Chapter 4: A progressive and equitable city

Strategic overview

The Council's aim is for everyone 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 were born or where they live. This means reducing the disparities between different areas of the city.

The Our Manchester Strategy sets out how we will strive to create a truly equal and inclusive city, where everyone can thrive at all stages of their life, and quickly and easily reach support to get back on track when needed. It also states our ambition to improve physical and mental health outcomes, and ensure good access to integrated health and care services across the city.

As citizens, we all need to recognise the responsibilities we have to ourselves, our families, our communities and the city. We also need to take an Our Manchester, strength-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 has made real progress towards achieving this aim, including improvements in education and housing, better access to jobs, and reducing the number of young people not in employment, education or training. To a large extent this has come from the strength of the collaboration between organisations, businesses and residents.

Despite these gains, there are still areas of deprivation in the city, with Manchester ranked the sixth most deprived local authority area in England.[1] These are less widespread than they were ten years ago, but exist nonetheless, and we must continue to address them. Over the past 18 months, the COVID-19 pandemic has deepened existing inequalities in the city, particularly for our more deprived communities, ethnic minorities, women, migrants, those living in poverty, and older people, meaning our focus on reducing inequalities is more important than ever. Low income and Black, Asian and ethnic minority households have been affected the most in terms of their health and unemployment.

Manchester's older people have been disproportionately affected by COVID-19 and the impacts of the lockdown, and many have reported they have felt marginalised. Older people are keen to play a part in Manchester's recovery, to be able to fully benefit from opportunities as more things open up and to be part of the process of finding solutions to a range of key issues that adversely affect residents in mid to later life from the age of 50.

There has also been a significant impact on our children and young people, with significant disruption to education, and there is evidence of a widening of the gap between those who are most disadvantaged and/or vulnerable and their counterparts.

1 Indices of Multiple Deprivation 2019

As a city we have been working for a number of years to radically transform 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 bringing together health providers, the Council, the voluntary sector, education providers and communities in ways that will target the specific challenges we have in Manchester.

Integration of health and social care is transforming the experience 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 that 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 have modernised services for children and their families. The vision is for our teams to work closer with health, schools, the police, and colleagues in neighbourhoods and localities to place a greater focus on prevention and early support. Wherever possible, it will prevent problems occurring and unnecessarily escalating by ensuring that people can access the help they need early and that they are equipped to take care of themselves, increasing the life chances of our children and supporting their future independence. It will 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.

Our approach is reflective of Manchester's Locality Plan and aligns with the Bringing Services Together for People in Places programme, which is part of the delivery plan for Our Manchester. In addition, we continue to increase our collaborative work across Greater Manchester, scaling up the programmes that work, and designing new programmes with the voluntary sector and other partners that address the challenges we have as a city.

The next phase of reforming services needs to connect more residents to the opportunities available in the economy, reducing dependency, and helping build an effective recovery from COVID-19, while recognising that the pandemic has had significant greater impacts on those residents with the poorest outcomes.

Analysis of progress

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

The number of individuals and households experiencing homelessness in Manchester has remained high during the past year, and there remain significant pressures on services that are working to prevent and tackle homelessness in the city.

The Homelessness Service has adjusted to new ways of working due to the COVID-19 pandemic. There have been changes in the numbers and reasons for households presenting to the service, and the number of households in temporary accommodation, with a reduction of move-on options at the beginning of the pandemic. The Government's 'Everyone In' initiative and the lockdown of the city centre, which led to a reduction in begging opportunities, also led to a greater engagement with statutory and support services from people who otherwise may not have accessed services.

The number of people presenting as homeless has decreased by 3% from 2019/20, largely due to a drop in presentations during the first national lockdown, which commenced in March 2020. However, the number owed a statutory duty has increased in 2020/21, which is in part due to people accessing support via emergency COVID-19 accommodation who would not have engaged with services in the past.

The main reasons that people present to the homelessness service for assistance are set out in Table 4.1. This shows an increase across all reasons since 2019/20 except in households presenting due to eviction from the private-rented sector (PRS) properties, where there has been a big drop due to the Government moratorium on evictions. However, the service has seen a 30% increase in presentations due to domestic violence and abuse.

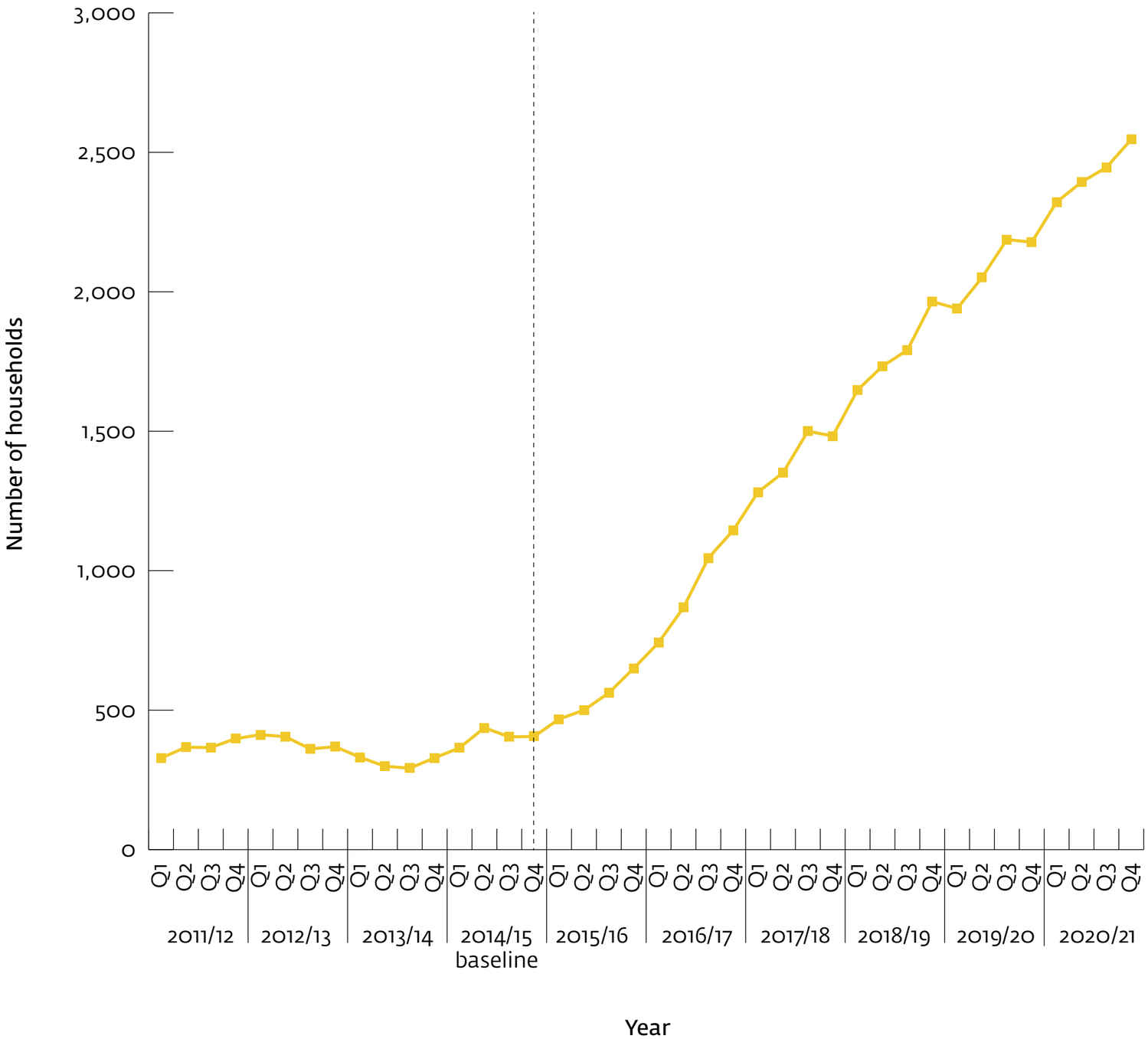
Figure 4.1 shows the number of households residing in temporary accommodation has increased significantly over the past six years, from 406 households at the end of March 2015, to 2,546 at the end of March 2021. There has been a 17% year-on-year increase in the use of temporary accommodation, in part due to the lack of move-on options during lockdown.

Table 4.1:
Homelessness presentations

Main reasons for loss of settled home	2018/19	2019/20	2020/21
End of private-rented tenancy – assured shorthold tenancy	972	1,116	749
Family no longer willing or able to accommodate	922	1,057	1,470
Other	827	824	1,063
Domestic abuse	366	536	697
Friends no longer willing or able to accommodate	382	417	436
Relationship with partner ended (non-violent breakdown)	255	325	440

Source: HPA2, Locata. Top six reasons for loss of settled home

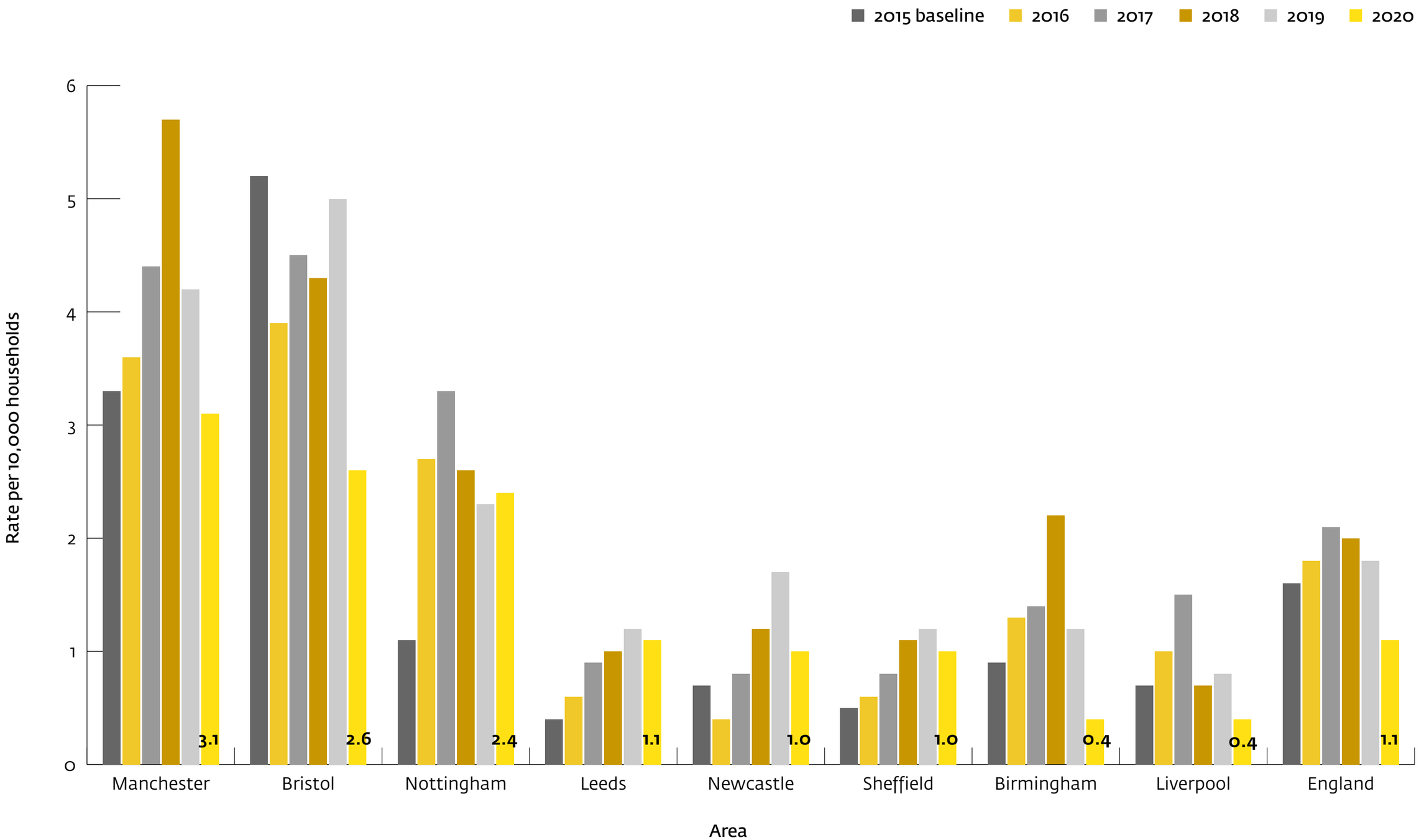
Figure 4.1:
Total number of households residing in temporary accommodation at the end of the quarter



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

However, the number of individuals recorded as sleeping rough in the city continues to decline. The 2020 single-night snapshot of people sleeping rough counted 68 people in Manchester, compared to 123 in 2018 and 91 in 2019. This represents a decrease of 25% since 2019 and provides some evidence of positive outcomes from the ongoing work of the homelessness service and partners in the city to tackle rough sleeping and move people away from a street lifestyle. Although the figures are moving in the right direction, rates of people who are sleeping rough remain high; Figure 4.2 shows that Manchester now has the highest rate of people sleeping rough per 10,000 households compared to other English Core Cities.

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

The Council, working in partnership with its voluntary, statutory and business partners in the city, continues to work to prevent and tackle all forms of homelessness.

Manchester's Homelessness Strategy 2018–2023 is key to tackling this challenge, setting 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

The Housing Solutions Service (HSS) continues to see high demand, and 2020/21 saw 9,608 people present as homeless. While this is a decrease of 3% compared to the previous year, this is largely because of a reduction in presentations during March to June 2020 due to lockdown. Demand for the service continues to be fuelled by loss of accommodation in the private-rented sector and increasing difficulties in finding affordable housing. Presentations from people who are in employment are increasing, particularly from those on zero-hour contracts, working irregular hours, or part-time.

In 2020/21, the Housing Solutions Service successfully prevented 789 individuals and families from becoming homeless through a variety of interventions. These included financial advice and income maximisation, applying for Discretionary Housing Payments, negotiating with landlords, securing housing within the private-rental sector before a household becomes homeless, and referring to specialist floating-support services that can work with households to help them maintain their tenancies where these may be at risk.

During the pandemic, the Customer Service Centre closed its doors to the public, which meant the HSS moved to a telephony-based-only service. Staff deal with between 500 and 600 calls per week. As services move out of lockdown, HSS will remain a largely telephone-based service, with face-to-face appointments being made as necessary.

The eviction moratorium, which was put in place early on during the pandemic, came to an end on 31 May 2021. Provisions were included in the Coronavirus Act 2020 to extend the notice periods that certain tenants in England and Wales are entitled to receive when a landlord is seeking to recover possession of their homes. On 21 August 2020 the Government stated that landlords in England would be required to provide tenants with six months' notice, except in cases involving issues such as antisocial behaviour and domestic abuse. The cessation of the moratorium, coupled with the fact that there are now approximately 26,000 households across Greater Manchester in rent arrears due to the pandemic, is likely to have an impact on the HSS in terms of increased presentations from June 2021 onwards.

Hospital and prison discharge

The Hospital and Prison discharge team was established to assist in the transfer of patients to alternative accommodation to reduce the risk of bed-blocking within hospitals and to provide a pathway for people being released from prison who had no alternative accommodation available to them. Between March 2020 and April 2021, the team received 732 'duty to' refers from hospitals and 688 from prisons.

In 2019, the discharge team was provided with time-limited accommodation at Dalbeattie Street in the Harpurhey area of the city. The property consists of ten self-contained flats, six ground-floor-level access flats and four first-floor flats. This type of accommodation is often difficult to source and in short supply in temporary accommodation for homeless people. Dalbeattie Street is consequently able to provide accommodation for people with physical and ambulatory issues primarily, those undergoing chemotherapy and radiation therapy, and people with mental-health issues.

To date, the scheme has housed 50 residents and rehoused 32, while 31 tenancies have been sustained. Owing to the success of Dalbeattie Street, the service is looking at procuring a larger property of 29 self-contained flats, which should be available in autumn 2021.

From January to June 2021, the Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) awarded Greater Manchester funding to support hospital discharge for people experiencing homelessness during the pandemic. It was set up to establish 'Covid Care' accommodation, where individuals of no fixed abode can be accommodated to allow safe and timely discharge from hospital with a positive COVID-19 diagnosis; it also offers this accommodation to individuals in the community who have a positive COVID-19 test and require

suitable accommodation and support to self-isolate. The accommodation is made up of ten self-contained flats based in the Cheetham Hill area of Manchester.

Greater Manchester Mental Health Discharge Pilot

A particular challenge in Manchester is the lack of settled accommodation for individuals who need a home as well as mental-health support. There are also individuals currently in supported accommodation who are ready to move into an independent tenancy with support but struggle to find long-term accommodation, thereby reducing access to supported accommodation for people needing to be discharged from hospital. Greater Manchester Mental Health (GMMH) have therefore partnered with the homelessness service to pilot an innovative approach to tackling some of these barriers. This has involved creating a specialist private-rented sector (PRS) Officer role within the PRS team, whose remit is to work with individuals in mental-health services to identify appropriate tenancies in the private-rented sector. In addition, GMMH have contributed funding to secure properties including deposits, and rent voids for these properties.

Making homelessness as brief as possible

An online gateway system for access to Housing Related Support (HRS) services has now been in operation for two years, and new partner agencies continue to come onboard to use the system. This has worked to streamline access to the city's HRS services, improving people's experiences of accessing and engaging with specialist accommodation and resettlement, and floating support.

In-house temporary accommodation has continued throughout the pandemic, with staff ensuring that COVID-safe practices are maintained throughout the buildings and appropriate PPE is worn. This has been a significant challenge in some hostels, as individuals who are vulnerable with some chaotic behaviour patterns have struggled to self-isolate. While managing business as usual, and the additional accommodation provided through 'Everyone In' and 'Cold Weather', the service has also managed to provide further accommodation for families and singles alike:

- Apex House is an alternative to emergency accommodation, consisting of 20 self-contained flats for families with low support needs.
- Princess Road offers shared accommodation for up to eleven people and operates as short-stay, move-on accommodation from the Longford Centre in Chorlton.
- Rams Lodge provides 30 bed spaces for singles and childless couples. Support staff take a keyworker approach and between September 2020 and April 2021 the service successfully supported 44 people into more settled accommodation.

In addition, the homelessness service continued to provide floating support for 1,974 dispersed temporary-accommodation properties across Greater Manchester.

Officers have had to adapt their ways of working, home visits being replaced by remote support by telephone, email and text. However, a risk-based approach has been adopted, with doorstep visits taking place where engagement or safeguarding issues have been identified. The pandemic has fuelled an increase in anxiety and mental health concerns across this client group. The service has supported families with practical issues such as obtaining food parcels and laptops for home learning, and linked them into wider support services.

Making homelessness a one-off occurrence

There is a continued focus on working with partners to increase access to settled homes in the social and private-rented sectors for people moving on from homelessness.

Initiatives within the private-rented sector have seen the Private Rented Sector (PRS) Service continue to operate as much of a business-as-usual model as possible throughout the pandemic. The PRS/Move-on teams ensure that properties are suitable for residents; this includes carrying out inspections to ensure all properties meet housing and health and safety rating standards prior to applicants taking occupation. Assessments are completed to ensure the property is affordable, suitable and sustainable. The team offers a range of incentives to landlords and tenants to facilitate access to tenancies in this sector.

The incentives were expanded in 2020 to include specialist resettlement support, financial assistance, rental guarantees and landlord insurance policies to provide landlords in this sector with additional support. The PRS and move-on teams have successfully helped to move 1,080 households into private-rented sector properties in 2020/21 and they continue to work across Greater Manchester to secure good-quality, affordable properties in the private-rented sector. The team is in consultation to review the current team structure, PRS offer, processes and procedures in order to increase the number of people moving into the PRS.

The PRS team is also working closely with the Ethical Lettings Agency with the aim of continuing to increase the amount of affordable, suitable accommodation the Council will be able to use to tackle and prevent homelessness.

2020/21 has also seen the launch of the Rough Sleeper Accommodation Programme (RSAP), which is a Government-funded scheme providing accommodation and support for individuals impacted by rough sleeping. The scheme allows those who are ready to move on from emergency, temporary and supported housing, but who have limited rehousing options, to access a short-term tenancy while they explore their long-term housing aspirations and options. Resettlement support is provided to help individuals manage and maintain their tenancy. As part of phase 1 of the scheme, officers have been working with housing partners to develop and deliver more than seventy properties in Manchester, with additional properties being sourced and delivered by GMCA. A bid has recently been submitted for phase 2 of the scheme, which would see additional properties purchased over 2021/22.

Tackling rough sleeping

The range of responses that have been developed to respond to and tackle rough sleeping in the city have been increased in 2020/21. The Council's Outreach Inreach Service has grown, and now includes a bespoke service called the Protect Programme. This service is funded by the MHCLG as a pilot service to respond to the support and accommodation needs of people long-term rough sleeping who have struggled in other accommodation services previously. The team consists of four in-reach workers, two social worker and two mental-health practitioners. They use targeted data of who is currently sleeping rough to provide them with a wrap-around support service into short-term accommodation, with a view to moving into a dispersed property. The support stays with the person from the streets and into accommodation.

The Housing First service provided a bespoke response for people who had experienced multiple and repeated episodes of homelessness and rough sleeping and accommodated 88 people in new homes with intensive wrap-around support. The service was expanded to provide a bespoke service for women with multiple disadvantages, and Manchester Action Street Health have delivered this in partnership with Housing First.

The funding from the MHCLG for the Rough Sleeper Initiative (RSI) was extended for an additional year, with some services funded via the initiative being refreshed and reviewed. Working closely in partnership with accommodation and support providers in the city, 710 individuals were relieved from rough sleeping in 2020/21, and a further 439 were prevented from rough sleeping in the same period using the funding from the RSI.

Cold weather

Manchester's cold weather offer is activated when the city sees temperatures of zero or below or other extreme weather patterns. While this is not a statutory duty, it is a support offer delivered by many local authorities, with Manchester operating an enhanced approach accommodating individuals for a minimum of three days each time the offer is activated.

This year, because of COVID-19, an extended service was delivered; individuals received a single en suite room offer on a no-return-to-streets principle. This aligned to the city's Everyone In programme.

Cold weather services are designed, delivered and reviewed through a partners group, which includes members who are experts through experience. Partners were heavily involved in referral and allocation processes, provision of food, phones and other welfare items (toiletries, clothes), as well as out-of-hours outreach into the early hours of the morning.

2020/21 saw 512 cold weather placements, with the offer extended from the first activation on 24 December 2020 to 31 March 2021. This provided an opportunity for clients to be linked into long-term accommodation and support pathways.

A Bed Every Night (ABEN)

Additional accommodation schemes for people who sleep rough have been developed to support Greater Manchester's A Bed Every Night initiative, and these continued to be delivered by the Council's partners across the city throughout lockdown. ABEN services responded well to the pressures and challenges, and there were notable successes in:

- Realigning and reconfiguring services to provide single-room accommodation
- Implementing COVID-safe practices for staff and residents, enabling them to provide accommodation for clients with symptoms and/or positive COVID-19 tests
- Supporting Everyone In by providing more stable move-on accommodation and acting as a significant accommodation source as the Council stepped down from the Everyone In accommodation offer.

There are 174 ABEN bed spaces available, all of which are single occupancy. This contrasts with the earlier ABEN offer, which was made up of 65% shared rooms or larger hostel-type accommodation. There are bespoke accommodation schemes for low and high-needs clients, as well as female-only, No Recourse to Public Funds (NRPF) and LGBT+ schemes.

In 2020/21, ABEN services accommodated over 420 people, and all sites provided a 24/7 staffing presence. The focus is on primary support and welfare, accessing benefits, GPs, bank accounts and ID, and – most importantly – referrals into drug, alcohol and mental health services. Over the past year, 230 residents have had a positive move into supported housing.

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

The Working Well offer, commissioned by Greater Manchester Combined Authority (GMCA), provides support for unemployed people with health conditions or disabilities who are long-term unemployed or out of work. Greater Manchester and London are the only two areas where the Department for Work and Pensions has devolved the commissioning for the Work and Health programme (WHP). The current phase of the programme is being delivered in Manchester by subcontractor 'The Growth Company' and was launched at the beginning of March 2018.

The programme builds on the Working Well approach by taking a holistic approach to supporting people into good-quality employment, offering a range of skill support, work experience and employment support. Alongside this, support is provided for a range of issues, including housing, debt and health, to enable participants to sustain this work. This is co-ordinated with the Council to ensure a broad range of support is available to participants. Referrals come predominantly from Jobcentre Plus (JCP).

By the end of March 2021, the Work and Health Programme (WHP) in Manchester had 3,021 starts (20% of all starts in Greater Manchester), with 85% of participants actively engaged. Of that number, 955 have started a job. The WHP has been delivering a service throughout the COVID-19 pandemic, adapting by carrying out all appointments via telephone, increasing the online health offer available (including access to the NHS cognitive behaviour therapy offer SilverCloud) and launching an online portal containing over 10,000 modules focused on work and health.

At the beginning of the pandemic, the programme saw no referrals coming from JCP, as their staff focused on processing an influx of Universal Credit claims. As the UK began to open up again, referrals onto the programme increased dramatically, reaching their highest since it began.

As part of the Plan for Jobs programme, announced by the Chancellor in June 2020, further funding was made available to DWP to expand the Work and Health programme with the Joint Entry Targeted Support (JETS) programme. This is aimed at people who have fallen out of work due to the pandemic, and the funding was devolved to GMCA. JETS is a light-touch support service that gives participants a tailored range of support, including, but not limited to, debt advice, transferable skills analysis, CV writing, job search, interview skills, self-efficacy and confidence-building in the current COVID-19 environment. The service also includes a Money Management Advice Service, bespoke to the need of the cohort coming onto the programme.

The Working Well Enterprising You programme, launched in February 2020, has continued to provide specialist support for those who are self-employed or in the gig economy. This included support for current businesses to help them become more resilient, reduce their costs, and diversify their service to survive through COVID-19 restrictions.

The Working Well Specialist Employment Service was launched using a digital offer in 2020, targeting those with severe mental illnesses, severe autism and/or learning disabilities. As the service follows a 'place then train' model focusing on engagement with employers to make the job possible, clients who were shielding or looking for work in sectors that were closed due to COVID-19 restrictions were placed on hold. However, the personalised support offer remained in place.

The Working Well Early Help programme, which supports a return to sustained employment for individuals with a health condition or disability who have either recently become unemployed or taken medical leave from an existing job, was also pivotal in Working Well's response to the pandemic. This supported key workers during the crisis by targeting hard-hit sectors such as Health and Social Care.

Overall, while impacted by the COVID-19 crisis, the Working Well programmes have worked closely with key referral partners (such as JCP, GPs and providers) to ensure growth in access to support, increased referrals (reflecting increased need) and positive programme start rates. The introduction of Working Well JETS, is a fundamental cornerstone

of adaptation to ensure Working Well programmes react positively to the pandemic and meet Greater Manchester residents' needs.

