any modifiable factors

Inadequate information upon which to make a judgement: The review was unable to identify if any modifiable factors were present.

Diagram 9: Categorisation of death for cases closed by the Manchester CDOP (2022/23)

Categorisation of Death	No. Cases Closed	
Deliberately inflicted injury, abuse or neglect	<5	5%
Suicide or deliberate self-inflicted harm	<5	6%
Trauma and other external factors, including medical/surgical complications/error	<5	0%
Malignancy	<5	3%
Acute medical or surgical condition	<5	8%
Chronic medical condition	<5	3%
Chromosomal, genetic and congenital anomalies	8	23%
Perinatal/neonatal event	15	43%
Infection	<5	6%
Sudden unexpected, unexplained death	<5	6%
Total	35	100%

Although the number of cases closed (35) is small, the largest number of deaths were categorised as chromosomal, genetic and congenital anomalies (8, 23%) and perinatal/neonatal event (15, 43%) reflecting a pattern experienced in previous years.

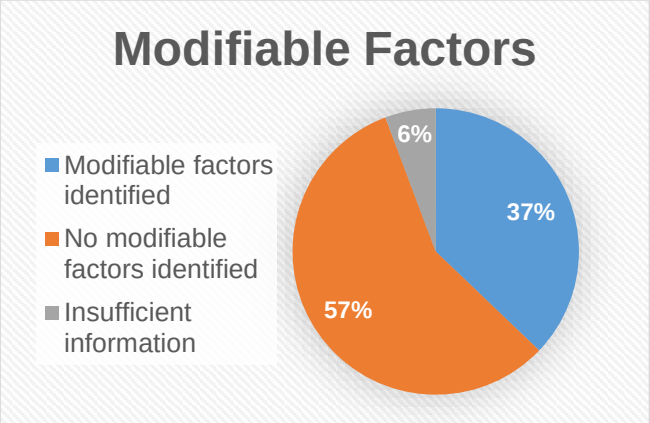
The majority of child deaths are due to medical causes which encompass multiple categories of death including acute medical or surgical, chronic medical, chromosomal, perinatal/neonatal event, malignancy and infection. Small numbers

were attributable to non-medical causes including trauma, deliberate harm/abuse/neglect, suicide/self-harm, and sudden unexpected/unexplained death.

Modifiable Factors	No. Cases Closed	
Modifiable factors	13	37%
No modifiable factors	20	57%
Insufficient information	2	6%
Total	35	100%

The Manchester CDOP identified one or more modifiable factors in 11 (41%) cases which is higher than the England average of 34% (as recorded by the NCMD). The highest number of modifiable factors were recorded in deaths categorised as a perinatal/neonatal event (<5).

Diagram 10: Modifiable factors identified in cases closed by the Manchester CDOP (2022/23)



Year on year, deaths categorised as a perinatal/neonatal event continue to have the largest number of modifiable factors identified in the review. Modifiable factors in perinatal/neonatal deaths mostly relate to antenatal maternal health and wellbeing, which can lead to poor outcomes for both mother and infant such as maternal smoking in pregnancy and maternal obesity in pregnancy. Factors also include engagement with health services in accessing antenatal care, social and environmental conditions during pregnancy.

The Manchester CDOP identified modifiable factors in 13 (37%) of the 35 deaths. These are factors where local or nationally achievable intervention could be modified to potentially reduce the risk of future child deaths. Of the 13 deaths with modifiable factors, 10 (29%) children died before the age of 1, 7 (20%) of which were during the neonatal period.

Some deaths feature multiple modifiable factors which vary depending on the circumstances leading to death and the cause of death ascertained. For example, deaths categorised as a perinatal/neonatal event, may exhibit more than one modifiable factor such as maternal smoking in pregnancy, maternal obesity in

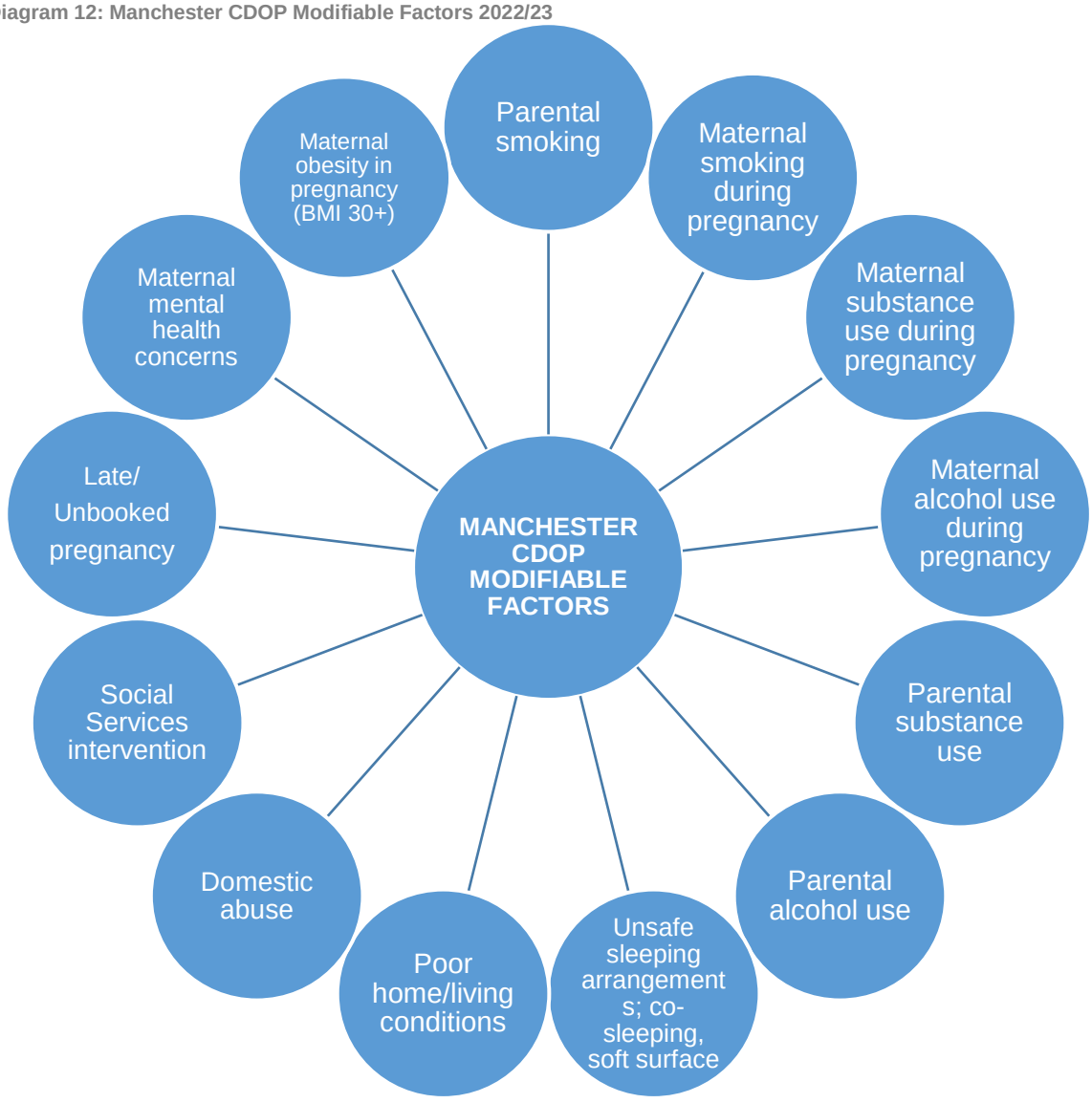
pregnancy and lack of antenatal care service uptake. Modifiable factors act as multiplier effect, increasing the child's vulnerability where multiple factors are present.

Diagram 11: Modifiable factors identified in cases closed by the Manchester CDOP and the CDOPs in the Northwest region (2020/23)

Year of Review	2020-2021			2021-2022			2022-2023		
CDOP	Number of reviews	Modifiable factors identified	%	Number of reviews	Modifiable factors identified	%	Number of reviews	Modifiable factors identified	%
Manchester	29	9	31	27	11	41	35	13	37
Northwest	318	136	43	341	138	40	415	213	51

Though attempts have been made to standardise the process of identifying and categorising modifiable factors, it is often a subjective matter which is decided on a case-by-case basis. The GM CDOPs continue to conduct reviews in line with an agreed GM set standard of modifiable factors, as developed by the GM CDOP Network. The standard ensures consistency across the four GM CDOPs when undertaking reviews and identifying modifiable factors.

Diagram 12: Manchester CDOP Modifiable Factors 2022/23



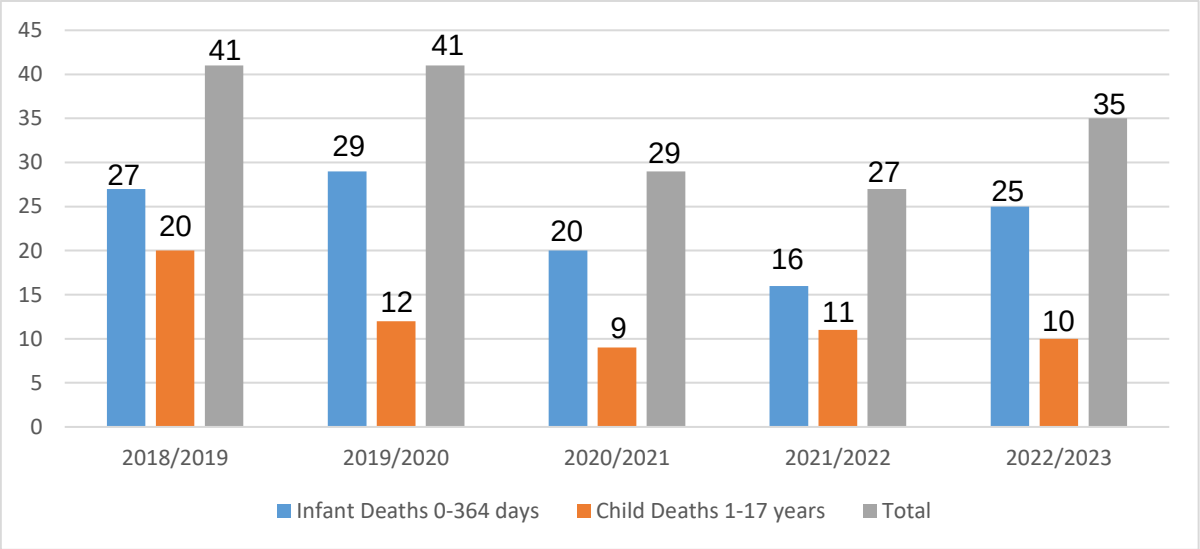
Across all categories of death, maternal obesity (where mother has a raised body mass index (BMI) of 30+ during pregnancy) has been identified as the most common modifiable factor identified by the Manchester CDOP. The second most common modifiable factor is smoking with maternal smoking in pregnancy and household smoking a factor in deaths categorised as a perinatal/neonatal event and sudden unexpected, unexplained death. This is followed by maternal alcohol and/or substance use during pregnancy. Multiple modifiable factors were also identified (antenatally and postnatally) in sudden unexpected, unexplained deaths, the most common being unsafe sleeping arrangements including parental alcohol and/or substance use.

Though the numbers involved are relatively small, it emphasises that factors relating to maternal obesity and smoking remain key modifiable factors for infant and child deaths. Despite ongoing efforts to reduce the rate of smoking, this continues to influence in the death of children and remains a steady modifiable factor. Further, the link between smoking and obesity strongly correlates with deprivation, meaning they represent a significant health inequality.

6.4 INFANT DEATHS (0-364 DAYS OF LIFE)

17 (49%) of the 35 cases closed occurred in the neonatal period (<28 days of life) whilst a further 8 (23%) infants died before the age of one (28-364 days of life). This total (25, 72%) remains to be a year-on-year trend highlighting infants under the age of one as the most vulnerable age group.

Diagram 13: Manchester CDOP cases closed by age at time of death (2018/23)



Of the 15 deaths categorised as a perinatal/neonatal event, 14 infants were delivered prematurely, with prematurity featuring as the registered cause of death. Many infant deaths were anticipated due to the death ultimately being related to perinatal/neonatal events and chromosomal, genetic, and congenital anomalies. This reflects those deaths in the first year of life are often due to the complications of prematurity or from underlying health conditions.

Babies are considered viable at around 24 weeks' gestation, meaning it's possible for them to survive at this stage. Infants delivered under 24 weeks' gestation, have a

significantly reduced chance of survival. The World Health Organization (WHO)[15] defines preterm birth as babies born alive before 37 weeks of pregnancy are completed, with sub-categories of preterm birth based on gestational age:

- extremely preterm (less than 28 weeks)
- very preterm (28 to 32 weeks)
- moderate to late preterm (32 to 37 weeks)

14 (56%) of the 25 infant deaths involved the babies being delivered preterm (<37 weeks). Babies born before full term (<37 weeks) are vulnerable to health problems associated with prematurity. The earlier in the pregnancy a baby is born, the more vulnerable they are. Preterm birth occurs for a variety of reasons. Most preterm births happen spontaneously, but some are due to early induction of labour or caesarean birth, whether for medical or non-medical reasons. Common causes of preterm birth include multiple pregnancies, infections, and chronic conditions such as diabetes, high blood pressure and genetic influence.

Around 8 out of 100 babies are born prematurely[16]. Using the WHO preterm birth sub-categorises highlights that 7 of the preterm infants were born extremely preterm (<28 weeks). Twins and triplets are often born prematurely with an average delivery date for twins at 37 weeks and 33 weeks' gestation for triplets. There were a number of infant deaths (<5) recorded as a twin pregnancy some of which also resulted in a late foetal loss (<24 weeks' gestation) or stillbirth (>24 weeks) although, in line with Child Death Review: Statutory and Operational Guidance (England), stillbirths and late foetal loss are not subject to CDOP reviews.

Low birth weight is defined by the WHO[17] as weight at birth less than 2500 g (5.5 lb). Low birth weight continues to be a significant health problem and is associated with a range of both short- and long-term consequences. Low birth weight is complex and includes preterm neonates, small for gestational age neonates at term and the overlap between these two situations. Typically, both preterm and small for gestational age neonates, have the worst outcomes.

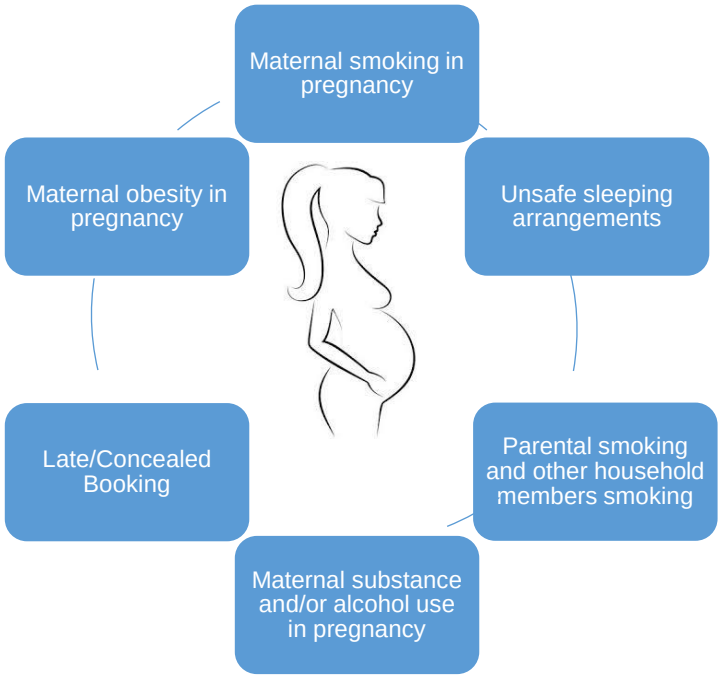
The Royal College of Obstetricians and Gynaecologists[18] defines small for gestational age to an infant born with a birth weight less than the 10th centile[19]. Historically small for gestational age at birth has been defined using population centiles. The use of centiles is customised for maternal characteristics (maternal height, weight, parity, and ethnic group) as well as gestational age at delivery and infant sex, identifies small babies at higher risk of morbidity and mortality than those identified by population centiles. Of the 20 infant deaths, 18 (90%) had a birth weight of less than 2500 grams, 16 of which were preterm deliveries (<37 weeks' gestation).

Whilst prematurity impacts the infant's birth weight, low birth weight is also influenced by maternal lifestyle such as smoking and wider maternal health including pre-eclampsia. When reviewing infant deaths, the Manchester CDOP identifies modifiable factors and relevant factors during pregnancy that increase the risk to both mother and baby. These factors may also contribute to an early onset of labour, leading to poorer

[15] https://www.who.int/news-room/fact-sheets/detail/preterm-birth
[16] www.nhs.uk/conditions/pregnancy-and-baby/premature-early-labour
[17] www.who.int/nutrition/publications/globaltargets2025_policybrief_lbw/en/
[18] www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf
[19] www.rcpch.ac.uk/resources/uk-who-growth-charts-neonatal-infant-close-monitoring-nicm

outcomes. All the associated factors act as a multiplier effect increasing the risk of prematurity, or that the infant may not be born in the best possible condition.

Diagram 14: Modifiable factors and/or relevant factors identified in infant death cases closed by the Manchester CDOP (2022/23)



7. LOCAL ACTIONS TO REDUCE CHILD DEATHS

7.1 MATERNAL OBESITY IN PREGNANCY

Maternal Obesity and infant mortality

Infants born to women who begin pregnancy obese have a higher risk of premature death than children born to mothers at a healthy weight. Children who are obese at reception age are more likely to become overweight or obese adults and have shorter life expectancy.

A modifiable and relevant factor highlighted by the Manchester CDOP is mother's raised body mass index (BMI) during pregnancy. Significant activity has been undertaken by Population Health to reduce obesity across the city following the launch of the five-year Healthy Weight Strategy[3] in 2021 The strategy advocates a population-wide, all-age, whole system approach which begins with pregnant women and babies. The strategy advocates equipping health professionals with the resources to begin sensitive conversations about weight in pregnancy, increasing breastfeeding and making healthy choices in weaning with infants.

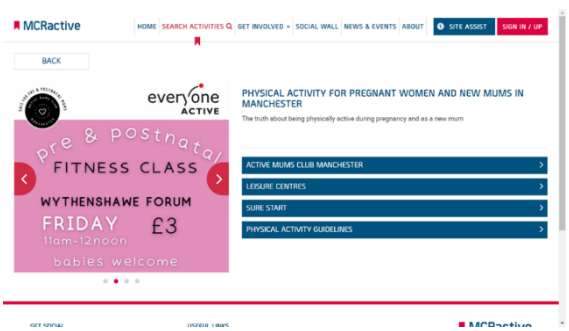
Physical activity and maternity

Earlier last year, a gap was identified in the physical activity provision available to pregnant women. A multi-agency group was established which endeavoured to map out current physical activity provisions across the city, and to engage with pregnant women and new mums to identify the barriers to accessing physical activity. A survey of 237 pregnant women / new mums highlighted only 17% of women were aware of the current physical activity guidance during pregnancy and as a new mum, and the barriers to accessing activities included time, cost, a lack of energy and difficulty finding suitable activities.

As a result, a 12-month pilot project is currently underway at three leisure centre locations across the city (North City, Moss Side and Wythenshawe Forum) where aqua natal and exercise classes are available for pregnant women and new mums to attend and are capped at £3 per visit.

An educational video has also been developed 'the truth about being physically active during pregnancy and as a new mum', that demonstrates different activities women can undertake when pregnant and with their baby to help them achieve 150 minutes of moderate activity a week.

A new landing page on the MCRactive website has also been created for pregnant and new mums to access resources and information to encourage them to be more physically active:



Further information about the different activities available for pregnant women and new mums is available at www.mcractive.com/activity/physical-activity-for-pregnant-women-and-new-mums-in-manchester

In 2023, Manchester launched the Manchester *Food Active! Healthy Weight Declaration.* This is a city-wide pledge signed by City-Leaders to emphasize and give leverage to our commitment to enabling residents to live healthy, physically active lives, and reduce obesity.

Healthy Weight Nurse Team & obesity safeguarding.

Manchester Department of Public Health commission a Healthy Weight Nurse Team. The team takes referrals of children aged 0-19 years, particularly under 5 years who are at the 96th centile (BMI) or above. The team puts the needs of children and families first, providing innovative, evidence-based intervention, and its work is now part of Manchester's Healthy Weight Strategy 2020–25. The team won the national *Nursing Times 'Public Health Nursing Team of the Year Award'* in December 2021.

The Healthy Weight Nurse Team manage the Childhood Obesity Safeguarding Pathway, which was established in response to rising levels of severe obesity and a Serious Case Review where a 13-year-old child (Child F1) died from a heart condition exacerbated by morbid obesity.

Manchester's Director of Public Health presented to the Coroners Court in January 2022 to demonstrate the measures Manchester had put in place and the work undertaken by numerous partners following the Serious Case Review to reduce childhood obesity.

Delivering on the healthy weight outcomes in maternity services and early years is a key outcome for the City's Start Well Board. Manchester City Council was one of only two authorities nationally to participate in a Public Health England pilot project in 2019/20, in which a maternal obesity resource was created for the benefit of Midwives and Health Visitors. After pandemic disruption, this resource has since been made available to a variety of health professional teams and partners across the city.

Healthy Weight Strategy

A dedicated Council Officer role in Public Health has been created to facilitate delivery of the Healthy Weight Strategy and increased access to commissioned services at a neighbourhood level, including partnership working between midwifery and weight

management services. A social prescribing service for pregnant women who have a BMI of 25 and over, offers a voucher to access a free local weight loss group, available through self-referral to Be Well FREE Slimming World vouchers - The Big Life group. A specialist service is also available for pregnant woman with a BMI of 35 or above, to encourage lifelong change by supporting pregnant women achieving a healthier lifestyle through education and personalised goal setting. Both programmes offer advice and support on nutrition, lifestyle, and behaviour change to enable women to be healthy throughout their pregnancy and beyond. Both services provide advice on nutrition in relation to breastfeeding and complementary feeding. Midwives can refer pregnant women into the tier three service from 12 weeks gestation which includes psychological therapy and, where appropriate, pharmacotherapy.

For most adults, an ideal BMI is in the 18.5 to 24.9 range (healthy weight range). The NHS defines the BMI categories[1] as:

- below 18.5 - underweight
- between 18.5 and 24.9 - healthy weight range
- between 25 and 29.9 - overweight range
- between 30 and 39.9 - obese weight range
- 40 and over - severely obese weight range

Being overweight increases the risk of complications for pregnant women and baby[2]. The higher a woman's BMI, the higher the chance of complications. Problems for baby can include being born prematurely and an increased risk of stillbirth (from an overall risk of 1 in 200 in the UK to 1 in 100 if mother has a BMI of 30 or more).

The increasing chances are in relation to:

- miscarriage - the overall chance of miscarriage under 12 weeks is 1 in 5 (20%); for women with a BMI over 30, the chance is 1 in 4 (25%)
- gestational diabetes - women with a BMI of 30 or above, are 3 times more likely to develop gestational diabetes than women who have a BMI below 25
- high blood pressure and pre-eclampsia - women with a BMI of 30 or above at the beginning of their pregnancy, have a chance of pre-eclampsia which is 2 to 4 times higher than that of women who have a BMI below 25
- blood clots - all pregnant women have a higher chance of blood clots compared to women who are not pregnant, for women with a BMI of 25 or above, the chance is increased further
- the baby's shoulder becoming "stuck" during labour (sometimes called shoulder dystocia)
- heavier bleeding than normal after the birth (post-partum haemorrhage)
- having a baby weighing more than 4kg (8lb 14oz) - the overall chance of this for women with a BMI of 20 to 30 is 7 in 100 (7%); for women with a BMI of above 30, the chance is doubled to 14 in 100 (14%)
- women are also more likely to need an instrumental delivery (forceps or ventouse), or an emergency caesarean section

Deaths categorised as a perinatal/neonatal event, where mothers BMI in pregnancy is recorded as underweight (BMI <18.5) or obese (BMI 30+), are deemed a modifiable factor by the Manchester CDOP. Obesity in the general population has increased, with

factors such as Covid lockdown and cost of living being a contributor. Maternal obesity in pregnancy continues to be a relevant factor and features as a modifiable factor for Manchester, and across GM, in deaths categorised as a perinatal/neonatal event.

