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MANCHESTER CITY COUNCIL

Health Scrutiny Committee

Date: Tuesday, 8 October 2019
Time: 2.00 pm
Venue: Council Antechamber, Level 2, Town Hall Extension

Everyone is welcome to attend this committee meeting.

There will be a private meeting for Members only at 1.30pm in Committee Room 6 (Room 2006), 2nd Floor of Town Hall Extension

Access to the Council Antechamber

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Membership of the Health Scrutiny Committee

Councillors - Farrell (Chair), Clay, Curley, Holt, Mary Monaghan, Newman, O'Neil, Riasat, Watson and Wills

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 3 September 2019.

5. Suicide Prevention Update 13 - 44
Report of The Director of Population Health, Nursing and Safeguarding, Manchester Health and Care Commissioning

This report provides the Committee with an update on the paper on suicide prevention submitted in December 2017 and specifically reports progress on the delivery of the local suicide prevention plan (2017 - 2019) and on the development of a refreshed plan for 2020 – 2025.

6. 2019 Public Health Annual Report 45 - 68
Report of Director of Public Health/Population Health Consultant in Public Health

As part of the statutory role of the Director of Public Health there is a requirement to produce an annual report on the health of the local population. This report can either be a broad overview of a wide range of public health programmes and activities or have a focus on a particular theme. The 2019 report has a focus on the first 1,000 days of a child's life, from conception through to the age of 2 years old.

7. NHS Long Term Plan 69 - 90

Report of the Head of Policy and Planning, Manchester Health and Care Commissioning (MHCC), the Head of Operational Finance, MHCC and the Performance Lead, MHCC

This report provides the Committee with information on the NHS Long Term Plan (LTP), published in January 2019, that set out a ten year programme of phased improvements to NHS services and outcomes, including a number of specific commitments to invest the agreed five year revenue settlement.

This has been followed in June 2019 by the publication of the NHS Long Term Plan (LTP) Implementation Framework.

8. Overview Report 91 - 102

Report of the Governance and Scrutiny Support Unit

The monthly report includes the recommendations monitor, relevant key decisions, the Committee's work programme and items for information. The report also contains additional information including details of those organisations that have been inspected by the Care Quality Commission.

Information about the Committee

Scrutiny Committees represent the interests of local people about important issues that affect them. They look at how the decisions, policies and services of the Council and other key public agencies impact on the city and its residents. Scrutiny Committees do not take decisions but can make recommendations to decision-makers about how they are delivering the Manchester Strategy, an agreed vision for a better Manchester that is shared by public agencies across the city.

The Health Scrutiny Committee has responsibility for reviewing how the Council and its partners in the NHS deliver health and social care services to improve the health and wellbeing of Manchester residents.

The Council 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 sheet.

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Smoking is not allowed in Council buildings.

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Further Information

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This agenda was issued on **Monday, 30 September 2019** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 3, Town Hall Extension , Manchester M60 2LA

Health Scrutiny Committee

Minutes of the meeting held on 3 September 2019

Present:
Councillor Farrell – in the Chair
Councillors Clay, Curley, Holt, Mary Monaghan, Newman, O'Neil, Riasat, Watson and Wills

Also present:
Councillor Craig, Executive Member for Adults, Health and Wellbeing
Cllr Ilyas, Assistant Executive Member for Adults, Health and Wellbeing
Andrew Gilliver, Pride in Practice / Community Involvement Coordinator, LGBT Foundation
Julia Stephens-Row, Independent Chair Manchester Safeguarding Adults Board
Lynne Stafford, Chief Executive Gaddum
Dave Williams, Chief Executive Manchester Carers Forum
Reko Smith, Carer

HSC/19/29 Minutes

Decision

To approve the minutes of the meeting held on 16 July 2019 as a correct record.

HSC/19/30 Discussion Item: LGBT Foundation's Pride in Practice

The Committee welcomed Andrew Gilliver, LGBT (lesbian, gay, bisexual and trans) Foundation who had been invited to the meeting to discuss Pride In Practice.

Mr Gilliver delivered a presentation that described that the LGBT Foundation's Pride in Practice was a quality assurance and social prescribing service that strengthened and developed primary care services relationships with their LGBT patients within the local community.

LGBT people had told the LGBT Foundation that it was important to them to be open and honest about their sexual orientation, gender identity, trans status and lives with their GPs. Service users wanted to feel confident that health professionals understood and could respond to their specific needs. Pride in Practice was a simple way for practitioners to inform their patients that they understood them and they could trust them.

Pride in Practice aimed to ensure that all LGBT people had access to primary care services that were inclusive and understanding of the needs of diverse communities. Through Pride in Practice, LGBT people highlighted the health and care inequities they had experienced across primary care services, as well as sharing many examples of best practice around LGBT inclusion in primary care. These experiences helped demonstrate the project's impact on the design and delivery of LGBT

inclusive services, highlighting the simple but important changes that could be made by health care providers to help reduce health inequalities and improve the health and wellbeing of our communities.

The Committee were informed that Pride in Practice was suitable for all Primary Care Services, including GP Practices, Dentists, Pharmacies and Optometrists and endorsed by The Royal College of GP's.

Members heard that Pride in Practice was a support package that enabled health professionals to effectively and confidently meet the needs of LGBT patients. It further supported practitioners in meeting the requirements of their Clinical Commissioning Group, the Care Quality Commission and other bodies that they worked with.

Pride in Practice provided Practices with an accreditation award, including a wall plaque and Pride in Practice logos for letterheads and websites. This enabled Practices to promote their equality credentials, and demonstrated their commitment to ensuring a fully inclusive, patient-centred service.

Members were informed that over 5000 healthcare professionals had received training, with 97% of those feeding back that their confidence in regard to this area had increased and 98% stating that they felt better informed.

Mr Gilliver informed the Committee that this project that had started in Manchester was beginning to be rolled out in areas of London and West Yorkshire.

A Member reflected upon his own personal experience when accessing health care and noted the positive improvements that had been achieved and enquired what were the challenges today. Mr Gilliver stated that the current challenge related to trans patients, stating that citizens had to wait a significant period of time to access specialist services and health professional had little or no training in the area of gender diversity.

He further commented that the LGBT Foundation would seek to train and support health professionals in this area and training could be tailored to suit the needs of different providers. He further commented that the LGBT Foundation served as a signposting service for wider sources of support, including specials support in recognition of our diverse communities that could assist both patient and their families.

In response to a comment from a Member regarding GP Practices that did not engage with this project, Mr Gilliver stated that if they received a complaint regarding the service received they would seek to engage with the Practice Manager and enter into a dialogue to promote this project and offer training and support. In response to a question from the Chair regarding turnover of staff in GP Practices, Mr Gilliver confirmed that they would refresh the training as and when required and remained a point of contact for support and advice for Practice Managers.

The Executive Member for Adults, Health and Wellbeing informed the Committee that the Manchester Health and Care Commissioning Board had agreed that this offer was to be mandatory for all GP Practices.

The Chair thanked Mr Gilliver for attending the meeting and discussing the project with the Committee. He informed Members that the LGBT Foundation would be invited back to attend the December meeting to discuss specific health improvement interventions for LGBT communities in Manchester, including the Greater Manchester Trans Health Service and Pride in Ageing.

Decision

1. To thank Mr Gilliver for attending the meeting and addressing the Committee.

HSC/19/31 Our Manchester Carers Strategy

The Committee considered the report of the Executive Director of Adult Services that provided an update on progress to implement the Our Manchester Carers Strategy since the last update to the Health Scrutiny Committee at the meeting held 17 July 2018. (See minutes of the Health Scrutiny Committee ref. HSC/18/31)

Officers referred to the main points of the report which were: -

- Providing a definition of a carer;
- The estimated number of carers in the city, noting that studies suggested that up to 25% of Carers provided care in excess of 50 hours per week and that 1 in 9 employees across the city were balancing work commitments with caring responsibilities;
- Describing the vision for Manchester Carers;
- The objectives of the Our Manchester Carers Strategy;
- Information on the biennial carer survey and its findings;
- Information on Young Carers, noting the Young Carers Operational Working Group had been established and would refresh the strategy with the aim to increase the identification and support for Young Carers and improve pathways.
- Information on the seven areas of action for the Strategic Action Plan for Young Carers;
- An update on the Greater Manchester Carers Strategy and the Greater Manchester Exemplar model for Carer Support
- Providing an update on the Manchester Carers Network;
- Providing an update on the work of the Gaddum Centre, who manage the Manchester Carers Network which included 20 voluntary organisations providing information, advice and support to Carers' (including an existing helpline delivered through Manchester Carers Centre.);
- An overview of the funding arrangements and the progress made in respect of additional funding to implement the offer to improve the lives of Manchester Carers;
- Governance arrangements; and
- The voice of Carers, noting that the voice of Carers was important to this work on the basis of "nothing about us, without us" being a core philosophy.

The Committee heard from Reko Smith, a carer who spoke eloquently about his own lived experience as carer for his mother. He spoke of the challenges he had experienced, particularly at the time of transition from Young Person to Adult Services and of the various sources of support, both formal and informal.

The Chair thanked Mr Smith for attending the meeting and noted that due to time constraints he was unable to remain for the duration of the item. He recommended that Mr Smith be invited to a future meeting to allow enough time for Members to learn of his experience and discuss this with him in further detail. The Committee supported this recommendation.

The Committee heard from the Chief Executive Manchester Carers Forum who spoke of his own lived experience of being a carer. He stated that it was important to recognise the significant contribution that carers made to the city, noting that it had been estimated that if carers stopped caring this would result in an additional £854m cost to the Council. He further commented that it was important to understand the positive motives of carers and not to view them as victims. He stated carers chose to care for their loved ones and they should be supported in this role.

A Member acknowledged this statement and commented that all services, such as transport, housing and education should be designed with this taken into consideration. The Commissioning Development Specialist stated that work was also ongoing to raise awareness of carers with employees so that their policies and practices recognised and accommodated the needs of carers.

Members then discussed the challenges and support offered to Young Carers. The Chief Executive Manchester Carers Forum stated that the conservative estimate is that there was in excess of two thousand young carers across Manchester. The Strategic Lead (Commissioning) stated that a lot of work was undertaken with education establishments to help identify and offer appropriate support to young carers, adding that an officer was dedicated to coordinating and overseeing this area of work. The Chief Executive Manchester Carers Forum stated that work was also underway at a Greater Manchester level to address the support needs of Young Carers.

Members discussed the issue of people self-identifying as carers and young carers being reluctant to access support for fear of negative consequences for them and their families.

The Executive Member for Adults, Health and Wellbeing informed the Committee that reports on the initiatives to support to Young Carers had been regularly considered by the Children and Young People Scrutiny Committee and these would be circulated to the Committee for information. The Strategic Lead (Commissioning) responded to a question from a Member by confirming that the report referred to that had been published following research on Young Carer's experience of transition would be circulated to Members for information.

The Strategic Lead (Commissioning) stated that the Our Manchester Carers Strategy would drive out inconsistencies and standardise the advice and information offer to carers. She said consideration would be given to how this was promoted to ensure it

was appropriate. The Chief Executive, Gaddum acknowledged that sources of support had been fragmented in the past and stated that the establishment of the Single Point of Contact, that would provide a gateway for all Carers to be triaged and supported to the most appropriate services, advice and information they required at an early stage would address any inconsistencies and standardise the offer. She further stated that this would also assist professionals across a range of partner identify carers.

A Member commented on the importance to carers of the provision and availability of respite care, noting the relatively low cost of this offer compared to the cost of longer term, full time care. The Strategic Lead (Commissioning) acknowledged this comment and stated that respite care was now referred to 'replacement care'. She descried that the intention was to commission a service that would enable Carers to be able to buy (using a Personal Budget approach) short term occasional support to help them have a break, attend appointments, knowing that the cared-for person is adequately supported and provided with the necessary care.

In response to a specific question regarding a reported underspend the Executive Member for Adults, Health and Wellbeing stated that this was related to staffing posts, and would be accounted for once posts had been filled.

Decisions

The Committee: -

1. Note the report.

2. Recommend that Mr Smith be invited to a future meeting of the Committee to learn of his experience as a young carer.

HSC/19/32 Annual Report of Manchester Safeguarding Adults Board

The Committee considered the report of the Executive Director of Adult Services and the former Independent Chair of Manchester Safeguarding Adults Board. It provided Members with an overview of the work of the Board for the period from April 2018 - March 2019.

The Independent Chair of Manchester Safeguarding Adults Board referred to the main points of the report which were: -

- Noting the priorities of the Board that were rolled forward from 2017/18 into 2018/19;
- Noting the key activities described in 2018/19; and
- Future challenges and improvement.

The Executive Director of Adult Services paid tribute to the former Independent Chair of the Manchester Safeguarding Adults Board for her commitment and diligence in safeguarding adults in Manchester.

The Executive Director of Adult Services stated that in recognition of the reconfiguration of services in Manchester new safeguarding arrangements were due to be announced in September and information on these would be shared with the Health Scrutiny Committee.

A Member commented that the use of the word ‘customer’ in the context of Domestic Violence was inappropriate. The Independent Chair of Manchester Safeguarding Adults Board acknowledged this comment and stated that this would be corrected prior to the reports formal publication.

A Member commented that the report referred to the Learning from Reviews Subgroup and noted that it stated ‘It had been a challenge to secure regular and consistent attendance from all agencies and the subgroup had three different Chairs which had led to some inconsistency and slow progress at times.’ and asked what was being done to address this. The Independent Chair of Manchester Safeguarding Adults Board informed the Committee that the new Chair of the Subgroup was addressing this issue and Learning from Reviews would continue within the new arrangements. She said this would be aligned with the Learning and Improvement Subgroup, and she was confident that this new arrangement would improve this situation.

The Executive Director of Adult Services commented that the new safeguarding arrangements would strengthen learning reviews and ensure that the right action was taken at the right time by the right partner.

In response to a question regarding the number of, and costs of legal challenges and how this was monitored and reported, the Independent Chair of Manchester Safeguarding Adults Board stated that it was not the role of the Board to consider any legal challenge and responsibility for that rested with the relevant partner. She further stated that the Board were satisfied with the approach taken to The Deprivation of Liberty Safeguards (DoLS). The Executive Director of Adult Services informed Members that she met with legal officers on a monthly basis to review and monitor any challenges.

The Executive Director of Adult Services responded to a comment from the Chair who noted that the membership list of the Board was predominantly statutory health providers and there appeared to be little or no representation from the Voluntary and Community Sector, and asked if this was typical. She advised that the levels of representation would be reviewed and workshops around this had been delivered with the intention to include both statutory and non-statutory bodies represented on the Board. She further stated that the recently appointed Director of Homelessness would be joining the Board.

Decisions

The Committee: -

1. Note the publication of the Manchester Safeguarding Adults Board Annual report 2018–2019.

2. Recommend that the word customer is removed and replaced with a more appropriate term when referring to victims of Domestic Violence.

[Cllr Watson declared a prejudicial interest in this item of business and withdrew from the meeting.]

HSC/19/33 Overview Report

A report of the Governance and Scrutiny Support Unit which contained key decisions within the Committee's remit and responses to previous recommendations was submitted for comment. Members were also invited to agree the Committee's future work programme.

The Chair informed the Committee that the report on Access to Primary Care was to be deferred to the November meeting, with invitations sent to Healthwatch. He further stated that the report on the Supporting People Housing Strategy would be deferred to a later meeting, with the date to be confirmed following discussions with the Executive Member. He further reiterated that the LGBT Foundation would be invited back to attend the December meeting to discuss specific health improvement interventions for LGBT communities in Manchester, including the Greater Manchester Trans Health Service and Pride in Ageing.

Decision

To note the report and approve the work programme subject to the above amendments.

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Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 8 October 2019

Subject: Suicide Prevention Update

Report of: Director of Population Health, Nursing and Safeguarding, Manchester Health and Care Commissioning

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Summary

This report provides the Committee with an update on the paper on suicide prevention submitted in December 2017 and specifically reports progress on the delivery of the local suicide prevention plan (2017 - 2019) and on the development of a refreshed plan for 2020 – 2025.

This report provides information on:

- The national and local strategic context of suicide prevention.
- Key trends, facts, figures and risk factors relating to suicides in Manchester.
- A summary of key areas of activity contributing to suicide prevention.
- Progress on delivery of specific actions within the local plan.
- Development of a refreshed plan for 2020 – 2025.

Recommendations

The Committee is asked to:

1. Note the contents of the report;
2. Consider the multiple factors that impact upon suicide rates; and
3. Provide feedback and ideas to support the refreshed plan for 2020 – 2025.

Wards Affected: All

Environmental Impact Assessment - the impact of the issues addressed in this report on achieving the zero-carbon target for the city

Manchester Strategy outcomes	Summary of how this report aligns to the OMS
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	
A highly skilled city: world class and home grown talent sustaining the city's economic success	For every life lost to suicide, the estimated total cost to the economy is around £1.67 million. This includes costs to public services and the impact of bereavement on others such as loss of earnings and mental health impacts.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Action to prevent suicide supports the wellbeing and potential of individuals and communities through the promotion of good mental wellbeing and encouraging people to talk about suicide and reduce the stigma.
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):

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.

Report to Manchester Health Scrutiny Committee - December 2017

Cross Government Workplan on Suicide
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772210/national-suicide-prevention-strategy-workplan.pdf

Manchester Joint Strategic Needs Assessment Report on Suicide
http://www.manchester.gov.uk/downloads/download/6672/adults_and_older_peoples_jsna_-_suicide_prevention

1.0 Introduction

1.1 Every suicide is an individual tragedy and a loss to society and one suicide is one too many. When someone dies by suicide the shock is felt by families, friends, neighbours, colleagues and professionals. Suicide, in contrast to other bereavements can bring silence and stigma which can amplify the impact on those left behind. As well as the huge social and emotional costs the economic costs are considerable - it is estimated that the cost of a completed suicide is £1.67m and a significant proportion of this relates to the impact of the bereavement on others, for example, lost earnings and mental health impacts.

1.2 Whilst people who are in the care of Mental Health Services are at increased risk of suicide, the majority of those who take their own lives have not been in contact with mental health services within the previous 12 months. Sometimes suicides occur without warning. This means that a broad-based approach that recognises the role that communities, organisations and individuals play in preventing suicide is essential.

1.3 There is much interest and commitment from a range of agencies and organisations across sectors in the city and Greater Manchester in contributing to preventing suicides that can be harnessed. Suicides are not inevitable. There are many ways in which services, communities, individuals and society can help to prevent suicides.

2.0 Defining and reporting suicide

2.1 Deaths from suicide are identified from death registrations. Registration of deaths is made following a coroner's inquest, when a conclusion is given.

2.2 The Office for National Statistics (ONS) definition of suicide includes deaths given an underlying cause of intentional self-harm or injury / poisoning of undetermined intent. Since 2016 the definition has been revised to include deaths from intentional self-harm in children and young people aged 10 - 14 years (deaths of undetermined intent continue to not be included). The numbers in this young age group are very low and have not had a significant impact on the age-standardised rates of suicide.

2.3 Previously, coroners and juries have applied the criminal standard to suspected suicides, meaning they had to be "sure" that someone had taken their own life. However, appeal court judges ruled in May this year that the civil court standard can be applied and therefore coroners and juries and only have to be satisfied that it was "more probable than not" that someone had deliberately killed themselves. This is expected to lead to more deaths being concluded as suicide, which may have an impact on reported rates and trends.

3.0 Strategic context for suicide prevention work

3.1 National strategic context

3.1.1 In 2012, the government published the cross-government National Suicide Prevention Strategy, which was updated in 2017. In January 2019, it published its first cross-government work plan to support the delivery of the National Suicide Prevention Strategy. The focus of this plan includes:

- Using social media and the latest technology to identify those most at risk.
- Improving data held on causes of death among veterans.
- A greater focus on addressing the increase in suicide and self-harm among young people including asking social media companies to take more responsibility for online content that promotes methods of suicide and self-harm.

3.1.2 This work plan has been informed by the 2016 Health Select Committee inquiry into Suicide Prevention that heard a range of evidence and made recommendations.

3.1.3 A new minister for Suicide Prevention was announced in October 2018 who will oversee the implementation of the cross-government workplan. In addition, the NHS Long Term Plan confirms commitment to reducing suicides by 10% by 2020/21. This was highlighted in the Five Year Forward View for Mental Health published in 2016 which states that ‘reducing suicides will remain an NHS priority over the next decade’. Specific commitment is made to providing 24/7 access to crisis support via the NHS 111 service and expanding specialist perinatal mental health services so that more women who need it have access to the care they need from preconception to two years after the birth of their baby.

3.1.4 In October 2016 Public Health England (PHE) published detailed guidance to support local authorities to establish a suicide prevention partnership, develop a local action plan and use data and evidence effectively.

3.1.5 NICE guidelines on suicide prevention in community and custodial settings were published in September 2018.

3.1.6 In October 2018, the Centre for Public Scrutiny published guidance for effective scrutiny of local strategies to prevent or reduce suicide.

3.1.7 In October 2018, the National Collaborating Centre for Mental Health published three parallel frameworks that describe the various activities that need to be brought together to support people who self-harm and/or are suicidal. The frameworks target those working with:

- children and young people (from 8 years upwards)
- adults and older adults (from 18 years upwards)
- the public (community and public health)

3.2 Greater Manchester Suicide Prevention

3.2.1 A Greater Manchester Suicide Prevention Strategy was endorsed by the Greater Manchester Health and Social Care Strategic Partnership Board in February 2017. Actions within the strategy are organised around six key objectives:

- All ten Boroughs (and Greater Manchester as a whole) will achieve Suicide Safer Communities Accreditation (the 'nine pillars of suicide prevention') by 2022.
- Mental Health Service Providers will incorporate the national requirement of a zero suicide ambition within their respective suicide prevention strategies and continue to work towards the '10 key ways for improving patient safety'.
- We will strengthen the impact and contribution of wider services.
- We will offer effective support to those who are affected or bereaved by suicide.
- We will develop and support our workforce to better assess and support those who may be at risk of suicide.
- We will use the learning from evidence, data and intelligence to improve our plan and our services.

