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Greater Manchester Children's and Young People's Health and Wellbeing Stakeholder Forum

CORE 20 PLUS 5- Addressing health inequalities for Children and Young People

Wednesday 8th February 2023

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Addressing health inequalities for Children and Young People

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Conference report

Background

For the first time in three years, the Greater Manchester (GM) Child Health and Wellbeing Stakeholder Forum met face to face at the British Muslim Heritage Centre, Manchester, to explore the health inequalities faced by children and young people in GM.

Variation and deterioration in health outcomes of our children and young people has always been highlighted by the impact of the social determinants of life and exacerbated during the COVID pandemic, and more recently with the cost-of-living crisis and austerity measures. Following the launch of the NHS CORE 20 PLUS 5[1] framework for Children and Young People (NHSE, 2022) in December, the Stakeholder Forum will explored the five clinical areas outlined in the document in the context of the most deprived 20% of the population, and through the lens of health inequalities.

Five clinical areas are identified as priorities within the framework:

Asthma

Diabetes

Epilepsy

Mental health

Oral health

The event brought stakeholders together from a wide range of disciplines including health, education, social care, and the voluntary sector, to explore the health outcomes of children and young people how these are impacted by poverty and inequalities.

[1] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

Welcome and Introduction

Dr. Carol Ewing, Chair of GM Child Health and Wellbeing Stakeholder Forum, Consultant Paediatrician (retired from clinical practice), Royal Manchester Children's Hospital (RMCH), Children and Young People's clinical adviser for the Greater Manchester and Eastern Cheshire Strategic Clinical Network (GMEC SCN)

Carol chaired the afternoon and in her opening statement welcomed all participants and affirmed her passion and advocacy for the voice of children, young people and families being part of the event today.

Carol described the purpose of the event and proposed that this be an opportunity to hear the views of the stakeholders on the Children's CORE 20 PLUS 5 framework, to review the five clinical areas through the lens of inequalities. The event also provided the opportunity to start to explore who the 'PLUS' groups are in Greater Manchester, to consider the impact of poverty and the current cost of living crisis on children and young people's health and wellbeing, and to develop an action plan for adoption across the Greater Manchester Health and Care system.

Lived experience of children and young people

Dr. Marie Marshall, Consultant Nurse for Transition, RMCH and Nicola Rigby, Teenage Cancer Trust Youth Support Coordinator, RMCH

Marie and Nicola presented some early qualitative findings from the ongoing evaluation of a pilot youth service provision in operation at Manchester University NHS Foundation Trust that supports young people who carry the burden of a long-term condition with their healthcare transition. The service launched in January 2022 with initial funding for 12 months.

A patient story was presented, describing the experiences of a 16-year-old with severe asthma, who had moved to Manchester with his girlfriend and her family. The move was unplanned and meant that there was no support in place around the long-term condition upon arrival. Prior to the move, Mum had supported his needs, for example, ensuring that he went to hospital appointments.

The youth worker was able to build a meaningful relationship with the teenager and communicated via WhatsApp. He was supported to communicate with his Mum, and the girlfriend and family received education about his condition. He was also supported with transport to hospital for appointments.

The youth worker programme opened channels of communication with the young person, carers and family. It enabled parent-carer voice and most importantly, supported the teenager to gain independence.

Launch video: edited version of the national launch by NHS England

The launch video saw Professor Simon Kenny talk of the importance of knowing the patients and the circumstances in which they live. Dr. Bola Owolabi described how the framework for Children and Young People was developed, stating that Integrated Care Systems should be looking toward population health data to identify their PLUS groups and that tackling inequality was down to everyone who worked with children and young people. Dr. Owolabi was followed by insight from two of the NHS Youth Board Members for the Children and Young People's Transformation Programme, who had been involved in the development of the framework- Aishah and Haris. Both were keen to impress the importance of involving and hearing from Children and Young People alongside the use of data, when identifying the PLUS groups in the Integrated Care System (ICS) area.

Ensuring children and young people are at the heart of NHS Greater Manchester plans

Gill Gibson, Deputy Chief Nurse, NHS Greater Manchester Integrated Care

Gill described the main job of the Integrated Care Board to be to reduce inequalities stating that the Board is very much integrated with Local Authorities. The integrated health function means that we also need to focus on other areas besides those outlined in the Core 20 Framework.

'In GM, we have a unique opportunity with our collective knowledge, expertise and clinical influence together to drive this agenda. Co-production is key and children, young people and families are at the heart of this. Within Local Authorities there is a focus on Public Health. Early intervention will empower children and young people and families to look after their own health so it is really important that we work together with Local Authorities and Public Health colleagues'.

Building Back Fairer in Greater Manchester

Dr. Deborah Thompson, Consultant in Public Health, GM Population Health, NHS Greater Manchester Integrated Care

Debs referenced the work of Sir Michael Marmot and the Marmot Review that raised health inequalities, as well as the more recent COVID-19 review: Build Back Fairer[2] (Marmot et al, 2020).

The Greater Manchester Independent Inequalities commission responded by publishing recommendations for tackling the causes and drivers of inequality. Population health is working alongside clinical leaders and the GM Equality and Inclusion team to deliver against the recommendations in a sustainable way i.e. against the 'Net Zero Strategy: Build Back Greener' agenda, and financially. The key principles of Build Back Fairer in Greater Manchester[3] are:

- Working with communities

[2] https://www.instituteofhealthequity.org/resources-reports/build-back-fairer-the-covid-19-marmot-review
[3] https://www.gmhsc.org.uk/news/new-bold-ambitious-framework-to-reduce-inequities-build-back-fairer-for-future-generations-if-government-is-serious-about-levelling-up-heres-how-to-do-it-says-marmot/

- Proportionate Universalism
- Building back with and for us all
- Representation of communities
- Health-creating places

Equality, Equity and Justice is a theme that runs throughout.

A GM framework for local action addresses upstream models of care (prevention and early help, poverty-proofing), Representation (demographically and of our communities), net zero (reducing the carbon footprint), person-centred care, trauma responsive care and targeted approaches.

Debs played a video describing the GM intelligence hub. The hub will have a 'single front door' that is open to everyone who works in health and care in Greater Manchester. This will enable us to access data and intelligence insights that tells us about neighbourhoods, communities and populations and what their health needs are. Further information about the 'Build Back Fairer Academy' is included in the slides.

Setting the scene ¦ A picture of health – what we know; what we don't know about the five clinical areas

Clinical advisers from each of the five clinical areas within the framework presented a snapshot of data about their clinical area, highlighting what the data tells us, and identifying some of the gaps in data and intelligence.

Mental Health

Joanne Taylor, Programme Manager, Greater Manchester CYP Crisis Care Pathway, GM CAMHS Lead Provider Collaborative, Pennine Care NHS Foundation Trust

Jo presented the available data, stating that the exercise had highlighted many data gaps, and issues with data quality. For example, ethnicity was recorded as 'not known' or 'not stated' in around 40% of all cases.

Data from 2021/22 shows that 48% (26,605 out of 55,495) of children and young people who needed to access services were doing so, which compares favourably against both North West (42.6%) and national (44.8%) figures. The average age of access was similar across different demographic groups. Current data is not stratified to quintiles of deprivation, but it is expected that this will be achieved within the next year.