Healthy Start Vitamins

The NHS Healthy Start Scheme aims to improve health and access to a healthy diet for families on low incomes across the UK. In addition to providing healthy food and milk, the scheme also includes Healthy Start vitamins. To support pregnant women and new mums access the Healthy Start Vitamin Scheme, Manchester Public Health provide free vitamins to a range of outlets in Manchester so that they can be given out free to women and children who reach the clinical criteria. Unlike the national scheme, there is a universal offer of Healthy Start vitamins in Manchester, so recipients do not have to be in receipt of benefits or have a low income.
The vitamins are free for pregnant women (from 10th week of pregnancy), new mums with a baby up to one year old, babies from birth, and children up to their 4th birthday. The women's vitamin tablets contain vitamins C and D, and folic acid. The children's vitamin drops contain vitamins A, C, and D. In Manchester Healthy Start vitamins are supplied by children's centres, health visitors, community midwives, and selected pharmacies. A full list of places which can supply women and families with Healthy Start vitamins is on Manchester City Council's website at:

https://hsm.manchester.gov.uk/kb5/manchester/directory/service.page?id=Qdk7i1o5uIE&directorychannel=0

7.2 SMOKING

Smoking affects mothers, the developing foetus and child health; doubling the chances of still birth and increasing the risk of sudden infant death threefold. (NHS)

Smoking continues to have a negative impact on the general health of children and remains a key modifiable factor for child deaths in Manchester. Depending on the nature of the death, the CDOP collates information regarding the smoking status of the child and during the antenatal period, maternal smoking in pregnancy and household members smoking, in order to monitor women who are exposed to harmful effects of Environmental Tobacco Smoke (ETS) during pregnancy.

Smoking in pregnancy has well recognised detrimental effects for the growth and development of the baby as well as the health of the mother. Smoking during pregnancy can cause serious pregnancy related health problems including complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy (SUDI). Maternal smoking in pregnancy or household smoking (in the main home or even in homes that a baby may stay in or visit) was the most common occurring modifiable risk factor which the Manchester CDOP deemed a “significant relevant factor” in relation to the child’s cause of death. Having a smoke free pregnancy and smoke free homes and cars is the best way of protecting babies and children. Children should not be exposed to tobacco smoke under any circumstances.

The National Tobacco Control Plan [1] includes an ambition to reduce smoking in pregnancy to 6% by the end of 2022, which is measured as Smoking At The Time of Delivery (SATOD). However, in Greater Manchester, there is an ambition to reduce

SATOD to 4%. The government has set an overarching target to reduce adult smoking prevalence nationally to under 5% by 2030.

Smoking in pregnancy and the number of babies and children living in smoke filled homes correlates with adult smoking prevalence in Manchester, which we know, correlates with socio economic disadvantage. Therefore, in some areas of the city, relatively high percentages of households contain a smoker. Adult smoking prevalence in Manchester averages at 16.8% (95% CI 13.1%-20.5%) and Manchester has the 4th highest smoking prevalence rate in Greater Manchester and the 14th highest in the list of Counties and Unitary Authorities in England. Whilst smoking prevalence is reducing, we do know that in some communities and people working in Routine and Manual Occupations, areas smoking prevalence will be much higher than 16.8% and that those communities may experience other risk factors which also impact on infant mortality potentially, such as poor housing. Making Manchester Fairer[20] is the over-arching strategy which describes how we will work to reduce socio-economic disadvantage in Manchester and as a consequence reduce smoking and smoking related health inequalities.

Making Manchester Fairer also describes how we will work to give children the best start in life, without being impacted by social and health inequality and having a smoke free pregnancy is one of the most important ways of doing this. SATOD in Manchester is 8.9%, which is slightly lower than the national average of 9.1%. However, this isn't low enough.

Manchester has been at the forefront of developing a Smoke Free Pregnancy Service since 2017, when the Public Health Team worked with Greater Manchester Partners to introduce an "in-house" maternity "stop smoking service" across Manchester hospitals. At that time, Manchester City Council part funded a Specialist Midwife and funded all Nicotine Replacement Therapy for pregnant women. In 2022-23 we saw the winding down of this offer because Smoking in Pregnancy will be delivered by NHS partners as part of the NHS Long Term Plan and NHS England Saving Babies' Lives initiative.[21]

Pregnancy and Other Forms of Tobacco Use

The Smoking in Pregnancy Service report that they see a significant number of women who also report using cannabis (which is mixed with tobacco to smoke), whilst pregnant, or being exposed to smoked cannabis. We know that the legal status of cannabis may well lead to under reporting of this issue too. Women who do disclose exposure to cannabis smoking are treated on the same pathway as general tobacco smokers and also referred to Drug and Alcohol Specialist Midwives.

Smoke Free Homes and Cars

Environmental Tobacco Smoke (commonly known as second hand smoke) is made up of the smoke that comes from a cigarette and the smoke that is breathed out by a smoker. All tobacco smoke contains toxins.

Carbon Monoxide breath tests provide an indication of whether a pregnant person smokes by measuring the concentration of Carbon Monoxide in exhaled breath. (Smokers have a higher concentration). However, people who are exposed to smoke

[20] https://www.manchester.gov.uk/makingmanchesterfairer
[21] https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/

in homes, or cars may also have high Carbon Monoxide levels, indicating elevated risk to an unborn baby.

Second hand smoke has more than 50 chemicals that are known to cause cancer and other diseases in adults. Because babies and young children are still growing, the chemicals in second-hand smoke harm them more than adults. Breathing second-hand smoke for even a short time can harm your baby's or child's body.

Therefore, an important part of the Manchester Tobacco Plan is promoting Smoke Free Homes and indoor spaces. During 2022-23 we have engaged in more discussions with partners about how we might progress a programme of partnership working to persuade more people not to smoke around children in their homes. It is acknowledged that more work is needed.

Less often mentioned is the importance of not smoking in cars around pregnant women or children. Smoke-free (Private Vehicles) Regulations were introduced in 2015. This requires all private vehicles to be smokefree when they are enclosed, contain more than one person and a person under 18 is present in the vehicle. Unfortunately, this regulation is not enforced in Manchester and awareness is low. In any future work around smoke free homes in Manchester, smoke free cars should feature too.

7.3 SUDDEN & UNEXPECTED DEATH IN INFANCY/CHILDHOOD (SUDI/SUDC)

Deaths categorised as a sudden unexpected, unexplained death where the pathological cause of death was recorded as either 'sudden infant death syndrome (SIDS)' or remains 'unascertained', continue to feature multiple modifiable factors relating to forms of unsafe sleeping arrangements. Unsafe sleeping arrangements such as co-sleeping, are particularly dangerous if the parent/carer has consumed alcohol or ingested substances, which may limit their awareness. Other known risk factors include co-sleeping with babies born prematurely or those with a low birth weight, overheating, covering baby's face or head while sleeping, loose bedding and falling asleep with baby on a sofa or in an armchair.

In deaths categorised as sudden unexpected, unexplained death, the Manchester CDOP highlighted several modifiable factors identified including:

- Maternal alcohol use in pregnancy
- Maternal substance use in pregnancy
- Maternal smoking in pregnancy
- Parental smoking and/or other household smokers
- Unsafe sleeping arrangements
- Co-sleeping
- Baby placed to sleep on a soft surface (parental bed)
- Parental alcohol use
- Parental substance use

The Manchester CDOP also highlighted several relevant factors (relevance 2) which may have contributed to the vulnerability, ill-health or death of the infant such as parental mental health issues, housing conditions, domestic abuse, poor parenting/supervision, and child abuse/neglect. It should be noted that factors (in the antenatal and/or postnatal period) act as multiplier effect, where there is more than one present this increases the vulnerability of the child.

The Manchester CDOP continues to raise awareness of safer sleep messages via quarterly newsletters[22] to embed safer sleep advice into multi-agency practice. The Manchester CDOP promotes consistent safe sleep advice, published by the Manchester Local Care Organisation Safer Sleeping Practice for Infants[23].

The Manchester Reducing Infant Mortality Strategy Steering (RIMS) Group works to the objectives of the Manchester Reducing Infant Mortality Strategy 2019 -2024. The strategy is sectioned into five themes, twenty-four objectives and sixty eight individual eight workstreams.

Themes:

- Quality, safety and access to services
- Maternal and Infant Wellbeing
- Addressing the Wider Determinants of Health
- Safeguarding and Keeping Children Safe from Harm
- Providing support for those bereaved and affected by baby loss

The work described by the strategy is very varied. Some is about clinical care and some is about the wider determinants of health, which is why Infant Mortality correlates with socio-economic disadvantage and why, perhaps, the infant mortality rate in Manchester rose from 6.4 per 1000 in 2015-17 to 6.7 per 1000 in 2019-21. This is higher than the England average of 3.9 per 1000.

It is clear that many of the causes of infant mortality are modifiable and relate directly to the lifestyle or living conditions of the mother, baby and its family, such as smoking in pregnancy, babies living in smoke filled homes, parents living in inadequate housing leading to co-sleeping etc, as detailed above. Therefore, the response which is needed is a whole system and multi-agency approach. It can neither be solely clinical or solely social.

As we started to emerge from the pandemic, the RIMS steering group continued to meet quarterly.

Some of our priority work continued, such as Safe Sleeping and Smoking in Pregnancy work. However, new workstreams emerged, not least a collaboration between NHS commissioners, Manchester City Council and Manchester University NHS Foundation Trust to deliver COVID-19 vaccinations “in house” in a maternity

[22] https://www.manchestersafeguardingpartnership.co.uk/resource/cdop/
[23] https://www.manchestersafeguardingpartnership.co.uk/resource/safe-sleeping/

setting as part of routine maternity care. This is an approach which worked well for Smoking in Pregnancy Services probably because it reduces the number of services and places that a pregnant person has to engage with and midwifes and their teams are trusted professionals.

Nationally, Measles rates are increasing, and Measles can be fatal. Children aged under 12 months old are at particular risk. Measles can be prevented by the Measles, Mumps and Rubella (MMR) vaccination in the first year of life with a second dose by the age of 5. Very worryingly, the percentage of children who have received two doses of the MMR vaccine at 5 years old have fallen quite rapidly since 2018 and are now 77.3% in 2021-22 compared to an England rate of 85.7% in the same year. Both figures are concerning because vaccination rates of 95% are required to give “herd immunity” i.e. a level of protection from contagion at a population level. Manchester now has a locality plan for prevention and containment of Measles, as part of a Greater Manchester Protect and Contain plan.

In autumn 2022, the RIMS group became concerned about the cost-of-living crisis and particularly around the cost of energy. The specific concern was that if parents and carers of babies could not afford to heat their homes, they might wrap babies up to keep them warm and in doing so, inadvertently cause babies to overheat, which is a risk to life. A small, multi-agency group developed a local communications campaign of posters, social media messages and a film made by one of our own Health Visiting Team.

During 2022-23 the RIMS steering group began a piece of work around Genetic Literacy in conjunction with the Local Maternity and Neonatal Service, specifically aimed at the Pakistani population in Manchester. This work began after Manchester was identified as one of eight priority areas by NHSE. The Umeed Project, working alongside a Specialist Midwife aims to promote a healthy pregnancy for Pakistani women, whilst also educating, empowering and improving access for women, couples and families to Genetic Services in Manchester.

Our programme continues to develop, and priorities are to focus on a review of progress post pandemic, focus on more Smoke Free Homes promotion and developing an insightful and meaningful approach to maternal and infant health in communities experiencing racial inequalities in Manchester.

7.4 GREATER MANCHESTER RAPID RESPONSE (JOINT AGENCY RESPONSE)

The Greater Manchester Rapid Response Team was established in January 2009, to provide a rapid assessment of each sudden and unexpected death of an infant or child. The team is made up of Senior Paediatricians who provide a 24/7 on-call service across GM, working in close collaboration with partner agencies such as Greater Manchester Police (GMP), the GM Coroners, Health, and Children's Social Care.

Following changes to the national guidance, the service falls under the remit of a CDRM and is now known as a Joint Agency Response (JAR). Revisions to the national guidance meant that it was no longer a statutory requirement to investigate all sudden and unexpected deaths with a 'Rapid Response' Team. Instead, a JAR should occur in a more limited number of circumstances. The new guidance was discussed with the commissioners for the GM Rapid Response Service who requested that the on-call team continue to respond at the point of a child's death. It was agreed that there should not be a narrowing of the inclusion criteria for such a response, and that the on-call team continue to respond to all deaths that were not anticipated as a significant possibility 24 hours prior to the death, or when the collapse that precipitated death was similarly unexpected (as defined in the Working Together to Safeguard Children 2008). The decision to see the same cohort of children was strongly approved by the Steering Group, the GM CDOP Chairs, and the local Coroners.

An ongoing challenge to the service has been maintaining the on-call rota, as doctors have moved on to new posts or retired. There continues to be a national shortage of Paediatricians, and this has been reflected in difficulties recruiting into vacant posts. Despite the challenges, increased used of virtual meetings has had a very positive impact on attendance at both initial meetings and CDRMs.

Deaths subject to the JAR process usually remain open to the CDOP for a longer period due to pending coronial investigations. Until the Coroner has ascertained a cause of death, the CDOP is unable to confirm if the death was in fact a sudden and unexpected death in infancy (SUDI)/childhood (SUDC). Where the pathological cause of death is recorded as 'sudden infant death syndrome' or 'unascertained', at any age, these deaths are categorised by the Manchester CDOP as a sudden unexpected, unexplained death (excluding sudden unexpected death in epilepsy).

The GM JAR Lead continues to be an integral part of the Manchester CDOP, attending panel meetings to interpret medical terminology and supporting the implementation of the Child Death Review: Statutory and Operational Guidance (England).

7.5 CHROMOSOMAL, GENETIC & CONGENITAL ANOMALIES

Of the 35 cases closed, 8 deaths were categorised as chromosomal, genetic and congenital anomalies, majority of which were infant deaths (0-364 days of life) and 5 cases recorded Asian/Asian British. The Manchester CDOP continues to determine the relevance of consanguinity in deaths categorised as chromosomal, genetic and congenital anomalies. Consanguinity refers to a relationship in which a couple are blood relatives, for example first cousins, second cousins etc. Consanguinity increases the risk of genetic disorders known as autosomal recessive disorders. Parents who are both unaffected healthy carriers of a genetic disorder present a 1 in 4 (25%) chance that the child could be affected and a 50% chance that the child could be a healthy carrier with no sign of the disorder but could pass the unusual gene on to the

next generation. Unrelated parents have a 2% risk of having a child with a severe abnormality, whilst parents who are first cousins have a 5% risk and second cousins have a 3% risk. However, couples that are more closely related, such as a family with a history of cousin marriages going back generations, will have a higher risk of having a child with autosomal recessive disorders. The data evidenced the association of consanguineous relationships and an increased risk of autosomal recessive disorders, in correlation with Manchester's infant mortality rate, with Longsight being the most common ward of residence.

The Manchester University NHS Foundation Trust (MFT) provides one of the largest and most comprehensive multi-disciplinary clinical genetics units in UK and Europe providing integrated clinical and laboratory genetics services[24]. The aim of the regional genetic service is to provide a diagnostic, counselling and support service to individuals and their families with a genetic disorder affecting any body system at any age.

Practitioners can make referrals to the service for several reasons including:

- organisation of specialist prenatal diagnosis for a known familial genetic disorder
- diagnosis and counselling on diagnosis of foetal abnormality either on genetic testing or ultrasound
- investigation and diagnosis of congenital abnormality
- investigation and diagnosis of abnormalities of growth or development in childhood
- diagnosis of a metabolic disorder
- diagnosis if a possible genetic disease, including eye, renal, cardiac and neurological disorders with known or possible genetic basis
- strong family history of cancer
- concern regarding personal or family history of a genetic disease
- access testing of family members for carrier status for single gene (mendelian disorders) including presymptomatic or predictive gene testing when indicated.

The specialist genetic service which is an integrated clinical and laboratory genetics service, aims to provide diagnostic, counselling and support to families with a genetic disorder. The service also offers management, support and appropriate information for genetic conditions and offers pre-symptomatic diagnosis.

The Manchester CDOP works with the Specialist Geneticist to request information to review factors in relation to service provision. The Manchester CDOP reviews whether a referral to the genetic service was made and if the family engaged, to access additional support and counselling. There are health requirements regarding awareness raising amongst both practitioners and the community about the associated health factors and services available that can provide advice and support.

One of the key objectives of the Manchester Reducing Infant Mortality Strategy 2019-2024 included genetic literacy for individuals and communities, ensuring clear pathways and referral processes were in place to signpost families to genetic counselling support.

[24] https://www.mangen.co.uk/

Manchester's Department of Public Health will establish the Umeed* programme (volunteer peer support programme). Volunteers (Apis'*) will provide healthy pregnancy advice to Pakistani women at the early stages of their pregnancy (5-8 weeks) up to 28 days after delivery, with the aim to promote a healthy pregnancy and improve outcomes for women at increased risk of having a child with a genetic disorder. This project will be launched in Sept 2023 focusing on Cheetham Hill and Longsight wards.

**'Umeed' is an urdu word meaning Hope.*

**Api is an Urdu word to describe 'big sister'*

The Health Visiting Teams deliver a universal screening service which is key in in the identification and referral of congenital anomalies found in infants and children. Data from the Manchester CDOP highlighted clusters and hotspot wards cross the City, where infant deaths and factors relating to consanguineous relationships were identified. Close relative (consanguineous) marriage has recognised benefits for couples and families. However, this pattern is linked to an increased risk of genetic disorders. The Health Visiting Teams in these localities have been provided with specialist genetic literacy training, so that they can explore potential indicators in the community and refer families to genetic services, for individual assessment, genetic testing, and discussions regarding support available. This is a new speciality within the Health Visiting Teams and supports an improved understanding of how genetics is expected to impact positively on mortality and morbidly in the City.

8. 2022/2023 MANCHESTER CDOP RECOMMENDATIONS

CDOP INTEGRATION INTO THE DEPARTMENT OF PUBLIC HEALTH

Since the Manchester CDOP function was relocated into Public Health in 2020, there has been a greater connectivity to public health strategic priorities that underpin many of the potentially modifiable factors related to child deaths. These include housing/living conditions, domestic violence, unsafe sleeping arrangements, maternal and family smoking, family substance misuse, and maternal obesity. This has also given a greater focus on the CDOP data and the prevalence of deaths in under one-year olds in relation to the unacceptably high infant mortality experienced in the city.

RECOMMENDATION 1: The CDOP Manager will continue to work with Public Health colleagues in the development and delivery of the refreshed Reducing Infant Mortality Strategy.

GREATER MANCHESTER CDOP WORKFORCE

There has been a strong history of working together as a GM CDOP Network, however, there has been an increasing concern about the resilience of local systems which are viewed as a significant risk. The current CDOP workforce arrangements are fragmented with limited resilience with no consistency between job role, banding, terms and conditions, and responsibilities for the CDOP managers/co-ordinators.

The proposal to develop a single GM CDOP system and team to manage the death notifications, information collation, panel processes and outputs for each of the four-locality based CDOPs and thematic panels has not gained practical support, in part due to the re-organisation of the NHS across the GM footprint. The adoption of the national eCDOP notification system across the GM CDOPs in 2020 remains a solid component to enable a newly established team to work on a GM footprint.

RECOMMENDATION 2: Manchester CDOP continues to work with the other 3 GM CDOPs, GM Association of Directors of Public Health, and the broader integrated care system leadership – involving specialist human resource and finance expertise – to initiate a change programme to create a sustainable and flexible workforce model hosted by an appropriate organisation within GM.

9. APPENDICES

APPENDIX 1: MANCHESTER CDOP MEMBERSHIP

The Manchester CDOP membership includes:

1. Manchester CDOP Chair, Assistant Director of Public Health - Manchester Health and Care Commissioning, Manchester Population Health Team
2. Manchester CDOP Lay Representative, Therapy Services Team Leader - The Gaddum Centre
3. Deputy First Officer/Deputy Service Manager and Senior Paediatric Coroners Officer - Manchester City Coroner's Office *(ad hoc member)*
4. Detective Chief Inspector - Greater Manchester Police
5. Project Officer - Manchester City Council, Strategic Housing
6. Programme Lead - Manchester Health and Care Commissioning, Manchester Population Health Team
7. Head of Service Children's Community Nursing Team - Children's Community Palliative Care Team (STAR Team)
8. Senior Officer for QA of Safeguarding in Schools - Manchester City Council, Education
9. Head of Services Vulnerable Baby Service, Health Visiting South and Lead for Early Help and Prevention Manchester University NHS Foundation Trust Vulnerable Baby Service and Health Visiting Service - Manchester Local Care Organisation
10. Designated Nurse Safeguarding Children/Specialist Nurse Safeguarding Children - Manchester Health and Care Commissioning
11. Named Nurse for Safeguarding Children - Greater Manchester Mental Health Foundation Trust
12. Safeguarding and Quality Assurance Team Manager - Manchester Children's Social Care
13. Community Paediatrician, Designated Doctor for Child Death, GM Joint Agency Response Lead - Manchester University NHS Foundation Trust
14. General Manager - Child Adolescent Mental Health Services (CAMHS) *(ad hoc member)*
15. Bereavement Midwife - Manchester University NHS Foundation Trust, Saint Mary's Hospital
16. Consultant in Paediatric Emergency Medicine, Group Associate Medical Director - Manchester University NHS Foundation Trust
17. Consultant Paediatric Intensivist - North-West and North Wales Paediatric Transport Service Intensive Care Paediatric Transport Service
18. Clinical Nurse Lead- Learning Disabilities, Learning Disabilities Mortality Review (LeDeR) Programme - Manchester Health and Care Commissioning *(ad hoc member)*

APPENDIX 2: C. ANALYSIS PROFOMA CATEGORISATION OF DEATH

1. Deliberately inflicted injury, abuse, or neglect
This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also, deaths from war, terrorism, or other mass violence; includes severe neglect leading to death.

2. Suicide or deliberate self-inflicted harm
This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.

3. Trauma and other external factors, including medical/surgical complications/error
This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. Excludes Deliberately inflected injury, abuse, or neglect. (category 1).

4. Malignancy
Solid tumours, leukaemia's & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.

5. Acute medical or surgical condition
For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.

6. Chronic medical condition
For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause.

7. Chromosomal, genetic, and congenital anomalies
Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.

8. Perinatal/neonatal event
Death ultimately related to perinatal events, e.g., sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause and includes congenital or early-onset bacterial infection (onset in the first postnatal week).

9. Infection
Any primary infection (i.e., not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.

10. Sudden unexpected, unexplained death
Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).

10. ACKNOWLEDGEMENTS

Thanks are due to Manchester CDOP and Themed Panel multi-agency members for their attendance and commitment, and colleagues in the Manchester Department of Public Health who have contributed to the content of this annual report.

The Manchester CDOP remains continually thankful for the support from the Manchester Child Health Department, Manchester City Coroner's Office, Manchester City Register Office, and Manchester University NHS Foundation Trust (MFT) in supplying the necessary information required to conducted a thorough CDOP review.

Finally, thanks to Eesha Naeem, who took up the role of CDOP Co-ordinator in September 2022 for all her hard work in ensuring the Manchester CDOP works effectively and efficiently to produce the reviews undertaken.

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Manchester Health and Wellbeing Board
Report for Information

Report to:	Manchester Health and Wellbeing Board - 24 January 2024
Subject:	Joint Strategic Needs Assessments (JSNAs) - Health and Homelessness and Gypsy, Roma and Traveller Communities
Report of:	Director of Public Health

Summary

Local Health and Wellbeing Boards are responsible for ensuring that a Joint Strategic Needs Assessment (JSNA) is published in line with the statutory requirements set out in the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012).