3.2.2 The Greater Manchester Strategy is being overseen by the Greater Manchester Suicide Prevention Executive Group. Manchester is represented on the group and will continue to support the strategy both through the delivery of our local plan and leadership in project work at a Greater Manchester level.

3.2.3 A Greater Manchester Suicide Prevention Programme Manager has been appointed to coordinate and provide leadership to the work of the ten local authorities.

3.2.4 A public facing Greater Manchester campaign 'Shining a Light on Suicide' has been created and launched along with a digital platform to provide information for those experiencing suicidal thoughts, concerned for another or who are bereaved by suicide. The digital platform also includes an opportunity to access free online suicide prevention training. To date approximately 9,500 people have completed the training. Further information can be found at www.shiningalightonsuicide.org.uk The training has been promoted to Manchester City Council staff and with partner organisations and an example of the information leaflet is provided as Appendix 1.

3.3 Manchester Suicide Prevention Partnership

3.3.1 The Manchester Suicide Prevention Partnership continues to be chaired by Councillor Joanna Midgley, Mental Health Champion. The partnership steering group meets regularly and oversees the operational delivery of the local plan and shapes the strategic direction of the work. Theme leads from different organisations take responsibility for different areas of the plan. To engage a broader range of partners and promote networking and learning, the partnership also holds regular open invitation forums on specific themes. These have included long term conditions and chronic pain and children and young people.

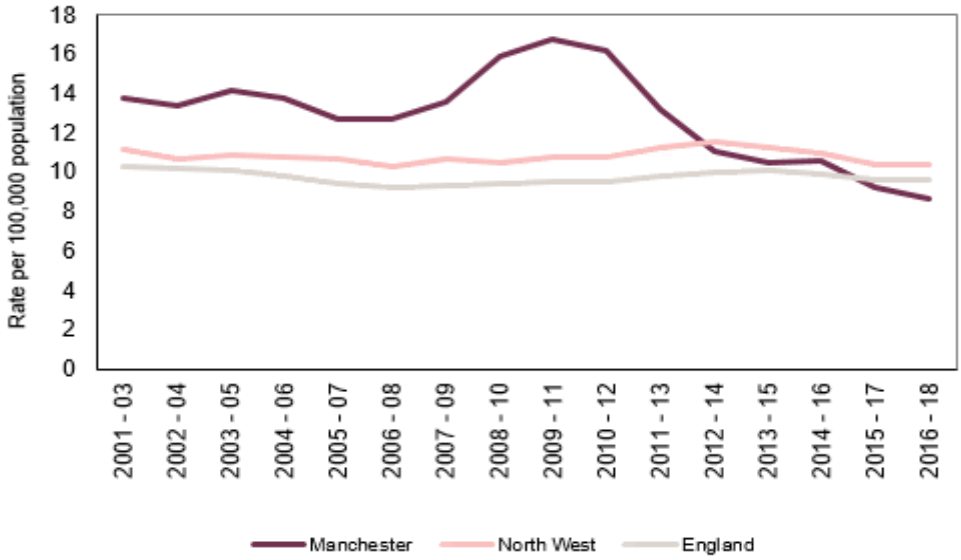
4.0 Summary of key facts and trends about suicides and self-harm

4.1 Suicides in Manchester

4.1.1 The all age suicide rate has fallen from 9.28 per 100,000 in 2015-17 to 8.69 per 100,000 on 2016-18. The suicide rate in Manchester is now below the England average (10.43 per 100,000) but the difference is not statistically significant (see Figure 1).

Figure 1

Deaths from suicide and injury undetermined

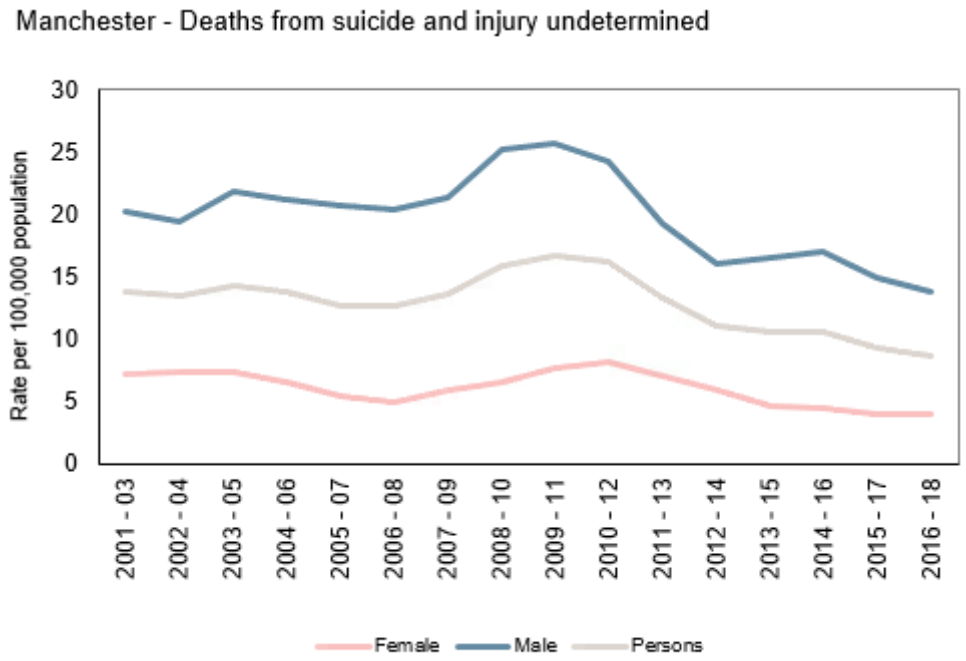


Source: Public Health England © Crown Copyright 2019

4.1.2 The number of deaths from suicide and injury of undetermined intent in Manchester remains unchanged (113) from the previous time period (2015-17). The number of deaths in men have fallen slightly (89 to 86) whereas the number of deaths in women have increased by the corresponding amount (24

to 27). The gender ratio (men to women) has fallen slightly (3.71 to 3.19) meaning there are 3.19 times more suicide deaths in men than there are in women (Figure 2).

Figure 2



Source: Public Health England © Crown Copyright 2019

4.1.3 Due to changes in the way that Civil Registrations (births and deaths) data is made available to local authorities it is not possible to supply single year figures for suicide at this time. The Council is required to update the Data Security and Protection Toolkit and this work is now underway involving officers from Population Health, Information Governance, ICT, Democratic Services, Children's & Families and Legal Services. This work will resolve the obstacles with gaining access to accurate and timely deaths information at individual record level.

4.1.4 Single year rates for the UK for 2018 show a significantly higher rate than for 2017 and represents the first increase since 2013. Further detailed data on suicide in Manchester can be found in appendix 2.

4.2 Self-harm in Manchester

4.2.1 Figures 3, 4 and 5 below show rates of hospital presentation for self-harm over time by people resident in the City of Manchester (individuals aged 15 years and over). Rates declined early in the period, but began to increase again around 2008, reaching a rate in males of around 450 per 100,000 of the population in 2012, and a rate in females of just over 500 per 100,000 of the

population in 2013. From 2013 the rates started to decrease but the 2016 data shows a slight increase.

4.2.2 In males who self-harm the highest rates have been in those aged 35 to 54. Rates had been declining since 2012 in all age groups however in the most recent year rates have increased in all age groups aged 55 and over.

4.2.3 In females the three older age groups have remained relatively stable or decreased over time. The youngest female age group (15 – 24 years) continues to have the highest rate of self-harm and recent data suggests this rate is increasing.

Figure 3 - Rates of self-harm by sex 2003-2016

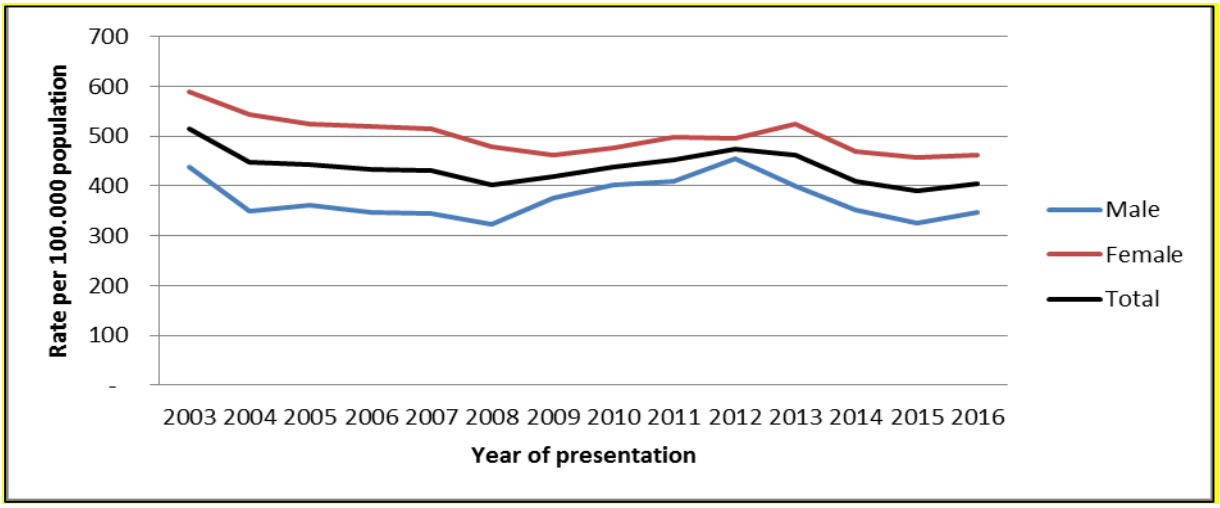


Figure 4 - Rates of self-harm among males, by age group, 2003-2016

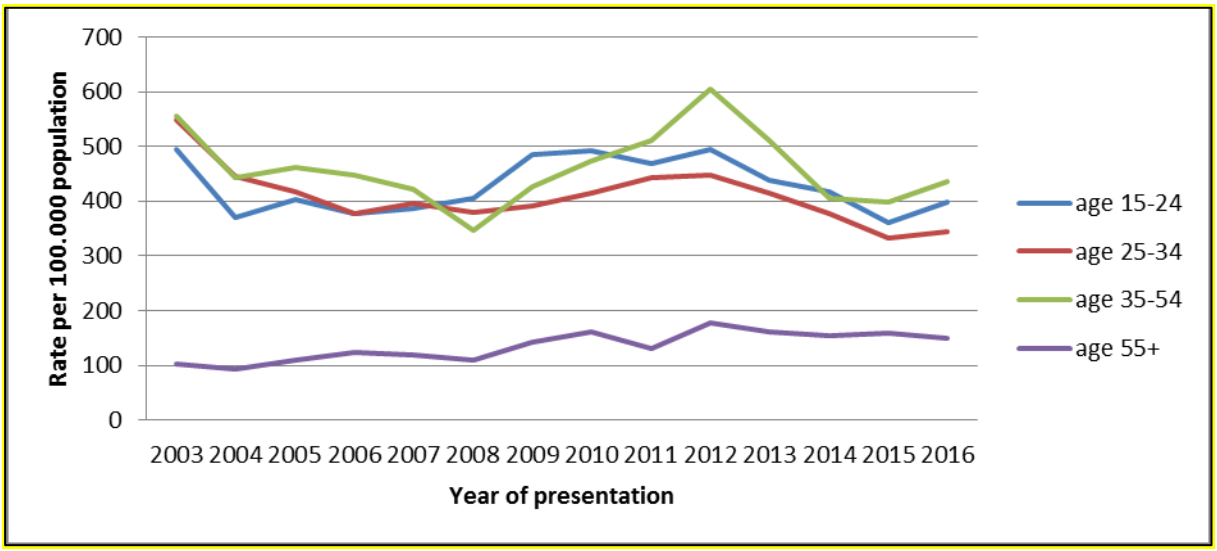
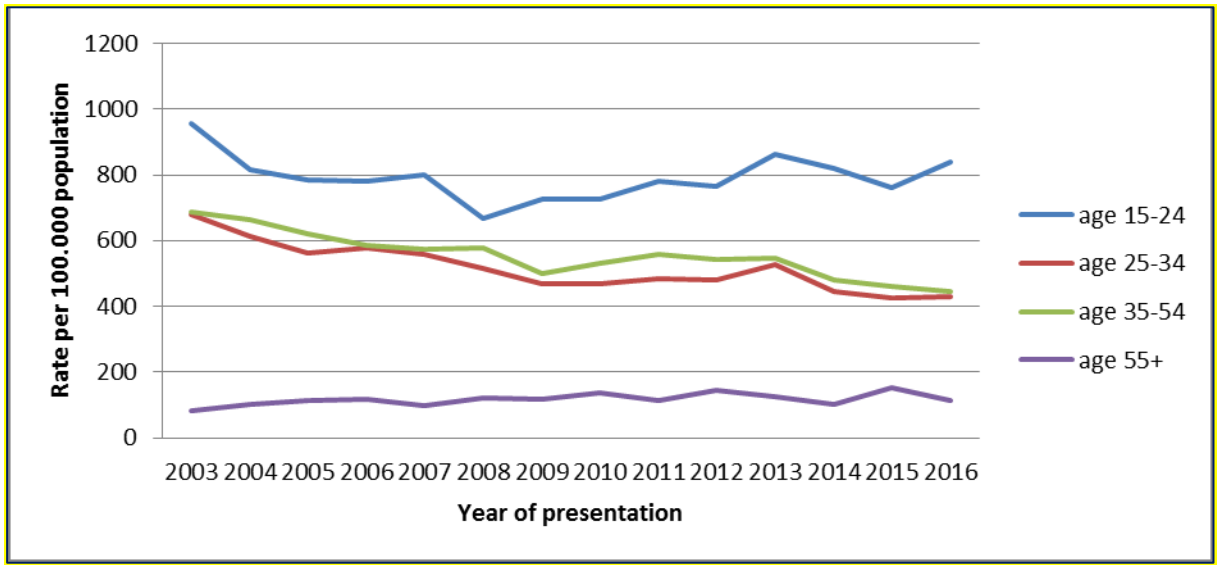


Figure 5 - Rates of self-harm among females, by age group, 2003 - 2016



4.3 Suicides by Children and Young People

4.3.1 Although numbers of children and young people under 18 who die by suicide are low, suicide is the leading cause of death in the UK in 10 - 19 year olds (Office for National Statistics). A recent study looked at 922 suicides by young people aged under 25 in England and Wales during 2014 and 2015. Key messages emerging from the research are that suicide in young people usually follows a combination of existing vulnerabilities and events. These stresses are common in young people and most do not come to serious harm. Themes for suicide prevention identified are support for family factors such as mental illness or substance misuse; specific support for vulnerable groups including young people who are bereaved; greater priority for mental health support within colleges and universities; housing and mental health support for looked after children; mental health support for lesbian, gay, bisexual or transgender (LGBT) young people.

4.3.2 It is of great concern that following a number of years where Manchester has had no deaths by suicide of under 18s there has been a small number of suspected suicides this year.

4.4 Risk factors for suicide

4.4.1 The causes and consequences of suicide are complex. Frequently, several factors act cumulatively to increase a person's vulnerability to suicidal behaviour. Research evidence shows the following groups to be at risk of suicide:

- **Men -** Males are three times more likely to die by suicide than females.
- **Age -** The highest rate of suicide for both men and women is 45 - 49 years.
- **Mental Health -** Although only about a quarter to a third of people who take their own life have been in contact with mental health services prior to their death, The Mental Health Foundation estimates that 70% of recorded suicides are by people experiencing depression - often undiagnosed.
- **Self-Harm -** A history of self-harm is a major risk factor for further self-harm and death by suicide.
- **Those who have experienced domestic abuse including sexual abuse -** There are strong links between intimate partner violence and suicidal thoughts and behaviours. Manchester has high rates of domestic violence compared to other core cities.
- **Veterans -** Veterans are at increased risk of suicide and this risk is increased for those who leave the armed forces early. (as opposed to longer serving personnel)
- **History of childhood abuse** and other adverse childhood experiences.
- **Lesbian, gay, bisexual or transgender community -** There is growing evidence of the increased risk of self-harm and suicidal thoughts amongst LGBT people and a study conducted in the UK highlighted the impact of homophobia and discrimination as key factors.
- **Black, Asian and minority ethnic groups -** Studies have found higher rates of self-harm and suicide amongst Asian women than for other groups. Prevalence data is limited however as ethnicity is not recorded on death certificates.
- **Criminal Justice System -** The World Health Organisation recognises that prisoners are a high risk for suicide, as are those on remand and those recently released from custody. The risk is greatest in the first week of imprisonment.
- **Social and economic circumstances -** People who are unemployed are 2 to 3 times more likely to die by suicide than those in work. High levels of deprivation and health-related worklessness in Manchester make this risk factor a particular concern.
- **Inequality -** People among the most deprived 10% of society are more than twice as likely to die by suicide than the least deprived 10%, according to the ONS.
- **Drug and alcohol use -** Alcohol and drug use can amplify suicidal thoughts, plans and deaths. A recent UK based study found that the use of alcohol significantly increased suicide risk, particularly in women.
- **People with physically disabling or painful illnesses including chronic pain and long term conditions -** The National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness (2015) found that around a quarter of patients who die by suicide have a major physical illness and this rises to 44% in patients aged 65 and over.
- **Bereavement by suicide -** people bereaved by the sudden death of a friend or family member are 65% more likely to attempt suicide if the deceased died by suicide than if they died by natural causes. As well as

the increased risk of suicide attempt, those bereaved by suicide were also 80% more likely to drop out of education or work. In total, 8% of the people bereaved by suicide had dropped out of an educational course or a job since the death.

5.0 What works to prevent suicide within the population?

5.1 There are a number of evidence-based activities to prevent suicide. In summary these include taking specific steps to reduce risk for those in mental health services and criminal justice services, for example by reducing access to the means of taking their own lives, and identifying and targeting population groups at potential risk and building resilience and support, for example survivors of domestic abuse. There is also evidence that raising awareness and improving skills of frontline professionals and members of the public to talk to and support people at risk of suicide is a key protective factor.

6.0 Current activity in Manchester and future plans

6.1 A summary of the range of activities taking place to reduce suicides in Manchester is outlined below. This is organised under the key themes of the local action plan. Some of this work is directly led by members of the suicide prevention steering group and other aspects are part of a broader system approach to suicide prevention in Manchester.

6.2 Data, research and intelligence

6.2.1 The Joint Strategic Needs Assessment (JSNA) on Manchester City Council's website includes a topic paper on suicide prevention. Furthermore, since January 2018, the Population Health Team (PHT) has been receiving 'real time' data of suspected suicides from the Manchester Coroner's office. This enables us to take any urgent action to coordinate a response that manages impact to prevent additional suicides, as well as identifying any trends or possible contagion. Additionally, the PHT also receive notifications of suspected suicides on our local railways from British Transport Police and are currently in the process of developing a formal response plan that clearly sets out the relevant action and partnership involvement for any potential suicide notifications received. Because of the highly sensitive nature of the data this is only shared (securely) on an absolute need to know basis. A summary of recurring themes for recent Manchester suspected suicides was shared at the recent Learning Circle event so that relevant partners could be engaged in developing our approach to suicide prevention across the city.

6.2.3 A pilot for the collection of key 'real time' data, co-ordinated by the Greater Manchester Suicide Prevention Lead, is currently underway with a limited number of our Greater Manchester partners. In Manchester we have our own system in place but will continue to work closely with the GM Lead.

6.2.4 Manchester is a national and international leader in suicide and self-harm research through the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) and the Manchester Self Harm Project (MaSH). Professor Nav Kapur has provided regular annual briefings to the Manchester Health Scrutiny Committee on the work of MaSH and will be attending the October 2019 meeting.

6.2.5 The Population Health team and partners are working with Network Rail, British Transport Police and Train Operators as part of their escalation processes to support a community response to suicide incidents on the rail network. This includes: targeting suicide awareness messages to local residents to support vigilance in relation to suicidal behaviour they might witness; working with local businesses to promote self-help materials and physical measures such as removal of bushes at stations and training for rail staff.

6.3 Awareness raising, training and communications and tailored support

6.3.1 As a key action in the local suicide prevention plan, suicide prevention awareness training continues to be delivered to a range of staff and volunteers across the city and more will be scheduled for next year (including targeted training for school nurses.) This half day training covers essential facts and figures about suicide prevalence and risk, the suicide continuum, understanding suicidal distress and building skills and confidence in talking to someone who may be suicidal. These sessions have been delivered collaboratively by colleagues across the partnership including the Population Health Team, Manchester University NHS Foundation Trust, buzz health and wellbeing service and Councillor Midgley.

6.3.2 Due to the limited capacity within the system to deliver the training and very high demand there will be a need to recruit a bigger pool of trainers. In addition, more specialist training for services in contact with high risk individuals is required. A comprehensive workforce training plan will therefore be developed and implemented as part of the refresh of the local suicide prevention plan. Finally, partners will be asked to consider making a small financial investment to sustain the ongoing training programme.

6.3.3 Suicide Prevention training for local Councillors is planned to take place on 19 and 21 November and information on the times and venues has been circulated by the Members Development Working Group.

