Chapter 4: A progressive and equitable city

Strategic overview

The Council's aim is for all residents in the city to have the same opportunities, life chances and the potential to lead safe, healthy, happy and fulfilled lives, no matter where they are born or live. This means reducing the disparities between different areas of the city. Manchester has made real progress towards achieving this aim, including making improvements in education and housing, providing better access to jobs, reducing the number of children growing up in poverty, as well as reducing the number of young people not in employment, education or training. These improvements have mainly come from the strength of the collaboration between organisations, businesses and residents.

Despite these gains, there are still areas of intense deprivation in the city. These are far less widespread than they were ten years ago, but exist nonetheless, and we must do more to address them.

As citizens, we all need to recognise the responsibilities we have to ourselves, our families, our communities and the city. We should all be committed to taking an Our Manchester, strengths-based approach, starting from understanding the needs of the individual, and connecting people to draw on the strengths of the communities in which they live.

Manchester City Council is in the process of radically transforming public services so they are focused around people and communities rather than organisational silos. We are working across traditional boundaries with the voluntary sector to bring innovation and new ways of working to the fore. We are working with health providers, the voluntary sector, education providers and communities in new ways that will target the specific problems we have in Manchester.

Integration of health and social care has the potential to transform the experiences and outcomes of people who need help by putting them at the heart of the joined-up service. There is a focus on public health and preventing illness, as well as transforming care for older people so they can stay independent for longer. As a city we have world-leading strengths in health-related research. We will use our research strengths and our capability for testing new drugs and therapies to benefit our residents and radically improve the city's health outcomes.

We are modernising services for children and their families. The vision is for our teams to work closer with health, schools, the police and other colleagues in neighbourhoods and localities. It will place a greater focus on prevention and early support, avoiding problems starting in the first place for children or families, wherever possible.

This will prevent problems occurring and unnecessarily escalating by ensuring that people can access early help and that they are equipped to take care of themselves. The vision is also to increase the life chances of our children and support their future independence to support people to find work, stay in work and progress at work, so that all residents can take advantage of the opportunities of economic growth and are able to provide for their children. There is a comprehensive programme of work in place to oversee and guide the planned changes.

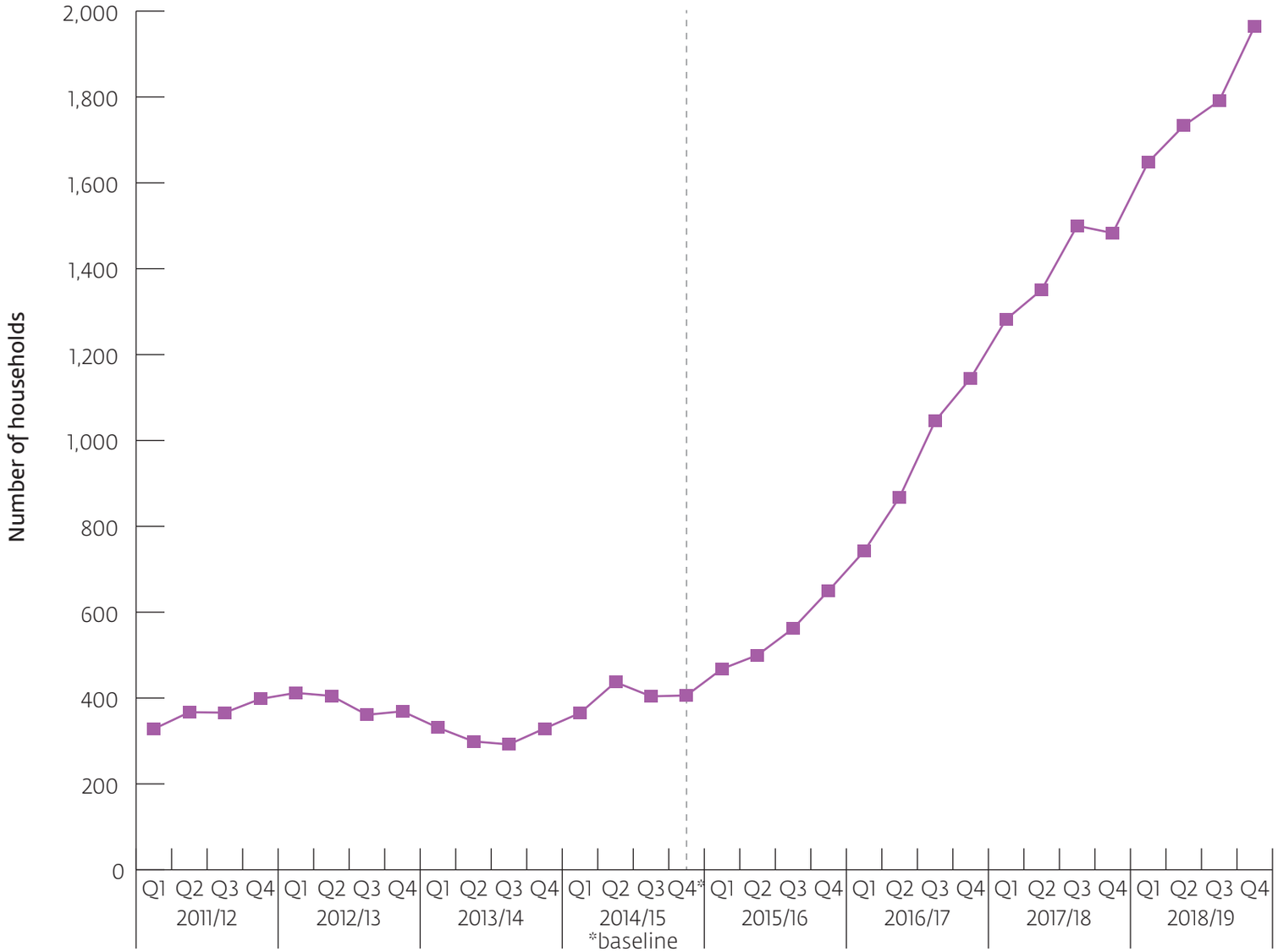
As we work towards delivering Manchester's Locality Plan and increase our collaborative work across Greater Manchester, it is most likely aspects of the aforementioned programme, scaling up the programmes that work, and designing new programmes with the voluntary sector and other partners that will address the challenges we have as a city.

Analysis of progress

Ensuring that shelter and support is available for homeless people who want and need it

Homelessness has been a growing challenge in Manchester over recent years, with more families presenting to the Council as homeless and more individuals sleeping on the streets. The Council has seen a significant increase in the number of people presenting as homeless and owed a duty. The number of people the city needs to work with has increased in 2018/19, with the introduction of the Homelessness Reduction Act and the continued delivery of Universal Credit. The number of households presenting to the Homelessness service increased 33% in 2018/19 from the number presenting in 2017/18. Furthermore, Figure 4.1 shows the number of households residing in temporary accommodation has increased significantly over the past four years, from 406 at the end of March 2015, to 1,965 at the end of March 2019. The Council, alongside its voluntary, statutory and business partners working across the city, has progressed significant pieces of work to help meet this challenge.

Figure 4.1:
Total number of households residing in temporary accommodation at the end of the quarter



Source: Ministry of Housing, Communities and Local Government (P1e and H-CLIC statutory return)

The Launch of **Manchester's Homelessness Strategy (2018–2023)** in October 2018 is key to tackling this challenge, and sets out three aims for reducing homelessness:

- **Making homelessness a rare occurrence:** increasing prevention and earlier intervention at a neighbourhood level
- **Making homelessness as brief as possible:** improving temporary and supported accommodation so it becomes a positive experience
- **Making homelessness a one-off occurrence:** increasing access to settled homes.

Making homelessness a rare occurrence

Increasing prevention has been supported by the introduction of the Homelessness Reduction Act in April 2018, placing new legal duties on local authorities so that everyone who is homeless or at risk of homelessness has access to meaningful help, irrespective of their priority-need status. Central to the new Act is an increased focus on the prevention and relief of homelessness, which includes an enhanced advice and support offer. In Manchester, the introduction of the Act has seen the expansion of the Council's Housing Solutions service, which successfully prevented 423 individuals and families from becoming homeless in the period from April 2018 to March 2019. A new Housing Solutions Hospital Discharge Team is being established. The service will support North Manchester General Hospital, Manchester Royal Infirmary and Wythenshawe Hospital through providing advice and guidance to complete assessments, and finding suitable move-on accommodation for homeless people either attending A&E or as patients receiving treatment. A key benefit of this service will be supporting and reducing length of stay in the acute and non-acute settings, where there is no longer a need for being in such a setting, and homelessness is the reason for the delay.

Making homelessness as brief as possible

A new gateway system will streamline access to supported accommodation, improving people's experiences of accessing accommodation. Improvements to temporary and supported accommodation have seen the introduction of new contracts linked to Our Manchester ways of working for commissioned housing-related support (HRS) services. Work is in process to appoint a not-for-profit organisation to manage temporary dispersed accommodation. The floating support teams have been increased to improve support, and an additional 'move on' team has been created to help people into permanent accommodation. In September 2018, automated bidding was introduced to assist people to move from temporary accommodation to permanent accommodation as quickly as possible.

Making homelessness a one-off occurrence

Increasing access to settled homes has involved various initiatives to increase access to both the social and private-rented sector (PRS). The Council and six Registered Housing Providers have a combined pot of over £14million to purchase approximately sixty large homes for Manchester families; these will have a 12-month assured shorthold tenancy, which can be extended. The rent levels are typically set at submarket rents, which could be set at 80% of the market rent or LHA cap at the discretion of the Registered Provider. Work is also ongoing to review Manchester's Social Allocations Policy to ensure that it continues to meet the housing needs of Manchester residents.

Initiatives within the private rented sector have seen a PRS team established to source permanent new tenancies for clients that present to the Council through the Homelessness service. The PRS team ensures that properties are suitable for residents, including carrying out inspections and completing affordability assessments. The team also offers a range of incentives to landlords to ensure that the tenancies offered are at affordable rents in line with Local Housing Allowance (LHA) rates, which are often below the current market rents for properties in Manchester. The team successfully helped to move 386 households into private rented sector properties in 2018/19 with the intention to support 800 families into PRS tenancies in 2019/20.

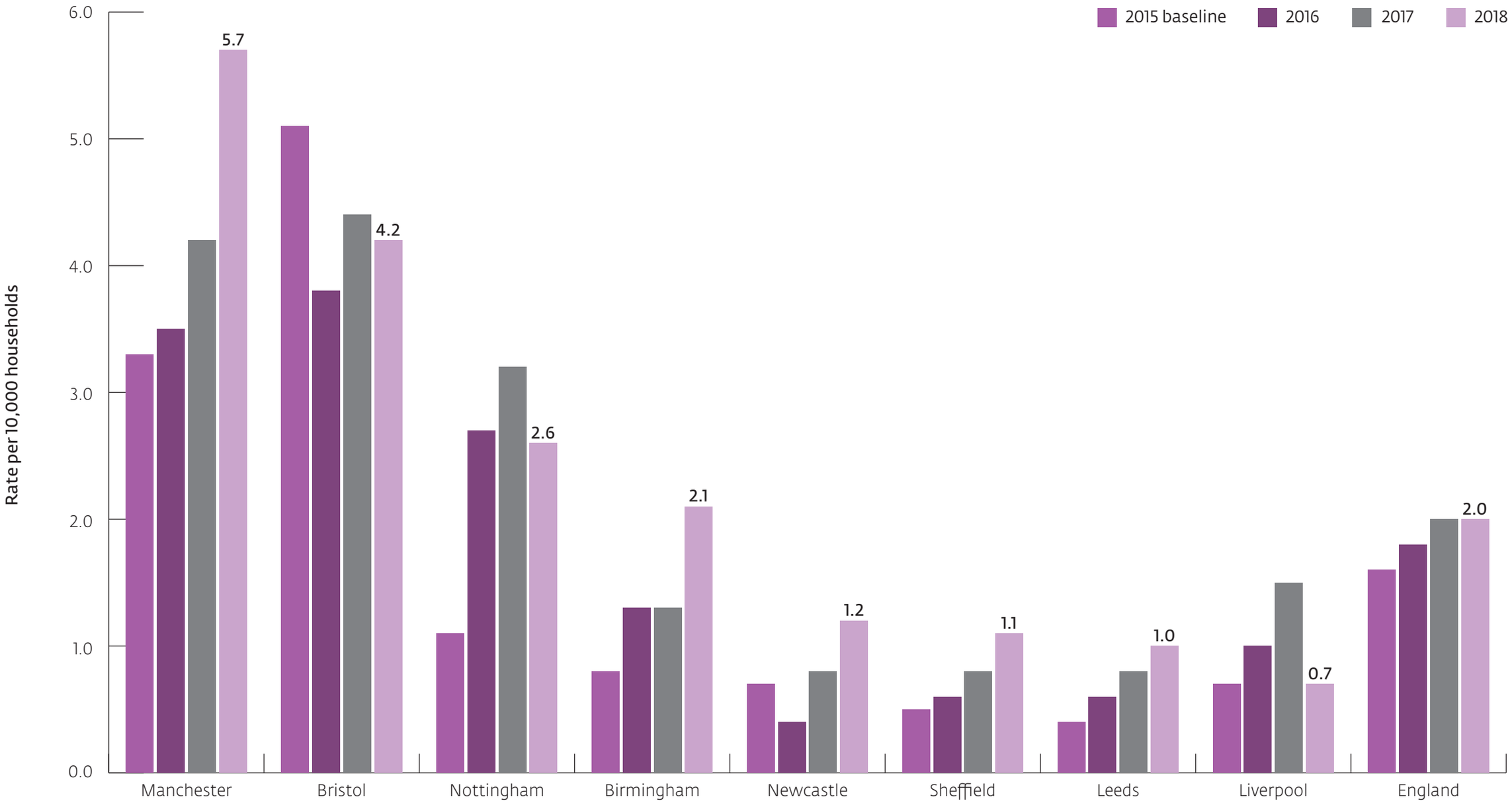
In April 2019, the Council was also successful in a bid of £401,190 through the Ministry of Housing, Communities, and Local Government (MHCLG) PRS Access Fund to increase our existing PRS offer for landlords. This funding will be used to finance the following:

- The purchase of a new on-line system called Local Pad, which will be used by landlords to update new properties as they become available for clients to view
- Expansion of the current paper bond scheme
- The purchase of a tenancy training e-learning-based system to equip tenants with the essential skills and knowledge required to maintain their new tenancies
- Financial assistance to pay for a deposit
- Two resettlement officers (to be employed for 12 months) to provide ongoing tenancy support for clients moving into the private rented sector.

Tackling rough sleeping

The 2018 single-night snapshot of people sleeping rough counted 123 rough sleepers in Manchester city centre, compared to 70 in 2015. Figure 4.2 shows that Manchester has the highest rate of people sleeping rough per 10,000 households when compared to other English Core Cities, and with a rate of 5.7 it is almost three times the national average. Significant work has been undertaken since the November count to support people to move away from the streets.

Figure 4.2:
Single-night snapshot of the number of people sleeping rough per 10,000 households



Source: Ministry of Housing, Communities and Local Government

Street homelessness is a complex issue and a range of responses have been implemented across the city to reduce the number of people who sleep rough. These include an expansion of the Council's Outreach Team, and the introduction of a Social Impact Bond and Housing First, which are both funded through MHCLG across Greater Manchester. In addition, the MHCLG Rough Sleeper Initiative Fund, which has facilitated the establishment of a multipartner response to preventing and relieving rough sleeping, saw 531 individuals relieved from rough sleeping between July 2018 and March 2019, and a further 161 individuals prevented from rough sleeping. Commencing December 2018, additional accommodation for people who sleep rough was also developed over the winter period to support the 'A bed every night' initiative. This accommodated over 377 individuals and provided almost 12,000 bed nights.

Homeless access to health care

Urban Village Medical Practice Homeless Service offers full registration to homeless single adults in Manchester using the broadest definition of homelessness. The service focuses on helping people experiencing homelessness to access mainstream health care, and offers appointments throughout the week alongside dedicated homeless drop-in sessions. The service is supplemented by other health care services, including drug workers, podiatry, drug assessments and an HIV clinic.

At the end of 2018, there were 754 homeless patients registered as part of the Homeless Service, of which 277 were newly registered in 2018 – an average of 23 new patients per month. Around 25% of new registrations were under the age of 30, 57% were aged between 30 and 50, and 18% were aged 50 and over. Just under half (49%) of all new registrations were from rough sleepers. A further 20% were people living in hostel accommodation, and 15% were 'sofa surfers'.

Manchester Health and Care Commissioning (MHCC) has funded a Homeless Partnership Worker who has been instrumental in attracting additional funding to support homeless people, including a National Lottery Community Fund transformational four-year grant of £1,528,299 to better link Groundswell, Crisis and Shelter to take a shared approach to health inequalities. It is envisaged that Peer Workers will be aligned to Homeless Access Practices from early 2020.

Work is also under way to establish a 'Homeless Access Hubs' pilot in seven 'hotspot' areas of the city, co-ordinated by Manchester Primary Care Partnership (MPCP) with the support of Urban Village Medical Practice. Examples of the sorts of work that will be delivered as part of the pilot include ring-fenced appointments for people experiencing homelessness, pop-up clinics in homeless hostels, enhanced support for GP registration, and extended new patient health checks for homeless patients.

Supporting people to find work, stay in work and progress at work

As we have discussed in the 'A highly skilled city' chapter, there is strong evidence to support the fact that being in good employment can protect health and wellbeing. Conversely, unemployment can have short and long-term effects on health and is linked to increased rates of long-term conditions, mental illness and unhealthy lifestyle behaviours. Access to good-quality work is key to reducing health inequalities and improving health and wellbeing. High rates of health-related worklessness have persisted in the city during times of economic growth, as well as during the economic downturn. Getting back into employment increases the likelihood of reporting good health and boosts the quality of life.

In Manchester, high rates of health-related economic inactivity have persisted and remained constant over the past decade, despite periods of growth and recession in the national and local economy. Nationally, there has been an absence of integrated health provision with programmes designed to move people into work. People with a long-term health condition are much less likely to be in employment than the population overall. In Manchester, the gap in the employment rate between those with a long-term health condition and the overall employment rate was 15.9 percentage points in 2017/18 – a much wider gap than the 11.5 percentage points reported for England.[1]

Employment Support Allowance (ESA), Incapacity Benefits (IB), and Severe Disablement Allowance (SDA) are benefits designed to provide financial support for people who are unable to work to their full capacity due to ill health or disability. The most common clinical reasons for claiming sickness-related out-of-work benefits in Manchester are behavioural and mental-health disorders, musculoskeletal disorders, and substance-misuse issues. In November 2018, 26,854 Manchester residents were claiming ESA/IB/SDA, a modest reduction of 4,904 claimants since November 2015. However, the introduction of Universal Credit for all new claimants across the city within this timeframe, including those with long-term health conditions, should be considered when reviewing recent trends.

Work as a health outcome continues to be a priority within the city's Population Health plan and is recognised as one of the social determinants that impact upon health within the Marmot review. This has been reflected in the governance arrangements for the city, which include the strong representation on the Work and Skills Board from Manchester Health and Care Commissioning, including a clinical (GP) lead and the Director of Population Health and Wellbeing.

While the evidence base and governance around work and health have increased in significance in the city over the past few years, health and social care, employment support and skills systems have historically not been well aligned and have had different drivers and incentives. Four years ago, the Manchester Health and Wellbeing Board and Work and Skills Board tasked a group of work and health leads to test new ways of addressing these system and cultural issues to support more people with a health condition to stay in or move into work.

1 Public Health Outcomes Framework: ONS Annual Population Survey, Crown Copyright Reserved

The **Manchester Fit for Work** and **Healthy Manchester** programmes were designed in collaboration with Public Health and primary-care providers to test a health-led model of employment support. These services proved effective in terms of supporting people in work with a sick/fit note at risk of falling out of work, and supporting long-term unemployed people to move into work. The delivery model for both services included developing self-care and self-efficacy, rapid access to counselling and musculoskeletal support, biopsychosocial assessment, and connections to local community assets. On this basis, having proved GP and resident demand for this type of support, the model was incorporated into the Public Health-commissioned social-prescribing service now known as Be Well. The Manchester model was also used to inform the development of the Greater Manchester Working Well Early Help service, which was commissioned in 2018/19.

Over the past four years, more than 3,000 Manchester residents have been supported to manage their health conditions, factoring in other social determinants and making adjustments to allow them to move into work or back into work.

In addition to the Working Well Early Help service we have continued to support the delivery of its predecessor services. Greater Manchester secured the devolution of funding for health and work programmes as a result of the poor performance of the nationally commissioned work programme for people with long-term health conditions. Greater Manchester made the case that better employment outcomes could be achieved through a locally commissioned and managed service, and has developed new service-delivery models since 2014 to tackle long-term worklessness, with a particular focus on those out of work due to a health condition.

The Working Well offer is continuing to evolve and inform further service provision. Greater Manchester and London are the only two areas where the DWP has devolved the commissioning for the new Work and Health programme. This programme focuses on support for disabled people and people out of work due to poor health and long-term unemployment. The new programme, being delivered by the Growth Company in Manchester, was launched at the beginning of March 2018. The programme builds on the Working Well programme by taking a holistic approach to supporting people into good-quality employment, offering a range of skills support, work experience and employment support. Referrals will initially come from Jobcentre Plus. This programme has introduced an Integration Co-ordinator, whose role is to work closely with Jobcentre Plus and the Council to ensure close integration with local services. By the end of March, Manchester had 532 starts on the programme, with 83% actively engaged. Of that number, 214 have started a job, which is 56% of the job-start target.

While the various Working Well and Be Well services provide support for some people in the city who are disabled or who have long-term health conditions, it has to be acknowledged that they alone cannot address the scale of health-related worklessness in the city. Generally, they have supported people with less complex health issues, although Healthy Manchester effectively engaged people within the Employment Support Allowance support group. In recognition of this, other initiatives have been developed in addition to a range of neighbourhood and citywide support services, such as work clubs.

Our Manchester Disability Plan

The Our Manchester Disability Plan (OMDP) was launched in 2017 with a wide range of stakeholders who have a role in supporting the 12 pillars of independent living; employment is one of these pillars. Importantly, the development of the plan has been led by disabled people and support organisations, and is based on the social model of disability – it is society that disables and creates barriers such as inflexible recruitment processes. According to the ONS Annual Population Survey (January 2018 to December 2018), disabled people remain significantly less likely to be in employment than non-disabled people. In Manchester, an estimated 43.7% of working-age disabled[2] people are in employment, compared to 76.1% of working-age non-disabled people. Therefore, there is a 32.4 percentage point gap between disabled and non-disabled people in Manchester, compared to a 26.8 percentage point gap across England.

The Our Manchester Disability work and skills action plan sets out some clear priorities and commitments from board members to increase recruitment, retention and in-work progression of and for disabled people. To support the development of the workstream, the Council's Work and Skills Team hosted two young disabled people on work experience to make recommendations on our approach. In line with these recommendations, the Our Manchester Disability Plan employment workstream members delivered a jobs fair in March 2019 targeted specifically at disabled Manchester residents who were looking for jobs. A range of employers with vacancies, training and pre-employment offers attended, along with support organisations that work with both employers and employees. Feedback from attendees and employers has been positive, and there have already been some job outcomes.

Linked to this, but also to the Health and Wellbeing Board priority described earlier, is the collaborative approach that Health and Wellbeing Board members have taken around Health and Wellbeing measures:

- The Board committed to demonstrate public-service leadership under the Strategic Priority 'bringing people into employment and ensuring good work for all' in 2015. This was in recognition of the importance of providing 'good work' to improve health outcomes for residents. The steering group established to lead on this provided a framework for member organisations to learn from good practice. It identified gaps and both individual and collective areas for improvement, particularly in terms of recruitment, retention and progression for disabled people, and people with long-term health conditions. By doing this, the intention was also to provide better working conditions and reduce the costs of sickness absence, presenteeism and turnover across the wider workforce. It also provided the opportunity for Board members to act as exemplar employers to support engagement with other public and private-sector employers on this agenda.
- A baseline assessment tool was developed collaboratively across Board-member organisations, and a report on findings and recommendations was presented to the Board in July 2017. The steering group has continued to meet to deliver the recommendations made within the report. Current membership includes Manchester Health and Care Commissioning, Manchester City Council, Manchester Foundation Trust, Greater Manchester Mental Health Trust, The Christie, Pennine Care, and the Manchester Local Care Organisation.

