Manchester City Council
Report for Information

Report to: Children and Young People Scrutiny Committee - 4 December 2018

Subject: Population Health Needs of Manchester Children

Report of: Director of Population Health and Wellbeing

Summary

This report provides an overview on the health of children in the city, including outcomes in relation to the first 1000 days of life, dental health, physical health, obesity and malnutrition.

Updates on the following commissioned services are given in the report: Health Visiting Service (including Infant Feeding Service), School Health Service (School Nursing and Healthy Schools) and Oral Health Improvement Service.

The report also outlines proposals which are currently being developed as part of the Children's Transformation work in the city to increase Health Visitor resources to meet the needs of the population and commissioning approaches to improving oral health and reducing childhood obesity.

Recommendations

Members of the Committee are asked to:

i) Note the report

ii) Comment on the collaborative work being undertaken to improve health outcomes for children in Manchester

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Wards Affected: All

Alignment to the Our Manchester Strategy Outcomes (if applicable)

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	Being in good health and developing good habits in personal health care is essential for our children and young people in enabling them to achieve their full potential in transition to adulthood. A healthy start in life is fundamental to our young people being able to contribute to the city and take employment opportunities.

A highly skilled city: world class and home grown talent sustaining the city's economic success	Improving educational outcomes is essential for young people to gain qualifications and contribute to Manchester's economic success. Ensuring our children are healthy in early years contributes to school readiness and reduced school absence through poor health conditions.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Ensuring the best health of our children is critical in addressing inequalities and the wider determinants that cause poor health. Our Health Visiting Service ensures that children, in particular those from our most disadvantaged communities, have access to good health care and referral for early and additional help.
A liveable and low carbon city: a destination of choice to live, visit, work	Demonstrating good health outcomes for our children is attractive to parents who choose to live and work in our city.
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.

None

1.0 Introduction

1.1 This report provides an update on key health outcomes for children and young people in Manchester, including outcomes relating to the first 1000 days of life (pregnancy up to the age of 2 years), dental health, obesity and malnutrition. The report also includes information about some of the children's services commissioned by the Population Health and Wellbeing team.

1.2 In April 2017 the public health responsibilities and resources transferred into Manchester Health and Care Commissioning (MHCC), the new integrated health and social care commissioning organisation formed by combining Manchester Clinical Commissioning Group and MCC's commissioning functions. The Director of Public Health was appointed as the Director of the Population Health and Wellbeing Directorate with the Public Health team renamed the Population Health and Wellbeing team.

1.3 The Manchester Population Health Plan sets out our vision that, by 2027, we will all be living longer, healthier lives. The plan has five key priorities:

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

The Manchester Population Health Plan can be found by following this link: https://secure.manchester.gov.uk/info/200048/health_and_wellbeing/5962/public_health/2

1.4 The first priority in the Manchester Population Health Plan is improving outcomes in the first 1,000 days of a child's life. This is the time during pregnancy and up to when the child is aged 2 years. Good health starts in the womb. What happens there, and as the brain and body develop through the first two years, has a lifelong impact on factors including obesity, success at school and even wealth in later life. Babies falling behind now are more likely to stay behind. By putting resources into a child's wellbeing in these important early years, it pays off more than spending later in life after a poor start.

1.5 Overall, children in Manchester have poorer health outcomes than children living in other areas of Greater Manchester and the country as a whole. Health outcomes are described in more detail in section 2.0. Headline data from Public Health England's Child Health Profile 2018 shows in Manchester we have:

- An increasing rate of deaths under the age of one year old compared to England
- A higher percentage of pregnant mothers smoking than in England
- A greater proportion of low birth-weight babies than the rest of England

- A lower percentage of children who are school-ready at age 5 than the rest of England. Although this has been improving, one in three Manchester children are not school ready at age 5
- Poorer dental health than the rest England
- A higher percentage of children who are obese at Reception age and Year 6 than the rest of England
- A higher percentage of children who are underweight at Reception age and Year 6 than the rest of England (Below 25th centile).

1.6 The Population Health Plan's priority on giving children the best start in life is largely dependent on a high quality Health Visiting service that is able to work with all families and identify those needing additional support, early help and intervention. The Health Visiting Service works in partnership with the Early Years Outreach Workers to deliver the Early Years Delivery Model in Manchester.

1.7 The Healthy Child Programme is delivered to school aged children through the School Health Service (School Nursing and Healthy Schools) and the Oral Health Improvement Team. This includes delivery of the mandated National Child Measurement Programme (NCMP) and the Oral Health Epidemiological Survey. Ensuring children are seen by School Nurses and Oral Health Practitioners seeks to achieve early intervention and treatment for tooth decay, obesity or other health needs in the school aged population.