6.3.4 The City Council sees supporting the health and wellbeing of its employees as a priority. Mental health awareness training is now available to all staff and managers. This training, delivered by Mind, is a core part of the Leadership and Management development programme for all managers and specifically

addresses suicide prevention. There is also generic mental health awareness training for all staff that can be accessed via the Learning and Events Team.

6.3.5 The City Council also has an Employee Assistance Programme (EAP) which provides free, confidential, 24/7 advice, emotional support and counselling to all employees and their immediate family.

6.3.6 A 'Safe Talk' training course (accredited suicide prevention training) has been delivered in Central Manchester aimed at barbers, hairdressers and tattooists. Feedback from the course was positive. However, it is recognised that it is a challenge for this profession to take time out from their working week to attend a face to face course and alternative methods of delivering messages and information will be explored.

6.3.7 As part of World Suicide Prevention Day on 10 September 2019 Manchester City Council supported the 'Exhibition of Hope' - an exhibition of photographs that represented hope for a group of patients and carers affected by suicide. The event was organised by researchers from the National Institute of Health Research Greater Manchester Patient Safety Translational Research Centre (NIHR GM PSTRC), working in partnership with a patient and carer involvement group. The event was held in Rates Hall of the Town Hall Extension which allowed a range of visitors to connect with the exhibition. Visitors to the exhibition also received a packet of seeds and were encouraged to share pictures of the plant's progress.

6.3.8 Manchester Suicide Prevention Partnership staffed a Shining a Light on Suicide campaign stall at Manchester Pride in August, reaching many attendees with messages about the importance of talking about suicide, where to get help and how to support someone you may be concerned about. The Shining a Light on Suicide Campaign highlights the LGBT community as a high risk group.

6.4 Mental Wellbeing Promotion

6.4.1 Manchester Health and Care Commissioning commissions a range of community based mental health and wellbeing support including:

6.4.2 Buzz Manchester Health and Wellbeing Service includes a team of Neighbourhood Health Workers, one in each neighbourhood of Manchester. They have a key role in delivering community development – working in each of the 12 Manchester neighbourhoods using community development approaches to increase the involvement of local people in developing projects that improve health and wellbeing. Suicide prevention initiatives / training can be more locally targeted this way.

6.4.3 Be Well is a citywide social prescribing service that offers free, confidential, one-to-one advice and support for people referred by primary care (GPs and services provided from GP surgeries) or other health and care services. Be Well workers (Community Link Workers and Health Coaches) support people to identify what will improve their health and wellbeing, access community support and services, and develop understanding and skills to manage their own health. Be Well can support people with a range of non-medical issues (e.g. housing, work, money), isolation, healthy lifestyles, and others.

6.4.4 Samaritans - Samaritans volunteers provide a 24 hour telephone, text and email service for people who need emotional support including those who have suicidal thoughts or plans. Samaritans also provides an outreach service to Manchester Prison and works in partnership with Network Rail to provide training to its staff and signage for stations. Samaritans also provide a support service to schools to prepare for or recover from a suicide or attempted suicide within the school community.

6.4.5 Adverse Childhood Experiences (ACEs) – In 2017, Our Manchester funded a twelve month place-based pilot to provide ACE awareness training to workers in Harpurhey. The training to was help workers be more ACEs aware and supported them to routinely enquire about ACEs with people they are working with and provide appropriate support and referral. Since the success of the pilot, partnership funding was secured for 2019-20 to expand the ACEs work into other areas of the city.

6.5 Clinical Support

6.5.1 Greater Manchester Mental Health (GMMH) has a comprehensive vision for suicide prevention within its organisation and convenes a regular suicide prevention group. Based on evidence and analysis of national and local data GMMH have adopted five priority areas as the key drivers for quality improvement across the organisation:

- Care provided will be evidence based, timely, safe and effective.
- We will work in partnership with Service Users and their Carers.
- We will support Carers and Staff when they have been bereaved or affected by suicide.
- We will be a learning organisation.
- We will have a competent workforce.

6.5.2 Following the formation of Manchester University NHS Foundation Trust (MFT) a transformational work stream for self-harm and suicide prevention has been set out. This includes the development of policy, education and training and audit/incident review across the entire organisation. Action so far includes:

- Publication of a comprehensive suicide prevention policy in July 2019, including patients of all ages, across a diverse range of clinical settings including community services.
- Delivery of training to support staff to implement key policy targets such as ligature incident prevention and management.
- Development of a mental health awareness level 1 e-learning to go live in time for World Mental Health Day on 10 October 2019 and to be mandatory for all new staff within the organisation.
- Implementation of an Integrated Care Pathway for Self-Harm and Suicide Prevention providing clear standards to support patients who are experiencing mental health crises.

6.5.3 Manchester Suicide Prevention Partnership convenes a clinical sub group to further identify opportunities to reduce suicide and self-harm risk through intervention and ongoing clinical / support. Priority objectives for this group include:

- Analysis of self-harm services to identify gaps and compliance with NICE standards
- Pilot and evaluate a ‘managing distressing thoughts’ course - due to start in January 2020 and run for 10 weeks
- Focusing on the following groups at increased risk of suicide - the leaving prison population, those with sleep disturbances and those with chronic pain conditions
- Promoting the role of pharmacy in the prevention of suicide.

6.5.4 The group has recognised the importance of including the voices of experts by experience in this work stream and is exploring the most effective way to involve service users and carers.

6.6 Children and Young People

6.6.1 Suicide prevention is part and parcel of work to support the mental health and wellbeing of children and young people within clinical and non-clinical settings. This work is overseen by the Thrive Partnership Board. Thrive is a partnership that includes Child and Adolescent Mental Health Services (CAMHS), Youth Justice, Safeguarding, Manchester Health and Care Commissioning, School Health Service (including School Nursing and Healthy Schools team), schools and colleges, community voluntary sector providers including 42nd street and Manchester Mind, Population Health, Greater Manchester Mental Health Trust and Children’s Social Care. The Thrive Partnership is overseeing the transformation of mental health services for children and young people in the city including treatment, early intervention and prevention. The Suicide Prevention Steering Group and Thrive Partnership are aligned and the Chair of Thrive Partnership is a member of the Suicide Prevention Steering Group.

6.6.2 Following a small number of suspected suicides in young people in Manchester in the previous 15 months (following several years of no cases), Manchester Safeguarding Children Board requested a learning circle to consider risk factors and themes and make recommendations. This took place on 18th September and themes considered included the impact of drugs and alcohol, family mental ill health, self-harm, support for students and relationship issues. The findings from the group discussions are in the process of being analysed and will feed into the refreshed suicide prevention plan.

6.6.3 Work is taking place, led by Child and Adolescent Mental Health Services and Education, to develop a robust critical response pathway to support schools and colleges and the wider community following a suicide or attempted suicide of a young person. Recent incidents have highlighted that whilst there is a high level of support from a range of organisations, this is not always coordinated as well as it could be.

6.6.4 A new student mental health service is currently being established in Manchester. The GM Universities Mental Health Service is a partnership with local higher education institutions (University of Manchester, Manchester Metropolitan University, Salford University, Bolton University and the Royal Northern College of Music), stakeholders including the GMCA Health & Social Care Partnership with support from local mental health organisation 42nd Street. A two year pilot has been funded and the service is now being set up, with plans to start undertaking clinical work in autumn 2019.

7.0 Support for those bereaved by suicide

7.1 A new Greater Manchester Bereavement Information Service was launched in April 2019 with two years funding from the Greater Manchester Health and Social Care Partnership. This recognises the importance of providing compassionate support and practical advice to people bereaved by suicide and the increased risk of suicide that those bereaved fall under. The service, based in Salford and provided by Six Degrees, has a dedicated office hours phone line and signposts callers to local services that can help. The service is already helping Manchester bereaved by suicide either recently or in the past. It is important to ensure that local service information is kept up to date to ensure seamless signposting and referral.

7.2 Manchester City Council is working in partnership with the Department of Work and Pensions to implement the Tell Us Once service in November 2019. This enables people to report a death just once and the information to be passed on to a number of government agencies, making things easier for next of kin at what is a difficult and distressing time.

8.0 Evaluation

8.1 Earlier this year an evaluation was carried out that combined a review of national evidence, Manchester Suicide Prevention Partnership documentation and eight interviews with a selection of partnership members, to explore their roles and experience within the partnership. The questions were based on the Centre for Public Scrutiny framework for suicide prevention plans. Each partner could clearly articulate their role and was happy with the leadership. Partners engaged through the steering group, forums and clinical pillar groups. Progress was perceived to be largely due to good leadership and commitment of members to make a change, often working voluntarily or in conjunction with other full-time posts. All the findings from the evaluation are contributing to the refresh of our Suicide Prevention plan.

"All members of the partnership stated how committed all partners were in implementing the plan".

8.2 National funding has recently been announced for the Service Led Improvement programme of the Local Government Association to support local authorities to strengthen suicide prevention plans including both regional and local support potential. This work is being coordinated at a Greater Manchester level and Manchester will have the opportunity to pair up with another local authority area to develop their plans.

9.0 Refresh of Local Manchester Suicide Prevention Plan

9.1 The current local suicide prevention plan expires at the end of 2019. Work is underway to refresh the plan for 2020 - 2025 and it is due to be approved at the Health and Wellbeing Board in 2020. The following steps have been taken to involve partners in the development of the new plan and inform its content:

- A stakeholder workshop in June 2019 to consider progress against existing objectives and develop ideas for future focus.
- Consideration by the Manchester Suicide Prevention Partnership Steering Group.
- Findings from the Partnership evaluation.
- Ensuring alignment with national objectives and the Greater Manchester Suicide Prevention Strategy.
- Development of recommendations from the Learning Circle on suicide in Children and Young People (under 25).

9.2 The plan will maintain the existing structure / model used in the 2017-19 plan. The Suicide-safer Communities Model is an evidence-based multi-agency approach to suicide prevention advocated as part of the Greater Manchester Suicide Prevention Strategy - organising activity under the following pillars:

1. Leadership
2. Evidence, data and intelligence
3. Suicide Prevention Awareness
4. Mental Health and wellbeing promotion
5. Training
6. Suicide intervention and ongoing clinical/support services
7. Suicide bereavement
8. Evaluation
9. Capacity building and sustainability

9.3 In addition to the pillar focus, it is proposed to identify the following groups for targeted work in order to ensure we have an impact. These are:

- Middle aged men.
- Children and young people, including students.
- People in the care of mental health services and who self harm.
- LGBT+ community.

9.4 Key objectives for the refreshed plan include:

- The development of a comprehensive workforce development strategy to ensure that training is embedded across organisations and communities.
- Improved communication of activities, learning and opportunities for engagement and networking.
- Implementation of competence frameworks across organisations.

10.0 Recommendations

10.1 The Committee is asked to:

1. Note the contents of the report;
2. Consider the multiple factors that impact upon suicide rates; and
3. Provide feedback and ideas to support the refreshed plan for 2020 – 2025.

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ARE YOU FEELING SUICIDAL?

"I'm now much better and am so thankful that I spoke to my wife and parents on that day when I'd reached my lowest point. If I hadn't, and instead acted on my suicidal thoughts, I would have ruined so many people's lives. If you are struggling, don't keep things bottled up like I did, seek help."

Danny, 39, former England Rugby League player

Sometimes life can feel so bad that you don't want it to go on any more.

Telling someone how you feel can be embarrassing or frightening. But talking to someone is the first step to staying safe, getting help and developing a sense of hope.

- **Take one step and one day at a time**
- **Find something to positively distract you from negative thinking**
- **Look after yourself – eat and drink healthily, take a little exercise**
- **Sometimes it's easier to open up to people you don't know – you could call Samaritans on 116 123**
- **Go to A&E or call 999 if you are concerned that you can't keep yourself safe at that immediate time or have taken steps to hurt yourself**

ARE YOU BEREAVED BY SUICIDE?

Know that you are not alone and many others have and are experiencing similar emotions to yourself. There is information about support available from the Greater Manchester Suicide Bereavement Information Service.

0161 212 4919

(Monday to Friday 10am – 4pm
excluding bank holidays)

Find out more at

shiningalightonsuicide.org.uk

SHINING A LIGHT ON
SUICIDE

TOGETHER WE CAN HELP PREVENT SUICIDE

shiningalightonsuicide.org.uk

Suicide affects us all

Encourage someone to talk before suicide seems their only option

ARE YOU CONCERNED ABOUT SOMEONE?

Talking could be all it takes for you to prevent a tragedy

3 in 5 of us has thought about suicide at some point[1]

You don't have to be a health professional to help; you just need to be able to listen

Asking directly about suicide is the right thing to do if you are worried

You won't put the idea in a person's head if you ask them if they are considering suicide

Anyone who talks or writes about taking their own life should be taken seriously

How you can help:

- Encourage them to ring and speak to Samaritans on **116 123**
- Suggest they contact their GP or mental health worker
- Talk through their Safety Plan with them, if they have one

Supporting information is available at shiningalightonsuicide.org.uk

If the person shares with you a specific suicide plan and has access to the means to take their life then they need urgent help - stay with them and take one of the following steps:

- Take them to the nearest Accident and Emergency (A&E) department
- Ring **999** or **NHS direct** *(111 from any landline or mobile phone, free of charge)*

Suicide is the biggest killer of men under 49[2]

Suicide is the leading cause of death in people aged 15–29 years[3]

Half of gay and bisexual men said they have felt life was not worth living[4]

Student suicides grew by 79% between 2007 and 2015[5]

Over 200 people take their own life in Greater Manchester each year[6]

For information visit shiningalightonsuicide.org.uk

If you're struggling to cope call Samaritans on 116 123

#shiningalightonsuicide

Sources

1 *Page 9 of Centre for Public Scrutiny report, October 2018 'Providing a lifeline: Effective scrutiny of local strategies to prevent or reduce suicide'*

2 *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016) Office of National Statistics, What do we die from? (2015)*

3 *GM Suicide Prevention Strategy 2017-2022*

4 *Gay and Bisexual Men's Health Survey, Stonewall and Sigma Research, 2011*

5 *IPPR Not By Degrees, September 2017*

6 *GM Suicide Prevention Strategy 2017-2022*

Appendix 2

Suicide deaths in Manchester 1997-2017
19th August 2019

Summary

- Suicide rates in the general population in Manchester appear to have fallen between 1997 and 2017 (Table 1 and Figure 1). Recent figures show they are similar to the England average and are now below the average for the North West (Figure 2).
- The proportion of people in contact with services before suicide has varied over this time period, but the average proportion in contact is similar to national figures.
- From 2006 to 2009 rates in both the general and clinical populations rose. It is possible that the general population increase was associated with socioeconomic factors. The increase in the patient figures is more difficult to interpret. It could simply reflect underlying trends but could also indicate better engagement of at risk individuals by services.
- Since 2009 rates of suicide have been falling, although there was a spike in 2014.
- The characteristics of Manchester residents who died by suicide are somewhat different to the characteristics of those who die by suicide in England as a whole. For example, Manchester residents have higher rates of death by self-poisoning; they are more often on long-term sick leave or from a Black, Asian and minority ethnic group; and they are more likely to have a history of drug misuse and alcohol misuse. This is probably a reflection of differences in the socio-demographic characteristics of the underlying population as well as possible specific risk factors for suicide.
- All data are based on individuals with postcodes in the City of Manchester.
- Because the numbers are relatively small, trends will inevitably be influenced by random fluctuations.

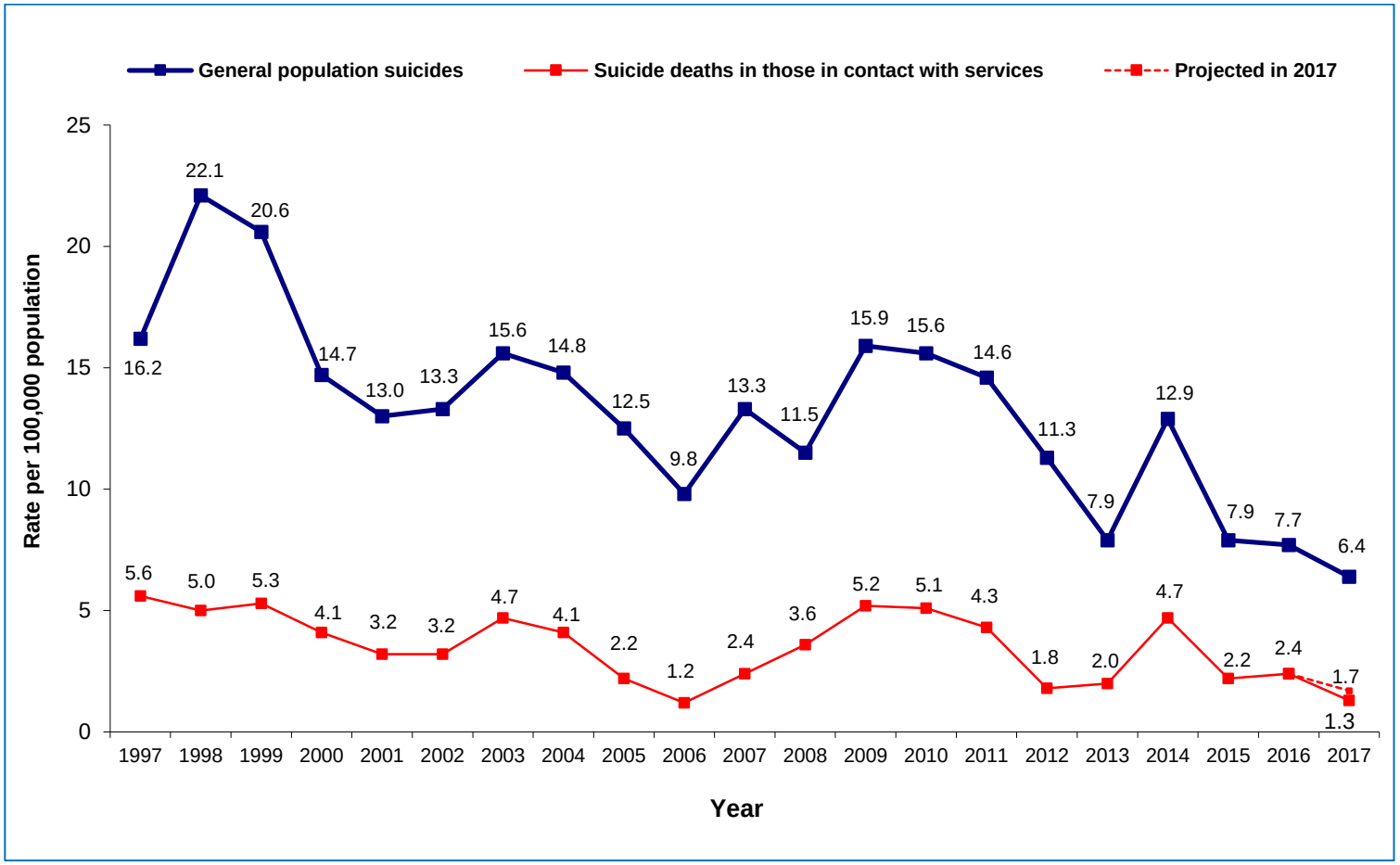
Table 1: Suicide deaths in Manchester (1997-2017)

	General population suicides N=1,117 N	Contact within 12 months[A] N=299 N	Manchester % in contact[B] (27% average)	England % in contact[B] (27% average)
1997	58	20	34%	24%
1998	79	18	23%	24%
1999	74	19	26%	25%
2000	54	15	28%	26%
2001	48	12	25%	27%
2002	50	12	24%	27%
2003	60	18	30%	27%
2004	58	16	28%	28%
2005	50	9	18%	29%
2006	40	5	13%	27%
2007	55	10	18%	27%
2008	48	15	31%	26%
2009	67	22	33%	27%
2010	67	22	33%	29%
2011	64	19	30%	30%

2012	50	8	16%	28%
2013	35	9	26%	28%
2014	58	21	36%	27%
2015	36	10	28%	26%
2016	36	11	31%	25%
2017	30	8	27%	29%

[A] Individuals who died by suicide within 12 months of mental health service contact (projected figure in 2017); [B] '% in contact' refers to the proportion of general population suicide deaths which occurred in individuals within 12 months of mental health service contact.