2 Definition: long-term disability that substantially limits their day-to-day activities and/or affects the kind or amount of work they might do

- An assessment tool has been developed, which can be used by any employer and is therefore ideal for integrated health and social-care working. All Manchester Health and Wellbeing Board organisations are committed to the completion of domain four of the assessment tool, which focuses on sickness absence, disability and long-term sickness in 2018/19.
- The group has collaborated on the design and delivery of initiatives, such as training for managers of disabled staff, and commitment to achieving Level 3 Disability Confident Leader status, aligned to the Our Manchester Disability Plan social model of disability.

As originally intended, the development of this approach has generated interest from other public and private employers. A similar piece of work is now taking place within the Greater Manchester Health and Social Care Partnership Locality Plan, and there have been discussions with and presentations to the following organisations: the GMCA Workforce Collaborative group for HROD leads, the NHS Clinical Commissioners membership organisation, NHS employers, and Greater Manchester Police.

In 2019/20, we will build on initial discussions around how the tool could be used by other employers through Manchester-based business networks, the Greater Manchester Mayor's Good Employment Charter, and within Manchester Health and Care Commissioning (MHCC) and the Council's Social Value requirements.

Working with families to lift them out of poverty

The Manchester Family Poverty Strategy (2017–2022) was developed to address child poverty in Manchester, which is a major challenge affecting many of the city's families. The Strategy was developed using the Our Manchester approach, which was co-designed with residents and partners.

The Strategy seeks to reduce the number of children and families living in poverty in the city, and supports them to be more resilient so they can reach their full potential and take advantage of the many opportunities Manchester has to offer.

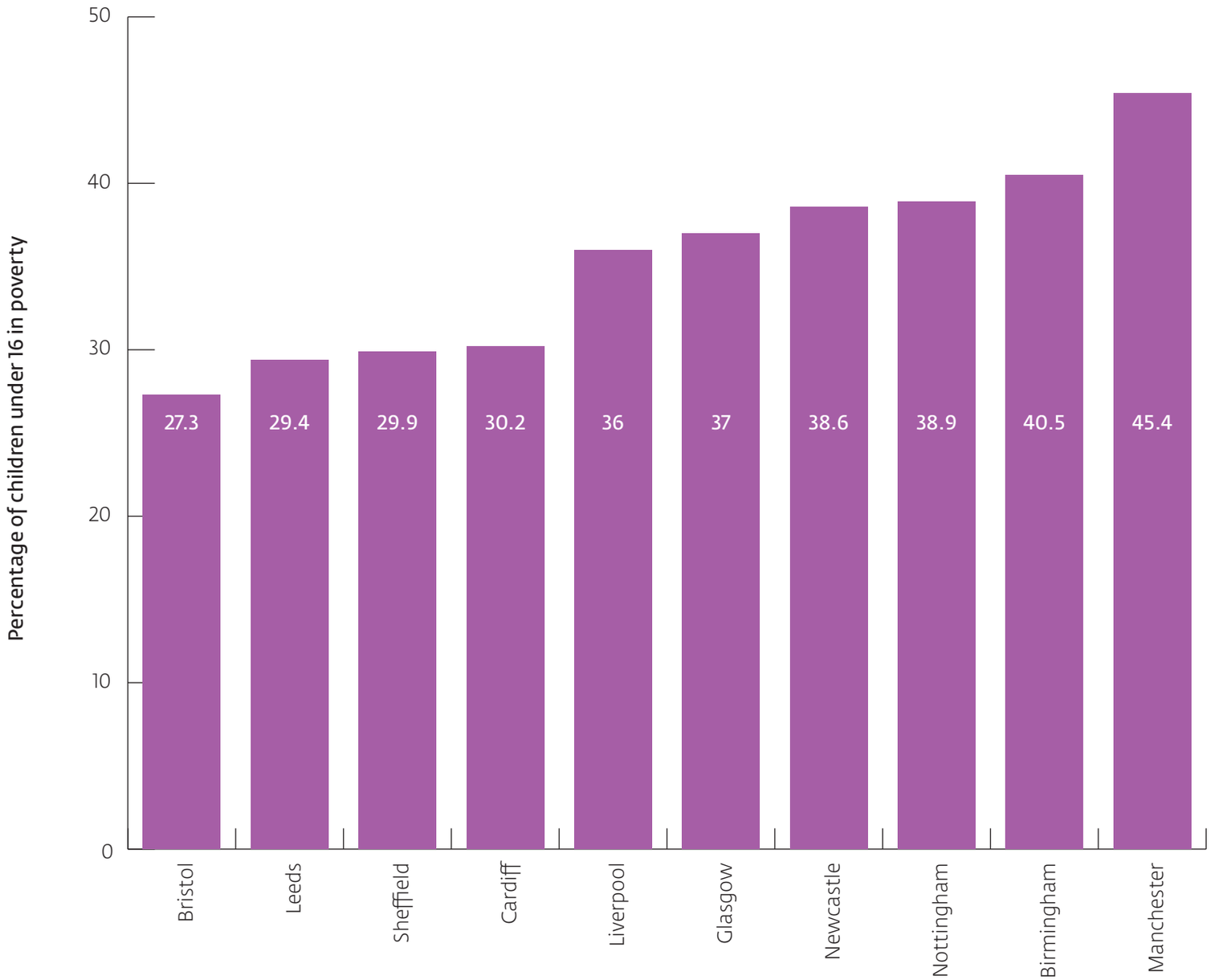
Although the economy in Manchester continues to thrive, some areas of the city still experience high levels of child poverty. There are a number of different ways to measure poverty, and no single uniform measure, so the true extent of child poverty in the city is difficult to quantify.

The HMRC Children in Low-Income Families figures were used as a baseline for Manchester's Family Poverty Strategy. This is one of the official measures of relative poverty at local authority level, showing the number of children living in families in receipt of out-of-work (means-tested) benefits or in receipt of tax credits where their reported income is less than 60% of the UK median income. This does not take account of Universal Credit, which is now claimed by a substantial number of residents in the city. It also underreports the volumes of in-work poverty.

The End Child Poverty figure is defined as 'an estimate of the true level of child poverty (defined as below 60% of median income)'.[3] Following a comprehensive review, it was decided that the End Child Poverty figure would be used as Manchester's official figure. Following this, the Centre for Research in Social Policy improved their methodology for producing the estimate in 2019. They now combine income data from the national Understanding Society survey, along with detailed administrative data about local areas – such as numbers of benefit claimants – to arrive at an estimate. This will enable changes to be tracked in future, but it does now make it more difficult to clearly see what changes have taken place since 2015, as the measure is different.

Using this measure, 45.4% of children in Manchester were living in poverty in 2017/18, the highest level of the UK Core Cities (Figure 4.3). For Manchester, the End Child Poverty estimate shows a rise of 2.4% since 2016/17, validating that a rise is taking place, as predicted by the Institute of Fiscal Studies (IFS) in 2017.

Figure 4.3:
Percentage of children under 16 in poverty in the UK Core Cities 2017/18



Source: End Child Poverty estimates, 2019

3 End Child Poverty, 2019

There are many factors that influence the increases in child poverty, but the IFS analysis[4] highlights some key drivers. First, there is the impact of benefit reforms, with those having the most impact being the benefit freeze from April 2015 to March 2020, the transition to Universal Credit, and cuts to child tax credit. Also, because poorer families with children get a relatively small share of their income from earnings, median income tends to increase faster than the incomes of low-income households with children, so relative poverty worsens. In terms of the impact of the economic status of the household, child poverty in working households is predicted to increase nationally by 3.3 percentage points over the period 2015 to 2021, reflecting the high exposure of families with children to planned benefit reforms. Children in workless households fare worse still, with a projected rise in their poverty rate over the period of nearly 12 percentage points.

Manchester City Council continues to work with academic and charity-sector partners to ensure that we keep pace with developments in the field.

Implementation of the Family Poverty Strategy

The Family Poverty Strategy is focused on three key themes:

- Sustainable work as a route out of poverty
- Focusing on the basics – raising and protecting family incomes
- Boosting resilience and building on strengths.

A 'Core Group' of officers, councillors, and partners oversees the delivery of the Strategy, and reporting into the Core Group are three working groups aligned to the three themes of the Strategy. The key priorities for each of the themes, together with progress, are as follows:

Sustainable work as a route out of poverty

Flexible childcare has been highlighted as a major issue affecting a family's income. To promote much-needed flexibility around childcare, the working group has identified local childcare providers who are able to provide flexible childcare. They are examining how these models work with a view to promoting and sharing good practice with other providers in Manchester. They are also addressing some of the challenges that childcare providers face to enable provision to be affordable, accessible and sustainable.

It is hoped that this will help boost access to job opportunities for those families currently unable to access work due to the lack of flexibility in childcare.

Focus on the basics – raising and protecting family incomes

Food poverty is increasingly recognised as a major issue for people living in poverty and has gained a much greater local and national profile. A small-scale mapping exercise helped to identify a number of models of food help, such as food pantries and food co-operatives. In addition, the group has supported the expansion of The Bread and Butter Thing[5] into two new locations in north Manchester to further support families struggling with basics in key areas of deprivation in the city. Furthermore, a new partnership of voluntary, private and public-sector organisations has been formed to address the issue of Holiday Hunger; this provides much-needed nutritional food and enriching activities during the school holidays.

4 **Living standards, poverty and inequality in the UK: 2017/18 to 2021/22** (Institute for Fiscal Studies, 2017)

5 The Bread and Butter Thing is a charity operating across 20 hubs within Greater Manchester. Members with very little disposable income are offered the provision of a deeply discounted food service to help their income go further

The national governing body for fuel poverty, the National Energy Action (NEA), was commissioned to provide free training and advice for frontline workers and schools to raise awareness of fuel poverty, its impact, and the support available to residents. Over three days in October 2018, NEA delivered the City and Guilds Level 3 Award in Energy Awareness to frontline workers in Manchester, including representatives from the Citizens Advice Bureau and Registered Housing Providers. In addition, as part of their offer, they also provided training for Early Help Hub Managers, focusing on the Home Life section of the assessment, which includes housing, money, and health and wellbeing. Feedback from sessions was extremely positive. Almost all delegates felt that their awareness about the causes of cold homes had improved as a result of the training.

There is a growing recognition that the poverty premium (the extra cost that people on lower incomes pay for goods and services, as they are less likely to access the best deals) impacts disproportionately on families living in poverty. To help counter this, Northwards Housing have launched a scheme with a large white-goods retailer to allow new tenants to rent a Candy washing machine for £8 a month. The deal will help with the heavy financial penalty people on low incomes often pay for the purchase of large white goods.

Boosting resilience and building on strengths

A number of poverty-proofing toolkits, which have been produced by national agencies or other local authorities, have been reviewed by the working group. Following this exercise, Children North East (CNE) were engaged, as they are well regarded nationally for undertaking audits that mitigate the effects of poverty on young people. The CNE model is currently being completed at Cedar Mount Academy, and it is hoped that the learning from this audit can be shared across the city's schools.

As well as the stigma of poverty in schools, the group has also recognised that people experience the same stigma when accessing other services. In response to this, a poverty-proofing toolkit will be developed and the poverty-proofing work will be expanded to include the workforce of the Council and partner organisations to ensure that workforces are equipped to recognise the signs of poverty and how to signpost to appropriate support.

Anchor institutions

Anchor institutions have a key role to play in supporting families out of poverty. As well as being key stakeholders in the economy, they create and sustain a significant number of jobs, procure billions of pounds' worth of contracts through their procurement processes, and are rooted in the city.

To harness the role anchor institutions can play in tackling poverty, two breakfast round-table events were organised and hosted by the Deputy Leader, Councillor Sue Murphy. Both events were well attended and included representation from a broad range of sectors from across the city, including construction, finance, legal, culture, transport, health, and higher education.

The anchor institutions offered a number of new themes and ideas, which included the following:

- Changing the narrative around poverty – recognising that people living in poverty have a significant contribution to make to society
- More focused Corporate contribution, so that it is meaningful and has a tangible long-term impact on the city's priorities.

The anchor institutions would like a 'go to' platform or resource to enable them to target their efforts.

Manchester Poverty Truth Commission

The Manchester Poverty Truth Commission was launched in June 2019. The Poverty Truth Commission, which was developed in Glasgow, engages people who have lived experience of poverty with key civic and business leaders directly, to influence and inform policy change. People told their own powerful stories at the launch. It is intended that the work of the Manchester Poverty Truth Commission will complement the implementation of the Family Poverty Strategy and will support, inform and influence the work of the Core, the working groups, the Council and the Manchester Local Care Organisation to help the city tackle poverty.

The Family Poverty Strategy is a strategy for the city and all its partners. It is important to recognise that the causes and impact of poverty are structural and deep-seated. The initiatives outlined above have made a difference to the lives of individual families, but there is a need for a sustained effort over the long term to tackle family poverty in the city.

Ensuring the best outcomes for vulnerable children

The Our Manchester Strategy sets out the city's vision for Manchester to be in the top flight of world-class cities by 2025. Critical to the delivery of the vision is supporting the citizens of Manchester, which includes its children, young people and their families, to achieve their potential and benefit from the city's improving economic, cultural, and social capital.

The Children and Young People's Plan – Our Manchester, Our Children (2016–2020) – translates the Our Manchester priorities and the 64 'we wills' into a vision for 'building a safe, happy, healthy and successful future for children and young people'. This means:

- All children and young people feel **safe**, their welfare promoted and safeguarded from harm within their homes, schools and communities.
- All children and young people grow up **happy** – having fun, having opportunities to take part in leisure and culture activities, and having good social, emotional, and mental wellbeing. It also means that all children and young people feel they have a voice and influence as active Manchester citizens.
- The physical and mental **health** of all children and young people is maximised, enabling them to lead healthy, active lives, and to have the resilience to overcome emotional and behavioural challenges.
- All children and young people have the opportunity to thrive and achieve individual **success** in a way that is meaningful to them. This may be in their education, or in their emotional or personal lives.

The plan also highlights particular areas that Manchester is 'passionate' about achieving: ensuring children and young people live in safe, stable and loving homes; reducing the number of children and young people in care; ensuring children and young people have the best start in the first years of life; and ensuring children and young people fulfil their potential, attend a good school and take advantage of the opportunities in the city.

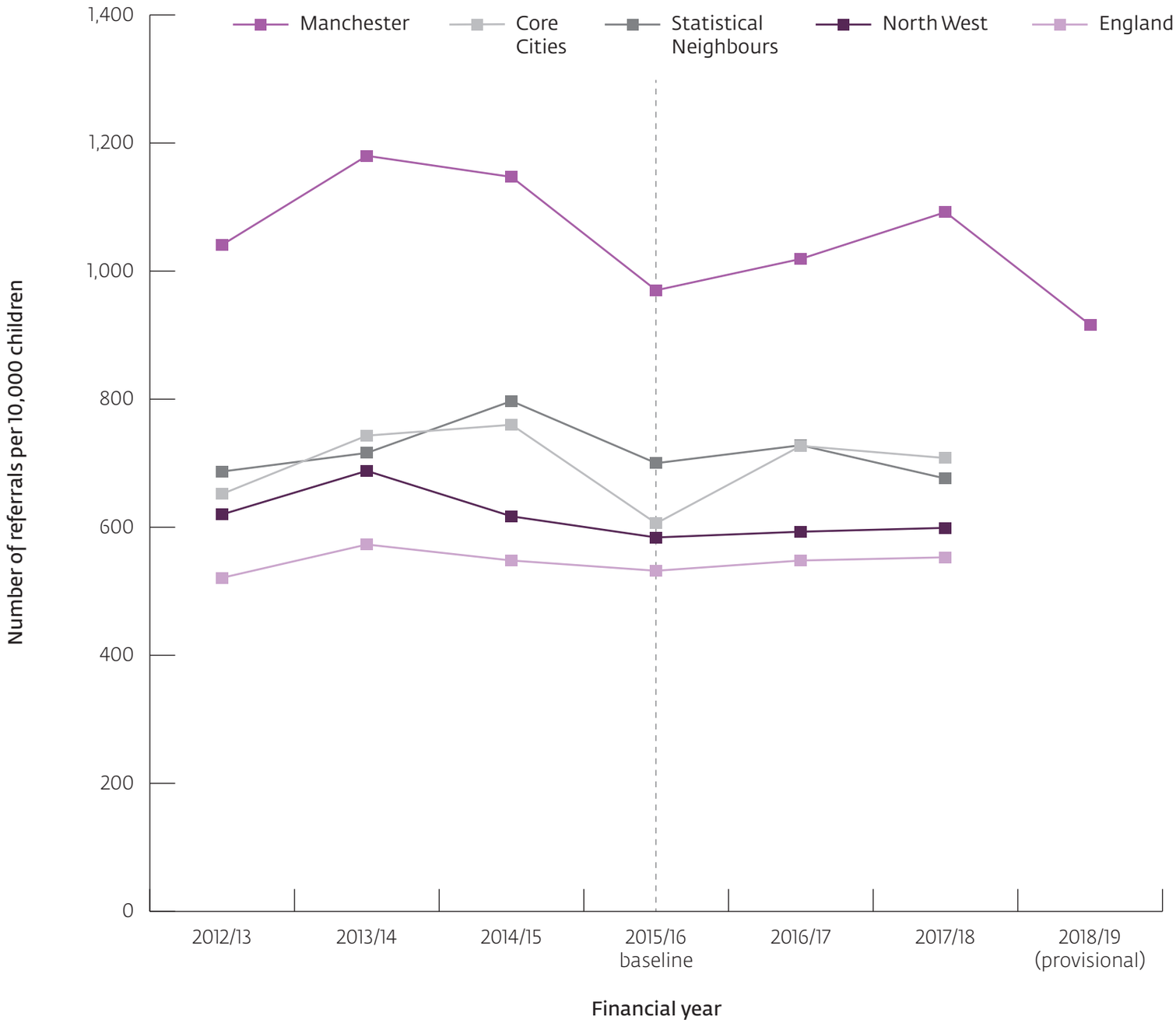
Since 2015, significant progress has been made within Children and Education Services in improving the services Manchester's children and young people receive. In November 2017, this resulted in Ofsted judging Children's Services to no longer be 'Inadequate'.

The delivery of Our Manchester and the Our Children Plan can only be achieved through strong partnerships. They can only be facilitated through effective leadership and management at a local level, and across the city there is a clear commitment to achieving positive outcomes for our children. The strength of the partnerships was recognised within Ofsted's inspection of the Children's Services in 2017, and again in a recent Peer Review undertaken by the Local Government Association (LGA in May 2019).

Referrals to Children's Services

The provisional 2018/19 rate of referrals of 916 per 10,000 children is the lowest rate for a number of years. However, Figure 4.4 shows that this rate is significantly above the national (553), regional (599), Core City (708), and statistical neighbour (676) averages for 2017/18.

Figure 4.4:
Rate of referrals per 10,000 of the child population aged under 18

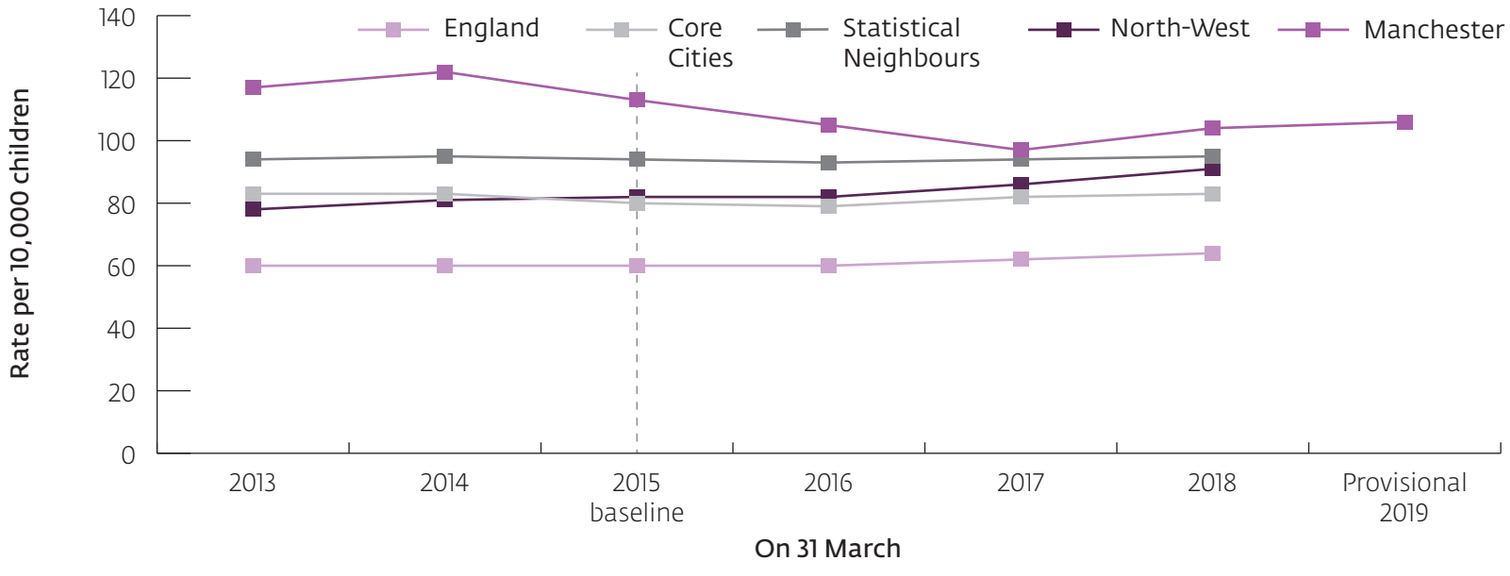


Source: Department for Education/MiCare

Looked After Children (LAC)

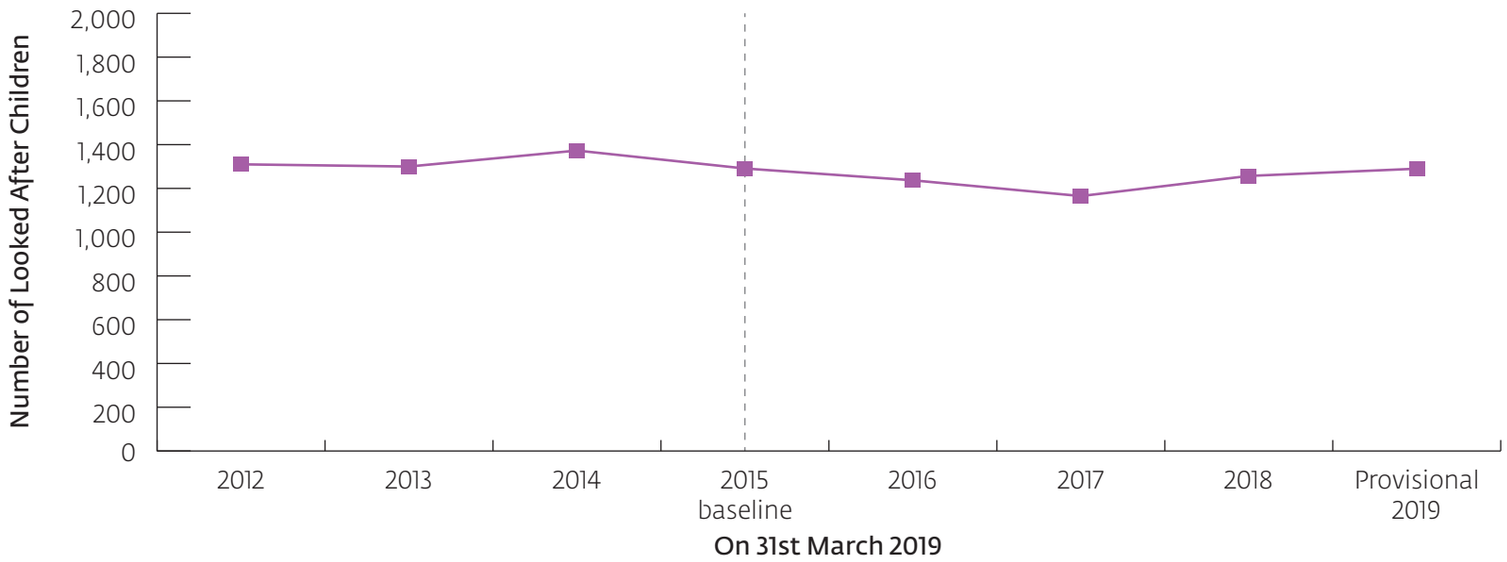
Figures 4.5 and 4.6 show that following a decrease between 2014 and 2017, the provisional number and rate of children looked after by the Council has continued to increase to 106 per 10,000 children in 2018/19, and remains above the national (64), regional (91), Core City (83) and statistical neighbour (95) averages for 2017/18. There were 1,290 Looked After Children at the end of March 2019 – a slight decrease from the 2015 baseline of 1,291. Although the rate of Looked After Children is consistently above comparator authorities, the increases are reflective of a national and regional trend.