Good practice was highlighted at Manchester NHS Foundation Trust (MFT) where a naso-gastric feeding clinic pilot for young people has been opened up within the Community Eating Disorders provision and can clearly demonstrate an avoidance of two hospital admissions from an initial cohort of five young people.

Oral Health

Dr. Heather Raison, Dental Public Health Speciality Registrar (GM), NIHR Academic Clinical Lecturer in Dental Public Health

Heather presented available data around oral health and dental service access for children and young people in Greater Manchester. This demonstrated that over third of children at 5 years of age in Greater Manchester have experience of tooth decay, and just less than 20% of two-year-

olds accessed NHS high street dental practices last year. Heather described dental service provision for children (routine and urgent care) for the GM population and pathways for vulnerable groups (including Looked After Children (LAC) and Child Friendly Dental Practices). Highlighted gaps in data were noted, particularly around deprivation and ethnicity.

Describing areas of good practice, Heather stated the impact of the GM transformation programme. For access, examples of good local activity included buddy practice schemes in Manchester LA and a dental voucher scheme in Bolton LA which help children access NHS high street dental practices.

Recommendations include need to agree metrics for dental data and pan-GM at-scale delivery of oral health improvement, alongside ensuring that improving oral health is embedded across the ICS.

Diabetes

Dr. Chris Cooper, Consultant Paediatrician, Stockport NHS Foundation Trust, GMEC SCN Clinical Advisor for CYP Diabetes

Chris stated that there is a relatively small proportion of children and young people with Type 2 Diabetes (T2D) compared to numbers with Type 1 Diabetes (T1D). There are striking differences between the quintiles of deprivation, with those in the most deprived 20% having the poorest outcomes in terms of HBA1c. Whilst outcomes have improved somewhat over the last few years, the gap between the most and least deprived has remained consistent. In terms of uptake of diabetes technology i.e. Continuous Glucose Monitoring and insulin pumps, the uptake is poorest amongst the most deprived. Further work is needed to understand the reasons behind this.

There are estimated to be around 73 children in Greater Manchester with T2D and there is a strong correlation between prevalence and the most deprived areas. Obesity rates have increased during the pandemic years according to the National Child Measurement Programme, and the gap between the most and least deprived areas again has remained consistent.

Chris presented a patient story, describing the impact of caring responsibilities on his diabetes management, with potential solutions being mental health support, access to a key worker or youth worker, and technology and apps to improve engagement.

Epilepsy

Dr Amy Wilson, Consultant Paediatrician, Salford Care Organisation Epilepsy Clinical Advisor CYP, GMEC SCN and Debbie Garner, Paediatric Epilepsy Nurse Specialist, Salford Care Organisation, GMEC SCN Clinical Advisor for CYP Epilepsy

Amy stated that the Epilepsy 12 audit provides some data and insight, but better data is needed to understand inequalities experienced by children and young people with epilepsy. Estimates suggest that there are around 360 new cases of epilepsy in children and young people across

Greater Manchester each year. Those living in the most deprived quintile have the highest rates of emergency admissions and attendances at hospital.

When comparing Greater Manchester data with England data, in GM 56% of new presentations were from the most deprived quintile compared to 27% for England. For children aged 0-18 years, there was evidence of a comprehensive care plan for 56% of children compared to 70% for England.

Debbie presented a patient story about a 6 year-old child with epilepsy living in the most deprived quintile. Issues of drug and alcohol use, and mental illness within the family led to non-compliance with medication regimes, an increase in seizures and non-attendance at school. Eventually, the child was placed in care. The adherence to medication in this new setting led to her being seizure-free.

Asthma

Professor Clare Murray, Honorary Consultant in Paediatric Respiratory Medicine, RMCH, GM Clinical Research Network Children's Lead

Clare presented available asthma data stating that emergency admissions for asthma in Greater Manchester of 180.1 per 100,000 population are much higher than the most recent England average of 60 per 100,000. In the most deprived quintile, the rate of admissions is almost double that of the least deprived.

Inhaler prescriptions showed that there were far more reliever inhalers prescribed for children and young people, than preventer inhalers. This could indicate that they are not managing their asthma well.

An example of good practice was shown where a checklist that aligned to the Making Every Contact Count (MECC) approach had been developed for use in the hospital setting within RMCH. The checklist is used when a child is admitted to hospital and completed before the go home.

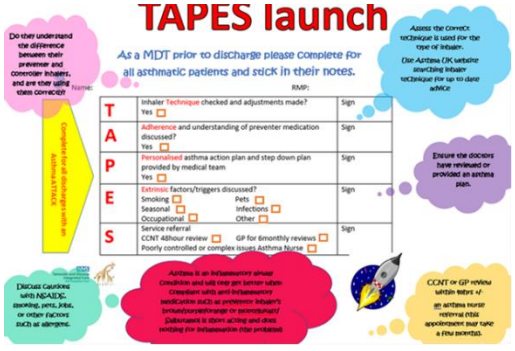
Technique

Adherence

Personalised asthma action plan

Extrinsic factors/ triggers discussed

Service referral



Poverty and inequalities in the North West Region ¦ The impact of poverty on health inequalities in the North West region:

Dr Ian Sinha, Consultant Respiratory Paediatrician, Alder Hey Children's Hospital, Consultant Respiratory Paediatrician, National Asthma and COPD Audit Paediatric Clinical Lead, NHS England NW Asthma CYP Clinical Lead, Honorary Associate Professor in Child Health

Ian began with an analogy of fleas in a jar to describe the impact of poverty on health, explaining that if fleas were kept in the jar with the lid on, over time they would lose their ability to jump out. Stark figures were presented showing higher mortality rates for children and young people in more deprived areas, and the seven-fold difference in mortality rates between the most and least deprived areas in the North West.

Data from the Office for Health Inequalities and Disparities (OHID) illustrated the inequalities in the North West that exist around health, school readiness and being overweight, with infants in the North West of England 55% more likely to live in low-income households than those in the South West.

The Child of the North Report[4] described the impact of the COVID pandemic and the ways in which children in the North West and North East of England were detrimentally impacted on a worse scale than those in other parts of the country. Loss of earnings for families had a big effect. The areas with the biggest budget cuts due to austerity measures were those areas where people were already dying early.

Ian stated that the cost-of-living crisis often referred to is not a crisis in the North West, but rather it is a normal but totally unacceptable way of life that other areas have been brought into.

Referencing *Child Poverty and Health Inequalities in the UK: a guide for paediatricians* Lee, A. et al (2022)[5], Dr Sinha finished by stating that the real killer is how poverty eats into a person's self-worth and self-respect, and referring back to the fleas in a jar: "We need to take the lid off - for our children and young people and for ourselves."

Mentimeter questions to attendees

Are there particular groups who experience worse health outcomes for the 5 clinical areas?

The answers to this question were captured in a word cloud which highlighted words that were used more often in larger text. Further analysis of the responses enabled a number of key groups that the attendees felt experienced worse outcomes than the general population. In order of the number of times these were highlighted, the groups are described below in **Table 1.**

[4] https://www.n8research.org.uk/research-focus/child-of-the-north/

[5] Lee, Alice & Kingdon, Camilla & Davie, Max & Hawcutt, Daniel & Sinha, Ian. (2022). Child poverty and health inequalities in the UK: a guide for paediatricians. Archives of disease in childhood. 108. 10.1136/archdischild-2021-323671.