This paper summarises the content of two recently produced JSNAs on Health and Homelessness and Gypsy, Roma and Traveller (GRT) communities (attached as Appendix 1 and Appendix 2). The JSNAs describe what we know about the heath and care needs of these two population groups and what Manchester City Council and other organisations working in the city are doing to address these needs.

Recommendations

The Board is asked to:

1. Note the content of the JSNAs.
2. Support the opportunities for further action described in the JSNAs.

Our Manchester Outcomes Framework

Manchester Strategy outcomes	Summary of how this report aligns to the OMS/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	People experiencing homelessness and members of the Gypsy, Roma and Traveller communities are at greater risk of financial and debt-related problems linked to poorer access to suitable employment opportunities. Interventions to promote healthy and resilient people and communities that can take advantage of jobs and other employment opportunities will support the local economy and reduce health inequalities.
A highly skilled city: world class and home-grown talent sustaining the city's economic success	A healthy population is essential for the city's future economic success. People experiencing homelessness and members of the Gypsy, Roma, and Traveller communities are more likely than the general population to be out of work due to long term sickness. Addressing this disparity will enable these groups to return to the workforce where possible and help contribute to sustaining the city's economic success.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	People experiencing homelessness and members of Gypsy, Roma and Traveller communities are more likely than the general population to be at risk of acquiring long term health conditions. Work to address these disparities and ensure that disadvantaged communities are able reach their full potential will contribute to strategies to tackle health inequalities in the city.
A liveable and low carbon city: a destination of choice to live, visit, work	Providers of services to support people who are homeless or rough sleeping contribute to zero-carbon targets in the city and moving forward, commissioned providers are required to pledge their zero-carbon targets as part of their contract with the Council.
A connected city: world class infrastructure and connectivity to drive growth	Supporting disadvantaged communities to be healthy and resilient will help them to make a positive contribution and reach their full potential, which in turn will drive growth within the city.

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Background documents (available for public inspection):

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

Manchester Homelessness and Rough Sleeping Strategy 2024-27

Health and Homelessness Joint Strategic Needs Assessment (JSNA)

Gypsy, Roma and Traveller Communities Joint Strategic Needs Assessment (JSNA) (see Appendix 2)

1.0 Background

1.1 The Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012) states that every local authority must produce a Joint Strategic Needs Assessment (JSNA) describing the health needs of the population(s) within its area. Local Health and Wellbeing Boards are statutorily responsible for ensuring that a JSNA is published and that local partners have regard to the JSNA when planning health and care services for the populations they are responsible for.

1.2 This report summarises the content of two recently produced JSNAs on Health and Homelessness and Gypsy, Roma and Traveller (GRT) communities. In line with other JSNAs, these products are designed to:

- provide a summary of the national evidence and data regarding the health issues that may affect members of these population groups;
- summarise what we know about the local situation based on 2021 Census and other sources of local data, evidence and insight;
- describe what Manchester City Council and other organisations working in the city are doing to support members of these population groups;
- outline some of the opportunities for action that exist to address the health and care issues that affect these communities in Manchester.

1.3 Following positive feedback from the Health and Wellbeing Board on the Armed Forces JSNA, both new JSNAs adopt a more succinct, slide-based format that is designed to highlight the key messages and actions. However, both products are underpinned by a more detailed and comprehensive set of evidence and data, which can be made available on request.

2.0 Health and Homelessness JSNA

2.1 The Health and Homelessness JSNA is a refresh of an earlier JSNA on working age adults experiencing chronic homelessness that was initially published in 2017. It provides a summary of what we know about the health issues that affect Manchester residents who are experiencing (or at risk of experiencing) homelessness and rough sleeping and describes what Manchester City Council and other organisations working in the city are doing to support this group of people as well as some of the opportunities for action that exist.

2.2 The work to refresh the JSNA has been sponsored and supported by members of the Manchester Health and Homelessness Task Group. The publication of the JSNA has been deliberately timed to coincide with the new Manchester Homelessness and Rough Sleeping Strategy 2024-2027. To reinforce the fact that addressing the heath and care needs of people experiencing homelessness is a partnership endeavour, we have taken the decision to 'host' the Health and Homelessness JSNA on the Manchester Homelessness Partnership (MHP) website.

2.3 The JSNA covers two distinct categories of people: individuals or families experiencing (or at risk of experiencing) homelessness, including families with children, and people (predominantly single people) who are rough sleeping or at risk of rough sleeping. Historically, work to address homelessness has focused on people who are rough sleeping. This means that the data and evidence that exists in respect of the health of people experiencing homelessness is mainly focused on this small cohort of rough sleepers. It is acknowledged that there is a gap in the evidence-base in respect of the health of individuals, families and children experiencing other forms of homelessness which we will seek to address in future iterations of the JSNA.

2.4 Appendix 1 contains a copy of the current version of the Health and Homelessness JSNA. Key points highlighted in the JSNA include:

- Nationally, nearly 80% of people experiencing homelessness report having a physical health condition and around a third of these report having between 5 and 10 diagnosed health conditions. A local audit of 76 homeless people registered with Urban Village Medical Practice between April and September 2021 shows high levels of substance misuse, mental health problems and blood borne viruses in this cohort of patients.

- Around 25% of people experiencing homelessness report having co-existing mental health and substance misuse needs (a ‘dual diagnosis’) and just under 50% of these report that they self-medicate with drugs and/or alcohol to help them cope with their mental health. Locally, around half of people sleeping rough in Manchester have been assessed as having dual mental health and substance misuse support needs.

- Just over 10% of people experiencing homelessness report that they had used A&E services more than 3 times in the past 12 months. Just over half (54%) of homeless women report being up to date with their cervical schedule screening compared to 70% of the general population.

- Nationally, there were 741 deaths of homeless people in England and Wales registered in 2021, of which 17 (2.3%) were in Manchester. The Manchester figure represents an increase of 6 deaths compared with the number registered in 2020 but is lower than the 28 deaths registered in the year immediately prior to the pandemic (2019).

2.5 Currently, there are around 4,500 children living in temporary accommodation in Manchester. Living in bed and breakfast (B&B) hotels and other forms of temporary accommodation can be particularly detrimental to the health and development of children. A recent study undertaken by the Shared Health Foundation found that children living in temporary accommodation are at greater risk of suffering from poorer health, social and educational outcomes, with indirect consequences to their emotional well-being and mental health.

2.6 More broadly, the UKHSA has highlighted the fact that people who are less able to control their environment, adapt their behaviours or respond to new risks will be particularly vulnerable to the health impacts of climate change.

Rough sleepers are likely to be particularly affected by changes in weather patterns, particularly extreme temperatures, rainfall and wind speed, and may also be more exposed to a range of outdoor air pollutants which are known to reduce life expectancy and are associated with a range of negative health effects, including respiratory and cardiovascular disease.

2.7 The JSNA goes on to summarise the work of the Manchester City Council Homelessness Service and Rough Sleepers Social Work Team and some of the organisations represented on the Health and Homelessness Task Group, including Urban Village Medical Practice (UVMP), the GM Mental Health Trust Mental Health and Homeless Team (MHHT), the drug and alcohol treatment and support services provided by CGL, the Homeless Families Health Visiting Team, Mustard Tree and St Ann's Hospice Homeless Palliative Care Service.

2.8 The JSNA ends by outlining a set of 12 actions that have been co-produced by members of the Health and Homelessness Task Group in support of the new Manchester Homelessness and Rough Sleeping Strategy 2024-2027.

3.0 Gypsy, Roma and Traveller (GRT) communities JSNA

3.1 The Gypsy, Roma and Traveller (GRT) communities JSNA outlines the current and anticipated future health and social care needs of individuals who identify their ethnicity as Gypsy, Roma or Traveller and are resident in Manchester.

3.2 Defining "GRT" communities is complex. "Gypsy", "Roma", and "Traveller" are terms that some use interchangeably, but none refer to a single, homogenous group. Historically, these terms have been used to refer to people who belong to a group that is, or was, nomadic. This may include Romany gypsy, Roma, Irish Traveller, Scottish Traveller, Show or Fairground people, Circus people, Boat Travellers, and New Travellers, although this list is not exhaustive.

3.3 The 2021 Census question on ethnic groups included the categories "White: Gypsy or Irish Traveller" and "White: Roma". Ethnic identity is self-ascribed, thus formal definitions are not stipulated. However, groups that are nomadic but that would not identify their ethnicity as "Gypsy or Irish Traveller" or "Roma" will not be captured in census data and their experiences and needs may not be reflected.

3.4 Censuses and other surveys may underestimate the numbers of people belonging to Gypsy, Roma and Traveller communities living in the UK due to:

- Digital exclusion
- Postal exclusion
- Lower levels of literacy in these communities
- Fear of self-identification by these communities due to discrimination

3.5 Additional limitations of census and other routinely collected data, particularly data gathered during the COVID-19 pandemic for the 2021 census, are outlined in the JSNA in Appendix 2. It is important to recognise the absence of adequate and accurate representation of these communities within routinely

collected datasets. This demonstrates the challenge in planning and commissioning services and thus increases the risk of disproportionately poor health outcomes for Gypsy, Roma and Traveller people.

3.6 Key points concerning the health outcomes of Gypsy, Roma, and Traveller communities highlighted in this JSNA include:

- The 2021 Census reported a total of 1,480 Manchester residents identified as Gypsy, Roma, or Traveller, of which 597 (40.3%) identified as Gypsy or Irish Traveller and 883 (59.7%) identified as Roma.

- The age profile of the Gypsy, Roma and Traveller population in Manchester is younger than the White British population, suggesting a lower life expectancy.

- Despite the younger age profile, 2021 Census data shows that self-reported health outcomes are worse in Gypsy and Irish Traveller communities compared with the White British population, but this is not the case for the Roma community. A higher proportion of Gypsy and Irish Travellers report they are not in good health (31.7%) compared with the White British population (22.6%) and a higher proportion of Gypsy and Irish Travellers are registered as disabled (34.6%) when compared to the White British population (23.7%).

- A higher proportion of the Gypsy and Irish Traveller population in Manchester smoke (26.8%) compared with the general Manchester population (16.9%) and there is a higher prevalence of chronic obstructive pulmonary disease (COPD) in Gypsy and Irish Traveller communities (2.5%) - a condition primarily caused by smoking - compared with the general population of Manchester (1.7%).

- A higher proportion of the Gypsy and Irish Traveller population in Manchester are obese (18.8%) compared with the general Manchester population (12.5%) and there is a higher prevalence of diabetes (8%) compared with the general population of Manchester (5.2%).

- A higher proportion of the Gypsy and Irish Traveller population are on the mental health register (1.9%) compared with the general Manchester population (1.2%), although more detailed data on the prevalence of specific mental health conditions or access to mental health support services was not available.

3.7 Health outcomes and life expectancy are largely determined by living and working conditions, such as education, employment, and housing. This is explored in more detail in this JSNA but key points to highlight are:

- Educational attainment is lower for children who identify as Gypsy, Roma, or Traveller at all key stages, and a higher proportion of adults belonging to Gypsy Roma Traveller communities have no qualifications when compared to the White British population.

- Gypsy, Roma, and Traveller young people are under-represented in higher education; it has been estimated that, on average, there are only 200 students who identify as Gypsy, Roma, or Traveller in higher education at any one-time which accounts for less than 0.007% of students enrolled in higher education institutions in 2021-2022.

- There are higher levels of unemployment and lower levels of economic activity amongst Gypsy, Roma and Traveller communities in Manchester compared with the White British population. Those in employment are more likely to be in routine and manual occupations rather than professional or managerial positions.

- Nationally, people who identify as Gypsy, Roma, or Traveller, are more likely to live in overcrowded or insecure accommodation. At present, there are no approved permanent sites for Traveller communities in Manchester despite a cultural need for 17 pitches identified in the most recent accommodation assessment. There is also no agreed negotiated stopping policy. As such, families that wish to live on sites or continue to travel have nowhere to stay in Manchester, leading to an increase in unauthorised encampments.

- In Manchester, a higher proportion of the Gypsy, Roma, and Traveller population reside in the most deprived areas of Manchester when compared to the general population of the city.

- Research on health inequalities has established an association between increased levels of deprivation and increased prevalence of smoking, poorer diets, increased obesity prevalence, and worse health outcomes.

3.8 Despite the greater health need established from a review of the available data, access to health care services, though difficult to measure, appears to be less in Gypsy, Roma, and Traveller communities

- Only 576 Manchester residents identified as Gypsy Roma or Traveller are registered with a GP practice as per a recent audit. This is lower than the figure of 1,480 residents identified in the 2021 census. It is unclear whether this is because Gypsy, Roma and Traveller residents are not registered with a GP or whether they registered but not identifying as Gypsy, Roma, or Traveller.

- There appears to be increased use of emergency services, with a higher rate of emergency department attendance observed in Gypsy and Irish Traveller patients who are registered with a GP when compared to the general Manchester population.

- Uptake of Breast, Bowel and Cervical cancer screening is lower in Gypsy Roma and Traveller communities compared with the general population of Manchester.

- There was a lower uptake of adult vaccinations against COVID-19 and flu amongst Gypsy, Roma, and Traveller communities. There is no data available to measure childhood vaccination uptake in these groups as the available data did not include a Gypsy, Roma, or Traveller ethnicity code.

- It has not been possible to determine whether other services, such as smoking cessation, weight management and psychological support services, are equitably accessible for Gypsy, Roma, and Traveller communities, as many services do not provide service users with the opportunity to identify as Gypsy, Roma or Traveller when collecting ethnicity data.

3.9 At present, none of the services commissioned by the Council undertake any outreach work to specifically support Gypsy, Roma, or Traveller communities. Although no bespoke Gypsy, Roma, or Traveller specific services are routinely available, instances of successful outreach work undertaken with the support of local VCSE organisations have been reported in primary care in Levenshulme. Anglia Ruskin University has undertaken a piece of participatory research to explore the health and wellbeing status of the Showman community in Cheetham and Crumpsall. This will help inform any future interventions for this group of people.

3.10 Community engagement work has been undertaken with Roma community members in Greater Manchester to help inform this JSNA. Health issues of importance to this community were identified using photovoice methodology and are reported in the JSNA. Participants were primarily concerned about mental wellbeing and expressed interest in health themed drop-in sessions that would adopt a positive focus and support improved mental health.

3.11 Looking forward, there is a need for further community engagement work involving the Irish Traveller community to better understand their lived experiences.

3.12 The JSNA concludes by identifying opportunities for action to address the observed health inequalities. These have been aligned with the following Making Manchester Fairer themes.

- Early years, children. and young people
- Poverty, income, and debt
- Work and employment
- Prevention of ill health and preventable deaths
- Homes and housing
- Places, transport, and climate change
- Communities and power
- Systemic and structural racism and discrimination

4.0 Recommendations

4.1 The Board is asked to:

- Note the content of the JSNA
- Support the opportunities for further action described in the JSNA

Health and Homelessness in Manchester

Joint Strategic Needs Assessment (JSNA)

December 2023

Contents

Introduction: What is the Joint Strategic Needs Assessment (JSNA)?

The Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012) states that every local authority must produce a Joint Strategic Needs Assessment (JSNA) covering the population(s) within its area

Local Health and Wellbeing Boards are statutorily responsible for assessing the health and wellbeing needs of their population and for publishing a JSNA.

Local partners are responsible for agreeing the content, format and frequency of update of the JSNA. There are no national standards for this.

Local authorities, Integrated Care Boards (ICBs) and NHS England must have regard to the JSNA when planning health and care services for the populations they are responsible for.

Health and Homelessness JSNA

This is a refresh of the Joint Strategic Needs Assessment (JSNA) on working age adults experiencing chronic homelessness that was initially published in 2017.

It provides a summary of the evidence and data regarding the health of people who are rough sleeping or experiencing homelessness in Manchester.

The JSNA describes some of the health issues that are known to affect Manchester residents experiencing, or at risk of experiencing, homelessness and rough sleeping.

It also describes what Manchester City Council and other organisations working in the city are doing to support this cohort of people as well as some of the opportunities for action that exist.

The content of the JSNA will support and inform the new Manchester Homelessness and Rough Sleeping Strategy 2024-2027

Populations covered in the JSNA

This JSNA covers two distinct categories of people:

- Individuals or families experiencing (or at risk of experiencing) homelessness, including families with children
- People (predominantly single people) who are rough sleeping or at risk of rough sleeping

The historical focus on people who are rough sleeping means that the existing data and evidence in respect of the health of homeless people is mainly focused on this cohort of people.

It is acknowledged that there is a gap in the content of this JSNA around the health of individuals, families and children experiencing other forms of homelessness which will be addressed in future iterations of the work.

Manchester Homelessness Partnership

The Manchester Homelessness Partnership (MHP) was formed in 2016 in response to growing concerns about high levels of visible rough sleepers in Manchester City Centre and a rise in all forms of homelessness across Manchester.

The partnership aims to bring together people with personal experience of homelessness with a range of charity and voluntary organisations, statutory bodies and businesses to co-produce solutions to end homelessness.

The MHP hosts a number of Action Groups that are designed to actively involve people who are or have been homeless in the planning, design and evaluation of services.

The new Homelessness and Rough Sleeping Strategy 2024–2027 has been developed with the Manchester Homelessness Partnership.

Manchester Health and Homelessness Task Group

The work to refresh the Health and Homelessness JSNA has been carried on behalf of the Manchester Health and Homelessness Task Group.

The Group was established in 2016 as part of the Manchester Homelessness Partnership (MHP) to support the vision set out in the Manchester Homelessness Charter to end homelessness and improve the health and wellbeing of homeless people in the city.

The Task Group is co-chaired by the Executive Director of Adult Social Services and the Director of Public Health

Membership of the group currently includes NHS Greater Manchester (GM ICB), the National Probation Service, Urban Village Medical Practice, Manchester NHS Foundation Trust (MFT), GM Mental Health Trust (GMMH), St Ann's Homeless Palliative Care Service, Change Grow Live (CGL) and the Mustard Tree (a local charity).

What do we know about the health of people experiencing homelessness or rough sleeping?

Why is the health of people experiencing homelessness an important issue?

- Health and homelessness are inherently linked. Poor physical and mental health, drug and alcohol misuse and co-morbidities are more likely to be experienced by homeless people, particularly those who are rough sleeping, compared with the general population.
- Accessing health care services is more difficult for homeless people because of practical, social, systemic, administrative and attitudinal barriers.
- These factors result in significant health inequalities for people experiencing homelessness. As a result, people experiencing homelessness are more likely to require urgent and emergency care because of advanced illnesses or conditions, rather than accessing preventative and primary care services.
- Physical disability, poor physical and mental health, drug and alcohol misuse can also contribute to an individual or family becoming homeless

Homeless Health Needs Audit (HHNA): Homeless Link

The Homeless Health Needs Audit (HHNA) is a survey tool developed by Homeless Link to help local areas to understand the physical and mental health needs of people experiencing homelessness in their communities and how they access service.

Homeless Link published the first Unhealthy State of Homelessness report in 2019. In 2022, they published an updated report ("The Unhealthy State of Homelessness 2022") which summarised data from 31 individual HHNAs carried out between 2015 and 2021. The largest group of people surveyed as part of these HHNAs were those living in a hostel / supported accommodation or rough sleeping.

In the absence of comprehensive local data, national data from the HHNA has been used as part of this JSNA to provide a picture of the health needs of people experiencing homelessness.

As part of the JSNA, we will work to collate existing local data on the health of people experiencing homelessness in Manchester and develop new data collection mechanisms to fill any gaps in the evidence base, particularly around the health of individuals, families and children experiencing homelessness / non-rough sleepers.

Physical health of people experiencing homelessness (rough sleeping)

- In 2018-21, 78% of people experiencing homelessness reported having a physical health condition. This represents an increase compared with 76% in 2015-17 and 73% in 2012-14.
- The most common reported condition was joint aches / problems with bones and muscles, followed by dental / teeth problems.
- 80% of those with a physical health condition reported having at least one co-morbidity, with 29% having between 5 and 10 diagnoses.
- 63% of respondents reported having a long-term illness, disability, or infirmity. This compares to 22% in the general population.

Source: National Homeless Health Needs Audit Report (Homeless Link, 2022)

Mental Health and Substance Use among people experiencing homelessness (rough sleepers)

- The number of people with a mental health diagnosis increased substantially from 45% in 2012-14 to 82% in 2018-21. This increase has been driven by increases in people reporting depression and anxiety.
- In 2018-21, 81% of those with a mental health condition reported experiencing at least 2 mental health conditions with 17% reporting 5 or more.
- Around 25% of respondents self-reported co-existing mental health and substance misuse needs and a further 45% reported that they self-medicate with drugs and/or alcohol to help them cope with their mental health.
- Just over half of respondents reported they had used drugs in the last 12 months. Cannabis was the most commonly used substance but reported use of heroin, cocaine and crack cocaine has been increasing.
- 76% of respondents reported that they smoke cigarettes, cigars or a pipe compared to a national figure of 13.8%.

Source: National Homeless Health Needs Audit Report (Homeless Link, 2022)

Health care provision among people experiencing homelessness (rough sleepers)

- In 2018-21, 71% of respondents reported they were currently taking a form of prescribed medication. This is a higher figure than for the general population for which it is reported that 48% of adults had taken at least one prescribed medication in the last week.
- 54% of eligible respondents in 2018-21 reported being up to date with cervical screening compared to 70.2% of the general population.
- 97% of respondents reported being registered with a GP or homeless healthcare centre - an increase from 92% in 2015-17. However, 6% reported that they had been refused registration in the past 12 months before completing the survey.
- 53% of respondents reported that they were registered with a dentist with 10% reporting that they had been refused registration in the past 12 months.

Source: National Homeless Health Needs Audit Report (Homeless Link, 2022)

Health care provision among people experiencing homelessness (continued)

- In 2015-21, 48% respondents had used A&E services in the past 12 months and 11% had used A&E services more than 3 times in the past 12 months.
- The most common reasons relate to physical health conditions (37%) but 28% of admissions were due to either a mental health condition, or self-harm or attempted suicide.
- Almost a quarter of respondents (24%) were discharged onto the street and 21% were discharged into accommodation that was not suitable for their needs.

Source: National Homeless Health Needs Audit Report (Homeless Link, 2022)

Deaths of homeless people in England and Wales

- Nationally, there were 741 deaths of homeless people in England and Wales registered in 2021, of which 17 (2.3%) were in Manchester.
- The Manchester figure represents an increase of 54.5% (or 6 deaths) compared with the number registered in 2020. The statistics mainly cover people who, at the time of their death, were sleeping rough or using emergency accommodation such as homeless shelters.
- The latest figures for 2021 are lower than the 28 deaths registered in the year immediately prior to the pandemic (2019) and follows a notable fall in 2020.
- The definition of homelessness used in these figures is based on information available in death registrations data and mainly includes people sleeping rough or using emergency accommodation, such as homeless shelters and direct access hostels, at or around the time of death.

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2021registrations

Health of homeless families and children

Living in bed and breakfast (B&B) hotels and other forms of temporary accommodation can be particularly detrimental to the health and development of children.

A study undertaken by the Shared Health Foundation found that children living in temporary accommodation are at greater risk of suffering from poor health, social and educational outcomes, with indirect consequences to their emotional well-being and mental health.

For example, living in B&Bs can reduce the ability of families to plan and cook nutritious meals, resulting in diets high in fat, sugar and salt, with a resulting impact on both short term and long-term health outcomes, inappropriate acute hospital admissions, as well as performance and behaviour.

The stressful or traumatic experiences of being made homeless and can also have an adverse and long-term impact on the social and health outcomes of children.

Source: Homeless Families: The Gold Standard (Shared Health Foundation, 2021)

Climate change and people experiencing homelessness

The UKHSA Health Effects of Climate Change in the UK report makes it clear that those less able to control their environment, adapt their behaviours or respond to new risks will be particularly vulnerable to the health impacts of climate change.