Figure 4.5:
Rate of Looked After Children per 10,000 of the child population aged under 18 (on 31 March 2019)



Source: Department for Education

Figure 4.6:
Number of Looked After Children



Source: Department for Education

Essentially, the service takes a threefold approach to work to reduce the number of entrants into the care system and the length of time children spend in local authority care:

- Continuing and developing edge of care and rehabilitation interventions
- Improvements to care planning and practice
- Shifting and accelerating the approach to permanence earlier in the child's journey through the social care system.

Edge of Care

Children's Services employs a range of evidence-based interventions aimed at supporting families to remain together, where possible preventing the need for children to be taken into care, and when they are, ensuring a timely return home. These include Families First, Multi-Systemic Therapy, Multi-Treatment Foster Care, and the Adolescent Support Unit – Alonzi House.

Case Study: Alonzi House

Alonzi House provides outreach and respite for families with young people between the ages of 11 and 17 approaching crisis point and on the edge of care. Planned respite support is provided for children to support the family through difficult times, mitigating the risk of a crisis that may require a formal response. This allows most families to work through their problems and to stabilise their family situation so their children can remain at home.

Involvement with Alonzi House is on a voluntary basis, and families only accept this offer if they want to engage with the team. The voluntary nature of the service and the skills and ability of the team to engage families now means that families that previously resisted support and intervention now accept support from Alonzi House.

Support ensures children receive the help and encouragement they need to take part in positive activities, develop pro-social friendships, and access their education offer in order for them to reach their potential. Additionally. The unit is now delivering the Family Group Conferencing Programme, which brings extended family networks together when there is a risk of children entering the care system. This mediates issues, develops wider resilience and support, and empowers the family network.

Care planning and practice

Fundamentally, the approach to reducing the number of children entering the care system is based on early intervention and high-quality practice that assesses risk and issues and plans for sustainable change in the behaviour of families and individuals. Children's Services has a well-developed workforce development strategy that is working to deliver improved practice in the key areas. Ultimately, it will improve outcomes for all children – including those in care or at risk of being taken into care – through improvements such as risk assessment and SMART planning.

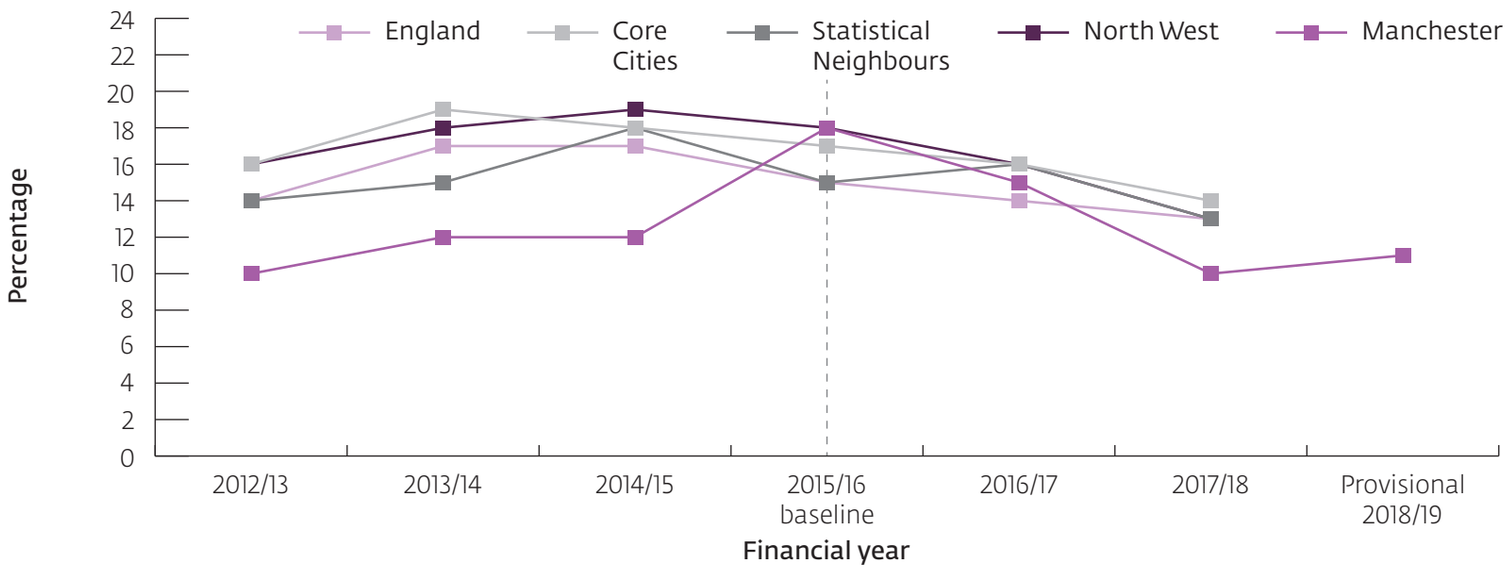
Permanence

Planning for a permanent 'forever home' for children begins with supporting them to remain within their family and community from the very first interaction with social-care services. This is the essence of reform being delivered by the service: to support children to remain within their family where it is 'safe' to do so, and to improve the timeliness in securing a permanent alternative arrangement for those who do become 'looked after'. It is essential that practice and the framework of policy and process that underpins it is focused on planning for and securing alternative solutions outside of the looked-after system as soon as possible, such as placement with family or friends through special guardianship orders or adoption; for some this will also include a long-term fostering arrangement. To promote this, the service has developed a new permanence policy and framework, alongside the ongoing workforce development strategy.

Percentage of children ceasing to be looked after during the year who were adopted

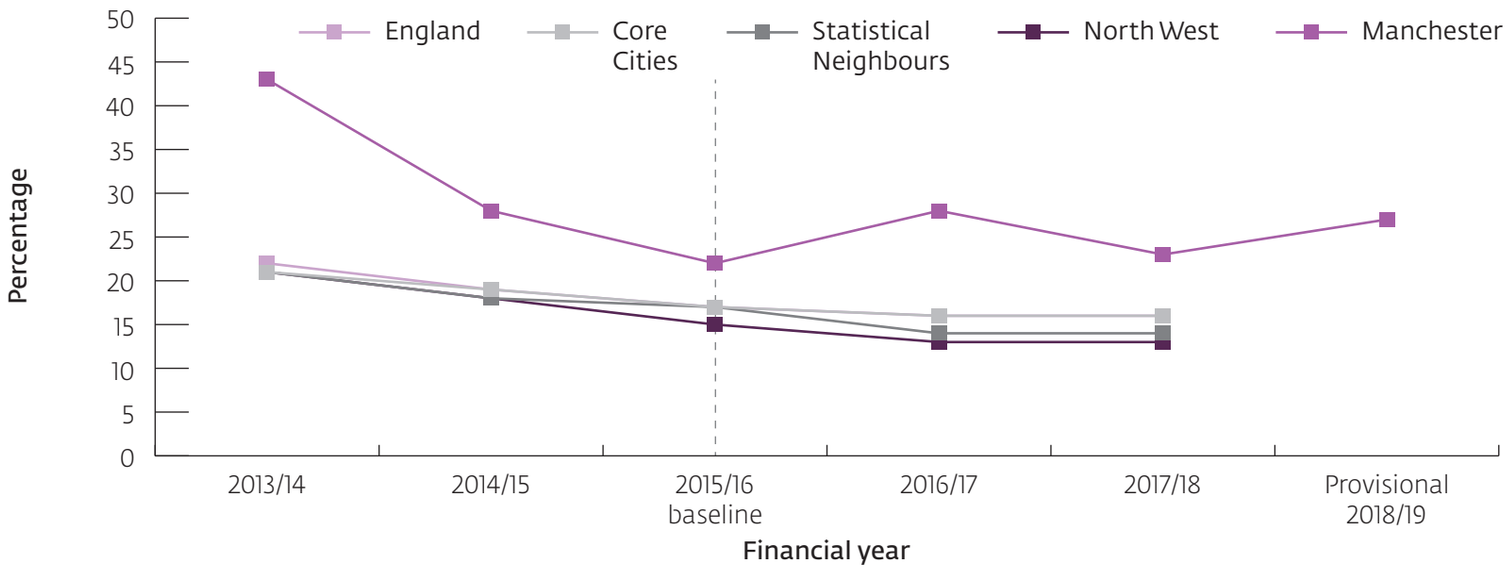
Figure 4.7 shows that the percentage of children ceasing to be LAC through adoption increased from 10% in 2017/18 to 11% in 2018/19. However, this remains lower than the 2015/16 baseline of 18%. Although the latest comparator figures are not yet available, the most recent national, regional and Core City average figures indicate rates have been falling since 2014/15.

Figure 4.7:
Percentage of children ceasing to be looked after during the year who were adopted



Source: Department for Education

Figure 4.8:
Percentage of care leavers aged 19–21 who were in unknown or unsuitable accommodation



Source: Department for Education

Percentage of care leavers aged 19–21 who were in unknown or unsuitable accommodation

Figure 4.8 shows that the percentage of care leavers aged 19–21 who were in unknown or unsuitable accommodation has increased from 22% in 2015/16 to 27% in 2018/19 (provisional figure). Manchester's performance remains below that of its comparator groups.

Like all local authorities, Manchester now has a duty to provide support for all care leavers aged up to 25 if they want it. In line with this, the Council has been reviewing its care leavers offer, with a strong focus on supporting young people to be independent, including ensuring that all care leavers have access to suitable accommodation.

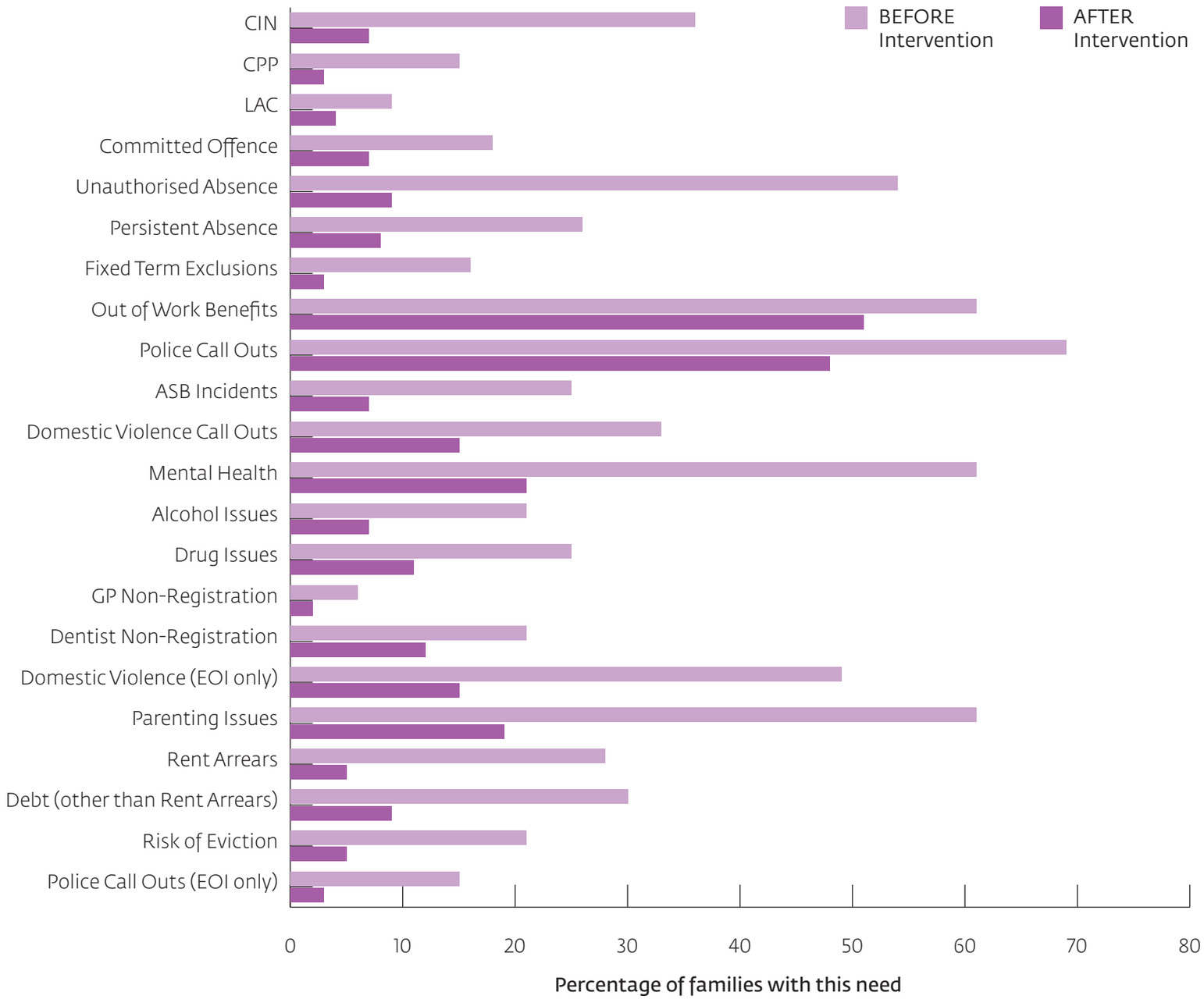
Early Help

Manchester has recently refreshed its strategic approach to Early Help. Our ambition, articulated in the Early Help Strategy (2018–2022), is that 'families, particularly those with multiple and complex needs, will have access to co-ordinated Early Help in accordance with need as soon as difficulties are identified. The offer is personalised, multi-agency and embedded within a whole-family approach. Children and young people in those families will live safe, happy, healthy and successful lives'.

A number of national reviews have identified that a focus on early intervention or prevention, Early Help, can both enable children, young people and their families to achieve their potential, and reduce demand on more reactive and expensive services.

In Manchester, we have measured the impact of our Early Help offer with a local evaluation. Figure 4.9 shows how a targeted offer of Early Help – this might be delivered by a school, early years setting, health or the local authority through an Early Help Assessment (EHA) – can make a significant difference to the lives of families in Manchester.

Figure 4.9:
Percentage of families with 'presenting need' vs percentage of those families with the 'presenting need' at 12 months post-intervention



Source: Manchester City Council, Performance and Intelligence Team. Based on 4,576 families who received support during the period 2012–2018. (EOI only) – End of Intervention only

Most importantly, the evaluation demonstrates that by offering support earlier and at the right time we can help a family sustain the progress they have made *12 months after* targeted support has ended. For example:

- Of the 54% of families who had a child with any unauthorised absence from school in the previous year, on average 84% had seen an improvement in their unauthorised absence 12 months after intervention.
- Of the 36% of families with a Child in Need (CIN) in the family, on average 81% of cases were successfully de-escalated by 12 months after intervention.

Finally, the national Troubled Families (TF) programme, which is fully integrated into our Early Help approach, comes to an end on 31 March 2020. The funding available for the successful delivery of the TF programme has been invested in supporting the delivery of the Early Help Strategy (2018–2022). To further integrate our approach, we will:

- Continue to grow the multi-agency offer of Early Help in the city through our locality-based Early Help Hubs, and other 'place-based' settings such as schools and children's centres
- Further develop an Early Help culture centred on positive behaviours such as strength-based conversations
- Promote the use of the Early Help Assessment as the tool to co-ordinate Early Help support around a family
- Create a visible and accessible Early Help offer through improved use of technology.

Integrating Health and Social Care

The key vision for Adult Social Care and Public Health in Manchester has been set out in the Manchester Locality Plan, **A Healthier Manchester**. This details the strategic approach to improving the health outcomes of the city's residents, while also moving towards financial and clinical sustainability of health and care services.

The Locality Plan builds upon the Manchester Strategy which, in turn, is underpinned by the **Joint Health and Wellbeing Strategy**, the city's overarching plan for reducing health inequalities and improving health outcomes for Manchester residents. The Locality Plan sets out how this transformation will be delivered. The plan is supported by growth, development of skills, education, early years, improved housing, and employment. Partners working across Manchester in businesses, the public sector, the voluntary sector and communities all have a role to play in making Manchester the best it can be.

A Healthier Manchester embodies the Our Manchester approach. It promotes:

- A stronger emphasis on prevention and enabling self-care, with people as active partners in their health and wellbeing
- A strength-based approach to assessment that focuses on what matters to the person
- The development of and connection to assets in communities that support people's health and wellbeing.

The 2018/19 refresher of the Locality Plan identified five strategic aims:

- Improve the health and wellbeing of people of Manchester
- Strengthen the social determinants of health and promote healthy lifestyles
- Ensure services are safe, equitable and of a high standard, with less variation
- Enable people and communities to be active partners in their health and wellbeing
- Achieve a sustainable system.

These aims are set within the context of the challenging and ambitious vision incorporated in the Our Manchester Strategy. This sets out the vision for the city to be in the top flight of world-class cities by 2025. To make this a reality, the health and care system will work together in a more joined-up way.

Manchester Health and Care Commissioning (MHCC) was established in April 2017, and has been responsible for the overall co-ordination of commissioning responsibilities for health, adult social care and public health for the past two years. In April 2018, the Manchester Local Care Organisation (MLCO) was launched. This is a milestone in terms of achieving the overall goal of bringing together community health, social care, primary care and mental health services in the city. The MLCO will ensure that people who are vulnerable or unwell get the right kind of help at the right time and in a more integrated manner.

The MLCO is a partnership that includes a range of organisations that provide community health, primary care and mental health services, including the Council's social-care services. It will join up the care that Mancunians get to help keep them out of hospital, and it will also help to enable them to live independently. It will transform how residents experience their community-based health and social care. It will reduce duplication, meaning that different organisations will talk to each other about a patient's care. It will help break down boundaries between different organisations and ensure that there's a smooth process for helping people in their homes when they are in recovery or dealing with long-term health issues.

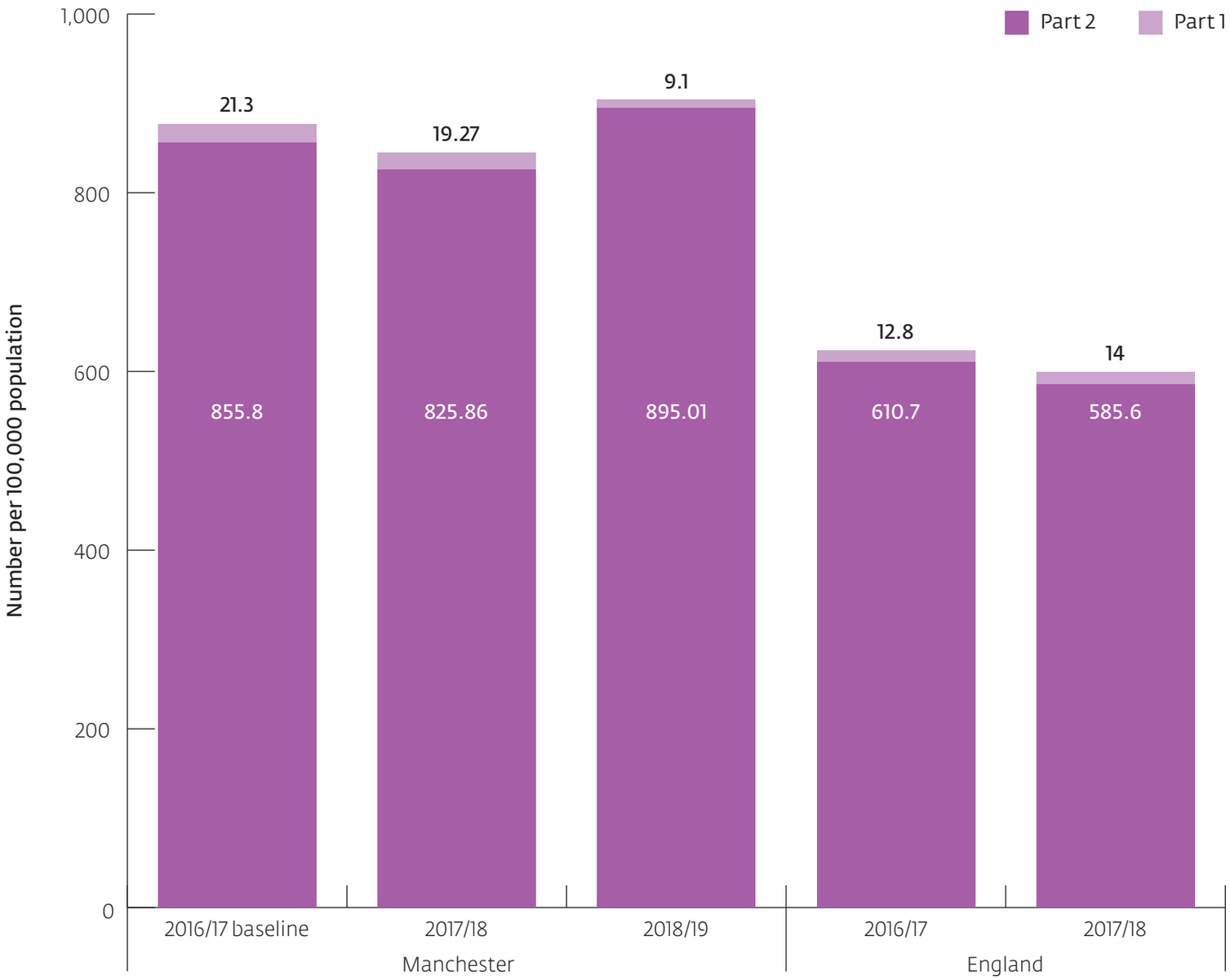
Some community-based health and social-care staff will be working collaboratively within MLCO, with other community-based staff joining them over the next few years. Getting the health and social-care basics right is crucial to our city's success. It has an impact on every one of the Our Manchester goals we're all working towards for 2025.

Supporting older people to live independently for longer

New admissions to local authority-supported permanent residential/nursing care

Figure 4.10 shows that the rate of those aged 18–64 admitted to permanent residential/nursing care was 9.10 per 100,000 in 2018/19; this is a significant decrease from the 2016/17 baseline of 21.30 per 100,000. The rate of those aged 65 and over admitted to permanent residential/nursing care was 895.01 per 100,000 in 2018/19; this is an increase from the 2016/17 baseline of 855.80 per 100,000.