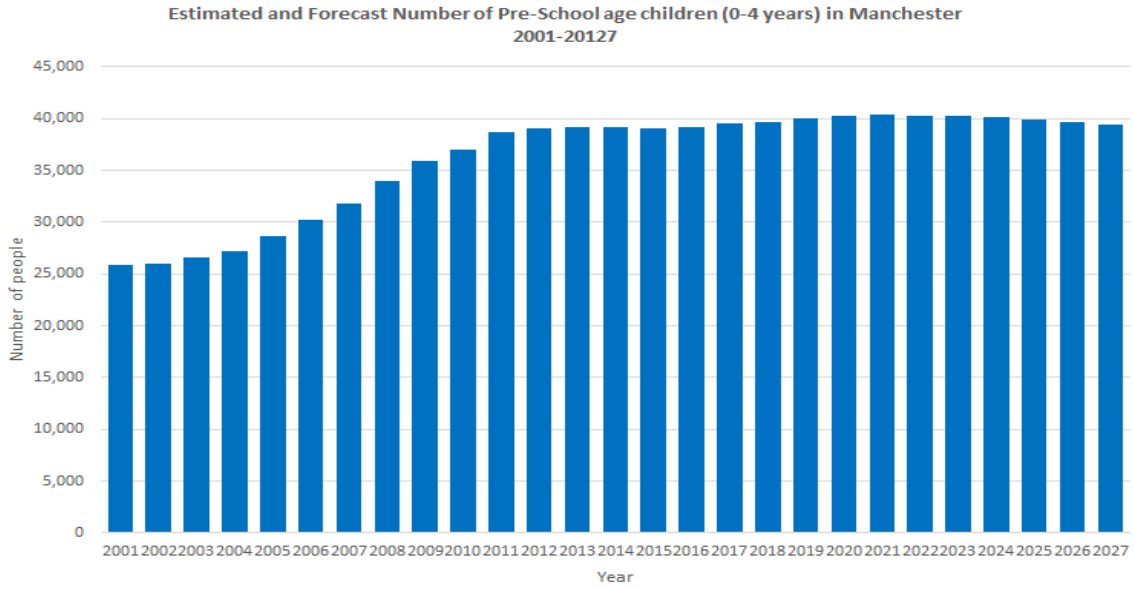
1.8 It is most important that children and young people are active, have a good diet and are given the right messages, opportunities and support to make informed decisions about their health as they transition to adulthood. Population Health and Wellbeing recognise this requires a whole system approach delivered collaboratively, particularly in our communities where health inequalities and the obesogenic environment present the greatest challenges.

2.0 Manchester Population Health Profile

2.1 The latest data from ONS shows that, as at mid-2017, there are estimated to be around 38,500 children aged 0-4 resident in Manchester. This is equivalent to just over 7% of the total resident population. This is a slightly higher proportion than in England as a whole (6.1%). 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.

2.2 Data from Manchester City Council's in-house forecasting model shows that the number of children aged 0-4 years grew rapidly over the 10 year period between 2001 and 2010, driven by increases in international immigration and the number of births to mothers born outside of UK. Although, the city is forecast to see a small increase in the population aged 0-4 years in the period up to 2021, the rate of growth has slowed considerably compared with the previous years (see chart below).

2.3 The reduction in the rate of population growth in children aged under 5 is due, in part, to a reduction in the rate of migration of women from countries that are traditionally associated with higher fertility rates. The proportion of the population of Manchester aged 0-4 years is forecast to reach its highest in 2022.



2.4 Although the rise of population growth is predicted to level off, the health and care needs of children aged 0-4 years remain high relative to other parts of England and comparable cities. Recent figures for August 2018 suggest that over half (52%) of children aged under 5 years in Manchester live in LSOAs which fall within the most deprived 10% of LSOAs in England. This compares with just 13% of children aged under 5 years living in England as a whole.

2.5 Data from the End Child Poverty Coalition (published in January 2018) shows that, in 2017, Manchester was estimated to have the second highest proportion of children living in poverty in UK (topped only by Tower Hamlets). Between 2016 and 2017, there were estimated to be an additional 5,890 children living in poverty across Manchester. In 5 out of the 32 wards in the city (Moss Side, Rusholme, Longsight, Cheetham and Ardwick) more than 50% of children were estimated to be living in poverty.

2.6 More in-depth analysis of these figures shows that the highest levels of out-of-work poverty are found in wards with high numbers of children from a white ethnic group as well as high proportions of lone parent families. In contrast, the highest levels of children living in households with in-work poverty are in wards with large numbers of children from BME groups.

2.7 Data on the number of families approaching Manchester City Council's homeless service shows that the total number of families approaching the service over the 5 year period 2012/13 to 2016/17 increased by around 30%. *The number of families approaching the service in 2016/17 was higher than at any point in the last 5 years*. In contrast, there was only a slight rise in the number of single people approaching the service.

2.8 Levels of child poverty are reflected in the poor health outcomes for young children in Manchester:

- The infant mortality rate is worse than England with an average of 50 infants dying before age 1 each year
- Babies being born in Manchester with low birth weight rate (7.5%) are marginally above the national average (7.4%)
- Although Manchester can demonstrate a significant reduction in smoking during pregnancy, the number of women who maintain the habit through childbirth (11.6%) is still above the national average.
- By age two, 90.2% of children have had one dose of the MMR vaccine and 94.4% of children have had the DTaP / IPV / Hib immunisation. This does not meet the minimum recommended coverage level of 95%.
- School Readiness: 67% of all Manchester children achieve a good level of development at the end of reception as a percentage of all eligible children. This has improved from the 2016/17 figure of 66.2% but is still lower than the GM average (68%) and the England average (72%).
- However, performance in achieving school readiness for children receiving free school meals in Manchester (59.5%) is above the national average (56.0%) and is the highest performing of all north west authorities.
- Dental health is worse than England. 43.0% of 5 year olds have one or more decayed, filled or missing teeth.
- Levels of child obesity are worse than England. 11.7% of children in Reception are classed as obese.
- Manchester also performs significantly below the national average in children being underweight. 1.71% of Year Six pupils are underweight compared to a national average of 1.34%. 1.36% of reception aged children present as underweight compared to a national figure of 96%
- Demographic profiles demonstrate children from Indian, Pakistani and Bangladeshi families are most prevalent in being underweight.