Exposure to high or low temperatures during periods of hot and cold weather can have negative impacts on human health and can lead to increased hospitalisations and deaths. Climate change is likely to increase the length and frequency of extreme weather events. People experiencing homelessness are thought to be at higher risk of harm during very hot or cold weather.

Rough sleepers are likely to be particularly affected by changes in weather patterns, particularly temperature, rainfall and wind speed, and may also be more exposed to outdoor air pollutants such as particulate matter (PM), nitrogen dioxide (NO2), and ozone (O3), which are known to reduce life expectancy and are associated with a range of negative health effects, including respiratory and cardiovascular disease.

Source: Health Effects of Climate Change in the UK (UKHSA, 2023)

What do we know about the patterns of homelessness and rough sleeping in Manchester?

Headline measures of homelessness and rough sleeping in England

Headline measures for homelessness and rough sleeping over the past five years (31 March 2018 to 31 March 2023) in England*

- The number of households assessed remained relatively stable between 70,000 and 80,000 per quarter
- The number of households in all types of temporary accommodation has increased by 26%
- The number of households in bed and breakfast placements has increased by 107%
- The number of households in bed and breakfast for more than six weeks has increased by 83%
- The single-night count of people sleeping rough decreased from 2018 to 2021 (partially as a result of 'Everyone In') but has since increased by 26% in 2022.

*England, as Wales and Scotland have different statutory duties

Homelessness applications and outcomes in Manchester (2021/22)

- In 2021/22, Manchester opened 6,525 homeless applications - the highest number of any Local Authority in England.
- The number of homeless applications opened increased by 54% between 2018/19 and 2021/22.
- The proportion of homeless applications opened at the prevention duty stage (when people are at risk of homelessness and no temporary accommodation is owed) is below the national average.
- The percentage of homeless applications in Manchester that result in a settled accommodation outcome at both the prevention and relief duty stage are below the national average.
- The rate of placements in temporary accommodation in Manchester (13.2 per 1,000 households) is amongst the highest outside of London.
- The number of children in temporary accommodation has doubled, peaking at 4,424 in January 2023. As of the end of June 2023, the number in Manchester has decreased to 3,830 - a reduction of 13% since January 2023.

Source: Report of Director of Housing Operations to Communities and Equalities Scrutiny Committee (Jan 2023)

Top 5 reasons for loss of settled home in Manchester

Manchester reflects the national trend in the reasons for the loss of a settled home. The top five reasons are:

1. Family or friends no longer willing or able to accommodate
2. End of private rented tenancy (assured short-hold tenancy)
3. Domestic abuse
4. Relationship with partner ended (non-violent breakdown)
5. End of private rented tenancy (not assured shorthold tenancy)

The categories above have remained the same over the period with a slight fluctuation in order between April 2020 and 31 March 2023.

Homelessness: social and economic factors

- There has been a significant increase in Black and Asian households owed a homeless duty (84% and 61% respectively)
- The availability of homes let through the Housing Register has decreased every year since 2018. In 2022/23, around 2,200 homes were let through Manchester Move compared to 2,850 in 2017/18
- The number of market and affordable homes completed in 2022/23 fell to 1,907, compared to 3,762 in 2021/22
- The average cost of renting a two-bedroom property is below the Local Housing Allowance (LHA) rate in every ward in the city. The average cost of renting a two-bedroom property outside the city centre is £336 above the LHA rate. For three-bed and four-bed properties, the figures are £523 and £718 respectively
- The long-term void rate of social housing remains low, with 1.2% of properties in the city centre and 0.6% of properties elsewhere remaining empty for more than 6 months.
- The Council's Local Welfare Provision spend (used for furniture packages, fuel grants and cash grants) increased from £473,900 in 2018/19 to £770,070 in 2022/23.

Health and other support needs of homeless applicants in Manchester

Where a local authority is satisfied that a homeless applicant is eligible and either homeless or threatened with homelessness, it must complete a 'holistic and comprehensive' assessment of their support needs.

The top three support needs of people owed a homeless duty in Manchester and the percentage increase since 2018:

1. History of mental health problems (56% increase)
2. Physical ill health and disability (103% increase)
3. At risk of or has experienced domestic abuse (97% increase)

The top three increases in support need recorded:

1. Old age (225% increase)
2. Care leaver aged 21 and over (125% increase)
3. Former asylum seeker (121% increase)

Levels of rough sleeping in Manchester

- Rough sleeping has decreased from 123 people seen bedded down in one night in November 2018 to 58 people seen bedded down in November 2022. The latest count showed that only 43 people were seen bedded down.
- Since November 2020, Manchester has also conducted bi-monthly street counts. This data shows that rough sleeping fluctuates seasonally, with more people being rough sleeping in the summer and fewer people found in the winter. The most recent bi-monthly count in May 2023 found 37 people - a steady decrease from a peak of 61 people sleeping out in September 2022.
- The number of people found sleeping rough by the Outreach Team each quarter has increased from 76 people in April-June 2018 to a peak of 293 people in January-March 2023. This suggests that while the number of people sleeping rough on a given night is decreasing, the cohort of people that the Outreach Team find sleeping rough and offer support to is increasing.

Levels of rough sleeping in Manchester (continued)

- Around 15% of people seen bedded down were female. However, this is likely to be an underestimate, as women are more likely to remain hidden when sleeping rough. The age profile of people found sleeping rough has got younger: the most common age groups are now 25–35 and 35–45 (previously 35–45 and 45–55).
- Around a third of people seen sleeping rough each quarter are new to rough sleeping. The remaining two thirds are already known to the Outreach Team.
- Someone is defined as sleeping rough 'long-term' if they have been seen in 3 or more separate months in the last 12 months. The percentage of people seen sleeping rough that were doing so long-term increased from 19.7% in April-June 2018 to a peak of 41.6% in April-June 2022. However, since that point, the percentage has decreased to 27.3% in January-March 2023.
- Someone is defined as 'returning' to rough sleeping if they are seen bedded down again after not being seen bedded down for 6 months. The percentage of people seen sleeping rough that are returners increased slightly from 14.5% in April-June 2018 to a peak of 24.3% in July-September 2021, but the figure has subsequently fallen to 15.4% in January-March 2023.

Health inequalities affecting people sleeping rough

- Access to primary care for people experiencing or at risk or becoming homeless/sleeping rough can be limited for people without a fixed address. This can be compounded by cultural or language barriers and affordability issues.
- Children living in Temporary Accommodation are at greater risk of suffering from poor health, social and educational outcomes, with indirect consequences to their emotional well-being and mental health (see APPG Call for Evidence, January 2023)
- Around half of people sleeping rough in Manchester have been assessed as having mental health and substance misuse support needs - commonly known as 'dual diagnosis' - which can make accessing support for either support need more difficult.
- Access to mental health support is a particular barrier facing people sleeping rough.

National and local strategies to address homelessness and rough sleeping

National and local strategies to address homelessness and rough sleeping

- National Rough Sleeping Strategy ('Ending Rough Sleeping for Good'), Department for Levelling Up, Housing and Communities (2022)
- Greater Manchester Homelessness Prevention Strategy 2021-2026
- Manchester Homelessness Charter (2016)
- Manchester Homeless Healthcare Standards (2015/16)
- Manchester Homelessness Strategy 2018-2023
- Manchester Homelessness and Rough Sleeping Strategy 2024-27
- Making Manchester Fairer (MMF) Plan 2022-2027

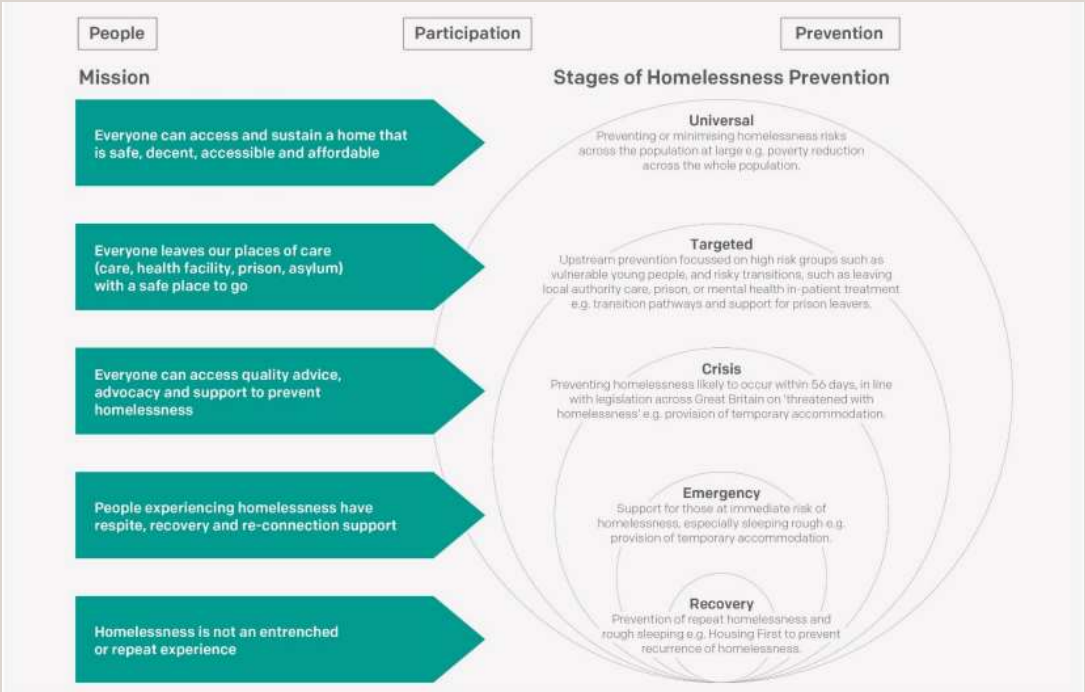
National Rough Sleeping Strategy ('Ending Rough Sleeping for Good')

- The National Rough Sleeping Strategy ('Ending Rough Sleeping for Good') is a cross-government strategy setting out how the government and its partners will end rough sleeping sustainably and for good.
- The Strategy takes a whole system approach to deliver:
  - better prevention
  - swift and effective intervention
  - extra help to aid recovery for those that need it
  - a more transparent and joined-up system
- The Strategy acknowledges that a step change in how the system is working to tackle rough sleeping is needed and that all those involved in central government and local areas need to work together to ensure better prevention of rough sleeping, targeted help where it does happen, and a route to an independent life off the streets.

Greater Manchester Homelessness Prevention Strategy 2021-2026

- The Greater Manchester Homelessness Prevention Strategy 2021-2026 was published in July 2021.
- The Strategy details action across GM to increase social and affordable housing supply, improve access to social housing for those who need it and support private rented tenants and more vulnerable households.
- It builds on other programmes of work, including A Bed Every Night, Housing First and the Social Impact Bond for Entrenched Rough Sleepers which have helped to reduce rough sleeping by 57% in four years.
- The Strategy also recognises the integral role the health and social care system has in reducing the inequalities that drive exclusion and homelessness.
- A co-produced set of deliverables, commitments and indicators are contained within an Action Plan.

GM Mission for Preventing Homelessness



Manchester Homelessness Charter

The Manchester Homelessness Charter provides a set of guiding principles concerning the rights of homeless people and the responsibilities of those providing support. It states that everyone who is homeless should have a right to:

- A safe, secure home along with an appropriate level of support to create a good quality of life
- Safety from violence, abuse, theft and discrimination, and the full protection of the law
- Respect and a good standard of service everywhere
- Equality of access to information and services
- Equality of opportunity to employment, training, volunteering, leisure and creative activities

It also states those who work with homeless people have a collective responsibility to ensure that:

- Good communication, coordination and a consistent approach is delivered across all services
- People with experience of homelessness have a voice and involvement in determining the solutions to their own issues, to homelessness, and in wider society.

Manchester Homeless Healthcare Standards

The Manchester Homeless Healthcare Standards were developed by Urban Village Medical Practice and the Council in 2015/16 to support statutory and voluntary agencies.

The Standards state that

- Health must form a significant element of any assessment of need and remain a priority.
- All homeless people must be registered with a GP.
- All homeless people should be supported to engage with primary and secondary health care services.
- Homeless people should be supported to be self-caring in relation to their health care.
- Appropriate access to out of hours emergency care

The standards were embedded in national guidance in 2018 and continue to inform good primary care practice.

Manchester Homelessness Strategy 2018-2023

The current Manchester Homelessness Strategy 2018-2023 represents an expansion of the commitments and pledges made through the Manchester Homelessness Charter.

It aims to make:

1. Homelessness a rare occurrence by increasing prevention and early intervention
2. Homelessness as brief as possible by improving temporary and supported accommodation so it becomes a positive experience
3. Experience of homelessness a one-off occurrence: increasing access to settled homes

The Strategy is built on the Our Manchester approach, putting people's strengths and potential at its heart.

Delivery of the Strategy requires contributions from a range of people and organisations, including those working in Manchester, across the Greater Manchester region and those working nationally.

Homelessness and Rough Sleeping Strategy 2024-27

The Homelessness and Rough Sleeping Strategy 2024-27 has been developed in partnership with the Manchester Homelessness Partnership and aims to make:

- Homelessness a **rare occurrence** by increasing prevention and earlier intervention at a community level
- Homelessness as **brief as possible** by improving temporary and supported accommodation so it becomes a positive experience
- Experience of homelessness **unrepeated** by increasing access to settled homes and the right support at the right time

The Strategy reinforces the commitment of the Council and its partners to preventing homelessness in all its forms and ensuring that residents of the city have a place to call home

Homelessness and Rough Sleeping Strategy 2024-27: Strategic Objectives

The Homelessness and Rough Sleeping Strategy is framed around the four principals of Manchester City Council's Homelessness Transformation Programme ("A Place Called Home"). These are:

- Increasing Prevention
- Reducing Rough Sleeping
- More Suitable and Affordable Accommodation
- Better Outcomes Better Lives

Improving access to services is the golden thread that sits across all strategic objectives.

The Strategy is backed up by an Action Plan owned by Manchester City Council (MCC) and its partners through the Manchester Homelessness Partnership (MHP). The Action Plan will be reviewed by partners and will be ready to go live in April 2024.

Making Manchester Fairer: Tackling Health Inequalities in Manchester 2022–2027

Reducing health inequalities is paramount to Making Manchester Fairer. There are clear links between housing and health outcomes that need to be addressed through the Homelessness and Rough Sleeping Strategy:

- Poor-quality housing is harmful to physical and mental health and widens health inequalities
- Unaffordable housing contributes to poverty and can lead to homelessness
- Homelessness often results from a combination of events, such as relationship breakdown, debt, adverse experiences in childhood, and ill health.

There are also clear links between housing, homelessness and poverty. Data shows that poverty in Manchester is distributed unevenly, with certain groups and communities likely to be disproportionately affected, including communities experiencing racial inequalities, particularly Black, Bangladeshi and Pakistani residents, women, disabled people, older people, children and young people and people living in certain parts of the city such as north and east Manchester and Wythenshawe.

Making Manchester Fairer Priority Themes

Making Manchester Fairer identifies eight themes that need to be addressed to tackle health inequalities.

Local services to support the housing needs and health of people experiencing homelessness and rough sleeping in Manchester

Manchester City Council Homelessness Service

- The work of Homelessness Services is closely linked to the Making Manchester Fairer programme through the Housing and Homes workstream, which focuses on reducing inequalities through preventing homelessness.
- Manchester City Council's Housing Strategy sets out the ambitions of the Council to work towards ending homelessness and provide affordable housing for all.
- The Council has long established partnerships with external agencies to support the delivery of the Homelessness Transformation Programme ("A Place Called Home") including the citywide Manchester Homelessness Partnership, GMCA and the Manchester Housing Providers Partnership Homelessness Group.

Local authority statutory obligations in relation to homelessness

The local authority's statutory obligations in relation to homelessness are listed in Part VII of the Housing Act 1996 (as amended by the Homelessness Reduction Act (HRA) 2017).

The principal homelessness duties owed by LAs are as follows:

- To open a homeless application if a person is believed to be eligible for assistance, homeless or at risk of homelessness.
- A duty to prevent homelessness if an eligible person is believed to be at risk of homelessness.
- A duty to relieve homelessness if an eligible person is believed to be homeless.
- A duty to secure suitable temporary accommodation if the person is believed to be in priority need.
- If homelessness cannot be relieved, then a duty to carry out inquiries to establish whether a person is eligible for assistance, unintentionally homeless and in priority need and, if so, to secure suitable temporary accommodation pending an offer of suitable longer-term accommodation.

Services supporting the health of people experiencing homelessness and rough sleeping in Manchester

- Urban Village Medical Practice (UVMP)
- Hospital in-reach service: MPATH
- Mental Health and Homeless Team (GMMH)
- Drug and Alcohol Treatment and Support Services (CGL)
- Homeless Families Health Visiting Team (Manchester NHS Foundation Trust)
- Manchester City Council Rough Sleepers Social Work Team (Adults Directorate)
- Mustard Tree

Urban Village Medical Practice (UVMP)

Urban Village Medical Practice (UVMP) delivers a primary healthcare service to homeless people in Manchester. The service includes:

- Proactive engagement with people experiencing homelessness including nurse led outreach sessions in a clinical van on the streets and at day centres and hostels.
- Full GP registration for patients that need it alongside care navigation for patients registered with a different GP.
- Flexible access to a range of comprehensive primary care services including GPs, nurses, tissue viability nurses, sexual health, blood borne virus treatment, drug misuse assessment and treatment and mental health services.
- A hospital in-reach service delivered by clinical and non-clinical team members offering comprehensive discharge planning in partnership with hospital teams for homeless people who are admitted to Manchester Royal Infirmary.
- Work with partner agencies to increase equitable access to healthcare for homeless people and help homeless people to access care and address their health needs.

Urban Village Medical Practice: Service Activity in 2021

- At the end of 2021, there were 764 adults experiencing homelessness registered with UVMP. Over the course of the year, the practice registered 203 people - an average of 17 people a month.
- Around 27% of patients registered were under the age of 30, 55% were aged between 30 and 50 and 18% were over the age of 50.
- 67% of people identified as male and 33% as female.
- At the point of registration, 17% of people were living in bed and breakfast accommodation, 39% were in a hostel, 1% in a night shelter, 16% were ‘sofa surfing’ and 27% were rough sleeping.
- People experiencing homelessness attended 2,227 GP appointments and 732 nurse appointments.
- 58% of the people that were registered with the practice received a full new patient health check (target: 80%).

Presenting health problems and interventions for new patients registered with UVMP

% of patients identifying as male		% of patients identifying as female
4%	Hep B/HIV	0%
68%	Hep C (antibody positive)	61%
22%	Alcohol Misuse	21%
43%	Heroin/Crack Misuse Intervention	58%
100%	NPHC offered	100%
60%	NPHC received	71%
0%	Contraception advice offered	56%
0%	Contraception advice provided	33%
0%	Cervical Screening	62%
94%	BBV testing offered	83%
63%	BBV testing completed	75%
56%	Mental health identified	46%
12%	Severe mental illness diagnosis	5%
40%	STI screen offered	71%
55%	STI screen completed	71%

This data is based on an audit of 76 new patients registered with UVMP between April and September 2021 (55 men and 21 women).

The findings of the analysis show high levels of substance misuse, mental health problems and blood borne viruses in this cohort of patients.

Homeless-friendly GP practices: Other examples of work in Manchester

Hawthorne Medical Centre has forged a partnership with a local homeless family charity providing temporary accommodation for homeless families in Greater Manchester

The practice designed and introduced an easy registration process resulting in families receiving immediate access to care. The CQC has highlighted examples of positive interventions from the GPs in this practices. For example, GPs liaising with multiple services and authorities to help permanently re-home a family.

Access to NHS dentistry and oral health care for people experiencing homelessness

- Poor oral health and access to dentistry is a major issue for people experiencing homelessness. Requests for urgent help with dental pain are a common reason why patients present to a GP practice or attend A&E on a regular basis. Dental pain is also one of the reasons why homeless people seek illicit substances.
- There is a designated NHS dental practice in Ancoats for homeless patients requiring urgent care, but this does not offer ongoing dental care and there are very limited appointment slots. It is also unclear whether those who are not on benefits or have no recourse to public funds can access the service.
- The standard basic advice offered by the NHS Dental Helpline (e.g. using saline mouthwashes or paracetamol for pain) is not realistic for the homeless population who often present late with very severe issues.
- Moving into temporary accommodation may lead to disruption in the ability of children to access already planned NHS dental care and treatment.

MPATH (Manchester Pathway)

- MPATH is a hospital in-reach service run in partnership by MFT and UVMP. It aims to reduce health inequalities and ensure continuity of care across primary and secondary care for people experiencing homelessness who have been admitted to hospital.
- The team includes a GP and specialist non-clinical case manager who work alongside the hospital teams to develop safe discharge plans for people experiencing homelessness who have been admitted to Manchester Royal Infirmary.
- The team can offer registration at UVMP to people where appropriate, or support patients to register with a local GP as required. This ensures that patients can access follow up healthcare once discharged.
- The team also works alongside Manchester City Council's Housing Solutions Service workers in the hospital to ensure access to statutory housing support.

MPATH (Manchester Pathway)

- Evidence suggests that the MPATH service leads to better outcomes, reduced hospital admissions / readmissions and reduced length of stay.
- During 2021, the MPATH in-reach service engaged with and assessed 384 patients. 34% (127) of the patients seen were registered with UVMP at point of discharge
- The service made 137 referrals to local authorities or other services for homeless assistance.
- 46% (176) of the patients seen saw retained housing placements whilst in hospital
- 22% (82) were offered a new accommodation placement on discharge from rough sleeping or sofa surfing

Mental Health and Homeless Team (GMMH)

- The Mental Health and Homeless Team (MHHT) is delivered by GM Mental Health NHS Foundation Trust (GMMH) and provides an assertive outreach model of engagement to homeless people in Manchester.
- The service is delivered by a multi-disciplinary team including mental health practitioners, psychiatry, psychology, social workers and mental health nurses.
- The service provides screening, assessments and low-level interventions for people presenting with mental health concerns, management of transitions into mainstream mental health services, liaison with speech and language and neuropsychology, management of co-occurring substance misuse and mental health issues, Psychological Informed Environment's (PIE) training to the wider homelessness sector.
- The latest data for Quarter 2 2023/24 (July-Sept 2023) shows that 213 referrals were received and accepted by the MHHT.

Drug and Alcohol Treatment and Support Services (CGL)

- Change, Grow, Live (CGL) provide a range of services to the homeless population, including structured drug and alcohol treatment and recovery support services.
- CGL also receives investment from the Rough Sleeper Drug and Alcohol Treatment Grant (RSDATG) to meet the needs of people experiencing rough sleeping or at imminent risk of doing so through enhanced delivery of structured treatment and in-reach / outreach provision.
- The service includes outreach support, non-medical prescribing, prison in-reach and trauma informed psychological interventions (supported by MHHT)
- CGL also provide additional outreach activity, via other funding schemes, to support people who are street based and/or homeless. This enables them to respond to the increasing engagement needs of the homeless population and to work in partnership with other support services to deliver outreach engagement.

Homeless Families Health Visiting Team

- The citywide Health Visitors Service is provided by Manchester NHS Foundation Trust (MFT) and provides mandated health checks for 0–2-year-olds, perinatal mental health assessments, and infant feeding support.
- A small Homeless Families Team is based within the service and is supported by health visitors from the main service. In the main service, caseloads are approximately 1:385 (i.e. 1 health visitor to 385 children).
- At the end of June 2023, there were 1,039 children aged 0–4 years living in temporary accommodation in the city. Caseloads are approximately 1 health visitor to 127 children (1:127) to ensure these families can be offered more prompt support.