Family poverty

"A society is strong when it cares for the weak, rich when it cares for the poor, and invulnerable when it takes care of the vulnerable" – Rabbi Jonathan Sacks, 'Morality: Restoring the common good in divided times,' 2020.

The Manchester Family Poverty Strategy 2017–22 was developed to address child poverty in Manchester, which continues to be a major challenge affecting many of the city's children and their families. The Strategy, which was co-designed with partners and residents, aims to add value to a small number of key priorities that would have the biggest impact on the lives and outcomes of children and families.

The past 12 months have had a huge impact on the city's residents, children and families. While the full scale of the economic impact of the pandemic is still not fully clear, emerging intelligence is indicating that COVID-19 has had and will continue to have an immeasurable impact on the city's children and families, plunging many more into poverty. The Council and its partners have worked tirelessly to understand the full scale of the challenge in order to reduce the risks and mitigate the impact where possible.

Reprioritisation of the Family Poverty Strategy 2017–22

A key focus of the family poverty work in the past 12 months has been in relation to the reprioritisation of the Family Poverty Strategy, given the impact highlighted by COV1D-19 and to ensure that the priorities in the Strategy continue to meet the needs of children and families living in poverty. The reprioritisation was based on a consultation with each of the working groups, including diverse partners from across the city, such as The Bread and Butter Thing, One Manchester, Greater Manchester Poverty Action and Northwards Housing – all of whom have expertise in their respective thematic areas. The consensus was that the existing priorities were still relevant but were strengthened. In addition, a small number of additional priorities were included, such as digital inclusion, which was highlighted as a particular challenge for vulnerable residents over the lockdown period.

In December 2020, the Family Poverty Strategy Reprioritisation was approved by the Family Poverty Core Group. The priorities for the Family Poverty Strategy Reprioritisation are:

- **Sustainable work as a route out of poverty:**
  - Affordable childcare for parents
  - The role of anchor institutions.

  Additional priorities:
  - Manchester as a Living Wage Place
  - Citywide commitment to good employment practices.
- **Focus on the basics – raising and protecting family incomes:**
  - Lobbying Government to mitigate the impact of welfare reforms on children and families
  - Tackling the poverty premium
  - Food and fuel.

  Additional priorities:
  - Debt and financial management
  - Digital inclusion.
- **Boosting resilience and building on strengths:**
  - Strength-based approach in communities (Belonging)
  - Improving the identification and signposting of families in poverty (Coping)
  - Poverty-proofing services (Coping)
  - Embedding careers advice and aspiration in schools (Learning).

  Additional priorities:
  - Maximising access to the benefits system
  - Holistic support offer for residents
  - Workforce support.

Progress to date is as follows:

Sustainable work as a route out of poverty

Flexible, affordable and high-quality childcare has been highlighted as a major issue affecting a family's income, and this has become a greater challenge over the lockdown period. Following the first lockdown, many childcare settings were struggling to survive. To support them, the Chair of the working group liaised with the Council's Business Rates team to support childcare providers through the extension of the criteria for the Additional Restrictions Grant. This, together with regular consultations with daycare providers to understand the impact of the pandemic on childcare settings, has helped inform the support offered to them. This has meant that an average of 90% of childcare settings remained open over the lockdown period.

Access and take-up of free childcare places for two-year-olds continues to be a challenge for some of the city's most vulnerable residents. The working group liaised with the No Recourse to Public Funds team and the Greater Manchester Immigration Aid Unit to develop a pathway to support newly arrived families to access the childcare offer they are entitled to. The group is also developing a campaign targeted at professionals working in north Manchester to raise awareness of the benefits of childcare for children, their families and society in general.

Focus on the basics – raising and protecting family incomes

Fuel poverty continues to be a challenge for families living in poverty. To support families living in fuel poverty, a Winter Warm Homes leaflet was produced, giving practical tips and advice on all aspects of fuel poverty, including details of the Council's Green Homes Grant. Approximately 1,250 leaflets were printed and translated into 17 community languages. The leaflet was targeted at those living in fuel-poor areas of Manchester in private-rented sector accommodation who tend to have the lowest levels of energy-efficiency. To further support residents with fuel costs, the Council, in partnership with Manchester Citizens Advice Bureau, assisted over 1,500 people to switch their energy provider and claim the Warm Homes Discount. It is estimated that residents in the city will save in the region of £70,000 a year as a result of switching energy providers.

Food poverty is a significant challenge for the city. Much of the work to support families with food poverty was undertaken by the Council's food response team with key partners from the basics group, including the Bread and Butter Thing and FareShare, playing a key role in supporting both the Council's and the city's food response. As well as supporting the city's food response, the group supported the set up and delivery of food distribution hubs in areas of deprivation and has commissioned research to identify gaps in food provision to provide a better food offer for residents living in food deserts.

Poverty Premium – At the start of the pandemic, the Government acknowledged the inability of some families to live on basic welfare provision and raised the Universal Credit payment by £20 per week. This has been a vital lifeline for many families living in poverty. The uplift ended in September 2021. The working group will continue to work in collaboration with partners across the city and nationally to support the campaign to make this temporary uplift permanent.

Boosting resilience and building on strengths

Prior to the pandemic, the working group started to design a programme of activity with key partners, including Early Help, to look at issues of poverty in schools based on learning from the Cedar Mount Audit. This work was paused following school closures; however, it will be resumed now that schools are fully operational.

Practical guide to support families – To give families in need much-needed practical support, the Our Manchester Pocket Guide was developed in July 2020 as a one-stop shop of information to support residents with money, health and wellbeing. The guide, which was co-produced with a number of statutory, voluntary and community organisations, including the Be Well Service, Cedar Mount Academy and Wythenshawe Community Housing Group, includes new contact information and signposting links, which have been uploaded to the Council's Helping Hands website. This means that residents have up-to-date information at their fingertips. The guide was distributed across targeted neighbourhoods citywide. The first phase (4,995 guides) was distributed through a number of statutory, voluntary and community organisations, including libraries; and the second phase (9,000 guides) was distributed via Neighbourhood Teams, BST partners, Sure Start Children's Centres and Food Partnership among other organisations.

COVID-19: food response – One of the biggest features of the pandemic has been the demand for food support and the city's food offer. In response to the increasing demand for food support over the period of the first national lockdown, the Our Manchester Food Partnership (OMFP) brought together social food providers, the NHS, housing providers, non-food delivery voluntary sector organisations and the Council to provide food parcels, which were delivered to residents' homes. March 2020 to March 2021 saw an unprecedented rise in demand on food banks and pantries – a 50% increase on average. This is in addition to over 110,000 food parcels delivered by OMFP-commissioned partners during the same period, administered and funded by the Council's Food Response Team.

Case study: Impact of COVID-19 on front-line NHS worker

Amanda (not her real name) is a front-line nurse, who has been working mostly weekend, evening and night shifts nursing COVID-19 patients since the start of the pandemic. Amanda's home life was challenging and she faced domestic violence. While she was ill with COVID-19, her partner left the family home, leaving a trail of debt behind that she did not know about, but became responsible for repaying. While she recovered from the initial virus, she developed Long Covid – a continued debilitating condition – and was unable to work.

Amanda was receiving sick pay from the NHS, but this was at a standard-hours level. Previously, her income had been enhanced by the unsociable working pattern she had developed. That, in addition to the debt situation, saw her unable to buy food via internet shopping. Feeling desperate at this point, she rang the freephone COVID-19 helpline number.

Following initial crisis intervention where food parcels were delivered via Manchester City Council's commissioned partners, Amanda was referred to Age UK, which accepted the referral even though Amanda was in her late 40s and not yet 50 years old. Age UK supported Amanda with food and debt management advice and is continuing to offer a range of support mechanisms.

Measuring child poverty in Manchester

Child poverty is defined as 'a household with children under 16 where income is less than 60% of the UK median' (ie. the UK average). Children in Low Income Families local area statistics,[2] is produced by DWP and HMRC, but does not take into account housing costs. The End Child Poverty Coalition (ECP) are using this dataset and combining it with housing-cost information from the Valuation Office Agency and the Understanding Society survey[3] to adjust for housing costs. These statistics have been adopted by Manchester City Council to measure progress.

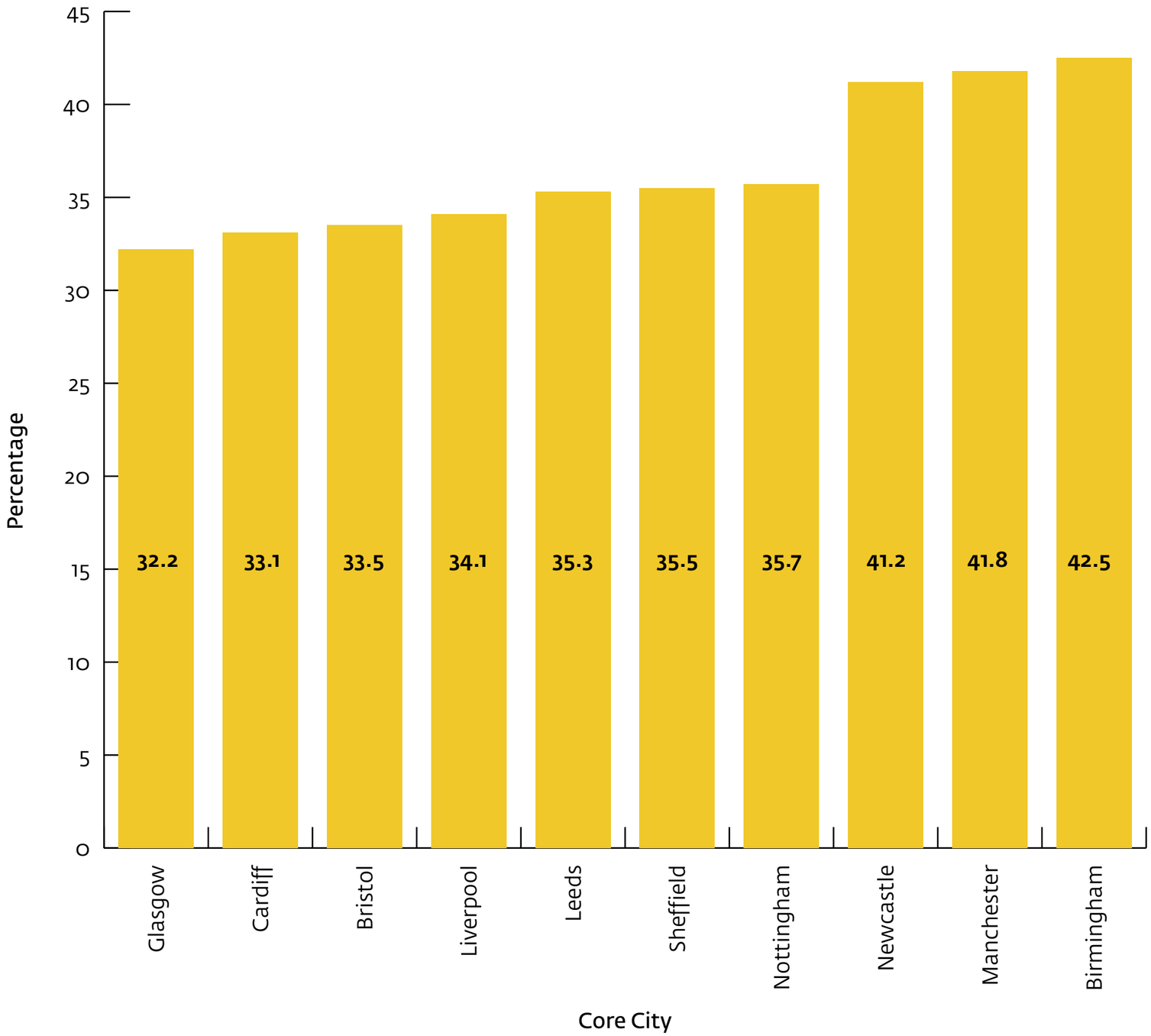
The ECP measure does not allow for a split of child poverty between working families and families not in work.

According to ECP, around 46,700 children in Manchester were estimated to be living in poverty (after adjusting for housing costs) at the end of March 2020 (the latest available data). Figure 4.3 shows this is 41.8% of those aged under 16 living in Manchester, based on the ONS population estimates, and a significantly higher proportion than the UK average of 31%. Of the local authorities in England, Manchester has the 12th highest rate of child poverty, compared with 17th in March 2019, when 40.6% were estimated to be living in poverty. It has the highest rate within Greater Manchester local authorities, and the second-highest rate for Core Cities, after Birmingham at 42.5%.

2 www.gov.uk/government/collections/children-in-low-income-families-local-area-statistics

3 www.understandingsociety.ac.uk/

Figure 4.3:
Percentage of children under 16 estimated to be living in poverty (after housing costs) in the UK Core Cities 2019/20



Source: Research by the Centre for Research in Social Policy at Loughborough University for the End Child Poverty Coalition, 2020

Statistics from the DWP and HMRC show that in 2019/20 there were 45,905 children in Manchester living in poverty, before accounting for housing costs; 31,500 of these children were living in in-work poverty, more than twice as many as the 14,405 living in out-of-work poverty. The change since 2017, which saw the restriction of child benefit to two children as well as amendments to child tax credit and working tax credit, is an overall 23.1% increase in in-work poverty and a 7.9% decrease for those living in out-of-work poverty.

According to DWP, in March 2020 Cheetham had the highest rate of children living in in-work poverty at 425.1 per 1,000 children aged 0–15, followed by Rusholme at 404.8, and Levenshulme at 403.4. Longsight and Crumpsall also have high rates of children living in in-work poverty. These figures (which do not reflect the impact of COVID-19), illustrate that in-work poverty is a significant issue in the city. The analysis also highlights that there is a correlation between the rate of children living in in-work poverty in an area, and the percentage of children living in that area who are from Black, Asian and minority ethnic backgrounds.

Both the DWP data and ECP figures only report until the end of March 2020 and therefore do not reflect the impact of COVID-19 on children and families. Free school meals (FSM) data is collected as part of the termly School Census and can be used as an indication of the number of children living in low-income households. In January 2020, 31.5% of the school population was eligible for FSM; in January 2021 this figure rose to 37.8%. There has been very little change in the size of the school population, so these figures indicate that the pandemic has seen a significant rise in the number of schoolchildren living in low-income households.

Healthy Start vouchers

As FSM numbers only include children attending Manchester schools, these figures do not account for any children under four years old living in low-income households. The number of women eligible for Healthy Start vouchers (available to pregnant women claiming benefits, and those who have a child under four years old) can give an indication of how this group of children may have been affected by the pandemic. From the start of the pandemic to the end of February 2021 there was a 15.8% increase in the number of women who were eligible for Healthy Start vouchers. This is the highest increase of the Core Cities and in line with the national increase; 61% of the 8,870 women eligible for Healthy Start vouchers are claiming their entitlement, higher than the national uptake rate of 54%, and ranking fifth in the Core Cities. Similarly, in January 2020, while 31.5% of pupils were eligible for FSM, only 82.8% of these pupils were claiming a meal. This compares with 78.7% nationally and ranks second highest of the Core Cities, behind Leeds.

Manchester Poverty Truth Commission (MPTC)

The Manchester Poverty Truth Commission, which was officially launched in June 2019, has now concluded its work. In March 2020 they agreed a number of specific themes and priorities to best address the systemic causes of poverty. The themes are child and family poverty, exploitation, and council tax and benefits. A number of key recommendations were published in the 'Key Findings and Impact Report 2019–21', including:

- Ensuring that low-cost school uniforms are accessible for all
- More accessible cultural offer in the city
- More easily accessible information on services in the city; broadband should be regarded as a utility and available to all regardless of their ability to pay
- Better support for those with lived experience of involvement in gangs to set up community groups or community interest companies
- Specific training on the link between poverty and exploitation should be developed for dissemination at the city's universities to inform policy responses
- More options given to Council staff to write-off council tax arrears where appropriate
- Designing community-based workshops/pilots to bring those with council tax debts together with money advice specialists as a way of tackling council tax arrears.

The report will also be disseminated to key organisations in positions of influence across the city for their consideration.

Anchor institutions

Anchor institutions have long been recognised as having a key role in tackling poverty, given their size, budgets and the fact that they are rooted in the city. More recently, in response to the significant economic and social challenges facing the city, there has been an increasing recognition in Manchester and Greater Manchester that social value in the broadest sense, encompassing good employment practices and procurement, is invaluable to the inclusive recovery of the city. It has also been recognised that anchor institutions, given their role, are an important vehicle to deliver this.

This is reflected in the Council's recent review of social value, which set out a more prominent role for anchors in helping the city to deliver social value, and in the Family Poverty Strategy Reprioritisation, where the role of anchors was further strengthened.

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, including its children, young people and 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 (2020–24), translates the Our Manchester priorities into a vision for 'building a safe, happy, healthy and successful future for children and young people'; this means:

1. All children and young people feel **safe**, their welfare promoted and safeguarded from harm within their homes, schools and communities.
2. 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 all children and young people feeling that they have a voice and influence as active Manchester citizens.
3. 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.

4. 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.

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

Impacts of COVID-19

Throughout the COVID-19 pandemic, Manchester's Children's Services and their partners have sought to continue to ensure the delivery of the services that underpin our children's strategy so that children can live safe, happy, healthy and successful lives. Overall, the partnership has demonstrated flexibility in responding to the challenges of lockdowns and associated restrictions to contain the virus.

The impact of COVID-19 and the periods of lockdown on the city and its children and young people is increasingly becoming evident. Although our children and young people have shown incredible resilience during this time, we know that children and young people, particularly from disadvantaged families, have been disproportionately affected, and so the opportunities for young people post-education will be reduced.

The full extent and impact of COVID-19 on the development, life chances and opportunities for the city's children and young people is not yet fully understood and may not be for some time. However, there are a number of known or emerging themes and issues:

- The education gap between those children considered to be disadvantaged and their counterparts will have widened.
- There are indications of increased rates of anxiety and mental health issues.
- The pandemic has increased inequality in the city – there has been a 6% increase in the overall number of children being eligible for free school meals. In addition, we have seen a significant increase in families accessing food banks over the past 12 months, and financial hardship has become a feature of everyday life for many children.
- There is the potential for increased levels of school exclusions as some young people struggle to return to routine and boundaries.
- Lack of opportunities for young people post-school and college are likely to lead to increased levels of Not in Employment Education and Training (NEET).
- Some children have reported feeling anxious about transition between school/college phases, their future opportunities, and feeling isolated/lonely. This appears to have the potential to compromise the aspirations and hopes of young people across the city.

The future delivery of the Children and Young People's Plan will therefore be considered within the context of COVID-19 and its anticipated impact on children, in addition to issues of race, disadvantage and discrimination.

Referrals to Children's Services

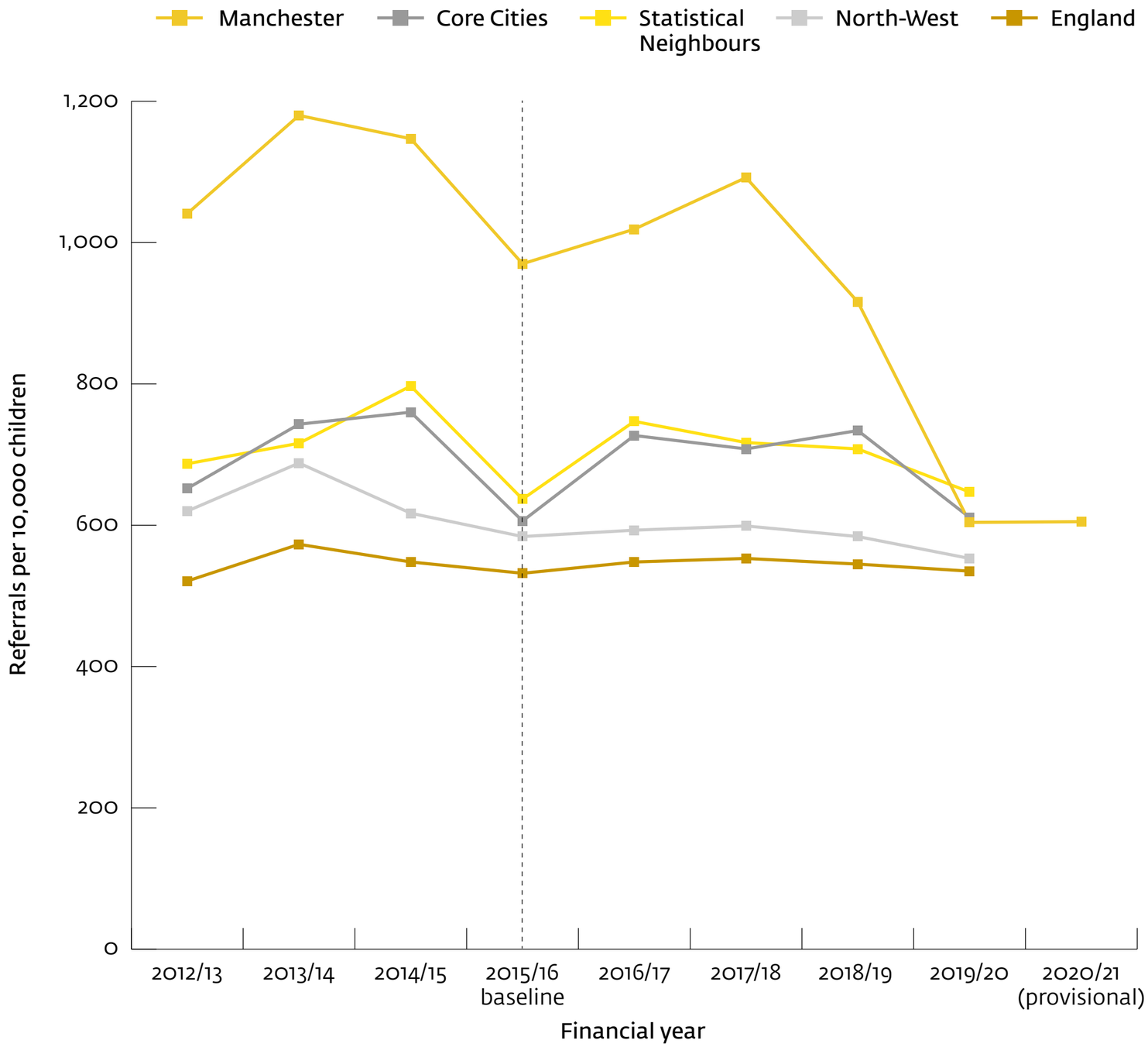
Children's Services in Manchester have continued to provide services for vulnerable children and their families throughout the COVID-19 pandemic. Since March 2020, the service has operated under the working premise of 'business as usual but doing things differently'. This mission statement reflected the service's commitment to ensure children were safeguarded and their needs were effectively met. The service has continued to work directly with children and their families throughout the pandemic, mindful of relevant health and safety advice. It has shown significant creativity and flexibility in its approach to service provision, while supporting the partnership's capacity to continue to develop collaboration in the knowledge that some families require a co-ordinated multi-agency level of support to safeguard children.

The Council has worked effectively to ensure the identification of vulnerable children, and, with schools, has jointly risk-assessed children to target support for them since the early phases of the pandemic. The service supported the expert advice on COVID-19 that children, on balance, were better

off at school, and supported many children and families to return to school during periods of lockdown. Further details of the pandemic's impact on schools, and the support provided for children and young people, is included in the 'A highly skilled city' chapter.

The provisional 2020/21 rate of referrals remains at a low level of 605 per 10,000 children. Figure 4.4 shows that this rate compares favourably to the national (535), regional (553), Core City (611) and statistical neighbour (647) averages for 2019/20.