Table 1: Plus groups identified by attendees

Order by number of responses	Theme	Number of mentions
1.	Those affected by poverty, deprivation and low income	42
2.	Children who are looked after and care leavers	36
3.	Children with learning needs including learning disability and autism, learning difficulties and who are neurodiverse	28
4.	Children who are vulnerable due to family/home circumstances including domestic violence/ abuse, children of sex workers and those who have had Adverse Childhood Experiences	21
5.	Minority ethnic groups and communities including Black and Asian, Orthodox Jewish and those impacted by racial inequality	16
5.	Refugees and asylum seekers including children who are unaccompanied	16
6.	Children with complex health needs including those with comorbidities, on palliative and end of life pathways and with physical disabilities	14
7.	Traveller communities	11
8.	Children living in inadequate housing including those who are homeless	8
9.	Children with language needs including where English is not the first language and those with speech, language and communication needs	7
10.	Those impacted by mental health issues	6
11.	Communities identified by gender including LGBTQ+ community and girls	5
11.	Children in the justice system	5
11.	Children with poor access to services including health, transport and other means of support	5
12.	Children who are not in mainstream services including school	4
13.	Infants and children under 5 years	3

What opportunities do we have to specifically address these groups and co-produce the offer?

Table 2: Opportunities

Order by number of responses	Theme	Number of mentions
1.	Integrated working including with statutory, voluntary, community and faith organisations	29
2.	Patient, parent, carer, family voice to help understand barriers to access, and to plan and commission services	22

3.	Settings utilisation of community and place-based settings such as schools, family hubs and sports clubs, to deliver services and offer support	18
4.	Planning and commissioning of services with adequate funding and priority around addressing health inequalities	16
5.	Education and health literacy development for children, young people, parents, carers and families	14
5.	Prevention and early help that addresses the family and the social determinants	14
6.	Service provision should be targeted and involve a range of organisations through a multidisciplinary team approach, with a variety of access options	13
7.	Service providers as a means to access those with poorer health outcomes including youth services, maternity, faith and voluntary sector organisations	12
8.	Support offer that includes peers and is for parents and carers	5
9.	Training of workers who are in contact with patients, parents, carers and families experiencing poor health outcomes	5

What specific actions are there for each clinical area in relation to CORE 20 PLUS 5?

Table 3: specific actions

Order by number of responses	Theme	Number of mentions
1.	Ensure accessible services through consideration of settings and appropriate workforce e.g. youth workers	11
2.	Share data and intelligence to inform service provision	9
2.	Co-produce services and pathways with children, young people and families	9
2.	Work across services and disciplines in an integrated way	9
3.	Ensure commissioning, service design and investment address those communities experiencing the worst health outcomes	6
4.	Target resources and services appropriately using a proportionate universalism approach	4
4.	Gain insight through data and intelligence to identify the plus groups and those who experience health inequity and inequalities	4
5.	Educate families about the five clinical areas	3

Workshops- round table discussions

Poverty-proofing child health pathways

Dr Simon Watts, Public Health Registrar and Dr Alice Willson, Paediatric Registrar/ Public Health Fellow

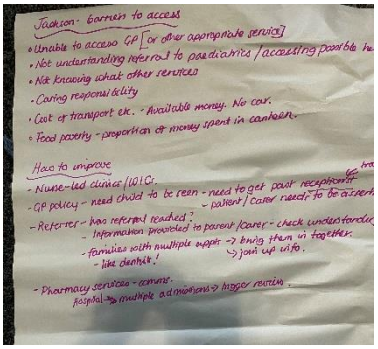
For some children and young people, clinical and referral pathways can mean disadvantage in access to healthcare and health outcomes compared to the rest of the population. The workshop aimed to explore key issues around poverty and health and how pathways can be 'poverty-proofed' to reduce health inequalities.

Simon and Alice led the session, describing practice from the North East of England around poverty-proofing pathways, and prompting discussion around a case study to enable participants to explore the poverty-related issues in accessing healthcare and achieving better health outcomes.

Data was presented that described the levels of poverty for households, and in particular for children in Greater Manchester, and how this can impact upon health and health outcomes. Examples were provided of influencing factors such as housing and air quality on asthma, low income on access to dental health care and having a low-cost, high-sugar diet which has a detrimental impact on dental health as well as diabetes outcomes, the impact of poverty and the worries that come with this can also have a detrimental impact on Children, Young People and families' mental health and wellbeing.

A case study was provided describing 'Jackson', a 5-year-old boy who has had multiple attendances to A&E in the previous year with wheeze. Although he had been referred to paediatric services, his mum was unsure why. Jackson's condition had impacted his school attendance and also his Mum's ability to work. Missing work to attend appointments and care for him meant that she didn't get paid. A long wait in the hospital meant she needed to buy food for Jackson and the baby which took a large chunk of the money she had with her.

Round table discussions were held to consider:



Exercise 1:

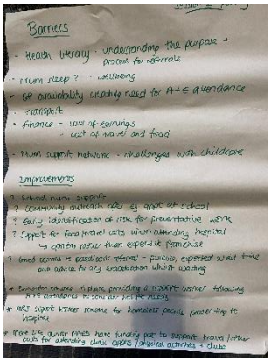
- What are the barriers to accessing good health for Jackson?

Exercise 2:

- In the case of Jackson, what could be changed to improve his care?
- Do you have examples of good practice from your work in mitigating the impact of or supporting people in poverty?
- What do you think could/should be done in your service?

Emerging themes from poverty-proofing workshop

Barriers to accessing good healthcare



Money

Money was highlighted a key factor in accessing health services and improving outcomes. Loss of earnings due to missing work to attend appointments is a factor in determining whether an appointment will be attended.

The cost of transport to attend appointments and the potential cost of food and subsistence should there be extended waits may cause additional stress for a family and have a knock-on effect of not being able to afford to pay household bills, which in turn could lead to cold, damp housing that exacerbates the condition.

Transport

Lack of access to a car, and no local health services may lead to attendance at the nearest hospital by public transport. This is likely to incur transport costs and time lost to travelling, leading to poor attendance at school and loss of earnings due to missed work.

Participants also highlighted the need for patients to understand transport routes to healthcare destinations. The use of public transport can be particularly difficult to undertake with children, but the use of private transport for shorter journeys could add to air pollution, potentially exacerbating any respiratory conditions.

Health Literacy

Many groups highlighted that the parent/ carer struggled to understand the nature of her son's condition and this may have been down to her own learning difficulties, or the lack of meaningful education and information provided to her by health care professionals.

Communication

Communication with the parent/ carer was noted including provision of information about her son's condition, and ensuring she understood the referral process and what to expect.

Additionally, lack of communication between services was highlighted in terms of the data and intelligence that could have been shared with the relevant services, healthcare and other sectors. This could have flagged any concerns and enabled the relevant professionals to address them or to signpost to additional support.

Navigating the system

The case study described how the parent was unable to get through to the GP and so went to hospital. Understanding the other options available such as NHS 111, community pharmacy may have resulted in one less attendance at A&E and the associated costs that were incurred for the family. Also, if families have access to technology, there would be additional sources of information to them to assist with navigating the system and accessing health care advice.