St Ann's Homeless Palliative Care Service

- Evidence suggests that patient centred, flexible and trauma informed approaches are essential to ensure people with advanced ill health who are homeless have access to appropriate care in the last year of life.
- The Homeless Palliative Care Service provides a range of support to people with advanced ill health who are experiencing homelessness.
- The service includes hostel in-reach support, education and training for health and social care staff, in-reach to Manchester Royal Infirmary and multi-disciplinary team (MDT) led case management with a heavy focus on advocacy.
- The service supports approximately 25 patients at any one time.

Manchester City Council Rough Sleepers Social Work Team

- The Care Act 2014 includes a requirement to assess the needs of anyone who appears in need of care or support.
- The Rough Sleeper Drug and Alcohol Treatment Grant (RSDATG) has been used to fund the development of a small social work team within Manchester City Council to focus on undertaking Care Act assessments.
- The team works with a wide range of partners to discuss and agree integrated multi-agency approaches.
- This builds on research undertaken following the COVID-19 pandemic, which revealed 'hidden' issues in a cohort of people whose rough sleeping was considered to be entrenched, including Trauma, Acquired Brain Injury (ABI) and Neurodiversity and other health related conditions.

Mustard Tree

- Mustard Tree is a registered charity based in Ancoats which aims to combat poverty and prevent homelessness by creating opportunities for homeless people to improve their economic wellbeing and find settled homes through the provision of community shops, training placements, support services, gifting schemes, vocational training and creative courses.
- Mustard Tree also hosts the Street Engagement Hub (SEH), a multi-agency initiative led by Community Safety officers in the Council and Greater Manchester Police (GMP). The Hub aims to reduce begging and anti-social behaviour in the city centre and engage people with services, reduce harm and move people away from a street-based lifestyle.
- An independent evaluation of the SEH was carried out in 2021 and included service user and practitioner feedback on the difference that this initiative had had on health.

Mustard Tree Impact Report 2022/23

In 2022/23, Mustard Tree had 9,209 active clients and registered 5,116 new people into their services (compared to 3,032 people the previous year).

The table below shows the number of people supported by Mustard Tree over the past 3 years.

PERFORMANCE INDICATORS - INDIVIDUALS	20-21	21-22	22-23
Freedom - skills, work and coaching placement	40	131	**266**
Support for new tenancies including gifted furniture	585	891	**952**
Training (English Language, Customer Service, IT, Job Club)	238	594	**998**
121 Support - hardship loans, finance & housing	1030	1956	**2240**
Families who use the Food Clubs	3049	3889	**5703**

Source: Mustard Tree Impact Report 2022/23

Mustard Tree Objectives 2023-26

By 2026 Mustard Tree will:

1. Help 30,000 people increase their financial wellbeing, increase their skills, increase self-belief, and ultimately reduce poverty across Greater Manchester
2. Help 3,000 people make settled homes and prevent homelessness across Greater Manchester
3. Develop a world-class organisation to support the delivery of its services so it can do more to the best of our ability
4. Increase connectivity and community networks and reduce social isolation across Greater Manchester

Service user and practitioner voices (from the Street Engagement Hub Evaluation, 2021)

"Co-located services full stop is a good thing - to build relationships where possible. Building and maintaining new relationships with other agencies, I think is important. A lot of people have different perspectives on how to work in this environment and the understanding of the other, the understanding of where others are coming from, whether it is substance misuse or the police or DWP (Department of Work & Pensions). It's understanding and respecting their knowledge and sharing your own position. Because we all have the same values, anyone who works in this sector, we all have the same kinds of values and sense of helping people. I think that's always important to share and understand across agencies or any opportunities." (Practitioner)

"This is the first time I've ever had my Hepatitis C and I'm 48 and I've also had both my Covid's and that's through this hub." (Service user)

Service user and practitioner voices (continued)

"I ended up with an ulcer on this leg, on my right leg. That gone really badly infected. I ended up with sepsis to start with. It turned to septicaemia, so I had full on blood poisoning. I was touching death. I don't say that lightly. I had stage 2 hypothermia. The Hepatitis C nurses were always on my case. Housing, CGL, St Johns. St Johns were brilliant with me. If it wasn't for them, I daresay I wouldn't be here now. That's the gospel truth that." (Service user)

"If you think like our population group are homeless and no fixed abode, we can't write to them to tell them they've got a letter. If they have a phone number, sometimes that phone, they lose it, or sell it, or we lose touch with them that way. And here, we can always access them this way because the Street Engagement Team, the police, will go out if they see them, if we say we are trying to find this person, or they'll direct them here. There's a guy this morning, he's mid treatment, I've rung him, he's said he's coming today, I've got his medication here. So, it's great that way that we have, like, you know, a place to meet them, and they know they can come here and there's other things available for them here as well." (Practitioner.)

Opportunities for action to improve the health of people experiencing homelessness and rough sleeping in Manchester

Opportunities for action: Health and Homelessness Task Group Action Plan

1. CGL to increase offer at Mustard Tree to reduce homelessness for prison leavers
2. Increase the reach of homelessness support in north Manchester
3. Explore options for other community-based wellbeing services in other parts of the city
4. Develop an offer to meet needs of people with neuro-diverse issues and acquired brain injury
5. Improve numbers of smoking cessation interventions delivered for the homeless population
6. Support timely admissions to drug and alcohol in-patient detox for people who are sleeping rough

Opportunities for action: Health and Homelessness Task Group Action Plan (continued)

7. Strengthen co-production and develop peer support opportunities
8. Deliver the work on Inclusion Health Standards
9. Improve care coordination for people who are sleeping rough
10. Scope feasibility of expanding MPATH (Manchester Pathway) to North Manchester and Wythenshawe Hospitals
11. Improve hospital discharge experiences for the homeless population
12. Make information on 'access' to services easy to follow and navigate

Health and Homelessness JSNA: Next Steps

The intention is for the Health and Homelessness JSNA to be a live resource that changes and develops over time.

Initial priorities for future work include the identification of:

- More locally specific data and evidence about the health needs of individuals and families experiencing homelessness and rough sleeping in Manchester (to reduce the reliance on national evidence and data)
- Data and evidence looking specifically at the health needs of families and children living in temporary accommodation.

The ongoing development of the JSNA will continue to be overseen by the Health and Homelessness Task Group.

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2. Report of Director of Housing Operations to Communities and Equalities Scrutiny Committee (Manchester City Council, Jan 2023)
3. National Rough Sleeping Strategy ('Ending Rough Sleeping for Good'), Department for Levelling Up, Housing and Communities (2022)
4. Greater Manchester Homelessness Prevention Strategy 2021-2026 (Greater Manchester Combined Authority, July 2021)
5. Manchester Homelessness Strategy 2018-2023 (Manchester City Council, 2018)
6. Manchester Homelessness and Rough Sleeping Strategy 2024-27 (Manchester City Council, 2024)
7. Making Manchester Fairer (MMF) Plan 2022-2027 (Manchester City Council, 2022)
8. Deaths of homeless people in England and Wales: 2021 Registrations (ONS, November 2022)
9. Homeless Families: The Gold Standard (Shared Health Foundation, 2021)

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Gypsy, Roma, and Traveller Communities in Manchester

Joint Strategic Needs Assessment (JSNA)

January 2024

Contents

Introduction

What is a Joint Strategic Needs Assessment (JSNA)?

The Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012) states that every local authority must produce a **Joint Strategic Needs Assessment (JSNA)** covering the population(s) within its area.

Local Health and Wellbeing Boards are statutorily responsible for assessing the health and wellbeing needs of their population and for publishing a JSNA.

Local partners are responsible for agreeing the content, format and frequency of update of the JSNA. There are no national standards for this.

Local authorities, Integrated Care Boards (ICBs), and NHS England must have regard to the JSNA when planning health and care services for the populations they are responsible for.

Why is a JSNA Needed for GRT+ Communities?

This Joint Strategic Needs Assessment (JSNA) provides a summary of the evidence and data regarding the current and anticipated future health and social care needs of the Gypsy, Roma, and Traveller communities living in Manchester.

Findings of needs assessments and research conducted in other parts of the country suggest that Gypsy, Roma, and Traveller communities experience worse health outcomes when compared to the general population.

“Making Manchester Fairer” is an overarching strategy recently launched by Manchester City Council that aims to reduce health inequalities within Manchester. A JSNA that explores the needs of historically marginalised groups that are likely to experience health inequalities, such as Gypsy, Roma, and Traveller communities, is therefore both timely and important.

Defining "GRT+" Communities

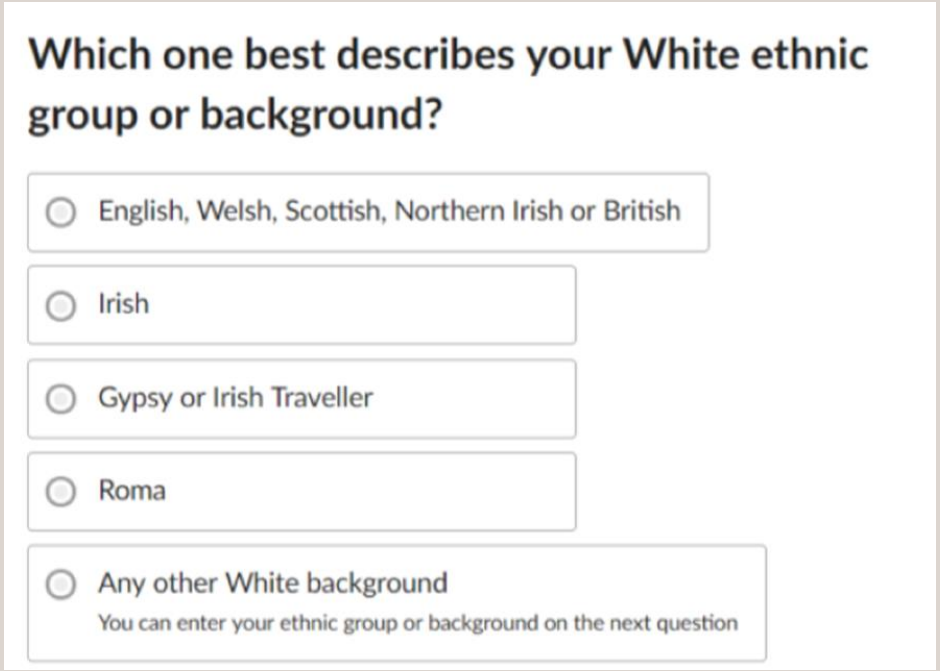
The terms Gypsy, Roma, and Traveller communities do not refer to one homogenous group, and the acronym "GRT+" may refer to one of many groups, including:

- **Romany gypsy**
- **Roma**
- **Irish Traveller**
- **Scottish Traveller**
- **Show or Fairground people**
- **Circus people**
- **Boat Travellers**
- **New Travellers**

Though this list is not exhaustive.

These groups may have a shared disadvantage, but the health and social care needs for the different groups encompassed by the acronym "GRT+" cannot assumed to be the same.

Defining "GRT+" Communities for the Census (2021)



Methods Used to Produce this JSNA

- Desktop Research
  - Data sources
    - Census 2021 data
    - Peer reviewed academic research
      - Systematic reviews
      - Health surveys
      - Secondary analysis of routinely collected GP data
      - Qualitative research
    - Reports and Grey literature
- Stakeholder and staff consultation
- Community engagement
  - Focus group
  - Photovoice methodology

Limitations of the Available Research and Data

- Data from surveys
  - Postal exclusion
  - Digital exclusion
  - Lower levels of literacy
- Census 2021 data gathered during COVID pandemic
  - Manchester City Council's own estimate suggests there could be as many as 33,000 residents and at least 7,000 households not appearing in the results, with most of those missing likely to be in 20-39 year age group
- Most research has been undertaken with communities that are settled in bricks and mortar or based on permanent sites
  - People who live a nomadic lifestyle may be systematically different from those who are settled and their health may have either better or worse than the research suggests.

The National Picture

Physical Health Issues Experienced by GRT+ Communities Nationally

A review of the literature has found a higher level of morbidity and poorer health-related quality of life amongst people belonging to Gypsy, Roma, and Traveller communities when compared to the general population.

Previous health surveys undertaken with Gypsy and Traveller communities report a higher smoking prevalence amongst Gypsies and Travellers. Survey findings also showed Gypsies and Travellers were more likely to consume diets with more fried foods and less fruit and vegetables.

The 2022 GP survey found a higher proportion of respondents who identified as Gypsy, Roma, or Traveller were smokers, had multiple long-term conditions and were more likely to report a musculoskeletal complaint when compared to the general population.

Mental Health Issues Experienced by GRT+ Communities Nationally

Significantly higher rates of suicide were reported in Irish Travellers in the All-Ireland Traveller Health Study (AITHS) when compared to the general Irish population.

Subsequent peer reviewed studies and anecdotal evidence reported in the grey literature also describe poorer mental health amongst members of Gypsy, Roma, and Traveller communities.

Child Health Issues Experienced by GRT+ Communities Nationally

There is a lower uptake of childhood immunisations amongst children from Gypsy, Roma, and Traveller families. Outbreaks of vaccine preventable communicable diseases due to lower rates of vaccination have previously been reported in these communities.

Authors of a 2017 qualitative study that explored Traveller and service provider views around barriers and facilitators to both child and adult vaccinations concluded there was overall reasonable levels acceptance of vaccines, particularly of routine childhood immunisations, but there remained issues with regards to accessibility.

Health Service Use for GRT+ Communities Nationally

Health service engagement in Gypsy, Roma, and Traveller communities is impacted by several factors;

- Physical access
  - impeded by arbitrary registration requirements and administrative burden
- Discrimination
- Cost of accessing services
  - direct and indirect
- Language or cultural barriers
  - Particularly for the Roma population due to a lack of Romani translators
- Lower levels of literacy
- Health belief system of communities

Health Service Access for GRT+ Communities Nationally

Difficulties in registering with a GP have been described in the grey literature, particularly if the individuals attempting to register did not have a fixed address or lived on site.

There is a lower uptake of cancer screening services amongst Gypsy, Roma, and Traveller communities, thought in part to be a result of mistrust in services by the community and the absence of culturally appropriate services.

Barriers in accessing end of life care have also been reported and felt to reduce the uptake of these services by these communities.

Wider Issues Experienced by GRT+ Communities Nationally

- Lower levels of educational attainment:
  - Lower proportions of Gypsy, Roma and Irish Traveller pupils achieve the expected standard in examinations when compared to other ethnic groups.
  - The proportion of children persistently absent, suspended, or permanently excluded were highest for Gypsy and Roma pupils.
  - Less than 0.007% of students enrolled in higher education institutions in 2021-2022 identified as Gypsy, Roma, Traveller, much lower than other ethnic groups.
- Higher levels of unemployment are observed in Gypsy, Roma, and Traveller communities.
- Reports suggest there are less employment opportunities available to members of Gypsy, Roma, and Traveller communities.
- A higher proportion of the Gypsy, Roma, and Traveller population live in insecure and overcrowded accommodation.
- Gypsy, Roma, and Traveller communities describe discrimination when accessing statutory services.

Sources: Gov.UK Attainment 8, ONS reports of Census 2021 Data, UK Higher Education Statistics (HESA)

Discrimination Experienced by GRT+ Communities

Hate crimes against Gypsy, Roma, and Traveller communities described as "regular as rain".

Gypsy, Roma, and Traveller young people reported they were less likely to remain in education due to school bullying.

When in the workplace, some Gypsy, Roma, and Traveller young people disclosed they would hide their ethnicity due to fears of discrimination.

Groups that experience racial prejudice had worse outcomes in relation to coronavirus disease (COVID-19). Systemic racism has been identified as a key driver of health inequalities that lead to disproportionate morbidity and mortality in minoritised ethnic groups. Though there is no data available exploring the outcomes of Gypsy, Roma, and Traveller communities in relation to COVID-19, systemic racism likely contributes to other poorer health outcomes observed in these communities, such as reduced life expectancy .

Lived Experience of GRT+ Communities Nationally

Some participants felt that attitudes towards schooling had changed, and now there is more encouragement for children to attend and remain in mainstream schools, though some families were keen for children to remain home-schooled, some citing concerns around bullying.

Some participants expressed a desire to be more involved with the settled community and to access mainstream services. However, others expressed fears of prejudice from the settled community and preferred services to be separate.

Some participants felt the location of some sites and the standards of living at some sites have contributed to poor health within the community, and that certain community members are exposed to additional harm through occupational hazards.

Source: Gypsies' and Travellers' lived experiences, overview, England and Wales: 2022

The Manchester Picture

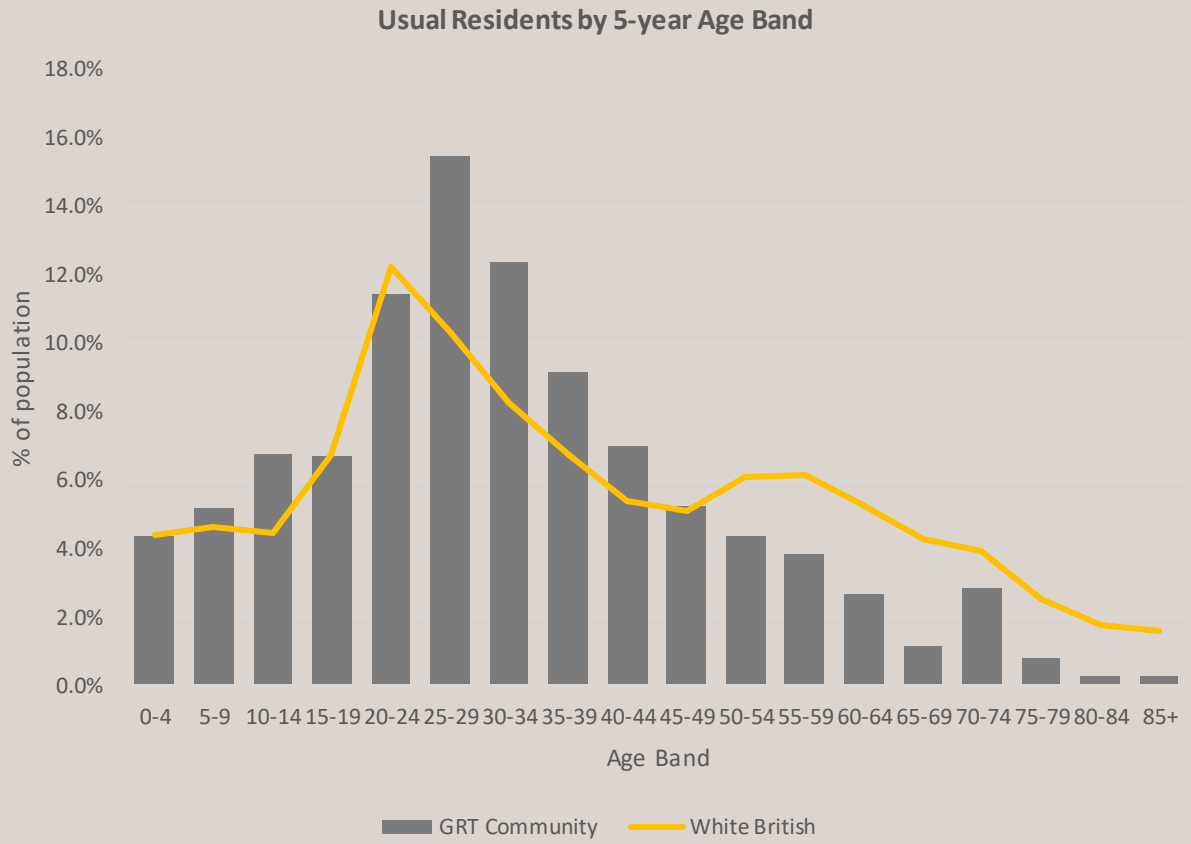
What do we Know about GRT+ Communities Living in Manchester?

- Manchester residents identifying as Gypsy, Irish Traveller or Roma is **1480**
- Manchester residents identifying as Gypsy or Irish Traveller **597**
- Manchester residents identifying as Roma **883**

Source: Census 2021 from the Office for National Statistics

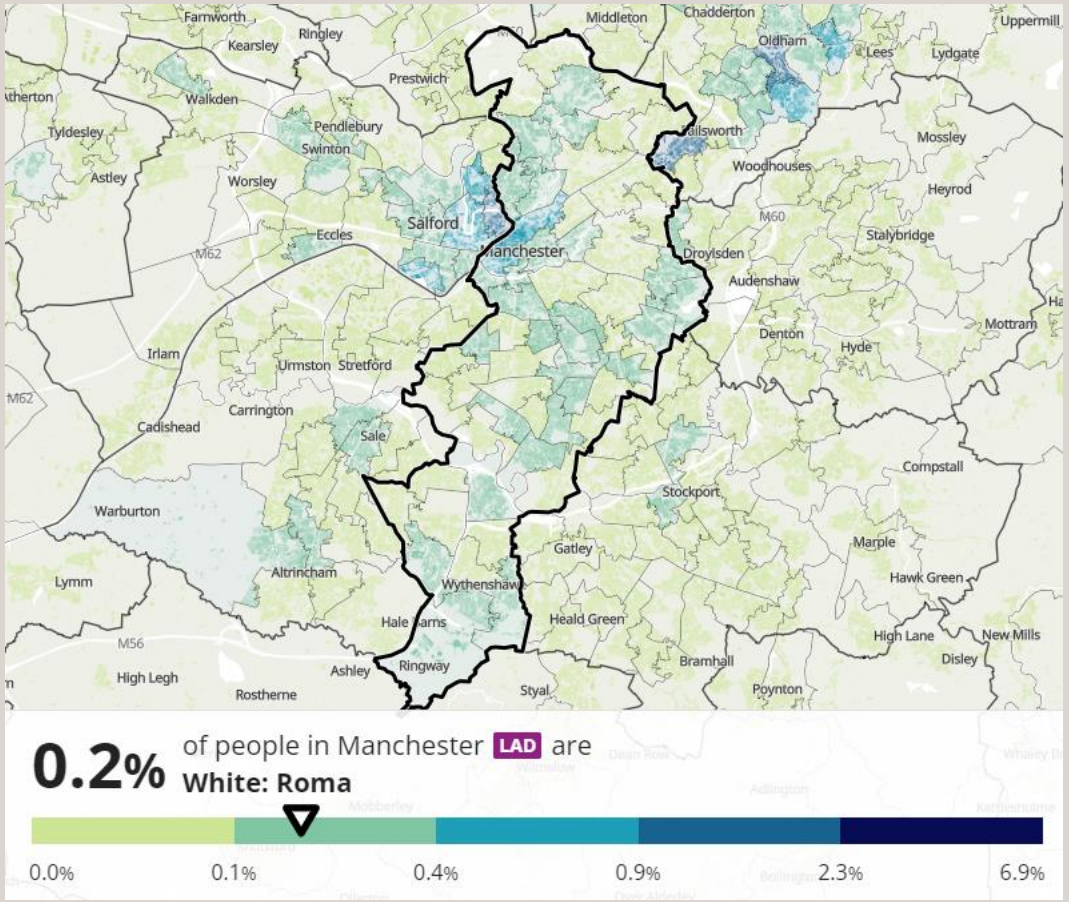
(*Nb census estimates that there was a much lower response rates for Gypsy and Irish Traveller groups than White British and Roma groups*)

Population Structure in Manchester



Source: Data from Census 2021 from the Office for National Statistics

Where in Manchester do GRT+ Communities Live?