Source: Public Health England Child Health Profile 2018

3.0 Commissioned services

3.1 To complement key programmes of work, children's public health services are commissioned to deliver the Healthy Child Programme and improve health outcomes for children and young people. Updates on the following commissioned services are given in the report:

- Health Visiting Service (including Infant Feeding Service)
- School Health Service (School Nursing and Healthy Schools)
- Services to reduce childhood obesity
- Oral Health Improvement Service

3.2 These services are commissioned until 2019 with option to extend.

3.3 The Health Visiting Service and School Health Service are commissioned with Manchester University Hospitals NHS Foundation Trust (MFT). The Oral

Health Service contract will transition to MFT in 2019 from the current provider Greater Manchester Mental Health Trust, to strengthen the joined up approach.

3.4 The Weight Management Service is commissioned with ABL Ltd.

4.0 Health Visiting Service (0 - 5 Years)

4.1 The Manchester Health Visiting Service provides a city wide, universal, service to all children resident in Manchester aged 0-5. The Health Visiting Service is a mandated service that works closely with Children's Centre Outreach Workers to deliver the Greater Manchester Early Years Delivery model.

4.2 The Health Visiting Service strives to ensure the highest possible uptake of the mandated Healthy Child Programme and there are a number of acknowledged challenges to achieving full engagement with all families. Many families in Manchester are experiencing a range of issues which have a detrimental effect on health outcomes such as poverty, poor nutrition, smoking, domestic abuse and poor mental health.

4.3 As part of the Healthy Child Programme the Early Years Health Visiting Services undertakes and reports on five nationally mandated contacts and one local Greater Manchester contact with newborn babies in Manchester. This is as follows:

- a woman who is more than 28 weeks pregnant (Antenatal Contact)
- a child who is aged between 1 day and 2 weeks (New Birth Visit)
- a child who is aged between 6 and 8 weeks (6-8 Week Review)
- a child who is aged between 9 and 15 months (9 Month Review)
- a child who is aged between 24 months (two years) and 30 months (two years and six months) (2 Year Review).

4.4 Performance of the Health Visiting Service has been impacted on by high caseloads and a move to electronic patient records in the last 12 months. The service performs well on new birth visits, maternal mental health assessments ad 6-8 week health development assessments but performs poorer on 9 month and 2 year Health Development Assessments. It is important that improvements are made to increase the number of these assessments as these contribute to improving school readiness.

4.5 The quality and performance of the Health Visiting Service has however been steadily improving over the past 12 months. The service provides quarterly data and reports, including case studies, to the commissioner which demonstrate impact.

4.6 The commissioner and provider are in the process of reviewing the key performance indicators and implementing a new performance framework to further evidence the effective work of this service. There is effective partnership working between the commissioner, provider, partners and service

users. This has been demonstrated through the joint work to co-design and implement the strengthened health visiting model.

Contact	Description	Q3 2017-18	Q4 2017-18	Q1 2018-19	Q2 2018-19	England Average
Antenatal	Visit to every pregnant woman between 28 and 36 weeks	604 (31%)	389 (20%)	476 (26%)	506 (28%)	41% NW (34%)
New Birth Visit	Visit to every new born baby between 10-14 days to include maternal contact	84%	70%	74% (23% over 14 days)	77% (20% over 14 days)	88.4%
Maternal Mental Health Assessment	Undertaken with every mother between 6-8 weeks	85%	69%	66%	83%	86.1%
6-8 week Health Development Assessment	Contact with every baby between 6-8 weeks to assess needs, including ASQ	80%	81%	89%	90%	N/A
9 Month Health Development Assessment	Appointment for every child at 9m old to assess development and need including ASQ	66%	60%	61%	67%	77.1%
2 Year Health Development Assessment	Appointment for every child at 2 Year old to assess development and need including ASQ	65%	60%	59%	61%	76.5%

4.7 The service is aware of the need to increase performance against the 9 month and 2 year Health Development Assessments and has identified a variety of city wide and pilot initiatives in different areas as part of an action plan, including:

- Implementing a monthly validation process to ensure all children are offered a 9 month and 2 year Assessment and all data is inputted into the EMIS I.T system / Child Health system
- offering all families who do not attend their offered clinic appointment a home visit to complete their child's developmental assessment
- incentivising parents to attend assessments by gifting of Book Start Pack and Dental Pack at 9 month assessment
- reviewing the invitation letter to improve clarity and to remove any confusion over appointments
- scoping transition arrangements for 2 year olds into school settings to improve performance in partnership with Primary Education.

4.8 Antenatal contacts are dependent on referrals coming to the service from the midwifery services, which is currently inconsistent. Newbirths visits are arranged when Health Visiting teams are informed of new-born babies via the Child Health System (CHIS). Newborn children not seen within 14 days are generally seen within 30 days. The main reason for breaches is due to 'no access'. These are families who are not at home when the Health Visitor has scheduled an appointment and are therefore reappointed.

4.9 By virtue of the face to face contact Health Visitors have with families, there are varied requests and pressures on the service to deliver additional interventions including perinatal mental health assessment, neglect screening, the homeless families offer and to support initiatives such as Homestart assessments and Care Reviews.

4.10 Commissioners have worked closely with the provider to implement the Strengthened Health Visiting Model for Vulnerable Families and Babies within a reduced budget.