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

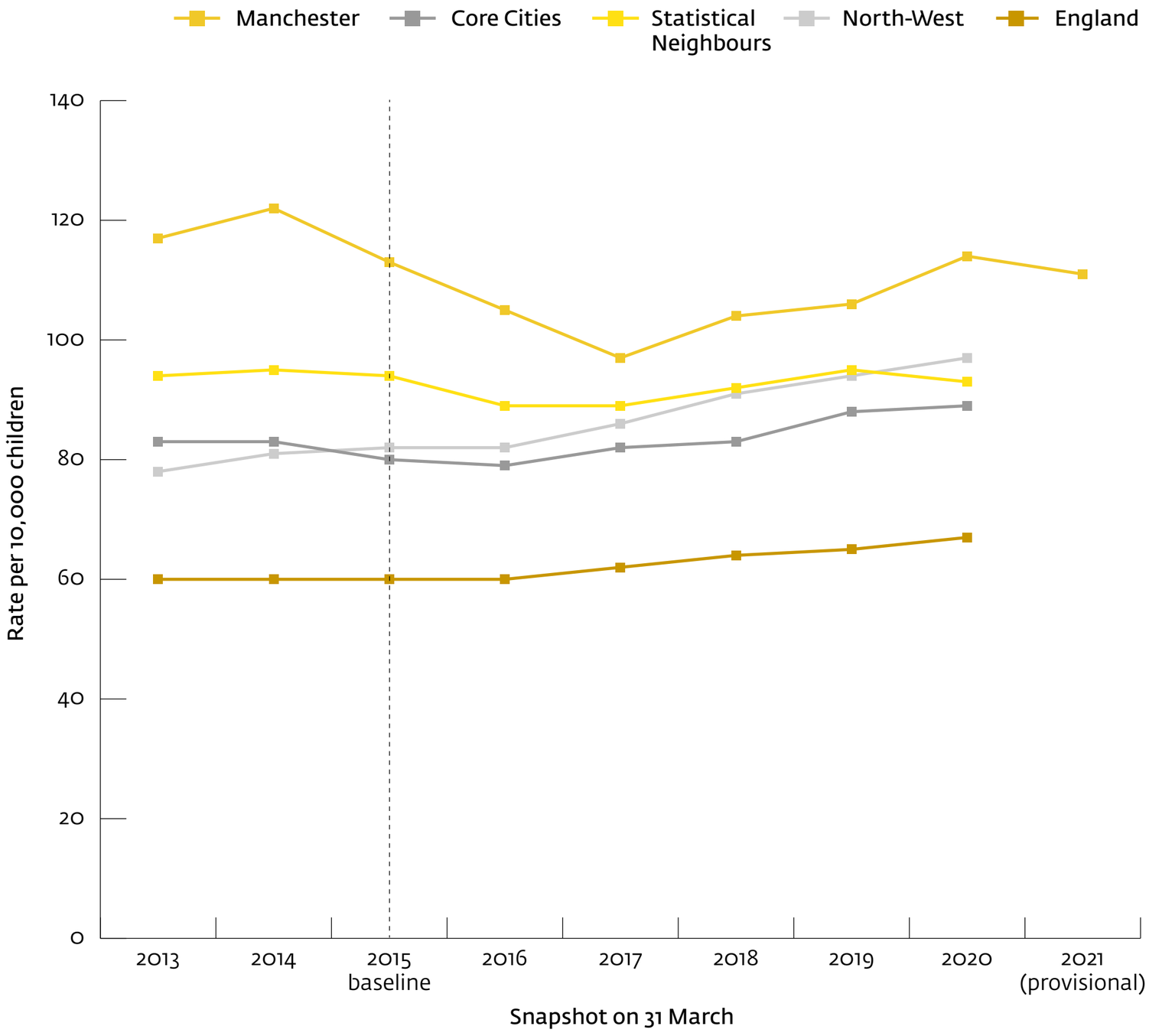


Source: Department for Education/MiCare

Looked After Children (LAC)

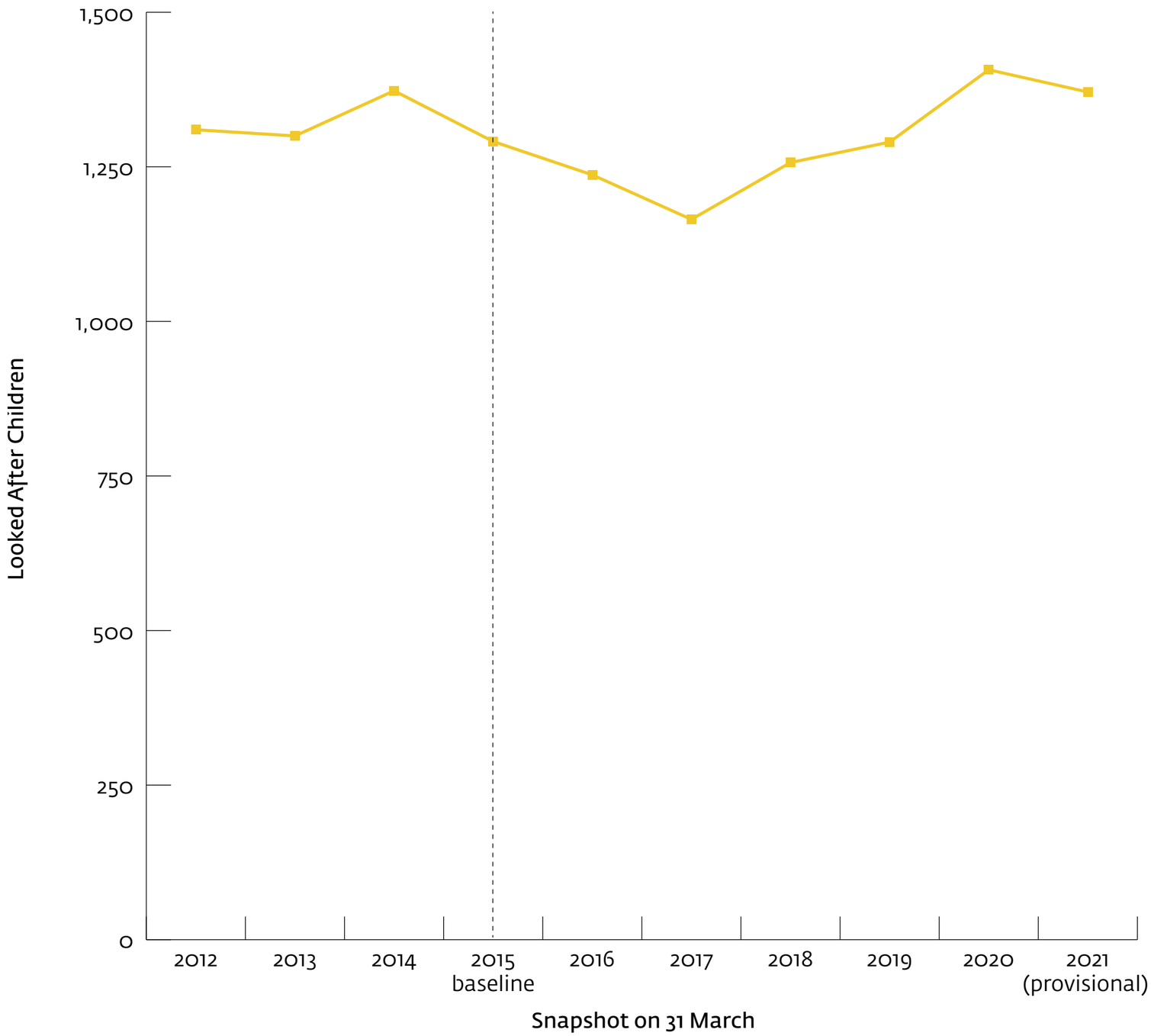
Figures 4.5 and 4.6 show that following a decrease between 2014 and 2017, the provisional number and rate of children looked after by the Council has risen to 111 per 10,000 children in 2021, and remains above the national (67), regional (97), Core City (89) and statistical neighbour (93) averages for 2020. There were 1,371 Looked After Children at the end of March 2021. Although the rate of Looked After Children is consistently above other local 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 (31 March)



Source: Department for Education

Figure 4.6:
Number of Looked After Children



Source: Department for Education

The service takes essentially 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 and where possible prevent the need for children to go into care, or where they do, to ensure a timely return home. These include Multi-Systemic Therapy, Multi-Treatment Foster Care, No Wrong Door and the Adolescent Support Unit – Alonzi House.

The services provided by Alonzi House have been adapted to include Looked After Children to promote stability and inclusion in family-based care arrangements. This has resulted in the multidisciplinary team operating out of Alonzi House to provide foster families with wrap-around support that includes an outreach element and both practical and emotional support, securing stability, permanent arrangements for children and significantly reducing 'unplanned' placement endings.

Care planning and practice

Fundamentally, the approach to reducing the number of children entering the care system is predicated on early intervention and high-quality practice that assesses risk and issues, and plans for

sustainable change in the behaviour of families and individuals. The successful delivery of the Children's Services Locality Programme during 2019/20 has enabled the redistribution of social worker capacity. The aim of this has been to secure a timely plan of 'permanence' for children who become looked after and the continued improvement in the overall quality of practice. Over time it may be possible to divert further resources from specialist social work to early help services.

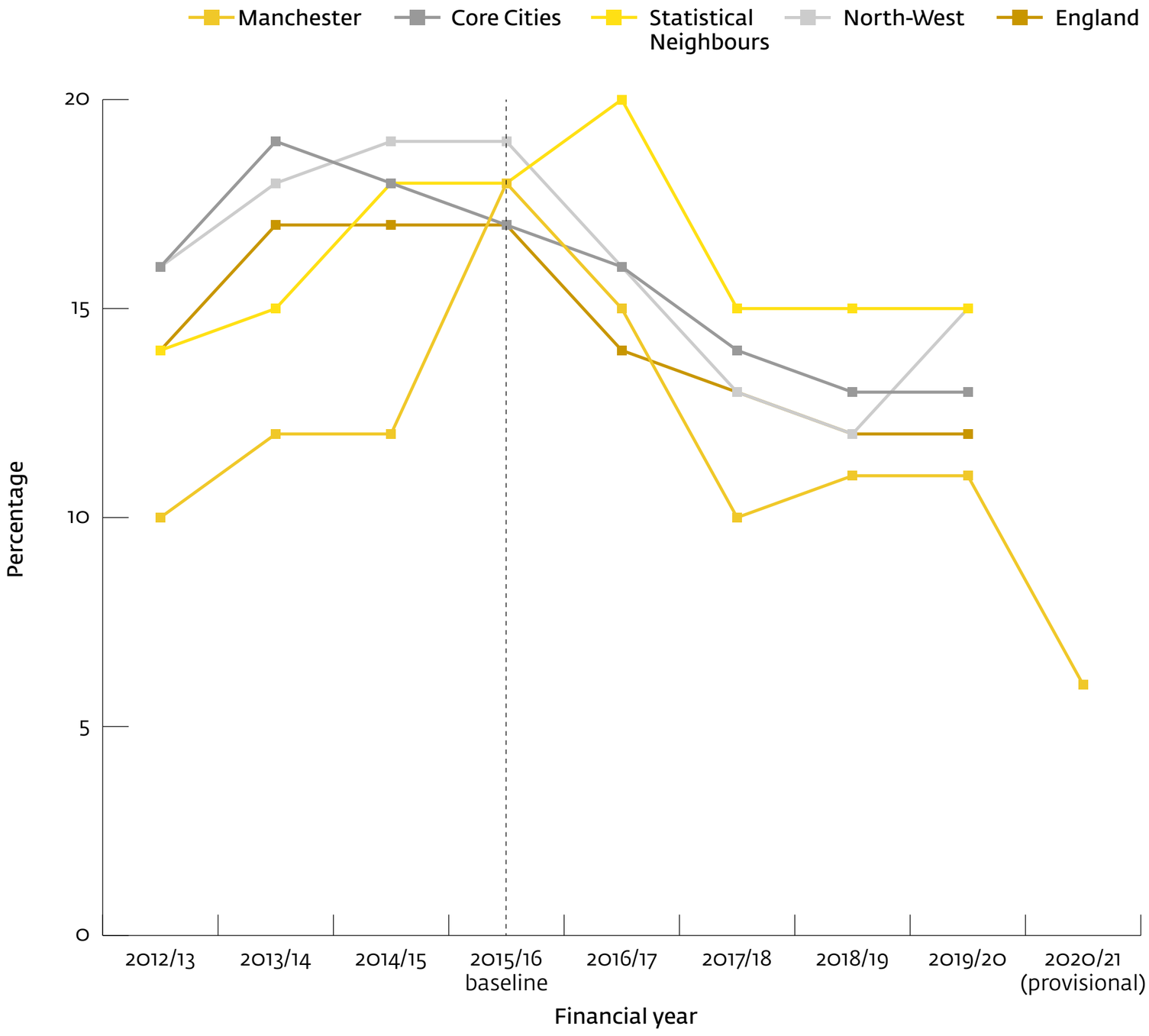
Permanence

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 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.

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 had fallen to 6% in 2020/21, compared to 11% in the previous year. Although the latest comparator figures are not yet available, the most recent national, statistical neighbour and Core City average figures indicate rates have remained relatively stable since 2017/18.

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



Source: Department for Education

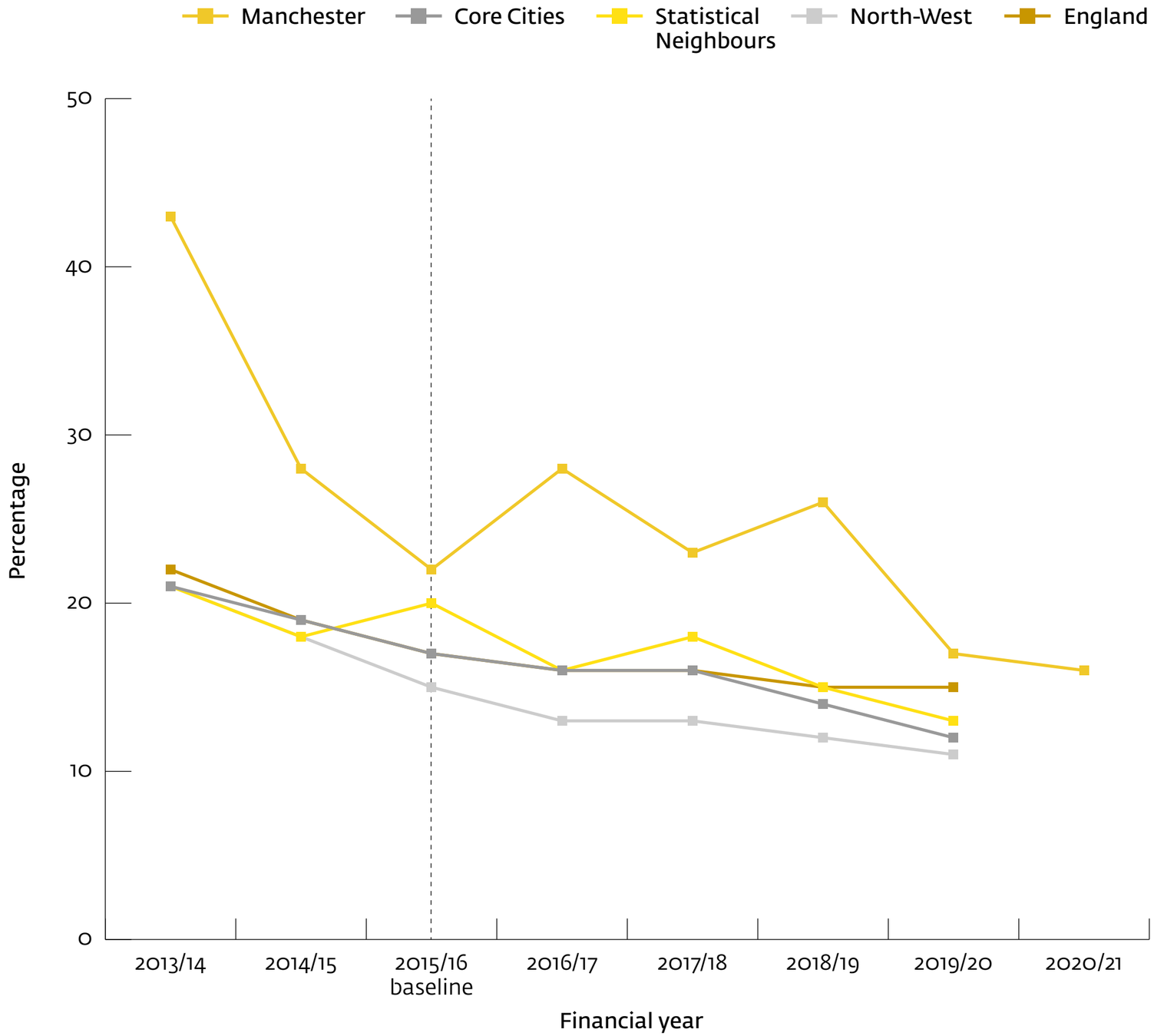
The number of children placed during 2020/21 has been affected by the pandemic, children being unable to be placed for part of the year due to restrictions that were in place. However, adopter approval numbers have remained consistent: 104 families have been approved this year, compared with 110 last year. This is a significant achievement during a time when many families delayed making applications or had to withdraw due to uncertainties in their lives, such as redundancies, caring responsibilities, home schooling etc. This consistency has ensured we continue to have a greater pool of prospective adopters available, all of whom have been assessed as having the skills needed to meet the needs of vulnerable children requiring permanence.

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 reduced slightly over the past year, from 17% in 2019/20, to 16% in 2020/21, closing the gap to comparator groups.

Like all local authorities, Manchester now has a duty to provide support for all care leavers who want it up to the age of 25. In line with this, the Council has been reviewing its Care Leavers Offer with a strong focus on supporting young people to independence, including ensuring that all Care Leavers have access to suitable accommodation.

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



Source: Department for Education

Early Years and Sure Start Children's Centres

The city's Early Years offer, including our Sure Start Children's Centres (SSCCs) and our integrated approach, ensure that our children have the best start in life and are ready for school. The SSCCs have now aligned to the 13 neighbourhoods. Our Early Years revised governance arrangements and our Early Years strategic partnerships, at a neighbourhood level, support a place-based approach to collaborative working with a wide range of partners. Our Start Well Partnership is focusing on the 1,000 days and developing our Start Well Strategy.

Throughout the pandemic the SSCCs have seen an increase in demand for services and activities for new parents and babies, as well as services related to presenting needs such as food poverty and children's delayed development. The SSCCs have therefore taken a targeted approach to meeting this demand, reaching out to new parents and vulnerable families with a bespoke offer of support, advice and guidance.

Large-scale national research indicates that the pandemic has prompted a decline in children's emotional wellbeing, with younger children being particularly affected in terms of their ability to listen, share and to be sociable and independent. There are particular concerns about children's writing, speech and language. We know there remains a stubborn 6% gap between the children in Manchester and the national average in relation to achieving a good level of development. We have a strong core offer delivered by our Children's Centres and pathways, which provide parenting interventions and programmes to support communication and language development. Approximately 2,000 children receive a Speech and Language WellComm screen annually, and approximately 60% of children screened show signs of delay and therefore receive the speech and language WellComm intervention. In addition, approximately 1,000 children benefit annually from our parenting intervention.Following intervention, approximately 66% of children no longer present with conduct-disorder behaviour problems.

The SSCCs' summer offer of services and activities has engaged with a high volume of children and their families, paving the way back to more universally available services and activities in line with the easing of restrictions.

Early Help

Manchester's 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'.

Our strategic approach is fully integrated with the national Supporting Families Programme, which was formerly known as Troubled Families. When the initial five-year national Troubled Families programme ended in March 2020 it was extended for a further year. During this six-year period (2015–2021) Manchester worked with 12,121 families, of which 9,372 met Government criteria for sustained change. As the national programme evolves, we will continue to align and integrate our local offer with the national programme.

A collaborative approach between Early Years, Early Help and the Local Care Organisation is developing new ways of working, reflecting a whole-family approach, and the Early Help Hubs have a key role to support this collaboration at a neighbourhood level. Engagement with families and partners on Start Well priorities is underway and is focusing on 'what matters to families', and this will inform and shape the Start Well and Early Help priorities. We will achieve further impact and sustainability of the Early Help Strategy and approach via the continued partnership arrangements, including the Early Help Hubs, Bringing Services Together and closer collaboration with the Manchester Local Care Organisation. Sustaining partnership collaboration will inform future delivery arrangements and enable us to collectively deliver integrated teams for families centred around neighbourhood assets such as Children's Centres or schools.

During the pandemic, the offer of Early Help has been responding to the COVID-19 crisis and supporting vulnerable families that might be struggling. There have been increased requests for support with parenting, emotional and mental health support and wellbeing, alongside continued demand in relation to domestic violence and abuse incidents.

For many families, poverty and hardship has been exacerbated. As part of the Council's response to COVID-19 food and fuel poverty, this was alleviated for some through the COVID-19 Winter Relief Scheme, which was administered through the Early Help Service. 2,872 children have benefited from payments to relieve hardship identified by schools; this equates to £186,640 being distributed to alleviate hardship. In addition, supermarket

vouchers have been provided for children entitled to benefit-related free school meals and other vulnerable children during every school holiday since September 2020.

Adaptation of delivery meant revised guidance for all staff in the service in relation to face-to-face contact with families. This included doorstep visits, outside contact (walking in parks and meeting at other venues such as Sure Start Centres) and undertaking home visits where required. Staff liaised with partners to ensure families were supported and seen and Early Help practitioners found creative and innovative ways of engaging, communicating and supporting their families.

Support to ensure children attended school has been a high priority for the hubs, and Early Help practitioners have monitored school attendance, worked with families to understand barriers, and liaised with Pastoral Leads to resolve issues. Early Help are key partners supporting the school clusters arrangements and this is ensuring the wider needs of families in the localities are focused on. Following the resumption of a return of all children to school in March 2021, requests for Early Help support have been consistently high, averaging in excess of 800 per month, increasing significantly in March 2021 to 1,079 new requests for Early Help.

Domestic abuse notifications remain high and Early Help contribute to the daily multi-agency Domestic Abuse and Child Concern (DACC) meetings with police and social workers. In March 2021 there were 1,785 children discussed at the daily DACCs, and 291 went on to receive an offer of Early Help, most of the new notifications being referred into the social work service due to risk and complexity.

Demand for parenting support has been high; lockdowns have disrupted the delivery of face-to-face and group-work evidence-based programmes. In response, the Early Help Parenting Team developed a telephone appointment service during the summer to signpost and help parents. The helpline offered advice, guidance and strategies to parents and was popular, but could not be resourced once the term-time delivery of parenting programmes resumed. There remains a huge demand for parenting programmes across all three hubs and similar high demand is reflected in the early years. There is ongoing work with a range of partners, including Manchester Adult Education service, Early Years, health providers, and voluntary and community groups, to develop the range of parenting provision; current provision has adapted well to virtual, face-to-face and one-to-one support.

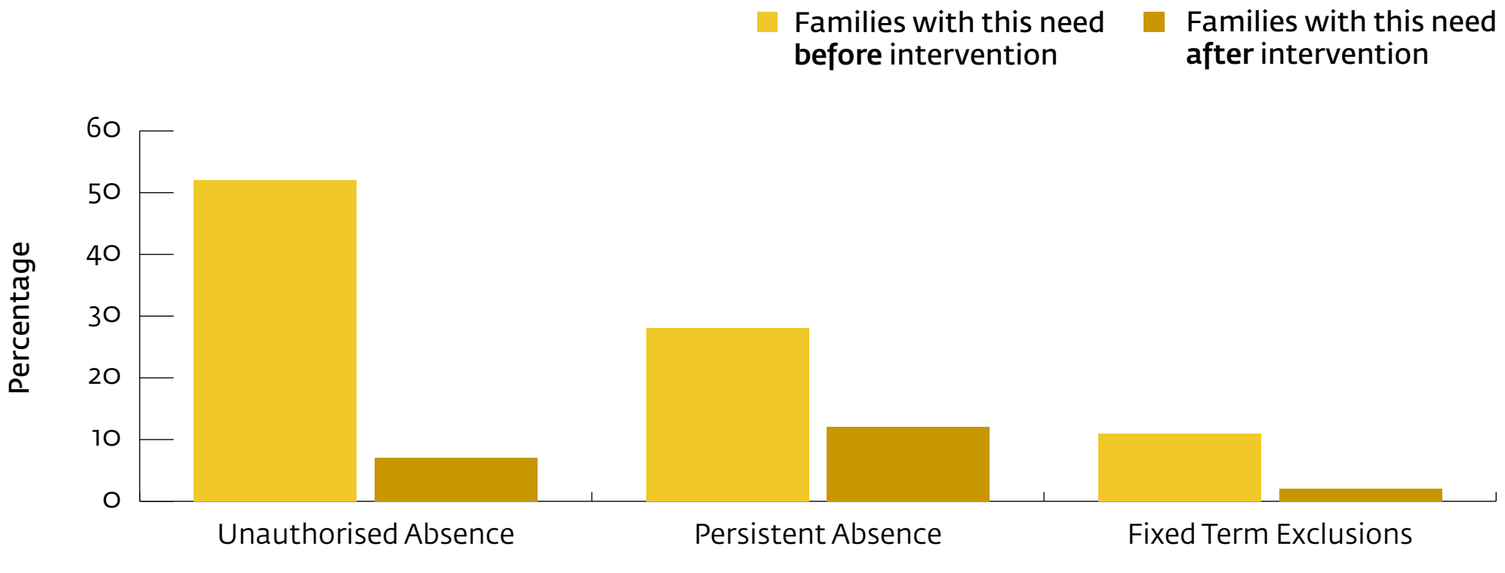
There is a strong focus on ensuring effective identification and support for babies –particularly babies born during the pandemic, who may have missed out on developmental opportunities around social and early years contact. This includes where developmental issues are not identified early enough and families where safeguarding and significant harm issues are being identified. During the pandemic we undertook a consultation and engagement as part of our Start Well Strategy, and 201 conversations were held with residents and 97 conversations with staff and volunteers. From these conversations, 91% of families reported that the pandemic had affected their experience of raising a baby. Families highlighted the lack of socialisation for babies and parents/carers, isolation from friends and wider family members, and fewer activities and groups available.

We are addressing this through the Start Well partnerships and via targeted projects such as our Thriving Babies and Confident Parents Project. This project will provide enhanced early prenatal and post-natal support for families with complex vulnerabilities to prevent escalation and achieve early permanency for families. A thriving baby's team has been established and this will work with voluntary, community and adult services to improve the co-ordination and offer.

How do we know Early Help is making a difference?

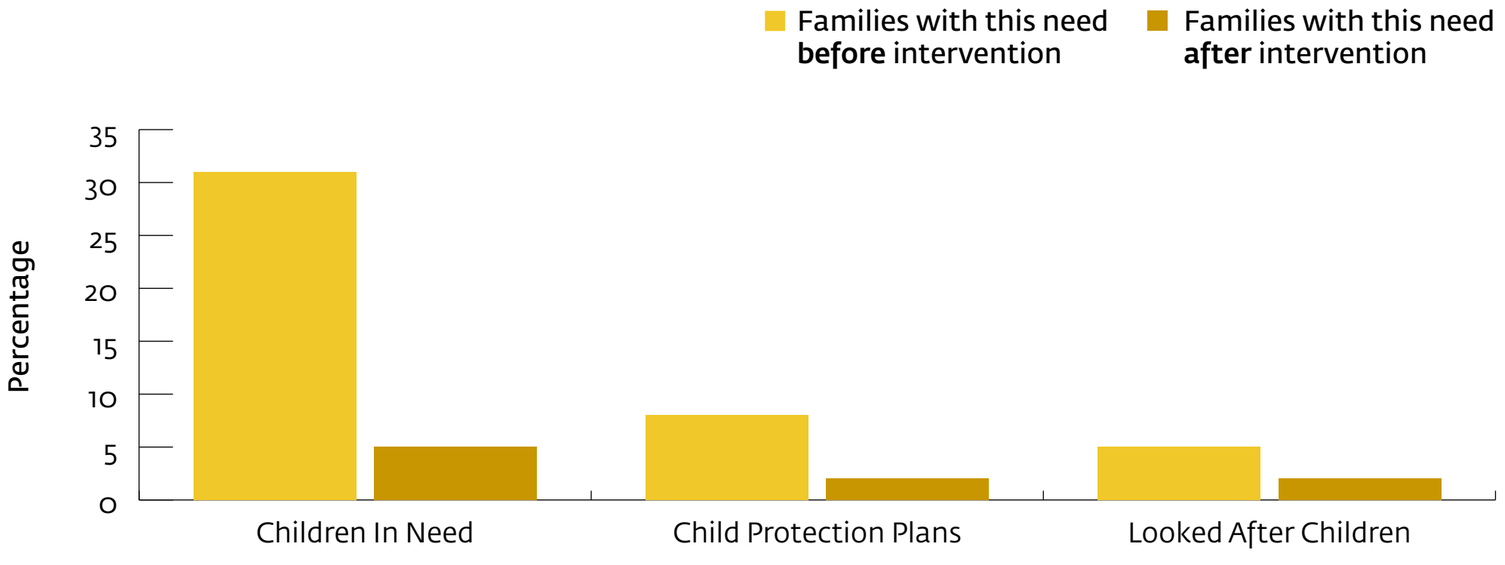
Our offer of Early Help is evaluated on a regular basis to ensure that families continue to make positive progress. Our latest evaluation demonstrates that a key-worker, whole-family offer can make a significant difference to the lives of families, including improving attendance, reducing involvement in crime, and keeping children and young people away from statutory services. Figure 4.9 shows that of the 52% of families who had a child with any unauthorised absence from school in the previous year, on average 87% had seen an improvement in their unauthorised absence 12 months after intervention. Figure 4.10 shows that of the 31% of families with a Child In Need (CIN) in the family, on average 83% of cases were successfully de-escalated by 12 months after intervention.