There was much discussion around where healthcare should be provided, with much emphasis on provision in the community wherever possible, including at home, in family hubs and in General Practices and pharmacy, but preferably not in hospital.

Childcare/caring responsibilities

Childcare was a particular issue in this case with a neighbour being relied upon to look after some of the siblings, but the baby needed to be taken to the hospital along with Jackson. The visit was lengthy and required mum to purchase food in the hospital for both children, which was costly and ate into the money that mum had with her.

Support networks

Many groups described the opportunities for support that the family could have accessed if they knew about them. These included voluntary sector organisations as well as family hubs.

School and work commitments

These were both highlighted as potential barriers to attending healthcare appointments. For Mum, missing work meant reduced income. Missing school impacts on the child's education, mum's anxiety around this and the potential to access support through the school setting.

Opportunities for improvement

Prevention

More upstream work that potentially requires policy change at local, regional and national level was described. Lobbying for change in the following areas may impact positively on health and care outcomes:

- Inclusion of children and young people in all policy making
- Living wage for all
- Investment in health and education services that will allow workforce time to have discussions and actions to address the detrimental impact of the social determinants on health and wellbeing
- Remove zero-hours contracts
- Better childcare provision for all

Greater Manchester Poverty Action[6] (GMPA) has been commissioned as part of the Greater Manchester Poverty proofing strategy to tackle poverty through prevention and reduction, and by ensuring a strategic approach.

Health literacy and education

Opportunities to educate the family about the health condition and how to self-manage/ when to seek help should be taken at each contact e.g. through schools (nursing), health visitors, community nursing, GP practices, pharmacies and at A&E. Additionally, through the GM plans to address digital poverty, improving and enabling access to technology would provide another resource to access health information and education.

Services should check understanding by the family and ensure that information is accessible to them.

[6] GM Poverty Action - Greater Manchester Poverty Action

Opportunities should be explored to educate health care professionals about health literacy, with a view to understanding what can be done to improve communication with children and young people, parents, carers and families, and ensuring that communications are accessible to all.

Communication

Better communication with the family should include:

- Information about the health condition, referral process, wait times etc. and a check back with the parent/ carer/ family for understanding
- Information about alternatives to GPs and hospital services, including what to do if help is needed before the child is seen by the paediatrician
- Information about transport links
- Information about other support options such as through community organisations

Better communication across services should include:

- Shared intelligence between healthcare and education
- A mechanism for flagging across services where extra help is required
- Knowledge of family circumstances e.g., siblings, financial, housing to inform appointment-setting

Support networks

Support networks should provide information about finances, healthcare, education, benefits and other aspects of support such as mental wellbeing. Schools were noted as a potential source for information and advice, and possibly venues for providing elements of health care.

Local offer

The local offer for health and care may be broader than the GP practice or a hospital. Other options should be considered and communicated out such as pharmacies, family hubs, drop-in clinics in community venues and nurse-led clinics.

Practical support for attending appointments

Suggestions for practical support to attend appointments included:

- Information about transport links
- Checking understanding of appointments, referrals and processes
- Provision of healthy food for free and transport vouchers/ funding to help families attending appointments
- Ensuring that where there is more than one family member requiring healthcare appointments, that these are joined up and arranged for the same date/ time wherever possible
- Ensuring that where a child has multiple appointments, possibly for a range of conditions, that there is communication between departments to ensure they all happen on the same day

Data workshop: Integrating the data, joining the dots, painting the picture

Dr. Deborah Thompson, Consultant in Public Health, Fatamah Shah, Senior Data Manager, GMEC SCN, NHS GM Integrated Care.

CORE20PLUS5 is a framework for reducing health inequalities in the 20% most deprived of the population and for those 'PLUS' groups who experience poorer health outcomes than the rest of the population. The workshop aimed to explore existing data, and to identify the gaps in data to enable a better understanding of who the PLUS groups are in Greater Manchester, and how we can make a difference to their health outcomes through a better understanding and use of data.

Debs introduced the session and Fatamah provided a brief overview of the data that she is able to access. This included hospital data for admissions and attendances, and publicly available data such as that published by the Office for National Statistics and the Office for Health Inequalities and Disparity. General Practice data is also soon to be made available.

The task for discussion in the workshop was explained:

Choose a focus for your table- either a or b:

a. Particular population group (eg specific ethnic group or children with a disability)
b. 2 (or more) of the clinical pathways

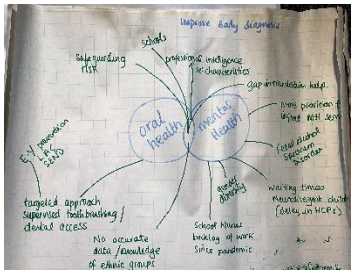
Each table was allocated a question to discuss what intelligence (data and insight) can help us to understand how to address their allocated question below.

1. How do we work with different communities and neighbourhoods to support people to stay well and prevent illness?
2. How do we work with different communities and neighbourhoods to improve early diagnosis?
3. How do we work with different communities and neighbourhoods to improve access to treatment?
4. How do we work with different communities and neighbourhoods to improve experiences and outcomes of treatment?

Emerging themes from the data workshop

Sources of data and intelligence

Many services hold 'health' data and other information and local intelligence that can help us to understand the health and wellbeing of communities at a more local level. Educational settings, third sector organisations, health service providers and commissioners and local authorities are mentioned as holding different types of information that may enable targeted service provision for our PLUS groups and those in the 20% most deprived of the population.



Communication

There was much reference throughout discussions in the need to better communicate within and across organisations and services. Data sharing was identified by many as an area for improvement, and access to good quality data. Additionally, at individual level it was felt there

was a need to triangulate data and information from different sources, some of which may raise flags and identify where additional and possibly immediate support is required.

Gaps in data and intelligence

Many attendees felt there were gaps in data and intelligence. Some of the discussion highlighted that there was much data available but that it was not readily shared.

Information about the wider contextual and social determinants of health and wellbeing

Examples were provided of how for example, housing, money and access to transport can impact upon a person's ability to access support and available services. It was felt that not enough intelligence existed to identify barriers to accessing services at community level, but also on a more individual level. Whilst there may be many services and organisations who have insight into these barriers, this is not necessarily shared with healthcare and other professionals who may be able to act upon the information by adapting healthcare provision to meet these needs.

Final comments from attendees

Dr. Ewing asked attendees for any further comments.

It was noted that mortality was referenced throughout the afternoon but that inequalities in access to Palliative and End of Life (PEOL) Care for children and young people had not really been considered, e.g. access to hospices. Children in poverty die in poverty.

All were asked to consider further how we share knowledge and insight into our communities- do we have communities of practice where this happens?

In terms of poverty, how do we communicate and what are the external factors affecting health? Is social prescribing used to address these factors for families?

Closing comments:

Dr. Carol Ewing

Carol stated that 'we are all advocates for this work and should take it back into our workplaces. The Greater Manchester Children and Young People Plan talks about prevention and equity, so let us address the balance. It is clear that there are data gaps and work to do here. Regarding poverty-proofing pathways, how do we address the problems we have identified?

Another workshop on inequality would help to continue the momentum'.

Carol thanked the British Muslim Heritage Centre for the excellent hospitality, the GMEC SCN Team for organizing the event, Fatamah Shah for producing the data pack around long-term conditions, and all of the speakers and attendees for their input.