Figure 4.10:
Long-term support needs of younger adults (aged 18–64) (part 1) and older adults (aged 65+) (part 2) met by admission to residential and nursing care homes, per 100,000 population



Source: ASCOF (2A parts 1 and 2), Department of Health, Adult Social Care Outcomes Framework 2018/19.
England 2018/19 figures not published until October 2019

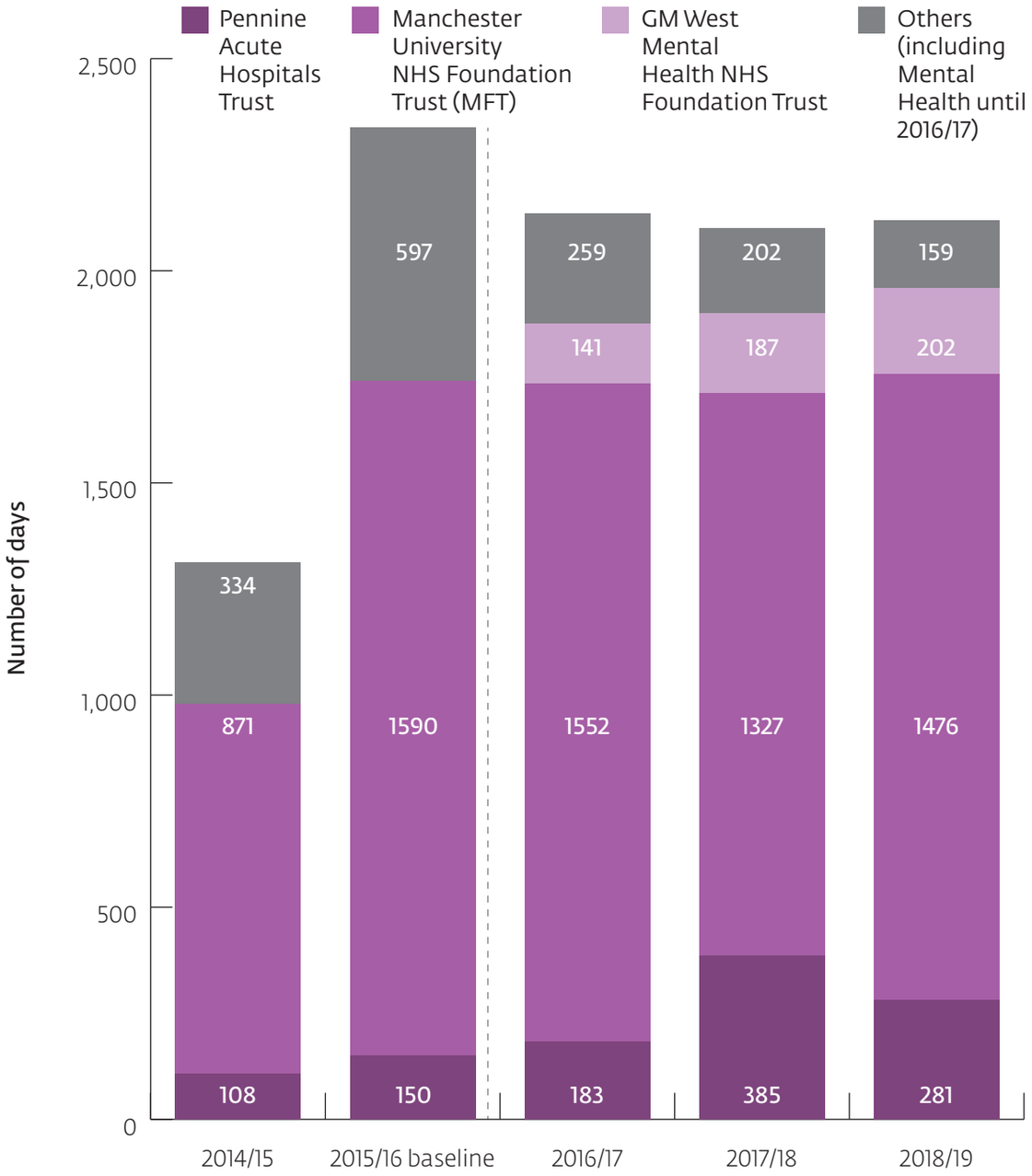
Delayed transfers of care

During the latter part of the financial year 2017/18, significant efforts were made to achieve the citywide target of no more than 3.3% of people experiencing a delayed transfer of care across the three hospital sites.

Figures from Thursday 28 March 2019 show that 5% of people experienced a delayed transfer of care at Central Manchester University Hospitals (central), compared to 3.2% at North Manchester General Hospital (north) and 3.3% at University Hospital South Manchester (south).

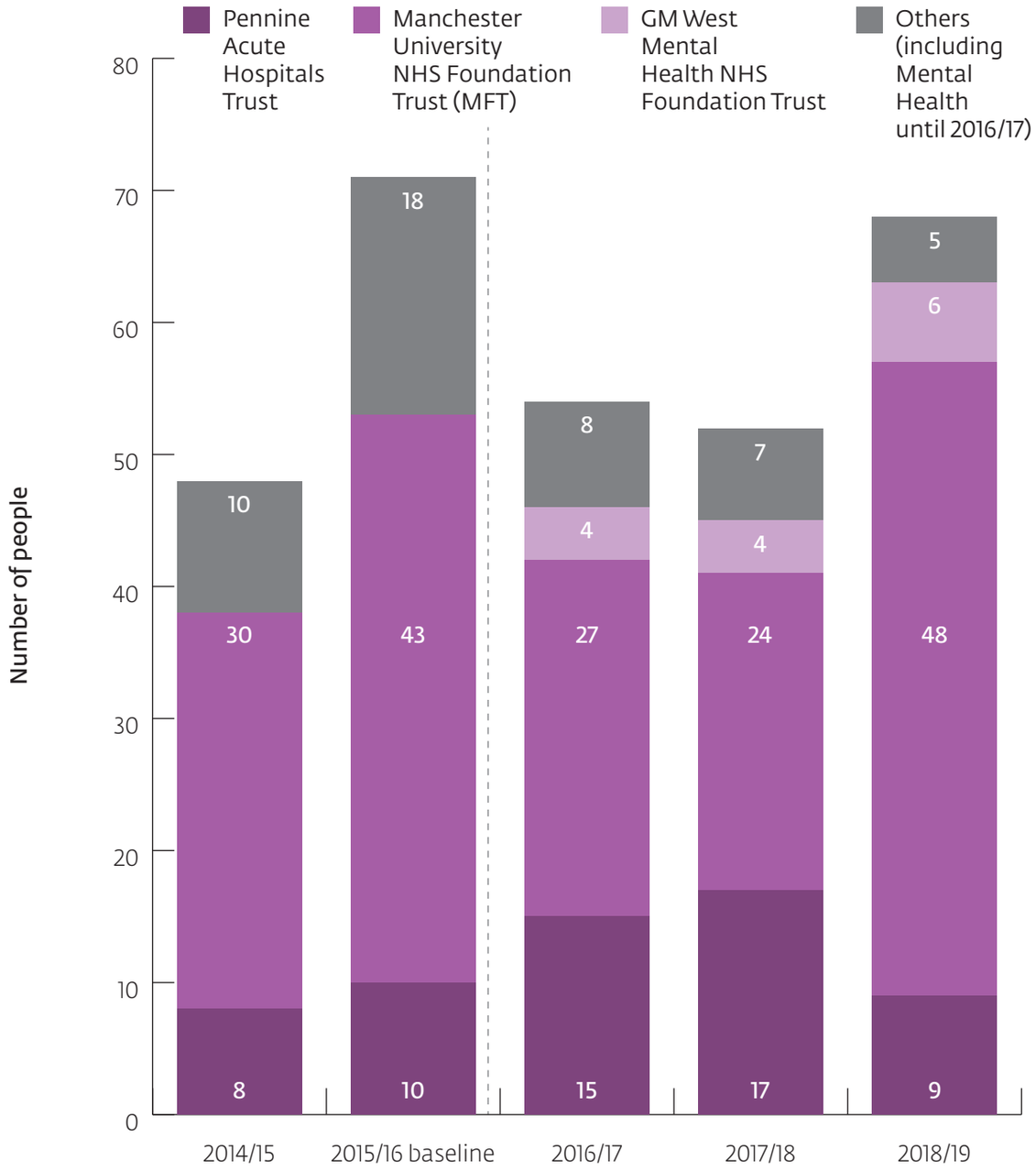
Figures 4.11 and 4.12 show that both the number of people delayed and the number of days delayed have risen slightly. On Thursday 28 March 2019, a total of 68 people were delayed for a total of 2,118 days between them.

Figure 4.11:
Delayed transfers of care (acute and non-acute delays): number of days delayed on Thursday 28 March 2019



Source: UNIFY2, NHS England

Figure 4.12:
Delayed transfers of care (acute and non-acute delays): number of people delayed on Thursday 28 March 2019

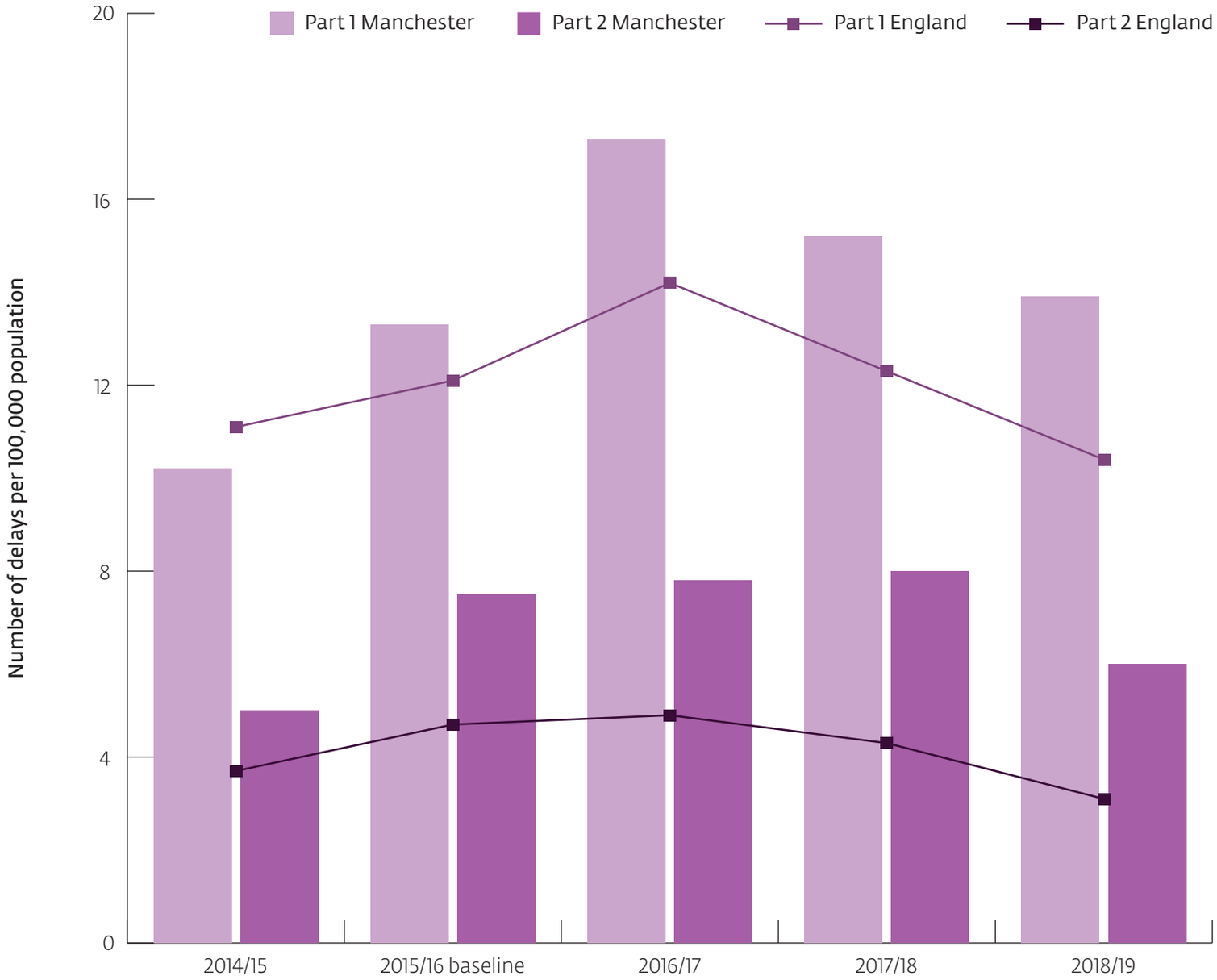


Source: UNIFY2, NHS England

The number of delayed transfers of care (for those aged 18 and over), based on the average of 12 monthly snapshots on the last Thursday of each month (part 1), has decreased over the past two years. In Manchester, the number of delayed transfers of care fell from 17.3 per 100,000 in 2016/17 to 13.9 per 100,000 in 2018/19 (Figure 4.13).

The average number of delayed transfers of care (for those aged 18 and over) attributable to social care or jointly to social care and the NHS, based on the average of 12 monthly snapshots on the last Thursday of each month (part 2), has also fallen over the past two years – from 7.8 per 100,000 in 2016/17, to 6.0 per 100,000 in 2018/19 (Figure 4.13).

Figure 4.13:
Delayed transfers of care from hospital (part 1), and those attributable to adult social care (part 2) per 100,000 population



Source: NHS England

Achieving timely safe and effective discharges requires effective partnership working across the whole health and social-care system, including ward, community and hospital discharge teams. For patients with multiple health and social-care needs this can be challenging, due to the numbers of professionals and organisations required to be involved in decision-making regarding future care. In addition, it is essential that citizens and their families are fully involved in the process and any decisions made regarding future care and actions required.

There is a continued effort to reduce delayed transfers of care, and work is under way to develop an integrated discharge team in the south of the city that will focus on a discharge-to-assess model, with Adult Social Care being a strong partner within the team. In addition, Adult Social Care's commitment to supporting people to return home safely has led to the creation of several apartments across the city to support people to get home safely, and with reduced dependence upon residential settings/care.

Improving health outcomes

In March 2018, the Manchester Health and Wellbeing Board and Manchester Health and Care Commissioning (MHCC) Board approved the Manchester Population Health Plan (2018–2027) – a long-term plan to tackle Manchester's entrenched health inequalities. Five priority areas for action have been identified to be delivered over the lifetime of the plan. These are:

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

The Plan is now the overarching health and wellbeing strategy for the city, under the governance of the Health and Wellbeing Board, and reflects the ambition of the Our Manchester Strategy. It aims to build on the successes and achievements of the past 20 years, while recognising that the population health challenges facing Manchester are considerable. The establishment of Manchester Health and Care Commissioning (MHCC), the Manchester Local Care Organisation (MLCO), and the Single Hospital Service (SHS) offers a real opportunity to break the cycle of health inequalities in Manchester and deliver prevention programmes at scale.

In the past year, good progress has been made in a number of areas. Manchester saw small (but not statistically significant) increases in life expectancy at birth for both men and women, as well as increases in Healthy Life Expectancy. The rate of alcohol-related admissions has fallen, and the proportion of cancers in Manchester diagnosed early has increased. Reducing the under-18 conception rate continues to be a success story, as the number of under-18 conceptions in Manchester fell below 200 a year for the first time in 2017. There has also been a significant reduction in the rate of suicides and injuries of undetermined intent.

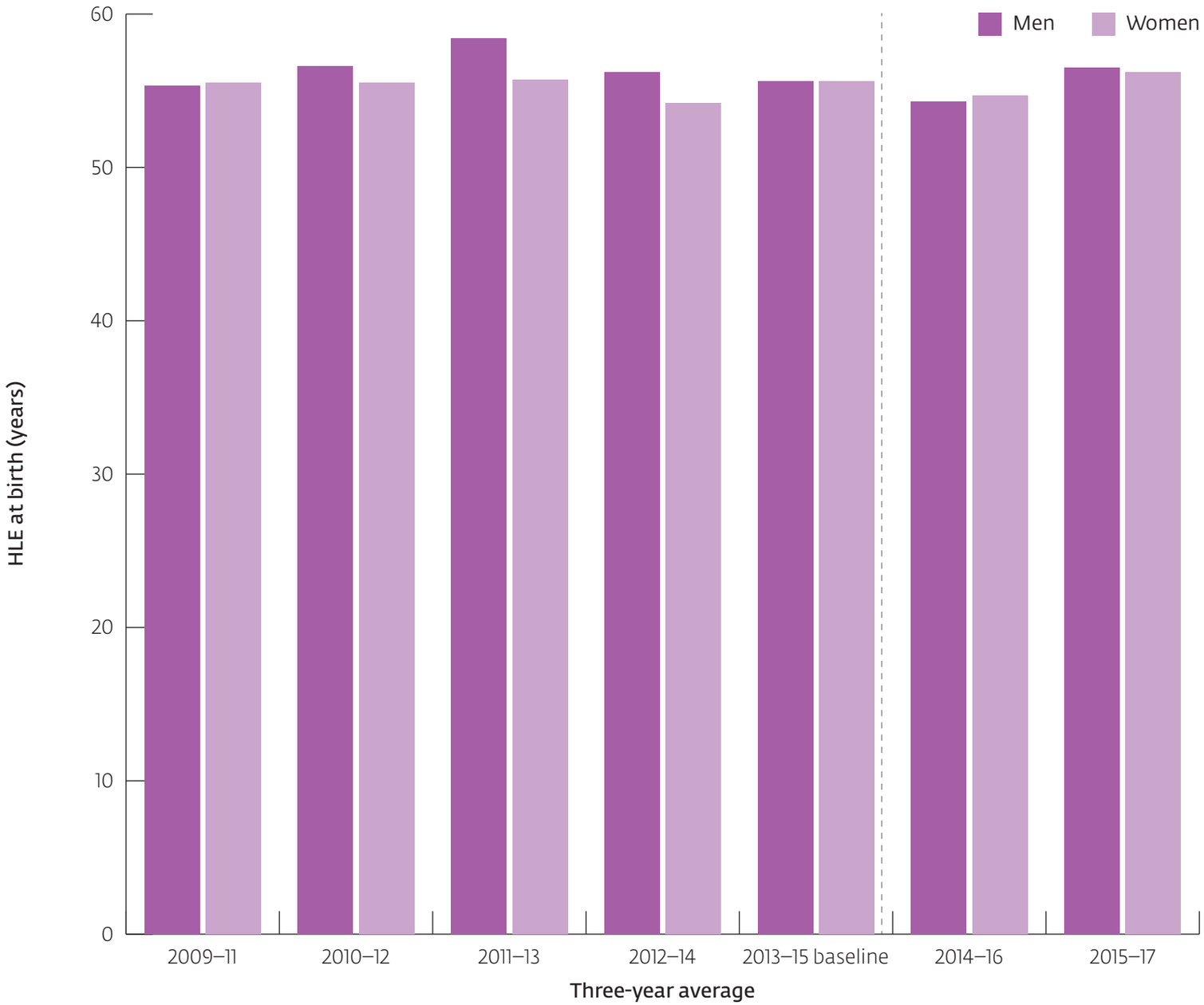
Despite these improvements, Manchester still has some of the worst health outcomes in the country. There are also significant inequalities within the city: in the most-deprived areas of Manchester, life expectancy is 8.1 years lower for men and 7 years lower for women than in the least-deprived areas.

Healthy life expectancy at birth (overarching indicator)

Healthy Life Expectancy (HLE) is a measure of the average number of years a person would expect to live in good health based on current mortality rates and the prevalence of self-reported good health. Estimates of healthy life expectancy are calculated using health-state prevalence data from the Annual Population Survey (APS), combined with mortality data and mid-year population estimates for each period (eg. 2015 to 2017).

The Office of National Statistics (ONS) has recently revised its estimates of healthy life expectancy using a new method; this is designed to address the current weakness of small sample sizes producing somewhat erratic health-state prevalence estimates across the age distribution in areas with smaller populations. The figures in this report may therefore differ from those cited in previous years.

Figure 4.14:
Healthy life expectancy at birth, 2009–11 to 2015–17



Source: Office for National Statistics © Crown Copyright 2018

Historical trends show that the improvements in healthy life expectancy (HLE) at birth seen in the early part of this decade had started to level off and fall slightly, particularly among men.

However, according to the latest published data (for 2015–17) in Figure 4.14, HLE at birth in Manchester increased for both men and women compared with the previous three-year period (2014–16). In men, the average number of years a person would expect to live in good health has increased from 54.3 years to 56.5 years, and in women it has increased from 54.7 years to 56.2 years. This represents a statistically significant increase of 2.2 years for men and a small but not statistically significant increase of 1.5 years for women. This compares to an increase of 0.1 for men and no change for women in England (HLE of 63.4 and 63.8 years respectively).

The increase in HLE for men in Manchester is greater than that for women, which means that men can now expect to live longer in good health than women.

Improving outcomes in the first 1,000 days of a child's life

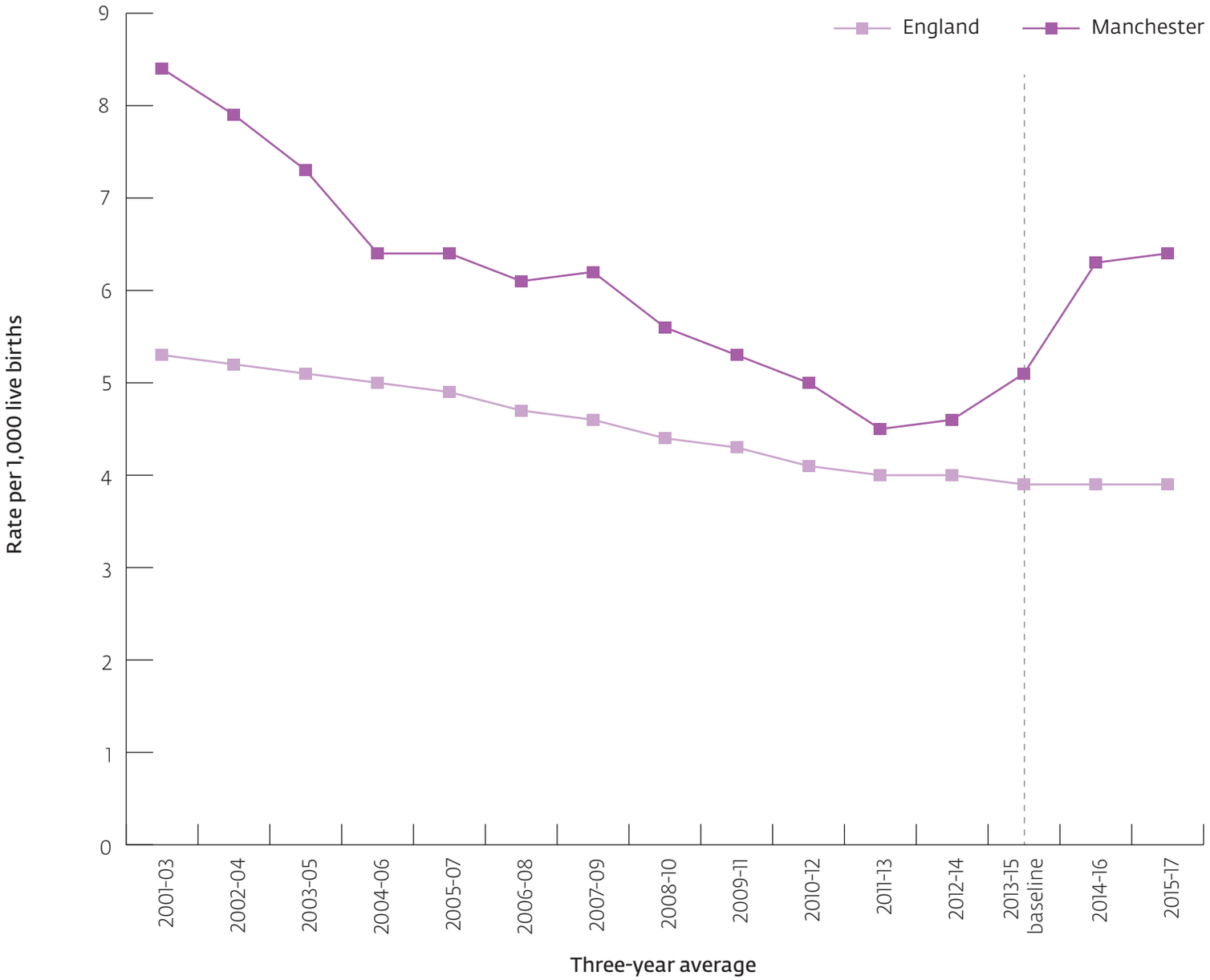
Infant deaths

Infant deaths (ie. deaths of children aged under one year of age) are an indicator of the general health of the entire population. They reflect the relationship between causes of infant mortality and other determinants of population health, such as economic, social and environmental conditions. Deaths during the first 28 days of life (the neonatal period) are considered to reflect the health and care of both mother and new-born child.