Figure 4.9:
Early Help impact on education



Source: Manchester City Council. Based on 7,734 families who received support during the period 2015–2020

Figure 4.10:
Early Help impact on Children's Services



Source: Manchester City Council. Based on 7,734 families who received support during the period 2015–2020

Integrating health and social care

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. A key priority of the Our Manchester Strategy is to radically improve health and care outcomes in the city. Manchester has some of the poorest health outcomes in the country, and there are very significant health inequalities within the city.

The Locality Plan, 'Our Healthier Manchester', represents the first five years of ambitious, transformational change needed to deliver this vision. The Locality Plan is fully aligned with the Our Manchester approach. This will mean supporting more residents to become independent and resilient, and better connected to the assets and networks in places and communities. Services will be reformed so that they are built around citizens and communities, rather than organisational silos. The Locality Plan is aligned to the Council's Corporate Plan priority 'Healthy, Cared-for People'.

Health and Adult Social Care Services within Manchester are delivered through the Manchester Local Care Organisation (MLCO). The MLCO is a public-sector partnership established by Manchester to deliver primary and community-based health and adult social care services, and its role has become even more critical due to the disproportionate impact of COVID-19 on many of our communities. It delivers services to adults and children across the city in partnership with Manchester Primary Care Partnership, Manchester City Council, Manchester University NHS Foundation Trust, and Greater Manchester Mental Health NHS

Foundation Trust. MLCO also works with many of the 3,600 voluntary, community and social enterprise organisations working across the city.

Grounded in the Our Manchester principles and the Manchester Strategy, the vision of the MLCO is to work together to support the people of Manchester to:

- Have equal access to health and care services
- Receive safe, effective and compassionate care closer to their homes
- Live healthy, independent, fulfilling lives
- Be part of dynamic, thriving and supportive communities
- Have the same opportunities and life chances – no matter where they were born or live.

The MLCO joins up the care that Mancunians get to help keep them out of hospital, taking a strength-based approach to help them live independently. The introduction of Integrated Neighbourhood Teams is transforming how residents experience their community-based health and adult social care. The integrated teams reduce duplication, meaning that different organisations talk to each other more about the care of patients, citizens and residents. It helps break down boundaries between different organisations and ensures there's a smooth process for helping people in their homes when they are in recovery or dealing with long-term health issues.

Case study: Integrated Neighbourhood Teams

There are 12 Integrated Neighbourhood Teams across the city, each serving a population of around 30,000–50,000 people. On a practical level, they co-locate adult social care and NHS community health staff in teams working together from neighbourhood hubs in the areas where they are based. That allows them to work closely together on a day-to-day basis.

For example, district nursing teams and social workers in Integrated Neighbourhood Teams carry out joint visits to citizens so that their health and care needs can be addressed in one visit. Teams also meet daily so they can share information on people and develop joint plans to meet their needs. Referrals that used to take place between organisations could take days or weeks, but can now be made immediately through the one-team approach.

The teams also work together with other partners – such as GPs, housing providers, pharmacies and the voluntary and faith sector – in multi-agency meetings through the Integrated Neighbourhood Teams. This allows action to be taken around the individual needs of people with all the right people in the room together.

As well as providing day-to-day services, the teams have a role in working with the community to build on existing strengths and tackle health and care issues that are important to each neighbourhood. This model of neighbourhood-based care is built on international best practice – that working in communities in an integrated way improves outcomes for citizens.

The integrated neighbourhood team model has seen strong relationships established in local communities over a number of years. These have come to the fore during the pandemic and allowed quick action to be taken to support communities. Health and social care teams have worked together with the Council's neighbourhood teams and other partners from the community to provide information and support for citizens. The voluntary sector has been a key partner in this work as well – tapping into their local knowledge and networks to meet the needs of communities of interest. This has been seen throughout the pandemic and also during delivery of the COVID-19 vaccination programme; it has included:

- Health and care staff working with places of worship to deliver information sessions on COVID-19 regulations and pop-up vaccination sessions
- Community newspapers developed to share health, care and wider community information with people who have poorer access to digital communications
- Takingan every-contact-counts approach so that health and care front-line staff have the right information to share with people in their interactions with them
- Working to provide information for ethnic minority communities in their own languages.

Impact of COVID-19 and response

Clear evidence has emerged that COVID-19 is having a disproportionate impact on some communities that have already experienced health inequalities in our city. Black, Asian and minority ethnic people, people with disabilities and people in poverty are more likely to contract COVID-19 and have poorer mortality outcomes. The long-term health impacts are not known yet, but it is expected that the socioeconomic impacts and impacts of higher mortality rates not directly linked to COVID-19 will also be within these communities, unless we radically change our approach to health and social care. This makes the need to embed inclusion and address inequality even more critical.

The COVID-19 pandemic presents a unique challenge for the country and Manchester. It also continues to present a challenge for Adult Social Care to undertake its functions of assessment, support planning, monitoring, review and safeguarding (the five core responsibilities of social work within the service) and the commissioning and delivery of care and support though internal services and the social care market within Manchester.

Adult Social Care has played a critical role in supporting vulnerable people across the city to remain safe and as independent as possible, and to continue to live within the community, preventing crisis and the need for more intensive health and social care services. In addition, throughout the pandemic, work has focused on the hospitals delivering discharge-to-assess arrangements, discharging as soon as people are medically fit, ensuring valuable capacity is available in hospitals.

From the outset, Adult Social Care's response plan was structured around clear objectives:

- Continuity of care for vulnerable people assessed under the Care Act
- Minimising risk of harm/fatality
- Protecting the credibility and reputation of health and social care and partners.

Focusing on these three objectives has meant that the service has responded well to the pandemic, including:

- Ongoing support to care providers
- Ensuring supply and provision of PPE
- Testing of citizens and staff
- Recruiting additional support workers to meet capacity gaps
- Undertaking safe-and-well calls to support vulnerable citizens and those not accessing services.

The service has been able to keep a close overview of issues and challenges within social-work teams, in-house provider services and the external care market, which has meant that support provided has been targeted and managed. Only a very limited number of services were paused (within Provider Services), while other services continued to operate throughout the pandemic, adapting to being delivered in a different way.

The Adult Social Care assessment teams have notably conducted welfare calls and visits as necessary to those vulnerable people known and newly referred via the contact centre at various points during the COVID-19 pandemic. The heightened response was to ensure those contacted were aware of the support available and were able to meet their own basic needs, and if not, measures would be put in place, such as delivery of food parcels.

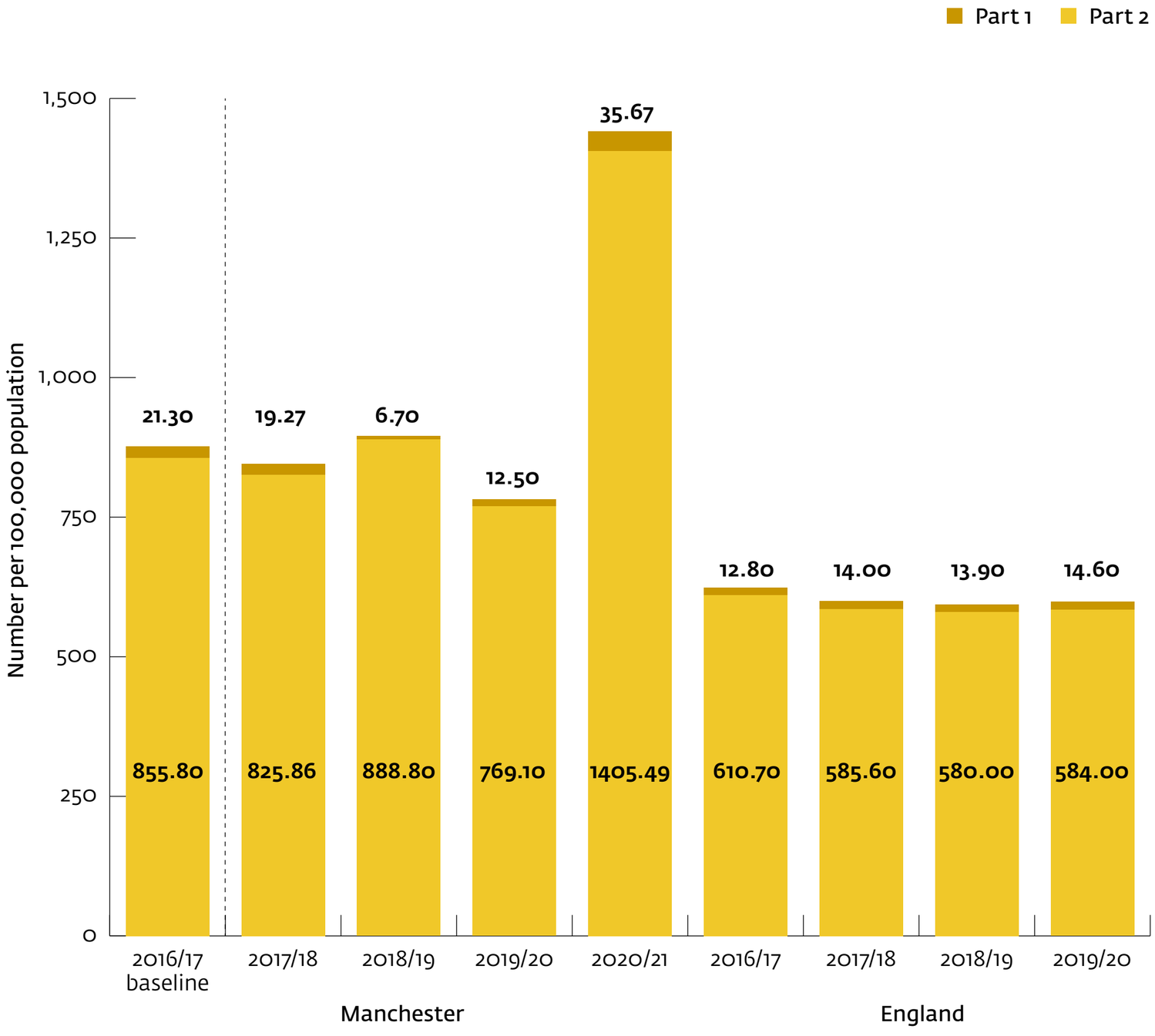
For those living in various supported settings, the combined efforts of the provider services, the assessment teams and public health and quality-assurance colleagues meant that they were updated, felt supported and had access to guidance and support. Health and social care system leaders in Manchester have agreed that in order to achieve the city's ambitions, the Manchester Local Care Organisation should be strengthened with the right resources and responsibilities to enable integrated working at scale and pace. As part of this work, a new section 75 agreement between Manchester City Council and the Manchester University Foundation Trust (MFT) has been developed. This allows the effective delivery of integrated health and adult social care and includes the delegation of responsibility for adult social care to MLCO.

Supporting older people to live independently for longer

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

Figure 4.11 shows that the provisional rate of those aged 18–64 admitted to permanent residential/nursing care was 35.67 per 100,000 in 2020/21; this is a substantial increase from the figure of 12.50 reported in 2019/20, and the 2016/17 baseline of 21.30 per 100,000. Provisional figures show that the rate of those aged 65 and over admitted to permanent residential/nursing care was 1,405.49 per 100,000, up from 769.1 in 2019/20.

Figure 4.11:
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 2019/20

Delayed transfers of care

Prior to 2020/21, delayed transfers of care data was collected, calculated and published by NHS England. However, this is no longer the case, stopping in February 2020 as a result of the COVID-19 pandemic. As such, the data for this year is based upon locally collected data and only for MFT (covering North Manchester General Hospital (NMGH), Manchester Royal Infirmary, Wythenshawe and Trafford General Hospital). It should also be noted that from this year, NMGH figures are now included in those for MFT, where previously they were included for data for Pennine Acute Trust.

While figures are therefore not directly comparable due to the addition of data from NMGH, it is still possible to determine trends from the MFT data over time. For March 2021, 28 people were delayed for a total of 604 days. This is considerably lower than both the end of February 2020 (157 people delayed for a total of 4,564 days between them) and March 2019 (48 people delayed for 1,476 days between them). The March 2021 figures are comparatively lower due to cross-partner efforts in discharging people from hospital during the COVID-19 pandemic.

The new Hospital Discharge Guidance was reviewed in July 2021, further embedding the Discharge to Assess model into the integrated health and social care systems and maintaining the ethos that no Care Act assessment or Continuing Healthcare assessment should take place in the hospital setting wherever possible.

To achieve timely, safe and effective discharges requires effective partnership working, and the services have been redesigned to facilitated this, with hospital Discharge to Assess teams working

alongside health colleagues. Assessments previously undertaken in hospital will now take place at home or in an alternative care setting if required. In addition, Adult Social Care's commitment to support 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

The Manchester Population Health Plan (2018–2027) is at the heart of our long-term plan to tackle Manchester's entrenched health inequalities. The plan contains five priority areas for action 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 make 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 forms 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.

Good progress has been made in a number of areas. Emerging evidence indicates that the pandemic has had a major negative impact on life expectancy, which will counteract the small increases seen prior to the pandemic. Likewise, recent improvements in the mortality rate from diseases considered preventable (cardiovascular diseases, cancer and respiratory diseases) may have been reversed by the pandemic. The proportion of cancers diagnosed early has increased in the city. Fewer Manchester mothers reported being a smoker at the time their baby was delivered. Reducing the under-18 conception rate continues to be a success story, and the number of under-18 conceptions in Manchester has remained below 200 a year since 2017. Fewer children aged 0–5 are being admitted to hospital for dental caries. There has also been a significant reduction in the rate of suicides and injuries of undetermined intent since the three-year period 2009–11.

Despite these improvements, Manchester still has some of the worst health outcomes in the country. There are also significant inequalities within the city; life expectancy at birth is 7.3 years lower for men and 7.8 years lower for women in the most deprived areas of Manchester than in the least deprived areas.

COVID-19 and Manchester's resident population

COVID-19 has had very significant impacts on people's health and the social determinants of health in Manchester. Since the first case of COVID-19 in Manchester was identified on 3 March 2020, there have been over 96,000 confirmed cases of COVID-19 in the city and, sadly, over 1,100 Manchester residents have died from causes directly or indirectly linked to the virus.

Table 4.2 shows that on 31 October 2021, there had been 96,046 Manchester residents with at least one positive COVID-19 test result since the start of the pandemic. This is equivalent to a rate of 17,283 cases of COVID-19 per 100,000 population, compared to a rate of 13,618 per 100,000 across England as a whole.

Table 4.2:
Number of COVID-19 cases and rate per 100,000 populationfor Core Cities, 31 October 2021 snapshot

Core City	Number of cases	Rate per 100,000 population
Birmingham	173,284	15,193
Bristol	68,893	14,788
Leeds	130,992	16,399
Liverpool	84,645	16,913
Manchester	96,046	17,283
Newcastle	50,204	16,363
Nottingham	53,369	15,832
Sheffield	86,010	14,597

Source: Coronavirus (COVID-19) in the UK dashboard

Expressing the total number of COVID-19 cases as a rate per 100,000 population gives a fairer comparison of the number of cases in each area. However, it does not take account of the different rates of testing or differences in the age and sex of the local populations.

Over the course of the pandemic, clear evidence has emerged of the disproportionate impact of COVID-19 on particular groups, notably Black, Asian and minority ethnic communities, those born outside the UK, disabled people and those at high occupational risk and/or in poverty. These groups were already known to experience poorer health and care outcomes before the pandemic and have also been shown to be more likely to contract COVID-19 and have a higher risk of mortality. For example, it is estimated that Black, Asian and minority ethnic groups account for 45% of the city's population; however, at the peak of the pandemic these groups accounted for approximately 60% of confirmed COVID-19 cases. Many minority ethnic groups are significantly more economically vulnerable than the rest of the city's population and were up to four times more likely to work in 'shut down' industries during lockdown. Nationally, disabled people accounted for some 60% of COVID-19 deaths and learning-disabled people were found to be up to six times more likely to die from COVID-19, trends that were reflected locally. Addressing the needs of high-risk, clinically vulnerable and underserved communities is one of the six key themes of the Manchester Local Prevention and Response Plan.

Manchester Health and Care Commissioning (MHCC) established the COVID Health Equity Manchester (CHEM) group as a vehicle for improving the experiences and outcomes for groups of people known to experience a disproportionate risk of transmission, severe disease and death from COVID-19, including Black, Asian and minority ethnic communities, some people born outside the UK or Ireland, people in specific occupational groups, disabled people, as well as other inclusion health groups (asylum seekers and refugees, gypsies and travellers, sex workers and ex-offenders).

The group has four clearly defined objectives:

- Development and delivery of culturally competent, targeted public-health messages and engaging and involving groups most at risk
- A whole-system approach to protecting people in identified at-risk groups from contracting the virus
- Preventing severe disease or death
- Addressing the immediate indirect consequences of COVID-19 on the at-risk groups.

The group has representation from equality and diversity leads and practitioners from health and care organisations across the city, communications and engagement leads, primary care, local neighbourhood teams, and VCSE organisations.

The strength-based approach of drawing from community insight and intelligence has enabled partners to better develop culturally competent messages and deliver preventative measures swiftly and effectively to communities that do not currently have good access to timely accurate public-health information.

The CHEM group has also been at the heart of the work to develop a Vaccine Equity Plan as part of the COVID-19 vaccination programme. There is evidence of positive progress in vaccine equity, with improved coverage and a narrowing of the gap between the general population and Bangladeshi, African and Pakistani people, people with a learning disability, and patients with a severe and enduring mental illness.

Life expectancy

Public Health England (PHE) has released provisional estimates of life expectancy at birth for 2020 to show the impact of the COVID-19 pandemic in England and its regions. These estimates indicate that life expectancy in England in 2020 was 78.7 years for males and 82.7 years for females. Compared with 2019, life expectancy in England in 2020 was 1.3 years lower for males and 0.9 years lower for females. These falls exceed any previous year-on-year changes seen since 1981.

Provisional estimates based on local calculations show that life expectancy at birth for Manchester residents has fallen by 3.1 years for men and 1.9 years for women in 2020 compared with 2019. This confirms what we already know in respect of the fact that there has been greater mortality from COVID-19 in men than women. Provisional data for Manchester residents shows that there were 568 more deaths in men and 295 more deaths in women in 2020 compared with 2019.

National data shows that, for both sexes, life expectancy fell in all of the deprivation deciles between 2019 and 2020. However, it fell by more in the most deprived areas of England. Data from the Indices of Deprivation 2019 shows that over 43% of LSOAs within Manchester rank in the most deprived 10% (decile) of LSOAs in England and just over 59% are in the most deprived 20%. Therefore, it is not surprising that the size of the fall in life expectancy in Manchester is in excess of that seen in England overall. This has had the effect of widening inequalities in life expectancy between Manchester and the national average.

Healthy life expectancy at birth (overarching indicator)

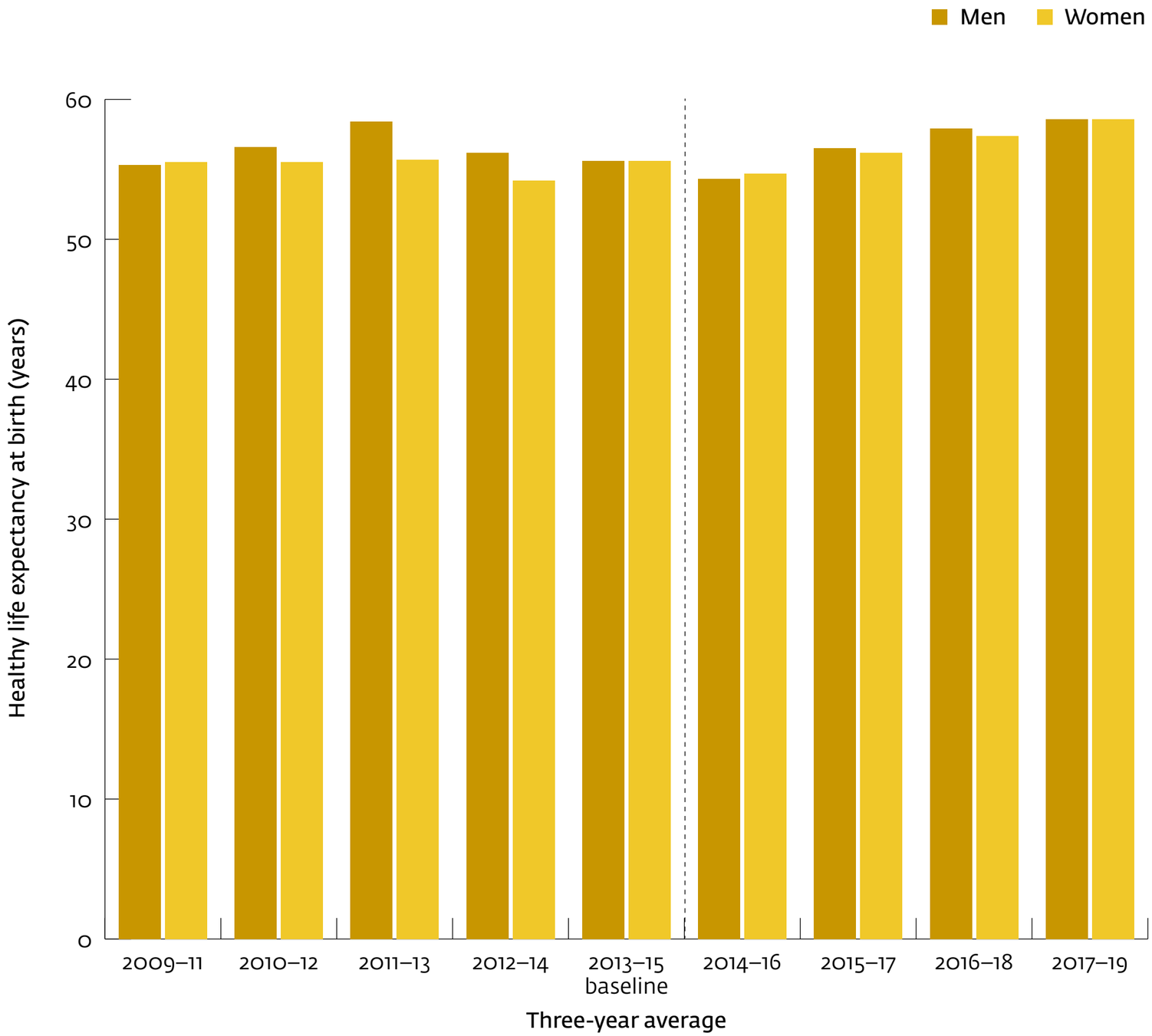
Healthy life expectancy (HLE) is a measure of the average number of years a person would expect to live in good health based on current mortality rates and the prevalence of self-reported good health. Estimates of healthy life expectancy are calculated using health-state prevalence data from the Annual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

In 2018, the Office for National Statistics (ONS) revised their 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.

Historical trends show that the improvements in healthy life expectancy (HLE) at birth seen in the early part of this decade did start to level off and fall slightly, particularly among men, but are beginning to take an upward turn again.

According to the latest published data (for 2017–19) in Figure 4.12, HLE at birth in Manchester slightly increased for both men and women compared with the previous three-year period (2016–18). In men, the average number of years a person would expect to live in good health has increased from 57.9 years to 58.6 years, and in women it has increased from 57.4 years to 58.6 years. Statistically, there has not been a significant increase, 0.7 for men and 1.2 for women. The figures compare to a decrease of 0.2 for men and 0.4 for women in England (HLE of 63.2 and 63.5 years respectively).

Figure 4.12:
Healthy life expectancy at birth, 2009–11 to 2017–19



Source: Office for National Statistics © Crown Copyright 2020

The previous data reported an increase in HLE for men in Manchester as greater than that for women. The gap has narrowed in years between men and women, which means that equally they can expect to live longer in good health.

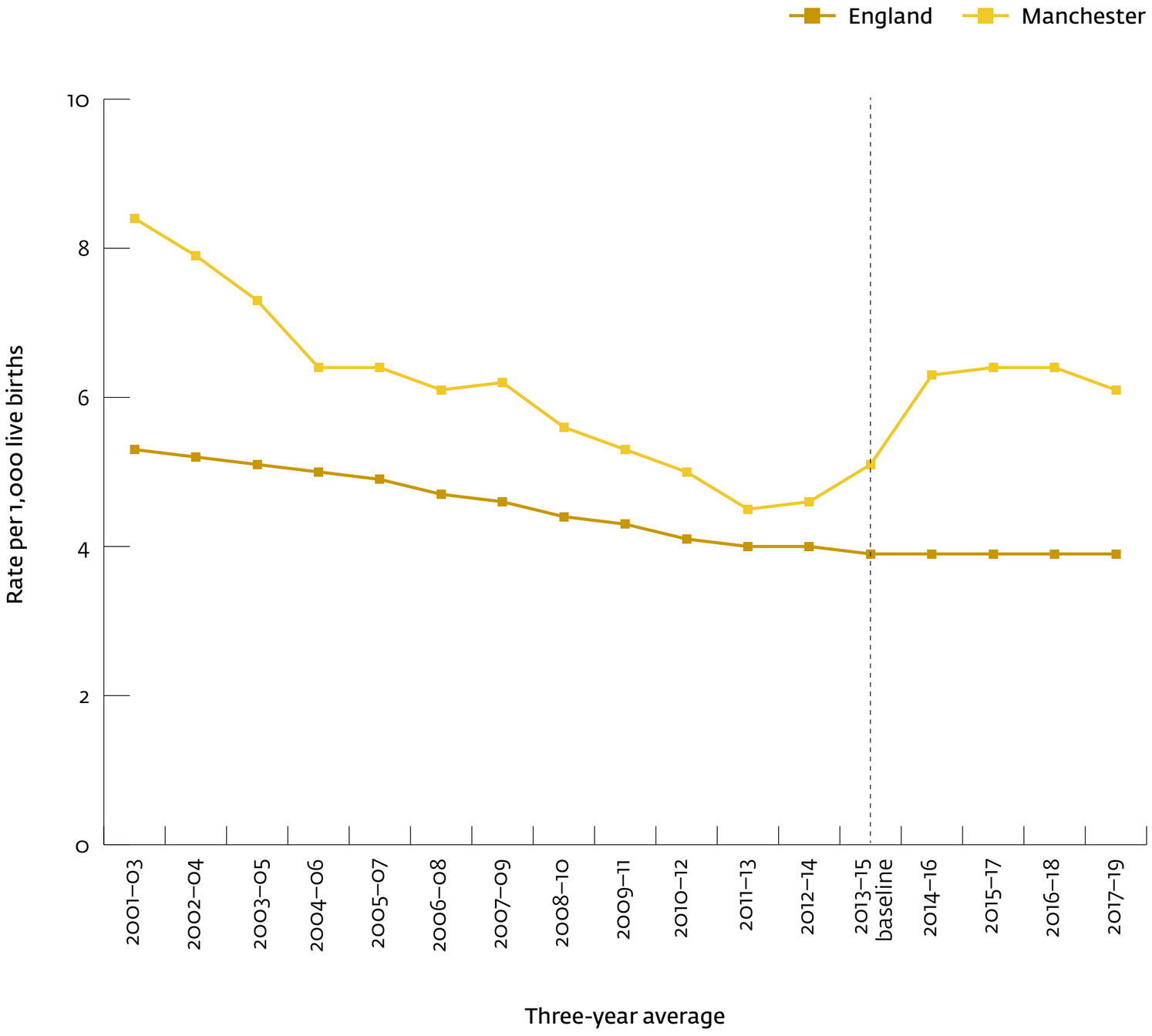
Improving outcomes in the first 1,000 days of a child's life

Infant deaths

Infant deaths (ie. deaths to 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 newborn child.