In summary:

The stakeholder event was well-attended by a wide range of children and young people stakeholders including health and social care professionals, education colleagues, voluntary, community and third sector, and parent voice representatives. The purpose of the event was to take a systematic approach and progress a journey of exploration around the groups of children and young people and their families who experience health inequalities. This event has begun to capture the views of a range of stakeholders, but in the true spirit of co-production, there is

further insight to be gained from the communities identified in this document, and from the data and intelligence that we hold, or have yet to gain access to.

The event has highlighted the vast quantity of data and intelligence, and the routes to accessing it. It also highlighted the need to focus in on what data and intelligence will be most useful to us, and how it can be joined up to describe those communities experiencing health inequalities. We must not forget that data in isolation does not tell us the whole story. It becomes meaningful when complemented by and overlayed with other data and 'soft' intelligence from service providers and lived experiences from service users in a range of settings.

The event has also highlighted the opportunities for communities, organisations both individually and in partnership across health and other sectors to work together to poverty proof services.

Recommendations

Further detail is summarised in Appendix 1

1. A report will be produced by the Children's Strategic Clinical Network that will be shared widely across the GM system and which will inform the direction of the GM Children and Young People Plan.
2. An action plan will be drawn up as part of this report that begins to address the issues identified in this document. The action plan will be owned by the Greater Manchester Integrated Care System (ICS) which is responsible for reducing health inequity and inequalities. Accountability should be with the Greater Manchester Children and Young People's System Board, NHS GMIC which is in the process of being established, for delivery of actions within the action plan.
3. Further insight work should be conducted around the 'PLUS' groups identified in this Stakeholder Forum event. How, where and with whom this insight work will be conducted should be agreed by the Children and Young People's System Board.
4. Each of our lead presenters for the 5 Long Term Conditions will be asked to review their programmes of work and develop action plans considering how the report can make a difference particularly using the two tables on Page10
5. Greater Manchester Business Intelligence leads to continue to work with clinical leaders in each of the five areas to agree and manage the data and intelligence that is required to understand the needs of those with the poorest outcomes both at GM system and locality levels.

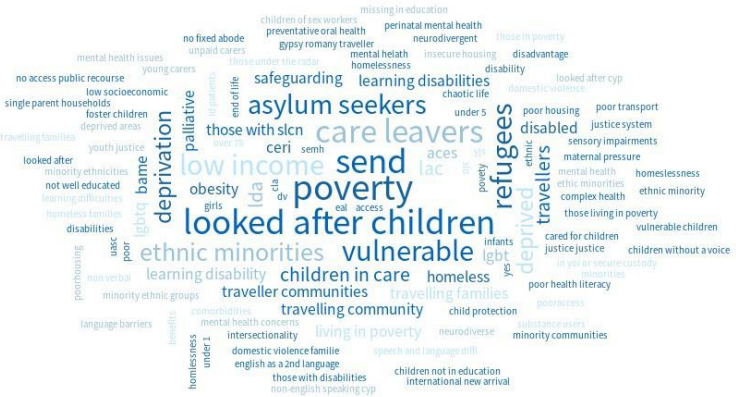
Appendices

Appendix 1: Action Plan

Ref.	Action	Expected outcome	Owner	Completion date
1.	Develop a set of standards that services should aspire to that ensure accessibility for our CORE 20 PLUS 5 population groups	Reduction in variation of access to services across Greater Manchester. Services are accessible to our CORE 20 PLUS 5 groups. Improved Health outcomes and reduced health inequalities.	Integrated Care Partnership Board, Integrated Children's Board, Greater Manchester Children and Young People's System Board NHS GMIC	
2.	Agree outcome measures (quantitative and qualitative) for these standards against which services can be measured/ self-audit	Service improvement that incorporates patient/ parent/ carer experience. Co-production of service design and improvement.	GM Quality Board	
3.	Develop a shared data and intelligence dashboard for CORE 20 PLUS 5 inform service provision	Early identification of and intervention with population groups that require enhanced service provision.	GM IC Business Intelligence	
4.	Co-produce with children, young people and families a set of standards that describe how co-production of services and pathways should look	CYP, parent, carer and family-friendly services for all of our population groups including those in the Core 20 Plus 5 groups.	Greater Manchester Children and Young People's System Board NHS GMIC	
5.	Agree the narrative around integrated working in Greater Manchester and an associated charter that all stakeholders can sign up to	Improved patient, parent, carer, family experiences of services.	Greater Manchester Children and Young People's System Board NHS GMIC	
6.	Ensure commissioning, service design and investment address those communities experiencing the worst health outcomes	Services are targeted where they are most needed. Health inequalities are reduced.	Greater Manchester Children and Young People's System Board NHS GMIC including Commissioners and Population Health.	
7.	Target resources and services appropriately using a proportionate universalism approach that is informed by data, intelligence and the voice of our children, young people and families	Services are targeted where they are most needed. Health inequalities are reduced	Greater Manchester Children and Young People's System Board NHS GMIC	
8.	Gain insight through data and intelligence to identify the plus groups and those who experience health inequity and inequalities through focus groups, data and intelligence	'Plus' groups are identified and regularly reviewed so that service provision can be modified to meet the needs of the changing population in Greater Manchester.	GM IC Business Intelligence	

Appendix 2: Mentimeter Outputs

Are there particular groups who experience worse health outcomes for the 5 clinical areas?



78

What opportunities do we have to specifically address these groups and co-produce the offer?

NHS England

Youth forum	Partnership working	Schools
Perinatal mentalHealth	Focus groups	Clear priorities
Every contact counts	Education	Youth workers

75

What opportunities do we have to specifically address these groups and co-produce the offer?

NHS England

Embed lived experience	Access Understanding of causes /barriers	Training all staff
Working with vcse and faith organisations	Schools	Carer support
Schools	Family hubs	CYP voice

What opportunities do we have to specifically address these groups and co-produce the offer?

- 0-19 services
- Work together with common purpose to improve outcomes
- Charity services
- Closer working with VCSE sector
- Transition
- Libraries
- Work with community organisations
- Focus groups
- Education's

What opportunities do we have to specifically address these groups and co-produce the offer?

NHS England

Youth workers	training opportunities	Collaborative working
Youth forum	Universal services	Parent/cater voice
Integration of services	Parent support	health visiting services

75

What opportunities do we have to specifically address these groups and co-produce the offer?

NHS England

Prevention work	Family Hubs funding	Properly funded services
Making every contact count	Every contact counts	Partnership working
Schools	Cross collaborative working within the system for a joined up approach to reduction of overall health inequalities	Education via schools

75

What opportunities do we have to specifically address these groups and co-produce the offer?

Innovation for healthcare inequalities programme (InHIP)

Intergration of services

Teamworking between health and social care

Early helpSelf management adress health ilteracy

Schools

Co production strategy

Work with care leavers and social housing providers who support them

Peer supoort

Family hubs

75

What opportunities do we have to specifically address these groups and co-produce the offer?

NHS England

Partnership working - must involve services wider than health

Community assests, family hubs, education

Parents

Reducing variation

maternity

Group work in schools/community

Collaboration

Staff training

co-working with multi-agencies

75

What opportunities do we have to specifically address these groups and co-produce the offer?