The infant mortality rate in Manchester has fallen substantially since the early 1990s. Between 1999–2001 and 2014–16, the rate fell by 32%. This is partly due to general improvements in healthcare, combined with specific improvements in midwifery and neonatal intensive care. However, in more recent years, the infant mortality has shown a worrying increase (although it still remains low in historical terms). Between the periods of 2011–13 and 2014–16, the infant mortality rate rose by 39%, despite the fact that the total number of live births in the city has remained relatively stable.

In that context, it is encouraging to note that the latest published data for 2015–17 shows some slowing of the rate of increase in the infant mortality rate for the city (Figure 4.15). Between 2013–15 and 2014–16, the infant mortality rate increased by 23.5%. Between 2014–16 and 2015–17, the rate of increase was just 1.6%.

Figure 4.15:
Infant mortality (number of infant deaths under one year of age per 1,000 live births)



Source: Office for National Statistics © Crown Copyright 2018

Reducing infant mortality is a complex picture of interrelated factors. Some of these factors are modifiable risks, such as maternal smoking, obesity in pregnancy, and parental/household smoking; others act as protective barriers that prevent infant deaths, including flu vaccination for pregnant women, breastfeeding and safe-sleeping practices (such as putting babies to sleep on their backs in a separate cot or Moses basket in the same room as parents).

In order to try to reverse the infant mortality trends in Manchester and ensure that those who experience baby loss get the support they need, a new multi-agency **Reducing Infant Mortality Strategy** has been launched. The strategy spans five years (2019–2024), allowing time for long-term outcomes to be realised. The implementation of the strategy will be overseen by a steering group that includes key partners with a role to play in the delivery of the strategy; they influence others, such as maternity services, health-visiting services, strategic housing, Early Help, early years, the Child Death Overview Panel (CDOP), safeguarding, and the voluntary and community sector.

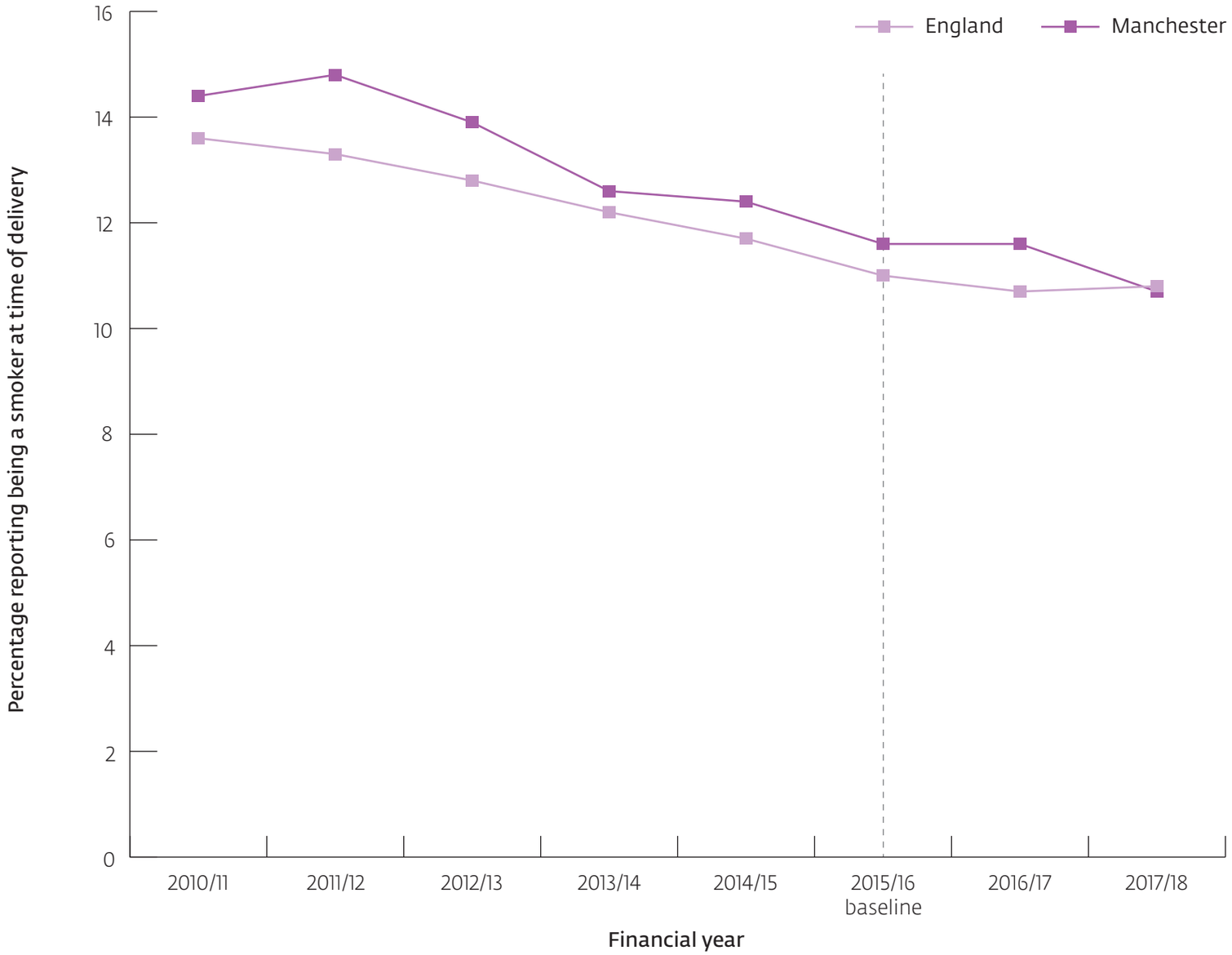
The strategy is a clear indication of the collective commitment of organisations in the city to ensure that the recent rise in infant mortality is reversed. By co-ordinating efforts across the city, we are confident that we can start to see a downward trend once again.

Smoking in pregnancy

Smoking during pregnancy can cause serious health problems for the mother and baby, including complications during pregnancy and labour. Smoking during pregnancy carries an increased risk of miscarriage, premature birth, stillbirth, low birth weight, and sudden unexpected death in infancy.

In 2017/18, 10.7% of mothers in Manchester reported that they were a smoker at the time their baby was delivered, compared with 10.8% of mothers across England as a whole. The percentage of mothers smoking at the time of delivery in Manchester has fallen from a peak of 14.8% in 2011/12, and the local rate is now on a par with the England average (Figure 4.16).

Figure 4.16:
Smoking status at time of delivery (percentage of women who reported being a smoker at the time of delivery)



Source: NHS Digital © Copyright 2018

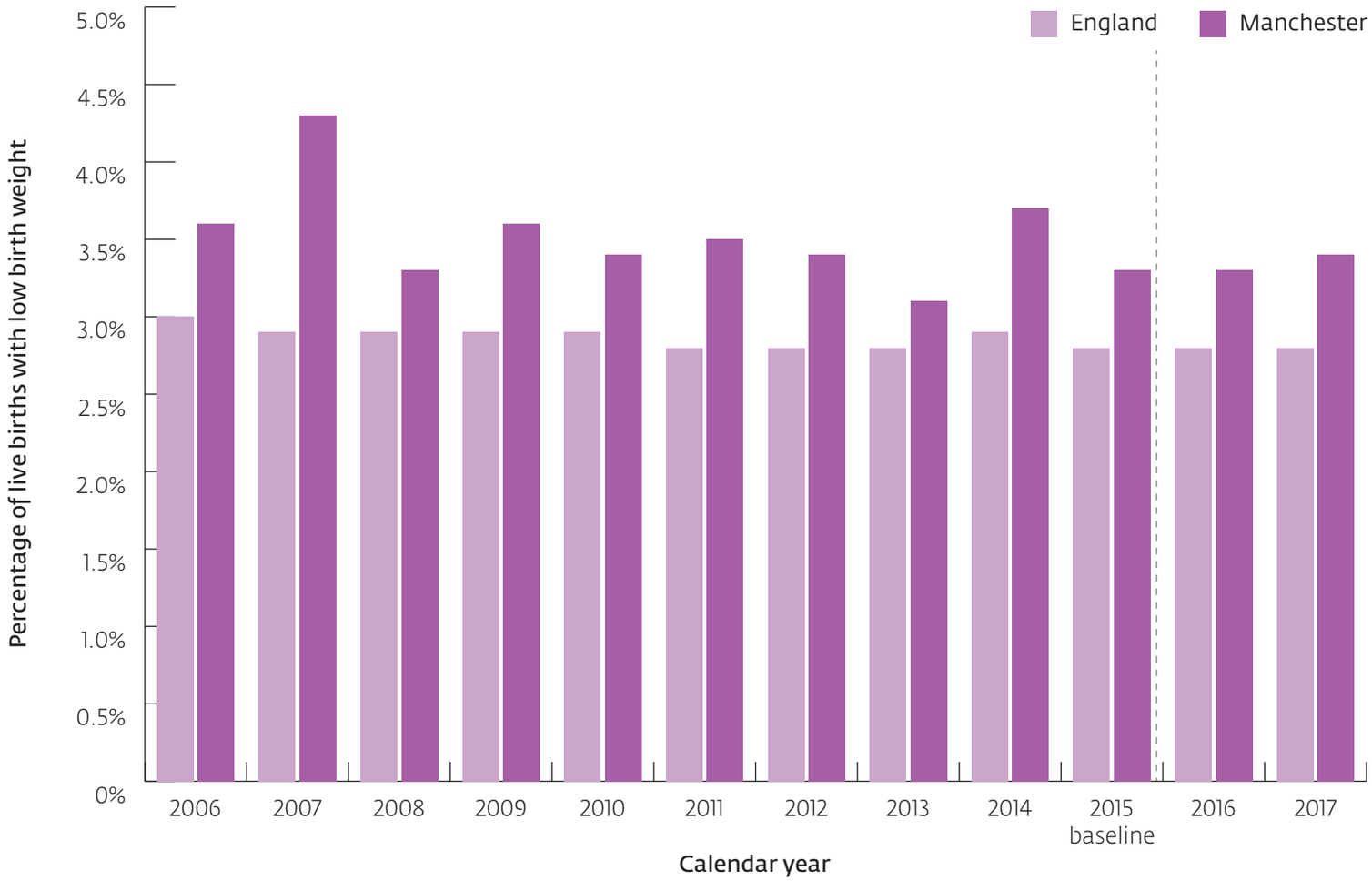
A Smoking in Pregnancy Programme is currently running in north Manchester, through which all pregnant women are referred to the Be Well Stop Smoking Service. The programme is also running in central and south Manchester. A new Specialist Midwifery post has been funded alongside free nicotine replacement therapy (NRT) for all pregnant women who smoke in central and south Manchester. This approach has been co-designed by the Population Health and Wellbeing Team, GM and St Mary's Hospital, and is very innovative because all treatment is given within maternity services. The effectiveness of the programme and quit rates will be carefully monitored.

Low birth weight of term babies

Low birth weight increases the risk of childhood mortality and developmental problems for the child, and is also associated with poorer health in later life. A high proportion of low birth weight births could also indicate poor lifestyles among pregnant women and/or issues with the maternity services.

Figure 4.17 shows the proportion of babies born to term (ie. a gestational age of at least 37 complete weeks) with a recorded birth weight under 2,500g. Despite year-on-year variations, historical trends point towards an overall reduction in the proportion of low weight births of term babies in Manchester, from a peak of 4.3% of term babies in 2007 to a figure of 3.4% in 2017.

Figure 4.17:
Low birth weight of term babies (live births with a recorded birth weight under 2,500g and a gestational age of at least 37 complete weeks)



Source: Office for National Statistics © Crown Copyright 2018

Implementing the Reducing Infant Mortality Strategy should lead to a reduction in low birth weight babies through a focus on supporting the health and wellbeing of pregnant women, improving quality, safety and access to services, and addressing the wider determinants of health.

Hospital admissions for dental decay in young children (0–5 years)

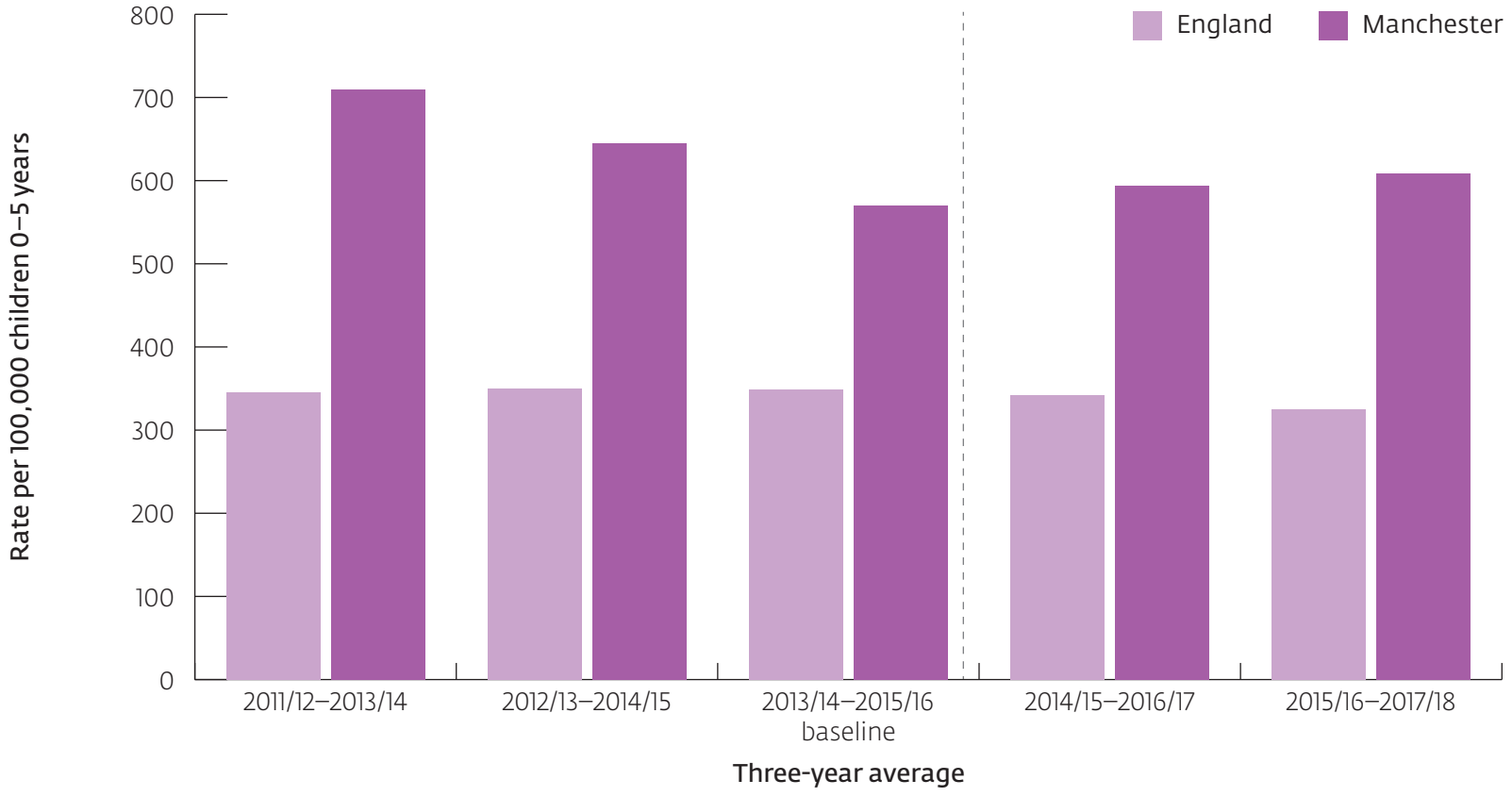
Dental caries (tooth decay) results in destruction of the crowns of teeth and often leads to pain and infection. Tooth decay is more common in deprived communities, and the prevalence of decay is a good direct measure of dental health, as well as an indirect proxy measure of child health and diet.

This indicator measures the number of children aged 5 and under who are admitted to hospital as a result of tooth decay. No assumptions can be made about the method of anaesthesia provided for these procedures, but it is likely that the majority of episodes of treatment will involve a general anaesthetic. In order to produce more reliable figures, a three-year average is reported.

The national definition of this indicator has been expanded to include five-year-old children; the indicator is therefore not directly comparable with the figures included in previous reports, which focused on children aged 0–4 years only.

Figure 4.18 shows the rate of children aged 5 and under admitted to hospital for tooth decay in Manchester fell dramatically, from 709.3 per 100,000 in the three-year period 2010/11–2012/13, to 569.6 in the three-year period 2013/14–2015/16. However, the rate has increased over the past two data periods to 594.3 in 2014/15–2016/17 and 608.5 in 2015/16–2017/18. The average number of children admitted for this condition each year has increased from 259 to 282.

Figure 4.18:
Hospital admissions for dental caries in children aged 0–5 years



Source: Hospital Episode Statistics (HES). Copyright © 2019, Reused with the permission of the Health and Social Care Information Centre. All rights reserved.

It should be noted that this data may be an underestimate of the true number of hospital admissions for this procedure in young children, because in some instances the Community Dental Service may provide the extraction service in hospital premises. These episodes of treatment may not be included in the published figures.

The Oral Health Improvement Team (OHIT) provides and supports a range of interventions that aim to provide oral health education alongside the means to improve self-care behaviour for different groups in the population, with a primary focus on children under 11 years of age. The OHIT delivers oral health improvement interventions that target the most vulnerable groups of children in the city, including deprived communities, looked after children, children with special needs, and homeless families with children. Examples of this work include the daily supervised toothbrushing scheme (The Brush Bus) and the Buddy Practice Scheme, which aims to increase attendance among preschool children and their families by linking schools and primary care dental practices.

Other measures of the health of children and young people

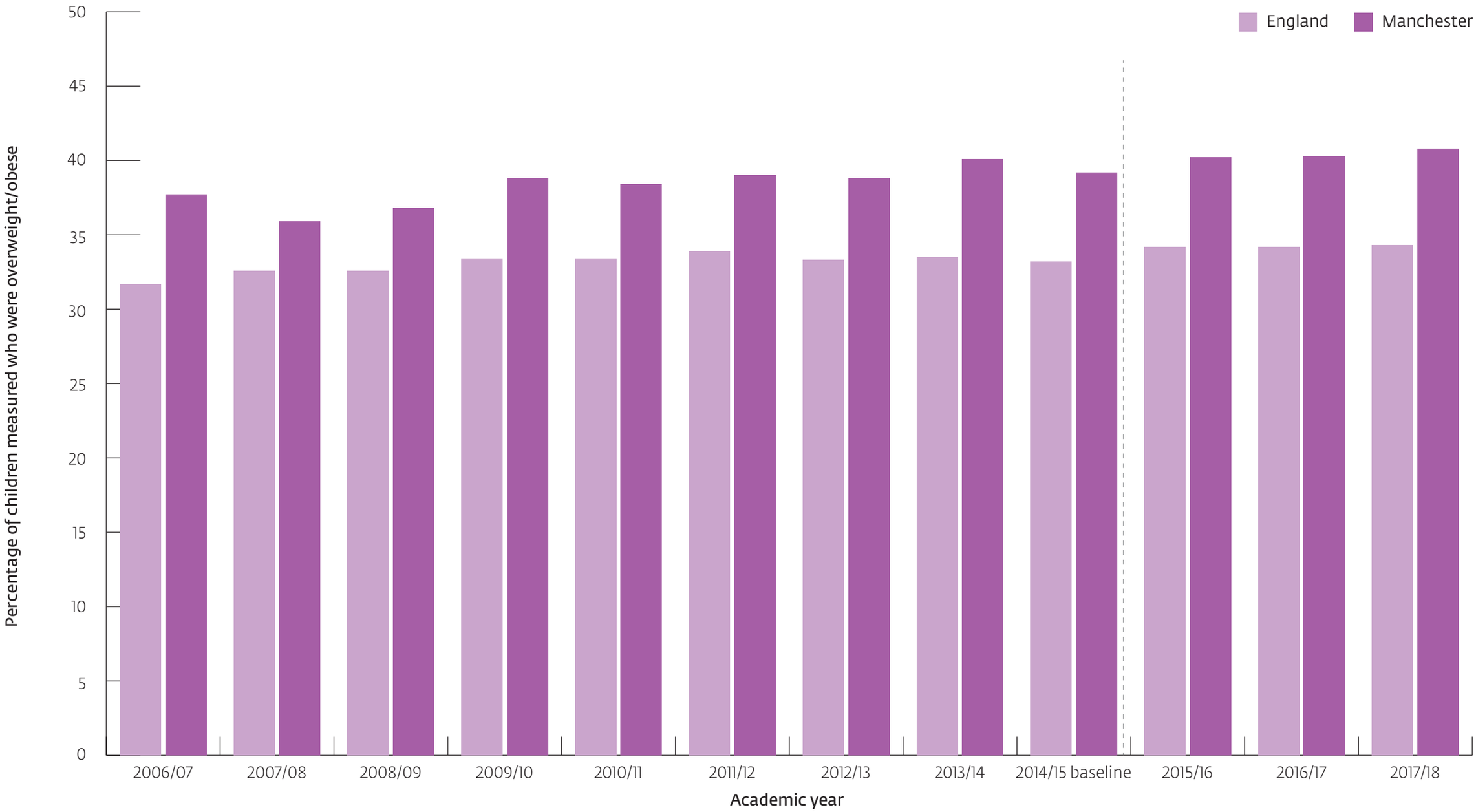
Excess weight in children at year 6 (10–11 years)

The health consequences of excess weight in childhood are significant and have implications for levels of overweight and obesity in adulthood.

This indicator measures the proportion of children in Year 6 (aged 10–11) classified as overweight or obese through the National Child Measurement Programme (NCMP). Children are classified as overweight or obese if their Body Mass Index (BMI) is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

Data for the most recent year (2017/18) shows that the proportion of children in Year 6 classified as overweight or obese has increased very slightly since the previous year (from 40.3% to 40.8%). Figure 4.19 shows that the rate of overweight or obese children in Manchester has shown a slight increase each year since the 2014/15 baseline, and there is little evidence of any significant increase or decrease in this measure over the life of the NCMP. More positively, the data shows that the proportion of children who have been measured has increased, meaning that a greater number of overweight or obese children are being identified and referred to the appropriate services. This should mean that the risk of childhood obesity persisting into adulthood will reduce.

Figure 4.19:
Prevalence of overweight (including obesity) among children in Year 6



Source: NHS Digital, National Child Measurement Programme

The Population Health and Wellbeing Team commissions a community-based, multicomponent 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. The intensive phase programme lasts for 12 weeks. Following completion of the intensive phase, all participants receive appropriate ongoing support for at least 12 months.

The commissioned weight-management service also provides National Child Measurement Programme (NCMP) feedback for parents/carers of overweight and obese children and young people in reception and Year 6. The weight-management service is required to proactively follow up these parents/carers to engage the family in a weight-management programme provided by the service.

Physical activity is also 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).