4.11 The new model includes the development of a Specialist Early Help Health Visiting Team, made up of the Specialist Early Help Case Planning team with the addition of the specialist Midwifery Liaison and Disability Health Visitors.

4.12 This will add to existing evidence based Best Practice Pathways to ensure vulnerable children are identified and provided with structured interventions. Pathways will cover:

- High impact areas
- Vulnerable Babies
- Drugs and Alcohol / Substance Misuse
- Homelessness
- Domestic Abuse
- First child to Mother under 21 years
- Mothers who are Care Leavers
- Disability of Mother and / or Child

4.13 Joint-working with midwifery providers will improve the number of notifications received by the Health Visiting service thus enabling more antenatal contacts to be undertaken between 28-36 week.

4.14 The following new assessments are being introduced: Newborn Behavioural Observation (NBO) at the New Birth Visit, Newborn Behavioural Assessment (NBAS) and Ages and Stages Questionnaires about children's social-emotional development (ASQ-SE) into the 2 years Health and Development Review.

4.15 A review of the Homeless Families Health Visiting team to consider the interface with the generic Health Visiting teams will take place, for prioritisation of caseload and delivery of the health offer in line with service capacity.

4.16 Working with Primary School Heads and Early Years leads will develop improved ways to support the transition of a child into school by supporting school readiness and appropriate information exchange.

4.17 Developing Electronic Patient Record and EMIS activity reporting to support the enhanced capture of Health Visiting activity attributed to vulnerable groups.

5.0 Early Help Assessment and Early Years Delivery Model

5.1 The Health Visiting Service is a major contributor to the Early Help Strategy. Health Visitors are required to meet targets for delivering Early Help Assessments in supporting the delivery of the Early Years Delivery Model, often in a lead professional role. Health Visitors follow health pathways to identify needs within families and offer support to reduce demands on services at a higher level of social need. It is notable that Health Visitors are consistently the most prolific in instigating Early Help Assessments for families needing support. With more capacity, the Health Visiting Service could carry out even more of these important assessments.

Month	**Apr 18**	**May 18**	**Jun 18**	**Jul 18**
Early Years Health Visitor	49	51	40	40
School Health	2	5	2	0
Midwifery	18	14	10	10
Child and Adolescent Mental Health Services	1	1	0	0
Early Years Outreach (Children's)	70	71	52	50
Primary Schools	29	32	25	37
Secondary Schools	14	16	22	21

5.2 With the numerous demands on the service, historic increases in the population aged 0-4 years and the high needs of families living in poverty, this has meant that the current Health Visiting Service has faced an increasing

challenge to deliver the Healthy Child Programme commissioned workload. The service has not increased to accommodate rising need and new challenges.

5.3 The current average caseload for a Health Visitor in Manchester is 300 families. The national caseload recommendation for Health Visitors working in the most deprived areas is 100 families per Health Visitor.

5.4 The Population Health and Wellbeing Team has submitted a report to Manchester Health and Care Commissioning Executive in October 2018, outlining the Health Visitor Service pressures and an options appraisal for an equity adjusted model of delivery which could be realised with additional investment. The model was supported in principle and a time limited working group has been established to work up detailed proposals relating to the options. The group will involve finance leads from MHCC and MCC and it is important to note that the current financial context will need to be a key consideration of the working group.

6.0 Infant Feeding Service

6.1 The Integrated Infant Feeding Service is part of the Health Visiting Service and was commissioned in 2017 to increase the uptake of breastfeeding in North Manchester, support women to continue to breastfeed and provide a more co-ordinated support to parents of babies who are having other feeding difficulties, such as cow's milk allergies.

6.2 There are 4 main elements to the new service offer:

- An early intervention, responsive home visiting service by a clinically appropriate professional (qualified prescriber with access to dedicated dietician) to support women to continue to breastfeed if they are having urgent feeding difficulties
- One to one support and infant feeding clinics for mothers and babies with complex and ongoing feeding challenges with integrated referral pathways with GPs, paediatricians, dieticians and midwives. This includes babies who have mild to moderate cow's milk protein allergy and management of babies with Ankyloglossia (tongue tie)
- Peer supporters to offer home visits in the early weeks to all women in North Manchester who are having feeding difficulties, to ensure initial support in establishing feeding in the early weeks
- Additional drop in clinics to be hosted within North Manchester.

6.3 The key performance indicators that have been agreed for the infant feeding service include:

Outcome / metric	Baseline	Target	Rationale	Timeline	2018-19 Q2 position	Notes
More specialist Infant feeding clinics available in N.M/C	1 clinic per week. 6 mothers.	7 clinics per week 42 mothers	Increase accessibility and opportunity for mothers in North Manchester	Running to timescale	1 x specialist Infant Feeding Clinic with dietetic support 1 x Specialist Infant Feeding drop-in 1 x IFSW drop-in	Ongoing planning of roll out: 3x Neonatal Outreach and Infant Feeding Drop-ins 1x Perinatal mental health and infant feeding session 1x Public Health and Art collaboration drop-in for infant feeding and aversive feeders
Increase number of home visits for urgent and complex feeding challenges.	5 urgent home visits per week *(service also carries out 20 non urgent home visits a week)*	10 urgent home visits per week as an initial estimate.	Reduce the number of mothers who stop B'Feeding prematurely due to complex situations *.	Running to timescale	Initial care contacts: 362 Follow up care contacts: 1,345 HV Urgent care contacts: 387 ***Please note – this is an initial***	

					report and data quality checks are ongoing	
Establish robust data set of babies breastfed at 6-8wks to include info highlighted in the Equality Impact Assessment	2015/16 64% breastfed Partially breastfed: 44.4% Totally breastfed: 26.2% Q2 2016 (initiation rates from Maternity Services) **Revised baseline agreed**	Minimum 90% with detailed recorded information	Understand the number of babies being breastfed at 6-8 weeks old.	Monthly	Q1 data 35.4% breastfed in North Manchester Q2 data to be finalised and submitted to DoH 14th Dec 2018	
			To increase number of babies being breastfed at this period due to health benefits for mother and child.	Monthly		