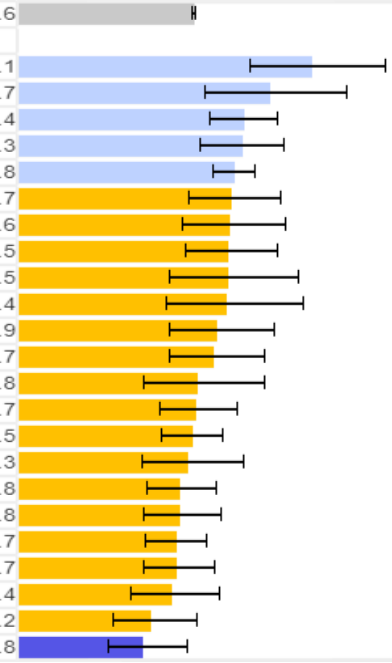
Figure 1: Rates of suicide per 100,000 population in Manchester (1997-2017)



Note: There was a statistically significant fall between 1997-2017 in the general population and patient suicide rate

Figure 2: Age standardised suicide rates in the North West (average rate 2016-18, based on year of registration)

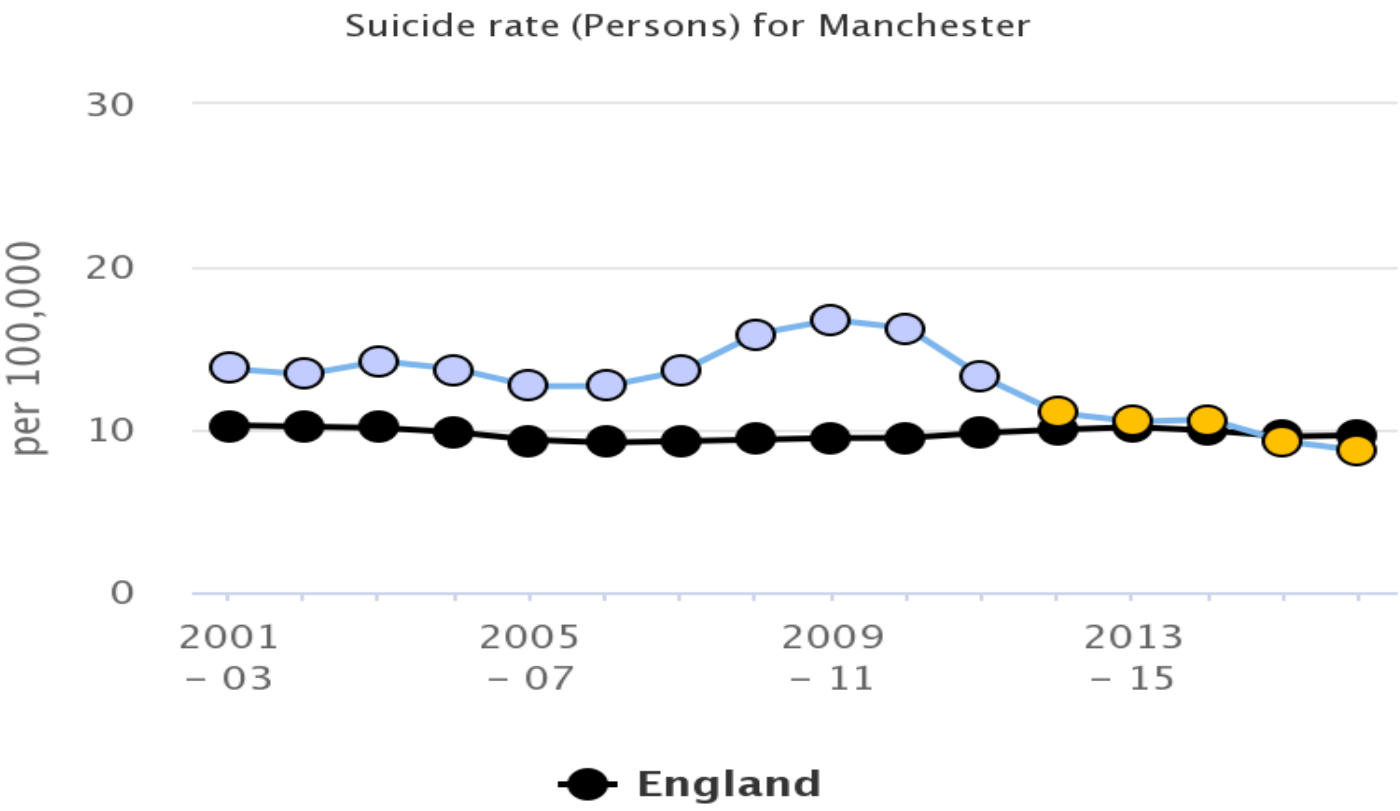
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	14,047	9.6	9.5	9.8
North West PHE centre	–	-	-	-	-
St. Helens	–	75	16.1	12.6	20.2
Blackpool	–	51	13.7	10.2	18.1
Cumbria	–	165	12.4	10.5	14.3
Wigan	–	106	12.3	9.9	14.6
Lancashire	–	371	11.8	10.6	13.1
Bolton	–	87	11.7	9.3	14.4
Tameside	–	68	11.6	9.0	14.7
Sefton	–	82	11.5	9.1	14.3
Knowsley	–	44	11.5	8.3	15.4
Halton	–	38	11.4	8.1	15.7
Rochdale	–	59	10.9	8.3	14.1
Salford	–	70	10.7	8.3	13.5
Blackburn with Darwen	–	37	9.8	6.9	13.6
Wirral	–	83	9.7	7.7	12.0
Liverpool	–	122	9.5	7.8	11.3
Bury	–	45	9.3	6.8	12.4
Cheshire East	–	86	8.8	7.1	10.9
Stockport	–	67	8.8	6.8	11.2
Manchester	–	113	8.7	7.0	10.4
Cheshire West and Chester	–	78	8.7	6.8	10.8
Oldham	–	48	8.4	6.2	11.1
Warrington	–	41	7.2	5.2	9.8
Trafford	–	41	6.8	4.9	9.3



Source: Public Health England (based on ONS source data)
https://fingertips.phe.org.uk

key
light blue – significantly higher than England
Yellow – similar to England
Dark blue – significantly lower than England

Figure 3: Public Health England suicide rates in Manchester (2001-2018)



Recent trend:

Period	Manchester				North West region	England
	Count	Value	Lower CI	Upper CI		
2001 - 03	146	13.7	11.5	16.3	11.2	10.3
2002 - 04	141	13.4	11.2	15.9	10.7	10.2
2003 - 05	155	14.2	11.9	16.8	10.9	10.1
2004 - 06	151	13.7	11.5	16.2	10.8	9.8
2005 - 07	144	12.7	10.5	15.1	10.7	9.4
2006 - 08	137	12.7	10.5	15.1	10.3	9.2
2007 - 09	153	13.6	11.4	16.1	10.7	9.3
2008 - 10	179	15.9	13.5	18.6	10.5	9.4
2009 - 11	191	16.7	14.3	19.5	10.8	9.5
2010 - 12	185	16.2	13.8	18.9	10.8	9.5
2011 - 13	156	13.2	11.1	15.6	11.3	9.8
2012 - 14	138	11.0	9.1	13.2	11.5	10.0
2013 - 15	130	10.5	8.6	12.6	11.3	10.1
2014 - 16	131	10.6	8.7	12.8	11.0	9.9
2015 - 17	113	9.3	7.5	11.3	10.4	9.6
2016 - 18	113	8.7	7.0	10.4	10.4	9.6

Source: Public Health England (based on ONS source data)
https://fingertips.phe.org.uk

Table 2: General population suicide deaths in Manchester (1997-2017)

	Manchester suicide deaths N=1,117		Remaining England suicide sample N=96,429	
	N	**%**	**N**	**%**
Age and sex				
Age: median (range)	41 (13-96)		45 (10-104) **	
Male	855	77%	72,635	75%
Method				
Hanging	464	42%	42,480	44%
Self-poisoning	341	31%	21,391	22% **
Jumping /multiple injuries	103	9%	9,753	10%
Gas inhalation	43	4%	5,501	6% *
Drowning	41	4%	4,560	5%
Other†	118	11%	12,007	13%
Unknown/unascertainable	7	1%	707	1%

** $p<0.001$ * $p<0.05$

†includes firearms, suffocation, electrocution, burning, cutting & other specified

Table 3: Suicide in patients in contact with mental health services in the 12 months before death (1997-2017)

	Manchester patient suicide deaths N=297		Remaining England patient suicide sample N=25,577	
	N	**valid %**	**N**	**valid %**
Demographic features				
Age: median (range)	41 (15-95)		45 (10-100) **	
Male	216	73%	16,891	66% *
Not currently married	232	82%	17,529	70% **
Living alone	144	51%	11,209	46%
Unemployed	141	50%	10,509	43% *
Long-term sick	68	24%	3,592	15% **
Black, Asian and minority ethnic group	39	14%	1,867	7% **
Method				
Hanging/strangulation	102	35%	10,384	41% *
Self-poisoning	114	39%	6,509	26% **
Jumping/multiple injuries	35	12%	3,874	15%
Other†	44	15%	4,702	18%
Priority groups				
In-patient	22	7%	2,711	11%
Post-discharge patients	41	15%	4,482	20%
Under crisis resolution home treatment services	15	7%	2,559	13% *
Missed last appointment	71	28%	5,749	26%
Non-adherent with medication in last month	51	20%	3,429	15%*
Clinical features				
Primary diagnosis:				
Schizophrenia & other delusional disorders	79	27%	4,443	18% **
Affective disorders (bipolar or depression)	108	37%	11,313	45% *

Alcohol dependence	36	12%	1,983	8% *
Drug dependence	24	8%	1,048	4% *
Personality disorder	17	6%	2,370	9% *
Other primary diagnosis‡	29	10%	3,521	14% *
Any secondary diagnosis	168	57%	13,145	52%
Duration of mental illness (under 12 months)	41	14%	5,142	21% *
Behavioural features				
History of self-harm	204	73%	16,474	66% *
History of alcohol misuse	164	59%	10,846	44% **
History of drug misuse	129	46%	7,869	32% **
History of violence	72	27%	5,111	21% *
Contact with services				
Last contact within 7 days of death	120	41%	12,344	49% *
Estimate of immediate risk: low or none	202	83%	19,816	85%
Estimate of long-term risk: low or none	107	51%	12,185	59% *

** p<0.001 * p<0.05; †includes gas inhalation, drowning, firearms, cutting, suffocation, burning, electrocution & other specified;
‡ includes anxiety disorders, eating disorders, adjustment disorders, dementia, organic disorder, conduct disorders, learning

Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 8 October 2019

Subject: Manchester Public Health Annual Report 2019

Report of: Director of Public Health/Population Health

Summary

As part of the statutory role of the Director of Public Health there is a requirement to produce an annual report on the health of the local population. This report can either be a broad overview of a wide range of public health programmes and activities or have a focus on a particular theme. The 2019 report has a focus on the first 1,000 days of a child's life, from conception through to the age of 2 years old.

Recommendations

The Health Scrutiny Committee is asked to:

1. Note and comment on the final draft of the report; and
2. Support the recommendations listed in the final section of the report.

Environmental Impact Assessment - the impact of the issues addressed in this report on achieving the zero-carbon target for the city
Encouraging physical activity from an early age with a focus on walking and cycling will not only improve the health of children and young people but instil behaviours in the family and wider community that will contribute to the zero carbon target

Manchester Strategy outcomes	**Summary of how this report aligns to the OMS**
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	Giving our children the best start in life will lead to better outcomes in relation to education, lifelong learning and employment
A highly skilled city: world class and home grown talent sustaining the city's economic success	Developing the early years workforce by working with our academic and training institutions will help to address potential shortages predicted over the next decade
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Reducing health inequalities during the first 1,000 days will have positive benefits for the rest of the lifecourse

A liveable and low carbon city: a destination of choice to live, visit, work	Providing more services closer to home will support the plans to achieve the zero carbon target for the city and have positive health benefits
A connected city: world class infrastructure and connectivity to drive growth	

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Background documents (available for public inspection): None

Manchester Public Health Annual Report 2019

The first 1,000 days

This report is dedicated to the memory of Dr Sally Bradley, Director of Public Health for the City of Manchester from 2007-2009.

Sally was tragically killed, along with her husband Bill, in the terrorist attack in Colombo, Sri Lanka on 21st April this year.

Sally was passionate about public health and tackling health inequalities and did so many great things throughout her public health career.

She secured additional investment for preventative services for children and young people in Manchester that are still in operation today.

Sally was also a great advocate for getting the basics right, such as the uptake of childhood immunisations. We owe it to Sally to continue to do our very best for the children of Manchester.

David Regan
Director of Public Health

Contents

Foreword

We know how important the first stages of a child's life are and, as Executive Member for Children & Schools, I am pleased that the 2019 Public Health Annual Report is focused on 'The first 1,000 days.'

Many families face huge challenges and whilst we have much to be proud of in our city, we also know that health outcomes for children could be much better.

All the evidence is clear that supporting families and children at the earliest opportunity leads to the best outcomes. If we get it right in these early years we can make a big difference - getting children starting school ready to learn and with better health as they grow.

We have an ambition that every child can grow up to be safe, happy, successful and healthy. This report describes some of the excellent programmes now being delivered and also highlights some of the key challenges we face.

Councillor Garry Bridges
Executive Member for Children & Schools

To help children get the best start in life we must also create the conditions that enable parents, families and carers to have greater control over their lives. In line with the Our Manchester approach we are focusing more on what matters to residents living in our diverse and vibrant communities, building on the strengths and assets that already exist.

As Executive Member for Adults Health and Wellbeing I not only want to see our residents live longer but also live more years free from illness or disability.

This then lays the foundations for good health across the life course with healthy parents, carers and grandparents better able to play a key role in supporting efforts to make those first 1,000 days the best that they can be.

Councillor Bev Craig
Executive Member for Adults
Health and Wellbeing

Introduction

Sir Michael Marmot clearly articulated that giving every child the best start in life was an imperative to improve health outcomes and reduce inequalities in later life.

He further evidenced how the first 1,000 days are truly critical to child development and that if a baby's development falls behind the norm during the first years of life, it is more likely to fall even further behind in subsequent years than to catch up with those who've had a better start.

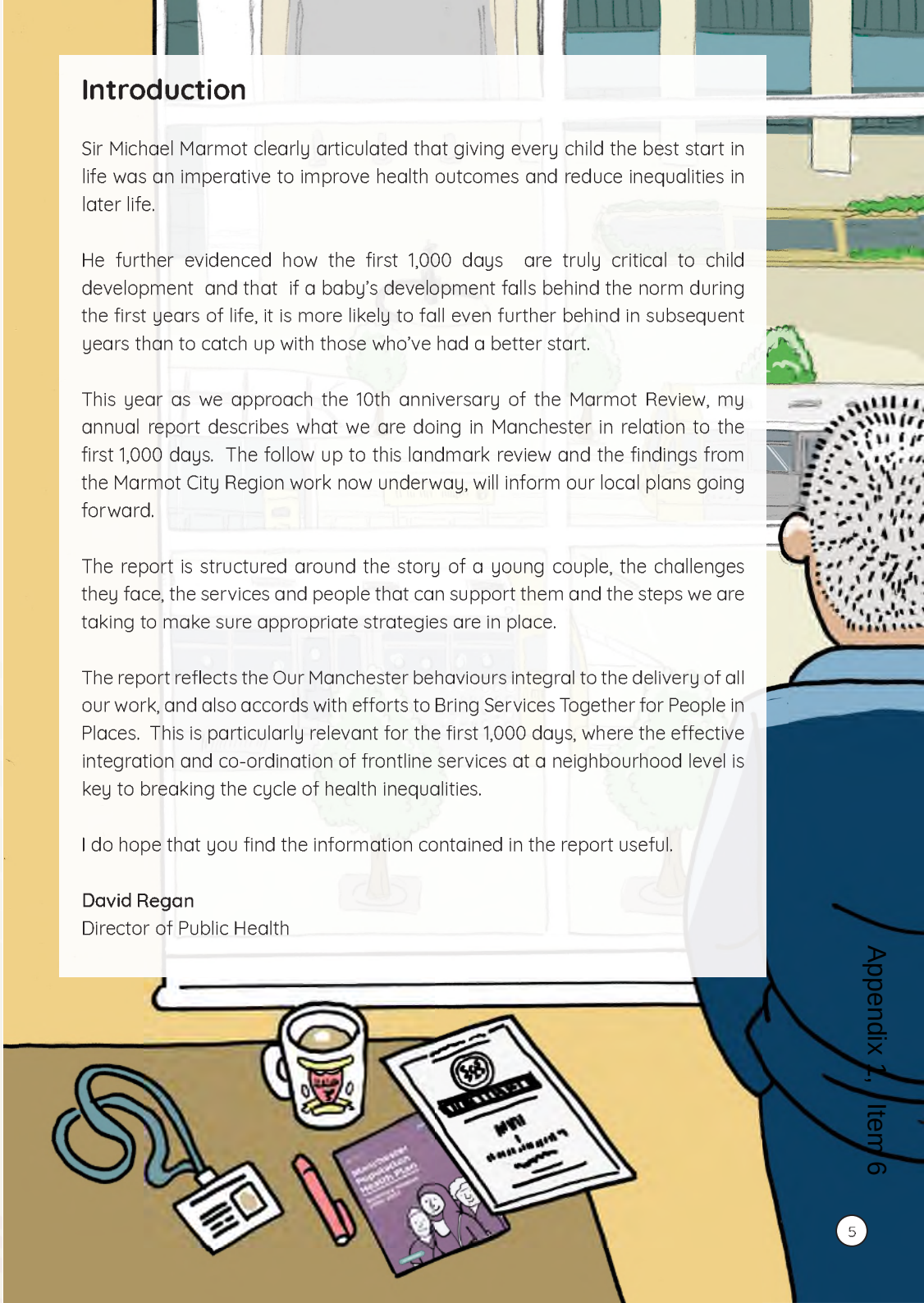
This year as we approach the 10th anniversary of the Marmot Review, my annual report describes what we are doing in Manchester in relation to the first 1,000 days. The follow up to this landmark review and the findings from the Marmot City Region work now underway, will inform our local plans going forward.

The report is structured around the story of a young couple, the challenges they face, the services and people that can support them and the steps we are taking to make sure appropriate strategies are in place.

The report reflects the Our Manchester behaviours integral to the delivery of all our work, and also accords with efforts to Bring Services Together for People in Places. This is particularly relevant for the first 1,000 days, where the effective integration and co-ordination of frontline services at a neighbourhood level is key to breaking the cycle of health inequalities.

I do hope that you find the information contained in the report useful.

David Regan
Director of Public Health



In 2018 there were an estimated 37,768 (45,240) children aged 0-4yrs in Manchester, accounting for 8.3% of the population.

Within the city, the proportion of the population aged 0-4 ranges from 11% of the population in Gorton South ward to around 1% of the population in the City Centre wards.

The 0-4 population is forecast to grow by 14.3% (1.4% a year) between 2018 and 2028.

The ‘first 1,000 days’ begins *every* day in Manchester

The first 1,000 days is the time from conception until a child is two years old. During this time of rapid growth, a baby’s brain is shaped by their early experiences and interactions.

When a baby’s development falls behind the norm during the first years of life, they are more likely to fall even further behind in subsequent years than catch up with those who had a better start.

It is essential that babies, mums, dads and the wider family receive the support needed to have ‘the best start in life’.

The first 1,000 days is included in citywide strategies and plans and is a priority area for all organisations.

The Manchester Population Health Plan 2018-2027 includes our ambition to:

- Reduce the rate of infant deaths
- Reduce the rate of mothers smoking in pregnancy
- Reduce the proportion of low birth weight term babies
- Increase the breastfeeding rate
- Reduce the number of children (0-4) admitted to hospital with dental decay
- Increasing the proportion of children who are ready for school

Preconception and pregnancy

The health of a would-be parent is an important factor in the preconception stage. Smoking, drug and alcohol use, poor nutrition or an unhealthy weight can all create difficulties in pregnancy and present significant risks to an unborn child. Smoking and obesity during pregnancy can contribute to an increased risk of miscarriage, premature birth, low birth weight and sudden unexpected death in infancy.

Antenatal care includes identification of potential risk factors to women and their babies. Support services offered in Manchester include weight management for obesity, the Vulnerable Baby Service, support for substance misuse and advice on stopping smoking.

Midwives carry out carbon monoxide testing with all pregnant women and refer women who smoke for advice and specialist support to help them quit.

Partners are also involved with the aim of ensuring that pregnant women and households, where babies and children live, are “smoke free”.

Better Births- Maternity Services

Every child deserves the best start from the very first moments of life and every parent, or parent-to-be, should feel confident they are receiving the highest standard of support and care. Manchester organisations work hard to make all our maternity services as safe, kind and personal as possible for everyone using them.

The Greater Manchester Maternity and Newborn Plan is based on the national 'Better Births' maternity review.

As part of the plan we will:

- Promote safe and effective maternity and newborn care
- Give women more choice and services personalised to them
- Increase continuity of care with women seen by the same health care professionals during their pregnancy
- Ensure babies and families that need neonatal care have access to the best possible service
- Provide parents with the postnatal care they need for their new family
- Give more recognition to and better treatment for mental health issues that arise during and after pregnancy

More recently, new national planning guidance has emphasised the improvements needed in maternity care. Manchester maternity providers are now working toward the national target that 35% of women should be booked on to the maternity pathway.

To complement this work the 'Fifteen Steps for Maternity Challenge' is a service user led approach that will contribute to improving the experience of using maternity services in Manchester.