Source: Census 2021 from the Office for National Statistics

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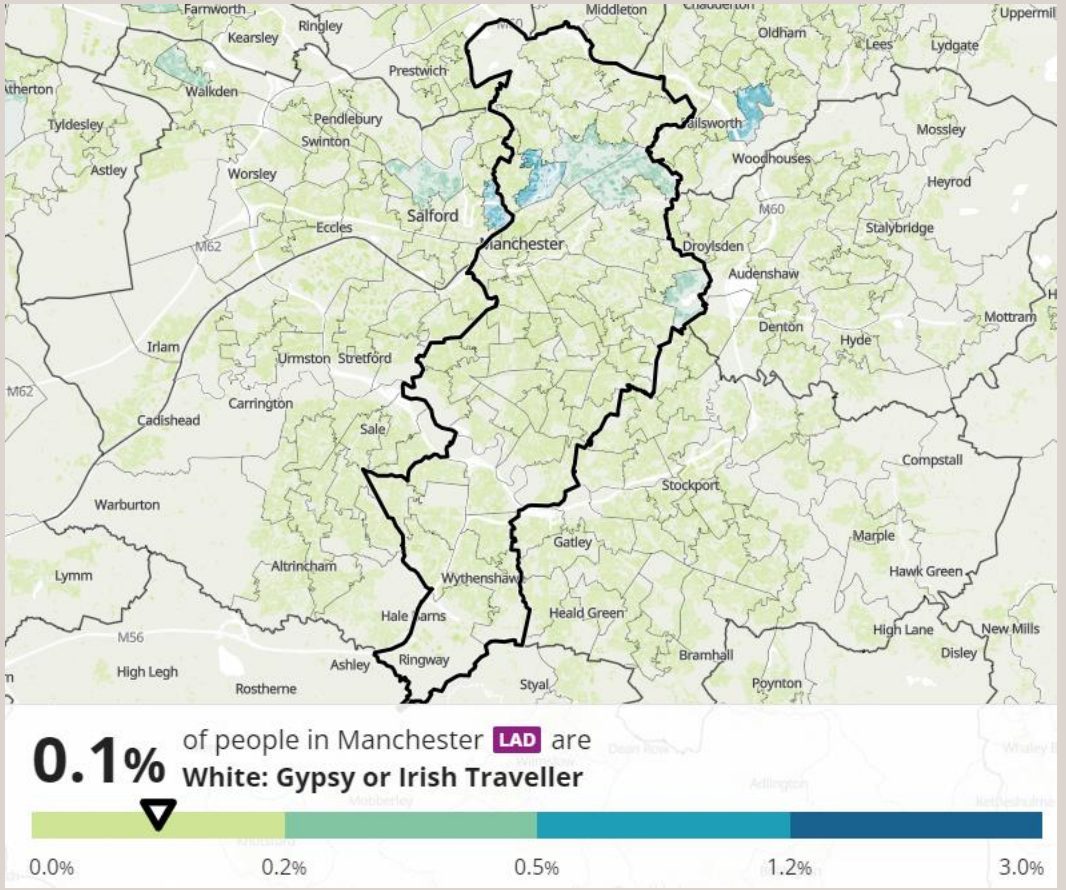
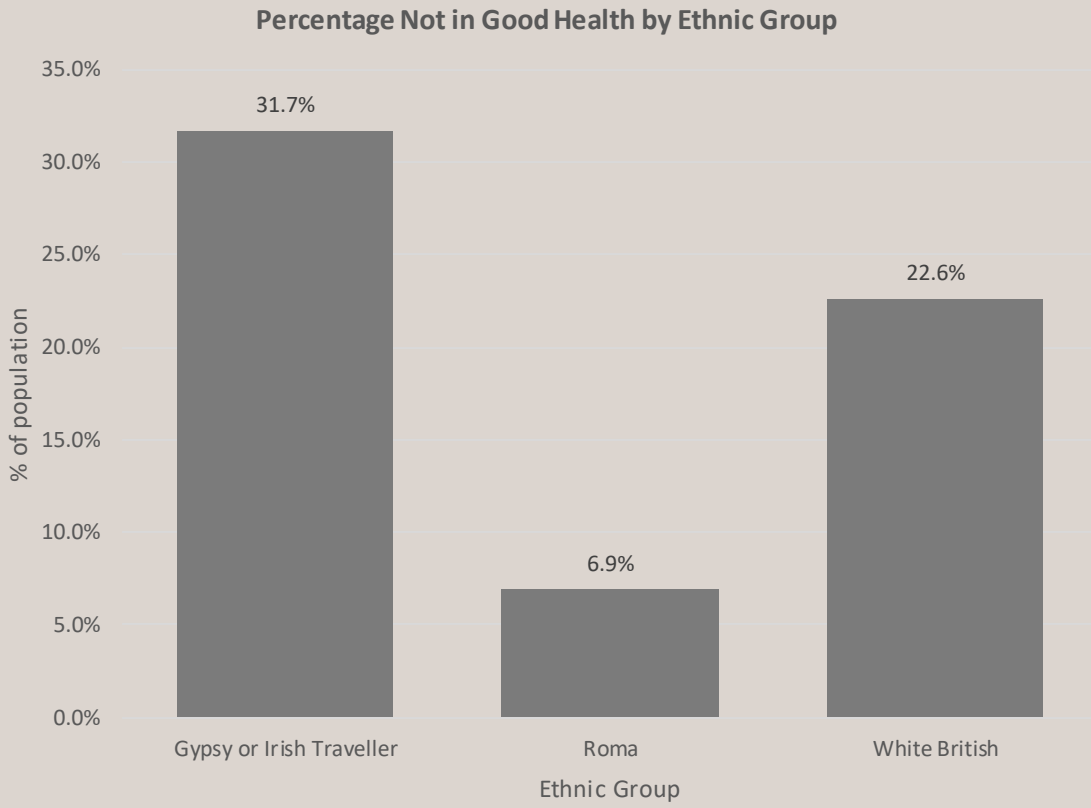


Source: Census 2021 from the Office for National Statistics

Self-reported Health Status



Source: Data from Census 2021 from the Office for National Statistics

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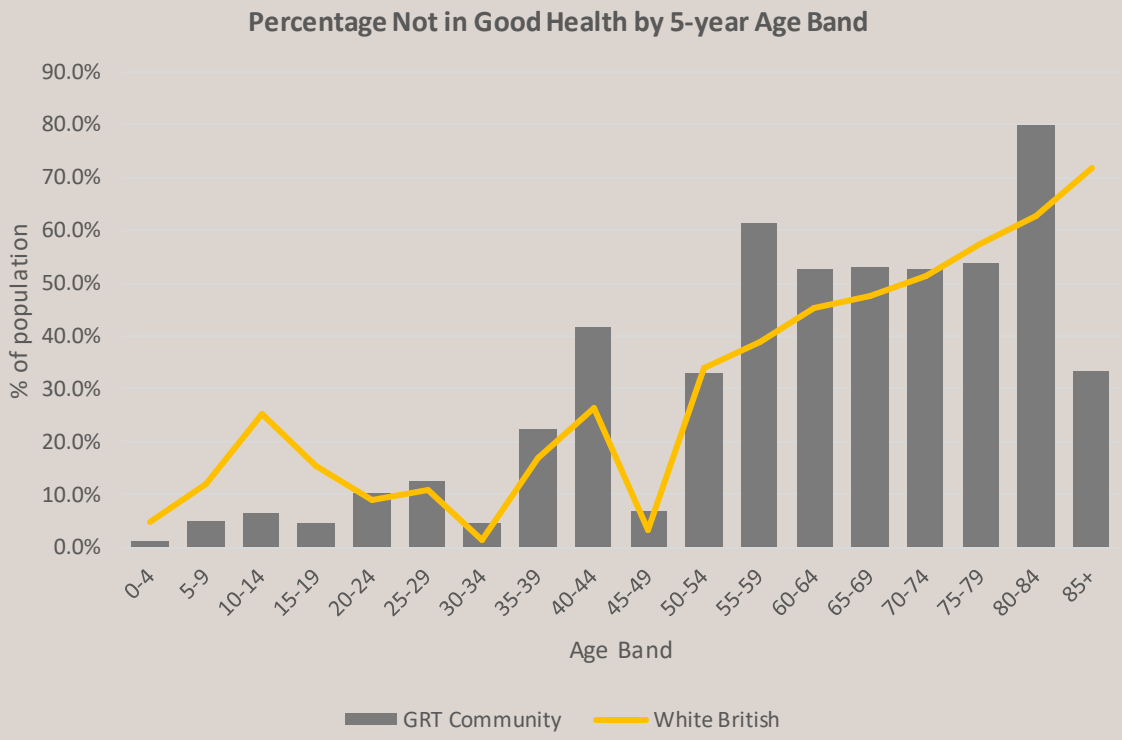
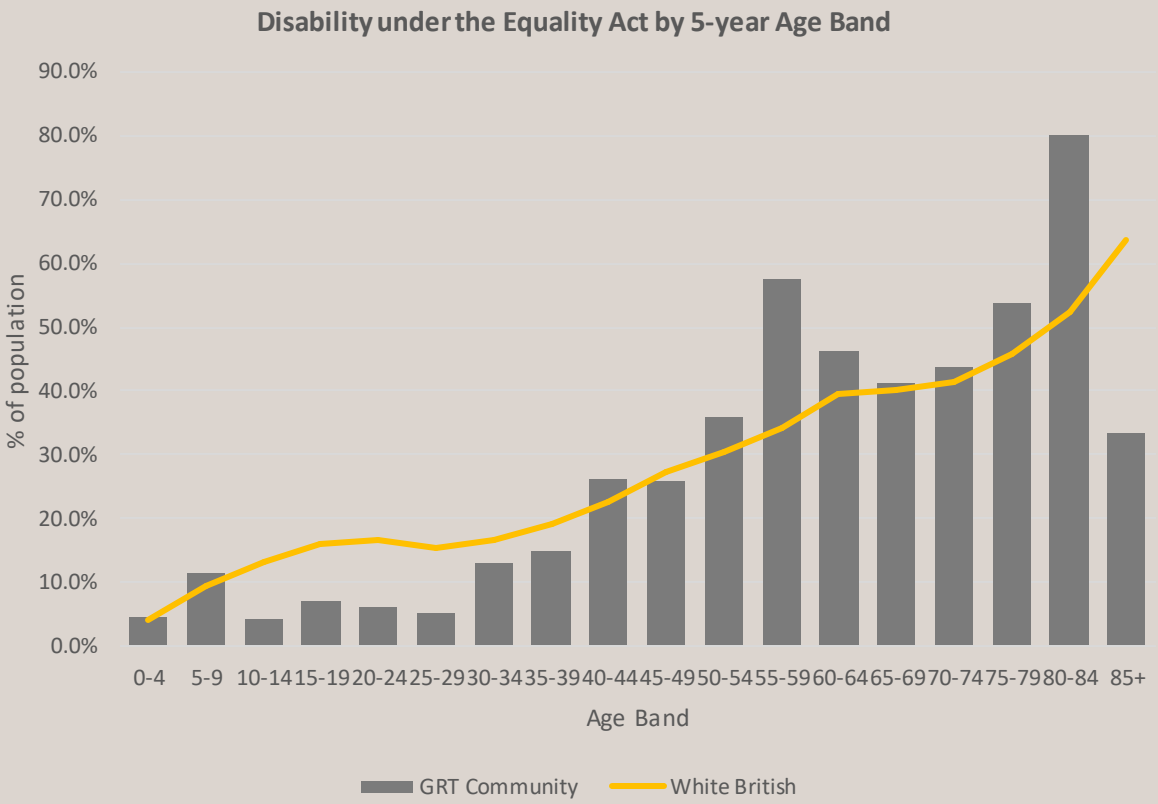


Source: Data from Census 2021 from the Office for National Statistics

Disability

Source: Data from Census 2021 from the Office for National Statistics

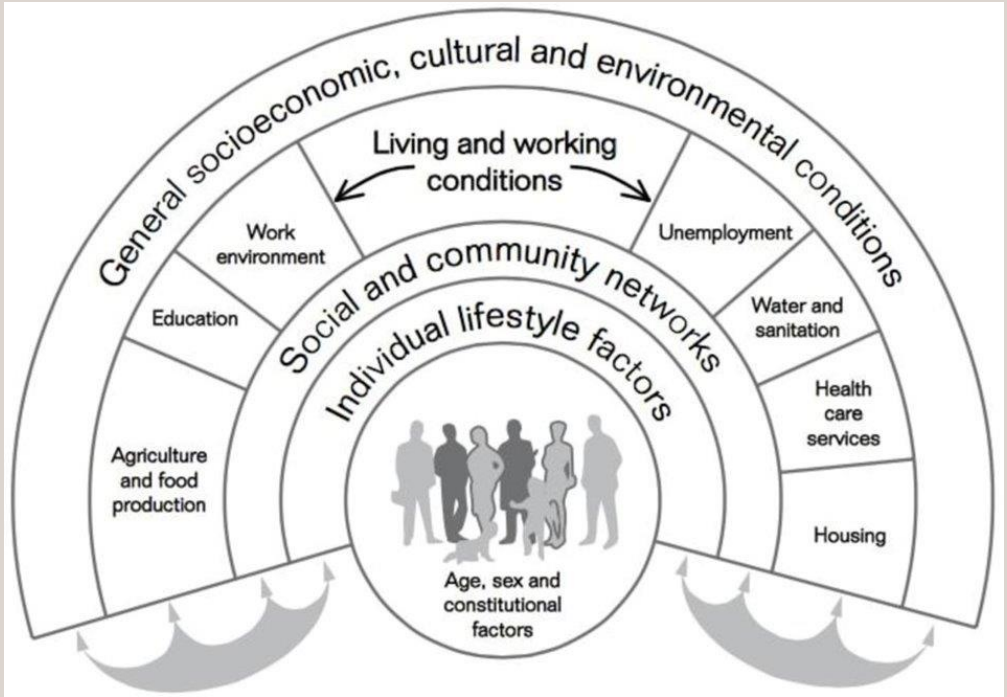
Disability



Source: Data from Census 2021 from the Office for National Statistics

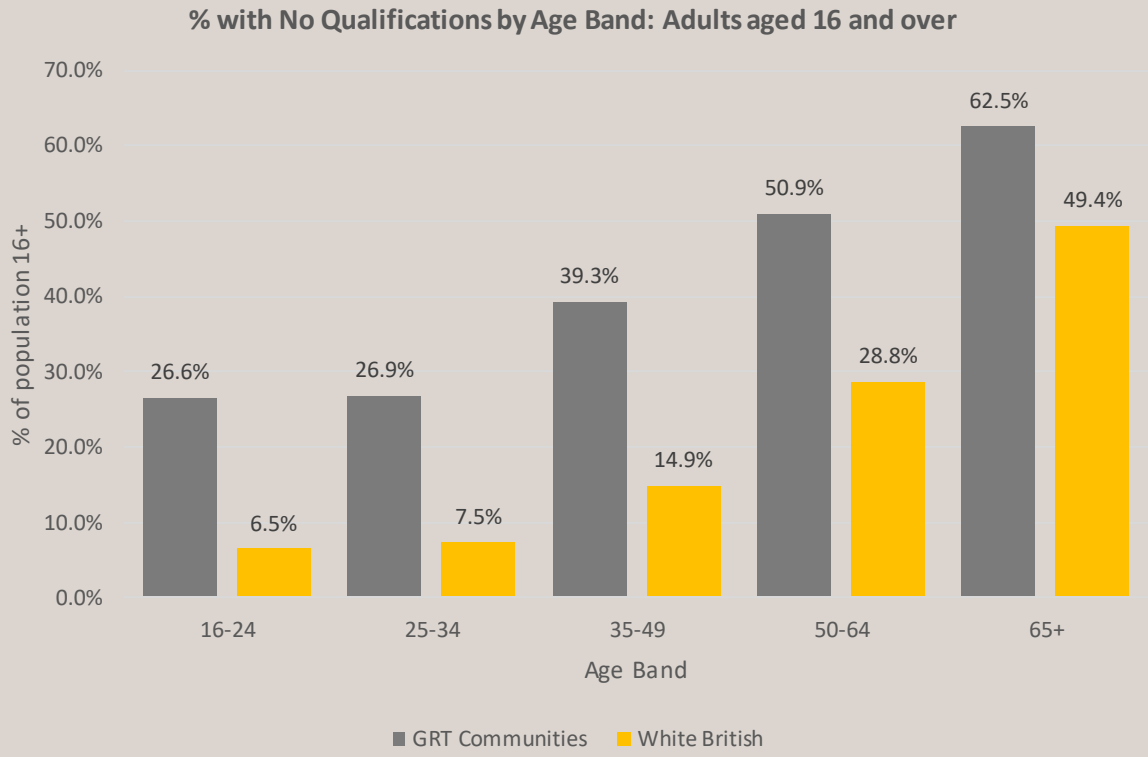
Determinants of Health

Health outcomes are not only determined by our genetics or access to healthcare, but are impacted by our living and working conditions and the wider socio-economic context.



Source: Dahlgren and Whitehead (1991)

Education



Source: Data from Census 2021 from the Office for National Statistics

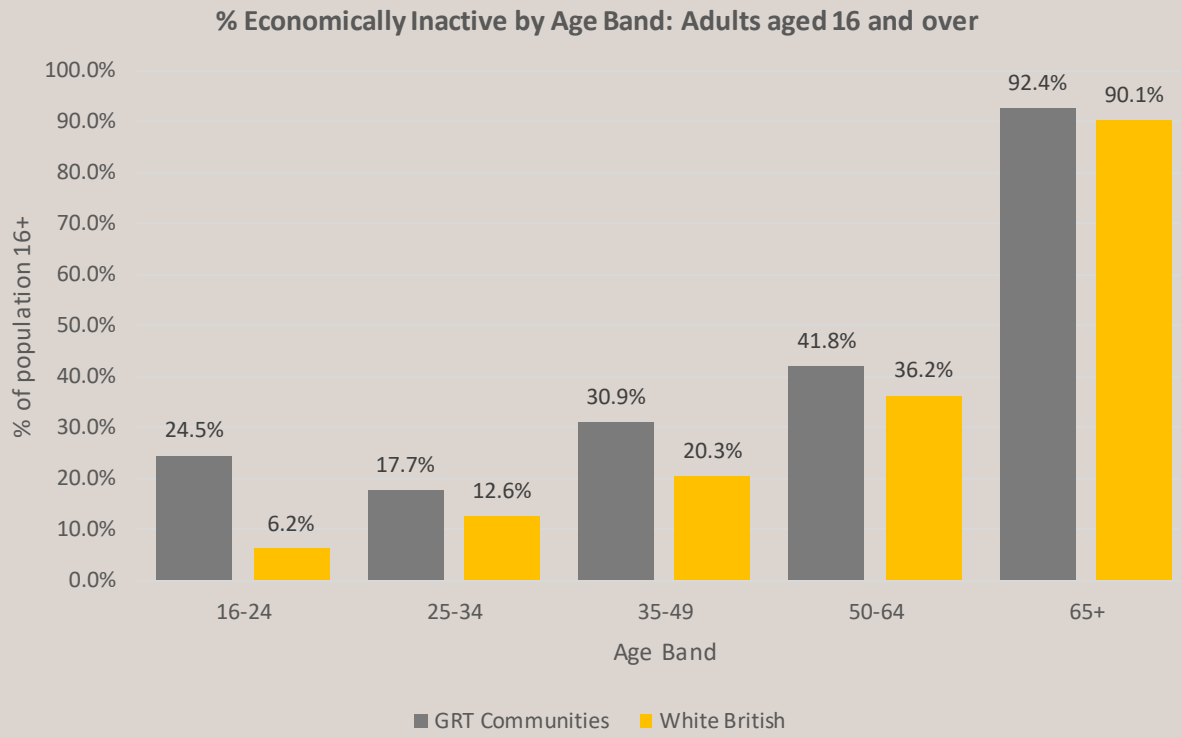
Education

The total number of children that live in Manchester, attend school in Manchester, and that identify as Gypsy, Roma, or Traveller is low (**183 in 2019 and 174 children in 2020).**

Analyses of local data have shown children who identify as Gypsy, Roma, or Irish Traveller are less likely to perform to the expected standard when compared to Manchester and National averages at all key stages.

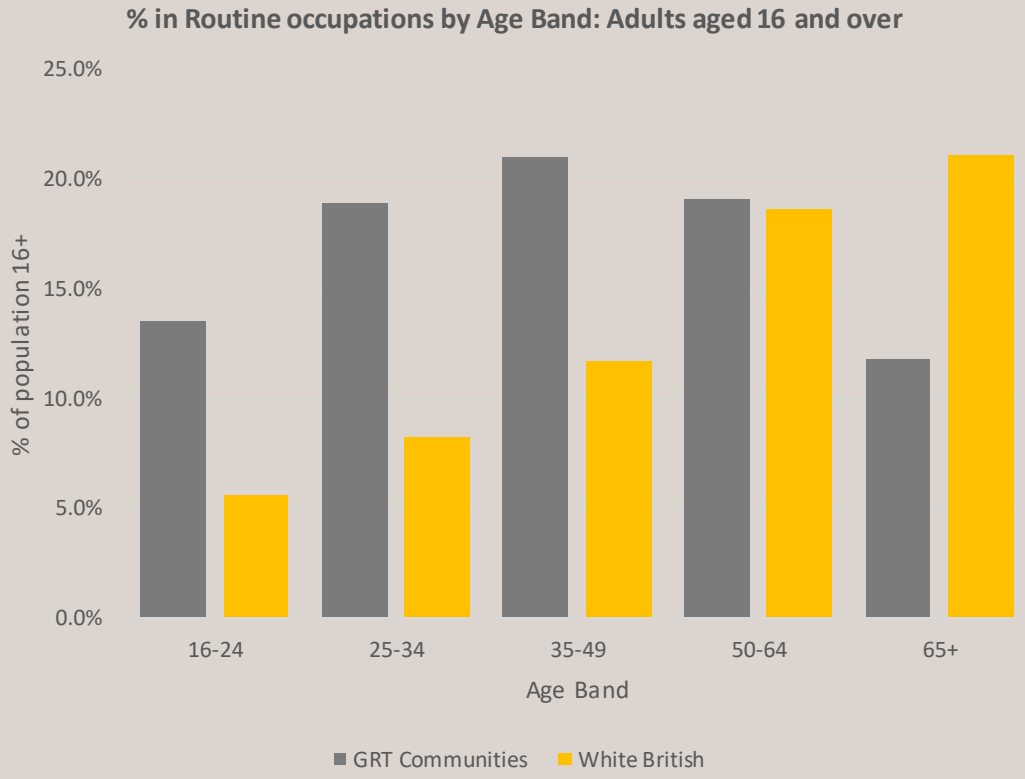
However, due to the small numbers of Gypsy, Roma, and Traveller pupils recorded in the education system in Manchester, it is not possible to determine whether observed differences in educational attainment in this group are due to real change or random variation.

Employment



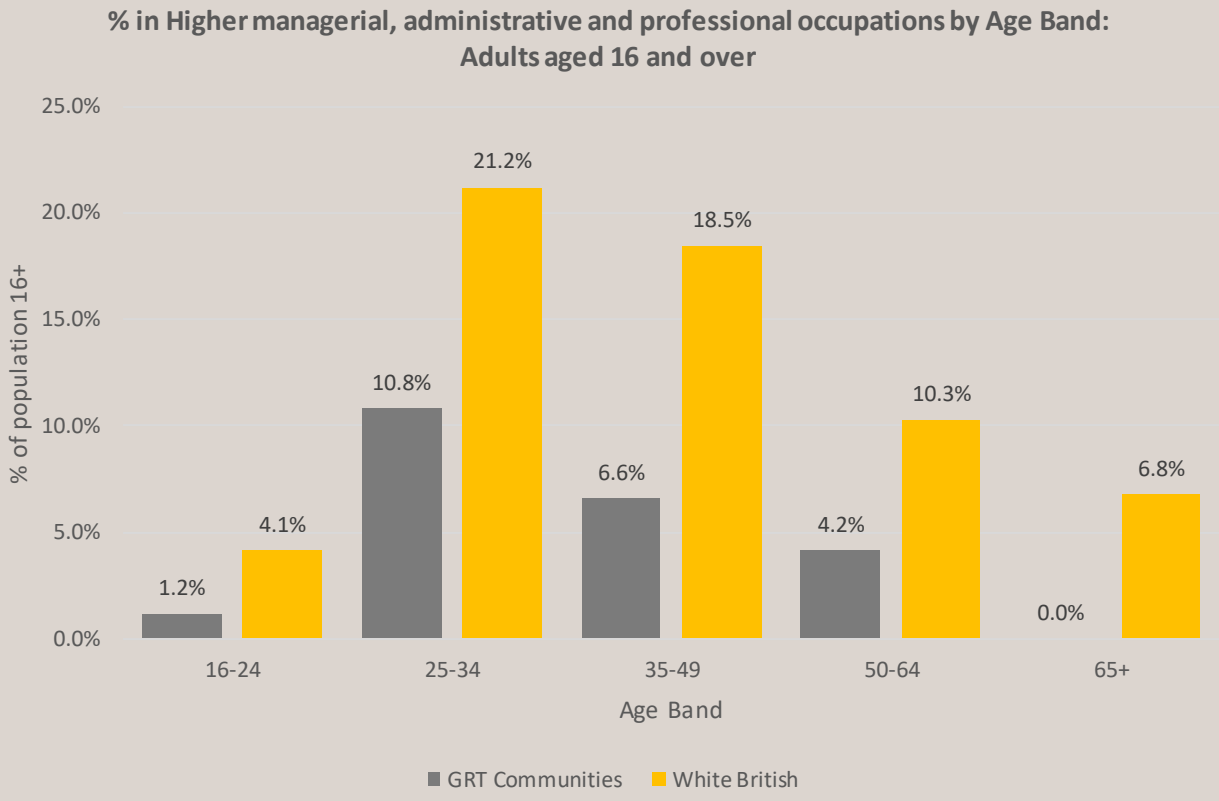
Source: Data from Census 2021 from the Office for National Statistics

Employment



Source: Data from Census 2021 from the Office for National Statistics

Employment



Source: Data from Census 2021 from the Office for National Statistics

Accommodation

There are currently no approved Traveller sites in the city of Manchester following the closure of the Dantzic Street site in 2021.