NHS England

- school
- Joint working
- Use lived experience of children young people and families
- Use voluntary sector e.g Barnardo's
- Collaborate and work in partnership with community leaders
- Vcse
- Targeted work. School based help
- Engagment workshops with carer groups
- Family hubs

75

What opportunities do we have to specifically address these groups and co-produce the offer?

NHS England

Enabling access	Invest in prevention	Integrated working
Linking with community organisations	Every contact counts	Every contact helps
Linking in to existing working groups (GM Cared for Children and Care Leavers working group)	Work with Social Care, early help and community groups	Family hubs

75

What opportunities do we have to specifically address these groups and co-produce the offer?

NHS England

- SEND agendas locally
- More focus on social determinants and commercial determinants
- Representative workforce
- Use community voice ask them what they need, rather than assuming
- Education
- Working in partnership across all organisations
- Engaging early with CYP
- Sports clubs
- Interpretation / translation services

75

What opportunities do we have to specifically address these groups and co-produce the offer?

NHS England

multi-agency approaches	Specialist support	Understanding that we are trying to address the inequity
Service user review of services to inform practice	Youth workers and early help	Holistic approaches
Sharing of data	Priority pathways	Healthwatch

75

What opportunities do we have to specifically address these groups and co-produce the offer?

Health assessmentsTargetted reviewsEarly help

Parent Chamipons

GM building back fairer and locality health inequality fora - partnerships across ststem to address causes as well as symptoms

Parent cater forums

Improved consistency across Greater Manchester - evidencing outcomes, coordinated pathways etc

Perinatal mental health mother and baby unit and community teams for parents with conditions and support for babies up to age 18 months for their relationship Infant and parent mental health services

Reach out + listenPoverty proofingAddress root causes of poverty / inequality - make manchester Fairer/ BBF

Joint commissioning. Neighbourhood and placed bard working. Coproduction with parent carers / CYP/ primary care links.

Access to services

75

What opportunities do we have to specifically address these groups and co-produce the offer?

Shared intelligence

Variety of access options

MDT working

Education from health professional

Youth forums, service users voice, community projects voice, see what is already being used, use the skills of the comissipned group

Partnership working

Community organisations, faith organisations,

listening events

Invest in health improvement

75

What opportunities do we have to specifically address these groups and co-produce the offer?

Collocation

Improved communication between services

Include palliative care as a GM +

We need to have a multiagency approach and here the voice of CYP and their families

Training Youth workers Charity Carers support

Support and fund community health champions and youth champions

Via engaging with young people in schools and in their communities

Understand the causes and barriers, cumtira awareness. Through forums, ssurveys etc. Raise concerns and awareness in key community hubs and forums

Local intelligence to identify where there can be service redesign

What opportunities do we have to specifically address these groups and co-produce the offer?

Do you really mean go production or consultation

Schools Collaborative working Education Training Effective plan planning Early intervention Preventative work Family work Children focused practice

Listen to families and young people

Make the case for resource being fairly given to support improving child health outcomes

Seek those who don't normally have a voice

Focus on whole person wellbeing

Networks for children YP and families

reducing waiting lists

Utilise data to highlight cohorts

75

What opportunities do we have to specifically address these groups and co-produce the offer?

Vol sector mou. Existing fora. Networks such as the community explorers

What specific actions are there for each clinical area in relation to CORE20PLUS5?

Identify cohort	Better data needed!	Family hubs
Better data	Engage perinatal mental health	Use of data
Collaboration with voluntary services	More investment	Recognition of those groups

What specific actions are there for each clinical area in relation to CORE20PLUS5?

Scope whats is available	Transition	Identify cohort
Understand and agree data metrics	Initial cohorts	Education
Advance care planning	Integrated action planning and delivery	Working collaboratively

What specific actions are there for each clinical area in relation to CORE20PLUS5?

NHS England

Integrated working	Data	Identifying high risk in each of the 5
Clear identification	Ensure Experience is factores	Engage services users
Greater support for young people	Asthma-education health inqualities	Sharing of data

70

What specific actions are there for each clinical area in relation to CORE20PLUS5?

Epilepsy specialist nurses

Funding

Breastfeeding

standardised data collection and analysis

Young peoples engagement and access to services

Engagement

Joined up working

Understand those who aren't able to access care and the reasons - take action

identify cohort

70

What specific actions are there for each clinical area in relation to CORE20PLUS5?

To make equality and equity plans in each service

Develop solitions

Engagement work

Sharing data between services

Closer working with schools in key areas

inclusivity

Sharing intelligence to provide targeted interventions

Colocated and neighbourhood based services

Focus on young people and gaining their voices

70

What specific actions are there for each clinical area in relation to CORE20PLUS5?

Use local data intel	Early identification	Air qality
Investment, priorities education	Reducing variation in care	Palliative and end of life data
Increase access to physical activities	Use data	Family hubs transition oral health

What specific actions are there for each clinical area in relation to CORE20PLUS5?

NHS England

- Joint approach
- Prioritise cyp who have the most needs
- More joint working / collaboration to avoid duplicated reviews.
- A joint approach to evidencing outcomes across services
- Using physical activity and increase access
- Links with HV
- education
- Gather and understand data
- Pilots

70

What specific actions are there for each clinical area in relation to CORE20PLUS5?

Data and metrics linked to educational outcomes and attainment

Co production

Patient and community involvement

Better support/planning

Healtyschools

Data

All age/family support

Access to specialist nurses

Workforce planning

70

What specific actions are there for each clinical area in relation to CORE20PLUS5?

NHS England

- Targeted resources
- Transition pathways
- Invest in clinical care AND prevention at population and community level
- Long term plan and government commitment to public services.
- Understand what works well for these groups and build from there
- Data
- Understanding wider need
- Collaboration
- Working across the system

70

What specific actions are there for each clinical area in relation to CORE20PLUS5?

Mental health - promoting and preventing as well as treatment (in partnership with wider system)

Consider communication skills needed by children/young people (and their parents/carers) within each clinical area

Children and Young people voice

Check your data is it robust Get a group of children and young people to work with

Hold each other to account

Shared learning

Collaboration

Better identification and collaboration

Prevention of ACEs

What specific actions are there for each clinical area in relation to CORE20PLUS5?

NHS England

- Workforce retention and recruitment
- Widen opportunities for integration
- Detailed data
- Collaborative working
- Collaboration across neighbourhoods/areas
- Targeted work at Place (neighbourhood) level
- Engaging with parent and child relationship
- Flex care off around patient needs
- How they link with family hubs or other local/GM initiatives

70

What specific actions are there for each clinical area in relation to CORE20PLUS5?

NHS England

- Speaking with comissioned groups
- Electronic sharing of info GMCR
- Adapting current pathways
- Collaborative working
- Data sharing where multiple conditions, issues and services being accessed
- Funding
- Clinically led pathways codeveloped with patients
- Proportionate universalism approach
- Links to schools

70

What specific actions are there for each clinical area in relation to CORE20PLUS5?

Youth worker

Asthma friendly schools

Working together across all desiciplines

School readiness

Understand local provision to identify improvements

Efficuent use of relevant data, collaborative worrking and sharing data, greater yp support

Work with university and students to understand data

Engagement with service users Data Identification

Integrated working Early identificationFollow up non attendance

What specific actions are there for each clinical area in relation to CORE20PLUS5?