Establish contacts from peer supporters to new mothers.	New Service.	70 contacts per month	To provide support and training on BF technique by non-clinical staff from women in their own communities taking into account cultural and social issues.	Monthly	Initial care contacts: 362 Follow up care contacts: 1,345 ***Please note – this is an initial report and data quality checks are ongoing***	Universal pathway in development– plan to implement January 2019
Improved infant feeding experience for mothers and babies	Currently short, simple feedback forms	Offer detailed client evaluation to at least 20% of clients seen each quarter	Record experience to show both positive feedback and the benefits experienced and issues to understand if common themes occur to understand educational needs.	Qu'tly		Client feedback system still in development – await transfer to mobile working using i-pads

6.4 The Infant Feeding Service supports delivery of the breastfeeding friendly city agenda. Local businesses are encouraged to sign up to the Breastfeeding Friendly Awareness programme displaying the local campaign logo for the benefit of mothers feeding infants.

6.5 The UK has one of the lowest breastfeeding rates in the world, though it is recognised that breast milk protects babies from infections and diseases and reduces mother's risk of breast and ovarian cancers, cardiovascular disease

and obesity. At 66.6% Manchester's rate of initiated breastfeeding at birth is below the national average of 74.5%

7.0 Child Accident Prevention Service

7.1 Creating a population that is better educated in preventing unintentional injuries is expected to reduce the number and severity of child accidental injuries, and contribute to meeting national and local targets.

7.2 A new service has been modelled, in line with new Public Health England guidance, and commissioned with Manchester University Hospitals NHS Foundation Trust. The new service recognises and responds to the fact that the majority of unintentional injuries in this age group occur in the home. The service seeks to raise awareness in Early Years Education Providers, Parents/Carers and Children (3 to 5 year olds) of the most prevalent cause of unintentional injuries in this age group: (choking/suffocation and strangulation; falls; poisoning; burns and scalds; and drowning)

7.3 The service specification aims to prevent unintentional injuries in this age group by providing education, training and advice to parents/carers, children and staff. Service users are educated on hazard awareness, practical safety behaviour and appropriate responses to emergencies including first aid.

7.4 The service responds to seasonal fluctuation in accidents and injuries, with greater quantity of falls and trips experienced in summer and more burns and scalds in autumn/winter.

7.5 A multi-agency steering group has since been established in October 2018 to develop an accident prevention strategy for the city. This includes membership from across Council Directorates (i.e. Trading Standards, Highways, Early Years, Housing Enforcement), from within Manchester Children's Hospital Trust (i.e. Burns Service, Major Trauma Unit) and with CAPT (Child Accident Prevention Trust) in an advisory capacity.

8.0 School Health Service (School Nursing and Healthy Schools)

8.1 School nursing is a universal public health service for children and young people of school age. The aim of the service is to ensure children, young people and their families have access to a core programme of preventative health care (universal Healthy Child Programme) with additional care based on need (universal plus offer, universal partnership plus offer).

8.2 Qualified school nurses are registered nurses who have completed a post registration graduate programme, and are registered as specialist community public health nurses. School nursing teams contain a mix of qualified school nurses, nurses and assistants.

8.3 Manchester re-modelled its School Health Services in 2015, based on the National and Greater Manchester service specification for School Nursing and an updated Healthy Schools specification. This model provides a named

school nurse to every school (excluding Special Schools as these are commissioned separately within MHCC), who is visible in schools each week to deliver the Healthy Child Programme.

8.4 The service comprises of five child focused functions: Immunisation, National Child Measurement Programme (NCMP) and Screening, Healthy Schools Programme Safeguarding (e.g. Obesity Pathway) and the Healthy Child Programme.

8.5 The Healthy Schools team work citywide to implement the Healthy Schools Programme which supports schools to adopt a whole school approach to improving the health and wellbeing of children and young people.

8.6 The Healthy Schools Service has a number of Public Health Specialists that offer training, support, direct interventions with pupils and resources to local authority schools focusing on the following themes: drug and alcohol education, emotional health and wellbeing, healthy lifestyles, sex and relationship education, safeguarding (including child sexual exploitation, female genital mutilation and domestic violence and abuse).

8.7 Currently 165 of 178 schools (93%) are engaged with the Healthy Schools Programme. This breaks down as:

93% of Primary Schools
97% of Secondary Schools
93% of Special Schools

This can be split into contacts with key groups; Staff (14%) Pupils (82%) Parents (4%) Governors (0%)

8.8 The annual School health check began in October 2018, to date 117 schools have completed the on-line health check assessment. Schools are given an overall score and work towards a Bronze, Silver, Gold award programme. Two schools have achieved Gold status this academic year; Newell Green Primary and Rack House Primary.

8.9 The quality and performance of the School Nursing Service has improved dramatically since the implementation of the re-modelled service and new key performance indicators. This is due to a clear specification and key performance indicators being implemented, effective partnership work between the commissioner, provider, partners and users and the commitment of the service and its staff.