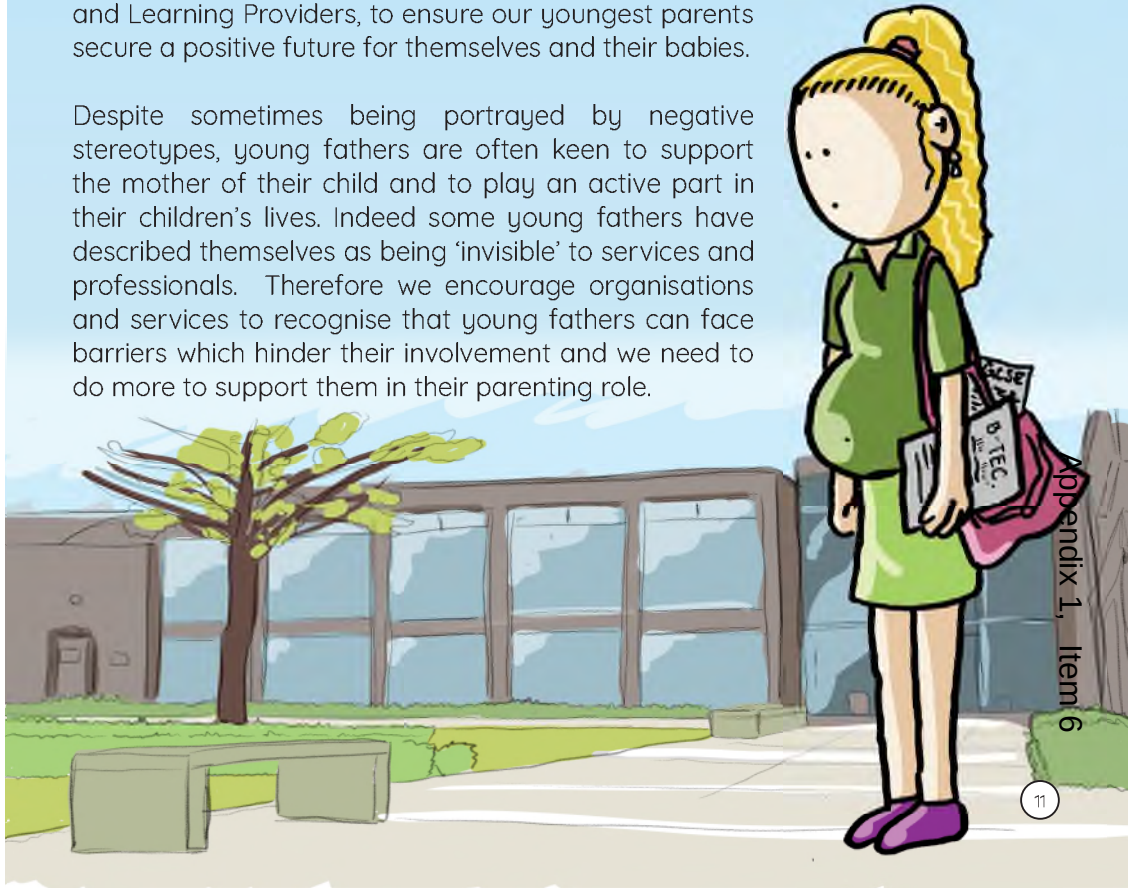
Teenage Pregnancy

Over the last decade we have achieved a significant reduction in the rate and number of Uunder 18 conceptions in Manchester. Whilst many young parents manage very well, others face a range of challenges.

The difficulties young parents may face compared to their peers without children and those who become parents at a later age include; increased risk of social isolation, economic hardship, lower attainment in education and less access to employment and training opportunities. The key to making a difference is to ensure that dedicated, coordinated and sustained support is in place. Our partnership approach, developed over a number of years, focuses on building confidence, skills and aspirations.

In 2019/20, we will appoint a citywide Teenage Parent Support Coordinator to work alongside specialist midwives to improve our support offer. They will also work with Early Years, Early Help, Supported Housing and Learning Providers, to ensure our youngest parents secure a positive future for themselves and their babies.

Despite sometimes being portrayed by negative stereotypes, young fathers are often keen to support the mother of their child and to play an active part in their children's lives. Indeed some young fathers have described themselves as being 'invisible' to services and professionals. Therefore we encourage organisations and services to recognise that young fathers can face barriers which hinder their involvement and we need to do more to support them in their parenting role.



‘Get your checks and immunisations done!’

At 12 weeks screening and immunisations are offered to pregnant women to protect the health of the mum and baby.

The 12 week scan identifies the baby’s gestation and provides the mother with an estimated delivery date. It also checks that the baby is growing in the right place and developing well. Some abnormalities can be detected at this scan.

The 20 week scan enables health professionals to identify any conditions where the baby may need treatment or surgery after they are born. In a very small number of cases more serious conditions are found and the mother, her partner and loved ones will receive specialist support and advice.

All eligible pregnant women in England are offered screening for infectious diseases, some inherited conditions and for any anomalies of the developing fetus. Women already known to have HIV or hepatitis B will receive early specialist appointments to plan their care in pregnancy.

Pregnant women are offered flu vaccination at any stage of pregnancy as they have a higher chance of developing complications if they get flu. There is also more risk of the baby being born prematurely or with a low birth weight and even potentially stillbirth or death. In 2018/19 only 44.8% of pregnant Manchester women had their flu vaccination against a national ambition of 55%. To increase uptake, midwives have now started to offer vaccinations in the antenatal settings.

Pregnant women are also offered Pertussis (whooping cough vaccine) from 16 weeks gestation. The uptake of the Pertussis vaccine in Manchester is 69.8% compared to 71.7% for England. The aim is to achieve a target of 75% uptake in line with the new national ambition.

Think Family

‘It takes a village to raise a child’ is a famous proverb that highlights the importance of the wider family and local community in helping children to grow up in a safe and healthy environment.

It is estimated that 97% of parents rely in some way on their wider family and trusted others to provide childcare. This could be grandparents, aunts, uncles or older brothers and sisters. Good neighbours and friends can also have a positive influence on a child’s life, helping them develop key relationships.

Manchester encourages a ‘Think Family’ approach, to co-ordinate services that meet the needs of families.

The ‘Think Family’ initiative was introduced in 2008 to work with families experiencing multiple and complex problems. The basis of the approach is to:

- identify families at risk of poor outcomes and to provide support at the earliest opportunity
- meet the full range of needs within the family that staff are supporting or working with
- strengthen the role of family members to provide care and support to each other
- provide a co-ordinated wrap around offer from key agencies

The ‘Think Family’ approach underpins all our core services to children and adults, particularly to those experiencing multiple and complex problems. This approach is now an integral part of the Early Help Strategy to improve the health and wellbeing of families.

Early Help - Family Intervention

Providing the right support at the right time is essential in meeting the 'Our Manchester, Our Children: Children and Young People's Plan'. This places children at the heart of the city, and ensures that they will grow up safe, healthy, happy and successful, arriving at school ready to learn, with increased life chances and with the necessary skills and support for future independence.

Early Help is about intervening early to tackle problems emerging for children, young people and families and it focuses on providing preventative support before issues become more complex and entrenched. By establishing networks within communities, individuals and families can build greater resilience that leads to a sense of wellbeing. Interventions can include universal support (e.g. referral to a local group) or targeted work specifically undertaken for a family's individual need.

Early Help approaches promote and develop community and family assets, building on strengths to be able to better respond to day to day challenges and difficulties. It is a collaborative approach, not a service. Referral for support is to one of the city's three Early Help Hubs, where the right support is offered from a variety of agencies. This can include;

- Access to benefits and entitlements
- Signposting to local services
- Physical or mental wellbeing support
- Referral to perinatal support or a local Children's Centre

Family Poverty Strategy

Manchester has high rates of child poverty with 45.4% of children under 16 living in poverty (63,427 children) after housing costs. The End Child Poverty Coalition estimates Manchester has the 8th highest proportion of children living in poverty in the UK (2019). In 10 out of the 32 wards in the city more than half of children were estimated to be living in poverty. The Institute for Fiscal Studies has also predicted that the number of children living in poverty will rise sharply by 2020, in part due to planned benefit reforms affecting families with children.

The Manchester Family Poverty Strategy aims to ensure that every child in Manchester has a safe warm home, stable parenting, regular healthy meals, access to healthcare and a family income above 60% of national median. Work is focused on the following areas:

Sustainable Route out of Poverty - raising awareness of affordable childcare for parents; identifying 'vulnerable' groups and the offer of a route into work; liaising with the large anchor institutions, such as NHS organisations and Manchester City Council, and promoting flexibility in working conditions.

Focus on the Basics – tackling the Poverty Premium whereby low income families pay more for everyday items; developing awareness raising campaigns and provision of bespoke support such as fuel vouchers for families facing disconnection; addressing food poverty by developing targeted resources, like food pantries and food bank expansions; support for the purchase of white goods.

Boosting Resilience and Building on Strengths - supporting work to 'poverty proof' structures, particularly in schools, as this will lead to a better understanding of the barriers faced by pupils from low income families; developing communication campaigns and asset mapping tools; improving intelligence and targeting by engaging with residents to understand need; and deliver support based on needs.

A family made up of Mum, Dad and an 11-month-old child came to Manchester from overseas. Mum was pregnant and had a traumatic unplanned birth at home, assisted by Dad. An outreach worker from the local Sure Start Centre and a midwife made a joint home visit and encouraged Mum to attend the Sure Start Centre for a baby play session and the healthy child drop-in clinic.

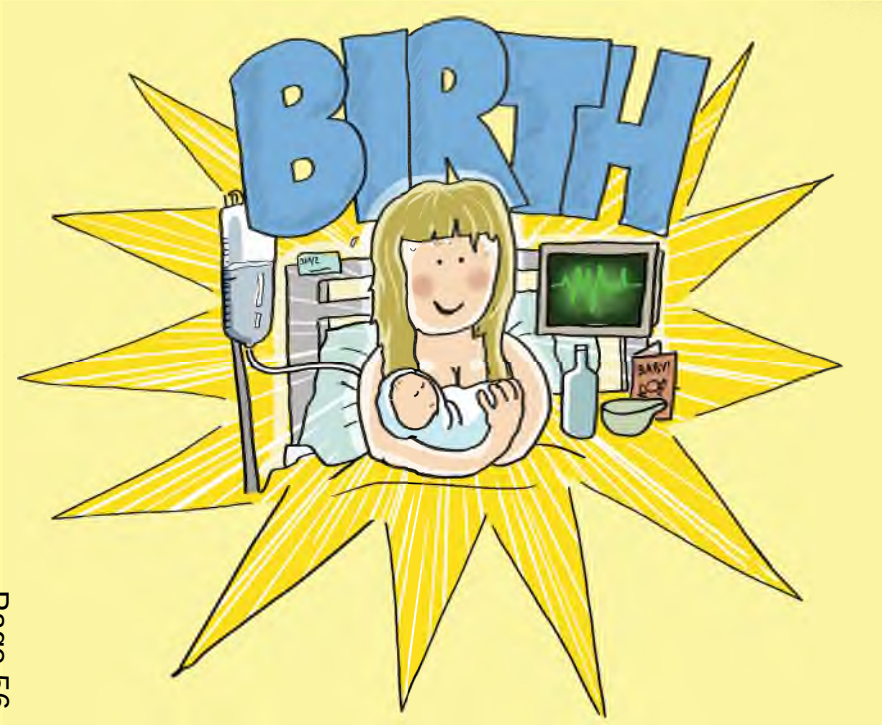
The family were living in a small, dark and damp private rented flat. Dad was working very long hours. Mum had social anxiety and found it difficult to leave the house and the 11-month-old baby had few toys, little space to play and was upset due to Mum's anxieties.

The outreach worker built up a good relationship with the family and worked with the health visitor and midwife to complete an Early Help Assessment.

Emotional, health, social and practical support for the family was organised. This included access to the local Children's Centre services, housing advice, support to attend hospital appointments for diagnosis and treatment for Mum's postnatal depression and toys for the children.

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

Birth



After approximately nine months the next phase of the first 1,000 days begins.

In 2017, 7,629 babies were born to Manchester residents and the child population is estimated to rise each year between now and 2023, with new births and new arrivals in the city.

Whilst most babies are born without complications, around 60,000 babies are born prematurely in the UK every year. This means that 1 in every 13 babies born in the UK will be born before 37 weeks of pregnancy.

All newborn babies in Manchester receive screening that includes a physical examination (eyes, heart, hips, testes and hearing loss) and a blood spot test for nine rare health conditions.

Healthy Start Vouchers are free for eligible families to spend on milk, fresh or frozen fruit, vegetables, infant formula milk and free vitamins. Midwives and health visitors can advise on where the vouchers can be exchanged with local retailers and pharmacies.

Reducing Infant Mortality

Infant mortality is deaths that occur in the first year of a child's life. It is linked to the health of the population and the wider social, economic and environmental determinants of health - such as poverty, housing and homelessness. Following a long period of year-on-year reductions, Manchester has seen a worrying increase in rates since 2011–13. It is hoped that this increase has started to tail off but the most recent unpublished figures have yet to be validated.

To tackle this we have developed the **Manchester Reducing Infant Mortality Strategy** (2019-2024). The aim is to reduce the rates of infant mortality, improve the health and wellbeing of pregnant women, mothers and infants and provide compassionate support for families that are bereaved following the loss of a baby.

We recognise the complexity of the work required and we will work collaboratively to deliver actions under the following themes:

- Quality, safety and access to services, including increasing awareness of the importance of antenatal care, identifying gaps in antenatal health education and increasing early booking into maternity services
- Maternal and infant wellbeing, taking a fresh look at maternal obesity, supporting pregnant women to stop smoking and support for breastfeeding
- Addressing the wider determinants of health by working with housing providers and the private rented sector to ensure housing is safe and warm and meets basic standards for mum, baby and the family.
- Safeguarding and keeping children free from harm, including education on safe sleeping, additional support for those most vulnerable, Independent Domestic Violence Adviser services to support pregnant women experiencing domestic abuse and implementing the ICON education programme to reduce abusive head trauma across the city.
- Providing support for those bereaved and affected by baby loss, taking a system-wide approach to making things as easy as possible for bereaved families. This includes training and building confidence in the workforce to talk about bereavement and increasing knowledge about bereavement services to improve access.

Health Visiting Service

The Manchester Health Visiting Service is an essential front-line service for the first 1,000 days enabling each Manchester baby to have the best start in life. Manchester partners have committed to funding additional University places for health visitor trainees in October 2019. This will in time increase the number of newly qualified health visitors in the city, reducing caseloads and making Manchester one of the best places to be a health visitor in the region.
Health visitors are registered nurses or midwives with specialist additional qualifications in child, family and public health. Their role is to offer information and support to families through the early years, from pregnancy and birth to primary school. In partnership with the Midwifery Service, health visitors will begin to visit pregnant mothers at between 28 and 36 weeks.

Within a fortnight of a child being born the Manchester Health Visiting Service will contacts the family again and make a visit to see the parent and child at home. This is an opportunity for parents to discuss the health and wellbeing of the whole family and the developmental progress of the child. The health visitor provides support, advice and information about local services and drop in sessions for children and families.

The health visitor also provides the Personal Child Health Record, or **'Red Book'** as it is more commonly known. This book is the family's own personal record which can be brought along to all future child health appointments. Every family in the city has access to the Health Visiting Service, and staff are based in Children's Centres, community buildings and GP surgeries.

Health visitors are part of the wider team of Council early years staff, voluntary sector workers, midwives and other health professionals who implement the Early Years Delivery Model (EYDM).

New born infant screening

Health Visitors will visit the home and conduct a range of screening tests to check the health of a child and identify conditions that are treatable but may not be clinically evident in the newborn period. Tests include weighing and measuring the child and taking a small blood sample, known as the heel prick test, from the child.

Low birth weight babies

Low birth weight babies are those who are born weighing less than 2,500 grams or 5 pounds, 8 ounces. A full term baby weighs on average 3,600 grams or 8 pounds. This may be sometimes due to smoking or alcohol use in pregnancy. In cases where a baby is at a significantly low birth weight, there will be a delay in hospital discharge as the baby may need to receive incubation or intravenous feeding.

Mental Health

A loving and secure relationship with a parent or carer supports a child's emotional wellbeing and development, enabling them to develop positive relationships with others. Most parents expect to feel happy, excited and positive through maternity but it is also natural to feel sadness or anxiety and this may lead to feelings of stress and poor mental wellbeing.

Perinatal mental health problems are those which occur during the first 1,000 days and can have a long-standing effect on a child's development. Perinatal mental illness affects up to 20% of women, and covers a wide range of conditions. If left untreated it can have significant and long lasting effects on the mum and her family.
Midwives and health visitors are trained to recognise signs of poor mental health and to refer for support where a family is struggling to cope.

Newborn Behavioural Observation (NBO) and Neonatal Behaviour Assessment Scale (NBAS)

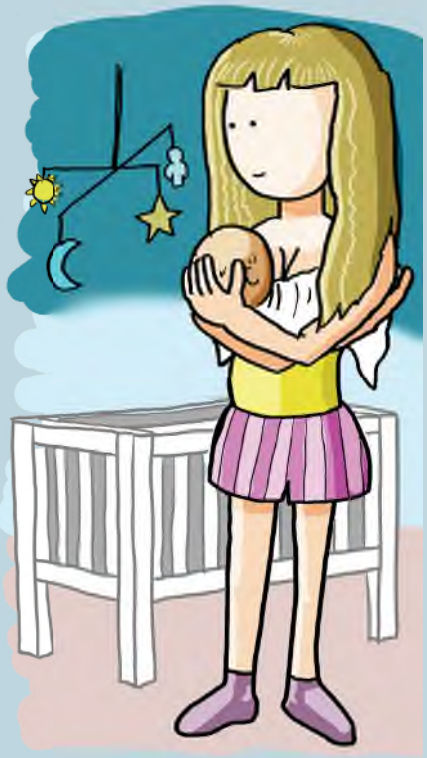
The Manchester Health Visiting Service uses the NBO and NBAS tools with parents to help them to observe and understand how their baby is communicating with them.
Manchester's specialist Mental Health Health Visiting Service also provides additional interventions including therapeutic targeted baby massage and non-directive counselling (listening visits), for mothers with mild to moderate perinatal mental health problems.

Infant Perinatal Mental Health Pathway

In Manchester we are developing a specialist perinatal mental health pathway for the city as part of a Greater Manchester programme of work. This includes four elements:

- Inpatient Mother and Baby Unit (Andersen Ward) at Wythenshawe Hospital for women who may be experiencing maternal post-natal depression, psychosis or an exacerbation of existing mental health difficulties.
- Specialist perinatal community mental health teams with particular skills and knowledge in nursing mentally ill women,
- Fast access to Increasing Access to Psychological Therapies (IAPT) services for parents
- The Parent Infant Mental Health offer delivers evidence based programmes and interventions to infants and their families delivered by partner agencies

Infant Feeding



Breastfeeding is important to child development and has long-term benefits for mother and baby.

Breastfeeding rates (2018/19) in Manchester at 6-8 weeks after birth are 43.4%. This is still below the England rate of 46.2%.
Manchester's Infant Feeding Group aims to improve infant feeding and increase rates of breastfeeding. It is a partnership that includes the Population Health Team, Health Visiting and Midwifery Services, Early Years and Primary Care.

The Group has been instrumental in developing the **Breastfeeding-Friendly Manchester** campaign to encourage more women to breastfeed in public places. They have developed a number of key priorities, increasing volunteer peer support across the city; improving knowledge and support from GPs on infant feeding issues; and encouraging employers to support staff returning to work who wish to continue breastfeeding.

The Integrated Infant Feeding Service for North Manchester was commissioned in 2018 to increase the uptake of breastfeeding, support women to continue to breastfeed and respond to other infant feeding difficulties. It includes a home visiting service, one to one support, infant feeding clinics, peer support in the early weeks and drop-in clinics. The service has helped to increase breastfeeding rates in north Manchester and improved infant feeding support.

Free Formula Milk for HIV Positive Mums

This year the Population Health Team introduced a new scheme to provide free formula milk and equipment to women in Manchester who are HIV positive. The scheme is administered by George House Trust, a local charity supporting people living with HIV who also offer other wellbeing support to mums. Mums can also access additional feeding support from the Health Visiting Service. The scheme is open to any woman who is HIV positive with an infant aged up to 12 months, regardless of income.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are stressful or traumatic events that happen in childhood and include:

- neglect (physical and emotional)
- abuse (physical, emotional and sexual)
- household challenges (having a parent who experiences domestic violence, a household member who is an alcoholic or using illicit drugs, a household member with a mental illness, parental separation or divorce or a household member in prison).

ACEs not only have the potential to cause harm to children but also affect people's lives as adults. Children experiencing ACEs without having a positive buffer, such as a nurturing parent or carer, are more likely to experience health problems such as asthma, poor growth and frequent infections, as well as learning difficulties and behavioural issues.

In the last year, the Population Health Team and partners commenced a 12 month place based pilot in the Harpurhey ward of the city. We have trained over 600 staff from a variety of organisations to be ACE aware and trauma informed, supporting them to use an ACE informed approach in their everyday work. We have also introduced ACEs recovery group work with parents and their children.

We are encouraging deeper conversations between staff and children, young people and their parents or carers living with ACEs. They are then able to highlight their experiences, acknowledge the impacts and build resilience by working on their strengths. In this way we can mitigate against the impact of people living with past ACEs and prevent ACEs in future generations.

We are already seeing positive results from the ACEs pilot in Harpurhey, including a reduction in challenging behaviours and fewer exclusions in schools who have adopted an ACEs informed approach. We have also secured partnership funding to expand this work into other neighbourhoods in the city over the coming year.

Oral Health

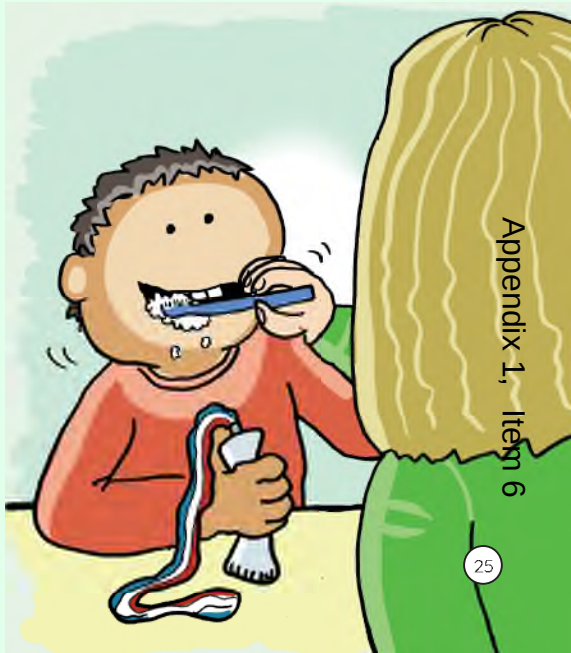
At an individual level whether a child experiences dental decay depends on three factors- how often they eat or drink sugar; their use of fluoride (e.g. from toothpaste or fluoride varnish) and how prone their teeth are to decay (individual factors). At a population level dental health is strongly associated with deprivation. Therefore work being done to reduce child and family poverty and improve living conditions will have a positive benefit for oral health. Manchester has invested in a comprehensive range of evidence based dental health programmes to improve dental health and reduce inequalities including:

The Oral Health Improvement Team works with early years workers, school staff and community health staff to deliver oral health education and promote better self care and good oral health behaviours. The Team primarily focus on children under 11 years of age and this work commences during the first 1,000 days.