Imtergrated working , greater sipport for young people ,

Using voices outside of clinical

Commercial determinants awareness and collective response

Workforce training

Sharing information

What t2 interventions do we have in GM for CYP?

Accessibility of clinics/where appointments are held

Education around clinical areas for families, schools, other young people

Parent infant mental health services

70

Appendix 3: Poverty-proofing workshop flipchart summaries

Exercise 1: What are the barriers to accessing good health for Jackson?	
Flipchart 1	• Housing • Transport • Living wage- NHS, and proper contracts • Subsidised food in hospital • Mental health • Subsidised childcare • GP Access • Stop cutting budgets • Recruitment/ workforce • Hospital letters à delay in referral • System too hard to navigate • Food should be available on the ward/ department à not unhealthy • GP barrier (in relation to accessing an appointment)
Flipchart 2	• Long waiting list, poor communication to mum • Zero hours/ poor workers' rights especially for carers- loss of pay • Barriers to primary care- emergency calls at 8-9 am • Lack of childcare • Poor public transport • Cost of food in hospital
Flipchart 3	• Family dynamics- single mother • Area is deprived • Knowledge of first five years- access to health visitor and children's centre, what has been tried already- family history • Access to GP
Flipchart 4	• Lack of family support- strain on relationship • Rely on public transport- distance/ times? • Lack of communication between services • Lack of capacity in system • No workplace support- no pay • Anxiety of effect of missing school- reason? • Phone cost and hospital food
Flipchart 5	• Single-parent household • No transport • Low income • Access to GP • Cost implications for calling GP (mobile phone) • Waiting times • Poor/ lack of communication re. condition • Childcare
Flipchart 6	• Support for childcare • Mum is a carer/ works night- sleep deprivation? • Finances • Concerns re. attendance at school- does this impact upon attendance at medical appointments? Impact on learning • Understanding of what medical appointments are for

Flipchart 7	• Education re. condition
	• Asthma plan
	• Local health facility/ hub
	  ○ To support
	  ○ To provide advice and treatment
	  ○ To screen for 'red flags'

Flipchart 8	• Waiting times (GP/ tertiary/ acute) • Poor communication • Mum's shift pattern • Lack of support network • Poor health literacy • Access to GP • Transport • Hidden costs- food • Loss of earnings

Flipchart 9	• Health literacy- understanding the purpose and process for referrals
	• Mum's sleep and therefore wellbeing
	• GP availability creating need for A&E attendance
	• Transport
	• Finance-
	  ○ Loss of earnings
	  ○ Cost of travel and food
	• Mum's support network- challenges with childcare

Flipchart 10	• Unable to access GP or other appropriate service • Not understanding referral to paediatrics/ accessing possible help there • Not knowing what other services there are • Caring responsibility • Cost of transport etc.- available money, no car • Food poverty- proportion of money spent in canteen

Exercise 2: **In the case of Jackson, what could be changed to improve his care?** **Do you have examples of good practice from your work in mitigating the impact of or supporting people in poverty?** **What do you think could/should be done in your service?**	
Flipchart 1	What could be changed? • Public health- prevention funded properly • Improved access to information- how to manage his condition • Electronic access to your health record • Direct access to asthma nurse • Pharmacy role in supporting • Explore health visitor support • Free travel cards/ voucher • Link with school- attendance • Healthy, free nutritious food in A&E, paediatrics • Healthy start information + money advice referral tool Examples of good practice

	• Perinatal community team is now home visiting to improve access rates. • School Readiness Board is improving uptake of 2-year free nursery placement, so children are getting 15 hours per week What could/ should be done? • Healthy start- money advice referral • Public health nursing- signpost to Start Well centres to enable a family worker to help family- prevent hospital admissions and gain better health outcomes.

Flipchart 2	What could be changed?
	• Re-thinking healthcare provision
	  ○ Linked primary and secondary care services
	  ○ Training different workers
	• Identifying environmental causes of ill-health and actioning on it (and training health care practitioners on this)
	• Working with family hubs
	• Free food for families in hospital

Flipchart 3	What could be changed? • Family support worker from Barnardo's in A&E- has mum got the skills with wider issues? Nothing happens in isolation • Nurse-led minor illness clinic • Pathways • Alternatives- 111- at point of contacting GP • Diagnosis- ask to get reviewed by practice nurse- you need to have one • Inter-partnership working- communication

Flipchart 4	Poverty-proof improvements:
	• Family support- family hub
	• Public transport- distance/ times
	• Communication between services- include education
	• Virtual appointments, capacity- include school- lack of funding and time
	• Guidance on community support- asthma nurse
	• Education for mum
	• Food- what's available from hospital
	• School support- school nurse
	• Environment check
	• Prevention and underlying cause
	• Early help
	• Duty of care for connecting to service
	  ○ Who else's job to pick up?
	  ○ Who is putting the whole puzzle together?

Flipchart 5	Opportunities:
	• Education for mum
	  ○ Key worker?
	  ○ Community asthma nurse?
	  ○ Early help/ TAF/ SC
	• Asthma friendly school project
	  ○ Access to virtual ward?

	○ Children's community nursing team • Does Mum understand? Learning Disability/ Difficulty • One-page profile/ hospital passport • Exploration data/ Joint Strategic Needs assessment/ Mum's voice- advocate • Co-production? • Hubs- located to most deprived.
Flipchart 6	Improve things: • Support network for Mum ○ Early help ○ Financially ○ School ○ Navigating systems • Support with understanding particularly with long-term conditions
Flip chart 7	• Education: ○ Schools- attendance ○ Schools- nursing ○ Health visitor ○ Housing/ social care ○ Practice nurse • Local health facility: ○ Children's community nursing team ○ Virtual ward ○ Avoid A&E
Flipchart 8	Improvements: • Health visitor/ school nurse alert to multiple attendances: ○ Availability of staff ○ Addressing delay ○ Information sharing • Access to specialist nurse • Outsourcing clinics/ health pods in community centres • Healthy families team • Early help services • Education to professionals • Triage of referrals à rapid access
Flipchart 9	Improvements: • School nurse support • Community outreach offer e.g. appointment at school • Early identification of risk for preventative work • Support for food/ travel costs when attending hospital ○ Options rather than expensive franchise • Good communications regarding paediatric referral- purpose, expected wait time and advice for any exacerbation whilst waiting Good practice • Barnardo's scheme in place providing a support worker following A&E attendance to consider holistic needs • MRI (Manchester Royal Infirmary) support worker scheme for homeless people presenting to hospital

	• More Life Junior PARS (Physical Activity Referral Scheme) have funding pot to support travel/ other costs for attending clinic appointments/ physical activities and clubs

Flipchart 10	How to improve:
	• Nurse-led clinics/ Walk-in Centres
	• GP policy- need child to be seen
	  ○ Need to get past the receptionist- training
	  ○ Patient/ carer needs to be assertive though
	• Referrer-
	  ○ Has the referral reached where it should have?
	  ○ Information provided to parent/ carer- check understanding
	  ○ Families with multiple appointments-
	  ▪ Bring them in together (like dentists!)
	  ▪ Join up information
	• Pharmacy services- communications
	• Hospital- multiple admissions- trigger review

Appendix 4: Data workshop flipchart summaries

1. How do we work with different communities and neighbourhoods to support people to stay well and prevent illness?	
Focus on	**Key points**
Epilepsy and Mental Health	Useful intelligence: • Rates of neonatal CNS infections • Rates of genetic disorders • Levels of consanguinity
General	Use of both NHS System and Public Health systems. Local Authority data visible to be able to compare across authorities and neighbourhood local patterns and trends.