8.10 The service provides quarterly data and reports, including case studies, to the commissioner, which demonstrate impact. The commissioner and provider have just reviewed the key performance indicators and implemented a new performance framework to further evidence the effective work of this service.

8.11 The quality and performance of the Healthy Schools Service has remained consistently high, this is demonstrated in the high percentage of schools

engaged in this voluntary programme. The service re-modelled its offer last year based on feedback from schools, which resulted in them re-implementing an awards scheme. Schools value the specialist support/input, training and resources that Healthy Schools provide in order to enable them to improve the health outcomes of their pupils.

8.12 The School Nursing Service has a number of elements of delivery and related key performance indicators. A sample of key performance indicators from each area has been provided below. Delivery in Quarter 2 is always lower than Quarter 1 due to the summer holiday period being in this quarter and education settings are closed.

Key Performance Indicator	**Q1 April 18-Jun 18**	**Q2 Jul 18- Sept 18**
Proportion of children that participate in the National Child Measurement Programme (NCMP) (Height and weight measurement)	The NCMP data is reported nationally on the previous academic year 201/18: The programme is ongoing with 3349 children measured at October 2018	
Percentage of children core screened where consent has been granted (Reception age)	The screening data is reported nationally on the previous academic year 2017/18: Reception – 4492 of 4545 consented children measured = 98.8%	
Number of young carers identified and referred onto a service by the School Nursing service in accordance with the Young Carers Pathway in Manchester	16 identified, 20 referrals	27 identified, 2 referrals
Number of school aged children on a Child Protection Plan with an identified health and development need, that requires input from the school nurse	705 children and young people	611 children and young people
Total number of children receiving an intervention from the school nurse service	124	65
Number of early help assessments with input from the school nurse	28	5
Number of young people supported via the extended role (Chlamydia screens in 15 -18 year olds, condoms, pregnancy testing and emergency contraception)	43	7

Number of children and young people receiving input from a school nurse for emotional health and wellbeing	424 (179 additional children were signposted to services excluding Child and Adolescent Mental Health Services (CAMHS) and 124 additional children were referred to CAMHS)	303 (156 additional children were signposted to services excluding Child and Adolescent Mental Health Services (CAMHS) and 37 additional children were referred to CAMHS)
Number of children measured as overweight or obese who are provided with an appropriate intervention within the school nursing service	124	65
Number of schools in which an awareness raising session around managing anaphylaxis, epilepsy and asthma has been delivered	87	80
Number of requests for health information received for education health and care plans and the numbers of health advice submitted in support of the plan	81 Requests 71 submitted	66 Requests 62 submitted
Uptake of the school leaver booster vaccine - Diphtheria, Tetanus and Pertussis (DTP) vaccine	This data is reported nationally on the previous academic year. Academic year 2017/18 data is: Year 10 DTP (School Leaver Booster) programme is completed and uptake is 78.4% 2018/19 data is not yet available	

9.0 Reducing Childhood Obesity

9.1 Increasingly, childhood obesity and inactivity presents as the major risk to children's health in Manchester. Our 2016/17 NCMP (National Child Measurement Programme) data presents 12,000 school aged children overweight (91st Centile) of which 2,500 are obese (96th Centile)

9.2 The Population Health and Wellbeing Team commissions a community based, multi component lifestyle weight management service, suitable for children

aged 2-18 years and their family members or carers (regardless of their weight), in accordance with applicable guidelines e.g. NICE (National Institute of Clinical Excellence). The intensive phase programme lasts for 12 weeks. Following completion of the intensive phase, appropriate ongoing support is provided to all participants for at least 12 months.

9.3 Group programmes are provided for children and young people (2-18 years) and their families, with 1-1 programmes offered to individual families where this better meets their needs, for example, children with learning disabilities.

9.4 The commissioned weight management service provide the National Child Measurement Programme (NCMP) feedback to parents/carers of children and young people in reception and year 6, who are overweight and obese. This follows the establishment of a data sharing agreement with Manchester University Hospitals NHS Foundation Trust who carry out the programme. The weight management service are required to proactively follow up these parents/carers to engage the family into a weight management programme, provided by the service.

9.5 Referrals to the service and adherence on the programme are lower than expected. However, 100% of children attending the programme achieve three or more outcomes compared to baseline. Outcomes can include weight maintenance, weight loss, improvements in psychosocial wellbeing and physical activity. To improve adherence on the programme, the provider consulted with clients and as a result of feedback trialled a shorter programme.

9.6 Unfortunately, this shorter programme did not deliver increased numbers or improved retention into the service. ABL Ltd (the provider) are now reviewing and evaluating provision to identify other opportunities to bring to the service to improve outcomes. An improvement plan has been put in place between the commissioner and provider to ensure outcomes such as adherence on the programme improve.

9.7 The Healthy Schools team refer young people into this service and have been the leader in establishing the *Obesity Safeguarding Pathway* and Assessment Tools.

9.8 The Obesity Safeguarding Pathway was launched in October 2018 and responded to actions from a serious case review where obesity through parental neglect was a significant risk to the health of the child.

9.9 The service handles a high number of complex families that would be more suited to an intensive service rather than a group programme (this is a gap in provision in Manchester and Greater Manchester).

9.10 A multi-agency whole system approach is being adopted in developing a specification for a Tier 3 weight management service for children at the 96th centile (those with the highest BMI where there is severe risk to health). This will be tendered in April 2019.