An Impact Assessment for the closed Dantzic street site highlighted the existence of unauthorised encampments within Manchester, reporting there were 32 encampments in the years 2021-2022 of which 6 were on private land. The impact assessment also acknowledged that Manchester does not currently have any provision for Travellers who are visiting or passing through Manchester.

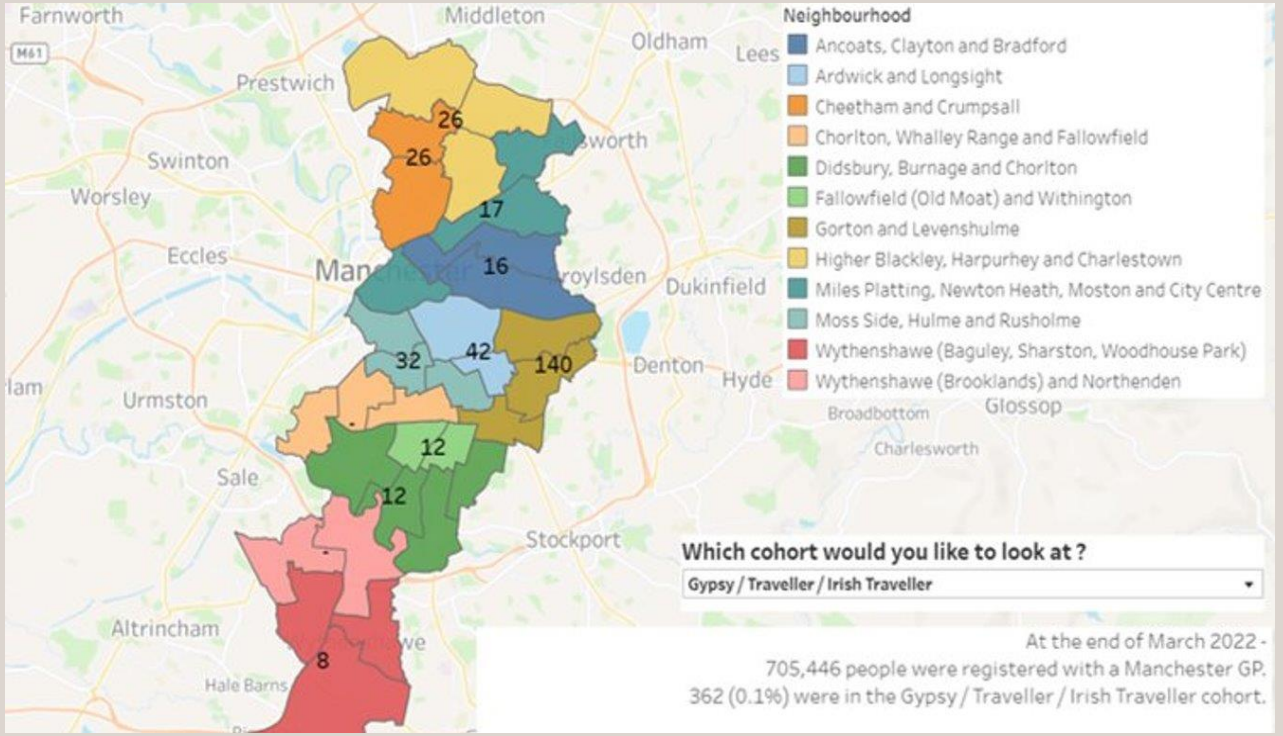
The 2022 Gypsy Traveller Accommodation Assessment (GTAA) reported there are currently three Travelling Showperson yards in Manchester providing a total of 73 residential plots. A need for 56 additional plots over the period 2017/18 to 2035/36 was evidenced. Soft intelligence indicates concerns have been raised with regards to the standards of accommodation at these sites.

Access to Health Care

Only **576** patients registered with a GP in Manchester identified their ethnicity as Gypsy, Roma, or Traveller as per an audit conducted in April 2023

This is much less than the **1480** residents identified in the 2021 census.

Where in Manchester are People who Identify as GRT+ Registered with a GP?



Source: Data from Manchester Health Care Commissioning Social Care Data Warehouse Ethnicity Cohorts Health Profile (mhcctableau.nhs.uk)

Please note the total number of patients recorded on the map in March 2022 (362) is less than the number of patients identifying as Gypsy, Roma, or Traveller captured in the most recent audit undertaken in April 2023. This may be due to different nomenclature or an increase in GP registration amongst these communities since 2022.

Access to Health Care

A higher rate of Emergency Department attendance was observed for Gypsies and Irish Travellers (459 per 1000) when compared to the general Manchester population (383 per 1000) between March 2021 and March 2022.

For those patients that go on to require an admission, the length of stay in hospital is typically shorter for Gypsy, Traveller and Irish Traveller patients and over half of the emergency hospital admissions in the Gypsy, Traveller, and Irish Traveller population end in a same day discharge.

This data only includes people who are already registered with a GP. This suggests something other than not being registered with a GP may be driving emergency and urgent care service use and warrants further exploration.

Source: Data from Manchester Health Care Commissioning Social Care Data Warehouse Ethnicity Cohorts Health Profile (mhcctableau.nhs.uk)

Cancer Screening in Manchester

Cancer Screening uptake is lower in Gypsy, Roma, and Traveller communities (GRT) in Manchester when compared to the general Manchester population

- Bowel cancer screening age 60-74 every 2- years rate for GRT communities 29% (Manchester average 57%)
- Breast cancer screening age 50-70 every 3 years rate for GRT communities 18% (Manchester average 39%)
- Cervical cancer screening age 24-49 every 3.5 years rate for GRT communities 41% (Manchester average 56%)
- Cervical cancer screening age 50-64 every 5.5 years rate for GRT communities 60% (Manchester average 70%)

Source: Manchester Health Care Commissioning Social Care Data Warehouse Screening and Immunisations

Morbidity Data for GRT+ Communities in Manchester

When compared to the general Manchester population, Gypsy, Roma and Traveller communities in Manchester have

- Higher smoking prevalence (GRT+ 26.8% vs General Manchester population 16.9%)
- Higher proportion of patients diagnosed with COPD (GRT+ 2.5% vs General Manchester population 1.7%)
- Higher obesity prevalence (GRT+ 18.8% vs General Manchester population 12.5%)
- Higher proportion of patients diagnosed with diabetes (GRT+ 8% vs General Manchester population 5.2%)

Source: Data from Manchester Health Care Commissioning Social Care Data Warehouse Ethnicity Cohorts Health Profile

Vaccine Uptake Amongst GRT+ Communites in Manchester

There was a lower uptake of vaccinations against both COVID-19 and flu in Gypsy, Traveller, and Roma identifying Manchester residents when compared to Manchester residents from other ethnic backgrounds

- COVID 19
  - Gypsy / Traveller 20.8%
  - Roma 30.5%
- Flu
  - Gypsy / Traveller 21%
  - Roma 31%

However, the flu vaccine uptake has increased from 6% to 31% in the Roma community since the COVID-19 pandemic

Absolute numbers are small, but this could suggest that engagement work during the pandemic has been beneficial in encouraging flu vaccination in this group

Source: Manchester Health Care Commissioning Social Care Data Warehouse Screening and Immunisations

Mental Health and Wellbeing in GRT+ Communities in Manchester

A higher proportion of GP registered Gypsy and Traveller patients are on the mental health register (1.9%) when compared with other Manchester residents (1.2%) though data on mental health condition prevalence is not available.

The commissioned Improving Access to Psychological Therapies (IAPT) services use nationally determined ethnicity categories that do not have either a Gypsy / Traveller, or Roma ethnic category, so it is not known how many people identifying as Gypsy, Roma, or Traveller are using these services and whether access is equitable or whether this is a barrier that results in a higher number of residents on the mental health register.

Source: Data from Manchester Health Care Commissioning Social Care Data Warehouse Ethnicity Cohorts Health Profile (mhcctableau.nhs.uk)

Support Available to Gypsy, Roma and Traveller Communities in Manchester

What is Manchester City Council Doing to Support GRT+ Communities?

The different roles of the Council may result in conflicting priorities, for example when considering the Council's role to enforce versus to deliver welfare support, which may impact community engagement.

The Council recognises this may put GRT+ communities at risk of reduced access to services, therefore plans have been discussed to engage third parties to help deliver welfare support services, demonstrating a commitment to supporting GRT+ residents.

There have been delays in identifying a new permanent site for the community, and at present the lack of culturally appropriate accommodation is having a negative impact on the community.

No GRT+ specific commissioned services are routinely available for GRT+ communities in Manchester.

VCSE Organisations working to support GRT+ Communities in Manchester: National Organisations

National VCSE Organisations offer support to Manchester residents who identify as Gypsy, Roma, or Traveller through remote and online services.

These are:

- **Friends Family Travellers (FFT)**
- **National Association of Teachers of Travellers and Other Professionals (NATT+)**
- **Advisory Council for the Education of Romany and other Travellers (ACERT)**
- **The Gypsy Council**
- **The Traveller Movement**
- **The Roma Support Group**
- **National Federation of Gypsy Liaison Group**

VCSE Organisations working to support GRT+ Communities in Manchester: ICC

Irish Community Care (ICC) is a voluntary organisation based in Manchester that works closely with the Irish community, including Irish Travellers. They offer advice and information to Greater Manchester residents on accessing benefits and services. They are also funded to provide more intensive support and advocacy services for Manchester residents.

They run several community engagement programs including social lunches and young women support groups in South Manchester and are looking to expand to offer more community group activities in North Manchester. They also provide cultural awareness training that is available for Council employees and those working in commissioned services.

VCSE Organisations working to support GRT+ communities in Manchester: Europia

Europia is a voluntary organisation based in Manchester that works closely with migrants and the Roma community. Europia provide administrative support to help the local Roma community navigate systems, for example through translation provision or help for those with lower levels of literacy. The support provided includes welfare advice, immigration advice, and health and wellbeing support.

Europia also provide weekly drop-in sessions that have been well attended by the local community, that includes a health hub.

Europia have also worked collaboratively with local health partners and academic institutions to facilitate community consultation and health service engagement.

What are Local GP Practices Doing to Support GRT+ Communities in Manchester?

Focused Care workers form a Levenshulme GP surgery worked with Europia to attend the homes of local Roma families when children had not attended planned vaccination or GP appointments.

Through this work, it was identified that some of the families had not understood the letter that had been sent to them that was written in English.

In another instance, there had been a misunderstanding about the need for a follow-up appointment with the GP as the families believed it was not necessary as they had already been seen in A&E.

As a result of this outreach work, communication to these families was improved, misunderstandings were addressed, the children were followed up by the GP, and vaccinations were administered as appropriate. Additional wrap around support by Europia was also offered. This shows how outreach can lead to improved access to healthcare for families.

Lived Experience of Roma Communities in Manchester

Photovoice Focus Groups: Methods

A community engagement photovoice project has been undertaken in partnership with Europia with a small number of people from the Roma community in Greater Manchester.

Participants brought photos to focus groups that were representative of things that made it easy or hard to be healthy and discussed what the images meant to them with the group. The sample was small and as such cannot be assumed to be representative of the wider community.

However, some interesting themes arose from the discussions around the photos taken that can inform actions moving forward.

Of note, many participants brought in photographs of things that impacted their mental wellbeing, and this was what participants wanted to spend time in the focus group discussing.

Photovoice Focus Group Findings: Food

Photovoice Theme: Food

Several participants brought photos of food. Discussions highlighted the importance of both eating a diet that allows you to feel healthy and how preparing and sharing food with family and friends improves wellbeing.

Through discussion, some of the barriers identified to following a healthy diet included lack of money and resources.

Participants that had previously been reliant on food vouchers discussed how food that was available from food banks is often unhealthy or “typically English food” and thus not culturally appropriate.

It was noted that participants did not feel they lacked the knowledge or skills to make healthy meals.

Photovoice Focus Group Findings: Pets, Transport and Surroundings

Photovoice theme: Pets, Transport & Surrounding Environment

Many participants brought in photos of pets, citing the love and connection they felt as a contributor to their wellbeing.

The ability to access greenspace and be in nature was considered important to participants, and barriers to this included health conditions that limited mobility, as well as distance from greenspace and the need for a car to access some greenspaces.

Though cars were cited as having a positive impact by allowing freedom to get around, traffic was also highlighted as a significant cause of stress and ill health. When the suggestion of using alternative forms of transport was discussed, such as public transport, or active travel, participants identified poor weather as a barrier to cycle, and the unreliability of bus and tram schedules as a barrier to using public transport.

Photovoice Focus Group Findings: Religion and Self-Care

Photovoice theme: Religion and Self-care

One participant brought in photos of objects that represented self-care rituals such as make up brushes and perfumes, leading to a wider discussion by the group of how important it is to partake in regular "self-care" activities to look after your mental wellbeing.

One participant brought in photos of the bible and religion was felt to be very important to several participants. The focus was primarily on the sense of purpose following a religion gave their lives, and the importance of a connection with a higher being, as both were felt to improve wellbeing. Less importance was assigned to the sense of community associated with organised religion.

Photovoice Focus Group Findings: "Bad Habits"

Photovoice Theme: "Bad Habits"

A picture of cigarettes was brought in by a participant who smoked who recognised the negative impact smoking was having on her health, describing this as her "bad habit". However, they described seeking support to quit smoking from the GP, but that a barrier to a successful quit attempt was that everyone around her continued to smoke, and so when she tried, she was unsuccessful.

Interestingly, participants that attended the focus group did not indicate lack of access to healthcare services had a significant impact on their health, and many participants with long term health conditions discussed how they would regularly see their GP and hospital consultants. However, it is important to note this focus group may not be representative of the wider community.

Photovoice Focus Group Findings: Ideas for Europia's Health Hub

Photovoice: Ideas for Europia's Health Hub

When discussing what they would like to change and what sessions they would like Europia to put on through their health hub, participants requested a reduction in traffic, and that they would appreciate sessions to support mental health and wellbeing.

They also requested any sessions adopted a positive focus.

Photovoice Focus Group Findings: Key Take Home Messages

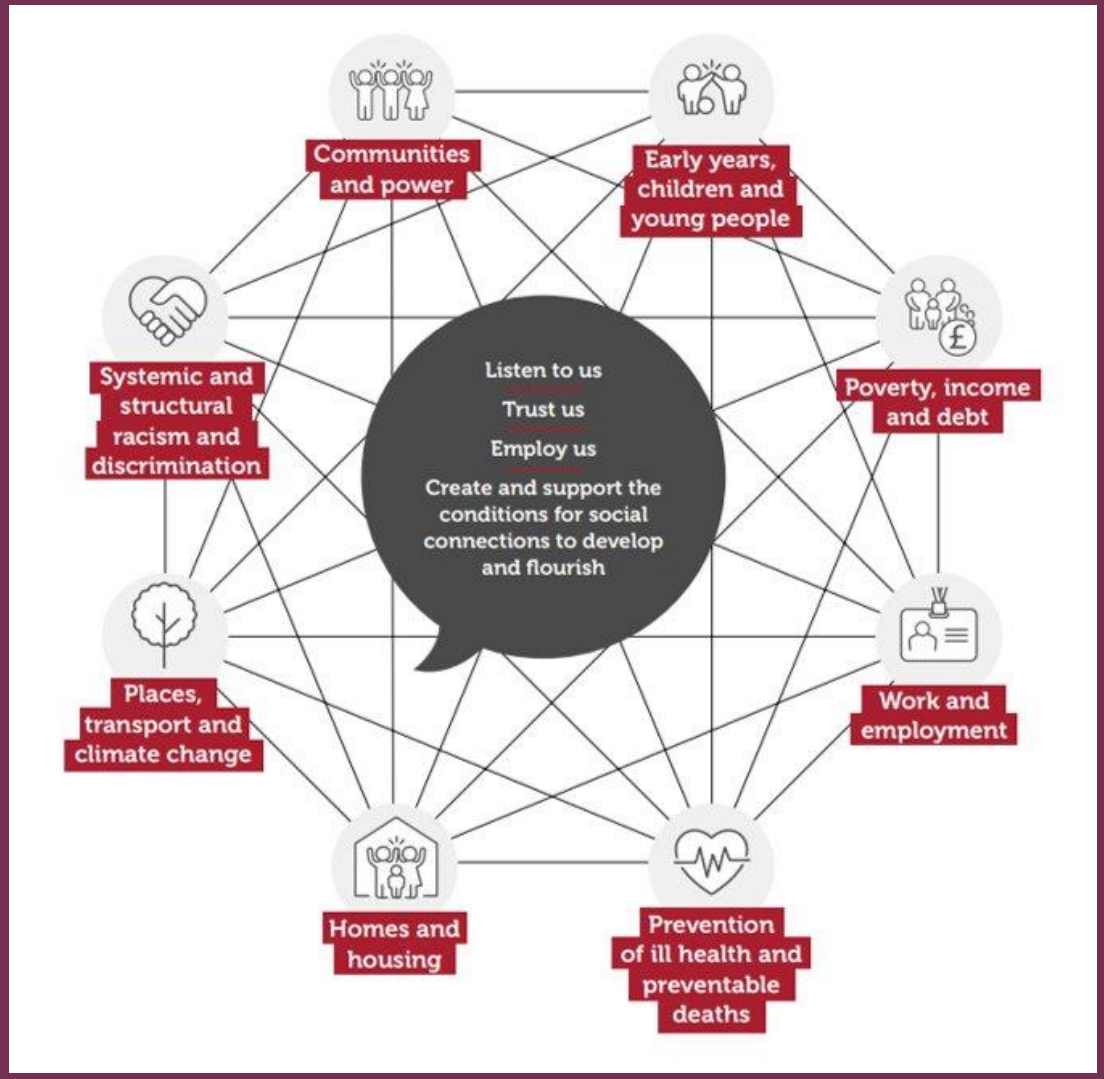
Mental Wellbeing is of paramount importance to the community when considering things that impact health.

Food, surroundings, religion, and self-care were all identified as important factors that influence mental wellbeing and therefore health.

The absence of culturally appropriate or healthy food from food banks is a barrier to health.

There was a preference for "focusing on the positives" when delivering interventions or supporting the community.

Opportunities for Action



Opportunities for Action: Early Years, Children, Young People

Early Years, Children, Young People

Review antenatal care and health visitor support available for mothers from GRT+ communities and consider local VCSE collaboration to co-develop initiatives.

Acknowledge poorer educational attainment in pupils from GRT+ backgrounds in schools and prioritise Gypsy, Roma, and Traveller pupils in kickstarter program.

Enable more pupils from Gypsy, Roma, and Traveller backgrounds to enter Higher Education (for example by asking anchor institutions such as the University of Manchester to adopt the GTRSB pledge).

Opportunities for Action: Poverty, Income, Debt

Poverty, Income, Debt

Anti-poverty strategy needs to specifically consider why members of Gypsy, Roma, and Traveller communities are more prone to poverty.

Closer working with local VCSE organisations that already support these communities to ensure all appropriate advice can be accessed during one port of call.

Direct consultation with local community members and VCSE groups to address the gaps in current service provision.

Opportunities for Action: Work and Employment

Work and Employment

Employment opportunities available for people from Gypsy, Roma, and Traveller communities need to be improved.

Local intelligence should be used to design and target interventions to reduce the barriers to learning and employment that these communities face.

Closer working with VCSE organisations and support the Neighbourhood work through the Bringing Services Together network.

Community-led training should be delivered for frontline work teams delivering local work club provision so services are culturally appropriate.

Larger GM commissioned back to work programmes can help ensure tailored employment support can be provided.

Opportunities for Action: Prevention of Ill Health and Preventable Deaths

Prevention of Ill Health and Preventable Deaths

A harmonised data standard must be adopted across all services to effectively monitor health inequalities.

Mainstream healthcare services need to be inclusive, therefore the implementation of the following interventions should be considered:

- Cultural sensitivity and awareness training for staff.
- Flexibility around appointments and the provision of drop-in services.
- Consultation with local communities and health service providers to determine possible barriers to service uptake.
- Further work should focus on the drivers of preventable deaths such as smoking, cancer screening, and obesity.

Opportunities for Action: Homes and Housing

Homes and Housing

The Gypsy Traveller Accommodation Assessment from 2022 identified the need for 17 pitches and recommended 2 new sites should be developed to meet the needs of the 2 extended families requesting site accommodation.

The planning team need to identify new sites as matter of urgency and commit to the development of new sites to meet this need.

Opportunities for Action: Places, Transport, Climate Change

Places, Transport, Climate Change (1)

- Adoption of a negotiated stopping policy
  - Provision of basic amenities at temporary sites, such as bins and toilets, will help reduce the impact of transient communities on neighbourhoods.
  - This will help foster better relationships between transient Traveller communities and settled residents, thus improving the environment and surroundings of the areas in which residents live.
  - Land which has the potential to accommodate smaller numbers (up to 10 caravans) and larger numbers (up to 34 caravans) should be identified for future transit use.

Opportunities for Action: Places, Transport, Climate Change

Places, Transport, Climate Change (2)

The increased vulnerability of Gypsy, Roma, and Traveller communities to climate change should be formally recognised.

This may be achieved through:

- Specific consideration of these communities in adverse weather plans.
- Caravan sites at risk of flooding to be included as a climate change vulnerability indicator for ongoing monitoring of the health impacts of climate change.

Opportunities for Action: Communities and Power

Communities and Power

Manchester City Council needs to demonstrate trustworthiness and commitment to tackling inequalities.

More direct consultation with the Gypsy, Roma, and Traveller communities is urgently needed.

Collaborative working with trusted VCSE partners is required to achieve this

- *community engagement projects*
- *participatory research*

Opportunities for Action: Systemic and Structural Racism and Discrimination

Systemic and Structural Racism and Discrimination

This must not be viewed as a stand-alone theme but must cross-cut all other themes.

Cultural awareness training for both front line staff and those involved in the strategic development of services is needed to ensure services delivered are not discriminatory.

- ICC offer both online and face to face training accessible for Council employees via learning hub.
- ICC also offer this training to other services.

Tackling discrimination may help reduce the burden of poorer mental health in these communities.

Ongoing direct consultation with Gypsy, Roma, and Traveller communities will then determine how effective these measures have been in tackling discrimination and the effect this has on the wellbeing of these communities.

Summary

People belonging to Gypsy, Roma, and Traveller communities have poorer health outcomes when compared with the general population.