Looked After Children, Diabetes Mellitus and Epilepsy	• Already have increased health needs
	• Increase in numbers of Was Not Brought (WNB)/ Did Not Attend (DNA)
	  ○ Flagging and informing other services- communication
	  ○ More robust measures for flagging DNA/ WNB
	• School attendances
	• Missing information in referral
	• What are the barriers?
	  ○ Parental mental health
	  ○ Parental literacy levels
	• Involving early health (help?)
	• Early support for those at-risk families
	• Can have screening tools but what to do if no onward services to utilise.
	• Long enough appointments to address issues.

General	• Better communications between services to be aware of multiple deprivation- one service could flag another potential concern so it can be acted on more quickly. • Direct support to most deprived areas e.g. air pollution for asthma services- use the data to plan services. • Best practice example- planting of bushes that absorb more CO_2 around schools as a protective measure- could direct this approach to 'at-risk' neighbourhoods/ high traffic areas. • Need to use data to identify needs- consider A&E repeat attendance etc. ○ Presenting to different A&Es means this can be missed- need joined-up systems with shared 'flags'. • Who is interacting with the young person/ family and what opportunity is there for signposting/ information- challenge for professionals in limited time for appointments/ contacts so don't delve into wider situational issues, purely focus on their part of the system. • Supervised teeth-brushing at primary school- make it part of their daily school routine. • Provide toothbrushes and toothpaste as part of early years 'pack' so cost is not a barrier.

	• Cash First- make money available- not vouchers or forms, give money for specific items directly e.g. paying for transport, paying for food etc.

2. How do we work with different communities and neighbourhoods to improve early diagnosis?	
Focus on	**Key points**
1001 critical days- maternal mental health, from conception- in Children's Centres	• Co-morbidity- what else is going on? • Profiling- housing, area lived in, traffic • Educate parents/ professionals to identify • Helpline- volunteers • Maternity • ACEs (Adverse Childhood Experience) score • Youth Zones, clubs • Sharing of information at transitions within health

Healthy weight/ oral health	• Consider assessment process
	  ○ Are we gathering enough information?
	  ○ Are we considering other children and not just the child in front of us?
	  ○ Capacity/ ability of parents/ carers
	  ○ Themes- difficulties attending- why? Look wider
	  ○ MDT approach- sharing of information
	• Are we overwhelmed with numbers?
	• Education/ public health message- how do we influence/ change practice/ habits?
	  ○ Dental health- impact upon speech and language
	  ○ Diet- impact upon activity levels/ learning
	• Impact on emotional health
	• Role of universal services
	• Wider lens to gain further information
	  ○ Speak with school nurses
	  ○ Local communities
	  ○ Schools
	  ○ Foodbanks
	  ○ Understanding barriers- speak with families
	• Action: RCLST (Royal College of Speech and Language Therapists) health inequalities audit tool

Oral health/ mental health	Oral health: • EY prevention, LAC, SEND • Targeted approach, supervised toothbrushing, dental access Mental Health: • More provision for infant mental health services • Foetal alcohol spectrum disorder • Waiting times- neurodivergent children (delay in HCPs) • Gender diversity • School nurses backlog of work since pandemic Oral health/ mental health: • Safeguarding risk

	• Schools • Professional intelligence re. characteristics • Gap in translation help • No accurate data/ knowledge of ethnic groups

3. How do we work with different communities and neighbourhoods to improve access to treatment?	
Focus on	**Key points**

Mental Health/ Asthma	• Intelligence- shared data/ insights
	• Individual needs and access requirements
	• How can we collate and share?
	  ○ Ex-service user feedback
	  ○ Parent/ carer forums and feedback
	  ○ Co-production
	  ○ Needs within a community →from local workers → Keyworker, Early help, Youth Worker
	  ○ Groups in pathways/ offers
	  ○ Lots of workers working to connect people to services/ people/ support- how do we share this? → offers.
	• System
	  ○ Professionals don't know what's available. How can people and families?
	Mental Health
	• Do people have support networks:
	  ○ Services
	  ○ Family
	  ○ Community
	Asthma
	• Education for parents
	• Meet family/ young person where they are
	• **Individual**
	• Where have they engaged before? → suggested community safe spaces
	• How we build trust in services from other professions.

Epilepsy Mental Health	Solutions • Access to MDT (consultant, psychologist, specialist nurse) • Local hub (family)- easily accessible, free parking • Virtual options/ social media/ communications • Parent/ peer group support • Health Visitor/ Nursery Nurse/ Parent Carers/ GPs/ Primary Care/ Schools/ School Nurse/ Special School Nurse/ Through all therapeutic domains • Community leaders- local radio- best ways to communicate. • Embedding cultures/ exploring barriers to engagement- identify champions • Webinars/ virtual access (free platforms/ Wi-Fi- offline options) • Community drop-ins- 24/7

	• HCP- Q code options- EHW (Education, Health and Wellbeing) • Digital flags/ GDPR- action following data • Explore patient journey • Text (free to reply/ text reminders appointments) • What does family/ CYP need- co-production • Consideration of various personalities • Person-based planning • Advocacy/ support/ key worker • Trauma-informed/ Thrive model • Reasonable adjustments
All conditions- clinical perspective	• Poverty, cost of travel, parenting • Join up of intelligence across the system • Joint Strategic Needs Assessment • Schools- 1st language information- local authority • Health profile for each school- Local Authority Public Health (Annual) • Location of services, access (transport/ bus routes etc.) • Health Visitor, School Nurse, Imms and Vaccs workforce • Children's centres and family hubs • Schools- can collect and give information- indication of deprivation, space to deliver health care provision? • Pre-school • Pupil Premium- SEND, Free School Meals, Education Health and Care Plans • SENCo returns • Safeguarding information • Family Hubs/ Best Start funding (0-2 years)

4. How do we work with different communities and neighbourhoods to improve experiences and outcomes of treatment?	
Focus on	**Key points**

0-25 years, Looked After Children, Transition	• Data?
	• Health assessment
	• Numbers
	• Dentist attendance
	• →Adverse Childhood Experiences
	• →robust Multi Disciplinary Team (MDT)
	  ○ Active
	  ○ Well-funded
	  ○ Adult equivalent
	• →co-production
	  ○ Focus group
	  ○ Voice- carers, LAC child
	• **→Joined up IT systems**
	• →Youth workers, PHE curriculum
	• **Reduce inequality across GM- Mental Health Support**

Homelessness	• Gaps in NHS data on the population:

	○ Manchester City Council ○ Third Sector Organisations ○ National Databases • Gaps in data on service provision: ○ Heterogeneous service provision ○ Ability to share data across services • How do we identify patients in this cohort? ○ Identifying at every stage ○ Difficulties in 9-5. Monday to Friday ○ Care provision • How do we identify and expand good practice? ○ Linking with communities ○ Urban medical practice **OPPORTUNITIES** • Better data synthesis→ by linking with community services and across services • Education for health service providers with patient voices • Working with families to build successful relationships