The infant mortality rate in Manchester has fallen substantially since the early 1990s. Between the three-year periods 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. Although there was a worrying increase in the infant mortality rate between the three-year periods 2011–13 and 2014–16, the position has since stabilised, and Figure 4.13 shows the rate has decreased between the three-year periods 2016–18 and 2017–19, from 6.4 to 6.1 per 1,000 live births, resulting in the number of infant deaths falling from 144 to 134. The England infant mortality rate has remained steady at 3.9 per 1,000 live births since the three-year period 2013–15.

Figure 4.13:
Infant mortality (number of infant deaths under one year of age per 1,000 live births)



Source: Office for National Statistics © Crown Copyright 2020

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, as well as 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 trends in infant mortality in Manchester and ensure that those who experience baby loss get the support they need, a multi-agency Reducing Infant Mortality Strategy was launched in 2019. This spans a five-year period (2019–2024), allowing time for longer-term outcomes to be realised. The implementation of the strategy is overseen by a steering group, which includes key partners with a role to play in the delivery of the strategy; they also 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.

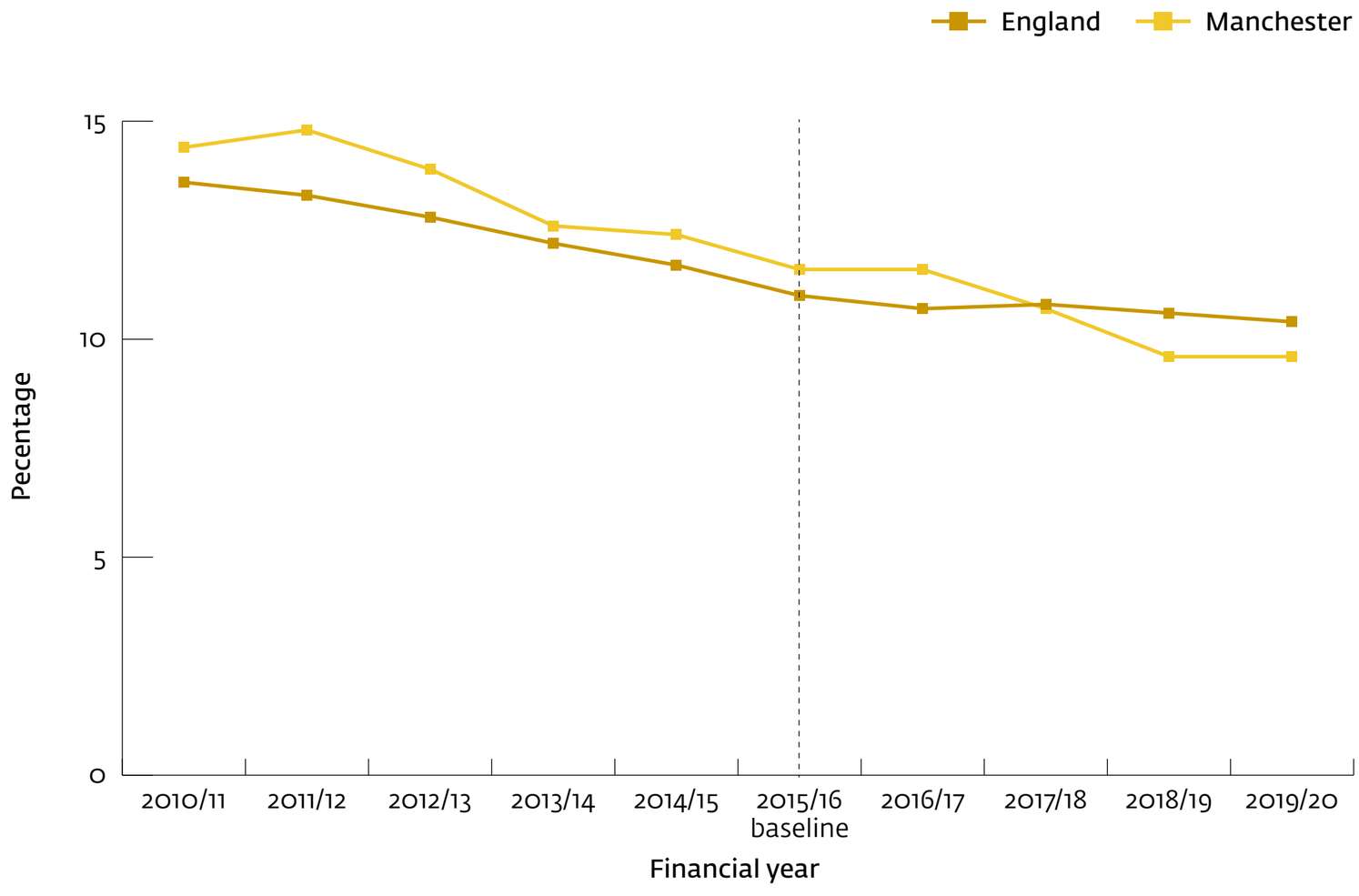
The strategy is a clear indication of the collective commitment of organisations in the city to ensure a reduction in infant mortality. By co-ordinating efforts across the city, we are confident we can start to see a downward trend once again.

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 birthweight, and sudden unexpected death in infancy.

In 2019/20, 9.6% of mothers in Manchester reported they were a smoker at the time their baby was delivered, compared with 10.4% of mothers across England as a whole. The percentage of mothers in Manchester reporting being a smoker at the time of delivery has fallen from a peak of 14.4% in 2010/11, and the local rate is now below the England average (Figure 4.14).

Figure 4.14:
Smoking status at time of delivery
(percentage of women who reported being a smoker at the time of delivery)



Source: NHS Digital © Copyright 2020

A new citywide community-based, nurse-led Tobacco Addiction Treatment Service, called Be Smoke Free, began operating on 1 April 2020. The service will link to primary and secondary care and will work out of 24 community locations, providing face-to-face consultations and support, as well as a direct supply of combination pharmacotherapy. Owing to the COVID-19 pandemic, the service provision was remodelled to see smokers who were most at risk from COVID-19 and hospital admission. Throughout the pandemic, the Be Smoke Free team assessed and supported all patients by phone or video call, offering the same planned 12-week support. Dedicated nurses ensured that all clients still received a personalised package of Nicotine Replacement Therapy by physically delivering medications to all clients' homes on a weekly basis, supporting some of our most vulnerable smokers to shield. Between April and June 2020, the service achieved a 44.4% quit rate for people with chronic obstructive pulmonary disease/coronary heart disease and other long-term conditions (NICE guidance seeks 35% quit rates).

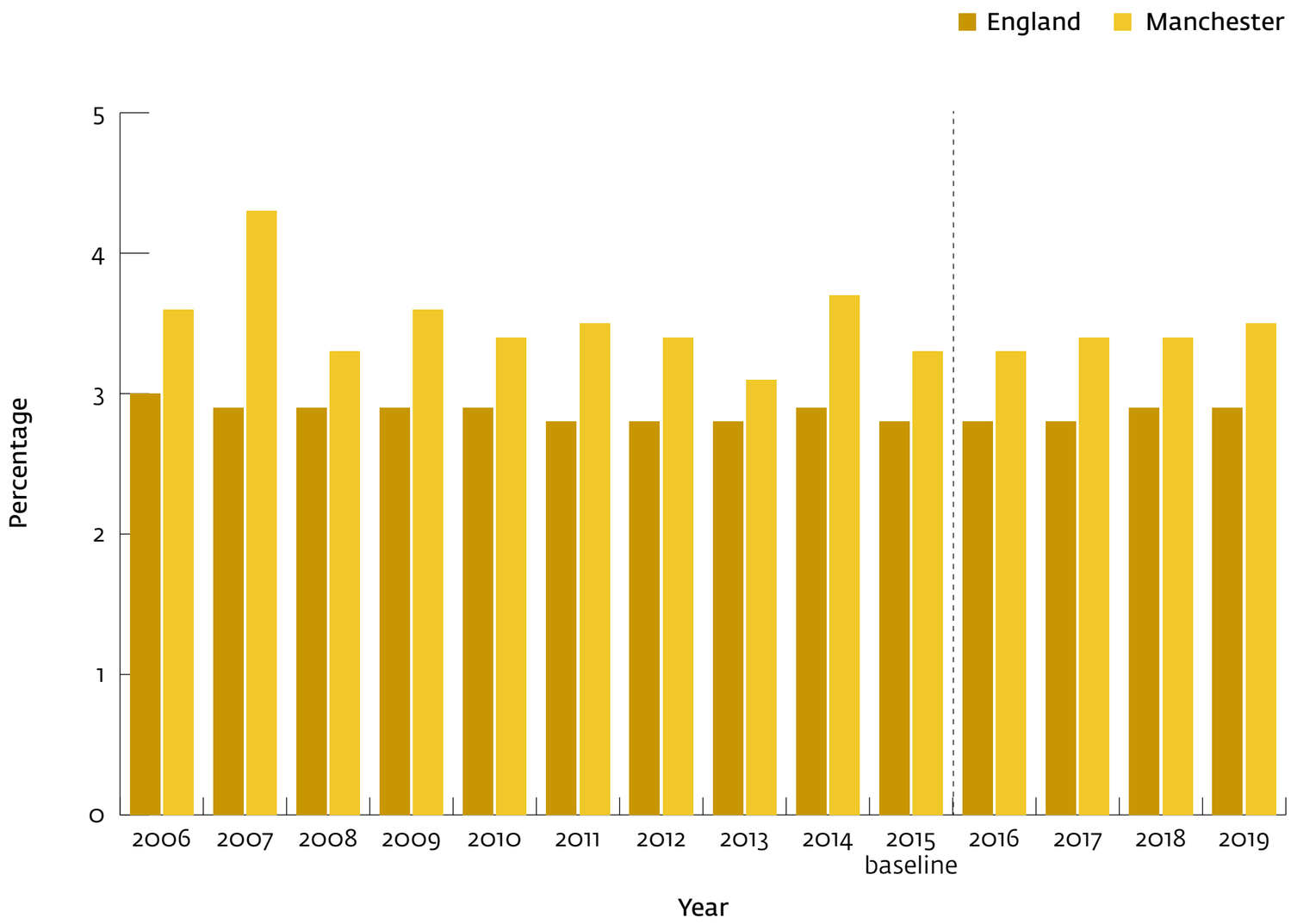
Low birthweight of term babies

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

Figure 4.15 shows the proportion of babies born to term (ie. a gestational age of at least 37 complete weeks) with a recorded birthweight that is 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 3.5% in 2019. In comparison, there has been little change in the England figures, reducing from 3% in 2006 to 2.9% in 2019.

Implementing the Reducing Infant Mortality Strategy should lead to a reduction in low-birthweight 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.

Figure 4.15:
Low birthweight of term babies
(live births with a recorded birthweight under 2,500g and a gestational age of at least 37 complete weeks)



Source: Office for National Statistics © Crown Copyright 2020

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

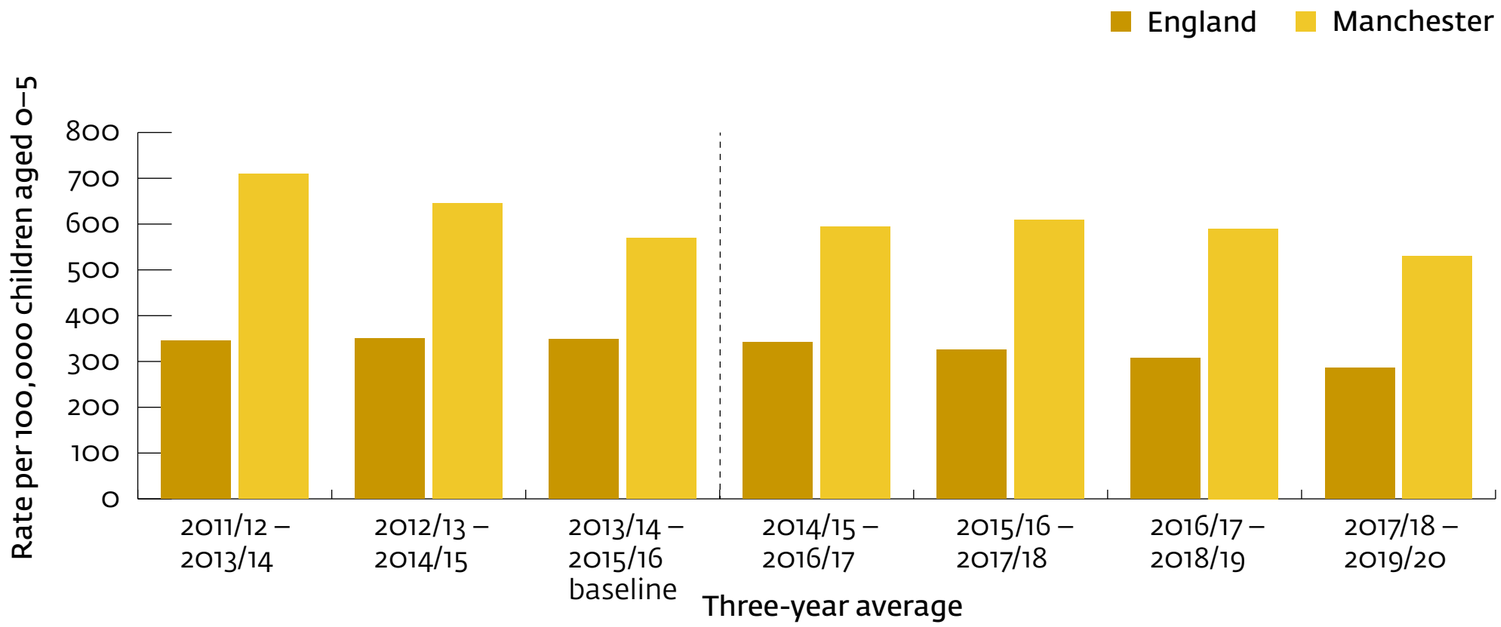
Dental caries (tooth decay) results in destruction of the crowns of teeth and often leads to pain and infection. Tooth decay is more common in deprived communities, and the prevalence of decay is a direct measure of dental health, as well as an indirect measure of child health and diet.

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 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 and is therefore not directly comparable with the figures included in previous reports, which focused on children aged 0–4 years only.

Figure 4.16 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 2011/12–2013/14 to 569.6 in the three-year period 2013/14–2015/16, before increasing back up to 608.5 in the three-year period 2015/16–2017/18. The figures have decreased since, reaching 529.1 in the three-year period 2017/18–2019/20. The England rate of admissions remains significantly lower than Manchester and has been reducing since the three-year period 2013/14–2015/16, reaching 286.2 for the latest period. This has significantly been the lowest rate for both England and Manchester.

Figure 4.16: Hospital admissions for dental caries in children aged 0–5 years



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 a range of interventions that 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 services provided by this team have been significantly disrupted by the COVID-19 pandemic in the past 18 months, perhaps more than any other children's community health provision. The team's ability to deliver 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 was initially suspended under Government guidance. Oral health work is only slowly being returned in a COVID-compliant way where settings allow, excluding fluoride varnishing and close-contact interventions. The OHIT team have been involved in the distribution of toothbrushing packs to targeted families in Early Years, as well as delivering training to staff working in children's settings, working within new COVID-19 restrictions.

Access to dental care for children has been challenging given insufficiencies in dental surgery waiting lists and loss of community settings due to COVID-19 restrictions. The Oral Health Improvement Service

has worked to ensure children's colleagues, such as Early Years or health visitors, can refer vulnerable children into community dental treatment.

Other measures of the health of children and young people

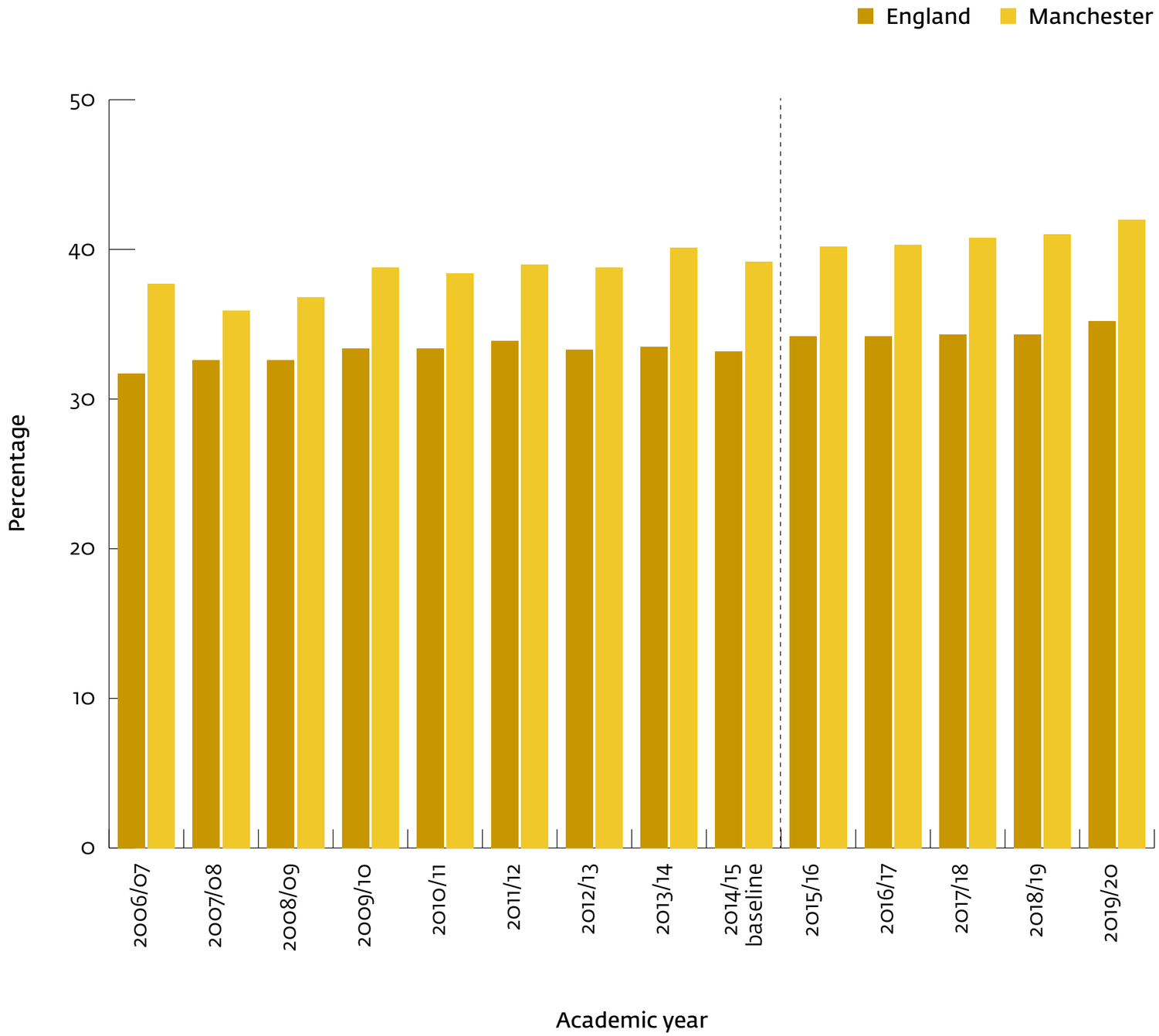
Excess weight in children in Year 6 (10/11 years)

The health consequences of excess weight in childhood are significant and also have implications for levels of overweight and obesity in adulthood. Although no demonstrable evidence has yet been produced, anecdotally, there is a sense that lockdown and home schooling have impacted poorly on maintaining a healthy weight.

The National Child Measurement Programme (NCMP) measures the proportion of children in Year 6 (aged 10 or 11) classified as overweight or obese, though the programme was paused in 2020 due to the COVID-19 pandemic. 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.

The proportion of Manchester children in Year 6 classified as overweight or obese has very slightly increased from 41% in 2018/19 to 42% in 2019/20. Figure 4.17 shows that the rate of overweight or obese children in Manchester and England has remained fairly consistent since the 2014/15 baseline, with England also increasing in the past year, from 34.3% in 2018/19 to 35.2% in 2019/20. The proportion of eligible children who have been measured in both reception year and Year 6 has increased, which means there is an increased likelihood that more overweight or obese children are being identified and referred at an earlier stage to the appropriate services. This means the risk of childhood obesity persisting into adulthood among this cohort of children could decrease.

Figure 4.17:
Prevalence of overweight (including obesity) among children in Year 6



Source: NHS Digital, National Child Measurement Programme

The Manchester Healthy Weight Strategy (2020–2025) was agreed by the Health and Wellbeing Board in March 2020, shortly before the global pandemic, and was launched in May 2021 in collaboration with MCRactive.

The strategy has been developed across four key themes, each of which will be developed further through a working group, including the Obesity Safeguarding Pathway. These themes are:

- Food and Culture
- Physical Activity
- Environment and Neighbourhoods
- Support and Prevention.

In line with the Public Health England guidance 'Reducing obesity is everybody's business' (Public Health England 2018) the strategy takes a whole-system approach to tackling obesity across each life course and has been informed by a wide variety of stakeholders. The strategy strives to develop early intervention and behaviour-change while seeking to challenge our obesogenic environments.

Children's weight management, particularly in early years, is a key priority for the Healthy Weight Strategy, as reflected in the commissioned offer for children. Increased investment has been made in the School Nurse Service and the dedicated Healthy Weight Project within Healthy Schools. The service also works with Health Visiting to target children at risk of being obese on entering reception (0–5 years). The School Nurse Service is also commissioned to provide the National Child Measurement Programme (NCMP), which provides feedback for parents and carers of children and young people in reception and Year 6 who are overweight and obese. It is intended that this service will be fully recovered in September 2021.

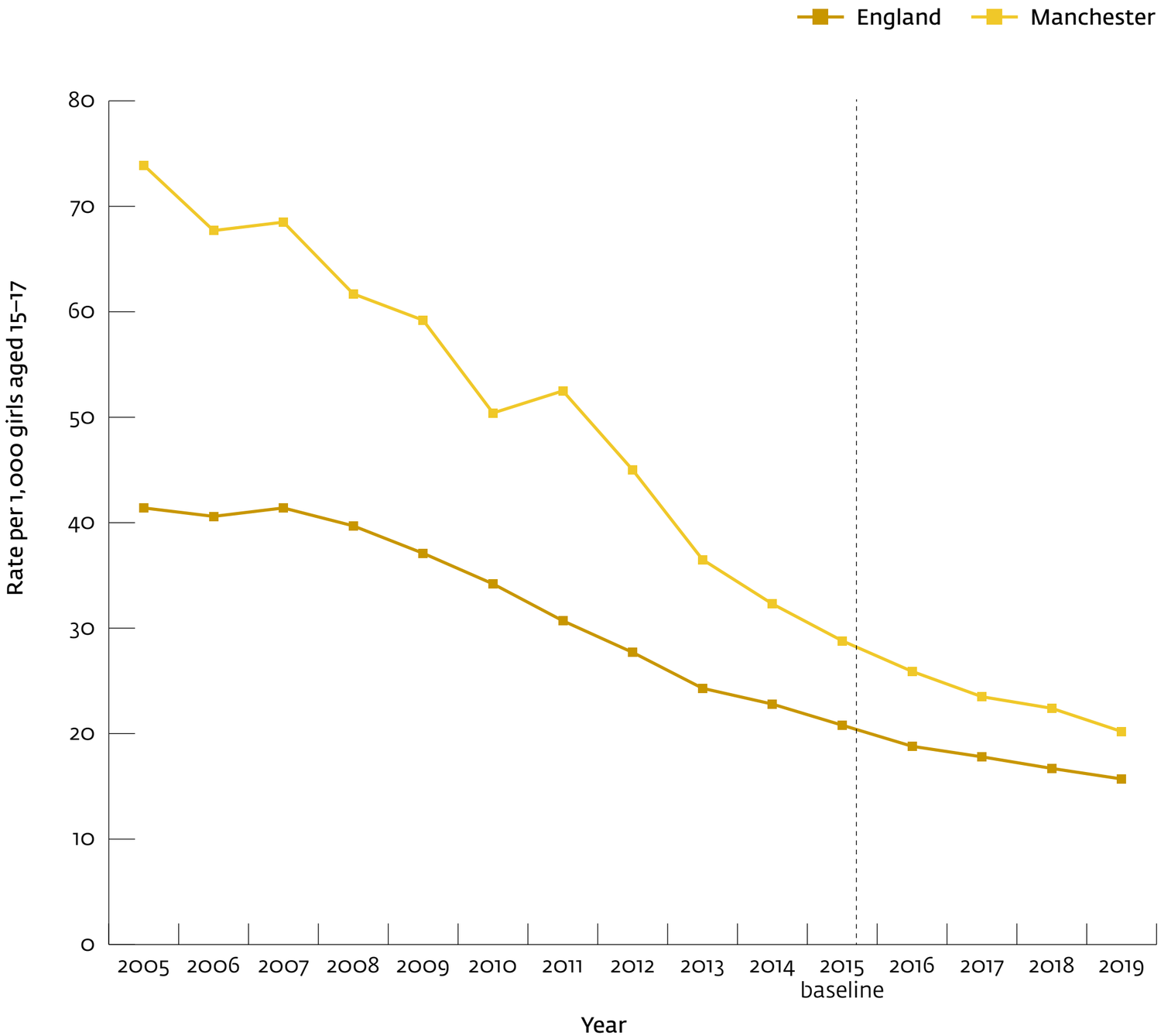
Physical activity is also an integral element of reducing obesity and maintaining a healthy weight. The School Health Service implements a number of activities within school settings to keep children and young people active. A new service was commissioned to begin in January 2021. The Under-18s PARS (Physical Activity on Referral Service) will enable health professionals to refer an overweight or obese child to a bespoke healthy weight offer in their own local neighbourhood. The Manchester Population Health Service has worked closely with Buzz (Manchester's NHS Health and Wellbeing Service) and MCRactive to develop this new service.