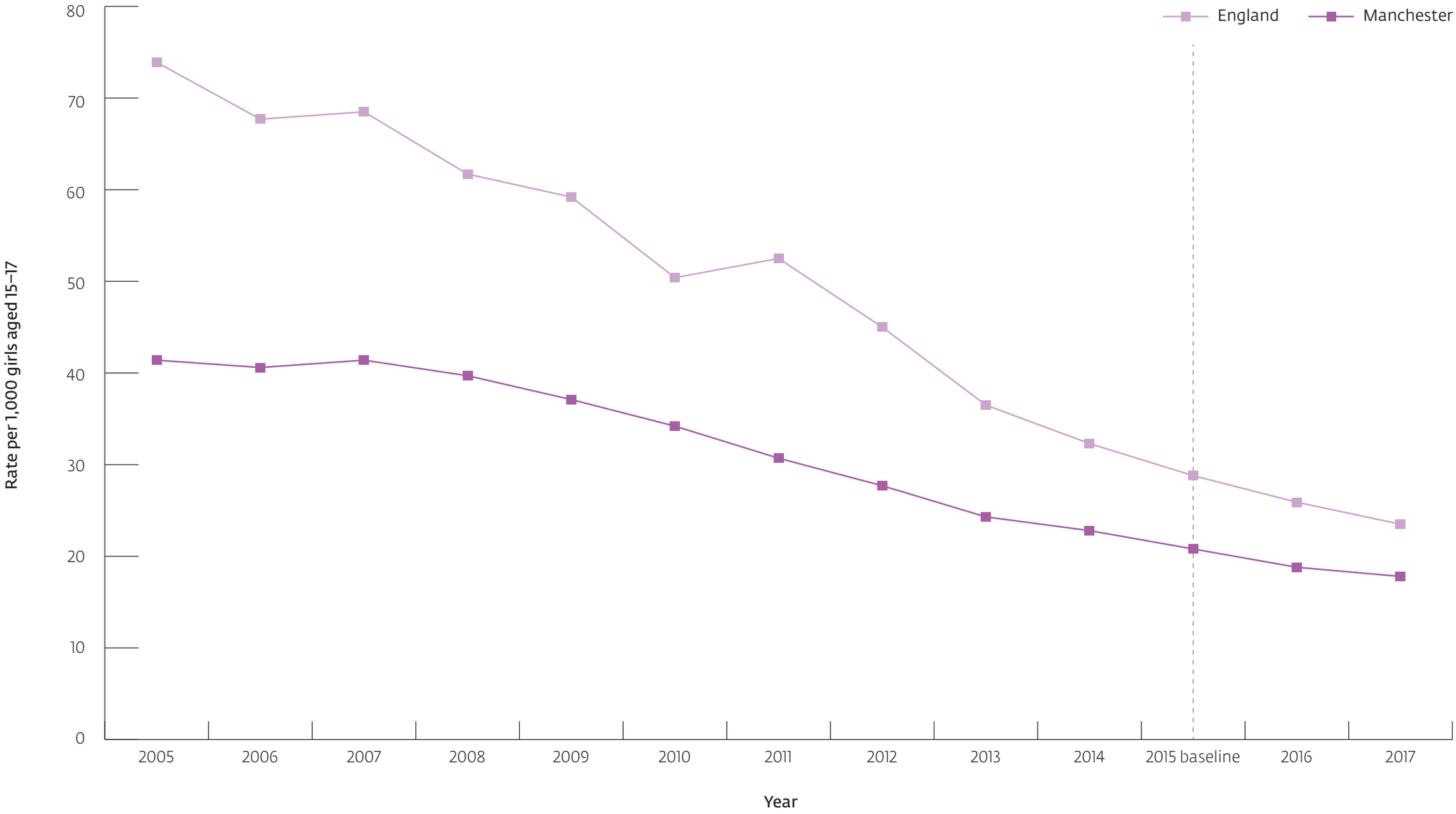
Under-18 conceptions

Most teenage pregnancies are unplanned, and while some young women find having a child when young can be a positive turning point in their lives, many more find that bringing up a child is extremely difficult. Unplanned teenage pregnancies often result in poor outcomes for both the parent and the child, in terms of the baby's health, the mother's emotional health and wellbeing, and the likelihood of both the parent and child living in long-term poverty.

Figure 4.20 shows that significant progress has been made in reducing the number and rate of under-18 conceptions in Manchester. The under-18 conception rate for Manchester has fallen from a peak of 73.9 per 1,000 in 2005 to 23.5 per 1,000 in 2017 (a reduction of 68%). However, this is still higher than the England rate of 17.8 per 1,000.

The number of under-18 conceptions fell from 591 in 2005 to 185 in 2017. This is the first time that the number of under-18 conceptions in Manchester has fallen below 200 a year.

Figure 4.20:
Under-18 conceptions (number of under-18 conceptions per 1,000 women aged 15–17 years)



Source: Office for National Statistics © Crown Copyright 2019

In line with the national trend, the proportion of under-18 conceptions ending in abortion has increased over the past decade, up from 40% in 2005 to 59% in 2017. In 2017, 109 under-18 conceptions ended in abortion and 76 resulted in a live birth.

Significant progress has been made in reducing both the number and rate of under-18 conceptions in Manchester. This has been achieved by strong local implementation of the long-term, evidence-based national Teenage Pregnancy Strategy, which was launched in 1999. The initial commitment to a ten-year strategy allowed for research and analysis to be undertaken that identified key factors for success. From the start, Manchester took a partnership approach to developing the Teenage Pregnancy Prevention work.

At the core of the work is a focus on ensuring consistent messages for young people across a range of different settings, alongside access to accurate advice and information and dedicated young people's services. This approach has had to adapt to changes across service areas and a changing demographic; it also now has to deal with emerging issues raised by young people themselves. Currently, activities are co-ordinated through the multi-agency Teenage Pregnancy Prevention and Support Programme.

Supporting people, households and communities to be socially connected, and making changes that matter to them

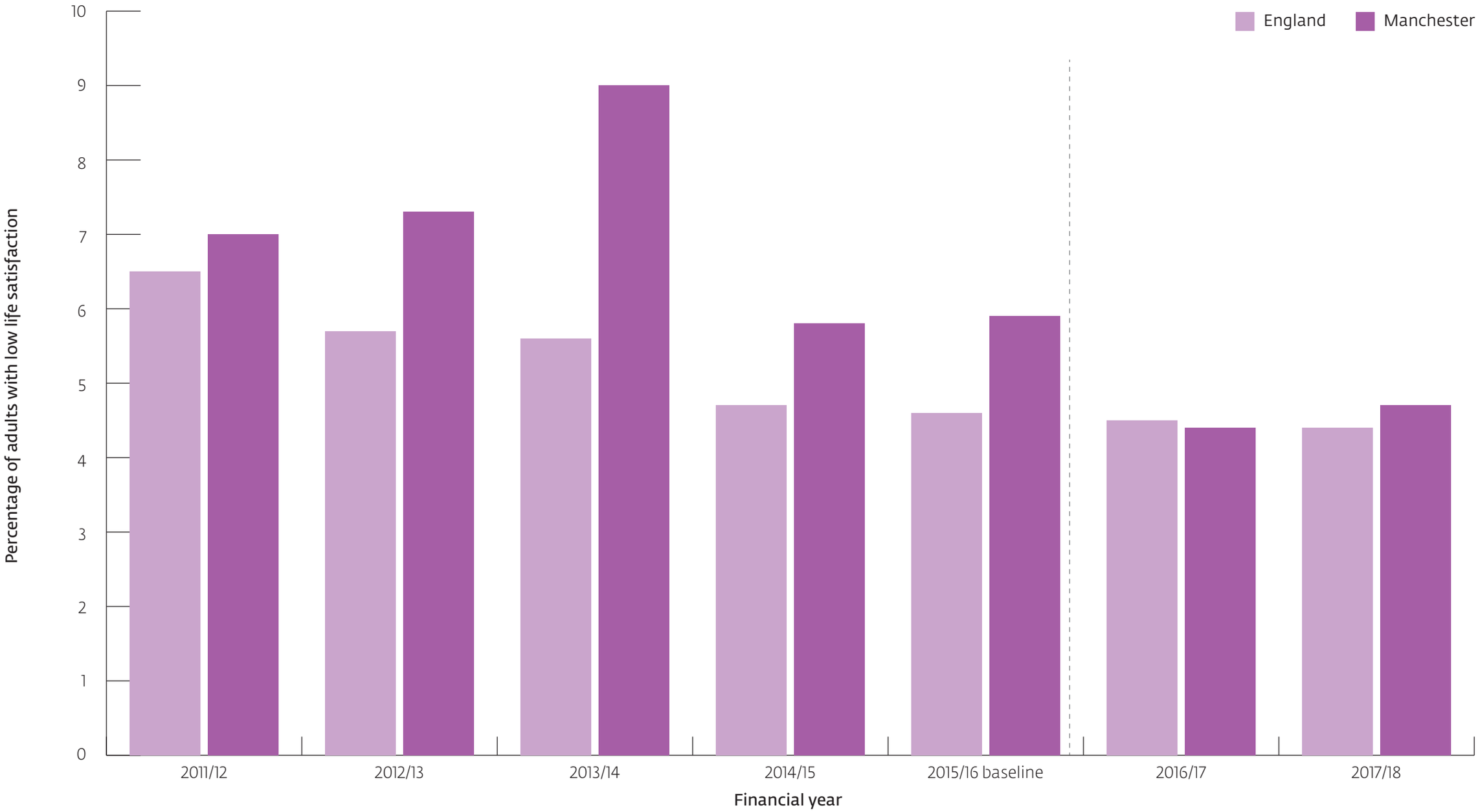
Self-reported wellbeing

People with higher wellbeing have lower rates of illness, recover more quickly (and for longer) and generally have better physical and mental health. Levels of individual/subjective wellbeing are measured by the ONS, based on four questions that are included on the Integrated Household Survey:

1. Overall, how satisfied are you with your life nowadays?
2. Overall, how happy did you feel yesterday?
3. Overall, how anxious did you feel yesterday?
4. Overall, to what extent do you feel the things you do in your life are worthwhile?

Figure 4.21 shows the percentage of adults aged 16 and over who rated their answer to the question 'Overall, how satisfied are you with your life nowadays?' as 0, 1, 2, 3 or 4 (on a scale between 0 and 10, where 0 is 'not at all satisfied' and 10 is 'completely satisfied'). These respondents are described as having the lowest levels of life satisfaction.

Figure 4.21:
Self-reported wellbeing (percentage of adults with a low life satisfaction score)



Source: Annual Population Survey, ONS © Crown Copyright 2019

Generally speaking, people in Manchester have lower-than-average levels of self-reported life satisfaction, although the gap between Manchester and England as a whole is comparatively small. In 2017/18, 4.7% of adults in Manchester had a low life satisfaction score, compared with 4.4% of adults across England as a whole. However, this comparison should be viewed with caution, as these figures are just an estimate based on data drawn from a survey with a relatively small sample size.

It is important to note that differences in people's wellbeing between areas should not be taken to directly indicate differences in people's views of their local area. This is because there are a number of factors – not just place – that influence personal wellbeing, eg. health, relationships and employment situation.

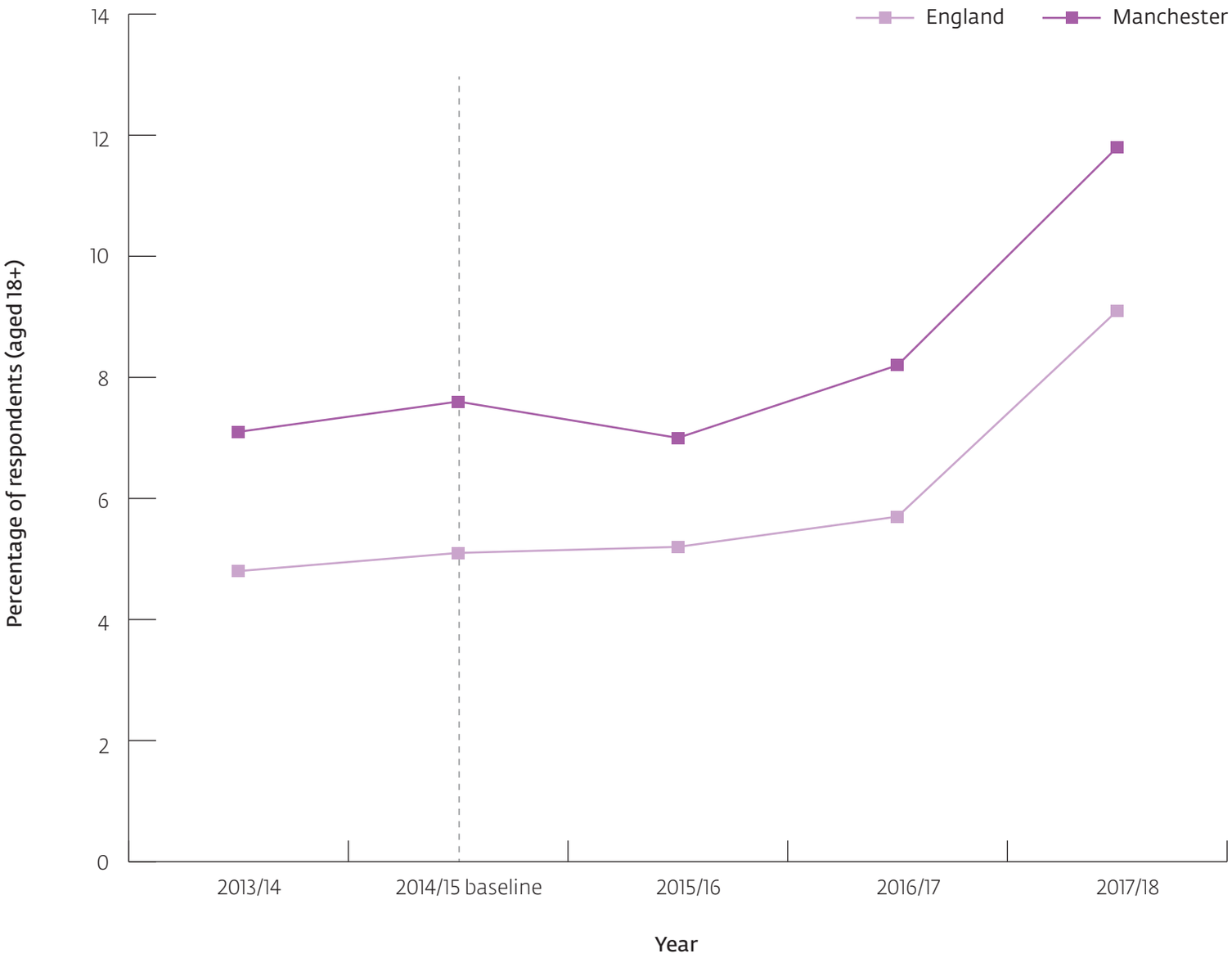
Long-term mental health problems in adults aged 18+ (GP Patient Survey)

The Adult Psychiatric Morbidity Survey 2014 identified that a significant proportion of people who have mental-health problems are not diagnosed. Knowledge of how many people state they have a long-term mental-health problem contributes to building up the local picture of prevalence. It may also highlight gaps between diagnosed and undiagnosed prevalence in a local area.

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over two million people across the UK. The survey asks patients about their experiences of their local GP practice and other local NHS services, and includes questions about a patient's general health. The chart below shows the percentage of all respondents to the question 'Which, if any, of the following medical conditions do you have?' who answered 'Long-term mental-health problem'. The survey did not go on to ask respondents about the nature of that long-term mental-health problem, so it is not possible to identify a specific mental-health condition or to describe the severity of the problem.

Figure 4.22 shows that in 2017/18, just under 12% of respondents in Manchester said they had a long-term mental-health problem compared with just over 9% of respondents across England as a whole. Survey respondents in Manchester were more likely than those in other parts of Greater Manchester to report that they had a long-term mental-health problem.

Figure 4.22:
Percentage of adults aged 18+ with a self-reported long-term mental-health problem



Source: Department of Health, GP patient survey

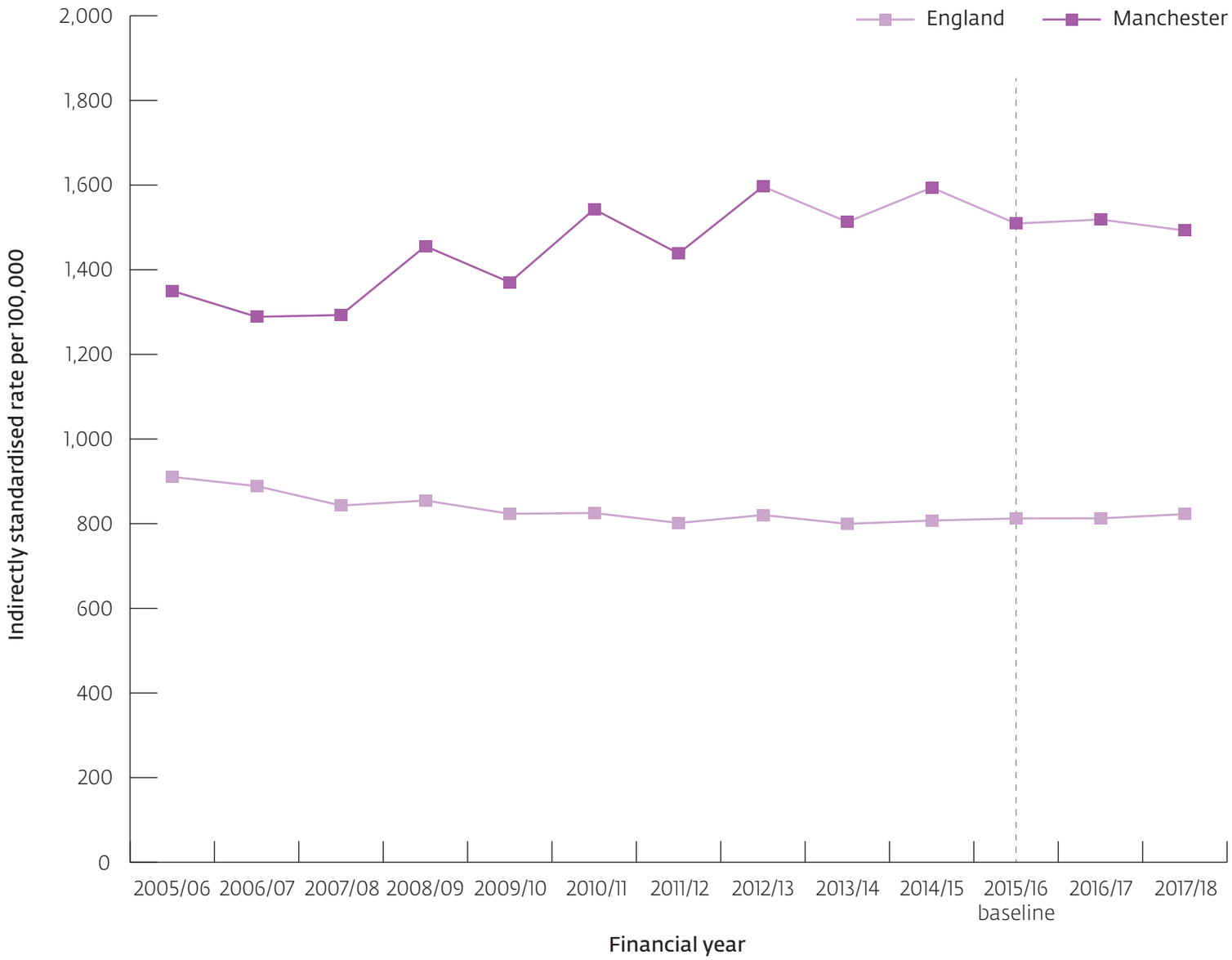
The percentage of respondents saying they had a long-term mental-health problem has increased in both Manchester and England as a whole, with a notable increase between the surveys conducted in 2016/17 and 2017/18. The reasons for this are unclear, and it is hard to tell at this point whether the increase reflects a genuine increase in the prevalence of long-term mental-health problems in the population, or a greater willingness of respondents to report that they have a long-term mental-health problem. It could also reflect a cultural shift in what people are willing to count as a long-term mental-health problem.

Unplanned hospitalisation for chronic ambulatory care sensitive conditions

Ambulatory care sensitive conditions are conditions where effective community care and case management can help prevent the need for hospital admission. An emergency admission for an ambulatory care sensitive condition is often a sign of the poor overall quality of primary and community care.

Figure 4.23 shows the rate of emergency admissions for ambulatory care sensitive conditions in Manchester has risen gradually over the past decade, rising from 1,350 per 100,000 in 2005/06, to 1,493 per 100,000 in 2017/18. However, the rate has steadied in recent years and has actually fallen from a peak of 1,597 per 100,000 in 2012/13.

Figure 4.23:
Unplanned hospitalisation for chronic ambulatory care sensitive conditions – indirectly standardised rate (ISR) per 100,000 population

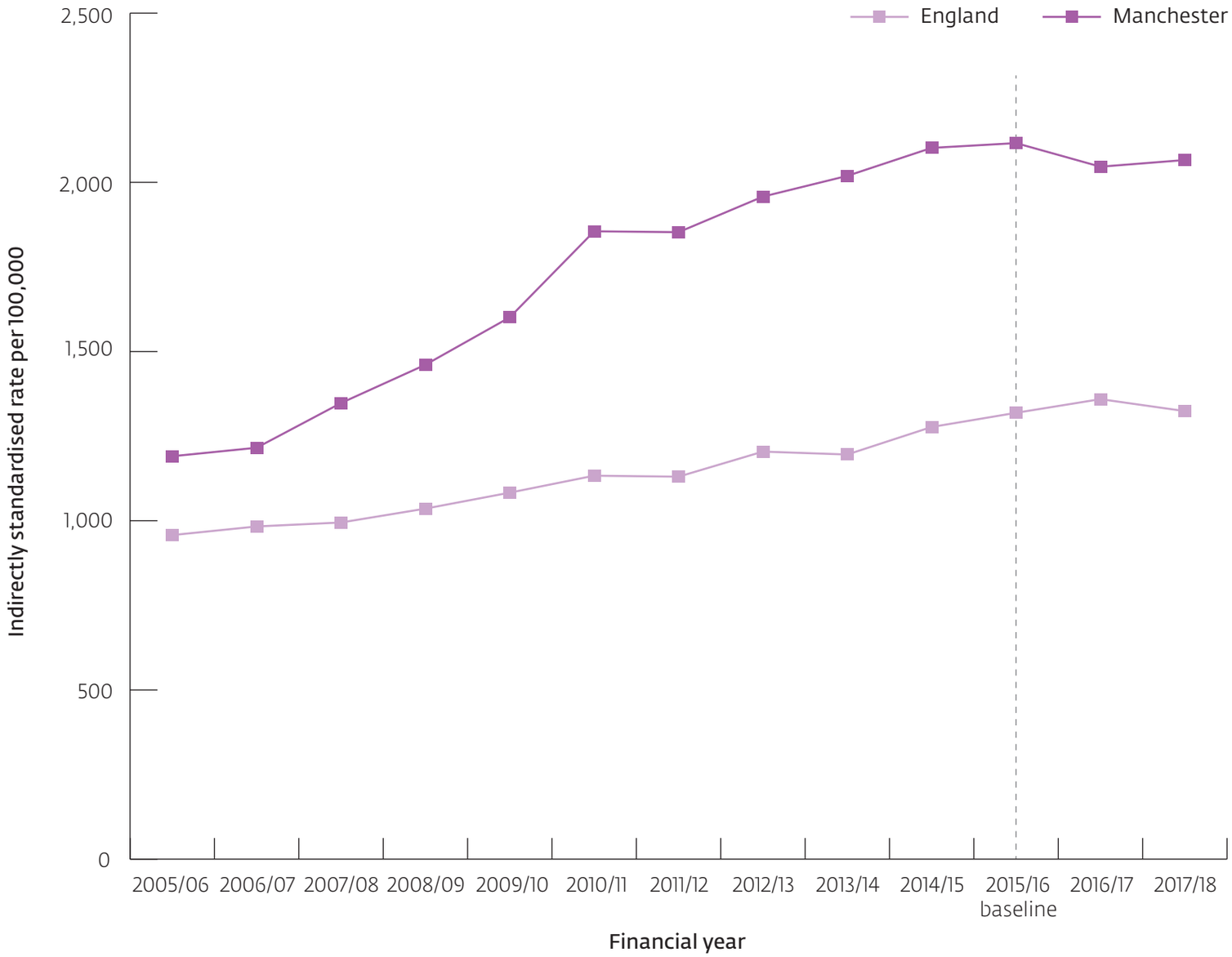


Source: Hospital Episode Statistics (HES), ONS mid-year population estimates, NHS Digital and Office for National Statistics

Emergency admissions for acute conditions that should not usually require hospital admission include ear, nose and throat infections, kidney and urinary tract infections, as well as acute heart disease.