9.11 Physical activity is an integral element of reducing obesity and maintaining a healthy weight. The School Health Service implements a number of activities within school settings to keep children and young people active, including the Daily Mile Initiative and the Physical Education, School Sport and Physical Activity (PESSPA) Plan in partnership with Sport and Leisure (Manchester Active).

9.12 Sport and Leisure and Population Health and Wellbeing are committed to submitting a joint scrutiny report titled 'Sport and Active Lifestyles for Children and Young People'. This will be presented at the January 2019 committee, and will describe the Physical Activity offer and 2018 performance in detail.

10.0 Improving school food in Manchester

10.1 Due to the School Food Standards not applying to academies founded between 2010-2014, the Healthy Schools Team have been working with secondary academies to encourage them to meet the school food standards. This is part of the Healthy schools Health Check. Schools are now encouraged to exceed the School Food Standards, such as selling water throughout the school day and removing foods such as pizza from the lunchtime offer.

10.2 The Manchester Healthy Schools team have been recognised nationally for good practise by Public Health England and the Local Government Association for their achievements on school catering, this includes;

- removing all drinks apart from water and milk from the school menu
- increasing fruit and vegetables available at break times while reducing the frequency of paninis and garlic bread
- reducing or removing puddings altogether with fruit, yoghurt or cheese and crackers as alternative

10.3 Catering staff, Pupils and Parents are sometimes opposed to improving the nutritional content of school meals, therefore annual training is delivered to school catering staff, taster sessions are offered to parents and the pupil voice is always captured when proposing changes to the school menu.

11.0 Oral Health Improvement Team

11.1 The Oral Health Improvement Team provides and supports a range of programmes which aim to provide education and the means to improve self-care oral health behaviour for different groups in the population but, primarily, focussing on children under 11 years of age. Many programmes aim to increase the availability and use of fluoride, particularly given the changes in affordability of fluoride milk.

11.2 There is a clear requirement for activities to be focussed on those that maximise the impact of increased availability of fluoride to all sectors of the population whilst targeting vulnerable groups experiencing the highest levels of health inequalities with oral health improvement interventions. Vulnerable

group include deprived communities, looked after children, children with special needs and homeless families with children.

11.3 Manchester does not have a fluoridated milk programme in schools or nurseries. On 1st January 2018, schools were required to register with the Nursery Milk Remuneration Scheme to declare the number of children they were ordering milk for. In this period it was identified within Department of Health on-line guidelines that “schools cannot claim the NMR subsidy for any milk that has anything added to it”. Fluoride was listed as one of those additives.

11.4 Manchester City Council queried this with the Department of Health on behalf of schools, with request that this policy be reviewed. A parliamentary review took place lead by Oral Health at Public Health England. The outcome stated that ‘DH policy is that fluoridated milk does not meet the criteria for the reimbursement under the NMRS Programme’.

11.5 Schools received a written communication to confirm that the milk fluoridation scheme in Manchester did not meet the criteria for the subsidy. Schools could no longer claim and would be required to find their own funding or suspend the scheme should they wish to continue supplying fluoridated milk. As most schools were reliant on claiming the subsidy for 3 - 4 year olds, a number of schools had come out of the scheme by April 2018.

11.6 Despite the reduction in fluoride milk take up, the Oral Health Improvement Team are still able to demonstrate above national average performance in delivering fluoride varnish.

	2016 / 2017	**2017 / 2018**
	Fluoride Varnish Rate (Q4 2016 / 2017)	**Fluoride Varnish Rate (Q4 2017 / 2018)**
Bolton	**51.4%**	**59.0%**
Bury	**57.6%**	**61.1%**
Rochdale	**58.1%**	**65.7%**
Manchester	**56.2%**	**71.4%**
Oldham	**65.5%**	**68.1%**
Stockport	**52.1%**	**55.7%**
Tameside	**59.1%**	**63.5%**
Trafford	**56.1%**	**61.5%**
Wigan	**58.5%**	**62.0%**
Salford	**50.6%**	**63.4%**
Greater Manchester	**56.4%**	**63.4%**
ENGLAND	**47.5%**	**54.6%**

11.7 In order to meet the needs of the most vulnerable families and children, the team works with Early Years workers, school staff and community health staff to provide oral health education.

11.8 Manchester's Oral Health Improvement Team lead the Buddy Practise Scheme, this is a preventative scheme that brings primary care dental practices and schools together in partnership. The current scheme has been in place since 2016. Parents of children in nursery or reception classes were asked about their child's dental attendance and those children who either had no dentist or who had not attended for some time were identified and consent was sought and provided. The parents of non-attending children were then invited to a 'meet the dentist' session at the school. These take place first thing in the morning as children arrive to encourage as many parents to stay as possible.

11.9 Establishing a regular attendance pattern emphasised and assisted, either by the clinician or a member of the Oral Health Improvement Team is a vital aspect of the programme. Details of the partner practice was given and information on the dental helpline to assist parents to make appointments elsewhere if they chose. All children were also given toothbrushes (1450 parts per million fluoride) and a toothbrush.

11.10 The attendance of each of the children is checked following the 'meet the dentist' sessions, after 4-6 months the programme is repeated for those children who still do not attend. After this follow up the small number of children, with identified clinical need, who had still not been taken to a dentist, were followed up and the School Nurse/ Health Visitor was contacted with the child's details.