Under-18 conceptions

Most teenage pregnancies are unplanned and, while for some young women having a child when young can represent a positive turning point in their lives, many more find that bringing up a child is extremely difficult. This often results in poor outcomes for both the teenage 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 4.18 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 20.2 per 1,000 in 2019 (a reduction of 73%). However, this is still higher than the England rate of 15.7 per 1,000. The number of under-18 conceptions in Manchester fell from 591 in 2005 to 163 in 2019. The number of under-18 conceptions fell below 200 a year for the first time in 2017 and has continued on a downwards trajectory.

Figure 4.18:
Under-18 conceptions (number of conceptions under 18 years of age per 1,000 women aged 15–17 years)



Source: Office for National Statistics © Crown Copyright 2021

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 50% in 2019.

Over the past few years, we have made significant progress in reducing both the number and rate of under-18 conceptions in Manchester. A commitment to local implementation of the long-term, evidence-based national Teenage Pregnancy Strategy, which was launched in 1999, has been at the heart of this. Nationally, the original commitment to a ten-year strategy allowed for research and deep-dive exercises to be undertaken that identified key factors for success. Our actions have been delivered through a multi-agency approach and co-ordinated through the Teenage Pregnancy Prevention and Support Programme.

Our priorities have included a focus on ensuring consistent messages for young people across a range of different settings, alongside access to accurate advice and information and to dedicated young people's services. Our locally commissioned sexual-health services have adapted to changes across service areas and a changing demographic and have responded well to emerging issues raised by young people themselves. Over the past few years, the Healthy Schools Team have developed excellent curriculum resources and programmes of work with schools. In September 2020, Relationships and Sex Education became a mandatory part of the curriculum across all schools.

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

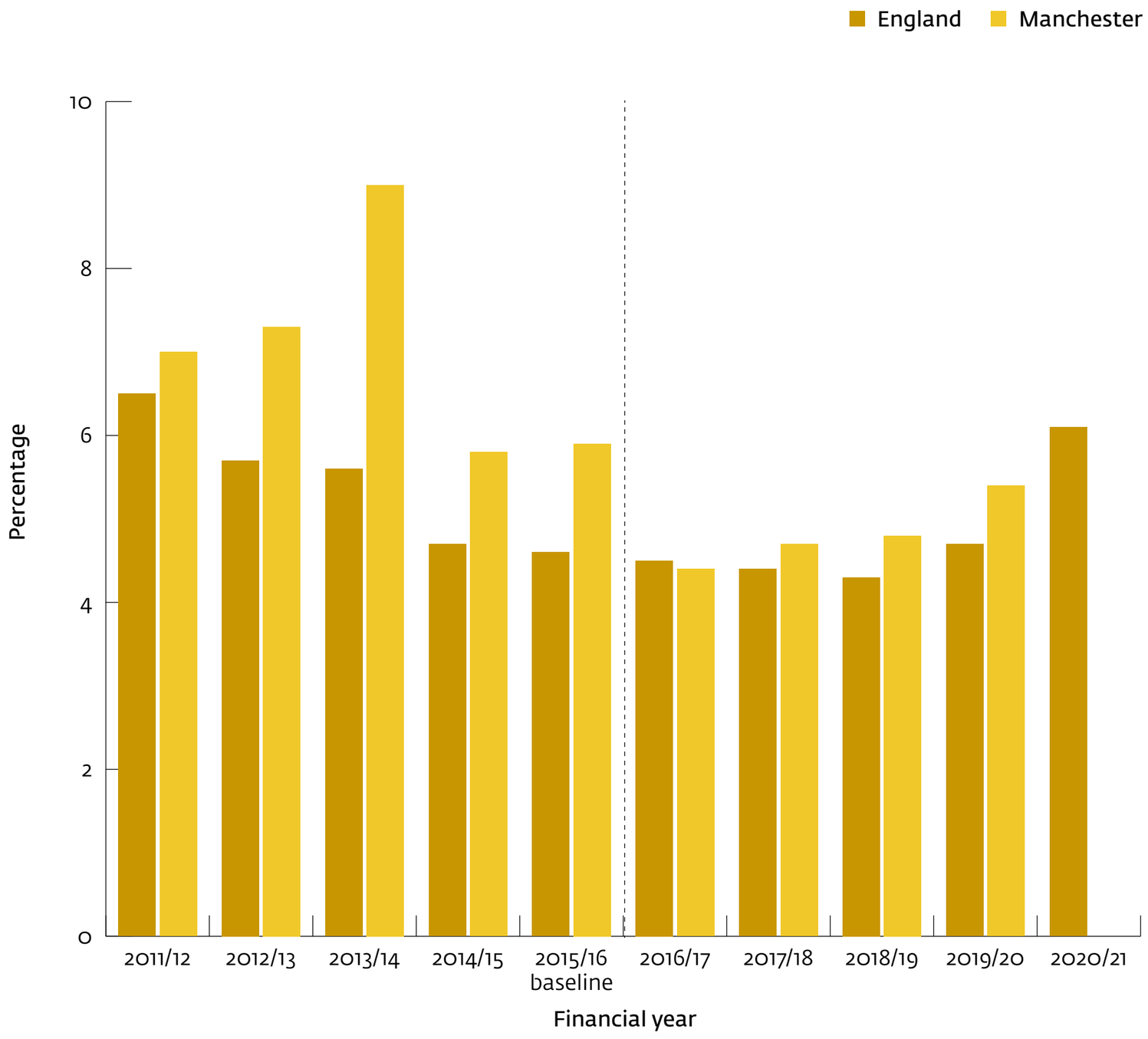
Self-reported wellbeing

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 4.19 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 4.19:
Self-reported wellbeing (percentage of adults with a low life-satisfaction score)



Source: Annual Population Survey , ONS © Crown Copyright 2021.
No Manchester rate available in 2020/21 as sample size insufficient.

Individuals in Manchester have lower-than-average levels of self-reported life satisfaction than those in England; in 2019/20, 5.4% of adults in Manchester had a low-life satisfaction score compared with 4.7% of adults across England. 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. In 2020/21, the Manchester sample size was insufficient to publish a low-life satisfaction score, but the England rate increased to 6.1%.

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.

Healthy people – health and wellbeing support for individuals

Be Well is the wellbeing and social prescribing service for Manchester. The service supports individuals and communities to improve their physical and mental health and wellbeing, increase resilience, live healthier lifestyles, connect with community support, and address the social determinants that impact significantly on health inequalities in Manchester. This has a number of benefits for individuals, communities, and the health and care system, including improved quality of life and mental wellbeing, reducing the likelihood of developing preventable long-term health conditions, working with communities to support good health, and reducing demands on the health and care system.

Be Well is a partnership made up of the Big Life Group, Pathways, Citizens Advice Manchester, One Manchester, Wythenshawe Community Housing Group and Southways and Northwards Housing. The service works with a range of other 'host' organisations to make sure that support is available in convenient community locations, and also works with Primary Care Networks to support their social prescribing delivery. Be Well services operated by the Big Life Group have been active in central and south Manchester since late 2018 and in north Manchester since spring 2020. To date, these services have received over 11,000 referrals (mainly from primary care) and supported 6,000 people to improve their physical and mental health and wellbeing, address the social determinants impacting on their health (in particular remaining in or returning to work while managing health issues), and connect to their local community.

During the COVID-19 pandemic, Be Well has been an essential component of neighbourhood support systems for Manchester residents. In the early stages of the pandemic, Be Well adapted its service delivery to ensure that a wider range of organisations could quickly refer people into the service, and that individuals could receive support more frequently if needed. The service also worked with partners across the city as part of a community response team for the most vulnerable, which involved providing support around the delivery of medication and food parcels within communities. Be Well continues to work with other community response services to ensure that vulnerable residents have the support they need, and more recently it has started working as part of citywide programmes to increase the uptake of COVID-19 vaccinations in at-risk groups.

Healthy communities – creating the conditions that support good health

The Greater Manchester Mental Health NHS Trust (GMMH) has provided a health and wellbeing service called buzz since 2016. In 2019, it was redesigned and relaunched with more of a neighbourhood community development approach.

The **buzz neighbourhood health workers (NHWs)** are providing a valued service that is particularly useful in COVID-19 recovery work to support communities to connect and re-establish community groups and activities. There is an NHW for each of the 12 neighbourhoods in Manchester, and there are additional NHWs in the buzz Age-Friendly and Start Well teams. These buzz teams develop community resources for children, families and people over the age of 50, in partnership with the Population Health teams for Starting Well and Age-Friendly Manchester.

Neighbourhood Health Workers work with local communities to develop community activity with local residents. Projects include gardening, social groups, health-support groups, singing, dancing, cinema clubs, writing groups, cookery and food, exercise, walking football, card-making, and craft and knitting groups. NHWs work in partnership with local community groups and organisations and are part of the prevention programme network in Manchester.

During the pandemic and lockdown, NHWs have adapted to the needs the pandemic created, including making welfare phone calls to vulnerable people, supporting online events, developing wellbeing packs for distribution, running a face covering-making project, supporting food banks, and the vaccination programme.

The **buzz Age-Friendly Manchester (AFM) Team** chair a range of age-friendly networks across Manchester, with an aim of building up a network in each of the neighbourhoods. Projects include placing age-friendly benches throughout Manchester, running dementia-awareness projects, falls-prevention events and age-awareness training for workplaces.

During the COVID-19 pandemic, the buzz AFM team have worked on digital literacy and inclusion projects, delivered weekly local radio broadcasts to inform and support older residents, phoned older people to check in and signpost if necessary, and helped produce a guide to staying active during lockdown.

The **buzz Start Well (SW) Team** engage with parents and young people to develop ideas and projects, and they have also been working closely with the Sure Start Centre Managers. Neighbourhood activities include baby yoga, first aid training for parents, and Black, Asian and minority ethnic peer support groups for mothers and separated fathers. During lockdown, the SW Team's work included developing a support and information pack for families and children, and producing activity packs, which they delivered to families.

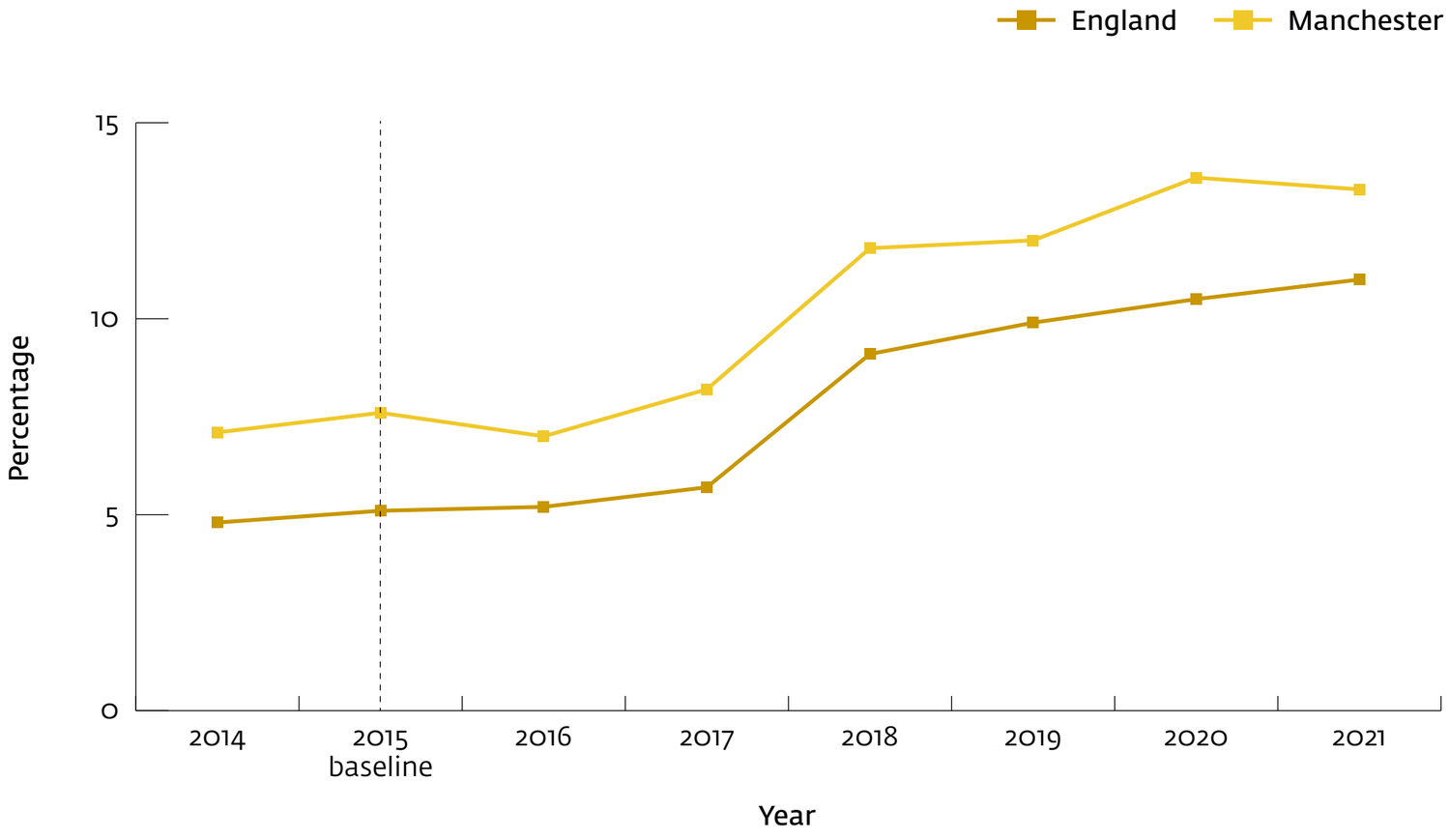
Long-term mental health problems in adults aged 18+ (GP Patient Survey)

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 also includes questions about their general health. Figure 4.20 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 their 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 4.20 shows that in 2021, 13.3% of respondents in Manchester said they had a long-term mental health problem compared with 11% of respondents across England as a whole. Survey respondents in Manchester were more likely than those in most other boroughs of Greater Manchester, apart from Salford and Tameside, to report that they had a long-term mental health problem.

Figure 4.20:
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 2017 and 2018. 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.

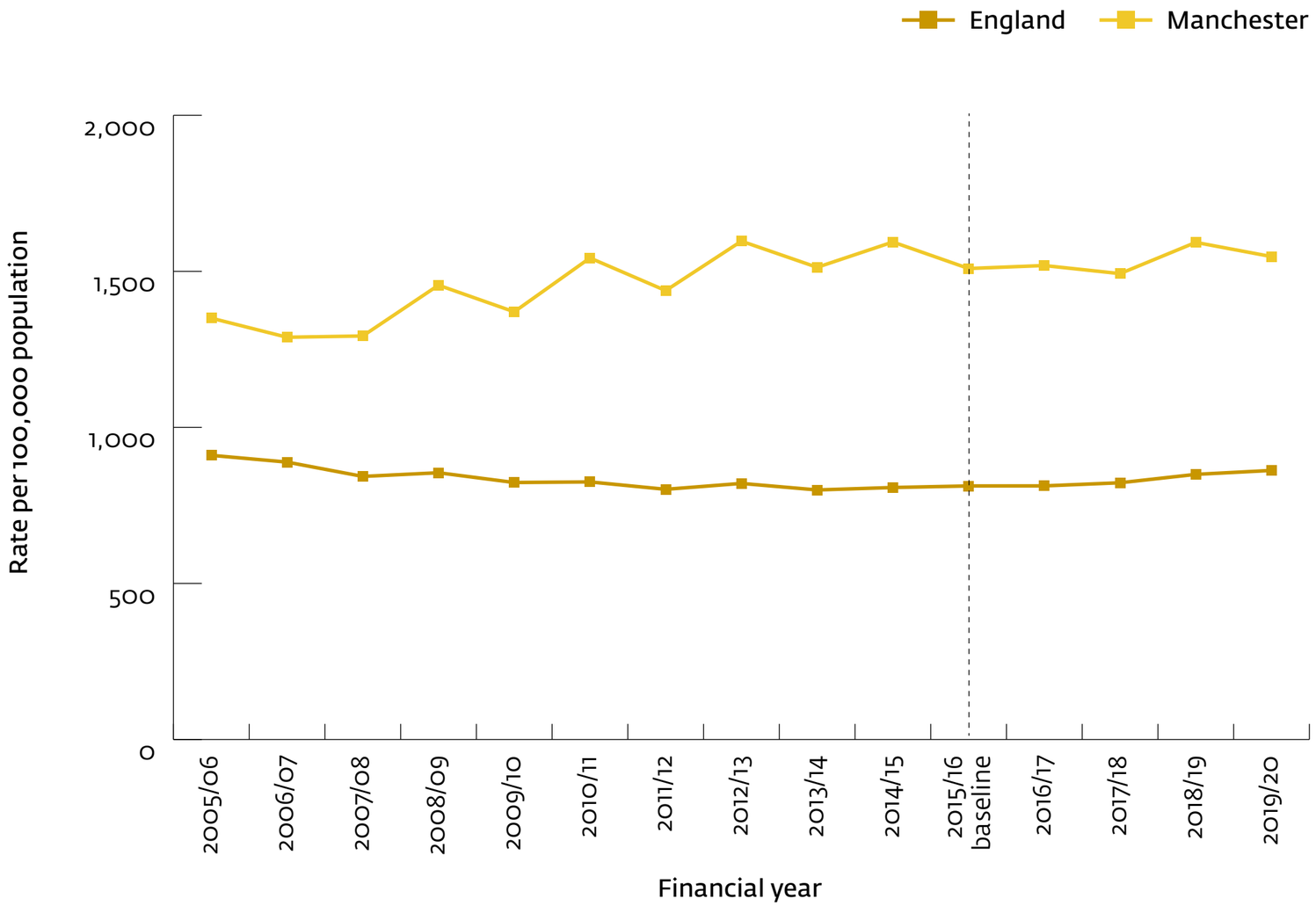
There is clear evidence emerging of the impact of COVID-19 on people's mental health. A recent report by ONS on Coronavirus and depression in adults looked at how symptoms of depression have changed before and during the pandemic. The report showed that the proportion of adults experiencing some form of depression has almost doubled compared with a period before the pandemic, and that one in eight adults has developed moderate to severe depressive symptoms during the pandemic itself. Adults who were aged 16–39, female, unable to afford an unexpected expense, or disabled were the most likely to experience some form of depression during the pandemic.

Unplanned hospitalisation for chronic ambulatory care sensitive conditions

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

Figure 4.21 shows the rate of emergency admissions for ambulatory care sensitive conditions in Manchester has risen gradually, from 1,350 per 100,000 in 2005/06 to 1,547.3 per 100,000 in 2019/20. Although the rate has steadied in recent years, and reduced from 1,592.8 per 100,000 in 2018/19, it remains much higher than the national rate.

Figure 4.21:
Unplanned hospitalisation for chronic ambulatory care sensitive conditions – indirectly standardised rate (ISR) per 100,000 population



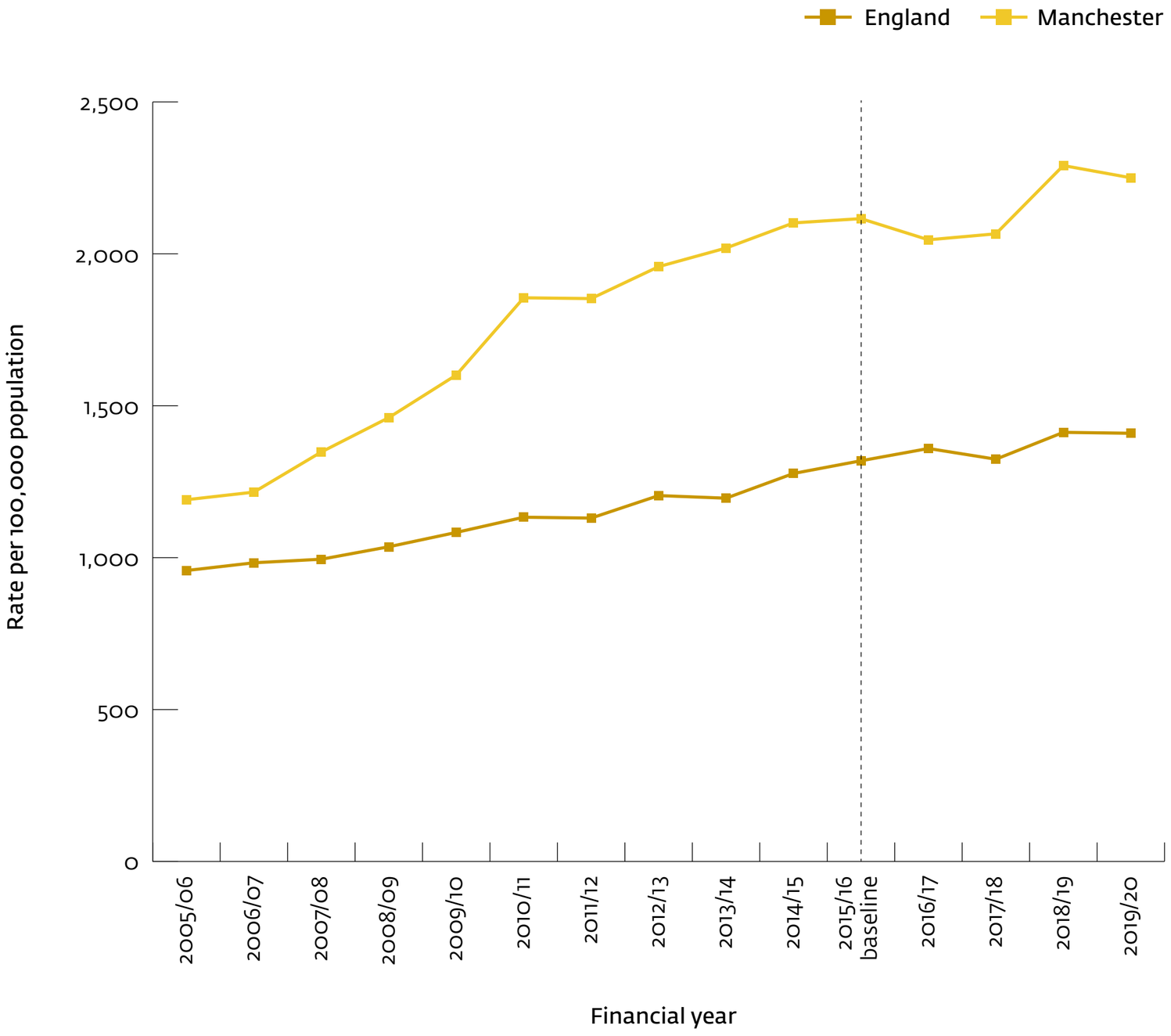
Source: Hospital Episode Statistics (HES), ONS mid-year population estimates, NHS Digital and Office for National Statistics © Crown Copyright 2021

The rate of emergency admissions for acute conditions not usually requiring hospital admission includes conditions that should usually be managed without the patient having to be admitted to hospital, such as ear, nose and throat infections, kidney and urinary tract infections, as well as acute heart disease.

Figure 4.22 shows the rate of emergency admissions for acute conditions not usually requiring hospital admission in Manchester almost doubled since 2005/06, rising from 1,191 to 2,291 per 100,000 in 2018/19, but it has recently reduced slightly to 2,250 per 100,000 in 2019/20. The rate of emergency admissions for these conditions across England as a whole has also increased since 2005/06, but at a lower rate than in Manchester, meaning that the gap between Manchester and the national average has widened.

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 operating at a neighbourhood level; it will also 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.

Figure 4.22:
Emergency admissions for acute conditions not usually requiring 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

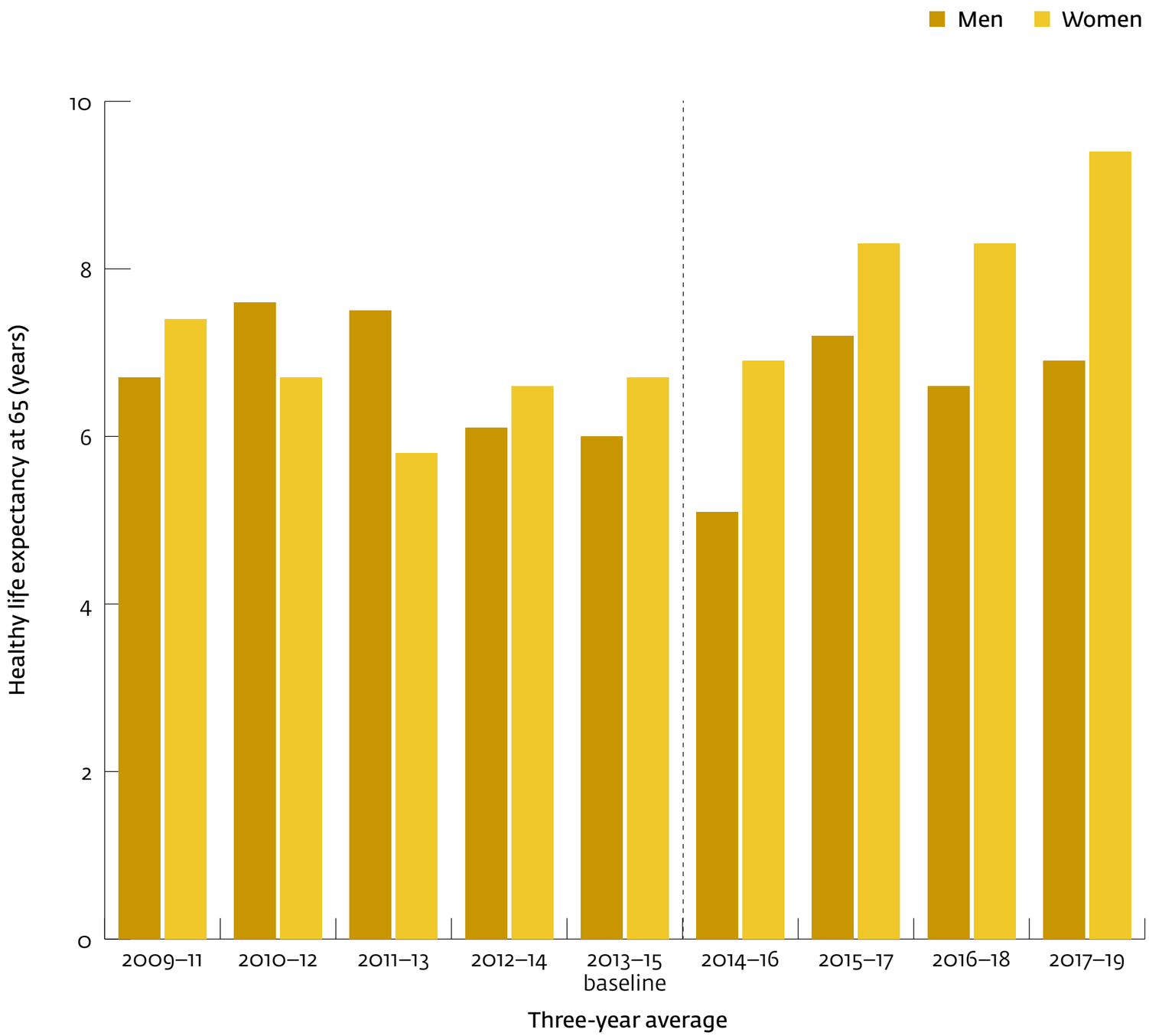
Creating an age-friendly city that promotes good health and wellbeing for people in middle and later life

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 health if he or she experienced the rates of mortality and good health among people of that age in Manchester throughout the remainder of his or her life.