Figure 4.24 shows the rate of emergency admissions for acute conditions that should not usually require hospital admission in Manchester has almost doubled over the past decade, rising from 1,191 per 100,000 in 2005/06, to 2,066 per 100,000 in 2017/18. The rate of emergency admissions for these conditions across England as a whole has also increased, but at a lower rate than in Manchester, meaning that the gap between Manchester and the national average has widened.

Figure 4.24:
Emergency admissions for acute conditions that should not usually require hospital admission – indirectly standardised rate (ISR) per 100,000 population



Source: Hospital Episode Statistics (HES), ONS mid-year population estimates, NHS Digital and Office for National Statistics © Crown Copyright 2019

Joining up the delivery of hospital and out-of-hospital services through the Manchester Local Care Organisation (MLCO) will have an impact on the rate of emergency admissions for both chronic ambulatory care sensitive conditions and acute conditions that should not usually require hospital admission. The development of new integrated models of care will help to keep people out of hospital and support them to live more independently. The MLCO model will help break down boundaries between different organisations. It will operate at a neighbourhood level and ensure that there is a smoother process for helping people in their homes when they are in recovery or dealing with long-term health issues.

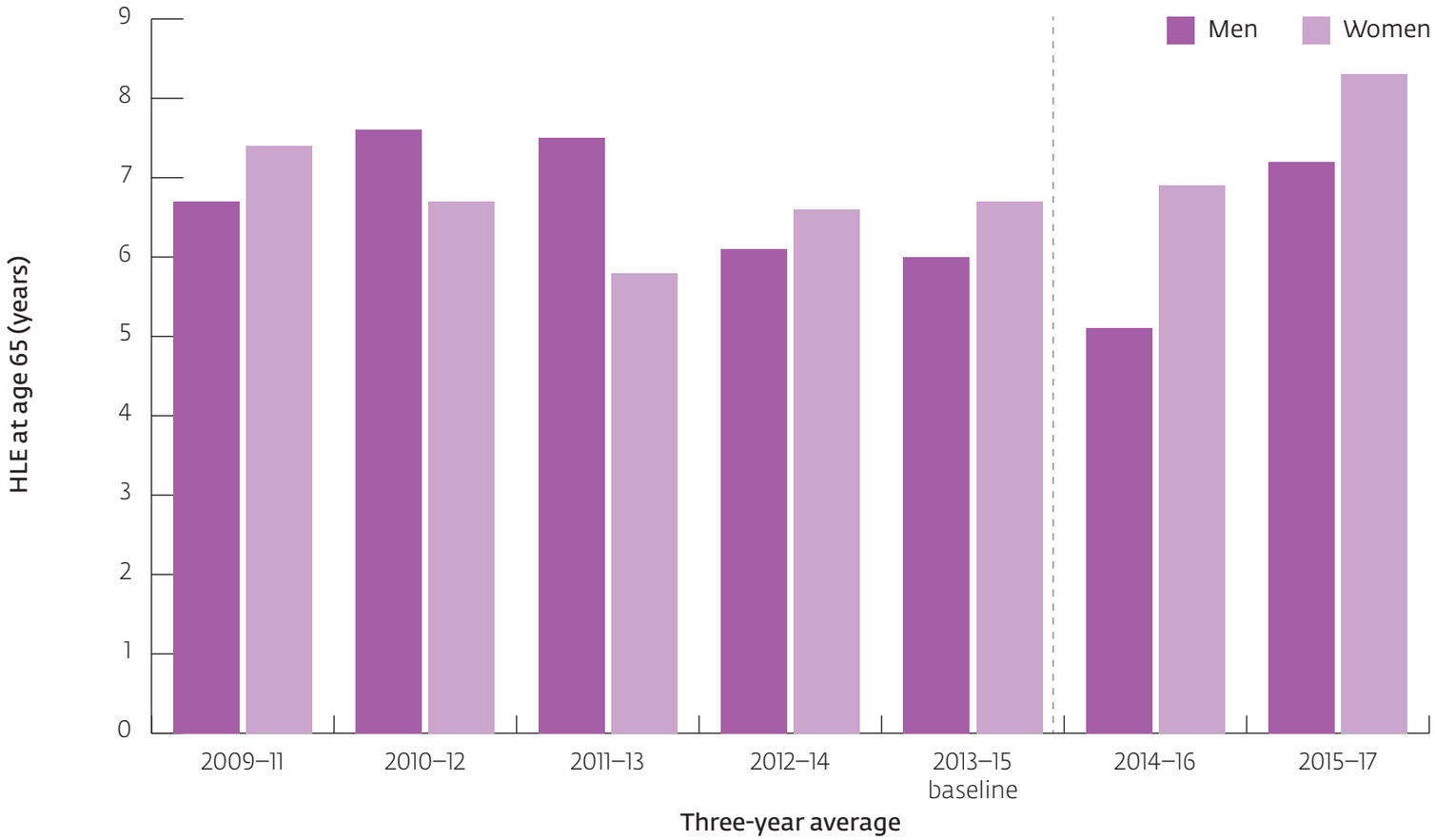
Creating an age-friendly city that promotes good health and wellbeing for people in middle and later life

Healthy life expectancy at age 65

This is a parallel measure to the previously described indicator of healthy life expectancy at birth. It shows the estimated average number of years a man or woman aged 65 in Manchester would live in good general health if he or she experienced the same age-specific mortality rates and prevalence of good health among Manchester residents throughout the remainder of his or her life.

The latest data for the three-year period 2015–17 shown in Figure 4.25 shows a more positive position for both men and women. For women, healthy life expectancy at age 65 has increased from 6.9 years in the three-year period 2014–16, to 8.3 years in the three-year period 2015–17 – an improvement of 1.5 years. For men, healthy life expectancy at age 65 has increased from 5.1 years in the three-year period 2014–16, to 7.2 years in the three-year period 2015–17 – an improvement of 2.1 years.

Figure 4.25:
Healthy life expectancy at age 65: 2009–11 to 2015–17



Source: Office for National Statistics © Crown Copyright 2018

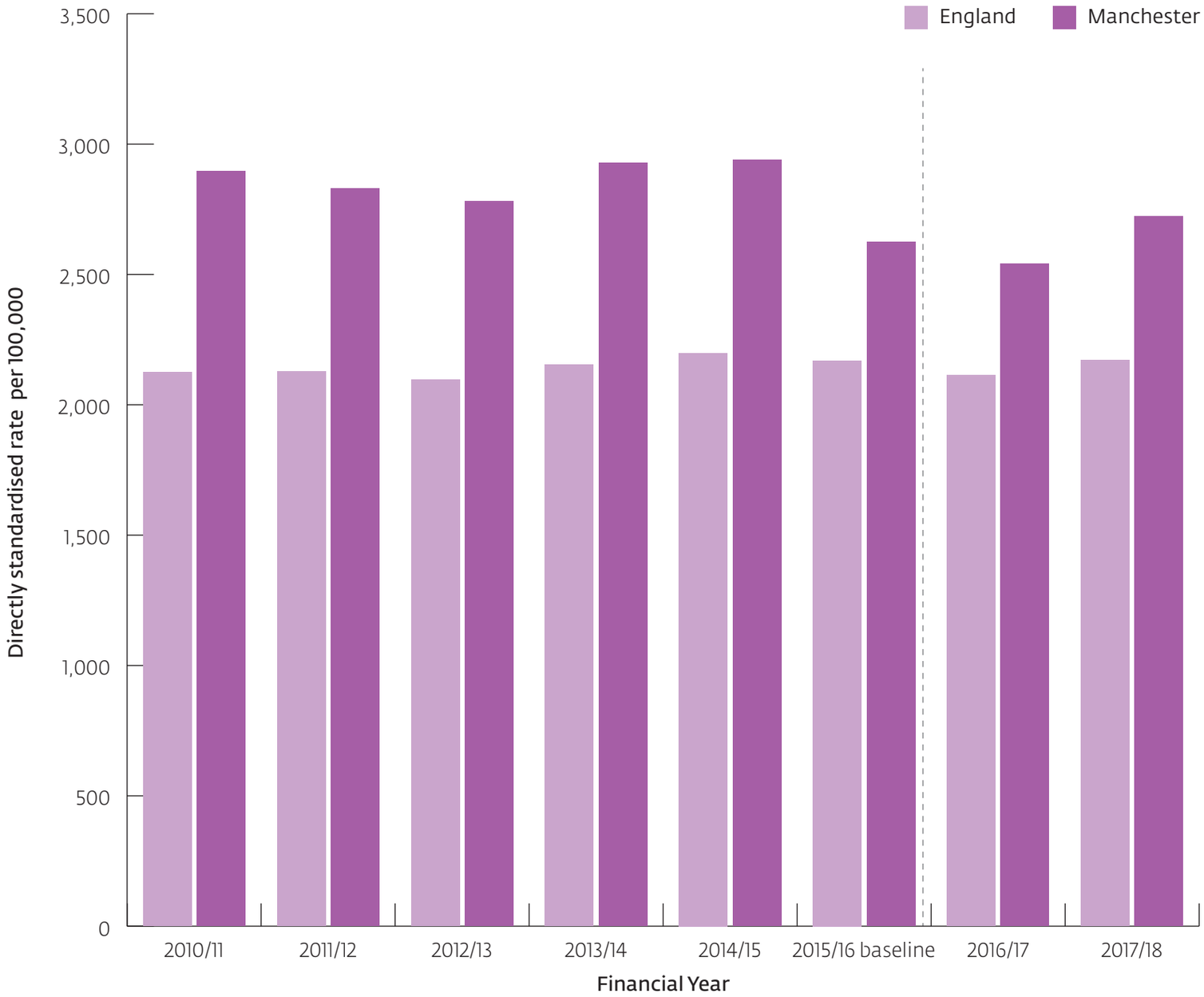
The reasons for this improvement are not clear. The fact that the increase in healthy life expectancy at age 65 marks a diversion from previous trends means that the improvement could be a statistical blip associated with a new method of calculating healthy life expectancy described at the beginning of this section. More work is needed to better understand the drivers behind this particular indicator.

Emergency hospital admissions for injuries due to falls in older people

Falls are the largest cause of emergency hospital admissions for older people and significantly impact on long-term outcomes. They are also a major precipitating factor in people moving from their own home to long-term nursing or residential care. The highest risk of falls is in those aged 65 and above.

Figure 4.26 shows that Manchester has a higher-than-average rate of emergency hospital admissions due to an unintentional fall in people aged 65 and over. In 2017/18, 1,358 people aged 65 and over in Manchester were admitted to hospital for a falls-related injury – a rate of 2,724 per 100,000 population. This is higher than the rate for the previous year (2,540 per 100,000) and is significantly higher than the rate for England as a whole (2,170 per 100,000 population).

Figure 4.26:
Emergency hospital admissions for injuries due to falls in people aged 65 and over



Source: Hospital Episode Statistics (HES) – National Statistics. ONS mid-year population estimates (based on 2011 Census) – National Statistics. Copyright © 2019, Health and Social Care Information Centre.

Specialist Community Falls Prevention Services in Manchester conduct multifactorial risk assessments, signpost for interventions, and carry out falls-reduction interventions for a time-limited period. The services also give specialist falls advice and provide support for generic health and social-care teams in the community. There are established links with care-home providers and voluntary organisations.

A new Manchester Falls Collaborative was established in early 2019 with the aim of developing an improved system-wide approach to falls prevention. This focuses on early identification of those at risk of falls, and improved training and communication. The Collaborative is led by Manchester Foundation NHS Trust and is backed by a strong relationship with research institutions in the city. It is unique in that it links practitioners, researchers and commissioners with a common set of objectives and a shared action plan. Over time, it is expected that the Falls Collaborative will be able to shape future commissioning arrangements and improve system-wide service models.

Case Study: Slipper Exchange Falls Prevention Initiative

The Slipper Exchange Falls Prevention Initiative is being delivered by Southway Housing. It was launched in January 2019 with health partners, including the Community Therapy Team (comprising Falls Prevention), and the Health Development Co-ordinators. The aim of the project is to reduce falls, trips and slips in the home and reduce A&E attendance. It works on the premise that a major cause of falls within the home is badly fitting, worn-out, sloppy slippers.

The scheme is targeted at people aged 65 and over living in Burnage, Chorlton Park, Didsbury and Withington, and enables them to exchange their old slippers for a new and safer pair, free of charge. Funding for the project came from Adult Social Care, Age-Friendly Manchester, and Southway.

Slippers can be exchanged at community venues and sheltered schemes, or dropped off at residents' homes via Southway's tenancy support team. There have also been a number of community-based promotional events. At the time of writing (May 2019), over 300 pairs of slippers had been distributed. There are plans to extend the scheme into Wythenshawe in the future.

Taking action on preventable early deaths

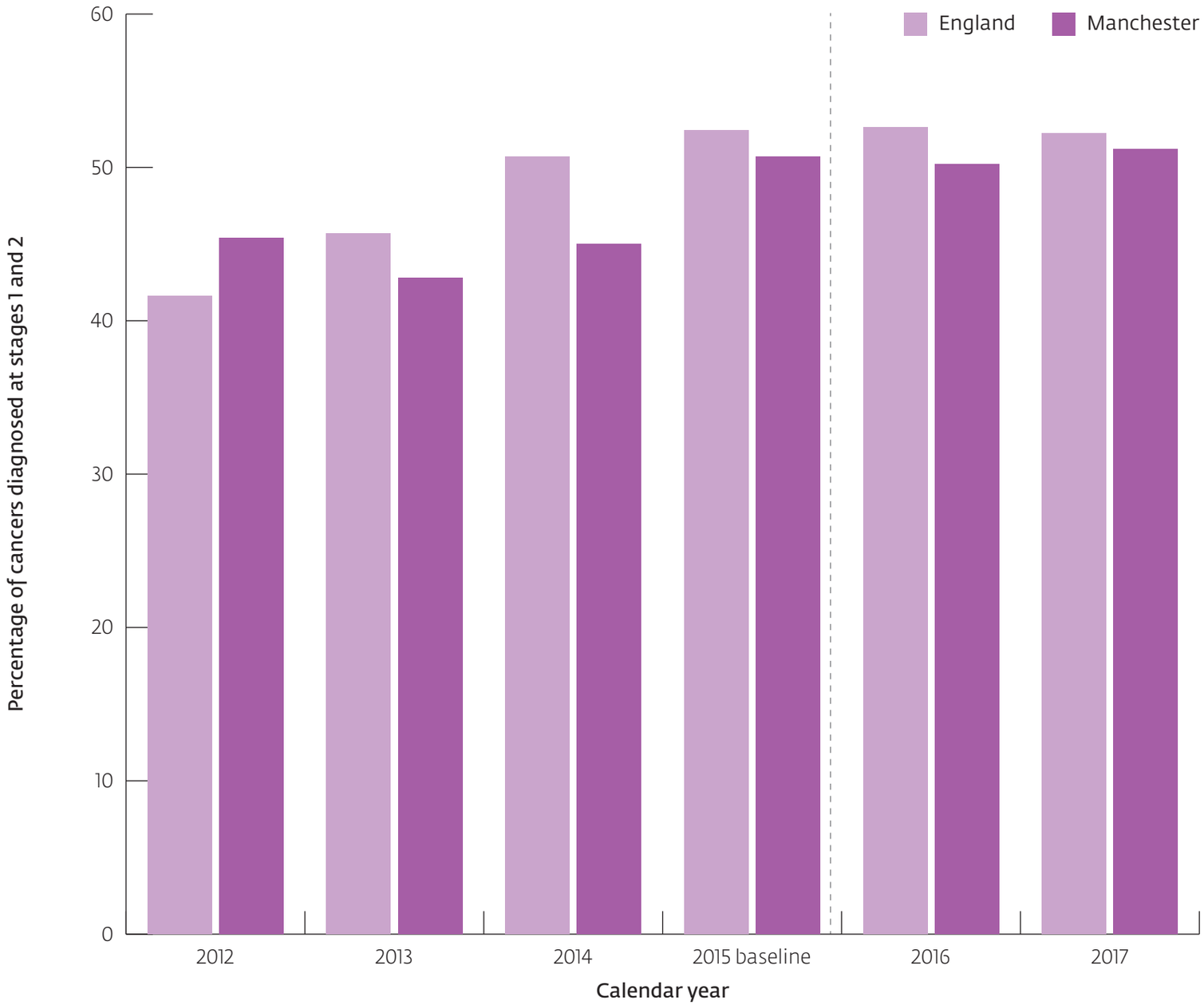
Proportion of cancers diagnosed at an early stage (experimental statistic)

Cancer is a major cause of death in Manchester. Nationally, more than one in three people will develop cancer at some point in their life. Diagnosis at an early stage of the cancer's development (stages 1 and 2) leads to a dramatically improved chance of survival. Specific public-health interventions, such as screening programmes and information/education campaigns, aim to improve rates of early diagnosis.

This indicator measures the number of new cases of cancer diagnosed at stages 1 and 2 as a proportion of all new cases of cancer diagnosed. Note that this indicator is labelled as experimental statistics because of the variation in data quality, and the indicator can be affected by variations in the completeness of staging information.

Figure 4.27 shows that in Manchester, just over half (51.2%) of new cases of cancer were diagnosed early at stages 1 and 2 in 2017. This represents a gradual improvement since 2012, when only 45.4% of new cases were diagnosed at this early stage.

Figure 4.27:
Early diagnosis of cancer (proportion of cancers diagnosed at stages 1 and 2)



Source: National Cancer Registry, Public Health England, 2019 (experimental statistics)

Rates of early cancer diagnosis in Manchester are now much closer to the England average. The latest figure in Manchester (51.2%) compares with a figure of 57.7% in Waltham Forest (the best performing local authority) and an England average of 51.9%. The average for the most deprived decile (10%) of local authorities is 51% and is therefore on a par with the figure for Manchester.

There are more new diagnoses of throat and lung cancers made in Manchester each year than there are of any other type of cancer. The survival rate from these forms of cancer is also relatively poor. This is due, in part, to the late stage at which people present to health services. Improving the rate of early diagnosis for these forms of cancer will therefore have a significant impact on the overall rate of early diagnosis.

In 2016, the Manchester Cancer Improvement Partnership (MCIP) piloted a community-based lung health check service, with low-dose CT scanning for patients found to be at increased risk of developing lung cancer in the next six years. Over two screening rounds, 80% of patients diagnosed with lung cancer were found to be in the early stages of the disease, and 90% were suitable for curative treatment, dramatically increasing their chances of survival.

The North Manchester Lung Health Check Service (NMLHCS) was launched in April 2019, in response to the successful MCIP lung health check pilot. There are currently proposals in place to expand the North Manchester model across central and south Manchester localities.

Premature mortality from causes considered preventable

Preventable mortality is based on the idea that all or most deaths from a particular cause could potentially be avoided by public-health interventions in the broadest sense. This indicator reflects Manchester's commitment to reducing avoidable deaths through public-health policy and interventions, such as those contained in the Manchester Population Health Plan.

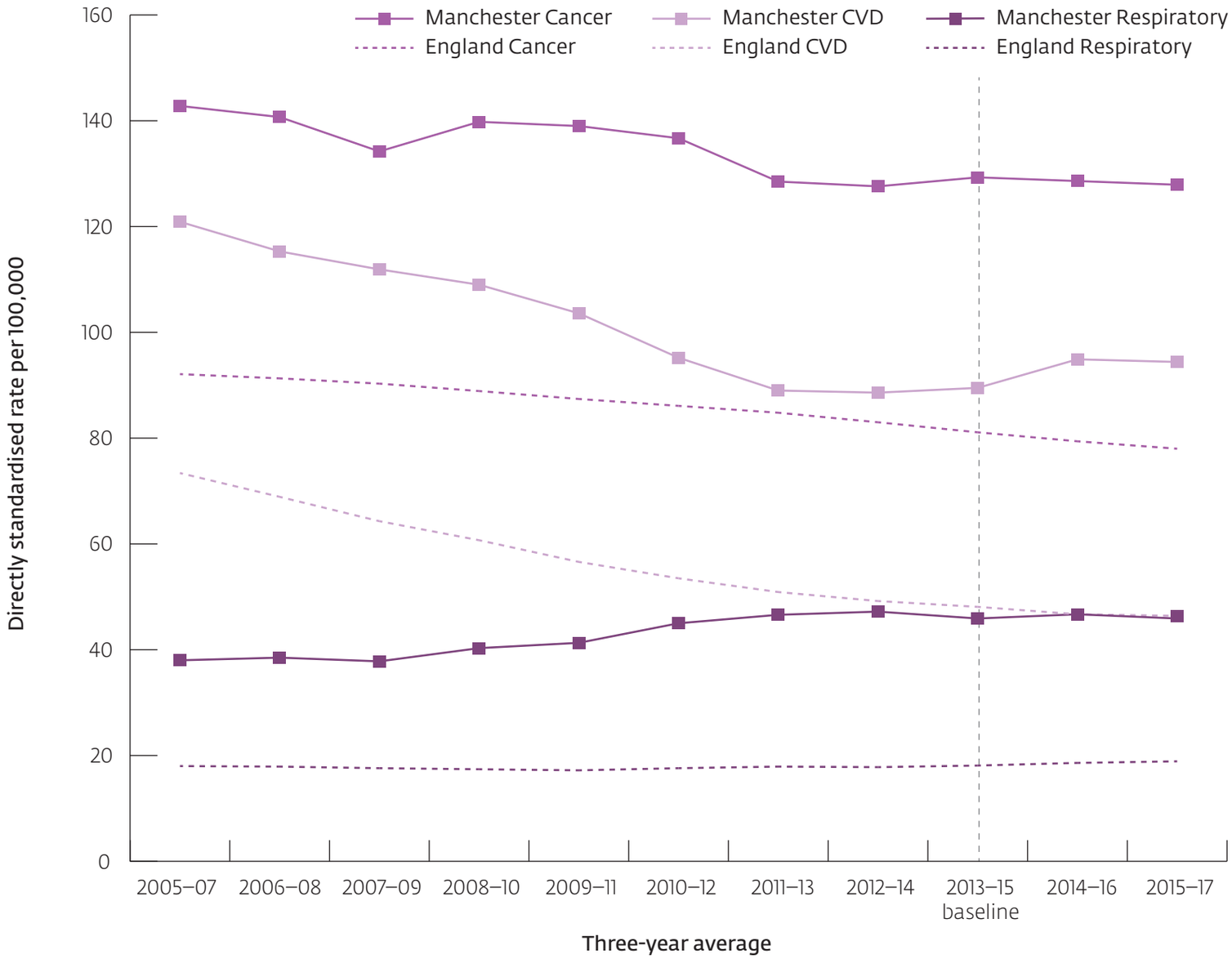
Cardiovascular disease (CVD), cancer and respiratory diseases are the major causes of death in people aged under 75 in Manchester. Research indicates that three lifestyle behaviours – tobacco use, unhealthy diet, and a sedentary lifestyle – increase the risk of developing these long-term conditions.

The rates of premature deaths from cardiovascular disease, cancer and respiratory disease in Manchester are all among the highest in England. Manchester is also the highest-ranked local authority for overall premature deaths from these diseases when compared with other similarly deprived areas, suggesting that deprivation alone is not the key factor in the high rates of premature deaths in the city.

There have been huge gains over the past decades in terms of better treatment and improvements in lifestyle, contributing to a significant fall in preventable premature mortality from cardiovascular disease since the middle of the past decade. However, Figure 4.28 shows that this downward trend may have started to flatten out or even reverse. Nationally, the decelerating rate of improvement in mortality from cardiovascular disease has been identified as a substantial contributor to the steady slowdown in longevity improvements. The underlying causes are unclear, but could include changes in risk factors such as obesity and diabetes, as well as the diminishing effects of primary and secondary prevention strategies.

Preventable premature mortality from cancer has also fallen, although not to the same extent as cardiovascular disease. In contrast, preventable premature mortality from respiratory diseases (including asthma and COPD) has gradually risen over the period since 2005–07; again, Figure 4.28 suggests this increase may be flattening out in recent periods. Smoking and air pollution are both common causes of respiratory disease.