The Buddy Practice Scheme has been in place since 2016 with the aim of increasing attendance at dentists among pre-school children and their families. This local programme links primary schools with local dentists to improve access to dental care and provide fluoride varnish twice yearly to children's teeth. The programme has been running for 5 years and is well respected.

Supervised Tooth Brushing Programme so that children in early years settings and schools regularly brush their teeth with fluoride toothpaste. This gets fluoride on the teeth and also develops good tooth brushing habits in young children, making it easier for parents to ensure children clean their teeth at home.

Health Visitors provide oral health packs and advice to parents and carers ensuring that messages about weaning, healthy eating, brushing teeth and visiting a dentist are embedded. The Chief Dental Officer is encouraging parents and carers of all children to visit a dentist by the time they are 12 months. The mandated health visiting check is another opportunity to reinforce this message.



Early Years

The Early Years Offer for the city has been developed in three parts:

- an Early Years Delivery Model (EYDM) with the City Council working in an integrated way with health partners and other providers;
- access to good quality, accessible and affordable childcare and early learning places across Manchester; and
- ensuring families are connected to a targeted family offer, delivered by Sure Start Children's Centres through the revised Sure Start core purpose

The Early Years Delivery Model (EYDM)

Manchester is below the national average when it comes to the proportion of children who are 'school ready', measured by the percentage of children achieving a good level of development at the end of reception year. The latest data for 2017/18 shows that 66.9% of eligible children had reached a good level of development at the end of the Early Years Foundation Stage, compared with 71.5% of eligible children across England. In Manchester, we want to see a year on year increase in school readiness to reduce the gap between England and Manchester within five years.

Children with a good level of development at age 5:

- Are able to communicate their needs and have a good vocabulary
- Are able to take turns, sit, listen and play
- Are able to socialise with peers and form friendships
- Are able to recognise numbers and quantities in the everyday environment
- Are independent in eating, getting dressed and going to the toilet
- Have developed motor control and balance for a range of physical activities
- Have received all their childhood immunisations
- Have good oral health
- Are well nourished and a healthy weight.

The EYDM is supporting work to increase school readiness by increasing the effectiveness of universal early years services. It takes a system wide approach and involves partnership working between midwives, health visitors, nursery nurses, early years practitioners and others such as speech and language therapists and the Children and Parents Service (CAPS).

The EYDM has a whole-family eight stage pathway from pre-birth to the last term before the child's fifth birthday. It supports the early identification of need, ensuring the right interventions are put in place to support school readiness. Since 2015, all babies born in Manchester have had access to the first five stages of the EYDM. The model aligns with the Healthy Child Programme (0-19) and uses the Ages and Stages Questionnaire (ASQ3) as the main assessment tool to identify any additional support that is needed. The ASQ3 is a parent-led assessment which helps to identify children and families requiring more targeted interventions. If a need is identified by the ASQ3 then additional support is offered through a variety of evidence based pathways, including the Communication and Language Pathway; the Parenting Pathway and the Parent Infant Mental Health Pathway.

The 8 stages are:

Stage One - Pre-birth	Midwifery Health and Social Assessment Health Visitor Antenatal Assessment	Before 12 weeks, 6 days 28 weeks
Stage Two - New Birth Visit	Health Visitor visit	10-14 days after birth
Stage Three - 2 months Visit	Ages and Stages Questionnaire (ASQ3) and Maternal Mental Health Assessment	2 months
Stage Four - 9 month assessment **Stage 4b - Targeted offer**	Ages and Stages Questionnaire (ASQ3) Targeted Twos pathway to give additional support to families where needed	9 months 18 months
Stage Five - Two Year Review	Ages and Stages Questionnaire (ASQ3) and Early Years Foundation Stage Health Visitor and Early Years Provider	24 Months
Stage Six - On entry to nursery (universal 3 and 4 year old provision)	Ages and Stages Questionnaire (ASQ3) and Early Years Foundation Stage Early Years Provider	24 Months +
Stage Seven - On entry to Reception in school	Ages and Stages Questionnaire (ASQ3) and Early Years Foundation Stage Early Years Provider and receiving school	3-4 Years
Stage Eight	Early Years Foundation Stage Profile and Ages and Stages Questionnaire	Undertaken by school within the last term before the child's 5th birthday

Early Years Outreach Workers

The outreach worker role involves working in partnership with health visitors to support the delivery of targeted interventions. They have an important proactive role in following up missed appointments and working with parents and carers at risk of disengaging to ensure they receive their free early education and practical support. The outreach workers contribute to WellcComm screening, a recognised speech and language toolkit, and Early Help Assessments. The workers carry an average case load of 12 children and link with the Early Help Hubs to support the step down process between different types of services.

Interventions to support progress

Evidence-based interventions are offered to children and families identified as making less than expected progress in child development, with a particular focus on communication, language and parental attachment. Additional support is given to address other barriers to achieving success such as or the take up of free childcare and early learning. The current range of services and programmes include:

- The Healthy Child Programme (health and development reviews, health promotion, parenting support, screening and immunisation programmes)
- Speech and Language Therapy
- Child and Parent Service (CAPS)
- New Born Behaviour Observation (NBO) and Neonatal Behaviour Assessment Scale (NBAS)
- Ages and Stages Questionnaire (ASQ3)
- Beck Depression Inventory (BDI-II) - assessment of mental health
- Beck Anxiety Inventory (BAI) - assessment of mental health
- Eyberg Child Behaviour Inventory (ECBI) - assessment of disruptive behaviours
- Parent Stress Index - screening for stress in parent child relations
- Care Index - mother and baby interaction measure
- WellcComm screening tool and WellcComm activities - speech and language toolkit
- Solihull Approach - supporting parents to understand and respond to their child's behaviour
- Every child a talker - language development
- 3-4 year old childcare
- Incredible Years Parent Training Programmes - for parents, children and teachers
- Video Interactive Guidance (VIG) - building parenting skills and confidence
- Pre School Psychology Clinics

Keeping children safe
'Safeguarding is everybody's business'.

Safeguarding means protecting a child's right to live in safety, free from abuse and neglect. It is about working together to support children and young people to make decisions about the risks they face in their own lives and protecting those who lack the capacity to make these decisions.

Abuse can happen to a child or young person at any age and can occur to children from any background. Abuse can happen because of the way adults or other children and young people behave towards a child. It also results from adults failing to provide proper care for the children they look after. It is often defined as physical, emotional, sexual abuse or neglect.

Manchester Safeguarding Children Board (MSCB) brings together a number of agencies across the city to ensure a joined up approach to safeguarding. From September 2019, partners will continue to work together under the new Manchester Multi-Agency Safeguarding Arrangements.

One of the main objectives of the revised arrangements is to ensure effective joint leadership across the three statutory partners, Manchester Clinical Commissioning Group (Manchester Health and Care Commissioning), Manchester City Council and Greater Manchester Police. This will also enable emerging safeguarding issues to be properly and quickly addressed and an example of this approach is described next.

In Manchester a recent addition to the City's Neglect Strategy has been the establishment of the Multi-Agency Obesity Pathway. More children are presenting at school in reception year as overweight and in some cases obese. Obesity in childhood is complex. It can be the result of a number of factors including poverty, lack of physical activity, Adverse Childhood Experiences (ACEs) and in some cases parental neglect.

The implementation of the Pathway will mean social workers, health visitors, school nurses and other professionals are trained in the use of an assessment tool and enable them to refer children and families to weight management support services.

Return to Work

Access to good quality, accessible and affordable childcare

Manchester benefits from a mixed economy of high quality, accessible childcare for children from 0-5 years of age.

Over the past two years the percentage of good and outstanding Ofsted registered provision has increased, with 97% of group childcare now classed as 'Good' or 'Outstanding'. The Manchester Childcare Sufficiency Assessment had identified pockets of the City where pressure on daycare places was most likely to be felt and plans to address these pressures have been developed and are currently being implemented.

The promotion of the entitlement of 2 year olds to early learning funding is a key priority as it will contribute to plans to increase the proportion of children who are school ready. To date, the take up rate of this funding in Manchester is 67% of the eligible cohort which is similar to the national average of 68%. '

A similar approach has accompanied the roll out of other funding streams targeted at 3 & 4 year olds, such as the Early Years Pupil Premium (EYPP) funding and the 30 hour free childcare offer available from September 2017. EYPP funding is available for childcare settings to invest in improving the early learning experience and environment and the 30 hour funding is intended to support working families with the costs of childcare. Currently, online eligibility checkers are being developed for all funding streams to further promote and encourage access to available resources.

Supporting breastfeeding

It is important that mums returning to work who want to continue breastfeeding are supported to do so by their employer. This support includes flexible working arrangements which allow for reasonable paid time to breastfeed and the provision of suitable facilities to breastfeed or express and store breast milk.

The Population Health Team are working with HR colleagues at the City Council to develop a model of best practice and the Corporate Estates team to assess whether Council buildings are conducive to enable staff to breastfeed.

Accident Prevention

Unintentional injuries, especially in and around the home are a leading cause of death and a major cause of ill health and disability for children under five. The accident rates are much higher in more deprived areas. The specific causes that are more likely to result in severe injury or death are:

- Choking
- Falls from furniture
- Tap water scalds
- Burns from food and hot drinks
- Poisoning from medicines

In Manchester rates of emergency admissions associated with these causes are higher than the national average, most significantly for falls from furniture (more than double) and burns from food and hot fluids (four times more).

This year, the Population Health Team have worked with the recently commissioned Accident Prevention and Unintentional Injury Prevention Service to develop a local action plan. This involves work with key partners such as the National Child Accident Prevention Trust, Royal Manchester Children's Hospital, North West Major Trauma Unit, Greater Manchester Fire and Rescue Service and the Manchester Local Care Organisation. This has enabled the Early Years and Children's workforce to get accident prevention messages out to parents, carers and young people. In addition there is a strong partnership approach to support the work of Road Safety, Water Safety and Trading Standards teams.

In Child Accident Prevention Week 2019, Manchester highlighted the risk of household poisoning and provided information resources to over 2,000 parents containing important home safety messages. An assessment of seasonal risks (e.g. swimming in canals, rivers and reservoirs in summer) is also reviewed to help deliver public safety messages at the most appropriate time.

2 Year Review

A young child will soon begin to develop relationships beyond the family home, interacting with other children in childcare settings.

On reaching the age of 2, children will be ready for another health and development review. This may take place at the local Children's Centre or baby clinic, with the health visitor undertaking the review sometimes with a nursery key worker, outreach worker or other key professional in attendance. Mum or Dad will have been asked to fill in the ASQ-3 Questionnaire before their appointment and the review will cover the following:

- speech, language, hearing and vision
- movement and general motor skills
- growth, eating habits and activity levels
- behaviour management
- good sleeping habits
- tooth brushing
- the child's safety

This review is particularly important, but unfortunately uptake has been lower than we would like it to be in Manchester and only 66% of parents took up the review in April 2019. We recognise that after the first 1,000 days many parents may feel sufficiently capable of managing and no longer require support. However, these vital skill checks can serve to identify any hidden development needs before starting school. Therefore we have recently launched a promotional campaign in children's settings to encourage all parents to take up their two year review.

Book Prescribing and Read Manchester

Read Manchester is a campaign by Manchester City Council and the National Literacy Trust to promote reading and boost literacy throughout the city. One of the aims of the campaign is to support young children through Bookstart, the provision of free books before school, and other activities.

Health visitors have been working with Libraries and Read Manchester staff to pilot an early years books on prescription scheme. This encourages parents to join a local library and borrow books to share with their children from a specially chosen list of titles.

Start Well Board

The Start Well Board has now been established to support a system wide consistent approach to the first 1000 days. The Board includes representatives from all health and social care partner organisations and the community and voluntary sector. The Board reports to the Children and Young People's Board and will build on the excellent work already taking place across Manchester. The Board will develop a programme of work based on Manchester's Reducing Infant Mortality Strategy, the Population Health Plan and other strategies with the aim of:

- Improving health outcomes
- Ensuring children are ready for school
- Ensuring a good level of development throughout early years
- Reducing infant mortality
- Reducing inequality

In 2019/20 one of the key priorities for the Board will be to ensure that the work on the first 1,000 days is fully embedded in Bringing Services Together (BST) for People in Places.

In addition, the Board will contribute to the Early Help/Early Years workstream of the Children's Locality Model Programme. This programme is currently being implemented across Manchester and reflects the geography of the 3 Early Help Hubs, 12 neighbourhoods and 12 schools and early years clusters.

Finally, the Board will play a vital role in driving forward our ambition for Manchester children to have a safe, happy, healthy and successful life.

Recommendations

To improve health outcomes in the first 1,000 days and throughout life, based on this report I would like to propose the following five recommendations:

1. Manchester Health and Care Commissioning working in partnership with the City Council and the Manchester Local Care Organisation should prioritise the training, recruitment and retention of health visitors in Manchester.
2. Work should be accelerated to fully integrate the early years workforce, strengthening relationships with early years providers and schools as part of the Children's Locality Model and Bringing Services Together for People in Places.
3. A sustainable funding model for the roll out of the Adverse Childhood Experience (ACEs) Programme should be agreed by commissioners.
4. Working with the Greater Manchester Health and Social Care Partnership, implement a joint plan to increase childhood vaccination uptake in line with national ambition targets.
5. The findings from the Marmot City Region work should be considered by the Health and Wellbeing Board and other partnerships in Spring 2020 to inform the refresh of local strategies and plans.

Glossary and Definitions

Childhood Immunisations - Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise. Most are delivered via injection. Each routine childhood vaccination has its own schedule for delivery and may be delivered through one dose or topped up with booster injections. Immunisations cover the following vaccine preventable communicable diseases:

- Tetanus.
- Polio.
- Pneumococcal infections.
- Diphtheria.
- Meningitis C.
- Whooping cough.
- Hib (Haemophilus influenzae type b).
- Hepatitis B.
- Rotavirus.
- Measles, mumps and rubella (MMR).
- Flu.

Vaccination Schedule (Early Years)

8 weeks	6-in-1 vaccine, a combined vaccine given as a single jab to protect against 6 separate diseases: diphtheria, tetanus, whooping cough (pertussis), polio, Haemophilus influenzae type b (known as Hib, a bacterial infection that can cause severe pneumonia or meningitis in young children), and hepatitis B Pneumococcal (PCV) vaccine Rotavirus vaccine MenB vaccine
12 weeks	6-in-1 vaccine, second dose Rotavirus vaccine, second dose
16 weeks	6-in-1 vaccine, third dose Pneumococcal (PCV) vaccine, second dose MenB vaccine, second dose
1 year	Hib/MenC vaccine, a combined vaccine given as a single jab to protect against meningitis C (first dose) and Hib (fourth dose) Measles, mumps and rubella (MMR) vaccine, given as a single jab, first dose Pneumococcal (PCV) vaccine, third dose MenB vaccine, third dose
2 to 9 years	Children's flu vaccine (annual)

Glossary and Definitions (continued)

Conception - conception statistics are estimates of all pregnancies of women usually resident in England and Wales. Figures are derived from combining numbers of maternities and abortions using information recorded at birth registration and abortion notification. Maternities are pregnancies that result in the birth of one or more children, including stillbirths; abortions are pregnancies terminated under the Abortion Act (1967).

Excess Weight - Children are classified as having excess weight if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

General Fertility Rate - The number of births divided by the population aged 15-44 years, multiplied by 1,000 to give the birth rate per 1,000 females aged 15 to 44 years
Icon stands for:

I = Infant crying is normal and it will stop
C = Comfort methods can sometimes soothe the baby and the crying will stop
O = It's ok to walk away if you have checked the baby is safe and the crying is getting to you
N = Never ever shake or hurt a baby

Infant Mortality Rate - The number of infant deaths aged under 1 year that were registered in the year, divided by the number of live births in the year, multiplied by 1,000 to give a rate per 1,000 births

Low Birthweight - Live births with a recorded birth weight under 2500g where the birth was at 37 weeks or later, divided by the total live births where weight was recorded and the birth was at 37 weeks or later.

Poverty - The End Child Poverty estimates are a combined estimate of survey and area level income data that is closer to the true level of child poverty (defined as below 60% of median income) than purely income based measures such as from HM Revenue and Customs. The estimates are produced by the Centre for Research in Social Policy.

School Readiness - Children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) as a percentage of all children completing EYFS. Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy.

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Finally, I would like to take this opportunity to thank all of the organisations, frontline staff, volunteers, families/carers and residents who live in our local communities, who all want the best possible start for children born and brought up in Manchester.

MANCHESTER CITY COUNCIL

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

Manchester Local Care Organisation
Leading local care, improving lives in Manchester, with you

‘What happens in these early years, starting in the womb, has lifelong effects’

Sir Michael Marmot 2010

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Manchester City Council
Report for Information

Report to: Health Scrutiny Committee - 8 October 2019

Subject: NHS Long Term Plan

Report of: Dr Leigh Latham, Head of Policy and Planning, Manchester Health and Care Commissioning (MHCC)
Kaye Abbot, Head of Operational Finance, MHCC
Zoe Mellon, Performance Lead, MHCC

Summary

The NHS Long Term Plan (LTP), published in January 2019, set out a ten year programme of phased improvements to NHS services and outcomes, including a number of specific commitments to invest the agreed five year revenue settlement.

This has been followed in June 2019 by the publication of the NHS Long Term Plan (LTP) Implementation Framework. This paper sets out:

- An overall summary of the guidance;
- National financial analysis;
- National Performance Indicator Requirements;
- National five year planning submission;
- Key planning milestones across health over the next 6 months.

Recommendations

The Committee is asked to consider 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 NHS Long Term Plan recognises the important role that NHS organisations have in contributing to reducing waste and carbon emissions.

Manchester Strategy outcomes	Summary of how this report aligns to the OMS
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	The implementation of the NHS LTP across Manchester will be underpinned by the OMS, and strategic aims of the Manchester Locality Plan.

A highly skilled city: world class and home grown talent sustaining the city's economic success	The implementation of the NHS LTP across Manchester will be underpinned by the OMS, and strategic aims of the Manchester Locality Plan.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	The implementation of the NHS LTP across Manchester will be underpinned by the OMS, and strategic aims of the Manchester Locality Plan.
A liveable and low carbon city: a destination of choice to live, visit, work	The implementation of the NHS LTP across Manchester will be underpinned by the OMS, and strategic aims of the Manchester Locality Plan.
A connected city: world class infrastructure and connectivity to drive growth	The implementation of the NHS LTP across Manchester will be underpinned by the OMS, and strategic aims of the Manchester Locality Plan.

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Background documents (available for public inspection): None

1.0 Introduction

1.1 The NHS Long Term Plan (LTP), published in January 2019, set out a ten year programme of phased improvements to NHS services and outcomes, including a number of specific commitments to invest the agreed five year revenue settlement. A glossary of terms is available on page 121 of the NHS Long Term Plan.

1.2 This has been followed in June 2019 by the publication of the NHS Long Term Plan (LTP) Implementation Framework. This guidance sets out the approach that Integrated Care Systems (working at the Sustainability and Transformation Partnerships level) are to take to create five-year strategic plans covering the period 2019/20 to 2023/24. For Manchester the 'system' is defined as the Greater Manchester Health and Care Partnership. The plans should be based on realistic workforce assumptions and deliver all of the commitments in the LTP. System plans will be aggregated, brought together with additional national activity and published as part of a national implementation plan by the end of the year.

1.3 MHCC is currently undertaking an analysis of its readiness against the requirements of this planning guidance. It is evident that the LTP does not make significant reference to Adult Social Care, however the local planning processes within MHCC do encompass integrated care, public health and Adult Social Care.

1.4 This paper sets out:

- An overall summary of the guidance;
- National financial analysis;
- National Performance Indicator Requirements;
- National five year planning submission;
- Key planning milestones across health over the next 6 months.

2.0 Background

2.1 The LTP Implementation Framework clearly sets out the expectation of systems to adopting an integrated approach to strategic and operational planning. Systems are expected to bring together member organisations and wider partners, adopting a common set of principles and leadership behaviours as they develop and deliver plans which span clinical leadership, local ownership of workforce planning, finance, delivery and reducing local health inequalities and unwarranted variation.

2.2 The investment to support the LTP implementation is set out to be either in existing CCG allocations, or available as additional funding on a 'fair shares' or 'targeted' basis. 'Fair shares' reflect the principle that the activity is expected to happen across the country, meanwhile 'targeted' reflects the fact the whole country is not covered by the service on specific needs or to test implementation approaches as evidence develops.

2.3 The service developments to be funded by the additional funding are detailed in the LTP guidance. The funding available has been confirmed at a national level, but not at a GM level currently, and there is a query on whether the additional funding is recurrent. The financial information is still being communicated by NHSE; this paper sets out what is known to date.

2.4 Within the guidance, some LTP commitments are referred to as 'critical foundations to wider change'; which all systems are required to deliver for both service transformation (Chapter 2) and system development (Chapter 3). This delivery needs to be in line with nationally defined timetables or trajectories, which will be published later in the year.

2.5 Systems have been given 'substantial freedoms' to prioritise and define the pace of delivery for the majority of commitments which are set out in Chapters 4 and 5 of the guidance; some of which will require national enabling actions before they can be implemented at scale across the NHS, although it is clear that all commitments are to be achieved by the end point of the Long Term Plan. For these commitments, delivery timetables and trajectories will be agreed by region. Clarification will be sought whether this will be the Greater Manchester Health and Social Care Partnership or the North West region.