Figure 4.23 shows that healthy life expectancy has increased (ie. improved) for both men and women since the 2013–15 baseline, particularly for women, from 6.7 years to 9.4 years for the three-year period 2017–19 – an increase of 2.7 years in total. For men, healthy life expectancy at age 65 has remained relatively stable since the 2013–15 baseline, increasing from 6 years to 6.9 years for the three-year period 2017–19.

Figure 4.23:
Healthy life expectancy at age 65: 2009–11 to 2017–19



Source: Office for National Statistics © Crown Copyright 2020

Emergency hospital admissions for injuries due to falls in older people

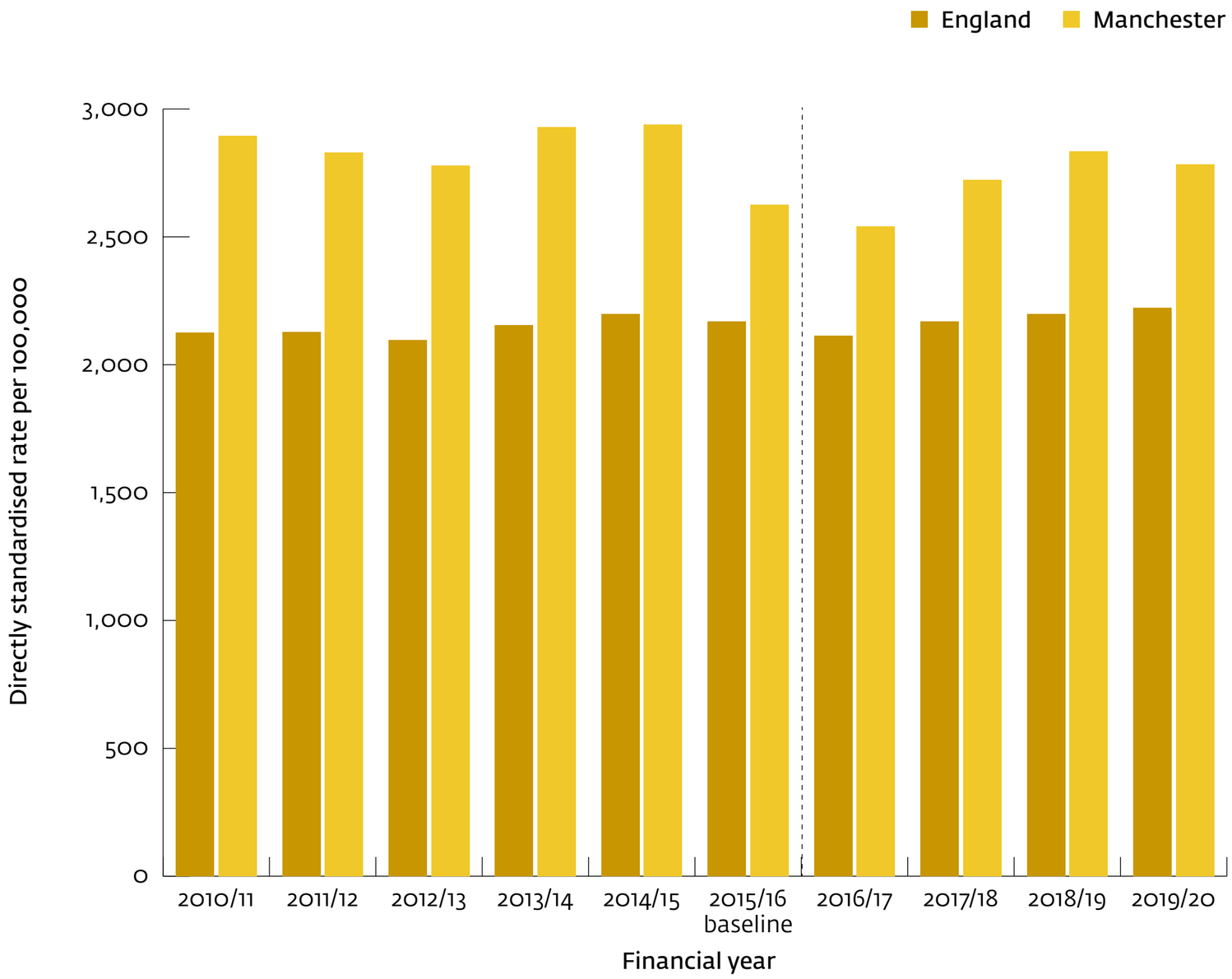
Falls are the principal cause of emergency hospital admissions for older people and significantly impact on long-term outcomes. They are also a major precipitating factor in people moving from their own home to long-term nursing or residential care. The highest risk of falls is in those aged 65 and above.

Figure 4.24 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 2019/20, 1,410 older people aged 65 and over in Manchester were admitted to hospital for a falls-related injury – a rate of 2,784 per 100,000 population. This is slightly lower than the rate for the previous year (2,836 per 100,000) but is significantly higher than the rate for England as a whole (2,222 per 100,000 population).

The three Community Falls Services in Manchester have now been merged into one single citywide service, while at the same time maintaining a local delivery model. This has enabled the best practice from each service to be used to shape a model that is now available across the whole city. There is an increased role for the service in supporting and contributing to broader neighbourhood-based falls-prevention work as well as playing an increased role in Manchester's Fall Collaborative.

Manchester's Falls Collaborative is unique in that it links practitioners, researchers and commissioners with a common set of objectives and a shared work plan. Since being established in early 2019, the Falls Collaborative has focused on three key workstreams: frailty, prevention, and pathways. These are underpinned by research and innovation and data and outcomes workstreams. The work of the Collaborative includes the development of a single point of access for those who have fallen, strengthening commissioning and operational links to broader wellbeing work, developing a multi-agency outcomes framework and a focus on best practice that helps reduce variation in fall-prevention practice.

Figure 4.24:
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 © 2020, Health and Social Care Information Centre.

Taking action on preventable early deaths

Excess deaths

Excess mortality is a term that refers to the number of deaths above what we would expect to see under normal conditions. This is usually measured by comparing the actual number of deaths occurring each week over a period of time with an estimate of the expected number of deaths based on the average number of deaths recorded in the corresponding week in a previous period. Excess mortality includes not only those who have died from COVID-19, but also those who have died from other causes. In the absence of a clear and agreed definition of which causes of death are directly and indirectly associated with COVID-19, excess mortality is seen as the best measure of the total mortality impact of the pandemic.

In 2020, there were 4,279 deaths registered to people usually resident in Manchester. The average total number of deaths registered each year over the five-year period 2015 to 2019 was 3,543, meaning that there were 736 (or 21%) more deaths in Manchester registered in 2020 than would be expected.

Looking at the place of death, there were 316 excess deaths in hospitals, 131 in care homes and 289 in other settings, such as a person's own home, a hospice, or another communal establishment. In relative terms, deaths in hospital were 17% higher than expected and deaths in care homes were 26% higher.

Manchester saw the third highest level of excess deaths in Greater Manchester (behind Rochdale and Bury) as measured by the percentage difference between actual and expected number of deaths. However, this measure does not take account of differences in the overall size of the population living in each local authority. For that reason, it is preferable to use the excess death rate (number of excess deaths per 100,000 population) as a means of comparison between local authorities. Based on this measure, Manchester has seen the lowest number of excess deaths in Greater Manchester, relative to the size of the population – an excess death rate of 133.1 per 100,000 population.

Note that this measure does not make any additional adjustments to take account of differences in the composition and health status of the population (age, gender, ethnicity and comorbidities etc) or socioeconomic factors, such as deprivation or occupation. These factors have been shown by ONS to explain some of the relative differences in the risk of death from COVID-19 and other causes.

The contribution of COVID-19 to excess deaths in 2020

In total, there were 3,407 deaths registered between 20 March 2020 and 1 January 2021, of which 703 (21%) involved COVID-19 (ie. COVID-19 was mentioned on the death certificate as a direct or contributing cause of death). Of the 738 excess deaths registered over this period, 95% involved COVID-19.

Deaths involving COVID-19 accounted for 29% of deaths in hospital and 20% of deaths in care homes over this period. In addition, there were 90 deaths involving COVID-19 occurring in other settings, such as the deceased's own home, a hospice, or another type of communal establishment. Deaths involving COVID-19 accounted for 8% of deaths in these other settings.

Overall, deaths involving COVID-19 accounted for 77% of excess deaths in care homes and 32% of deaths in other settings between 20 March 2020 and 1 January 2021. In terms of deaths occurring in hospitals, the total number of excess deaths is less than the number of deaths with a mention of COVID-19, indicating that there were fewer deaths from other causes than expected in these weeks.

ONS have used death registrations data for England, linked to data from the 2011 Census and primary care and hospital records, to compare the risk of COVID-19 mortality among different ethnic groups in both the first and second waves of the pandemic.[4] This analysis shows that during the first wave of the COVID-19 pandemic (24 January to 11 September 2020), people from all ethnic minority groups had higher rates of death involving COVID-19 compared to the White British population. The rate of death involving COVID-19 was highest for the Black African group, followed by the Bangladeshi, Black Caribbean and Pakistani ethnic groups.

In the second wave of the pandemic (from 12 September 2020 onwards), the differences in COVID-19 mortality compared with the White British population increased for people of Bangladeshi and Pakistani ethnic backgrounds. Although people from Black Caribbean and Black African ethnic backgrounds remained at elevated risk in the second wave, the level of risk compared with White British people was reduced compared with the first wave. Adjusting for location, measures of disadvantage, occupation, living arrangements and pre-existing health conditions accounted for a

4 Office for National Statistics: Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 24 January 2020 to 31 March 2021. Published 26 May 2021

large proportion of the excess COVID-19 mortality risk in most ethnic minority groups. However, most Black and South Asian groups remained at higher risk than White British people in the second wave even after adjustments.

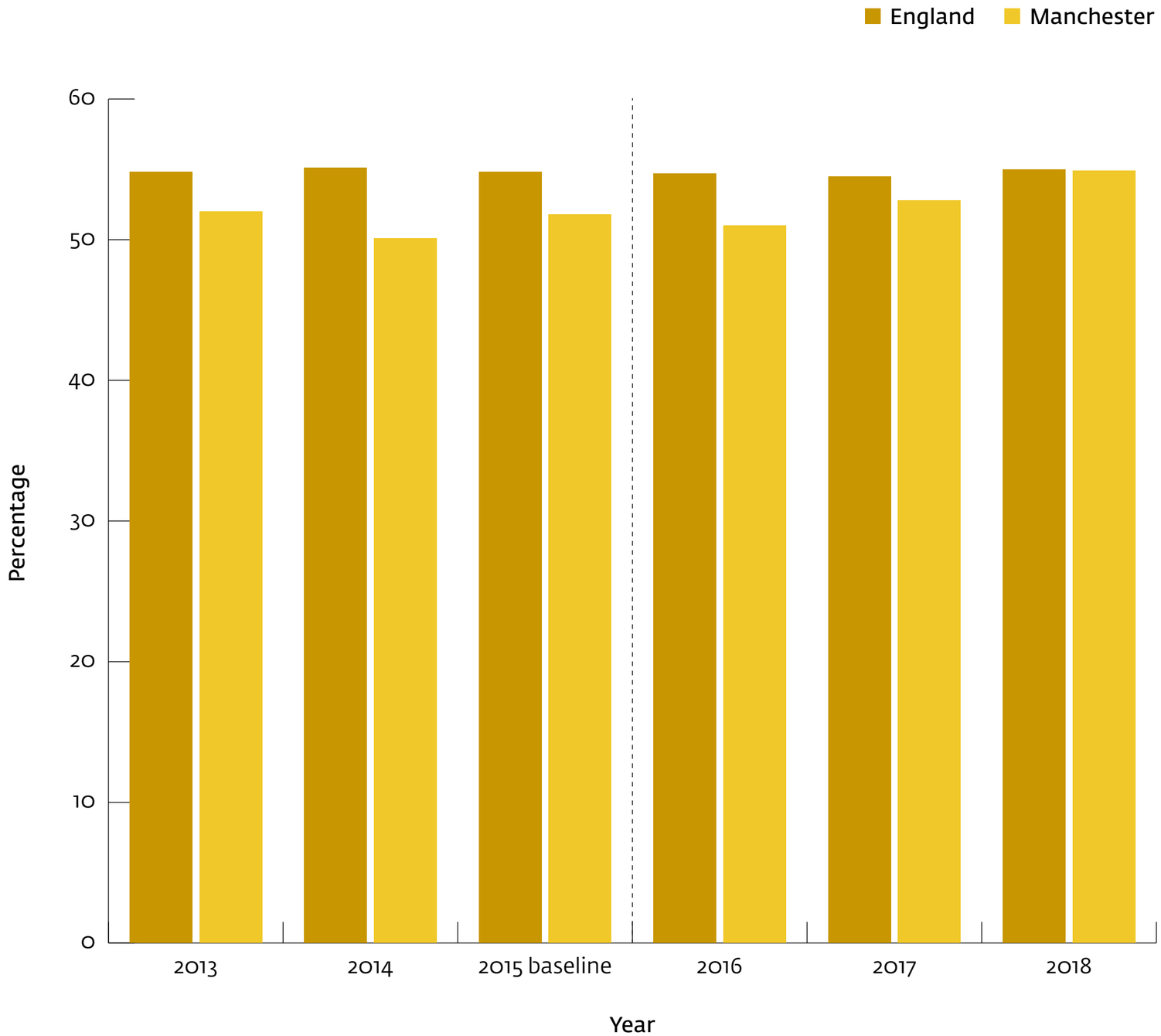
Proportion of cancers diagnosed at an early stage (experimental statistic)

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 an experimental statistic due to the variation in data quality and because the indicator can be affected by differences in the completeness of staging information. In June 2020, the indicator definition changed to include 21 cancer sites (previously the definition was based on 11 cancer sites); data from 2013 has been recalculated based on the new definition and is presented in Figure 4.25. Note that any data published prior to June 2020 is not comparable with the data presented here.

Figure 4.25 shows that in Manchester, over half (54.9%) of new cases of cancer were diagnosed early at stages 1 and 2 in 2018. This represents a gradual improvement since 2013, when 52% of new cases were diagnosed at this early stage.

Figure 4.25:
Early diagnosis of cancer (proportion of cancers diagnosed as stage 1 or 2)



Source: National Cancer Registry, Pubic 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 (54.9%) compares with a figure of 63.8% in Bath and North East Somerset Clinical Commissioning Group (the best-performing Clinical Commissioning Group) and an England average of 55%.

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 partly due 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.

The Manchester Lung Health Check (LHC) Programme is a collaboration between the Manchester University NHS Foundation Trust (MFT) thoracic oncology team and Manchester Health and Care Commissioning (MHCC), and is the first local NHS commissioned service of this kind. The service was designed with a strong emphasis on community engagement so that the service could be put at the heart of our local communities for patients with the most need. Clear clinical pathways ensure that patients are managed appropriately to minimise harm and delays. Feedback from participants has shown that people like what has been provided and, importantly, where and how it has been provided. Lung health checks and targeted lung cancer screening is now a key feature of the NHS long-term plan and has been identified as a national priority programme.

The Manchester LHC service has now completed checks on almost 9,000 eligible participants, of whom 4,500 had a baseline scan due to increased risk of lung cancer. The RAPID team at Wythenshawe Hospital assessed 240 people, and 4,300 people have completed a 12-month surveillance scan. Those patients will be scanned at regular intervals to check for early signs of lung disease.

During the first two years of delivery, the Manchester LHC service has identified:

- 150 people with lung cancer (80% at Stage 1 or 2)
- 260 people with symptomatic undiagnosed respiratory disease
- 3,000 people at increased risk of cardiovascular disease
- 180 people with imaging abnormalities that identified underlying health conditions.

Plans are being developed to continue with the Lung Health Check service and to expand into central and south Manchester from 2023 onwards.

COVID-19 has had a major impact on cancer services, including referral, diagnosis and treatment. There was a significant dip in GP attendances between April and September 2020, and over 73,000 fewer presentations to GP practices throughout 2020 compared to before the pandemic. This has led to a significant drop in suspected cancer referrals. In particular, there was a reduction of 33% in suspected lung cancer referrals during 2020. This compares with an 11% reduction for all suspected cancer referrals.

Referrals for suspected cancer are now back to pre-COVID levels, but there is some evidence of continued hesitancy among patients required to attend hospital for investigations, leading to delays in diagnosis and treatment.

National cancer-screening programmes were suspended between the end of March and the end of July 2020. Diagnostic capacity was also significantly affected due to the need to implement social distancing and enhanced cleaning measures. In addition, many patients were choosing to delay their required investigations because of isolation and shielding requirements.

Breast screening – between January and December 2019 there was a 6.2% decrease in breast screening uptake. Between January and September 2020 there was a further 4.1% decrease (an 11.7% decrease in 21 months). These figures were falling even before the COVID-19 pandemic and the first national lockdown started to impact on services. It will be important to consider how to re-engage patients with breast screening services and how to improve access by removing barriers to participation.

Bowel screening – between January and December 2019 there was a 6.2% increase in bowel screening uptake. Between January and August 2020 there was a further 1.8% increase (an 8.7% increase in 21 months). The increase slowed during the early part of 2020, but showed promise that we can get patients to engage with the programme.

Cervical screening – between January and December 2019 there was a 0.9% increase in cervical screening coverage. Between January and December 2020 there was a further 3.4%

decrease. This may be linked to COVID-19 and national lockdowns but is a cause for concern, and there is a need to consider how to re-engage women with cancer screening programmes (including breast) and halt the decline in participation.

The number of patients diagnosed with cancer at Manchester University NHS Foundation Trust fell between April and June 2020, linked to a reduction in referrals, screening and access to diagnostics. At the start of the pandemic, there was also a reduction in the number of cancer treatments performed, including surgery, chemotherapy and radiotherapy; however, as guidance emerged, cancer treatments were restarted in line with national recommendations and the capacity at MFT. Patients were prioritised according to their immediate clinical need and reviewed regularly. Escalation policies were established between primary and secondary care for any patients whose condition was deteriorating or symptoms worsening.

Delays in diagnosis and treatment scheduling has resulted in an increase in the number of patients waiting longer than 62 days for treatment, meaning that patients may receive treatment when their cancer is at a more advanced stage. However, patients were (and continue to be) carefully monitored by their clinical team for any deterioration or change in presentation.

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.

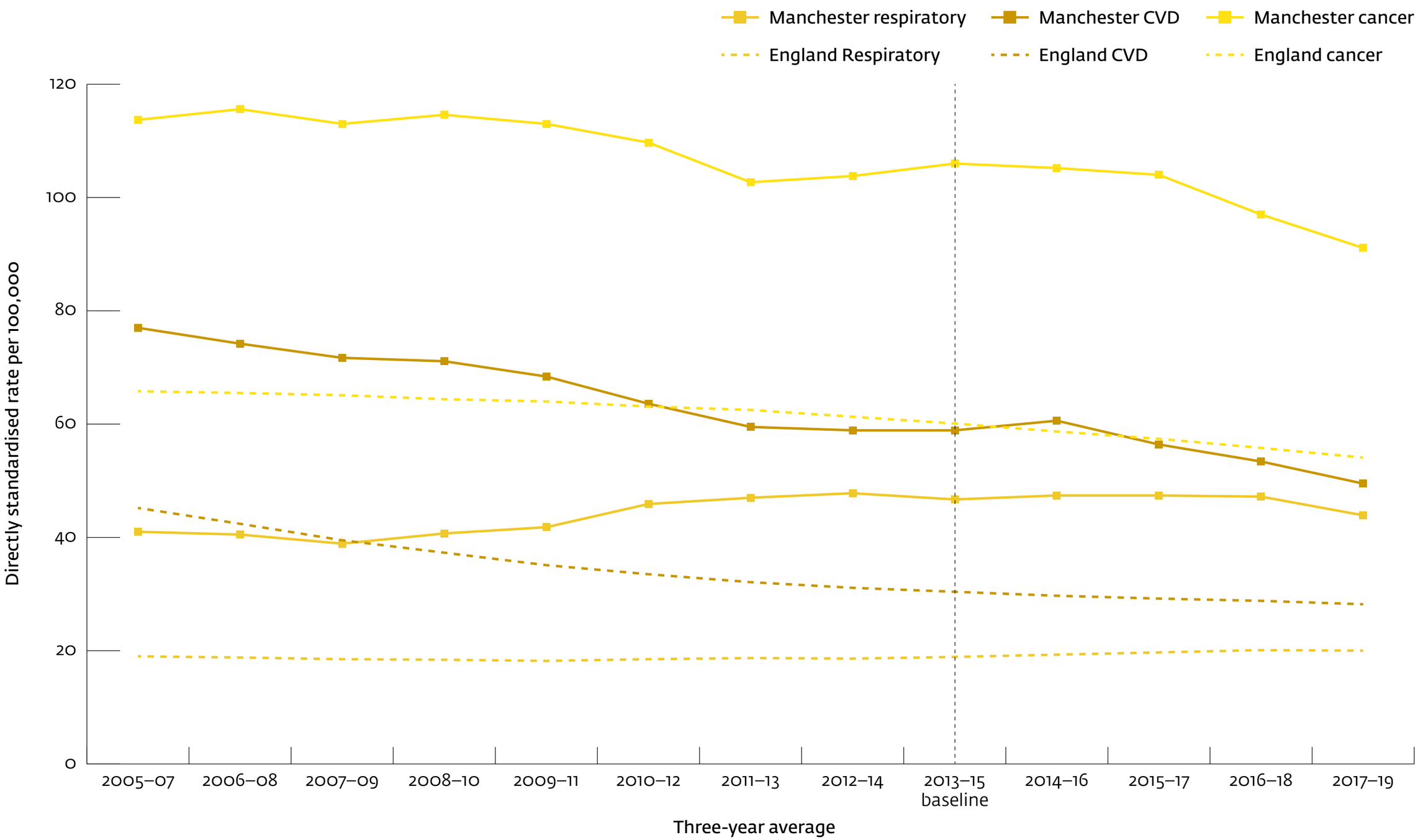
In 2017, an Organisation for Economic Co-operation and Development (OECD) working group was set up to review the definitions of avoidable and preventable mortality used internationally with a remit to create a harmonised definition. The group proposed a new definition of avoidable and preventable mortality, and in 2019 the ONS ran a public consultation to review this definition. As a result of the consultation, it was agreed the ONS would implement the new international avoidable and preventable mortality definition to ensure statistics were comparable. The new definition has been implemented from data year 2001 onwards and is presented in Figure 4.26.

According to the new definition, in Manchester the rate of preventable premature deaths from cardiovascular diseases is the highest in England and the rates of premature deaths from cancer and respiratory disease are the second highest in England. Manchester is also the highest-ranked local authority for overall premature deaths from these diseases 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, and this has contributed to a significant fall in preventable premature mortality from cardiovascular disease since the middle of the past decade. However, Figure 4.26 shows that this downward trend has started to flatten out in recent years. 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 since 2005–07 although, again, Figure 4.26 suggests this increase may be flattening out in recent periods. Smoking and air pollution are both common causes of respiratory disease.

Figure 4.26:
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, and working with people, groups and organisations that are trusted in communities. This includes targeted approaches for NHS health checks and the launch of the Lung Health Check Programme, as well as the promotion of cancer-screening programmes (breast, bowel and cervical) for the groups of people most at risk.

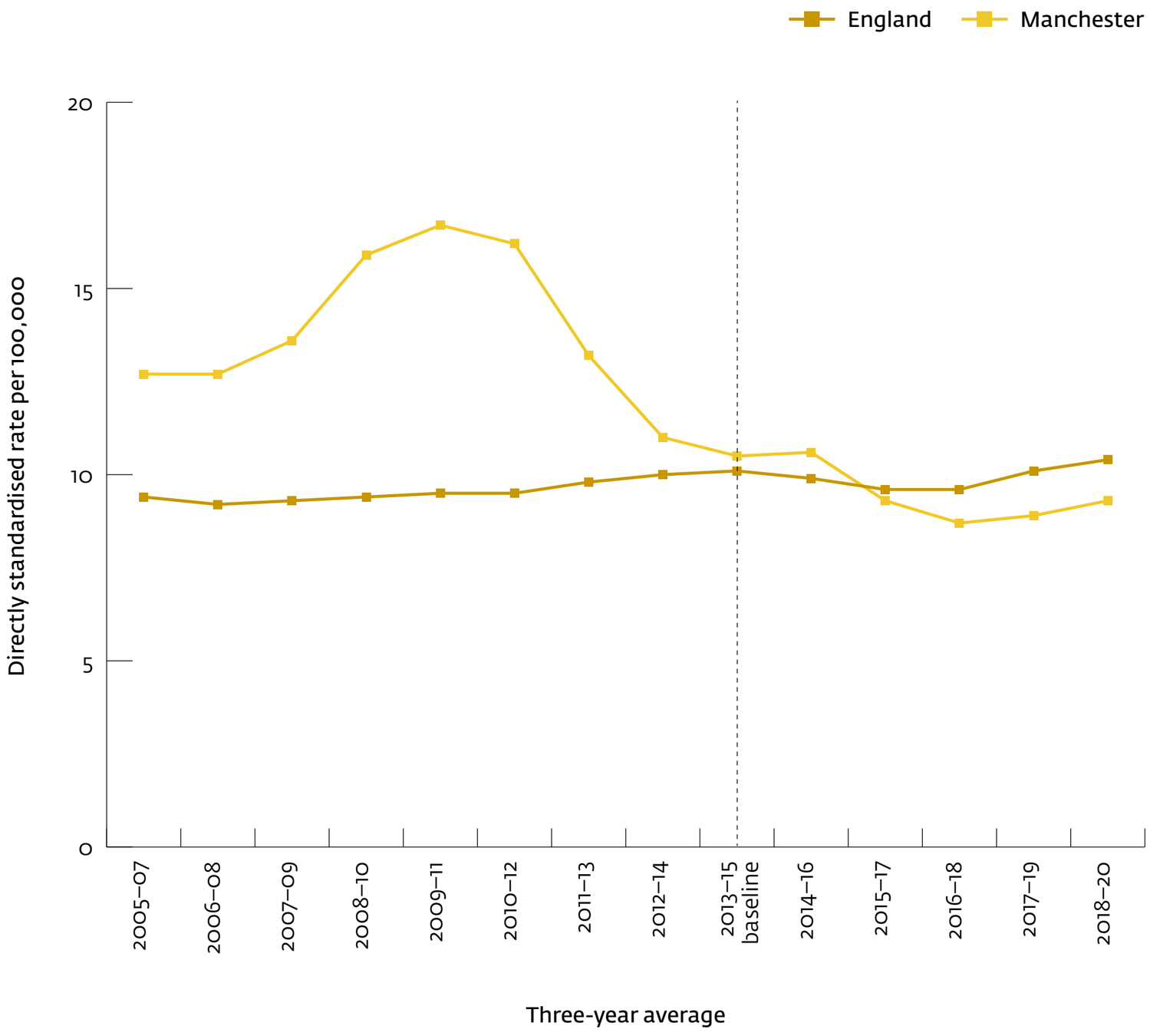
We are also seeking to improve outcomes and reduce unwarranted variation for people with respiratory illness through a system-wide approach to change, which includes improving the timing and quality of diagnosis, better co-ordinated care, and enabling self-care.