Figure 4.28:
Mortality rate in under-75s from diseases considered preventable (cardiovascular disease, cancer and respiratory diseases)



Source: Public Health England (based on ONS source data)

Taking action on preventable early deaths is one of the five priority areas set out in the Manchester Population Health Plan. Key to this work is the delivery of community-centred approaches to detecting conditions early by going to places where people naturally and frequently congregate, to work with people, groups and organisations that are trusted in communities. This includes targeted approaches for NHS Health Checks, delivery of the Lung Health Check Programme, and the promotion of cancer-screening programmes (breast, bowel and cervical) for the groups of people most at risk.

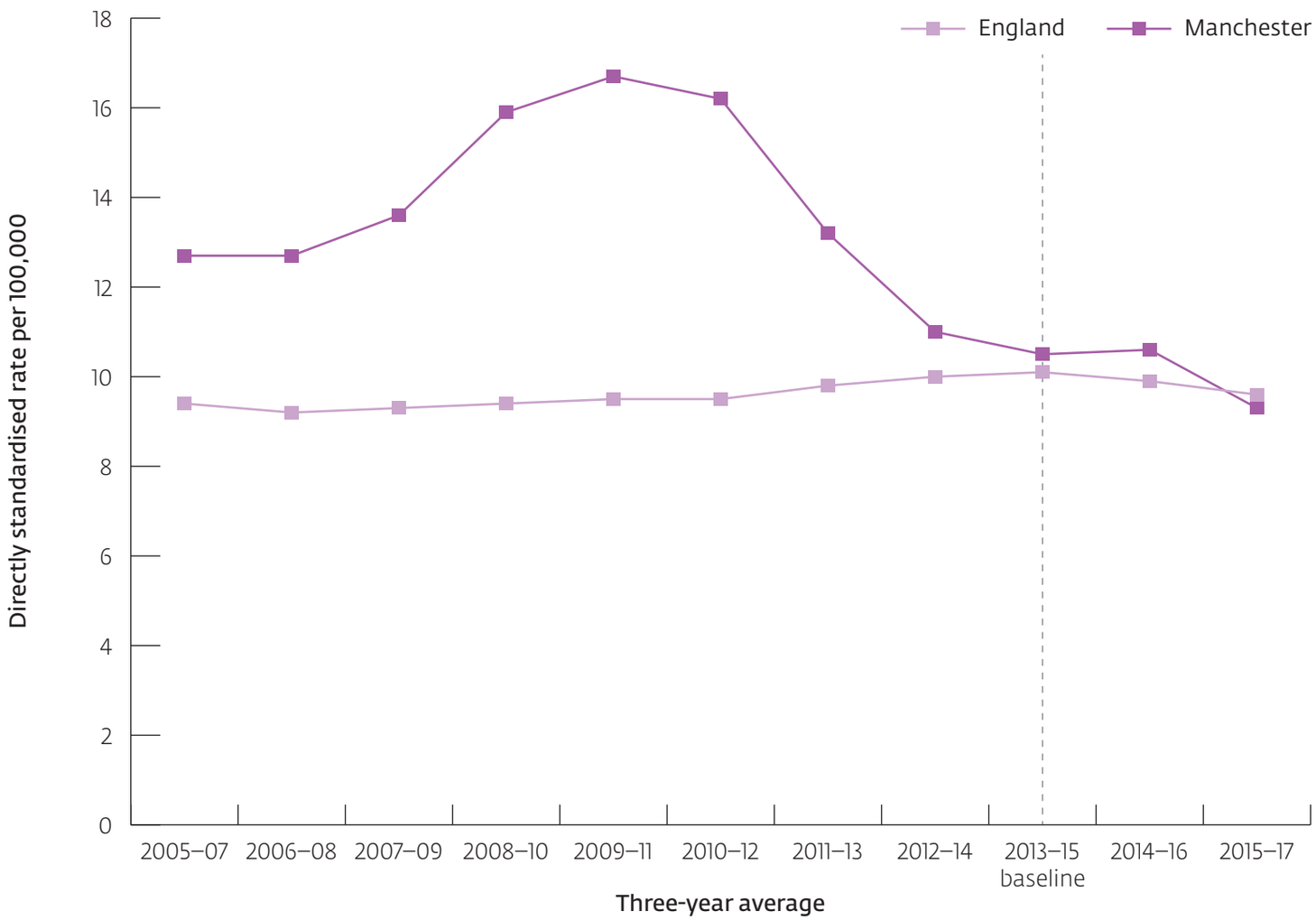
We are also seeking to improve outcomes and reduce unwarranted variation for people with respiratory illness. This will be done through a system-wide approach to change, including improving the timing and quality of diagnosis, better co-ordinated care, and enabling self-care.

Reducing deaths from suicides and injuries of undetermined intent

Suicide is a major issue for society and a leading cause of years of life lost. It is a significant cause of death, particularly in young adults, and can be a reflection of the underlying rates of mental ill health in an area.

Figure 4.29 shows that Manchester has seen a significant reduction in the rate of suicides and injuries of undetermined intent in recent years, from a rate of 16.7 per 100,000 in the three-year period 2009–11, to 9.3 per 100,000 in the three-year period 2015–17. Between the periods 2009–11 and 2015–17, the number of suicides has fallen from an average of 64 per year to 38 per year.

Figure 4.29:
Mortality rate from suicide and injury undetermined



Source: Public Health England (based on ONS source data)

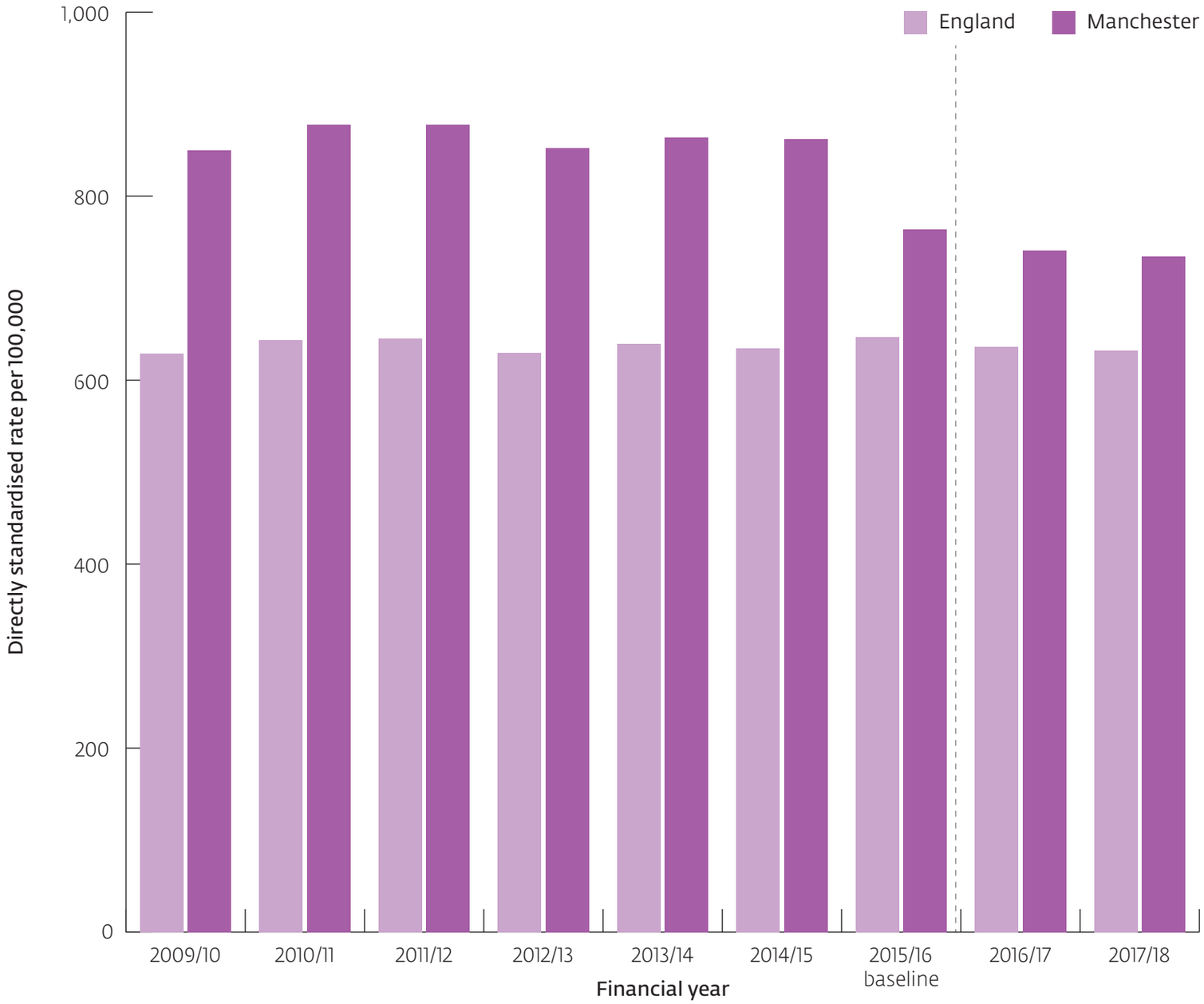
Suicide is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals and society as a whole can help to prevent suicides. The implementation of the Manchester Suicide Prevention Plan will help to reduce the number of attempted suicides and deaths in Manchester through awareness-raising and training, anti-stigma campaigns, and work with the rail network and highways to limit access to high-risk locations.

Admission episodes for alcohol-related conditions

Alcohol consumption is a contributory factor to hospital admissions and deaths from a diverse range of conditions. Alcohol-misuse is estimated to cost the NHS about £3.5billion per year, and society as a whole £21billion per year. Reducing alcohol-related harm is one of Public Health England's seven priorities for the next five years. Alcohol-related admissions can be reduced through local interventions to reduce alcohol-misuse and harm.

Figure 4.30 shows the number of admission episodes for alcohol-related conditions expressed as a directly age-standardised rate per 100,000 population.

Figure 4.30:
Admission episodes for alcohol-related conditions (narrow definition)



Source: Public Health England (based on Hospital Episodes Statistics and ONS mid-year population estimates)

Recent data shows a clear improvement in the rate of admission episodes for alcohol-related conditions in Manchester compared with previous trends. In 2017/18, the rate of admission episodes for alcohol-related conditions was 734 per 100,000 – a reduction of 16% on the peak rate for the year 2011/12 (878 per 100,000). The gap between the rate of admission episodes for alcohol-related conditions in Manchester and the England average has also narrowed. In 2011/12, the rate of admission episodes for alcohol-related conditions in Manchester was 36% higher than the England average. In 2017/18, it was just 16% higher.

The Communities in Charge of Alcohol (CICA) pilot project began in September 2017 and aims to build a network of community alcohol champions across Greater Manchester. The project is based on the principle that local communities should be empowered to take charge of their own health and that people in these local communities are best placed to influence their friends, families and colleagues. The project is a partnership between the ten Greater Manchester local authorities, Public Health England, GMCA, the Royal Society of Public Health (RSPH) and the University of Salford, which are all evaluating the work.

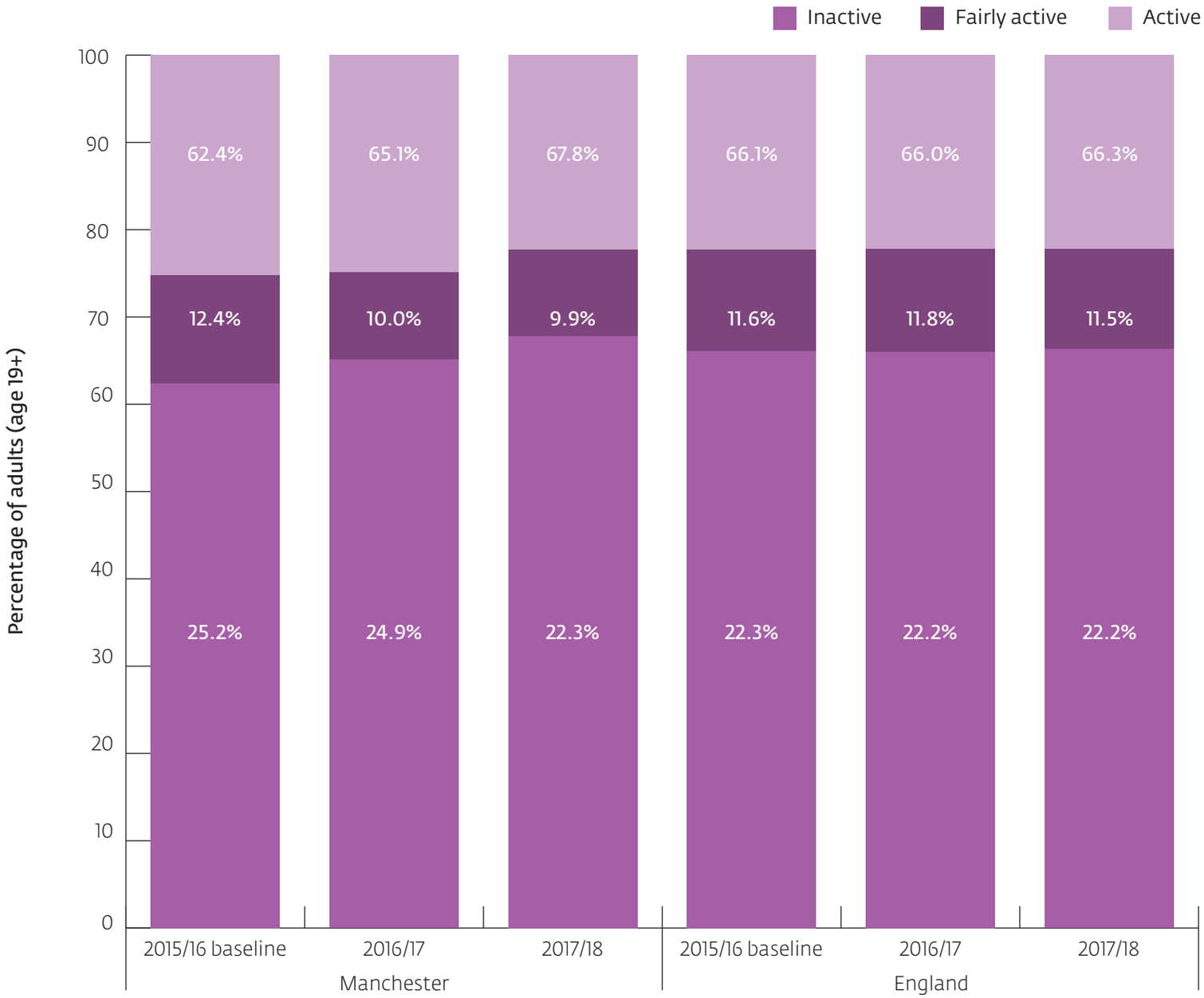
The Manchester pilot started in June 2018 in Newton Heath and Miles Platting. Five residents from the area were recruited to become 'alcohol health champions' (AHCs) and have been trained to deliver alcohol brief interventions.

Physical activity and inactivity

Physical inactivity is the fourth-leading risk factor for global mortality, accounting for 6% of deaths globally. The Chief Medical Officer (CMO) currently recommends that adults undertake a minimum of 150 minutes of moderate physical activity each week, or 75 minutes of vigorous physical activity each week, or an equivalent combination of the two in bouts of ten minutes or more.

According to the Sport England Active Lives Survey for 2017/18, 68% of adults (aged 19 and over) in Manchester are classed as 'active', compared with 22% who are 'inactive'. Figure 4.31 shows that the proportion of adults classed as 'active' has increased since the last survey period (2016/17), and the proportion of 'active' adults in Manchester is now slightly above the England average (66%). This reflects the fact that the population of Manchester contains a growing number of young people who are more likely to be physically active.[6]

Figure 4.31:
Weekly physical activity (age 19+)



Source: Public Health England (based on Active Lives Survey, Sport England)

6 Broad physical activities include sporting activities, fitness activities, cycling, walking, creative or artistic dance, and gardening

The multi-agency Winning Hearts and Minds Programme has been developed in partnership with Manchester City Council Sport and Leisure Service, and Mcr Active. The programme involves:

- Investment in community-led initiatives in the most challenging areas in the north of the city to help reduce health inequalities
- Working with communities to identify new ways of encouraging physical activity through the Sports England-funded Tackling Physical Inactivity Initiative
- Delivery of community-centred approaches to improving the detection of cardiovascular disease and its risk factors
- Co-production of approaches to improving the physical health of people with severe mental illness.

Continuing to be recognised as a pioneering age-friendly city

Age-Friendly Manchester

The Age-Friendly Manchester (AFM) programme aims to improve the quality of life for older people in the city and to make the city a better place to grow older. Part of the Council's Population Health and Wellbeing Team, AFM is an active member of the World Health Organization Global Network of Age-Friendly cities.

The programme has built on the success of the previous 15 years, initially as the Valuing Older People team, and was identified as a leading example of the Our Manchester approach in 2015. The cornerstone of the AFM programme is to improve the social participation of older residents and the communities in which they live. This is central to reducing demands on services, and improving the quality of life of older residents.

Since the launch of the Our Manchester strategy, AFM has continued to drive activity that ensures older residents have a greater sense of belonging, confidence and ownership across the city. Manchester is a space for all, no matter what their age.

The programme is based on collaboration and partnership, and giving older people a leading role. Since 2004 there has been an elected and representative Manchester Older People's Board and an Age-Friendly Manchester Assembly (over 100 older people) that shape the strategic direction of the programme and act as consultative bodies.

The AFM family includes a wide range of partnerships, including The University of Manchester; Manchester Metropolitan University; the statutory, voluntary and private sectors; and national and international collaborations. Four times a year, AFM brings its family together for an Age-Friendly Neighbourhood Co-ordination Group meeting. Members work to create Age-Friendly Neighbourhoods – places where people age well, with access to the right services, housing and information, as well as social, cultural and economic opportunities.

Over the past year, AFM has worked hard to re-energise its partnership, engagement and governance structures. In addition to the Neighbourhood Co-ordination Group, Assembly and Board, we have revitalised the programme's high-level Steering Group. Together, these structures ensure consistency across the programme's different levels of engagement and collaboration, and the voice of older people is given priority at all levels.

In 2017, following a comprehensive consultation, AFM published Manchester: a Great Place to Grow Older (2017–2021). As the city's ageing strategy, A Great Place to Grow Older outlines how the city's systems and structures will work together to improve the health and wellbeing of older people. Examples of recent successful age-friendly work are set out below, under the strategy's three key priorities.

Developing age-friendly neighbourhoods

➜ We have developed a neighbourhood working model for commissioners that sets out how services and resources can be deployed in a more integrated and age-friendly way. Over the past year we have worked to establish the building blocks for this model: involvement in the redesign of the Buzz health and wellbeing service; helping to shape the focus of the population health-targeted fund, which will support and increase the level of community support for older people; the systematic expansion of age-friendly networks; and identifying opportunities to embed the age-friendly approach in work led by the Manchester Local Care Organisation.

➜ We have worked closely with older people, academia and the Council's Strategic Development team to investigate how age-friendly principles can be incorporated into plans for the Northern Gateway to make it a place for all ages. The Northern Gateway is one of the UK's largest redevelopment opportunities, proposing to build 15,000 new homes on land between the city centre and north Manchester.

➜ We have been involved in the shaping of the UK's first extra care housing scheme designed for older LGBT people, which will be in Whalley Range. We have contributed to the creation of a Pride in Ageing Manager post, based at the LGBT Foundation. This role aims to strengthen the voice of older LGBT people in our age-friendly work, and the postholder has a representative seat on the AFM Older People's Board.

Developing age-friendly services

➜ 2019 marks ten years since the publication of the Over-50s Relationships and Sexual Health Guide, produced by Age-Friendly Manchester. Research continues to show not enough is being done to ensure older people have access to good sexual health care and support. Together with colleagues from Manchester's universities, the charitable sector, healthcare professionals and older Mancunians, we are developing a set of standards designed to ensure age-equality and inclusion in sexual health services.

- Some recent examples of our focus on the value of older workers include: establishing a 50+ employment and skills support group; working directly with Manchester-based employer networks to heighten awareness of the age-friendly approach; and working on the Council's commitment to become an age-friendly employer. We have also collaborated closely with the Council's Work and Skills team to promote apprenticeships to older residents.
- It is vital that we recognise not only the benefits of culture in the lives of older people, but also the talent, experience and enthusiasm that older people bring to the arts and cultural activity in Manchester. AFM has continued to expand its culture programme; it works hard to embed culture into the development of age-friendly neighbourhoods and services by bringing together cultural organisations, housing providers and the city's healthcare sector. We have further continued to support the city's Culture Champions programme, a network of over 100 older volunteers whose aim is to increase the cultural participation of older people.

Promoting age equality

- The Age-Friendly Manchester e-Bulletin is published every month, and now reaches well over 9,500 subscribers. The bulletin champions positive images and stories of ageing in Manchester, provides information on age-friendly work throughout the city, and promotes events and activities for older people.
- In summer 2018, we celebrated Greater Manchester's Festival of Ageing, which was themed around recognising positive and diverse experiences of ageing. Events in Manchester attracted an estimated 3,500 attendees, and included garden parties, choir concerts, music festivals, and a special age-friendly Levenshulme Market. A number of One Small Thing 'grants' were made to local groups of older people, to better support their involvement and prevent exclusion of communities that can sometimes feel left out.
- In response to older residents raising the value and importance of effective information-sharing, AFM have continued to work closely with the Council's Communications Team to develop an age-friendly communications strategy. The strategy includes a commitment to produce a communications standard, which will set out how we and our partners can better talk to and about older people in a positive and non-ageist way. We have partnered with the Centre for Ageing Better to begin developing this piece of work.

Conclusion

Improvements have been made for residents of all ages in meeting the Council's priorities, and working towards the delivery of the Our Manchester Strategy vision.

Although homelessness has increased, there are significant pieces of work being taken forward by the Council and its partners to help meet this challenge. There is a focus on prevention and relief of homelessness, enhancing advice and support, and improving access and transition to settled homes.

While there are still significant numbers of people in the city who have no contact with employment and skills provision – whether they are out of work due to a health condition, or in work that does not offer good terms and conditions – more people are being supported into work through targeted interventions. There is a noticeable cultural shift in terms of increased focus on work as a health outcome, as well as some successful initiatives to tackle gaps in mainstream provision.

We will therefore continue to develop opportunities to engage more people in 'good' work initiatives and to address systemic issues that do not support employment, eg. working with health commissioners to ensure that people are not at risk of losing their job because of daytime medical appointments. This will be framed within the context of the planned migration of claimants of health-related out-of-work benefits to Universal Credit, increasing the number of residents on Universal Credit who will need to find more hours.

Although rates of looked after children remain high compared to national averages, the number of looked after children is decreasing safely and steadily, and outcomes are improving. There is a focus on reducing the number of children and young people being taken into care, by using evidence-based interventions aimed at supporting families to remain together, and where possible preventing the need for children to be taken into care, or when they are, ensuring a timely return home.

Intervention, prevention, reablement and services that better serve people's needs in the community are resulting in fewer adults and older people in need of going into residential or nursing care. The move to integrated teams, with community-based health and social-care staff working collaboratively within MLCO, is crucial to our city's success. It has an impact on every one of the Our Manchester goals we're all working towards for 2025.

Looking forward

The Council and its partners continue to develop and transform services under the Our Manchester Strategy, and as new arrangements continue as part of the integration of Health and Social Care through the Locality Plan.

There will continue to be a shift in the focus of services towards prevention of problems and intervening early to prevent existing problems getting worse across the whole life course. The Council and its partners will continue to focus services within communities, bringing more together in 'hubs' in order to aid integration, and maximising the impacts of the strengths of the communities in which people live. Through this we can ensure that people:

- Get the right support from the right place at the right time
- Can lead safe, healthy, happy and fulfilled lives, no matter where they were born or live
- Can benefit from the success of the city.