This is driven by inequalities in the wider determinants of health.

There is limited data on how equitable health service access is for people from these communities in Manchester but the data that is available suggests GRT+ communities are less likely to access primary and preventative health care.

Opportunities for action to tackle these health inequalities have been aligned to the 8 MMF Themes.

The council and commissioned services must commit to the accurate monitoring of inequalities through adoption of harmonised data standards.

Sources

In addition to analysis of locally gathered data, the following sources were used to compile this JSNA

- 2021 Census data and associated reports published by the Office of National Statistics and Gov.UK concerning the Gypsy, Roma, and Traveller communities
- Making Manchester Fairer Strategy
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Manchester City Council
Report for Information

Report to: Manchester Health and Wellbeing Board – 24 January 2024

Subject: Making Manchester Fairer: Update on the Kickstarter Schemes

Report of: Deputy Director of Public Health, Manchester City Council

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Summary

This report provides a progress update on the implementation and delivery of the Making Manchester Fairer Kickstarter Schemes:

(i) Improving Health Equity for Children and Young People- Children's Element
(ii) Early Help for Adults Experiencing Multiple and Complex Disadvantage
An update on the Young People's Mental Wellbeing scheme will be presented at the next MMF update to the Board.

Recommendations

The Board is asked to note progress made on the delivery of these MMF Kickstarter schemes.

Wards Affected: ALL

Environmental Impact Assessment -the impact of the issues addressed in this report on achieving the zero-carbon target for the city.	*NA*
Equality, Diversity and Inclusion - the impact of the issues addressed in this report in meeting our Public Sector Equality Duty and broader equality commitments	All Kickstarter models featured in the report have completed an Equality Impact Assessment (EqIA) with the focus on improving health equity for the target population groups.

Manchester Strategy outcomes	Summary of how this report aligns to the OMS/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	There is a recognition that Covid-19 has had a disproportionate impact on certain communities in our city. In delivering Making Manchester Fairer we will address the health inequalities that have been exacerbated by the Pandemic and the Cost of Living Crisis. The plan, sets out how we will build on the strengths of Manchester as a city and the amount of work that is already taking place to improve lives for residents, reflecting the OMS outcomes: • A Progressive and Equitable City : We will strive to create a truly equal and inclusive city, where everyone can thrive at all stages of their life, and quickly and easily reach support to get back on track when needed. • A highly skilled city: world class and home grown talent sustaining the city's economic success • A liveable and low carbon city: a destination of choice to live, visit, work
A highly skilled city: world class and home grown talent sustaining the city's economic success	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

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Background documents (available for public inspection):

Building Back Fairer – Tackling Health Inequalities in Manchester – Health and Wellbeing Board, 6 July 2022

Making Manchester Fairer, Tackling Health Inequalities in Manchester 2022-2027 – Health Scrutiny Committee, 12 October 2022

Making Manchester Fairer - The Anti-Poverty Strategy 2023-2028 – Economy Scrutiny Committee, 18 January 2023

Making Manchester Fairer - – Tackling Health Inequalities in Manchester – Health and Wellbeing Board, 25 January 2023

Making Manchester Fairer - – Tackling Health Inequalities in Manchester – Health and Wellbeing Board, 7 June 2023

Making Manchester Fairer - – Tackling Health Inequalities in Manchester – Health and Wellbeing Board, 20 September 2023

Making Manchester Fairer - – Tackling Health Inequalities in Manchester – Health and Wellbeing Board, 1 November 2023

1 Introduction

1.1 Making Manchester Fairer (MMF) is Manchester City Council's five-year action plan to address health inequalities in the city focussing on the social determinants of health.

1.2 The delivery of Making Manchester Fairer can be summarised by its eight themes, four ways of involving communities and six principles that underpin the way the programme will be delivered.

Figure 1: MMF Delivery Plan Themes, Principles and Ways of Involving communities.

Themes	Principles for delivery	Ways of involving communities *
❖ Early years, children and young people. ❖ Poverty, income and debt. ❖ Work and employment. ❖ Prevention of ill health and preventable deaths. ❖ Homes and Housing. ❖ Places, transport and climate change. ❖ Systemic and structural racism and discrimination. ❖ Communities and power.	❖ Proportionate universalism and focus on equity. ❖ Respond to and learn from impact of COVID-19. ❖ Tailor to reflect the needs of Manchester ❖ Collaboration, creativity, and whole system approach. ❖ Monitor and evaluate to ensure we are Making Manchester fairer – narrowing gaps within Manchester as well as regional and national averages. ❖ Take a life course approach with action on health inequalities starting before birth and right through to focus on ageing and specific needs of older people.	❖ Listen to us ❖ Trust us ❖ Employ us ❖ Create and support the conditions for social connections to develop and flourish

*Based on insight from community group engagement

2 Background

2.1 Making Manchester Fairer is a broad and ambitious plan that will take time to get underway and deliver well. In recognition of that, a number of Kickstarter schemes were identified to 'kickstart' delivery of the plan with a focus on improving health equity, exemplifying the MMF principles and building momentum for the plan's delivery whilst the detail of the broader approach takes shape. Two of these schemes have been prioritised for investment in the first phase and will be expected to deliver financial benefits as well as improving health equity for the target population groups.

3 Overview of Kickstarter Schemes and Investment Fund

3.1 Four Kickstarter schemes were initially identified focusing on Children and Young People, Early Help for Adults, Work and Ill Health and Physical Activity.

3.2 The Making Manchester Fairer Investment Fund is currently City Council funding that is expected to deliver savings within the next three to five years. The Phase One Kickstarter schemes are expected to deliver financial benefits as well as improving health equity for the target population groups. The two Kickstarter schemes that were prioritised for investment within Phase One are: (i) Improving Health Equity for Children and Young People, with a costed budget of £1m for the children's element and £430k for the young people's element.~

(ii) Early Help for Adults Experiencing Multiple and Complex Disadvantage, with a costed budget of £850k.

3.3 The development, endorsement and delivery of the schemes has been an iterative and supportive process whereby implementation of the schemes could begin at a small scale without waiting for final endorsement by the MMF Programme Board. The Board is being used at check points to endorse ongoing development and ensure delivery is in line with the objectives of the MMF plan. This should provide assurance for the Kickstarter schemes and investment without causing a delay to implementation.

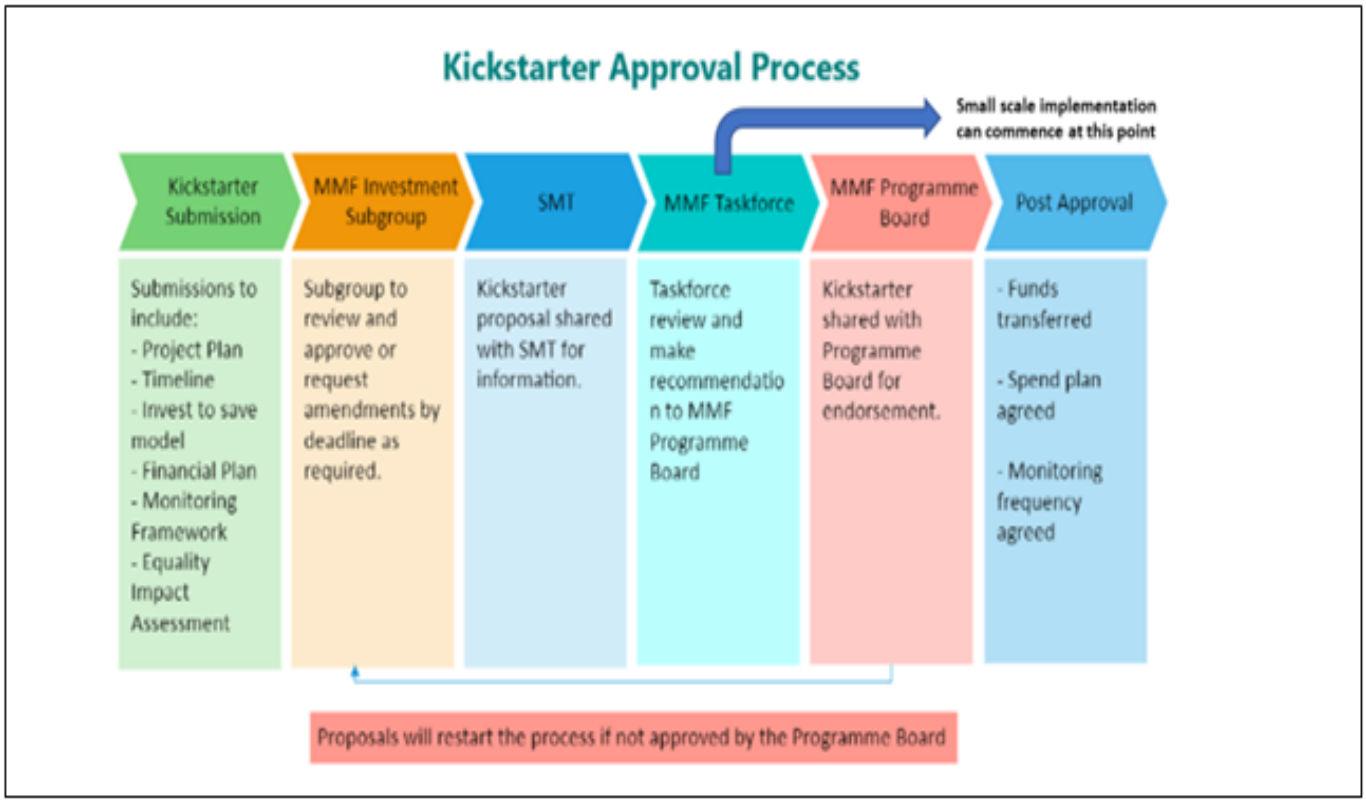

Figure 2: Kickstarter Scheme Approval Process

4. Improving Health Equity for Children and Young People - Children's Element

4.1 The children's element of this Kickstarter scheme is a 3-tier support offer delivered by a collaborative task force of services to provide intensive, targeted and universal support and interventions for children and families in early years and their families.

4.2 Schools with a cohort of children with a widening gap in Early Years and Family Services outcomes were identified and triangulated with data on deprivation, not reaching good levels of development (GLD), free school meals, English as an additional language, numbers not taking up the two-year-old offer, and those with the highest number of EHCPs (Education, Health and Care Plans).

4.3 This put schools into five clusters across thirteen wards, where the need is highest. The clusters of schools are based on geographical areas and include intensive support schools and targeted support schools. See list of clusters of schools in Appendix 1.

4.4 These schools will access a multi-agency task force provision wrapped around the early years cohort in school to ensure that identified and emerging needs within the cohort are responded to. This includes a focus on approaches in school as well as family work and the wider community offer for families to ensure that children are accessing as many opportunities as possible to support their development. Strong links to Family Hub services and Early Years provision will be developed, ensuring families have access to high quality universal service.

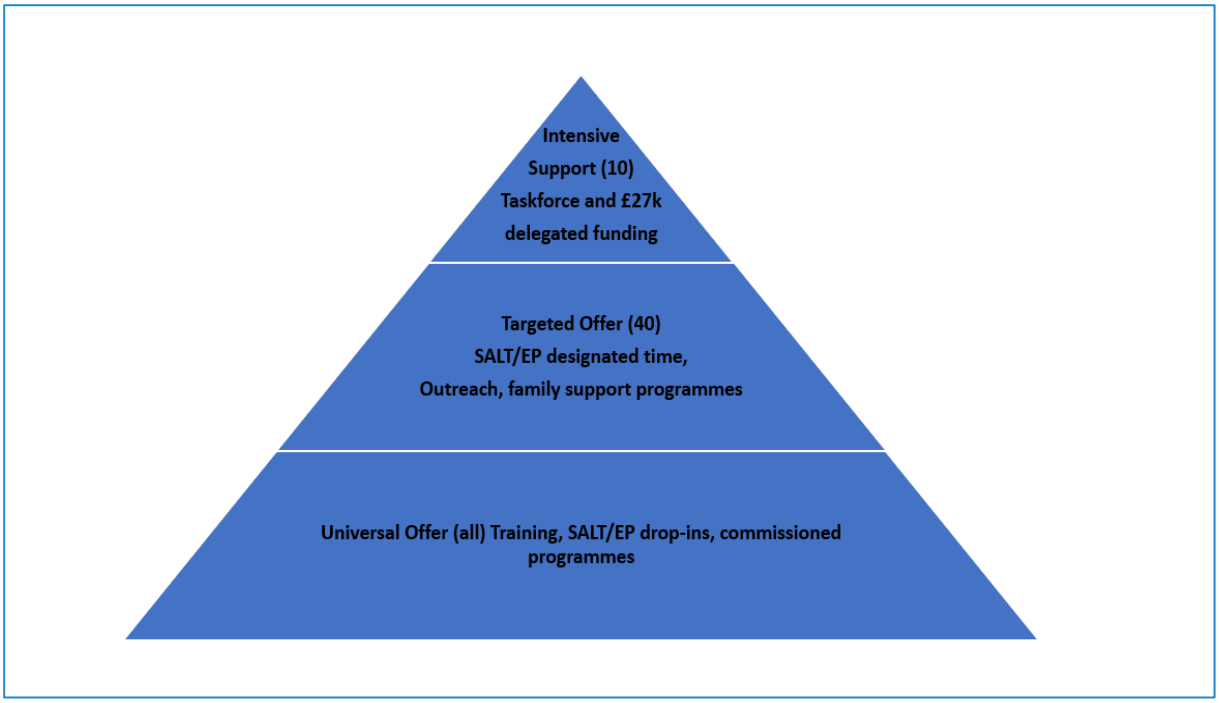

Figure 3: Three Tier Support Approach

4.5 Benefits of the scheme will be in the short/medium-term:

- Improved school attendance
- Improved uptake of Early Years offers/free two-year-old childcare
- Improved school readiness.

4.6 Longer term benefits will be realised in two to three years through:

- Reduction in demand for specialist services such as speech and language therapy

- Reduction in Education, Health, and Care Plans (EHCPs) due to needs being met at SEND (Special Educational Need and Disability) services.
- Increase in children reaching the appropriate level at each transition stage.

Progress on implementation and delivery:

4.7 Intensive schools: All ten schools have been appointed a Support Worker which has enabled the assessment, training and input from an Educational Psychologist (EP) and Speech and Language Therapist (SALT). Accompanying this, each school established a taskforce group made up of partners based on the needs and challenges of the school.

4.8 Targeted schools: Support started in the Autumn term. Each of the five clusters completed a needs analysis to identify how they could best utilise the support from the EP and SALT to meet their needs. The Early Years Outreach Workers were also appointed and started working with each cluster of schools, taking referrals for families from the schools.

4.9 Universal Offer: The early years transition reading book was given to all children going into a reception class in a Manchester school before the Summer term ended. This was supported with enrichment packs for pre-school professionals, parents and the reception class staff to support the transition. A webinar was delivered covering social housing and homelessness prevention following feedback that housing was an issue many families faced. An offer has been developed for schools and early years practitioners that provides links to different peer networks, training and support that will help to address inequalities which will be available through the 2024 Spring and Summer terms. A similar offer is being finalised for pre-school professionals and will be sent out by the end of January 2024.

Monitoring:

4.10 Initial baseline data has started being collected from schools now information sharing agreements are in place. Further data will be collected at the end of the Spring and Summer terms to allow assessment of the intervention on pupils' progress, their attendance and parental engagement.

4.11 The impact of the interventions on early years will be collected on a termly or quarterly basis with the first data being available from January 2024. This will look at the numbers of Early Years and REAL programme referrals (Raising Early Achievement in Literacy) and WellComm screenings (a language screening tool used assess language development and identify where interventions are needed) and the outcomes of these together with uptake of the Early Years core offer and free two-year-old nursery places.

4.12 Qualitative analysis will also be carried out to better understand the outcomes of the interventions and their impact through structured interviews with those involved with the project. These findings will start to become available in the Spring term.

4.13 *Next Steps:*

- Finalising the last part of the universal offer for pre-school professionals
- Continuing to monitor and support the intensive and targeted offers to ensure they achieve the best outcomes for families and establish processes and tools needed for data collection and analysis to enable evaluation of the interventions.

5. Early Help for Adults Experiencing Multiple and Complex Disadvantage

5.1 Following a successful pilot in Old Moat, Withington, Wythenshawe, Harpurhey and the City Centre, funded through the national Changing Futures programme, this Kickstarter will expand a keyworker-led, multi-disciplinary support offer to have City-wide coverage. The target group is adults experiencing multiple barriers to health and wellbeing including homelessness, mental ill health, substance misuse, and unemployment. A significant number of this cohort will also have grown up in challenging social conditions, and experienced adverse childhood experiences which compound these factors. The service design and delivery will be developed in a way that expands on the original pilot, ensuring it works with cohorts and groups that were missed.

5.2 The scheme will be expanded to Gorton, Abbey Hey and Levenshulme, Ancoats, Beswick, Clayton and Openshaw; Cheetham and Crumpsall; and Hulme, Moss Side and Rusholme. The expansion of the project will work with c.100 new people in the target group.

5.3 This will allow Multi-Agency Prevention and Support (MAPS) meetings to be delivered citywide, bringing together locality-based professionals with intelligence and experience working, with adults who require supportive interventions.

5.4 A commissioned local support provider with experience of working across sectors will draw on the intelligence of all MAPS and VCSE partners and to provide a bespoke holistic support intervention and a single point of contact for the individual receiving support.

5.5 Benefits will be in short/medium term:

- Referrals to new MAPS meetings
- Relationship-building and intelligence-sharing with MAPS partners
- Embedding of Early Help for Adults Case Management within MAPS supporting the wider support network.

5.6 Longer term benefits in three years will be seen by preventing the need for further interventions by high demand services and may include:

- Reduction in A&E presentations
- Reduction in the number of people sleeping rough or who are homeless
- Reductions in demand for adult social care services
- Reduction in intensive mental health support.

Progress on implementation and delivery:

5.7 A lessons learnt analysis and evaluation of MAPs governance, the current model, and Changing Futures is currently underway and will be completed by January 2024. This will establish any changes that need to be made and inform the development and roll out of MAPS. It will also include a review of MAPS geographical locations. Work is taking place with Adult Social Services to improve alignment with MAPS and Changing Futures.

5.8 Funding for the Kickstarters is being match funded with Changing Futures to fund a city-wide Early Help for Adults model attached to MAPS. A procurement exercise has been undertaken, and the contract will be awarded by January 2024, with service mobilisation achieved by April 2024.

5.9 Internal vacancies will be filled by January 2024 to support, coordinate and embed the expansion of MAPS.

5.10 A monitoring and evaluation framework is in development. Workshops to facilitate and develop the framework took place on the 24th November and the 13 December.

Monitoring:

5.11 Monitoring of the Kickstarter scheme will be finalised in January 2024, once the review analysis and evaluation of MAPs governance, the current model, and Changing Futures pilot has been completed and the monitoring and evaluation framework is completed.

5.12 *Next Steps:*

- The tender for the procurement of the support service closes in early January, with evaluation and review of bids to be completed in late January. It is estimated the contract will be awarded by 5th March and service will mobilise by 1st April.
- All the internal MAPS coordination posts to commence in January/February 2024.
- Completion of the evaluation of MAPS will take place in January to inform recommendations on the governance, referral routes, processes and future model and delivery. These recommendations will then help form the action plan for this programme for the next twelve months.

6. MMF Programme Monitoring of Kickstarter Schemes

6.1 The MMF approach to monitoring, within a framework for measuring short-, medium- and longer-term progress, combines qualitative and quantitative data and is linked with the evaluation of each Kickstarter scheme.

6.2 Each Kickstarter scheme has key inequalities that have been identified to be addressed, triangulating what we know from research, what our residents and staff have said in relation to inequality and key groups, and what is apparent from the data. Kickstarter metrics will be incorporated into the annual MMF temperature check as the schemes develop, providing opportunity to capture and report on activity, benefits and outcomes.

6.3 To assess the financial benefit of Kickstarters, a Social Return on Investment model will be used to link expenditure on the services to an assessment of the potential benefits of the outcomes. The intention is to show that the money invested into the Kickstarter schemes produces tangible outcomes and indicates that there is a financial benefit to the interventions.

7. MMF Programme Evaluation of Kickstarter Schemes

7.1 The approach to the evaluation of each Kickstarter schemes varies depending on the resources available, timescales and nature of the scheme. The approach to evaluating the Early Help for Adults Kickstarter is being developed alongside the development of the scheme.

7.2 For the Children's Kickstarter, in-depth work is being carried out to explore the views of the staff involved in delivering the interventions to support children and families. The analysis will include the identification of early outcomes and impacts that demonstrate a trajectory towards higher-level change, utilising the monitoring data. Qualitative evaluation data has been collected using semi-structured interviews with 44 participants who are staff from eight schools in the intensive and targeted support cohorts, and support workers co-ordinating and supporting the Kickstarter task force. This data will be analysed thematically to describe the key issues, mechanisms, facilitators and barriers around achieving the aims of the Kickstarter.

8. Summary and Recommendations

8.1 This paper has provided a progress update on the Childrens and Early Help for Adult’s Kickstarter schemes. An update on the Young People’s Mental Wellbeing scheme will be presented at the next MMF update to the Board.

8.2 The Board is asked to note progress made on the delivery of these MMF Kickstarter schemes so far.

Appendix 1 – Clusters of schools for children's scheme (intensive support schools in yellow)

	Cluster of Schools for intensive and targeted support	Wards
Cluster 1	**St. Barnabas CE Primary Academy**	**Clayton & Openshaw**
	St. James' CE Primary (Gorton)	**Gorton & Abbey Hey**
	St Anne's RC Ancoats	Ancoats & Beswick
	St. Clement's CE Primary	Clayton & Openshaw
	Gorton Primary	Gorton & Abbey Hey
	Medlock Primary	Ardwick
	St. Josephs RC Primary	Ardwick
	St. Luke's CE Primary	Ardwick
	St. Chrysostom's Primary	Ardwick
	Plymouth Grove Primary	Ardwick
Cluster 2	**Rolls Crescent Primary**	**Hulme**
	Sacred Heart RC Primary (Gorton)	Gorton & Abbey Hey
	All Saints Primary (Gorton)	Gorton & Abbey Hey
	Chapel Street Primary	Levenshulme
	St. Richard's RC Primary	Levenshulme
	Crowcroft Park Primary	Longsight
	Stanley Grove Academy	Longsight
	St. Agnes CE Primary	Longsight
	Armitage CE Primary	Ardwick
Cluster 3	**Haveley Hey Community**	**Sharston**
	St. Bernard's RC Primary	**Moss Side**
	Heald Place Primary School	**Moss Side**
	Baguley Hall	Baguley
	St. James' CE Primary (Rusholme)	Rusholme
	The Willows Primary	Burnage
	Benchill Primary	Woodhouse Park
	Ringway Primary	Northenden
	Claremont Primary	Moss Side
	Acacias Community Primary	Hulme
	Webster Primary	Hulme
Cluster 4	**Unity Primary School**	**Cheetham**
	Saviour CE Primary	**Harpurhey**
	St. Augustine's CE Primary	**Harpurhey**
	St. Chad's RC Primary	Cheetham
	Holy Trinity CE Primary	Harpurhey

	St. Edmund's RC Primary	Harpurhey
	St John Boscoe	Charlestown
	Park View Community	Miles Platting & Newton Heath
	Christ The King Primary	Miles Platting & Newton Heath
	All Saints CE Primary (Newton Heath)	Miles Platting & Newton Heath
	St. Patrick's RC Primary	Miles Platting & Newton Heath
Cluster 5	**Lily Lane Primary**	**Moston**
	St. Dunstan's Primary	Moston
	New Moston Primary	Moston
	Moston Lane Primary	Moston
	St. Clare's RC Primary	Higher Blackley
	Pike Fold Primary	Higher Blackley
	E-Act Blackley Academy	Higher Blackley
	Bowker Vale Primary	Crumpsall
	Moston Fields Primary	Charlestown