2.6 System plans will also need to prioritise actions that will help improve the quality of, and access to care for their local populations, with a focus on reducing local health inequalities and unwarranted variation. Additionally, ensuring that the requirements relating to staff (Chapter 6) and the development of a digitised NHS (Chapter 7) are detailed.

3.0 High level LTP Implementation Framework summary

3.1 The LTP Implementation Framework guidance is set out in chapters, each of which is structured to clarify how the LTP commitments should translate into local system implementation plans. The next section will give a headline summary and pull out the areas for which additional funding has been identified. It should be noted that whilst the overall timeframe for delivery is 2023/24, the phasing and trajectories associated with individual requirements are not yet known.

Delivering a new service model for the 21st century (Chapter 2)

3.2 This chapter sets out 'critical foundations for change'. Plans will need to set out how these commitments will be delivered and the five year trajectories for doing so. The chapter covers:

- Transformed 'out-of-hospital care' and fully integrated community-based care
- Reducing pressure on emergency hospital services
- Giving people more control over their own health and more personalised care
- Digitally-enabling primary care and outpatient care
- Better care for major health conditions: Improving cancer outcomes

- Better care for major health conditions: Improving mental health services
- Better care for major health conditions: Shorter waits for planned care

Transformed 'out-of-hospital care' and fully integrated community-based care

3.3 There are a significant number of requirements related to transforming out of hospital care / integrated community based care, linked to Primary Care Networks (PCN) and community services, which is an area within MHCC for which the working approach has not yet been fully defined. As a minimum system plans should focus on:

- Meeting the new funding guarantees for primary medical and community health services
- Supporting the development of their PCNs
- Improving the responsiveness of community health crisis response services to deliver services within 2 hours of referral; and reablement care within 2 days of referral (linked to the four strategic priorities for community services, two of which will be jointly delivered by PCNs)
- Creating a phased plan of the specific service improvements and impacts (including the new GP contracts with seven new service specifications) that will enable primary and community services to achieve, year by year.

3.4 The schedule of improvements must be approved by the community providers and PCN clinical director, and be linked to the new funding guarantee.

Reducing pressure on emergency hospital services

3.5 System plans are required to show how local urgent and emergency care services will work to provide an integrated network of community and out of hospital care. Where systems can reduce pressure on emergency services they can benefit from an upside financial, capacity and staffing 'dividend' which can be re-invested in local priorities. How this would apply in GM will need to be considered.

Giving people more control over their health and personalised care

3.6 Systems are expected to implement the six components of the NHS Comprehensive Model for Personalised Care. Funding to support this is detailed as:

- The Network Contract Direct Enhanced Services (DES) 2019/20 – employment of social prescribing link workers.
- Targeted funding to deliver the NHS Comprehensive Model for Personalised Care from 2019/20 to 2021/22.
- Targeted funding 2019/20 to 2021/22 to CCG Champions to deliver components of the model.
- NHSE/I commitment to increase funding for children's palliative and end of life care; with an expectation that this is match funded where CCGs commit to increase their local investment.

Digitally-enabling primary and outpatient care

3.7 Plans should show increased use of digital tools to transform how outpatient services are offered and provide more options for virtual outpatient appointments, in order to remove the need for up to a third of face-to-face outpatient visits.

3.8 The requirements focus on the primary care delivery of the 2019/20 planning guidance and General Medical Services Contract framework such as on-line and video consultations. Targeted funding will be available for selected sites to test 'digital first primary care', with further detail to follow.

Better care for major health conditions: Improving cancer outcomes

3.9 Systems need to practically set out how they will deliver the LTP commitments, while improving operational performance in a number of stipulated areas including:

- Improving 1-year survival rate.
- Improving bowel, breast and cervical screening uptake.
- Rolling out FIT (bowel screening) and HPV primary screen in cervical screen programme.
- Improving GP referral practice.
- Implementing faster diagnosis pathways.
- Improving high quality treatment services through the roll out of Radiotherapy Networks, Children and Young People's (CYP) Cancer Networks and reform of Multi Disciplinary Teams (MDT)
- Roll out of personalised care interventions.
- Addressing unwarranted variation.

3.10 Funding (£400m) will be distributed on a 'fair shares' basis to Cancer Alliances by 2023/24 to support delivery. Targeted funding will support roll out of lung health checks, rapid diagnostic centres, and innovation for early diagnosis.

Better Care for major Health Conditions: Improving Mental Health Services

3.11 There is a strong focus on improving mental health within both the LTP and the Implementation Framework. There is a commitment that investment in mental health services will grow faster than the NHS budget overall for each of the next 5 years, and in addition CYP Mental Health services will grow faster than both overall NHS funding and total mental health spending. Funding to deliver the Mental Health Five Year Forward View (MH5YFV), and LTP commitments will be available via a mix of CCG base-line allocations and transformation funding over 5 years.

3.12 System plans will need to set out how they will meet Mental Health investment standard, and deliver commitments taking account of patients and carers race equality framework, which is in development.

3.13 Specialist mental health and learning disability services will be managed by NHS Provider-led collaboratives, with a plan to increase devolvement to lead providers for child and adult low and medium mental health services.

3.14 The increased funding within existing allocations will be expected to deliver the LTP including stabilising and expanding core community teams for adults and older adults with severe mental illness , rolling out adult community access targets and services for people with diagnosis of 'personality disorder', Early Intervention Psychosis, adult eating disorders and mental health community rehabilitation.

3.15 Additional fair share will be available to support delivery of:

- 345,000 additional CYP (0-25) nationally to access support vis NHS-funded mental Health services. (in addition to the MHFYFV commitment)
- Expansion of specialist community perinatal mental health in 2019/20.
- 24/7 access to adult crisis resolution and home treatment team by 2020/21.
- 24/7 crisis provision for CYP by 2023/24.
- 100% coverage across the country for local mental health crisis pathways by 2023/24.
- To deliver in new models of integrated care with PCNs from 2021/22 to 2023/24.

3.16 Individual systems will receive funding for salary support for IAPT trainees (60% of salary) and school /college based mental health support teams which will contribute to the CYP mental health access. Targeted funding will be provided to specific regions for a number of pilots and smaller initiatives which span primary, community and acute care, forensic services and wider government strategies such as rough sleepers.

Better Care for major Health Conditions: Delivering Shorter Waits

3.17 Systems will be required to set out how they will expand the volume of planned surgery year on year, reduce waiting times and size of waiting list. There is a requirement for no 52 week referral to treatment (RTT) waits, a planned NHS-Managed Choice process in place for patients who exceed 26 week wait, and by 2023/24 for all patients to have access to musculoskeletal (MSK) First Contact Practitioner.

Increasing the focus on population health – moving to Integrated Care Systems (ICS) everywhere (Chapter 3).

3.18 Chapter 3 is focused on the development of integrated care systems, with the clear requirement that **all STPs need to set out a plan to become an ICS by April 2021.** Systems are expected to assess as 'Mature' against the ICS Maturity Matrix' by April 2021 (characteristics are listed in the guidance).

3.19 The Integrated Care Provider Contract was published in the summer 2019, which is expected to offer greater opportunity for the greater integration of primary medical services with other services care with other services.

NHS Action on Prevention (Chapter 4)

3.20 There is an expectation for systems to work in close partnership with public health and set out how preventative services will develop to respond to local need and deliver the commitments of the LTP. Nationally, a set of indicators and datasets will be developed to monitor the impact of the prevention activities.

3.21 Additional funding will be available for prevention programmes related to:

- **Smoking** – NHS funded smoking cessation selected sites in 2021/22; additional indicative allocations for all STPs in 2021/22 for the phased implementation of NHS smoking cessation for all inpatients who smoke, pregnant women and users of high-risk outpatient services.
- **Obesity** – local referral trajectories to be set out for Diabetes Prevention Programme uptake; targeted funding for small number of selected sites to pilot an enhanced weight management service (focused on people with Type 2 diabetes, and morbidly obese)
- **Alcohol** – targeted funding for 2020/21 to develop Alcohol Care Teams in hospitals with the highest rate of alcohol dependence related admissions
- **Air Quality** – targeted support provided from NHS Sustainable Development Unit to spread best practice.
- **Antimicrobial resistance** – targeted support available via regions to implement the five-year national action plan.

Delivering further progress on care quality and outcomes (Chapter 5)

3.22 The commitments for the wider service transformation and areas where additional funding will be made available are set out in Chapter 5 covering:

- A strong start in life for children and young people.
- Learning Disabilities and Autism.
- Better care for major health conditions.
- Research and innovation to drive future outcomes for improvement.
- Genomics.
- Volunteering.
- Wider Social Impact.

A strong start in life for children and young people (including maternity and neonatal)

3.23 Local Maternity Systems (LMS) are allocated fair shares funding to 2020/21 to support ‘Better Births’ and will continue to receive financial support for senior clinicians up to 2023/24. The majority of additional funding will be available for systems to support a range of initiatives 2021/22, with the exception of the UNICEF Baby Friendly Initiative, for which targeted funding is available from 2019/20.

3.24 In April 2019 the national Children and Young People's Transformation programme was established. Local plans will need to include the establishment of local leadership and clearly show how improvements will be made in childhood immunisations and childhood screening to meet the baseline standard in the NHS public health agreements.

3.25 The local plans are required to have a specific focus on developing age appropriate integrated care, improving care for children with long term conditions, treating and managing obesity, mental health services and improving cancer outcomes.

3.26 Additional funding will be available to systems as follows:

- 2021/22 to 2022/23 targeted investment to support integration and CYP services with additional indicative funding to all systems in 2023/24 to support integrated services
- Targeted funding from 2021/22 to increase capacity to treat obese children and their related severe health complications.

Learning Disability and Autism

3.27 System plans will need to cover a range of elements spanning the system leadership arrangements for the local plan, appropriate use of digital flags within a patient record and the specific achievement of standards such as the reduction of impatient bed usage and achievement of physical health checks for people with Learning Disability. System investment should identify what community provision is in place that can be built on for intensive crisis and community support.

3.28 Funding to deliver the LTP is available through allocations and additional service development funding, distributed to all systems, which includes agreed transfers for specialist services, community investment and for Transforming Care Partnerships.

3.29 Targeted funding will be available to:

- Support pilots for community services from 2020/21. Indicative additional funding allocations have been made to support roll out in 2023/24.
- Development of key workers for CYP inpatient unit in 2020/21(initially focused on inpatient units). Indicative additional funding allocations have been made to support roll out in 2023/24.
- Catch up for Learning Disabilities Mortality Review (LeDeR) Programme in 2019/20.
- Roll out, as part of the PCN arrangements, of STOP – STAMP programmes, available from 2020/21.
- Test models of eye, dental and hearing services going into residential schools from 2021/22.
- Capital investment for 2019/20 and 2020/21 to develop new housing options and accommodation in the community.

Better care for major health conditions

3.30 The ‘major health conditions’ covered under the guidance are cardiovascular disease (CVD), stroke, diabetes and respiratory disease.

3.31 **CVD:** The focus required for CVD is to improve prevention, early detection and treatment. Funding is included in indicative allocations, with additional fair shares funding available from 2020/21 to increase the number of people with CVD treated for Atrial Fibrillation (AF), high blood pressure and high cholesterol. Additional targeted funding is available as follows:

- Increasing the numbers of people with CVD treated for AF, high blood pressure and high cholesterol, supported in 2020 by the CVD PREVENT. From 2020/21 funding will be included in the fair shares for systems.
- Testing use of technology to increase referrals / uptake to cardiac rehab. Funding for wider roll out included in fair shares funding from 2023/24.
- Pilots schemes to increase access to ECG / increase detection and treatment of people with heart failure and valve disease. Funding for wider roll out included in fair shares funding from 2022/23.

3.32 **Stroke:** The focus is on the establishment of Integrated Stroke Delivery Network (ISDNs), improving stroke services, and ensuring that Early Supported Discharge (ESD) is routinely commissioned, integrated with community services and available to all patients for whom it is appropriate.

3.33 Additional targeted funding will be available for roll out of the ISDNs, with additional targeted funding available for testing post hospital rehabilitation models available in 2020/21 and 2021/22. Fair shares funding for wider roll-out will be available from 2022/23.

3.34 **Diabetes:** Systems are required to set out their approach to improved services for people with Type 1 and Type 2 diabetes in line with the LTP commitments. The series of requirements covers management, treatment targets, structured education, health inequalities, self-management and access to inpatient specialist nurses.

3.35 Additional funding is available as follows:

- Central reimbursement arrangements to support 20% of people with type 1 to have access to ‘flash glucose monitoring devices’ in 2019/20 and 2020/21.
- Targeted funding for multidisciplinary foot care teams (MDFTs) and diabetes inpatient specialist nurses (DISNs) transformation projects.
- Targeted funding 2019/20-23/24 to support the delivery of the 3 recommended treatment targets and structured education.
- Targeted funding (for demonstrator sites) to test low calorie diets for obese people with Type 2 diabetes.
- Ensuring continuous glucose monitoring is available for pregnant women with Type 1 - funding to be confirmed later in 2019/20.

3.36 **Respiratory:** system plans are to focus on identification of respiratory disease and increasing referrals to pulmonary rehabilitation with a particular focus on the most socioeconomic disadvantaged people who are disproportionately represented in this cohort.

3.37 Targeted funding will be available for a number of sites in 2020/21 and 2021/22 to test expansion of pulmonary rehab and new models of care for breathlessness. Fair shares funding for wider roll out will be available from 2022/23. Additional Targeted funding to increase spirometry training via Primary Care Hubs will be available from 2020/21.

Research and innovation to drive future outcomes for improvement

3.38 System plans will need to set out how they will increase public and patient participation in research, work with innovators to test innovations, and work with Academic Health Science networks to ensure local adoption and spread of proven innovations.

Genomics

3.39 Systems will be required to work with their relevant Genomic Laboratory Hub and NHS Genomic Medicine Centres to ensure clinical pathways in place and operating to the required standard. This should ensure that all eligible patients should have access to the appropriate genetic testing.

Volunteering

3.40 Systems will be required to increase the appropriate use of volunteering across health and care services. Funding to facilitate expansion of volunteers will be available on a fair shares basis in 2019/20 to support the growth of volunteering especially in areas of deprivation. Further targeted funding will be for selected sites in 2020/21 and 2021/22.

Wider Social Impact

3.41 System plans will need to show how they are supporting and aligning with supporting wider social goals. In Annex D of the LTP Implementation Framework, a set of requirements are set out relating specifically to Health and the justice system, Veterans and Armed Forces, Health and the environment, Health and employment, and Anchor institutions.

Giving NHS staff the backing they need (Chapter 6)

3.42 In line with the themes of the Interim NHS People plan, system plans will be required to set out the actions that will be taken along a number of themes covering workforce transformation, leadership culture, workforce planning and growth, and the changing the workforce operating model. Specifically, the plan will need show how it will meet the requirements relating to:

- BME representation, the workforce Disability Equality Standard, setting out the planned workforce growth for particular groups.
- Improved retention, international recruitment and Apprenticeship Levy.
- Improve workforce efficiency and release 'greater time for care' linked to efficiency and productivity plans.

Digitally enabled care across the NHS (Chapter 7)

3.43 Systems are required to develop a digital strategy and investment plan consistent with the Tech Vision that describes how digital technology will underpin their local transformation plans over the next 5 years. This will include the approach to ensure that all secondary care providers are fully digitalised by 2024, and integrated with other parts of the health and care system e.g. through local shared health and care platform. There are a number of stipulated digital requirements relating to a defined level of digital maturity, adoption of Global Digital Exemplar Blueprints, and adherence to Health System Support Framework.

3.44 The strategy is expected to include plans to improve provision of services and information through digital routes, for which NHSX will provide guidance and support to accelerate. In relation to the security of data, 100% of organisations will be required to be compliant with a series of mandated cyber security standards by summer 2021.

3.45 Central funding will be available to support the delivery of digital strategies, with regions to establish pipeline of digital investment.

3.46 The guidance sets out how NHS organisations will be supported by a 'robust IT infrastructure' by 2024, and a list of digital services that will become available to patients over the next 4 years, including reference to nationally available services such as NHS.uk, NHS Login and NHS App. In addition an outline of the national work supporting the development of locally-delivered access to care records is provided.

4.0 Planning Assumptions / Greater Manchester process / National Process

4.1 The guidance sets out the funding at a national level, which has been allocated to support the commitments of the long term plan, the requirement from the Five Year Forward View, in addition to published indicative CCG allocations.

4.2 The guidance confirms two funding sources, one based on 'fair shares' and one based on 'targeted' funding. Both allocations are for specific schemes outlined in the guidance and contained within Section 3.

4.3 GM have confirmed that the 'fair shares' funding will be deployed based on local decision making, although confirmation if this is Manchester or GM is outstanding. GM has confirmed that the final two years of GM Transformational Funding (GMTF) are the first two years of five year planning round, with the balance in the remaining three years.

4.4 The tables below summarise the national funding available for 'fair shares' in Table 1, with an estimate of what the GM allocation may be which is highlighted in Table 2.

Table 1 - Additional indicative funding allocations					
England	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
	£m	**£m**	**£m**	**£m**	**£m**
Total	**538**	**560**	**814**	**1,219**	**1,779**
Of which:					
1. Mental Health	60	65	220	441	592
2. Primary Medical and Community Services					
(a) Primary Care	321	335	359	369	364
(b) Ageing Well	0	30	70	204	343
3. Cancer	118	89	71	68	68
4. Other	39	41	94	137	412

4.5 GM has estimated the additional funding as outlined in table 2 below:

Table 2 - GM Calculation of 'Fair Share'						
	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**Total**
	£m	**£m**	**£m**	**£m**	**£m**	**£m**
GMTF	70	50				120
LTP Fair Share	8	11	44	67	98	228
Total	**78**	**61**	**44**	**67**	**98**	**348**

4.6 The national level of targeted funding is summarised in Table 3 below.

Table 3 - Targeted funding available to systems					
England	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
	£m	**£m**	**£m**	**£m**	**£m**
Total	**418**	**939**	**1,101**	**1,249**	**1,481**
Of which:					
1. Mental Health	182	251	190	234	292
2. Primary Medical and Community Services					
(a) Primary Care	100	208	303	381	475
(b) Ageing Well	6	40	40	24	24
3. Cancer	46	121	198	186	398
4. Technology	26	238	199	192	179
5. Other	58	82	172	231	114

4.7 The targeted funding share for GM has not been calculated, but GM would like this to be allocated directly to them akin to the GMTF funding and the original Devolution agreement.

4.8 Indicative provider lead figures for specialised commissioning funding will be shared with local systems for planning purposes, at the time of writing this report, this information had not been shared.

4.9 There is a requirement to increase investment in mental health, children's, primary medical and community health services, with further information to be provided. The guidance stipulates allocation growth plus a percentage uplift, with the actual numbers unconfirmed currently.

4.10 The LTP includes 5 financial tests, which are summarised below and will be required to be demonstrated within the return.

Test 1 – the NHS will return to financial balance;

Test 2 – the NHS will achieve cash-releasing productivity growth of 1.1% per annum, with all savings invested in frontline care. In order to do this, there are a number of asks:

- Improving clinical productivity and releasing more time for clinical care.
- Maximising the buying power of the NHS.
- Development of pathology and diagnostic imaging networks.
- Pharmacy and medicines optimisation, including increased patient facing roles and Medicines Value Programme to deliver better value from medicines expenditure.
- Admin cost savings. (nationally £290m commissioners and £400m providers)
- Better use of capital investment and existing assets to drive transformation.
- Evidence based interventions programme.
- National Patient Safety Strategy, identifying improvements in patient safety.

Test 3 – The NHS will reduce growth in demand for care through better integration and prevention;

Test 4 – The NHS will reduce variation in performance across the health system; and

Test 5 – The NHS will make better use of capital investment and its existing assets to drive transformation.

5.0 Performance Indicator Trajectories

5.1 All commissioning organisations are required to set performance improvement trajectories in a number of areas. These are set out in Appendix 1.

5.2 Final performance trajectories will be submitted to the Greater Manchester and national teams in November, in line with the national timetable. The trajectories will reflect the programmes of work over the next five years. The accountable Executive Team member will sign off these trajectories prior to submission.

6.0 Five Year Planning Submission

6.1 A draft national template has been released which requires high level of detail of income and expenditure, activity, workforce and capital plans for the duration for the five year period.

6.2 The first draft national submission was 27 September, with a final submission by 15 November. A request has been made within the Manchester locality planning meeting that the submitted templates are shared to inform the work / agreements required for the national submissions.

Funding Allocations

6.3 CCG allocations have been published for 2019/20 to 2023/24, with 2022/23 and 2023/24 being indicative. The guidance confirms that running cost allocations will be reviewed and may be changed to reflect population changes before 2021/22, but currently to remain flat over the planning period at the value after the 20% reduction.

6.4 Additional allocations for the LTP are to be issued. The guidance confirms that these are additional to core CCG allocations, but may include recurrent funding for commitments which were supported on a non-recurrent basis in 2019/20; the implication of this needs to be understood.