11.11 In the academic year 2017/18, the programme involved 50 schools, 909 children consented to be seen in phase 1 of the programme and 747 children had a fluoride varnish application with 230 children requiring treatment (25%). In phase 2, 431 children received consent to be seen and 301 of those children had fluoride varnish applied. Treatment need was much lower in the second phase with 73 children requiring treatment although again a treatment need remained.

Key Performance Indicator	Q2 Jul 18-Sept 18
Facilitate the drinking of fluoridated milk at primary schools and special schools in Manchester	**681 children drinking dental milk on a daily basis** **15 primary schools currently taking part in this academic year**
Maintain the number of targeted schools and Early Years establishments that deliver a daily supervised tooth brushing scheme - The Brush Bus.	**78 of 100 schools in most deprived areas of the city (78%) have brushing programmes** **84 of 132 Private nurseries have a brushing programme (64%)**
Buddy Practice Scheme to increase attendance among pre-school children and their families.	**Phase 1 for this academic year started with 50 schools 909 children have visited a dentist as a result. 431 had previously not seen a dentist**
Facilitate fluoride varnish applications with 3- 5 year old children in Early Years settings	**747 (82%) children had fluoride varnish applied**

11.12 The Oral Health Improvement Team is currently located within a Well-Being Services contract commissioned with Greater Manchester Mental Health Trust (GMMH). The contract is intended to transfer to the LCO in April 2019, which will align all of the Health Child programme contracts with one provider.

11.13 The original Local Care Organisation (LCO) plans were for the Health Visiting and School Health Services to transfer into the LCO in 2020/21. However, with agreement from MHCC and MCC, both the Health Visiting and School Health Services transferred to the LCO in April 2018.

12.0 Next Steps - Children's Services Transformation

12.1 As part of Manchester Children's Services Transformation work, the Population Health workstream is focusing on the following areas of work:

- Work to resolve capacity issues in the Health Visiting Service
- Strengthening joint working between Early Help, Early Years and Health Visiting in localities
- Transitioning the oral health improvement service from the Greater Manchester Mental Health NHS Foundation Trust to Manchester University Hospitals NHS Foundation Trust
- Reviewing current work and taking a whole systems approach to reduce obesity, including exploring opportunities through the Trailblazer Fund.

13.0 Government Trailblazer Fund

13.1 In November 2018 the Government announced a new Trailblazer Fund for childhood obesity offering £300,000 over three years to five successful bidders. This supports the Government and Public Health England's 'Action Plan on Obesity (2016) and 'Making Obesity everyone's business (2018)' reports which advocate for whole system approaches.

13.2 Manchester intends to apply to the fund with an initial expression of interest, in hope to be one of twelve authorities who are invited to develop their application in a 'Discovery Phase'.

13.3 The application will be made in collaboration with Manchester Local Care Organisation, Manchester Active and Growth & Neighbourhoods.

13.4 The expression of interest and proposal borrows learning from the Winning Hearts and Minds Programme, a whole system approach to improving heart and mental health outcomes in Manchester, developed in partnership with Manchester Health and Care Commissioning, Manchester City Council's Sport and Leisure Team and Eastlands Trust.

13.5 The core ambition of the programme was that early deaths (under 75) from heart disease would drop 50 per 100,000 by 2027 (Manchester currently has the worst early death rate from heart disease in the country at 85 per 100,000). The programme was driven by community-led initiatives in keeping with the Our Manchester approach. With a similar partnership base and targeting those same communities (and parents) where health inequalities are most prevalent, there is an opportunity to explore learning in this approach and infrastructure for partnership work to engage and retain children and families in physical activity.

14.0 Conclusion

14.1 On 30th October 2018, Manchester was host to Sir Michael Marmot (Institute of Health Equity). Eight years previously Sir Michael had authored the hugely influential *Marmot Review 'Fair Society, Healthy Lives'*. It was this report that highlighted the social gradient of health inequalities- the lower one's social and economic status, the poorer one's health is likely to be.

14.2 The return of the Institute of Health Equity to the city for a workshop with Health Professionals and Service Leads sought to learn from the changes that have occurred in addressing health inequalities in the period since the report was published. Manchester's experiences in challenging health inequality would partly inform a new publication due in 2020 *'Health Inequalities: What next? Ten years on from the Marmot Review'.*

14.3 What is evident in our city is a landscape that has changed immeasurably in how we respond to the health of children, through the ongoing transformation of health and social care. We recognise that we need to intervene earlier, *sometimes as early as a child is conceived*, to ensure children have the

correct support and have the best start in life in their first 1,000 days. Having a Health Visiting Service that has the resources to manage this demand and work closely with Early Years and Children's Centres to support infant well-being, parental mental health, child development and school readiness is key.

14.4 In their journey to adulthood, children are supported in that transition so that they can be their best and achieve personal and economic well-being (recognising the further benefits of work to health) as they get older, supported on that pathway by a school nurses linked into schools, a healthy education environment and targeted interventions such as Children's Mental Health, Dieticians or Occupational Therapy.

14.5 Acknowledging the societal elements of health linked to inequality, we are increasingly moving towards a whole system approach, whereby the health of our children, be that obesity or mental health, is the responsibility of everyone.

14.6 This whole system approach will be developed further under integration into Local Integrated Neighbourhood Teams (INTs) within the Local Care Organisation, and in work with Neighbourhood colleagues and other Directorates and organisations as we seek to address social determinants of health (obesogenic environments, clean air, green spaces and good housing) in our approach to developing happy, active and healthy children in Manchester.