Manchester City Council
Report for Information

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

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

Report of: Director of Population Health and Wellbeing

Summary

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

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

Recommendations

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

Wards Affected: All

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Background documents (available for public inspection):

None

1. Introduction

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

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

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

2. Manchester Population Health Plan 2018-2027

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

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

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

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

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

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

3. Tobacco

3.1 Introduction

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

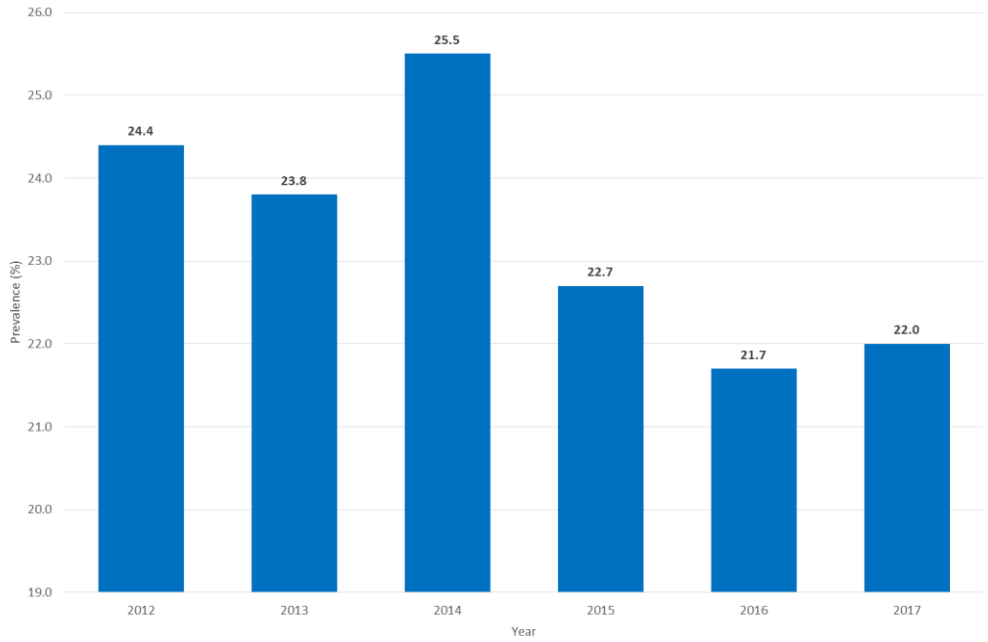
3.1.2 Manchester has a stretching target to reduce adult smoking prevalence from the current rate of 22.0% to 15% by 2021. To achieve this, a comprehensive, well defined and well led programme of activity is required. The Smoke Free Manchester Plan for Tobacco Control 2018-2021 aims to do this in line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

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

3.2 Tobacco related harm in Manchester

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

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



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

Smoking Related Conditions and Hospital Admissions

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

Table One: GP data on respiratory conditions in Manchester

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

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

3.3 The Greater Manchester (GM) Programme

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

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

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

3.4 Areas for development

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

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

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

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

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

3.5 Commentary from external partners

Greater Manchester Health and Social Care Partnership

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

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

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

Our priority programmes are:

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

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

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

Public Health England

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

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

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

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

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

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

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

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

Cancer Research UK

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

University of Manchester

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

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

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

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

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

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

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

4. Alcohol

4.1 Introduction

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

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

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

4.2 Alcohol related harm

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

4.2.2 The key indicators:

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

4.3 The Draft Greater Manchester Strategy (2018-2022)

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

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

4.3.2 The strategy identifies 6 priority areas:

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

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

4.4 Areas for development

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

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

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

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

iii) Reducing drug and alcohol related crime and disorder

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

iv) Managing availability and accessibility

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

v) Establishing diverse, vibrant and safe night time economies

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

4.5 Commentary from external partners

Greater Manchester Health and Social Care Partnership

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

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

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

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

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

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

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

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

Public Health England

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

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

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

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

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

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

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

University of Manchester

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

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

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

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

5. Physical Activity

5.1 Introduction and Manchester context

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

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

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

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

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

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

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

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

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

5.2 All ages approach

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

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

5.3 Physical Activity Indicators

5.3.1 The key indicators are:

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

5.4 Greater Manchester Plan

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

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

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

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

<u>Leadership</u>

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

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

<u>Start Well</u>

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

<u>Develop Well</u>

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

<u>Live Well</u>

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

Age Well

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

Place

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

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

Workforce

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

Evidence, Data and Insight

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

Evaluation

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

Marketing and Communications

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

5.5 Areas for development

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

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

5.6 Commentary from external partners

Public Health England

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

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

Connections can be made to:

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

Local authorities should work with:

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

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

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

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

University of Manchester

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

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

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

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

Greater Manchester Moving

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

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

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

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