Expenditure Assumptions

6.5 The guidance confirms the following assumptions need to be applied

Element	2020/21	2021/22	2022/23	2023/24	Notes
Tariff					
AFC pay deal	2.9%	0.7%			Price only
Pay and mix effects - AFC	n/a	2.1%	2.1%	2.1%	Price only
Pay and mix - other HCHS workforces	2.1%	2.1%	2.1%	2.1%	Price only
Tariff drugs	0.6%	0.6%	0.6%	0.6%	Price only
Revenue consequences of capital	1.8%	1.9%	2.0%	2.0%	Price only
Other operating costs	1.8%	1.9%	2.0%	2.0%	Price only
Weighted inflation	**2.4%**	**2.4%**	**2.0%**	**2.0%**	
Efficiency factor	-1.1%	-1.1%	-1.1%	-1.1%	
Tariff uplift	**1.3%**	**1.3%**	**0.9%**	**0.9%**	
Other provider cost/income					
CNST contributions	10.5%	10.5%	10.5%	10.5%	Total cost
Other commissioner costs					
Primary care prescribing	0.5%	0.5%	0.5%	0.5%	Price and volume

6.6 Commissioners should reflect CNST increases in addition to the tariff uplifted as per the table below:

Provider Type	Assumed impact on spend (national and local prices)
Acute and specialist	0.25%
Ambulance	0.06%
Community	0.02%
Mental Health	0.03%
Total	**0.21%**

6.7 Funding will be available from Financial Recovery Fund and Commissioner Sustainability fund, where an agreed recovery plan is in place.

6.8 Funding for Health Education England, research & development and the local authority public health grant planning assumption is to use net tariff as the price assumption.

6.9 Systems should assume nil pressure on employer pension contributions as a result of the 14.38% increase to 20.68% in April 2019.

6.10 CCGs should plan on continued growth in mental health spend in line with the Mental Health Standard. In 2020/21 the increase in expenditure will be allocation growth plus an additional percentage increment, in subsequent years, the assumption would be allocation growth. In 2019/20, the additional uplift over and above allocation growth was 0.6%. Confirmation of the planning assumption is outstanding.

6.11 The additional funding from the ‘fair shares’ and ‘targeted funding’ on mental health has to be spent in addition to the increase above.

6.12 The LTP commits to increase real terms expenditure on primary medical and community health services, specifically outlined are:

- Spend primary care (GP) allocation in full.
- Increase expenditure on primary medical, community services and continuing healthcare above overall CCG allocation growth, together with additional LTP allocations. This includes the commitment to invest £1.50 per registered patients to PCNs.

6.13 Indicative capital assumptions will be produced at a system level to support planning.

Activity Assumptions

6.14 Plans on activity should be based on local trends and reflect the following LTP Implementation Framework:

- How increased allocations will improve elective treatments year on year, cut long waits, and reduce size of long waiting lists.

- Set out how they will transform outpatients, increasing use of digital tools to redesign how services are offered and remove a third of face to face outpatient visits.
- In terms of urgent care, assumptions should be reviewed for demand growth, adjusted for demand management and reflecting delivery of national priorities. Ongoing service improvement for cancer treatment and A&E until any new standards are implemented.

7.0 Key planning milestones across health over the next 6 months.

7.1 The GMHSCP have issued guidance on the approach that GM will take in response to the NHS Planning guidance with a timetable for the various submissions that will be made up to November (below). Essentially, a GM lead has been allocated to each of the LTP areas to coordinate the response across GM that will inform GM Delivery Plan, and Locality Plan refresh process. MHCC is leading the development of the Locality Plan across Manchester, and linking with each of the GM areas work streams via the existing governance across the GMH&SCP.

7.2 The MHCC Operational Plan will describe how MHCC will meet the requirements of the 2020/21 NHS annual planning guidance which is expected to be in line with the LTP Implementation Framework. Locally, the planning process for 2020/21 has now begun. As stated in the introduction, the local MHCC planning process is essentially an integrated process working with all partners and the resultant single MHCC plan will encompass health, public health and adult social care. Our aim, is to deliver an operational plan which sets out the priorities across the system for the 2020/21 period that will read across the Locality Plan, wider policy and the City Council budget setting process.

7.3 Ultimately the plans will go through a number of bodies for scrutiny and decision including the Health Scrutiny Committee, the Council Executive, Manchester Clinical Commissioning Group (MCCG) Governing Body and the MHCC Board which will take place during January and February 2020.

Key NHS planning milestones timetable:

Action	Responsible	Due By
10 Refreshed Locality Plans	Locality Leads	29 November 2019
Locality Finance, Activity and Workforce Returns	Locality Leads	November 2019
Prospectus Implementation Plan	Exec Lead – Strategy & System Development	18 October 2019
Submission of Annual Operational Plans to relevant bodies for scrutiny and decision.	MHCC	Various submissions between December 2019-April 2020)

8.0 Recommendations

8.1 The Committee is asked to consider the report.

Indicator	Baseline	National Expectation / Supplementary information
Proportion of the population with access to online consultations **Source – GP Forward View Survey** **Leads** **Exec – Manisha Kumar** **SLT – Paul Wright / Chris Upton** **PQI – Jayne Cooney**	**NA**	**National Expectation** - By March 2020, 75% of practices are offering online consultations to their patients.
Citizen facing tools: Proportion of the population registered to use NHSApp **Source – NHS Digital App dashboard** **Leads** **Exec – Manisha Kumar** **SLT – Paul Wright / Chris Upton** **PQI – Jayne Cooney**	**0.1%** **(18/19 – 487 / 559,369)**	**National expectation** - 30% by end of long term plan
Cyber Security - Organisations in area who have met or exceeded the mandated standard **Source - DSP Toolkit Return** **Leads** **Exec – Manisha Kumar** **SLT – Chris Upton** **PQI – Darren Wagstaff**	**100%** **(18/19 - 1/1)**	**National Expectation** - By summer 2021, we will have 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system.
Number of CYP aged under 18 receiving treatment by NHS funded community mental health services **Source – MH Services dataset** **Leads** **Exec – Ed Dyson** **SLT – Darren Parsonage** **PQI – Miladur Rahman**	**6,315** **(18/19)**	**National Expectation** -The LTP set out expansions to Children and Young People's Mental Health Services (CYPMHS) that will ensure delivery of the FYFVMH commitment to provide access to 70,000 additional CYP each year by 2020/21 and an additional 345,000 year CYP aged 0-25 by 2023/24.

Perinatal Mental Health: Number of women accessing specialist perinatal mental health service **Source – MH Services dataset** **Leads** **Exec – Ed Dyson** **SLT – Darren Parsonage** **PQI – Miladur Rahman**	**3.3%** **(18/19 – 260 / 7,946)**	**National Expectation** - By 2023/24 at least 66,000 women with moderate to severe perinatal mental health difficulties will have access to evidence-based specialist perinatal mental health care when they need it (30,000 increase from FYFVMH, 24,000 increase from LTP and best available baseline figure).
EIP Services achieving Level 3 NICE concordance **Source – Clinical audit of psychosis** **Leads** **Exec – Ed Dyson** **SLT – Jane Thorpe / Sarah Ives** **PQI – Miladur Rahman**	**Level 1** **(Greatest need for improvement)** **(18/19)**	**National Expectation** - The expectation is that the access element will be maintained and that 95% of services will achieve Level 3 NICE Concordance by 2023/24. **(The targets here are taken from national trajectory guidance).**
Coverage of 24/7 crisis provision for children and young people (CYP) that combine crisis assessment, brief response and intensive home treatment functions. **Source – NHS Survey of Crisis Services** **Leads** **Exec – Ed Dyson** **SLT – Darren Parsonage** **PQI – Miladur Rahman**	**1 (18/19)**	**National Expectation** - The expectation is that by 2023/24 CYP mental health crisis services across all CCGs will provide a fully comprehensive service based on an annual assessment, in line with the NHS Long Term Plan commitments. The indicator assessment scale is as follows: • No dedicated crisis, brief response and intensive home treatment • Partial crisis, brief response and intensive home treatment (services that do not meet the threshold for 'comprehensive' as described below • Comprehensive crisis, brief response and intensive home treatment, which includes: ➢ Assessment and brief response in both emergency departments and community settings ➢ 24/7 operating hours ➢ Service for children and young people aged 0 up to their 18th birthday
Reliance on inpatient care for people with a learning disability and/or autism - adults - CCG Commissioned	**10** **(18/19)**	**Adults** By 2023/24, each CCG is expected to require inpatient capacity for no more than 30 adult inpatients in CCG-commissioned or NHS England-

Source – NHS Digital Assuring Transformation **Leads** **Exec – Ed Dyson** **SLT – Kirsten Windfuhr** **PQI – Alicia Lucas**		commissioned beds per million adult population (aged 18 and over).
Reliance on inpatient care for people with a learning disability and/or autism - adults - Spec Com commissioned **Source – NHS Digital Assuring Transformation** **Leads** **Exec – Ed Dyson** **SLT – Kirsten Windfuhr** **PQI – Alicia Lucas**	**20 (18/19)**	
Number of Annual Health Checks carried out for persons aged 14+ on GP Learning Disability Register. **Source – NHS Digital LD Health Check scheme** **Leads** **Exec – Manisha Kumar** **SLT – Caroline Bradley / Tony Ullman** **PQI – Jayne Cooney**	**1,814 (18/19)**	**National Expectation -** The National target is by the end of 2023/24, 75% of people on the Learning Disability Register will have had an Annual Health Check. There is also a national ambition for the Learning Disability Register to have year-on-year growth.
Personal Health Budgets **Source – NHS Digital PHB Collection** **Leads** **Exec – Manisha Kumar** **SLT – Kirsten Windfuhr** **PQI – Darren Wagstaff**	**160 (18/19)**	**National Expectation -** The Long Term Plan committed us to delivering 200,000 PHBs by the end of 2023/24.
Social Prescribing Referrals **Sources**	**18 / 19 below**	**National Expectation -** The Long Term Plan makes a commitment to funding 1000+ new social prescribing link workers embedded in PCN multi-disciplinary teams by 2020/21. Link workers will support over

Referrals - GPES **Link workers – PCN NWRS Tool / CCG link worker count** **Leads** **Exec –David Regan** **SLT – Cordelle Mbeledogu** **PQI – Jayne Cooney**		900,000 people to access social prescribing support by 2023/24.
• CCG Funded Social Prescribing Link Workers (FTE)	**29**	
• Other Funded Social Prescribing Link Workers (FTE)	**0**	
• Social Prescribing Link Worker Referrals	**4,112**	

Manchester City Council
Report for Resolution

Report to: Health Scrutiny Committee – 8 October 2019

Subject: Overview Report

Report of: Governance and Scrutiny Support Unit

Summary

This report provides the following information:

- Recommendations Monitor
- Key Decisions
- Items for Information
- Work Programme

Recommendation

The Committee is invited to discuss the information provided and agree any changes to the work programme that are necessary.

Wards Affected: All

Contact Officers:

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Background document (available for public inspection):

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

None

1. Monitoring Previous Recommendations

This section of the report contains recommendations made by the Committee and responses to them indicating whether the recommendation will be implemented, and if it will be, how this will be done.

Date	Item	Recommendation	Response	Contact Officer
3 September 2019	HSC/19/32 Annual Report of Manchester Safeguarding Adults Board	Recommend that the word customer is removed and replaced with a more appropriate term when referring to victims of Domestic Violence.	This recommendation has been forwarded and accepted.	Julia Stephens-Row Former Independent Chair of Manchester Safeguarding Children Board

2. Key Decisions

The Council is required to publish details of key decisions that will be taken at least 28 days before the decision is due to be taken. Details of key decisions that are due to be taken are published on a monthly basis in the Register of Key Decisions.

A key decision, as defined in the Council's Constitution is an executive decision, which is likely:

- To result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates, or
- To be significant in terms of its effects on communities living or working in an area comprising two or more wards in the area of the city.

The Council Constitution defines 'significant' as being expenditure or savings (including the loss of income or capital receipts) in excess of £500k, providing that is not more than 10% of the gross operating expenditure for any budget heading in the in the Council's Revenue Budget Book, and subject to other defined exceptions.

An extract of the most recent Register of Key Decisions, published on **1 October 2019**, containing details of the decisions under the Committee's remit is included below. This is to keep members informed of what decisions are being taken and, where appropriate, include in the work programme of the Committee.

Decisions that were taken before the publication of this report are marked *

Decision title	What is the decision?	Decision maker	Planned date of decision	Documents to be considered	Contact officer details
Contract for the Provision of Homecare Services - Phase 2 (2019/07/26E)	The appointment of Providers to deliver Homecare Services.	Executive Director of Adult Social Services	Not before 1st Nov 2019	Report and Recommendation	Mike Worsley mike.worsley@manchester.gov.uk
Carers Strategy (2019/08/22A)	Allocation of Our Manchester Funding to support the Our Manchester Carers Strategy over a period of two years.	Executive	16 October 2019	Report to the Executive	Zoe Robertson z.robertson@manchester.gov.uk

Subject **Care Quality Commission (CQC) Reports**

Contact Officers Lee Walker, Scrutiny Support Unit
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Please find below reports provided by the CQC listing those organisations that have been inspected within Manchester since the Health Scrutiny Committee last met:

Provider	Address	Link to CQC report	Date	Types of Services	Rating
City Care Partnership	Fairleigh House 34 Wellington Road Whalley Range Manchester M16 8EX	https://www.cqc.org.uk/location/1-117300110	20 August 2019	Residential Home	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Outstanding Well-led: Good
Daisy-Fieldz Care Services Limited	Daisy House 1139 Hyde Road Manchester M18 7LN	https://www.cqc.org.uk/location/1-5548473300	30 August 2019	Residential Home	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good
Victoria Dental & Healthcare	Victoria Dental & Healthcare 109 Corporation Street Manchester M4 4DX	http://www.cqc.org.uk/location/1-490964600	29 August 2019	Dentist, Doctors/GPs	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good

NorthStar Home Care Ltd	NorthStar Home Care Ltd 3 Carloon Road, Manchester, M23 0BR	http://www.cqc.org.uk/location/1-6381281250	19 September 2019	Homecare Agency	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well-led: Inadequate
QAS Ambulance Limited	QAS Ambulance Limited Unit 4 Cornishway Industrial Estate Austell Road Manchester M22 0WT	https://www.cqc.org.uk/location/1-7294636642/contact	6 September 2019	Patient Transport Service	**Overall: Inadequate** Safe: Inadequate Effective: Requires Improvement Caring: - Responsive: Requires Improvement Well-led: Inadequate
Anchor Carehomes Ltd	Lightbowne Hall 262 Lightbowne Road Moston Manchester M40 5HQ	https://www.cqc.org.uk/location/1-363198488/contact	12 September 2019	Residential Home	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Requires Improvement Well-led: Good

Belong Ltd	Belong at Home Didsbury 178 Palatine Road Manchester M20 2UW	http://www.cqc.org.uk/location/1-5622074851	14 September 2019	Homecare Agency	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good
The Seymour Home Ltd	Seymour Care Home 327 North Road Clayton Manchester M11 4NY	http://www.cqc.org.uk/location/1-118274983	10 September 2019	Residential Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Requires Improvement Responsive: Requires Improvement Well-led: Requires Improvement
Mr Bradley Scott Jones and Mr Russell Scott Jones	Brownlow House 142 North Road Clayton Manchester M11 4LE	http://www.cqc.org.uk/location/1-131420845	14 September 2019	Residential Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Good Caring: Requires Improvement Responsive: Requires Improvement Well-led: Requires Improvement

Avery Homes Moston Ltd	Acacia Lodge Care Home 90a Broadway New Moston Manchester M40 3WQ	https://www.cqc.org.uk/location/1-343004792/contact	21 September 2019	Residential Home	**Overall: Outstanding** Safe: Good Effective: Good Caring: Outstanding Responsive: Good Well-led: Outstanding
Northstar Home Care Agency	NorthStar Home Care Ltd 3 Carloon Road, Manchester, M23 0BR	https://www.cqc.org.uk/location/1-6381281250	19 September 2019	Homecare Agency	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well-led: Inadequate
Park View Medical Centre	Park View Medical Centre 66 Delaunays Road Crumpsall Manchester M8 4RF	http://www.cqc.org.uk/location/1-566796375	16 September 2019	Dr/GPS, NHS Practice	**Overall: Requires Improvement** Safe: Inadequate Effective: Requires Improvement Caring: Good Responsive: Good Well-led: Inadequate

Health Scrutiny Committee
Work Programme – October 2019

Tuesday 8 October 2019, 2pm (Report deadline Friday 27 September 2019)				
Item	Purpose	Lead Executive Member	Strategic Director/ Lead Officer	Comments
Suicide Prevention Local Plan refresh	To receive the refreshed Suicide Prevention Local Plan. The Committee will also hear from Prof Navneet Kapur Head of Research at the Centre for Suicide Prevention, University of Manchester.	Cllr Craig	David Regan	Invitation to Prof Navneet Kapur Head of Research at the Centre for Suicide Prevention, University of Manchester
2019 Public Health Annual Report	To receive the 2019 Public Health Annual report which has a focus on the first 1000 days of a child's life.	Cllr Craig	David Regan	Invitation to Chair of CYP Scrutiny
Local NHS planning	To receive a report that describes the planning of NHS services in Manchester including a summary of the national NHS Long Term Plan.	Cllr Craig	Nick Gomm	
Overview report	The monthly report includes the recommendations monitor, relevant key decisions, the Committee's work programme and items for information. The report also contains additional information including details of those organisations that have been inspected by the Care Quality Commission.			

Tuesday 5 November 2019, 2pm (Report deadline Friday 25 October 2019)				
Item	Purpose	Lead Executive Member	Strategic Director/ Lead Officer	Comments
Primary Care Access in Manchester	To receive a report that updates the Committee on access to Primary Medical Care in Manchester; both in core and also extended hours.	Cllr Craig	Nick Gomm	Healthwatch are to be invited to contribute to this item.
Overview Report				

Tuesday 3 December 2019, 2pm (Report deadline Friday 22 November 2019)				
Item	Purpose	Lead Executive Member	Strategic Director/ Lead Officer	Comments
Discussion item: Health improvement interventions for LGBT communities in Manchester	The Committee have invited representatives from the LGBT (lesbian, gay, bisexual and transgender) Foundation to discuss specific health improvement interventions for LGBT communities in Manchester, including the Greater Manchester Trans Health Service and Pride in Ageing.	Cllr Craig	-	
Overview Report				

Items to be Scheduled				
Item	Purpose	Executive Member	Strategic Director/ Lead Officer	Comments
Autism Developments across Children and Adults	To receive an update report on Autism Developments across Children and Adults. This item was considered by the Health Scrutiny Committee at their January 2015 meeting.	Cllr Craig	Bernadette Enright	Learning Disabled citizens, family and carers to be invited.
Update on the work of the Health and Social Care staff in the Neighbourhood Teams	To receive an update report describing the work of the Health and Social Care staff in the Neighbourhood Teams.	Cllr Craig	Bernadette Enright	
Manchester Health and Care Commissioning Strategy	To receive a report on the Commissioning Strategy for Health and Care in Manchester. The Committee had considered this item at their July 2017 meeting.	Cllr Craig	Bernadette Enright	See minutes of July 2017. Ref: HSC/17/31
Public Health and health outcomes	To receive a report that describes the role of Public Health and the wider determents of health outcomes.	Cllr Craig	David Regan	
Manchester Macmillan Local Authority Partnership	To receive a report on the Manchester Macmillan Local Authority Partnership. The scope of this report is to be agreed.	Cllr Craig	David Regan	See Health and Wellbeing Update report September 2017. Ref: HSC/17/40
Mental Health Grants Scheme – Evaluation	To receive a report on the evaluation of the Mental Health Grants Scheme. This grants programme is administered by MACC, Manchester's local voluntary and community sector support	Cllr Craig	Nick Gomm	To be considered at the March 2019 meeting. See minutes of

	organisation, and has resulted in 13 (out of a total of 35) community and third sector organisations receiving investment to deliver projects which link with the Improving Access to Psychological Therapies (IAPT) services in the city.			October 2017. Ref: HSC/17/47
Single Hospital Service progress report	To receive a bi-monthly update report on the delivery of the Single Hospital Service.	Cllr Craig	Peter Blythin, Director, Single Hospital Service Programme	See minutes of 17 July 2018. Ref: HSC/18/32
Workforce Strategy	To receive a report on the Workforce Strategy.	Cllr Craig	Bernadette Enright	
Assistive Technology and Adult Social Care	To receive a report on how assistive technology will be used to support people receiving adult social in their home. The Committee will hear from individuals who have benefited from using assistive technology to learn of their experience.	Cllr Craig	Bernadette Enright	
NHS Dental and prescription charges	To receive a report on NHS Dental and prescription charges.	Cllr Craig	NHS England	
Air Quality and Health	To receive a report on the work being done to address air quality and the effect this has on health.	Cllr Craig	David Regan	
Reablement services	To receive a report that describes the activities to improve Hospital discharge rates; the activities to prevent hospital admissions and reablement services.	Cllr Craig	Bernadette Enright	
Prevention and Wellbeing Services - Social	To receive a report on social prescribing that includes information on the rationale and theory for this approach, information on the uptake and how this approach is	Cllr Craig	Nick Gomm	

Prescribing	monitored.			
Inclusive Health Care	To receive a report that describes the activities and initiatives to engage with and deliver health care to traditionally hard to reach groups.	Cllr Craig	Nick Gomm	
Estates and the delivery of Primary Care	To receive a report on the estates in which Primary Care is delivered.	Cllr Craig	Nick Gomm	
Manchester Mental Health Transformation Programme	To receive a report a progress report on Manchester Mental Health Services.	Cllr Craig	Nick Gomm	
Falls Prevention	To receive a report on the Falls Collaborative work.	Cllr Craig	Nick Gomm Sue Ward Manisha Kumar	To be scheduled for Feb or March 2020.
Supporting People Housing Strategy	To receive a report on the Supporting People Housing Strategy (including extra care, dementia friendly and learning disabilities.)	Cllr Craig Cllr Richards	Eddie Smith	