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 reflect the underlying rates of mental ill health in an area.

Figure 4.27 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 2018–20; this remains below the England rate of 10.4 per 100,000. Between the periods 2009–11 and 2018–20, the number of suicides fell from an average of 64 per year to 43 per year.

Figure 4.27:
Mortality rate from suicide and injury undetermined



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

There were 38 suicides registered in 2020, compared to 46 in 2019 and 45 in 2018. It is worth noting that due to registration delays, some suicides in 2020 may not have been registered by the coroner at the time. Also, the COVID-19 pandemic may have had the effect of increasing the registration delay, which may partially account for a lower number of suicides registered in 2020 than those in 2019. Recently, there has been a small increase in the three-year suicide rate, from 8.7 per 100,000 in 2016–18 to 9.3 per 100,000 in 2018–20. Nationally, the suicide rate for England has increased from 9.6 in 2016–18 to 10.4 in 2018–20.

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 done with the rail network and highways to limit access to high-risk locations.

The precise impact of COVID-19 on suicides and people's contemplation of suicide is still not yet clear. The often lengthy delay between occurrence and death registration means that the impact of COVID-19 on suicides will not be seen in the official data for some time. However, the current evidence suggests that the COVID-19 pandemic has had profound and long-lasting psychological and social effects.

National data from the ONS Opinions and Lifestyle Survey shows that during the lockdown in early 2021 (27 January to 7 March), the proportion of adults experiencing some form of depression was more than double the rate seen before the pandemic. Younger adults and people living with a child aged under-16 had the largest increases in rates of depressive symptoms compared with pre-pandemic levels. Around three in ten adults aged 16–39 (29%) experienced some form of depression (indicated by moderate to severe depressive symptoms), compared with 11% in July 2019 to March 2020. Rates of depression also doubled among adults aged 70 and over in the same period.

Social isolation, anxiety, fear of contagion, uncertainty, bereavement, chronic stress, and rapid change in people's circumstances (particularly economic) may also lead to the development or exacerbation of depression, anxiety, substance use and other psychiatric disorders in vulnerable populations, including individuals with pre-existing psychiatric disorders and people who resided in high COVID-19 prevalence areas. Stress-related psychiatric conditions, including mood and substance-use disorders, are also associated with suicidal behaviour. All these factors may have increased suicide rates during the pandemic and may increase them post-pandemic.

The latest evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) and the Centre for Mental Health and Safety at The University of Manchester did not find a rise in suicide rates in England in the 12 months following the first national lockdown in 2020, despite evidence of greater distress. However, several caveats apply: these are still early figures and may change; any effect of the pandemic may vary by population group or geographical area; the use of real-time surveillance in this way is new and further development is needed before it can provide full national data.

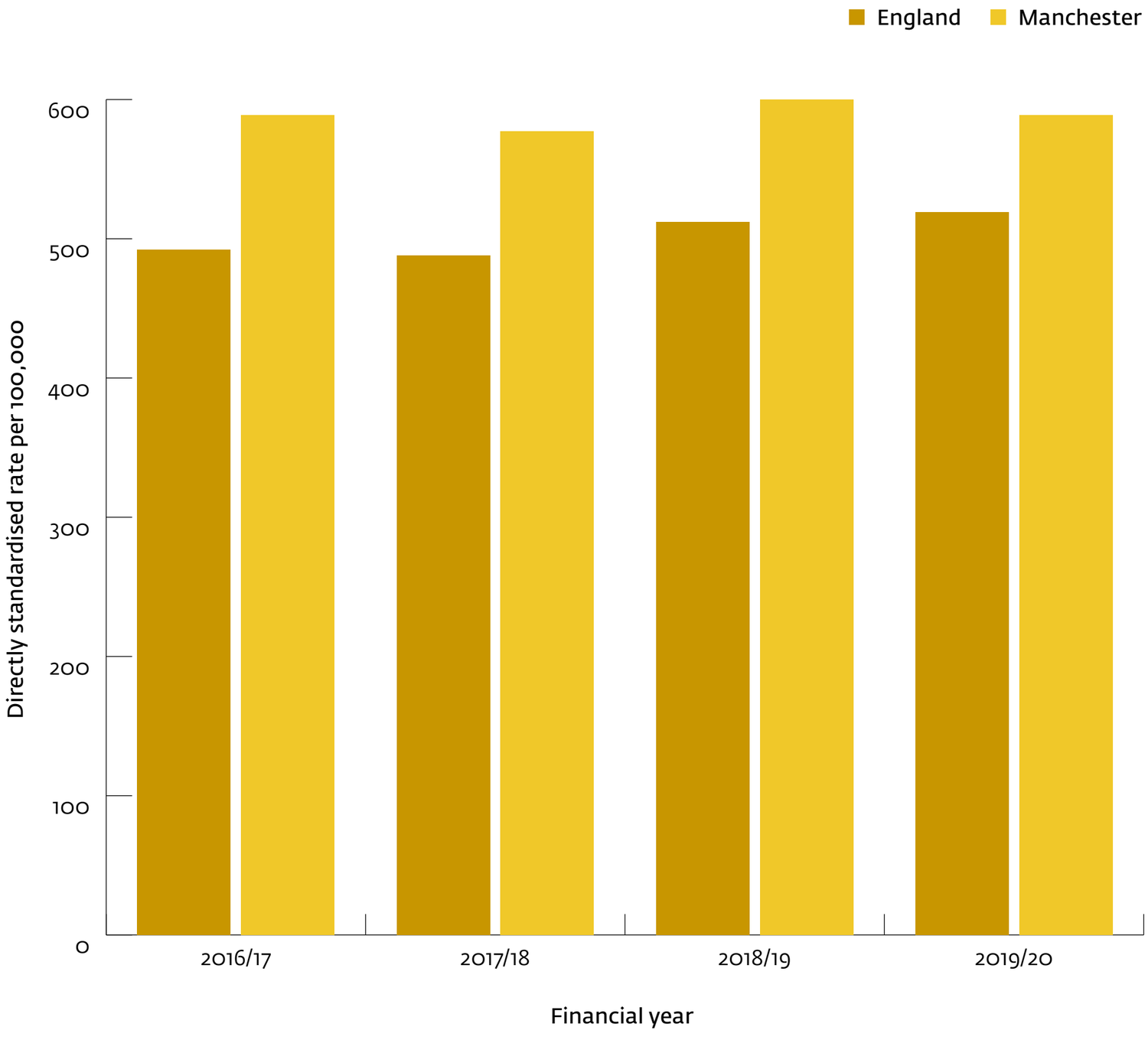
The Manchester Suicide Prevention Partnership continued to meet virtually throughout the pandemic to share data and good practice. Suicide-awareness training has been provided for 45 front-line staff (including those from the Council's Contact Centre, Homelessness and Early Help). This has given them the skills and confidence to talk with residents about suicide, provide them with support, and link them to additional services where appropriate.

Admission episodes for alcohol-related conditions

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Each year, alcohol misuse is estimated to cost the NHS around £3.5billion and society £21billion. 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 4.28 shows the number of admission episodes for alcohol-related conditions expressed as a directly age-standardised rate per 100,000 population using a new method. Newly published admission rates are lower than those previously published due to a change in methodology, considering the latest academic evidence and more recent alcohol-consumption figures. Hospital admissions attributed to alcohol have reduced because in general people are drinking less today than they were when the original calculation was made.

Figure 4.28:
Admission episodes for alcohol-related conditions (narrow definition, new method)



Source: Public Health England (based on Hospital Episodes Statistics and ONS mid-year population estimates).
New method: this indicator uses a new set of attributable fractions, and so differ from that originally published

Recent data shows a slight improvement in the rate of admission episodes for alcohol-related conditions in Manchester. In 2019/20, the rate of admission episodes for alcohol-related conditions was 589 per 100,000 – a reduction of 2% compared to 2018/19 (600 per 100,000). The gap between the rate of admission episodes for alcohol-related conditions in Manchester and the England average has narrowed. In 2016/17, the rate of admission episodes for alcohol-related conditions in Manchester was 20% higher than the England average; in 2019/20, it was 13% higher.

The evidence in respect of the impact of COVID-19 on alcohol consumption is mixed. Nationally, the volume of alcohol sold during the 17 weeks up to 11 July 2020 reduced to 1.3billion litres, down from 2billion litres the previous year. The Public Health England (PHE) wider impacts of the coronavirus (COVID-19) pandemic on population health monitoring tool shows that alcohol intake across the population as a whole has remained about the same during lockdown, with almost half of people reporting they had neither increased nor decreased their drinking. Those aged 18– 34 were more likely to report consuming less alcohol each week than before, and those aged 35–54 were more likely to report an increase. However, there was an increase in the proportion of 'increasing and higher-risk' drinkers between April and August 2020.

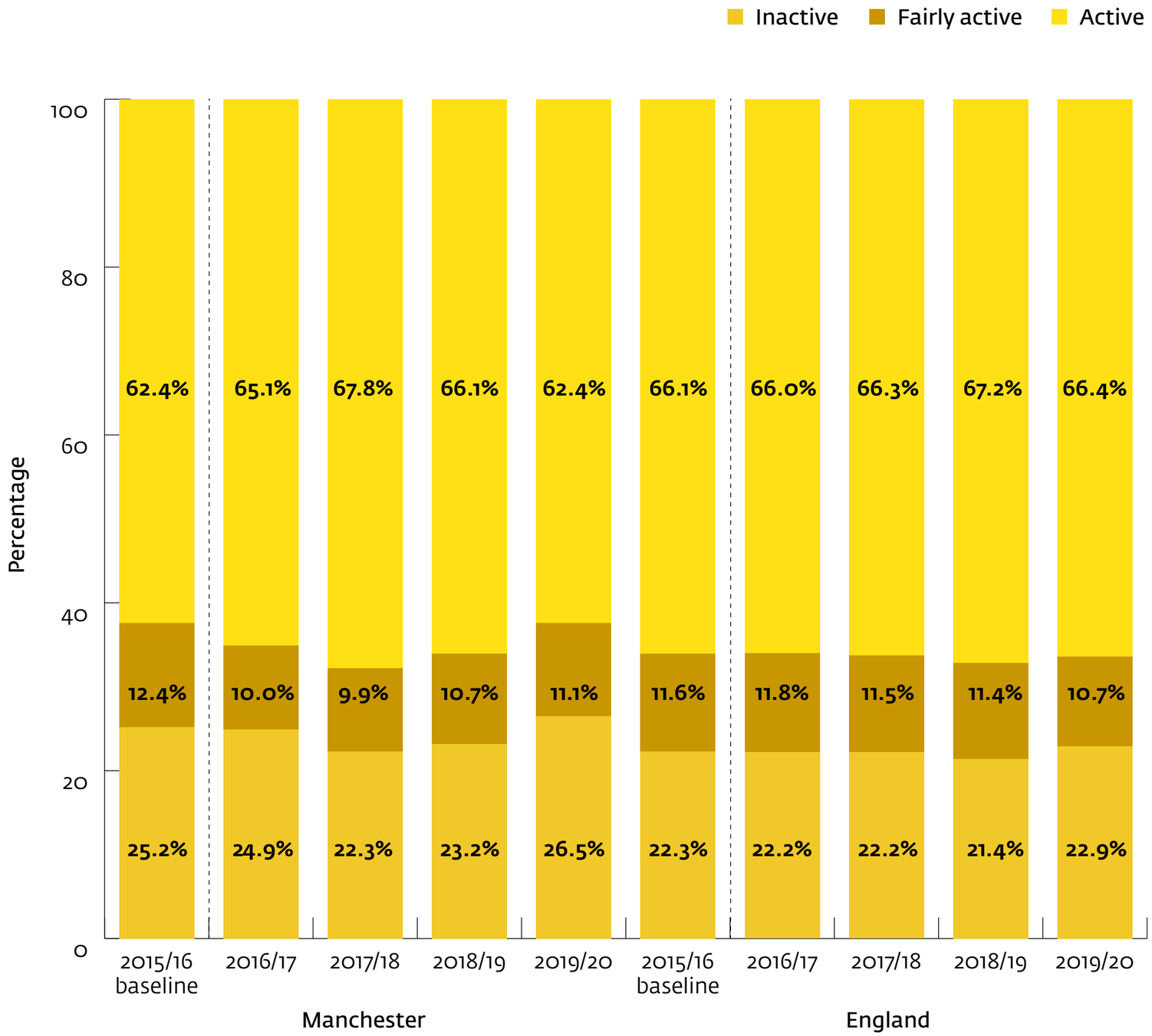
Locally, we will continue to monitor the data on the number of new entrants into either structured alcohol treatment or brief interventions with our service provider, as well as the nationally published data on hospital admissions for alcohol-related conditions.

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 (2.5 hours) of moderate physical activity per week, or 75 minutes of vigorous physical activity per week, or an equivalent combination of the two (MVPA), in bouts of ten minutes or more.

The latest Sport England Active Adult Lives Survey covers the period from mid-November 2019 to mid-November 2020, including eight months of restrictions imposed in response to the COVID-19 pandemic. It reveals that the pandemic has had an unprecedented impact on our ability to take part in sport and physical activity. Nationally, there has been a reduction in activity levels and an increase in inactivity over the past year. Figure 4.29 shows that in 2019/20, 62% of adults (aged 19+) in Manchester were classed as 'active' compared to 66% in 2018/19. The proportion of 'inactive' Manchester adults has also increased from 23% to 27%. The proportion of Manchester adults classed as 'active' has been decreasing since 2017/18 and is now well below the England average (66%). It is worth noting that these figures are estimated based on data drawn from a survey with a relatively small sample size.[5]

Figure 4.29:
Weekly physical activity (age 19+)



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

5 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 MCRactive. It 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 improve the detection of cardiovascular disease and its risk factors
- Co-production of approaches to improve the physical health of people with severe mental illness.

Case study: Winning Hearts and Minds – supporting our communities through COVID-19

In the first weeks of the COVID-19 pandemic and the arrival of lockdown in the UK, we quickly realised that we couldn't continue as before. We needed to totally reshape our work because we couldn't get out and talk to people in the same way. We also recognised the immediate challenge faced by residents and community groups, particularly those that might be more in need of help, and those who supported them.

It felt very difficult to sit and wait, even just for two or three weeks. We soon realised that we just needed to start helping wherever we could. We didn't plan what we were going to do, especially as we were restricted by being out in the community. However, we knew that the why and the how that drives our work wasn't going to change – they are so important to the core of what we do.

As volunteering opportunities presented themselves, we were able to offer help very quickly. We knew lockdown was hurting our communities and we wanted to help. We also came up with some of our own initiatives, based on what we were hearing from our communities and groups in north Manchester.

Everyone was free to take up the work they felt was needed most, and what suited them best. Some fieldworkers took up full-time redeployment in new Council roles, such as food delivery; some worked full-time on more typical Winning Hearts and Minds-type projects, such as befriending, and the Activity Packs project; some did a mix of the two.

Taking up such a variety of projects in areas we wouldn't have traditionally worked in gave us some new connections to residents, colleagues, groups and organisations we wouldn't have had contact with before. Every project and redeployment taught us something we didn't see before or already know about our community or sector.

COVID-19 has shown, more than ever before, the impact of health inequalities on our communities, with the most deprived facing much poorer outcomes. The Winning Hearts and Minds work will continue to be essential in how this increasingly complex area is tackled and in how we bring people along this journey with us.

Continuing to be recognised as a pioneering age-friendly city

Age-Friendly Manchester

The Age-Friendly Manchester (AFM) programme aims to improve the way we all age together, so that people in their middle and later life can enjoy a better quality of life and fully participate in all that Manchester has to offer. A part of the Council's Population Health Team, AFM is an active member of the World Health Organization's Global Network of Age-Friendly cities, and on the Steering Group of the UK Network of Age-Friendly Cities and Communities.

The AFM programme, initially called Valuing Older People, has built on the successes of its 15-year existence, being identified as a leading example of the Our Manchester approach in 2015. A cornerstone of the AFM programme is to help increase the social participation of older residents and the communities in which they live.

The programme is underpinned by collaboration and partnership and guarantees older people a leading role. Since 2004 there has been an elected and representative AFM Older People's Board and an Age-Friendly Manchester Assembly of over 100 people aged over 50. Both of these help shape the strategic direction of the programme, acting as consultative bodies, and help shape the design of Council policies.

The wider AFM family includes a diverse range of partnerships, including The University of Manchester; Manchester Metropolitan University; the statutory, voluntary and private sectors; culture; and national and international collaborators. The Age-Friendly Manchester Steering Group meets four times a year and brings senior representatives together from all these different sectors with responsibility for the successful delivery of the programme's AFM Delivery Plan.

In 2017, following a comprehensive consultation, AFM published Manchester: A Great Place To Grow Older (2017–2021). As the city's ageing strategy, this outlines how the city's systems and structures will work together to improve the health and wellbeing of residents as they age. Progress over the past year includes:

- **Sustaining the voice of older people:** with the outbreak of COVID-19 AFM Older People's Board meetings (which have taken place physically every two months since 2004) came to an abrupt halt. Many Board members either lacked access to digital technology, or the experience to use it. Through phone conversations it was clear that Board members were feeling very isolated and were increasingly concerned about the impact of COVID-19 upon older people and their negative portrayal in the media. At the same time, the Board had lost its ability to speak up on behalf of older people. The AFM team supported Board members to obtain digital devices, gave advice on how to use them, and provided materials. The team also held a number of one-to-one and trial meeting events to get Board members up to speed and confident with videoconferencing. This resulted in the Board reconvening, and it has been meeting on a monthly basis via Zoom ever since.
- **AFM Scrutiny Committee Recovery Report:** moving to a digital platform enabled the AFM Board to articulate their concerns at the disproportionate impact of COVID-19 on the over-50s and the negative portrayal and treatment of older people in the media. This was discussed in a meeting with the Leader and Chief Executive of the Council where the Board was asked to identify its recovery priorities for people in middle to later life in Manchester. The AFM team set out these priorities in a report to the Council's Communities and Equalities Scrutiny Committee, where it received unanimous support. The AFM Recovery Report now forms the basis for the city's recovery plan for the over-50s.
- **Establishment of the AFM Executive:** the AFM Executive is chaired by the Executive Director of Adult Social Services and brings together system leadership from across the city and Greater Manchester with responsibility for overseeing the delivery of recommendations and the accompanying action plan coming out of the report.
- **Equalities Impact Assessment Guidance on age:** the AFM Recovery report made a number of recommendations centred around ageism and age as a protected characteristic. The AFM team has produced guidance on equalities, which considers ageing and the equality characteristics of middle to later life.

Case study: Equality Impact Assessment age-friendly guidance

Activities and projects taken forward to advance age equality in the Council should be underpinned by robust Equality Impact Assessments (EIAs). In order to support Council officers to complete an EIA that focuses on age and ageing as a protected characteristic under the 2010 Equality Act, the Age-Friendly Manchester team has created age-friendly EIA guidance. This provides some insight into the challenges people face when ageing in Manchester and also highlights some of the opportunities for residents to age well and have a happier and successful later life. The guidance will help ensure that services and policies in the city are age-aware and address the specific age-related inequalities that arise as people get older.

The guidance will help officers to adopt and build on best practice and avoid common pitfalls when completing an EIA. It highlights some of the key issues affecting people as they age and presents this thematically for ease of use. The guidance also draws attention to intersectionality, where equality issues and characteristics around age may cross over with equalities considerations around race, gender, disability and sexuality. It ends with a section covering the disproportionate impact that COVID-19 has had on the over-50s, and its effect on people in middle and later life.

The guidance has been produced in conjunction with the Council's Equality Diversity and Inclusion team. It draws on evidence from research collaborations with the city's universities and beyond, as well as older people via formal engagement with the Age-Friendly Manchester Older People's Board and a range of older people's organisations. An appendix provides links to further reading and supporting evidence and features good-practice examples of age-friendly work being delivered across the Council.

The guidance has been adopted as a standard Council equalities document and has generated interest as a good-practice example at a Greater Manchester and national level. It can be used as a tool more widely by anyone whose work might affect older people, or who wants to improve their understanding of the characteristics of ageing.

The impact of COVID-19 on the over-50s

COVID-19 and the resulting restrictions that have been in place during 2020 and 2021 have disproportionately affected older people. The pandemic has had a negative impact on many of the social and economic circumstances that shape experience of ageing and which can lead to inequalities persisting into later life. COVID-19 has led to an increase in physical deconditioning and a decline in mental health among older people, while having a disproportionate impact on unemployment levels among workers aged over 50. Restrictions have also impacted on older people's social connections, particularly among an age group with low levels of digital access, leading to increased loneliness and social isolation.

A recent report by Ipsos MORI and the Centre for Ageing Better illustrates further the impact lockdown has had on those aged 50–70, revealing dramatic changes to people's lives and their plans for the future. It shows that:

- One in five feels their physical health has worsened since lockdown
- Just under a third (32%) have been drinking more
- Over half have had a medical or dental appointment cancelled
- Over two-thirds (68%) of those who are currently workless do not feel confident they will be employed in the future
- 30% have been volunteering informally.

Age-friendly programme priorities and reset priorities

The Age-Friendly Manchester Older People's Board, working with broader neighbourhood networks and through the wider social networks of individual Board members, has been articulating the experiences of many of Manchester older residents since the beginning of the pandemic. As signs of the lockdown being lifted began to emerge, the AFM Board looked again at the age-friendly programme's priorities and identified ten reset priorities:

1. Tackling health and other inequalities in later life
2. Age-Friendly Services: reapplying an older people's focus on whole-population services across design, delivery and commissioning stages in recognition of the fact that many older people's needs have changed, and how we deliver services in the post COVID-19 era will need to be rethought
3. Age-Friendly Places: relaunching and expanding the Ageing in Place Programme (AiPP) across all 13 neighbourhoods, underpinned by the Age-Friendly Neighbourhood model, creating lifetime neighbourhoods with a range of age-friendly housing
4. Developing an additional focus on the most vulnerable and isolated over-70s as restrictions begin to be lifted
5. Extra effort in offering social and emotional support for Manchester's 'non-vulnerable' older people
6. Adopting a system-wide approach about how services communicate with older people, including a communications campaign to counter the ageist narrative about older people that was evident during the first stage of COVID-19
7. Responding to the economic impact on older workers and a social-inclusion offer for those who may never be able to work again
8. Digital inclusion: enabling those who have no access to or experience of using IT to gain the means and skills to connect digitally to services and social networks
9. Financial inclusion, including benefits maximisation, eg. pension credit and support to move to a more cashless economy
10. Relaunching the AFM governance, partnership and engagement structures virtually

A paper describing the views and insights of older people in more detail was presented at the Communities and Equalities Scrutiny Committee on 3 December 2020. The report identified five key recovery priorities that need to be addressed if Manchester's older people are to be able to contribute to and benefit from Manchester's post COVID-19 recovery.

These are:

1. **Ageism** – tackle ageism and inequality experienced in middle to later life by taking a more systematic approach to using Equalities Impact Assessments; developing a Council age-friendly communications strategy and communication standards; and developing an age-friendly approach to commissioning, service development and service delivery.

2. **Care homes** – work with the Care Homes Board to develop a model that connects care home residents to their fellow neighbours and the opportunities and activities available locally.

3. **Neighbourhoods** – via the Team Around the Neighbourhood develop 12 age-friendly neighbourhoods, where people can age well, that are easy to get around, and that are supported by a vibrant voluntary sector and robust age-friendly service standards. Using an equalities approach to develop a set of age-friendly service standards with libraries, parks and the Neighbourhoods Service.

4. **Employment** – address the disproportionate unemployment impact of COVID-19 on workers aged over 50, with targeted employment support, volunteering and quality-of-life support. In line with this, the Council has a commitment to become an age-friendly employer.

5. **Our Manchester Reset** – ensure the voice of older people and the AFM Older People's Board inform the Our Manchester Reset and its strategic delivery.

Working alongside the AFM Older People's Board and the AFM Executive, the Age-Friendly Manchester team will work to support lead officers across these five key areas to deliver on the recommendations in the report.

Conclusion

The past 18 months have had a huge impact on the city's residents, children and families. While the full scale of the social and economic impact of the pandemic is still not fully clear, emerging intelligence is indicating that COVID-19 has had and will continue to have an immeasurable impact on the city's children and families, plunging many more into poverty. The Council and its partners have worked tirelessly to understand the full scale of the challenge in order to reduce the risks and mitigate the impact where possible, and this will continue as we move into the recovery phase.

Despite the impacts of the pandemic, progress continues to be made for residents of all ages in meeting the Council's priorities, and working towards the delivery of the Our Manchester Strategy vision.

Although overall incidences of homelessness have decreased slightly, the number of people engaging with homelessness services has increased as a result of the pandemic. However, there are significant pieces of work being taken forward by the Council and its partners to help meet this challenge. There will be a continued focus on prevention and relief of homelessness, enhancing advice and support, and improving access and transition to settled homes and making homelessness as brief as possible.

While the number of people in the city who have no contact with employment and skills provision is still significant, whether they are out of work due to a health condition or in work that does not offer good terms and conditions, people are being supported into work through targeted interventions. This work has been able to continue throughout the pandemic due to investment and adaption, which stands us in good stead in terms of being able to react positively to meeting the needs of Manchester residents in the future.

Children's Services continue to focus on reducing the number of children and young people going into care by using evidence-based interventions. These support families to remain together and where possible prevent the need for children to go into care, or where they do go into care, ensure a timely return home. Our teams are working closer with health, school, police and other colleagues in neighbourhoods and localities to place a greater focus on prevention and early support, avoiding problems starting in the first place for children or families, wherever possible.

The introduction of Integrated Neighbourhood Teams is transforming how residents experience their community-based health and adult social care, which has proved crucial during the pandemic. Intervention, prevention, reablement and services that better serve people's needs in the community have supported vulnerable people. This has prevented crisis and the need for more intensive health and social care services, also ensuring safe discharge from hospital as soon as people are medically fit so that hospital capacity is optimised.

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.